**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**296 – 314**

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| **296** | Submitter name | [redacted] |
| Submitter organisation | Wairarapa, Hutt Valley, Capital and Coast DHBs |

**Submission on the Draft Refreshed New Zealand Health Strategy and Draft Roadmap of Actions**

**Prepared by**

**the Service Integration and Development Unit (SIDU) on behalf of Wairarapa, Hutt Valley, Capital and Coast DHBs**

**Key Contact:** [redacted]

**5 December 2015**

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1. **Introduction**

Wairarapa, Hutt Valley and Capital and Coast District Health Boards (DHBs) welcome the opportunity to comment on the *Draft Strategy-Future Direction (Draft Strategy)* and *Roadmap of Actions (Roadmap)* as part of the Refreshed New Zealand Health Strategy consultation process.

The *Draft Strategy* aligns with the 3 DHBs’ strategic priorities[[1]](#footnote-1) and provides strategic ‘hooks’ on which we can link our local level activity to national strategic priorities.The Sub Regional DHB Boards Vision is a whole of health system approach and to develop an integrated service approach to improve:

* preventable health and empowered self care;
* provision of relevant services close to home; quality hospital services including highly complex care for those who need it;
* a focus on improving the health of our local people, families and communities; and
* reducing inequalities within our population**.**

Overall, we support the development of a refreshed *Draft Strategy* and associated *Roadmap*. We note that the *Draft Strategy* continues on the path of incremental change. It, keeps elements of strategies that are effective, and incorporates a longer term view into health services and health outcomes.

However incremental change is not enough. The  *Draft Strategy* could be bolder particularly with respect to national and regional service planning and is silent on infrastructure. It is important that the *Draft Strategy* considers the place of national services and decision making on regional services. We want to see the addition of a key area – dying well [[2]](#footnote-2) and the staturory role of DHBs. Our population needs to be supported to live well and die well. The *Draft Strategy* should strengthen DHBs and stop fragmentation. It should support the Productivity Commissions report on *More Effective Services* relating to Health and Social Services. There is a need for more concrete actions including coherent policy, incentives and funding actions to facilitate a greater focus on primary and community-based care. A serious change to key incentives in this area is essential otherwise any shift will be slow and incremental.

A considered assessment of the key policy directions is needed, in particular:

1. the desire and need to shift more services into community settings;

2. greater working across sectors to address determinants of health (and other key social outcomes);

3. further and faster progress on reducing inequalities; and

4. what the policy, regulatory, infrastructure, funding, information technology, workforce etc barriers are and what needs to be done to address these.

This should then be reflected in the actions (the *Roadmap*).

The actions in the *Roadmap* should be reviewed to identify interventionsd/ actions that more strongly support the *Draft Strategies* directions and outcomes.

We support the approach that builds on existing good relationships and system enhancements.

We believe that the suggestions above and those that follow will strengthen the *Draft Strategy* and *Roadmap* and bolster the outcomes that the *Draft Strategy* aims to achieve.

Feedback is structured according to the headings of the *Draft Strategy.*

1. **Health in its wider context, challenges and opportunities**

**2.1 Pressures on health and health services**

We support that the *Draft Strategy* places health and health services in a wider context. A thorough identification of challenges and constraints in a wider context is vital because most of the determinants of health lie outside of the health system. The *Draft Strategy* points to potential and existing gains from cross-government partnering, particularly for Māori; health gains can be leveraged across a wider social service context as health, disability and social services become more coherent and pull together for favourable health and social outcomes (as illustrated by Fig. 3). We strongly support this alignment of strategies across government services.

Non communicable diseases (NCDs) will impact significantly on health service resources in the future. Obesity is emerging as the leading risk factor for health loss.

To lessen the impact of NCDs on individuals and society, a comprehensive approach is needed that requires all sectors, including health, social services, education, and others, to work together to reduce the risks associated with NCDs, as well as promote the interventions to prevent and control them.

**2.2 Evaluation and planning**

*The Draft Strategy* points to a significant increase in evaluation and planning capability across the whole health sector. If we are to take an investment approach which requires robust intervention logics and skills in evaluation, then there should be a corresponding increase in funded capacity within the health sector.

**2.3 The future we want**

We support the principle of equity that underpins the *Draft Strategy* to achieve fair health outcomes for our populations and cultures. However, we note that the *Draft Strategy* contains an implicit assumption that there will be savings that result from some of the actions. However, demographic and epidemiological drivers mean that there may be no savings, simply a demand for more of the same or a need to reinvest in different areas of service. At a DHB level these pressures create a need for robust prioritisation systems that use the principles underpinning the strategy in resource allocation. We recommend the development of robust prioritisation systems that make all criteria explicit when trading off different demands on the health dollar and that are supported from the Centre when applied appropriately. Support from the Centre to apply robust processes and make good decisions is essential.

DHB prioritisation occurs within a national prioritisation process that not many New Zealanders are aware of. Currently there is a gap in New Zealand public’s understanding about how much money we have to spend and what trade-offs need to be made to deliver a fair mix of services within the total health dollar available. We recommend that the Ministry of Health’s officials work with colleagues across government to develop mechanisms to engage with the public to have such discussions.

We note that sustainability and stewardship are themes in the *Draft Strategy* and the *Roadmap*.

* 1. **Investment approach at a DHB level**

**2.4.1 Underpinning principle**

The narrative surrounding the intended outcomes for the investment approach are reasonable and the intended outcomes make sense (detailed in the *Draft Strategy*, page 4). However, the implementation of an investment approach will be vital to maintain the integrity the principles that underpin the *Draft Strategy*. We note the approach needs to be applied thoughtfully, tested and refined on a defined service area before wider application.

At a DHB level we take a population approach to the way we fund and plan the mix of services in our Districts.

**2.4.2 Funding**

There are tensions between a population-based and fee-for-service (FFS) base for funding and that in reality there is no perfect balance between the two methods of funding services and a mix is appropriate.

**2.4.3 Planning services**

The strength of the DHB system is that it allows a local flavour to the implementation of Government policy because it takes a ‘bird’s eye view’ of what is happening in a District. While Alliances and Primary Health Organisations have this function for particular service areas and populations, the DHB is the only organisation with an overall view for a District. This puts DHBs in a unique position of making sure the mix of services aligns with health need, not simply what the providers want to or are able to provide. For these reasons we recommend the final Strategy reinforces the role of DHBs in service funding and planning. As noted by Graham Scott – Commissioner,New Zealand Productivity Commission “DHBs are a natural option for integrated services that are needed by the populations they serve”[[3]](#footnote-3). Further the Productivity Commission’s report *More Effective Social Services* notes “DHSBs would build on existing organisations and structures, with fewer of the risks of costly disruption and unintended consequences that come with completely new organisations”.[[4]](#footnote-4)

**2.4.5 Purchasing and service provision**

We note that consumer choice was a strong theme*.* We agree that it is best for citizens to access services that meet their overall needs which are decided on a mix of price, convenient hours, range of services, location etc. Therefore, there is a need for choice within the system. However, we do not recommend choice at the expense of comprehensiveness, effectiveness and efficiency of services.

1. **5 strategic themes for the Draft Strategy**

This section comments on the policy outlined in the *Draft Strategy* and the associated actions in the *Roadmap* for the first five years of policy implementation.

Our overarching comments are that the actions in the *Roadmap* should be reviewed to identify interventionsd/ actions that more strongly support the *Draft Strategies* directions and outcomes.

We note that while the first part of the *Draft Strategy* talks about prevention, more concrete actions to prevent illness should be captured in the *Roadmap.*

The *Draft Strategy* is supposed to be a sector-wide (one team) strategy but the actions are framed or at least appear to be as Ministry Actions.

* 1. **People powered**

***Draft Strategy***

As DHBs we look for principle driven, pragmatic action to improve health across the population and to make sure that our investments have maximum impact. In particular we support the *Draft Strategy’s* notion of engaging and empowering populations to take an active interest in their own health. Health Literacy is an important component in this and the investment and time required to achieve this should not be underestimated.

***Roadmap actions***

***We note that actions* proposed are very technology dependent**. Not all the people who have most capacity to benefit from health care have smartphones and data plans that allow for prompts or to make use of the technology available. We note that this is changing and will change further over time. We recommend that a range of interventions are made available.

**We support the idea of having people informed and involved**. However, we will have to be very stringent in how we hold ourselves to account for this. It is too easy to devolve responsibility without resource to meet the responsibility and to say that a population has been informed when our communications have been ineffective.

**Action 1.**  **Information and involvement** are very powerful tools to involve people in their health care. However, as noted above, for the poorest, oldest and disabled - arguably the populations who have most capacity to benefit - there may be barriers to becoming involved.

**Action 2**. **Know and design.**  Exemplars from across the country about what can be done to make the system to be more responsive are very helpful (e.g. patient posters in Emergency Departments (ED)to explain why some people are seen earlier).

Further, the fact that it is clinician-led is a way to get buy-in from an influential group in the health system and make use of their leadership and expertise. Further, involving users in service design is vital. The idea of co-design will be very helpful in identifying the bottlenecks or barriers across the health and disability system.

* 1. **Closer to home**

***Draft Strategy***

**Integration and an investment approach**

We support the focus on prevention, especially the early life, integrated services, closer to home, and the focus on wellness and prevention. These areas build on existing work and will allow us to leverage off the gains that we have already made at a DHB level.

We note there is no mention of ‘dying well’ as part of end of life care and decision making. We think this is critical and should be included.

The goals for the first five years are ambitious, in particular the vision for most services for chronic illness management to be shifted into the community. There is a need for more concrete actions including coherent policy, incentives and funding actions to facilitate a greater focus on primary and community- based care. A serious change to key incentives in this area is essential otherwise any shift will be slow and incremental.

Sufficient resources to support the change and ensure our workforce is up skilled to meet these needs is important.

***Roadmap actions***

**Action 3 - informed discussion about moving, consolidating and rationalising services** would be welcomed. Support form the Centre will be critical to facilitate this. However, as noted in 2.3 above, the sector is still new to having such conversations. Resourcing will need to be considered to meet this change process. Taking our communities on the journey takes time and this requires resourcing as well.

**Action 4 - shifting of services.** We support the moves to have different professions work to the full scope of their training.

**Action 5** - the focus on prevention, early intervention, rehabilitation and wellbeing is sensible. However this has been a focus since the last strategy – consideration needs to be given to what else is needed to achieve the outcomes sought.

Addition of actions around dying well and end of life care and choices should be added. These should include:

* Upskilling aged care facilities through specialist input, quality audits and monitoring, benchmarking admissions to hospital and ED presentations.
* Advanced Care Planning – maximising control and choice, involving family in decision making.
* Specialist palliative input to aged residential care and to community.
* Regulatory/ policy to recognise patient needs are met.

Suicide Prevention actions should also be included.

* 1. **Value and performance**

***Draft Strategy***

To make the *Draft Strategy* a success and to deliver on the sustainability goals we should be very clear about our social, financial and clinical values. We recommend that the *Draft Strategy* and *Roadmap* separate out intrinsic goals/principles (e.g. equity, sustainability) and instrumental goals that help us reach our intrinsic goals (e.g. efficiency). Otherwise, we risk missing the point of the whole health system, which is to improve health, be responsive to expectations and ensure fairness in financial contribution[[5]](#footnote-5), because we have too many high-level goals that we are trying to address.

We appreciate that some of the rationale behind the *Roadmap* action is to avoid being locked into services that are not working. We must allow new ways of working to embed throughout formative evaluation periods.

Again, the vision for the next five years is challenging. The following comments refer to funding and information system changes proposed on page 39 of the *Roadmap*. DHBs are in the best place to take the lead on funding and commissioning of services for their population because of our birds eye view.

***Roadmap actions***

**Action 7 – service user experience measures** will need to prioritise hard to reach and high needs populations to get robust information about what is not working.

**Action 8 – health outcome frameworks.** We would welcome the opportunity to participate in the development of a national framework. Since 2003 we have used outcomes frameworks to guide primary care investment. Our local evidence shows the importance of understanding the needs at community level in funding models and service delivery to get good gains.

**Action 9** – **performance management.** Streamlining current performance management structure will assist DHBs. The costs/ benefits of the framework are important. An evaluation framework must be in place so that we know whether the actions being undertaken are making a difference and whether we have reached our goals. We agree that the tight-loose-tight approach should be in place and note that in recent times some units in the MOH have struggled with this concept and taken micromanagement approaches to the development and implementation of initiatives. However local evidence does show that working collaboratively with providers in designing a performance system and key metrics and then reviewing it together can assist in quality improvement through out the life of the service agreement.

**Action 10c – contracting for equity.** We agree that contracting approaches can ensure equity. DHBs should be enabled to ask the question as to whether services should be contracted out in the first place, before moves to the contracting out phase. We strongly advise against picking any one purchasing model as the preferred one because the purchasing model needs to respond to the situation it is being used in.

**Action 11- target investments.** We understand that this proposed action aims to remedy some of the bluntness in the current funding system. However, we do not want to lose the advantages of a population-based approach. Any targeting should link to individuals in their context, not individuals separated from context.

* 1. **One team**

***Draft strategy***

We note the actions described in the *Draft Strategy* and believe that the Ministry of Health’s role as the source of Policy advice should be maintained.

***Roadmap Actions***

**Action 14 - Roles and accountabilities** and changes to regulatory settings will enable staff to work within the full scope of their practise and the system to make the most of their skill and talents. We note that this may be a long-term task as long held ways of working and attitudes may be challenged by different ways of working. However, we have to change the way that we make use of staff to respond to health need.

* 1. **Smart system**

***Draft Strategy and Roadmap actions***

We welcome the focus on a smart system. We support the use of technology as an enabler for health system improvements. We recommend that the notion of ‘smart’ system should focus on processes and good ways of working together. These processes and ways of working are captured in strategic themes 1-4. We recommend that the strategy is redrafted to emphasise that smart working is paramount but that technology is auxiliary and an enabler. Smart work would be supported by smart Information Technology (IT) solutions.

A smart system should release time for care, not distract time away from care. There is a need to line up the IT system changes in advance of supporting national analytical capability requirements. Current experience is that bespoke local solutions are often implemented to support nationally driven analytics requirements or individual DHBs work with the IT vendors directly. Further, systems are often required to provide data that they were never designed to provide or do not necessarily produce data as a by-product of people doing their job. This results in health professionals spending time doing compliance related data entry to support reporting to the Ministry. We would like the strategy (Action 18) to include a more explicit focus on national vendor management for IT system changes that support national analytical capabilities.

There is a need to ensure that data and information is provided back to the sector. Considerable data is provided to the Ministry but currently what the sector can access in a usable form is limited due to technical or policy constraints. A smart system is more than a one way flow of data and information for analytical purposes.

 For a smart ICT system to work we believe the focus should be on:

* Innovation – large complex systems can limit the speed of innovation. There are tradeoffs between local innovation and system standardisation which can suppress innovation. We need to strike the right balance to meet the demands of the sector the smart system framework and architecture need to enable rapid innovation and the sharing of innovation across the sector.
* Access to clinical record information;
* Interoperability;
* Standardisation – standards in terms of models of care, care pathway, information stands are important enablers of a smart system. We suggest investing in joined up systems based on standards will enable a system that is more responsive to the changing needs of the sector and enable earlier realisation of benefits; and
* Investment in joining up multiple systems rather than single software solutions.

In summary the technology driven elements of a smart system need to enable the other four focus areas (people powered, closer to home, value and performance and one team) to work to maximum efficiency.

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| **297** | Submitter name | National Nursing Organisations Group |
| Submitter organisation | [redacted] |

**National Nursing Organisations Group (NNOg)**

*Many roles and one profession*

**Response to the 2015 Health Strategy consultation November 30 2015**

The NNOg is made up of New Zealand’s key nursing stakeholder organisations comprising representatives from employers, educators, professional bodies. The Regulator and the Office of the Chief Nurse are part of this group but operate within the boundaries of their particular roles and responsibilities. The group provides a national forum to discuss, consult and develop consensus positions on the direction of nursing. We provide a single point of contact for the nursing profession and see a close relationship with the Ministry of Health as an important enabler in achieving the population health goals of the Ministry.

The NNOg has identified three main themes for consideration by the Ministry of Health as part of the 2015 Health Strategy refresh.

**Models of care and funding**

Historical funding models have tended to support a downstream and reactive focus to illness care.  That is they have focused on the 'tyranny of the acute' without managing to reduce the overall long term demand. In order to re-design funding models that will support new ways of working we need the MOH and DHB's to communicate, engage and partner with all relevant health and social services. We suggest, in line with the goal of keeping people well, that co-designing services and contracting with providers who have a focus on embedding community wellness across the lifespan and from a basis of equity and access should be given greater consideration.

**Workforce**

Current descriptions of primary care/primary health care exclude the work of many services which make a significant difference to wellness for vulnerable populations. Nursing/Midwifery/ Allied Health professionals/Māori providers understand the importance of upstream and early intervention to wellness. The nursing and midwifery workforce can and do provide care particularly for many groups e.g. 0-24 year olds and the elderly, outside the boundaries of the general practice model. However the value of these services is obscured by the focus on General Practice and these services are often disarticulated and fragmented by contracting structures.

Maternal health, maternal child attachment, family cohesion, absence of violence, and good health literacy are all predictors of improved health outcomes. Those working in these early years include midwives, well child-Tamariki Ora, school and public health nurses.  We would suggest critically re-examining how these workforces could be funded and employed to provide mainstream delivery of a flexible and responsive workforce to meet the demand.

**People**

Co-design is integral to people centred care and requires an understanding of what matters most to them as individuals, hapu, iwi and communities. Critical to effective engagement in co-design is personal capability underpinned by health literacy, social determinants and the ability to self-determine health outcomes. Co design is about working ‘with’ and not ‘doing to’. We would suggest providing appropriate  interventions to support capability development as part of the health strategy action plan e.g. see patient activation report from Kings Fund <http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf> .

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| **298** | Submitter name | [redacted] |
| Submitter organisation | Consumer Council and Whaanau Care Advisor |

Feedback to Ministry of Health-Consumer council 

8 members from the Consumer council plus Patient and Whaanau Care Advisor

Slide 5: Needs to acknowledge importance of support groups

Recommendation: to work with NZ housing agencies in more integrated way.

Warm up counties- when will the funding run out? Ask the PWCC board

Strategy to date: 250 interviews approx, query about consumer involvement- implies no/ little consumer engagement to date.

Written feedback can be sent in up to 4th December.

Queries about Pharmacy strategy links to this strategy- [redacted]to respond to the council with this detail.

Equitable access: Barriers- finance for Mana kids is finishing, it has proven to work- feel like we are used as a pilot site then get penalised when funding is removed. Mental health and addictions are in the same boat- people in community refused entry to hospital services.

Projects should be ring-fencing funding earlier.

Health strategy should signal clearly an inequity in equipment, access to services based on the cause of their injury. If its ACC as opposed to an acquired disability due to medical condition or birth etc. What would make a difference to the people falling through the gaps?

We don’t address what’s causing the inequity.

Closer to home: Nurses in schools in some areas, Rheumatic fever campaign, but not in general areas, only in high deprivation areas only.

Request to consider adding Nurses back in schools, due to cost savings in younger years, coming back to bite us back in later life.

Long term condition funding- for people that have common. Transport allowances-For chronic conditions.

Value and high performance:

Consider increasing scopes of roles, and allowing staff to work at upper limits.

Money wasted on duplicate/ competing systems.

Recognise and resource the NGOs and social services that provide services in the community with a health outcome

Adjust resourcing annually when the NGO or social service shows that they have increased demand and are delivering more service than previous

Realise that as the population ages the demand for service will increase and fund that accordingly in line with inflation so that the NGO can concentrate their efforts on delivering the service rather than finding the funding shortfall.

Continue to develop digital technology like Health point that can help large chunks of the community to find services appropriate to them and their whanau in the community, however also recognise that there are sectors of the community that are isolated (example older people) and some of those demographics are going to continue to grow as the population ages.  These members of our community are not only socially isolated they are isolated by a digital divide and social services are probably the most resourceful way of connecting with these people.

Work together with social services, NGOs and community groups to find the needs of the community and engage in a less clinical way?

This Strategy is an update from 2000 - what is good in the 2000 Strategy and can these be transferred to the new one?

Could not the Housing Corporation identify houses that need insulation and arrange for insulation be done asap

Regarding Older people - there are there figures to confirm that older people are still contributing financially because many of them are still working well into their 70s.  These figures can be obtained from the Ministry

Dementia - what is rationale that these figures have nearly doubled in 15 years.  If so, is there a reason for this rise?

Why are the overseas medical qualifications not accepted in NZ - there is an untapped source of highly qualified people who cannot get work e-Referrals opposed to hard files - there still seems to be lots of Clinics, Hospitals, Drs etc., that are still using paper files, thus, the information is not being transferred and it is frustrating to keep on filling in forms!

Telehealth - a great idea
**Values and high performance:**
Quote from this strategy:  "Start doing things we are not currently doing"  What are they and how do you propose to do this?
**One team:**
How do you propose to reduce the fragmentation of care in the Health system?
**Standardisation across Doctors and Hospital etc:**
How and when will this be accomplished?  What is the Budget?   What is the backup system?

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| **299** | Submitter name | John Smeed |
| Submitter organisation | The New Zealand Society of Actuaries |

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| This submission was completed by: *(name)* | The New Zealand Society of Actuaries |
| Address: *(street/box number)* | PO Box 10087 |
|  *(town/city)* | Wellington |
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| Organisation (if applicable): | The New Zealand Society of Actuaries |
| Position (if applicable): |  |

Are you submitting this *(tick one box only in this section)*:

[ ]  as an individual or individuals (not on behalf of an organisation)

√ on behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

[ ]  I do not give permission for my personal details to be released.

(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

√ Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| The Strategy identifies a number of challenges and opportunities that impact the public health sector. We note in particular the projected future funding position as identified in figure 1.5. As the population ages, so there will be increased funding pressure across health and social security and the need to review coverage and funding.With regard to healthcare, it is unusual for a government to make policy solely on public health without regard to total healthcare expenditure. In the National Health Accounts all expenditure on health is aggregated, including that on the public health system, ACC, private health insurance and out-of-pocket expenditure. The New Zealand government, through the Ministry of Health, should take up the role of stewardship across all of healthcare. The World Health Organization describes the important role of governments as stewards of health resources, saying: “the ultimate responsibility for the overall performance of a country’s health system must always lie with government. Stewardship … makes possible the attainment of each health system goal: improving health, responding to the legitimate expectations of the population, and fairness of contribution. …The notion of stewardship over all health actors and actions deserves renewed emphasis.” (The World Health Report 2000: Health systems: Improving performance 2000. Geneva: World Health Organisation. URL: <http://www.who.int/whr/2000/en/index.html>)We submit that the health strategy for New Zealand should cover all forms of health expenditure, as categorised in the National health Accounts. The OECD (*Private Health Insurance in OECD Countries*. URL: http://www.oecd.org/document/10/0,3343,en\_2649\_37407\_3391322 6\_1\_1\_1\_1,00.html) provides a useful diagram for considering how government policy on private health insurance fits into health policy and other government policy, as shown below:  |



### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| It is important to recognise that life is finite and that end of life care is also a part of the healthcare system. While deaths are currently roughly half of births each year, Statistics New Zealand project that the number of deaths will become more than 85% of the number of births by 2060. Recent analysis has identified the marked increase in health care expenditure associated with proximity to death (Blakely, T., Atkinson, J., Kvizhinadze, G., Nghiem, N., McLeod, H., Davies, A., & Wilson, N. (2015). Updated New Zealand health system costs by sex, age and proximity to death: further improvements in the age of ‘big data’ N Z Med J, 128(1422), 13-23. URL: <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1422-25-september-2015/6662>). Given this, greater recognition of the inevitability of death is an important signal in the rationing of care. We submit that the Future Direction should include reference to end of life care. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| We agree with the principles identified. In addition we support recognition of the requirement to balance these principles with the ability of New Zealand to fund health (and other) services. |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| We have limited our comments to Strategy 3 and Strategy 5.**Strategy 3 – value and high performance**We support the use of an investment approach as an appropriate mechanism for considering long term funding of healthcare initiatives. Actuaries have been closely involved in the development of investment approaches used within ACC and the Ministry of Social Development (MSD), and are similarly well placed to assist with the development of an investment approach for health. There are however important differences to consider when looking at the use of an investment approach for health relative to social welfare and ACC. For both the MSD and ACC the investment approach has initially focused on a valuation of the future liability; that is, the expected value of a “customer’s” entitlement to benefits provided by MSD and ACC. Given the nature of both of these agencies, there is a close alignment between a better outcome for the customer (however that might be defined) and a reduction in the future liability. Analysis of the drivers of change in the liability has allowed officials to develop insights into the key factors leading to improved customer outcomes.For health, similar linkages between improved outcomes for customers and a reduced liability may apply when considering preventative care. However in other circumstances it will be necessary to consider the associated “asset” created by expenditure. The “asset” being the benefits of improved quality of life, and/or increased longevity of life. This will require an adaption of the approaches used within MSD and ACC, and actuaries are well placed to assist the Ministry with this.In our view the greater long term value derived from an investment approach is gained from understanding the drivers of change in the valuation result rather than the quantum of the result itself.We note also that there are strong linkages between health and other social outcomes, such as mental illness. So an investment approach can have a purely health lens, or alternatively on other occasions should have a wider lens.Health actuaries have the skills and expertise to assist the Ministry to * Set performance / objective targets and understanding how these targets may drive behaviours;
* Apply behavioural economics to modify lifestyle; for example compliance mechanism for managing chronic disease, social bonds, incentives for employers who are able to improve staff health outcomes, or for health practitioners who achieve patient health outcome targets

**Strategy 5 –Smart System**Good quality, centrally held data is essential for high quality analysis and outcomes. Development of comprehensive data sources including both public and private expenditure on and provision of, health care services should be an objective of the Smart System strategy.Health Actuaries are well placed to analyse datasets and interpret results. |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

|  |
| --- |
| We have limited our comment on the Roadmap of Actions to areas we are qualified to comment on.**Action 10: Align Funding**. As noted above we believe better outcomes overall can be achieved by taking a total system view of health funding including ACC and private health insurance and out-of pocket expenditure. **Action 11: Target investments**. We support the development of a health investment approach. Actuaries have been responsible for the development of the investment approaches used in MSD and ACC. As noted it is our view that the approaches used within these agencies will require adaption in order to be more useful in a health environment. Actuaries are well placed to assist the Ministry with this. **Action 19: Use electronic records and patient portals**. We support the development and implementation of a national electronic health record and submit that this should include data associated with privately provided health care services. |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| --- |
| No comment |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| It seems inevitable that an ageing population will put increased pressure on healthcare funding and thus there will be a need to ration or limit publicly-provided care. Health actuaries, epidemiologists, health economists and public health specialists will be needed to evaluate broad areas of expenditure and develop evidence for the most effective use of scarce financial resources. The importance of good data on which to build evidence cannot be overstated. We recognise that any discussion of health care and funding can be politically and emotionally charged. As a consequence, evidence based decision making is essential. A well thought through and developed investment approach can become a key input to any such discussion. |

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| Submitter organisation |  |
| This submission was completed by: *(name)* | Heber Fruean  |
| Address: *(street/box number)* | [redacted] |
|  *(town/city)* | [redacted] |
| Email: | [redacted] |
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| Position (if applicable): |  |

Are you submitting this *(tick one box only in this section)*:

* : as an individual or individuals (not on behalf of an organisation)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

[ ]  I do not give permission for my personal details to be released.

(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

* Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

|  |
| --- |
| I applaud consultation process and welcome new strategy. This is a continuation of positive things to happen for the health of New Zealanders, more especially for the most vulnerable in our communities. |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

|  |
| --- |
| It is a good brief. Leaves room for many things to fit under those headings.  |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

|  |
| --- |
| • At least some acknowledgement of the 2025 goal within the strategy, • Build more regulations in our environment to support it. A Smokefree National Action Plan • The need for measurable outcomes on tobacco control, ie prevalence, consumption, uptake at year 10 targets specifically for Maori and Pacific populations. • Sufficient funding and empowerment of networks to produce a targeted, evidence-based best practice health promotion that will achieve these outcomes |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

|  |
| --- |
| What looks great does not include a smokefree Aotearoa where there is low smoking prevalence for all New Zealanders especially Maori and Pacific |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| Smokefree action plans in promotion, legislation and support, especially for high prevalence populations specifically Mari and Pacific  |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| When you eliminate tobacco, that removes a financial, health, social and emotional burden from many people.When the Govt removes tobacco product manufacturing then it would not be seen as do what I say and not what I do.  |

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| **301** | Submitter name | [redacted] |
| Submitter organisation |  |

[redacted]

[redacted]

Minister of Health’s foreword

* *Population changes, for example, mean a greater proportion of Kiwis will be older and require increased care and support.*
	+ Not absolute that increased age equals increasing care and support, but reasonable assumption.
* *Specific action plans to tackle long-term conditions are under way but need to focus on the same end goal overall to ensure our health investment achieves the best equity, health and social outcomes.*
	+ Can you say “best equity” or is that like saying “best equalness”

Future Direction

* *While we have made significant progress since then in areas such as the affordability of primary care and elective surgery waiting times, the challenges now facing the system mean there is a need for a renewed clarity of direction.*
	+ Possibly change to “need for renewed clarity of the direction.”
* *This means finding new ways of working to deliver the services we need.*
	+ Perhaps say “the ever changing services we need”
* *90 percent of New Zealanders report they are in good, very good or excellent health, the highest percentage reported across the OECD; for those aged over 75 the figure is over 80 percent (Ref NZHS and year)*
	+ Change to “report their health as good, very good or excellent”
* *Source: Ministry of Health. 2014. Health and Independence Report. Also unpublished Ministry data.*
	+ Should reference closer to source rather than use intermediate reference)

Health in its wider context

* *People working in the system carry out a wide range of activities: they provide immunisations, diagnose illness, treat injuries, deliver specialist hospital and community care, ensure safe drinking-water, and provide advice through community services such as pharmacies.*
	+ - Suggest reword so that is says some of the activities are those stated. Reading this literally it looks as though this is all it does – what about screening and oral health)
	+ *In a similar way, wider factors such as home and workplace environments also contribute to people’s health.*
		- Not sure what “vulnerable” means here. Maybe better just to say Older people are more likely to have a disability and also to have more than one health condition.
* ***Figure 1.2:*** *Health links with the wider environment*
	+ - Could rephrase. “Health is intertwined with wider environment” or “Health effects the wider Environment and the wider environment effects health”
	+ *Could slip an adjective in here such as “quality” or “improve” and replace “contribute to” with improve.*
		- Could slip an adjective in here such as “quality” or “improve” and replace “contribute to” with improve.
* *Its ‘better public service priority sets challenging targets for government agencies. These include the specific targets for the health system for immunisation and rheumatic fever prevention.*
	+ - Some health professionals may challenge rheumatic fever prevention being a “specific target” for the health system as many factors outside health directs juristriction such as household conditions and household crowding.

Challenges and Opportunities

* *Among our strengths are: a unique public health and no-fault accident compensation system, which serves the whole population throughout their lives*
	+ - * Could add including accidents that occur overseas or add visitors to NZ as well are covered, However probably gets too wordy so better to just leave as is.
* *Global challenges - Providing health and social services to increasing numbers of older people who are living longer*
	+ - * is life expectancy of 65 Year olds increasing ( good to check as this sentence implies OLDER people are living longer.
	+ *New Zealanders are living longer and every year there are more people aged over 65.*
		- Better to say “aged 65 years and older.”
	+ *Older people are also more vulnerable to disability and to having more than one health condition.*
		- * Not sure what “vulnerable” means here. Maybe better just to say Older people are more likely to have a disability and also to have more than one health condition.
	+ *Figure 1.5: Projected government health spending as % GDP*
		- Would like reference for this. As graph is solid past 2012 I assume 2013 is a real figure. This figure would not have been available in the 2013 report.
* An independent review of New Zealand’s health funding system noted three ways in which it sometimes acts as a barrier*.*
	+ - Does NZ have these barriers worse or more so than other countries?
	+ *New Zealand’s health workforce also faces challenges. It is ageing– 39 percent of doctors and 46 percent of nurses are aged over 50*
		- In itself 39% of doctors being over 50 is not surprising. If said even spread form 25-65 then 15/40=37.5% would be over 50. Nurses 22-65 so 15/43 = 36% so is ageing. Does this relate to graduate numbers.
	+ *Many of our workforce have trained overseas – 43 percent of our doctors, 34 percent of our midwives and 26 percent of our nurses – and are not permanent residents*
		- Think this is misleading as I am sure that not all foreign trained Dr, nurses and midwifes do not have permanent residency.
	+ *This means we need to continually invest in training to ensure that the skills of our health workforce can meet the health needs and expectations of care of New Zealanders.*
		- Why does the ageing and overseas trained people mean we need to invest in skills – we can just get people from other countries to do the work.
	+ *These needs and expectations are themselves changing, not only with population ageing, but also with the growing ethnic diversity in New Zealand.*
		- I do not like this. It reads like the needs and expectations are changing due to 1) ageing and 20 ethnic changes. I would have preferred to see medical technology changes and or patient use of IT second. It almost seems like NZers are blaming ethnic differences for creating the problem.
* *A focus on prevention and making healthy choices easy, through approaches at both population and individual levels, can help stop or slow the occurrence of some health conditions.*
	+ - Suggest say “can help delay the occurrence of many health conditions”
	+ *Like other sectors, the health sector can also take advantage of advances in technology and related infrastructure such as broadband.*
		- Is this the best IT term to use. I think of broadband as something old – Wi Fi been better.

People powered

* *This can involve the development of tailored services that better cater for population segments; for example, providing access to health services in community settings such as schools or churches rather than in a clinic.*
	+ Suggest –This can “lead to a population segment having tailored services for them;” for example…
* *It requires us to use data to better understand people and populations, know what works for people and why, and continuously adapt service and funding approaches.*
	+ Replace with “It requires utilise data, sometimes from different sources, to better understand people and populations. Knowing what works for people and why means we can continuously adapt services and funding approaches.
* *What great might look like in 10 years: Health and injury services provide a more consistent experience for people.*
	+ Add to list “System improvements have occurred based on people powered feedback”

Closer to home

* *Table 1.1:- Percentage of adults reporting unmet need for primary health care, 2013/14*
	+ Good to state age is 15 years and over. Also need more words to have correct meaning.
	+ *Children living in deprived neighbourhoods are more likely to be obese.*
		- Change “in deprived” to “in socio-economically deprived”
* *We are good at identifying key health problems, preventing them or slowing their deterioration, and keeping people well*
	+ - * Could be better worded.
* *This theme is about: striving for equity of health outcomes for all New Zealand populations*
	+ - * ‘Should this just say equity of health’.
	+ *To achieve this, our focus must be on removing the infrastructural, financial, physical and other barriers to delivering high-quality health services that exist within the health sector and between our sector and other sectors.*
		- Change “to delivering” to “so everyone receives not only the high quality services that exist in the health sector but also the services in other sectors that facilitate good health as well”.
	+ *The health system provides high-quality, accessible, health services that best help people live well, stay well, get well, at the lowest cost it can and within the income it has.*
		- * Change “Improvement, and engage in analysis and modelling.” To “improvement including utilising analysis and modelling.”
	+ *The service is delivered by non-clinical Māori staff working alongside clinicians and health professionals. It is available 24 hours, 7 days a week*
		- * Often people in these position, although being non-clinical, have had several years’ experience with health services. The results may not be the same if new people are employed without the background years of involvement in the health services.
	+ *Technology can perform some tasks for us, help us communicate with each other and ultimately improve our productivity.*
		- Care is needed that some of the “new data” may not match “old data”. For example BP measurement a doctors may be different to BP measurements with an ambulatory cuff.

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| **302** | Submitter name | Janice Riegen |
| Submitter organisation |  |
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| Address: *(street/box number)* | [redacted] |
|  *(town/city)* | [redacted] |
| Email: | [redacted] |
| Organisation (if applicable): |       |
| Position (if applicable): |       |

Are you submitting this *(tick one box only in this section)*:

√ as an individual or individuals (not on behalf of an organisation)

[ ]  on behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

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Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

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[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research √Other *(please specify)*: My personal perspective of having been working in healthcare and undertaking research in the field of healthy workplaces.

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| ***Health, work and wellbeing are inextricably linked*** (Black, C. 2012 p.c.). To increase people’s wellbeing, it is imperiative to understand the critical role of the workplace. “A healthy workforce is key to a healthy population” (Lisle, 2009). ‘Good work’ is one of the influences on the social determinants of health and health inequalities affecting, individuals, families, communities, socitey, business, the economy and sustainability. The workplace is a microcosm of society, an ideal place to be part of improving and influencing the health and wellbeing of all New Zealanders.**International sanpshot:*** Interantionally there has been for many years a foucs on the importance of the workplace and the part it plays in improving the health and wellbeing of nations. There is a vast amount of evidence supporting the key roles for policy makers at all levels to understand the connection and act on it
* NICE have recently released guidelines re workplace, policy and mangement to improve health and wellbeing of employees. National Institute of Health and Clinical Excellence. (2015). *Workplace policy and management practices to improve the health and wellbeing of employees*. Retrieved from https://www.nice.org.uk/guidance/ng13
* UK Public Health Responsibility Deal recognizes the importance of the workplace
* In 2008, the UK government responsed to the Black report and identified a vision ***“We want to create a society where the positive links between work and health are recognised by all…”*** (Health, Work & Wellbeing Steering Board, 2008, p.9). https://www.gov.uk/government/publications/2010-to-2015-government-policy-employment/2010-to-2015-government-policy-employment
* A recent announcement by the UK Treasury, indicates that they are taking this seriously, with acknowledgement of its critical importance. ***“Over £115 million of funding will be provided for the Joint Work and Health Unit, including at least £40 million for a health and work innovation fund, to pilot new ways to join up across the health and employment systems.”*** <https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015>
* The Work Foundation from the UK has an abundance of evidence based research to give some understanding. <http://www.theworkfoundation.com/Research/Workforce-Effectiveness/Health-Wellbeing/Health-at-work-policy-unit>
* Sir Michael Marmot and Sir Mansel Alyward, both note the importance of ‘good work’ in reducing health inequalitities and increasing wellbeing (the Marmot Review, 2010; Australian Government, Comcare, 2010). Alyward equates ***long-term worklessness as one of the “… greatest risks to public health”.*** Alyward was questioned as to where these issues should be addressed, politics, economics or the health system. He notes that given the choice, he would opt for all three: “the solution as I see it, is a dramatic change in culture of our ways of living. That includes economic and political thinking – changing people’s attitudes and beliefs across the spectrum” (Espiner, 2012, p.22).
* You comment re working from an evidence base, where is this reflected with not including the workplace as key to improving the health and wellbeing of all NZers? Dame Carol’s work has been leading the way for many years, with recognition of the requirement to have cross govt work focusing on the importance of ‘Good work’ as it influences all ages and spans. Huge research from her group, including a meta analysis ‘Is work good for your health and wellbeing?’ (Waddel & Burton, 2006)
* My own research from a few years ago, mainly from an international perspective looking at the literature to do with healthy workplaces, came up with 85,000 hits, with many linked to improving health and wellbeing. With an explosion of evidence in this area, it could have doubled since then
* The World Health Organisation (WHO) Healthy Workplaces, definition and action framework is a great place to start. Their holistic, strategic, quality improvement framework, incorporates the opportuinity under the personal health resources section for health promotion and the enterprise community brings in corporate social responsibility, but influences familes etc…… This aligns well with The Treaty of Waitangi and Te Whare Tapa Wha
* There is a realisaiton of the importance of enhanced wellbeing with Seligman identifying that there is ample evidnece suppporting “’Positive Health’ as a major public health strategy” (Youngson, 2012, p.12)
* Mindful Nation UK (Oct 2015) recognizes the role of Mindfulness in tackling a mental health crisis. Key themes of recommendations: health, educationa, **workplace**  & criminal justice <http://www.themindfulnessinitiative.org.uk/images/reports/Mindfulness-APPG-Report_Mindful-Nation-UK_Oct2015.pdf>
* Total Worker Health from America, focusing on health, safety & wellbeing http://www.cdc.gov/niosh/twh/
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| **NZ Snapshot:*** On an average an adult spends a third of their time at work, the workplace consequently has the potential to significantly impact on their wellbeing (Russel, 2009). Workplace is second to education for health promotion as identified by the MoH comissioned Literature Review
* Karacogulu from the NZ Treasury idnetified that they were looking holistically at the multiple factors necessary for wellbeing. These were individual, family, society, economy, government and the natural envriornment. The importance and influence of ‘good work’ on wellbeing at all of the levels is a critical component. He stated that “Employment underpins the whole lot” (Karacaogulu, 2012)
* NZ Treasury documents in 2010 by Anastasiadis & Holt clearly link employment and wellbeing
* There is huge opportunity to invest in the workplace. Occupational Health and Safety are in an ideal position to have inroads to workplaces. Many business now are using the evidnece base that improving the wellbeing of their workforce, improves individual & organisational health and wellbeing, their bottom line and has huge influences on society. Occ Health Nurses are already well placed, going into organisaitons, factories, reaching ‘at risk’ populations. But unfortunately there is a disconnect with few linkages to public health. There is opportunity, with an inevstment in training, support and funding of this specialty to build the workforce for sustainability towards future ways of working
* We have the Australasian Conensus Statement on the Health Benefits of Work. The MoH are signaturies to this, yet no mention or recognition of this. Current call for signaturies to be part of working party, would be a good way for the MoH to get a better understanding of the critical importance of the workplace <http://www.racp.org.nz/page/afoem-health-benefits-of-work>
* Toi Te Ora: have followed Dame Carol’s work and have excellent resources, planning <http://www.workwell.health.nz/workwell_home>
* The Health Promotion Agency recognizes the importance of the workplace: <http://www.hpa.org.nz/>

**Generic comments:*** Great to see a holistic approach, it will take time to build a culture change with systems to support this
* It is time to stop the silo working. Our small but specialized field of Occupational Health (as far as I am aware) was not even advised of this strategy. As you indicate ‘one team’, expanding our thinking, new ways of working – there will need to be a lot more invested in cross government and NZ as a whole, not just the traditional groups
* Your diagramic view notes the workplace, great to see, but as there are no real actions about how to engage or achieve them being active participants in this work

**Education focus:*** We need to have a more positive targeted education focus
* Positive Mental Health and health and wellbeing needs to start from a young age, they can contribute into influencing the next generations, but also directly their families etc
* Poor mental health, mainly depression and anxiety are set to be come the leading cause of workplace absence, there needs be a lot more focus on this at all levels and mulitple areas
 |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

|  |
| --- |
| Yes, if there was a larger focus in the working documents about the importance of the workplace would cover this.  |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

|  |
| --- |
| Again they could be applied, if workplaces were more of a focus and inclusive in the working documents and the roadmap |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| --- |
| These could be applied, if the Workplace is considered in greater depth in the documentation and road map |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

|  |
| --- |
| Again the workplace is critical to moving forward this agenda. If you want new ways of working to support the health and wellbeing of New Zealanders, stronger partnersips and changing approaches, there needs to be a stronger cross government approach and more inclusive of a wider group.A stocktake of the international evidence would contribute to identifying how to be more evidenced-based in this approach and identify the holistic, strategic approach at multiple levels needed. Intersection point between halth services, the broaders community and business environment is good, but no actions to enable this to happen. Except for vocational rehabilitation to maintain employment for people with long term conditions, which is great. We have good case manage for vocational rehab through ACC and the Partnership Programs. We need to learn from these for best practice of integration for illness and disability and they need to be supported in the workplace.Education needs to play a key role as role, at many levels. With an increase in long term conditions and other factors, it is about a culture change. Where does the ‘Nudge Theroy’ come into play?***Health Workforce:*** we must understand the need to support the health and wellbeing of the healthcare workforce to lead by example, to support, enable and empower them to become flexible and adaptable to the changing environment we require with new ways of working. We have an ageing workforce, that will have long term conditions and there is the threat of a healthcare shortage. There is a huge evidence base into increasing burnout, low morale, moral distress, depression, bullying & harrassment and more in our healthcare workplaces. If we want to attract and retain quality staff there needs to be a greater focus on this area. We have no national direction and leadership around creating healthy workplaces. A number of us are working on this, and could contribute to the knowledge base. NSH Employers in the UK are taking an active role. <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing>. There are numerous other areas internationally focusing on this. Closer to Home: needs to be broadened in its focus to be inclusive of workplaces and education. |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| --- |
| Following models of cross government work, that involve businesses and other areas. There needs to be more done on the public/private interface. To have a wider focus, to actually do a stocktake of what we actually have and use the evidenced based practices from abroad to make them work in a NZ system.Education focus on the importance of health, work and wellbeing. DHB’s and PHO’s are often medical models and not looking holistically at the whole picture. |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| --- |
| Thank you for an opportunity to contribute to this document. The holistic approach is well recognised as essential to move forward. I would have like to see more alignment with Te Whare Tapa Wha, as for many cultures, this aligns with what they relate to as their health and wellbeing. Professor Dame Carol Black has met with the previous Minister of Health and more recently with the Social Services minister. It is a shame that NZ is not taking on the extensive knowledge and work already done from other areas. I would like to have seen where the evidence came for this document more. There needs to be a huge push to educate all areas around the importance of the workplace on improving the health and wellbeing of all NZers. For many of my friends and colleagues, whom may well have contributed, especially in forums, this consultation document and the focus groups were not even known about. As you note, a key factor will be our ability to work together for improving outcomes at multiple levels. I would like to see work streams, that are inclusive of all areas firstly identified then put to work, as to how to make this work. I am keen to be involved if there is an opportunity to contribute to being inclusive of the critical role of healthy workplaces on the improving the health and wellbeing of New Zealanders. I have a vast knowledge base and a passion to move this forward.  |

**Snapshot of References for Submission to MoH Strategy 4/12/15**

By Janice Riegen (MHSc – Examining Healthy Workplaces [1st Class Honours]; PGDip HSc; BN; RN)

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| Submitter organisation | Pacific Reference Group |
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|  *(town/city)* | 160 Bealey AveChristchurch 8140 |
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| Organisation (if applicable): | Pacific Reference Group |
| Position (if applicable): | Chair |

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[x]  on behalf of a group or organisation(s)

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[x]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

**New Zealand Health Strategy Feedback Submission**

Ni sa bula vinaka, Talofa lava, Kia orana, Taloha ni, Malo e lelei, Fakaalofa lahi atu, Talofa, Tēnā koutou and Warm Pacific Greetings.

This submission is on behalf of the Pacific Reference Group. The Pacific Reference Group (PRG) is a Canterbury-wide combined group comprising representation from primary care organisations, clinicians, community organisations, Pacific health providers, Government and the Canterbury District Health Board.

The Pacific Reference Group does not deliver health services but seeks to provide support to a broad range of health organisations who work to improve the health and well-being of our Pacific communities in Canterbury.

Thank you for the opportunity to provide feedback on the draft update of the New Zealand Health Strategy. We commend the Minister on the decision to update the existing Strategy.

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| The PRG recommends the Strategy include the following three opportunities: **1. Health inequities** While addressing inequities in the health system is broadly captured within the Strategy, addressing health inequities is such a fundamental issue that it needs to be explicitly referenced in the background as a particular challenge. High quality ethnicity data is vital to monitoring and measuring progress towards achieving health equity, and informs the design and delivery of responsive health services. It is recommended that the Ministry reveals inequities by reporting all performance data stratified according to parameters of equity e.g. ethnicity and socioeconomic status. **2. Access to health services** Differential access to health care services and differences in care for those receiving services has a considerable impact on Pacific peoples’ health status. For example, Pacific peoples experience high rates of ambulatory sensitive hospitalisation, suggesting that high-quality primary health care may not be reaching Pacific peoples as effectively as other population groups. There are a number of barriers for Pacific peoples in accessing health care services. Flexible provision of these services in order to meet Pacific needs and expectations is required. Actions to meet those expectations must be clearly articulated in the Strategy. **3. Inter-sectoral collaboration – Health in All Policies** Many of the health challenges faced by Pacific peoples are highly complex and often linked. Ensuring healthy and flourishing Pacific communities requires that the social determinants of health are addressed, including transportation, education, access to healthy food, economic opportunities, and more. This requires structures that break down the siloed nature of government in order to advance inter-sectoral collaboration. One way the Strategy could achieve this is to foster and implement cross agency engagement at a national level, including local and regional government.  |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| The phrase ‘**all** New Zealanders...’ is not supported as it lacks focus on achieving equity as a priority. Initiatives that promote equity invariably lead to improved health for all. But initiatives aimed at improving health for all frequently either maintain or increase inequities. Further, the phrase ‘people powered’ is not supported. It is exclusionary and does not take into account that for many Pacific peoples barriers exist which cannot be overcome by simply ‘powering’ themselves to access health services or to take a more proactive role in their health. It is suggested that ‘people centred’ or ‘focus on people, families and whanau and communities’ is a more inclusive alternative. It is recommended that the first part of the statement be changed to read: ‘That all New Zealanders *have equitable access to resources to enable them to* live well, stay well, get well’.  |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| In order to maintain a greater focus on equity and inter-sectoral collaboration, it is recommended that Principles 1, 2, 5 and 8 are amended (italics) to read as follows: Principle 1: *Achieve health equity and optimal health and wellbeing* for all New Zealanders throughout their lives Principle 2: *A focus on improving the health* of those currently disadvantaged Principle 5: Timely and equitable access *and quality of care* for all *groups of* New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay Principle 8: Thinking beyond narrow definitions of health *and supporting improved health outcomes and health equity through collaboration with other partners who have influence over the determinants of health.*  |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| The previous comments relating to the importance of focusing on equity and ‘people centred’ as opposed to ‘people powered’ are reiterated. In terms of ensuring that an equity focus is interwoven through the 5 themes, the following are suggested as alternatives (in *italics*): 1. People *centred*, *equity focused* 2. Closer to home 3. *High quality and* value 4. One *equity focused* team 5. Smart system The healthcare system’s lack of responsiveness to the health needs of Pacific peoples has had a significant detrimental impact on health outcomes. In order for Pacific peoples to be ‘powered’, the healthcare system first has to be ‘people focused’ – specifically Pacific peoples. The ‘Closer to Home’ theme is supported. It is noted that *Ala Mo‘ui: Pathways to Pacific Health and Wellbeing 2014–2018* recognises the need to provide high quality and culturally competent health care services closer to home. The ‘One Team’ theme is supported but would be strengthened and more effective by including: (i) an equity focus; and (ii) reinforcing inter-sectoral collaboration  |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| There is a disconnect between the actions listed in the Roadmap, the 5 year vision of the Roadmap, the 10 year vision of the draft Strategy, and the principles that underlie the Strategy. For example, the draft Strategy states that ‘Māori and Pacific health models, such as Whānau Ora and the Pacific Fonofale model, are used to provide effective and accessible care responsive to their communities’ is a vision for health services in 10 years’ time. However the 5 year outcomes listed in the Roadmap make no mention of using these models, and nor do the immediate actions listed in the Roadmap. There will not be optimal development of Māori and Pacific health models as a way to provide effective and accessible health care in the next 10 years if steps leading towards this are not identified as a priority in the short to medium term. A commitment to health equity must be explicit across all action areas within each strategic theme. Actions explicitly focused on Pacific health must be comprehensively developed and all other actions require a strengthened focus on Pacific health to align with *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018*. The following suggested amendments (*italics*) do not address all of the actions but highlight some of the shortcomings of the actions listed, which for the most part, fail to adequately consider the needs of Pacific and other population groups that experience inequity in the present health system. Action 13: Improve governance and decision-making processes across the system through a focus on *equity,* capability, innovation and best practice in order to *achieve equity and* improve overall health outcomes a. \*Review governance arrangements across the system, including those of the Ministry of Health and ministerial advisory committees. b. Develop and implement a regular review of DHB governance performance. c. *Require DHBs and governance bodies to self-audit their performance in terms of an equity focus.* Action 14: The Ministry of Health will work with leaders in the system to improve the cohesion of the health system, including clarification of roles and responsibilities/ accountabilities *including for achieving health equity* across the system as part of the planning and implementation of the Strategy. a. \* The Ministry will review its structures, processes and culture to ensure it is well positioned for its stewardship role in the system and its leadership role in implementing the Strategy, including ensuring good-quality policy, *a strong equity focus* and legislative/ regulatory advice, and monitoring of equity parameters e.g. ethnicity. b. DHBs will carry out their roles and responsibilities at national, regional and local levels, including any changes to these as a result of implementation of the Strategy. Action 15: \* The Ministry of Health, with input from the system, will establish a simplified and integrated health advisory structure *that includes representation from existing Māori and Pacific national organisations* that *will* oversee health system changes and incorporates or takes into account other relevant existing national committees (e.g. the National Health IT Board, the Capital Investment Committee, Health Workforce New Zealand, the National Health Board and the National Health Committee). |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| There should be mandated equity focused reporting, ensuring that targets can only be counted as being met if the target is met for Pacific and other demographic groups that experience health inequities. An approach that mandates equity focused reporting will best support an ongoing focus on achieving health equity. Currently, service providers can reach health targets for ‘all New Zealanders’ while failing to reach the same target for Pacific. For example, a provider may ensure that 80.9% of New Zealand Europeans access a service, but only 61.5% of Pacific, resulting in a total population result that nearly reaches an 80% target. In summary, data can be reported either in an equity focused or total population manner. Both methods send very different messages to the reader; for one, equity is the focus; for the other, equity is not the focus.  |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| The PRG recommends that *Ala Mo‘ui: Pathways to Pacific Health and Wellbeing 2014–2018* be referenced in the actions for the revised NZ Health Strategy. The PRG would also like to see acknowledgement of the unique role of the Pacific Health Workforce as detailed below: • There is limited reference to the additional responsibilities that our health system places on Pacific health practitioners. For example, Pacific health improvement is the responsibility of the health system, not just that of Pacific health practitioners. However, Pacific health practitioners are expected (both by their own communities as well as by non-Pacific) to work over and above their professional obligations in order to mitigate the negative impacts of the inequities that Pacific patients experience with respect to health determinants and the access to resources needed to improve their health outcomes. • The Strategy must acknowledge and respond to the additional expectations placed on Pacific health practitioners by ensuring that the health system supports and maintains their additional training and ongoing cultural and other professional development needs. • In addition, it is imperative that the Strategy focuses on the non-Pacific health workforce and the role of the health system in ensuring that the health workforce is high quality, culturally competent, health literate and therefore fit-for-purpose to meet the needs of the Pacific population and all population groups within New Zealand.  |

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| **304** | Submitter name | Shayne Wijohn |
| Submitter organisation | Te Runanga o Ngati Whatua |
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| Position (if applicable): | General Manager – Health |

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[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

## Consultation questions

These questions might help you to focus your submission and provide an option to guide your written feedback. They relate to both parts of the Strategy: I. Future Direction and II. Roadmap of Actions.

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| The strategy emphasises a number of strengths of New Zealand’s health system. However some of the key strengths identified are not included in the opportunities component of the strategy. In particular:* A strong desire to better integrate health and social services – the integration of health, social, education and other services provides a key opportunity to reduce inequalities and improve health outcomes for patients and their whānau. It is well known that factors outside of the health sector impact on people’s health and wellbeing. The provision of services which acknowledge the links between education, employment, income and other factors and the ability for patients and whānau to manage their own health and wellbeing goals is critical. In order for this to be achieved the strategy needs to more clearly articulate the expectations for this to occur, not only in the challenges and opportunities section but also in the rest of the strategy, particularly the road map.
* Māori and Pacific health providers, connected to their communities that model integrated approached to health – there is a growing body of evidence for the effectiveness of utilising family or whānau centred approaches to improve the health and wellbeing individuals and their whānau. The opportunities section should acknowledge this and look to support building the capacity and capability of such providers to expand on the work they are doing.
* We are supportive of the acknowledgement of inequitable health outcomes in the challenges section. However, we do not think that it provides an accurate picture of the substantial and ongoing inequity in many of the health indicators for Māori. Unfortunately there is no acknowledgement of addressing inequities in the opportunities section. There is a need to ensure the strategy has a clear and explicit focus on equity to achieve Māori health gain. Initiatives that promote equity invariably lead to improved health for all. But initiatives aimed at improving health for all customarily either maintain or increase inequities. The health inequities experienced by Māori in our region include barriers such as access to and through services, service design, quality and safety and data quality. Opportunities in this area include increasing our Māori clinical workforce, Clinician and whānau health literacy, service redesign and improving cultural competency and responsiveness. There is a requirement to consider the needs of Māori exclusively from other high needs and vulnerable populations given the expectations as a Treaty of Waitangi partner.

Whilst it is acknowledged that cross-government strategies such as Whānau Ora, Social Sector Trials and others are mentioned in the background section, there appears to be very limited mention of them in the rest of the strategy. We would like to see the health strategy clearly articulate actions to support the operationalisation of such strategies.  |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| We are supportive of the focus on achieving wellness, the provision of services close to home and use of a systems approach. However, we are concerned that the statement does not have a component focusing on the reduction of inequities. This appears to be at odds with three of the eight guiding principles which are focused on equity. Furthermore, it is widely acknowledged that universal interventions have a tendency to maintain or increase inequity. There is a need to have both universal and targeted interventions to reduce inequity. In order for this to occur it is imperative that the overarching statement includes an equity component to support our sector to focus on achieving equitable outcomes. This also needs to be a focus of the strategy and the road map of actions. We believe that the statement should also include a component for putting the needs of people and their whānau at the centre of our service delivery. Providing a health service that does not operate in a way that meets the needs of its patients, within their wider whānau context, will inevitably result in increased inequity and poor health and wellbeing outcomes. The provision of whānau ora approaches has been shown to improve health and wellbeing outcomes. At the core of whānau centred approaches is the provision of services which improve whānau wellbeing and address the needs of the individual within the whānau context.  |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| We are supportive of the new principle as it acknowledges the impact the wider socioeconomic determinants of health (housing, education, income, poverty, etc) have on health outcomes. Having such a principle is also supportive of a Whānau Ora approach. We are concerned that the road map of actions does not appear to provide clear actions around supporting the implementation of Whānau Ora despite mentioning the strategy in the background section. We would also expect that the updated strategy would have more links to not only Whānau Ora but also He Korowai Oranga, which in only mentioned once, throughout the documents to support a reduction in equitable outcomes for Māori. Genuine partnership and collaboration takes a lot of energy and resource and at times remains elusive despite significant goodwill and passion. We would like to see much clearer activity in the roadmap to indicate how this will be resourced and enabled (for all partners) and how this will be measured, evaluated and appropriately strengthened. It is imperative that this also includes appropriate representation and input from Māori. Whilst we are supportive of the equity focus of some of the principles, we think there is an opportunity to strengthen the principles by including a focus on eliminating inequities in health outcomes for Māori.  |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| **People-powered** addresses co-design, individual responsibility for health and health literacy which are all important elements to consider including funding implications. We believe that there should be a component in this section which focuses on equity as well. The health sector needs to ensure that the people, activity and resources provided support a reduction in inequity rather than maintaining or increasing it. We would be even more supportive of a strategic theme that focused solely on equity and how it would be achieved. We believe this would elevate the Ministry of Health’s commitment to reducing inequity and would provide a platform for clear actions for the sector. A key component of people-powered is the capacity and capability of the workforce. We believe there needs to be a stronger focus on strengthening the workforce’s cultural competency and expanding the Māori regulated workforce. There is clear evidence that having a workforce that is more culturally responsive and reflective of the community it serves results in better health outcomes. There is mention of new initiatives across the health, disability and wider social sector which utilise a people-centred approach. The second point in this list provides a good example understanding the needs and goals of the individual and their whānau. However, we believe this could be strengthened by including a clearer link between the provision of services which are outside of the health sector to support improved health and wellbeing outcomes. **Closer to home** – we are supportive of the intent of this theme and the focus on children, whānau and long term conditions. We are supportive of obesity as a priority area but are concerned that smoking is not included due to the impact smoking has on Māori health outcomes. We believe that it is imperative to provide easily accessible and culturally appropriate services in the community and in the home. We believe that point 5 in the ‘what great looks like in 10 years’ section needs to be modified. There is already evidence that using Māori health models such as whānau ora are effective at providing effective and accessible care to their communities. Indeed, a recent report has found that a whānau centred approach has contributed to several immediate outcomes (improved access to services, increased motivating) and intermediate outcomes (improve employment, increased income, etc)[[6]](#footnote-6). The statement should focus on expanding the current level of delivery of Māori and Pacific models of health in the community primarily though the expansion of services provided by Māori and Pacific providers among other strategies. We are supportive of point eight in the list which focuses on the health system working more effectively with other agencies to improve outcomes. We believe that this point could have a stronger emphasis on the reduction of inequities. **Value and High Performance** – we are supportive of the intent of this theme and are pleased that there is mention of equity and the use of investment processes to address health and social issues. |

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| Unfortunately it appears that there are no associated actions in the road map to support a reduction in inequity. This appears to be a missed opportunity to ensure that equity of outcome is consistently applied as part of the value/investment /performance equation (as DHBs are legislatively mandated to do to address health inequality). There is opportunity here to include equity as a key health and wider system performance measure and to refocus funding to achieve this. We consider responsive services (culturally responsive and responsive to patient experience and to people with disabilities) to be a key performance measure in itself.For point 4 in the ‘what great might look like in 10 years’ section we believe this should be strengthened to focus on accelerating health outcomes for Māori and other populations with inequitable outcomes whilst also focusing or reducing inequities. **One Team** we are supportive of the intent of this theme and are pleased with the focus on strengthening the roles of people, whānau and communities as carers and the focus on leadership and the flexible workforce. We believe a key component of this theme is true integration of services across the health sector and also starting to improve integration with other agencies to support improved health and wellbeing outcomes. We acknowledge that integration remains a challenge and opportunity for DHBs in many areas and will require appropriate support at all levels to achieve. We are supportive of increasing investment in the NGO and volunteer sector. **Smart System** We agree that technological solutions are an important element of focus; however Smart Systems should also be linked to multidisciplinary team approaches and to integrated care. Technology also need to be seen as more than enabling patients to make their own appointments and review tests online (although this is important); the potential of technology application to drive more efficient, faster, safer and more accurate care is a broader conceptualisation. |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| Action 3: Shift services1. It is important that any redesign of services includes consultation with Māori which is not articulated in the activity. The activities in this section seem vague and do not provide enough detail. We would like to see investigation into building capacity of Māori providers to deliver improved primary care and specialist secondary services closer to home.

Action 5: Tackle long-term conditions and obesityd. An important risk was noted under Action 5d ; requiring partnering with only with strong/best performing partners. We are comfortable working with high performing organisations and providers and sharing the learnings across the system as is proposed here, however there is a risk in *requiring* partnerships with those best performing/most equitable providers. Some of our providers have high performance because they deliver services to well-resourced populations. We see significant learnings to be had from providers and organisations working in areas of deprivation or high need and still managing to achieve reasonable performance or more importantly to maintain or improve their performance. We are concerned that requiring partnership only with top performers would risk our support for smaller or poorer performing providers in key localities or populations of interest to the DHB. Losing DHB focus or support could mean that some providers (eg Māori or Pacific providers) services are unsustainable and this would risk our ability to improve equity, choice and patient experience. .e. With regards to population segments, greater effort must be directed to Māori and Pacific ) population groups in targeted prevention, promotion and early interventions for diabetes and cardiovascular disease. Actions in this area should support sound moved from risk assessment to appropriate management. The Diabetes Service Level Alliance in Auckland DHB and Waitemata DHB is an example of planned activity to make this shift.Action 8: Improved performance and outcomesDevelop and implement a health outcomes framework. We have DHB outcomes frameworks and a Māori Health Outcomes framework *Nga Painga Hauora* among other service level outcomes frameworks developed or in progress. We are aware of the importance of measuring outcomes to determine whether we are meeting need, however determining/attributing contribution of an intervention or programme to that outcome remains challenging. We note our position that it is important that we continue to report intermediate outcomes/outputs that we can be confident are linked to outcomes (by evidence) and are clear about our contribution to these. We are happy to work with the Ministry on reducing the administrative burden of our current performance reporting and reconsider selected outcomes and programme outputs in terms of ongoing monitoring. We have begun such a process in our integrated contracting approach with Pacific and Māori Providers under the Māori Health Outcomes Framework *Ngā Painga Hauora*.Action 13: Clarify roles, responsibilities and accountabilitiesWe would like to see a component included around the measurement of DHB governance performance for equity of health outcomes for Māori. It is also imperative that the Ministry of Health have much clearer accountability for the achievement of reduced inequity for Māori. Action 16: Build system leadership, talent and workforceWorkforce development needs to include a focus on empowering providers of care and the population and to enable inclusive approaches to addressing inequalities (including the range of disabilities). In addition, there needs to be explicit actions to improve the current workforce’s cultural competency and expanding the Māori regulated workforce across all levels including leadership and management.  |
| Action 3: Shift services1. It is important that any redesign of services includes consultation with Māori which is not articulated in the activity. The activities in this section seem vague and do not provide enough detail. We would like to see investigation into building capacity of Māori providers to deliver improved primary care and specialist secondary services closer to home.

Action 5: Tackle long-term conditions and obesityd. An important risk was noted under Action 5d ; requiring partnering with only with strong/best performing partners. We are comfortable working with high performing organisations and providers and sharing the learnings across the system as is proposed here, however there is a risk in *requiring* partnerships with those best performing/most equitable providers. Some of our providers have high performance because they deliver services to well-resourced populations. We see significant learnings to be had from providers and organisations working in areas of deprivation or high need and still managing to achieve reasonable performance or more importantly to maintain or improve their performance. We are concerned that requiring partnership only with top performers would risk our support for smaller or poorer performing providers in key localities or populations of interest to the DHB. Losing DHB focus or support could mean that some providers (eg Māori or Pacific providers) services are unsustainable and this would risk our ability to improve equity, choice and patient experience. .e. With regards to population segments, greater effort must be directed to Māori and Pacific ) population groups in targeted prevention, promotion and early interventions for diabetes and cardiovascular disease. Actions in this area should support sound moved from risk assessment to appropriate management. The Diabetes Service Level Alliance in Auckland DHB and Waitemata DHB is an example of planned activity to make this shift.Action 8: Improved performance and outcomesDevelop and implement a health outcomes framework. We have DHB outcomes frameworks and a Māori Health Outcomes framework *Nga Painga Hauora* among other service level outcomes frameworks developed or in progress. We are aware of the importance of measuring outcomes to determine whether we are meeting need, however determining/attributing contribution of an intervention or programme to that outcome remains challenging. We note our position that it is important that we continue to report intermediate outcomes/outputs that we can be confident are linked to outcomes (by evidence) and are clear about our contribution to these. We are happy to work with the Ministry on reducing the administrative burden of our current performance reporting and reconsider selected outcomes and programme outputs in terms of ongoing monitoring. We have begun such a process in our integrated contracting approach with Pacific and Māori Providers under the Māori Health Outcomes Framework *Ngā Painga Hauora*.Action 13: Clarify roles, responsibilities and accountabilitiesWe would like to see a component included around the measurement of DHB governance performance for equity of health outcomes for Māori. It is also imperative that the Ministry of Health have much clearer accountability for the achievement of reduced inequity for Māori. Action 16: Build system leadership, talent and workforceWorkforce development needs to include a focus on empowering providers of care and the population and to enable inclusive approaches to addressing inequalities (including the range of disabilities). In addition, there needs to be explicit actions to improve the current workforce’s cultural competency and expanding the Māori regulated workforce across all levels including leadership and management. Action 18: Strengthen national analytical capability People are increasingly able to interact with the health system online – this requires online functionalities to provide information to users in their preferred language with funding earmarked for ongoing support. English should not be the only language option available to individuals who wish to access information about the health system online.Action 20: Strengthen health research and technologyIt is important to acknowledge that a lot of useful health services analysis, research and evaluation is conducted in DHBs and within providers. This can be usefully strengthened, rather than the singular focus on the Health Research Council suggested in this action.  |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| There is a growing call for equity focussed health reporting. An approach that mandates equity focussed reporting will best support an ongoing focus on achieving health equity. Currently, service providers can reach health targets for ‘all New Zealanders’ while failing to reach the same target for Māori or other priority populations. For example a breast screening provider may ensure that 80.9% of New Zealand Europeans access a service, but only 61.5% of Māori, resulting in a total population result that nearly reaches the 70% target. There are a number of ways to require, provide and enable equity focussed reporting across the sector and we recommend leadership and investment in this area.Investment in evaluation of activities with a focus on equity of outcomes for Māori. This can feed into programme and intervention development and support accelerated health gain for Māori and other high needs populations. In fact, we believe there should be a theme dedicated to the measurement and monitoring of outcomes and successes in the strategy which in turn provides a suite of activities in the road map.  |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| There is a definite lack of an equity focus for Māori throughout the strategy and the associated road map. This is unfortunate given the legislative and strategic levers that are in place to support accelerated health gain and reductions in inequitable health outcomes for Māori. We would like to see this addressed by providing more detailed reference to inequity throughout the strategy and clear activities to address inequity in the road map.  |

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| **305** | Submitter name | [redacted] |
| Submitter organisation | Te Whare Punanga Korero Trust |

Tena koe

The purpose of this email is to advise that at a joint meeting of Te Whare Punanga Korero Trust which represents the eight iwi of Taranaki, and the Taranaki DHB held on Tuesday 24 November 2015 the following resolution was passed unanimously:

**RESOLUTION:**

That the joint boards make a submission to the NZ Health Strategy consultation that there be explicit linkage to Pae Ora as described in He Korowai Oranga, embedded into the strategy.

MOVED:           [redacted]

SECONDED:    [redacted] CARRIED (Unanimous)

The Chairs of either or both Boards may advise you of this direct however I wanted to ensure you have their position recorded.

Nga mihi

[redacted]

Chief Advisor Maori Health | Taranaki District Health Board | 27 David Street,  Private Bag 2016 | New Plymouth 4310 | Taranaki, New Zealand

Taranaki whanui,he rohe oranga - Taranaki together, a healthy community

|  |  |  |
| --- | --- | --- |
| **306** | Submitter name | [redacted] |
| Submitter organisation | Quality, Improvement & Patient Safety, Canterbury DHB |
|  |  |
| This submission was completed by: *(name)* | [redacted] |
| Email: | [redacted] |
| Organisation (if applicable): | CCDHB |
| Position (if applicable): | Executive Director Quality, Improvement & Patient Safety  |

Are you submitting this *(tick one box only in this section)*:

[ ]  on behalf of a group or organisation(s)

(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Professional association (DHB - National Quality & Risk Managers Group)

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

|  |
| --- |
| * 1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?Must focus on all agencies working together and not in silos (a whole of system approach especially coordinating services for children) , and work plans aligned to the strategy.
* Landscape of health needs is changing –i.e. immigrant population
* Aging workforce, capability & aging population
* Evidence based care – i.e. surgical interventions = rationalised and rationalisation of services
* Challenge of not stifling innovation when really we still have a number 8 wire mentality
* Transport system-rurality and ability to provide services closer to home, health service delivery in the right place for the patient
* Ensure the focus on quality care and patient safety is protected in times of fiscal constraint as it does add value
* Standardisation
* Centres of excellence not trying to everything in all DHB’s
* Equitable access to funding , ability for variable funding
* Review of the funding model
* Challenge all of govt working together
* Social pressures
* Unmet need moving forward
* IT Smart systems –fast moving environment
 |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

|  |
| --- |
| * Live Well Stay well Get well need to add die well
* Personal accountability on consumers to access services
* Active partnerships in service delivery
* Consumer engagement
* Providing accessible services
* Issues with connecting words such as ‘providing’
 |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

|  |
| --- |
| Yes |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

|  |
| --- |
| * System needs to be an intelligent,
* That we learn from failures and prevent reoccurrence across the system
* Across whole health system – journeys of care
* Public/Private provider interface –variable access across country
 |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

|  |
| --- |
| People Powered Need to add actions that people will be empowered to take control of their wellness and able to navigate the system Self accountability Value and High Performance Point 7 change to “System” user experience measures Point 12 should point seven in that a higher priority, interpreted across whilst system not just health One TeamStructure /process/outcomeSmart System 18 Improve transparency, change to health and social system Focus on improvement Not restrictive to health Improved information sharing  |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| --- |
| Inter-sectorial working Engage technical experts |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| Ensure risks to the implementation and roadmap are identified and discussed across the sector This is a good document (A3 Summary great too.. very visual & clear)HSQC need to align programmes to this strategy to support and enable DHB’s to succeed  |

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| **307** | Submitter name |  |
| Submitter organisation | Acupuncture NZ |
|  |  |
| This submission was completed by: *(name)* | Acupuncture NZ (NZRA) |
| Address: *(street/box number)* | P.O.Box 14-105 |
|  *(town/city)* | Wellington |
| Email: | nzra@acupuncture.org.nz |
| Organisation (if applicable): | Acupuncture NZ (NZRA) |
| Position (if applicable): |  |

Are you submitting this *(tick one box only in this section)*:

[ ]  as an individual or individuals (not on behalf of an organisation)

[x]  on behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

[ ]  I do not give permission for my personal details to be released.

(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[x]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[x]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| At present acupuncture and Chinese medicine are an under-utilised aspect of healthcare that is already working in NZ. There is an increasing number of rigorous studies from New Zealand, and around the world, to show that acupuncture and Chinese medicine offer a low-cost, effective treatment option in a world of budget constraints and a burgeoning call on health services.The opportunity here is proactively to integrate acupuncture and Chinese medicine into the health service by providing a safe, effective and economic healthcare option. |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| --- |
| This statement does capture what New Zealanders want from our health system, however it does seem ironic that MOH is promoting working as “one team in a smart system” when acupuncture continues not to be included under the HPCAA. Although acupuncture has been included in ACC legislation since 1990, and in 2012 there was a recommendation that acupuncture should become a registered profession, until this discrepancy is rectified acupuncture will struggle to reach its full potential in New Zealand and to provide more widely the services that will enhance and promote the health and wellbeing of New Zealanders. It is well established evidentially that acupuncture provides an effective and holistic healthcare model and therefore should be integrated into the “One Team” approach. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| --- |
| The set of eight principles say all the right things, however we would like to see how acupuncture and Chinese medicine fit into the model presented here. Acupuncture and Chinese medicine are a primary care model that works well alongside other medical models and allied health practices. As such, practitioners of acupuncture and Chinese medicine often already work collaboratively within integrated healthcare environments. Many of our members would welcome the opportunity to work more extensively with other sectors throughout the health professions. |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| --- |
| 1: People Powered: People in New Zealand, and around the world, are turning to acupuncture and Chinese medicine to help with their health needs in greater numbers every year. The fact that they find the treatments to be cost-effective, non-invasive and continue to return for more must lead one to question why acupuncture is not more fully integrated into NZ’s Health Strategy. We would like to suggest that, in order to adapt the health services that are offered to New Zealanders, acupuncture and Chinese medicine should be investigated further for MOH to ensure collaborative health promotion.2: Closer to home: Acupuncture is a highly mobile practice, which means a practitioner can easily move from one location to another. Therefore moving between the wider community and traditional institutional treatment environments can be done with ease. This then creates the opportunity to provide care closer to where people live and to promote health and wellbeing to the whole of a family and whanau.“Great”, in 10 years’ time, would have to see acupuncture as a fully integral part of the health system, providing safe and effective healthcare for all New Zealanders. We would like to see a closer working relationship, both in the governance roles and within the health and wellbeing community, which encompasses all that Chinese medicine and acupuncture can offer to all New Zealanders. |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

|  |
| --- |
| Acupuncture New Zealand is a people-focused organisation suitable for all populations. A health strategy that includes us would increase the effectiveness of prevention, early intervention, rehabilitation and wellbeing for many conditions, including obesity. We consistently improve our safety with regular reviews of our practices. To include us would give New Zealanders access to the ultimate “One Team.”  |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| We would like to see that New Zealanders **get well** first, then **stay well** and ultimately **live well**. |

|  |  |  |
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| **308** | Submitter name | [redacted] |
| Submitter organisation | OraTaiao – the New Zealand Climate and Health Council |



[www.orataiao.org.nz](http://www.orataiao.org.nz/)

**OraTaiao: The New Zealand Climate & Health Council’s submission**

**on the Update of the New Zealand Health Strategy**

**Introduction:**

This submission is completed by [redacted], OraTaiao Co-convenor and is submitted on behalf of OraTaiao: The New Zealand Climate and Health Council.

Contact details:

Address: 261 Morrin Rd, St Johns, Auckland 1072

Email: [redacted]

Phone: 021 411 743

OraTaiao: The New Zealand Climate and Health Council [www.orataiao.org.nz](http://www.orataiao.org.nz) (hereafter ‘OraTaiao’ or’ The Council’) is an incorporated society of over 400 health professionals deeply concerned about the impacts of climate change on health and health equity.

OraTaiao represents the non-governmental organisation, academic/research and professional association sectors (<http://www.orataiao.org.nz/about>).

OraTaiao welcomes the opportunity to discuss climate change implications for health and health equity with the Ministry and we would like to present an oral submission.We agree that the health of our population is a positive investment and fundamental to New Zealanders’ wellbeing.

**Consultation Questions:**

**Challenges and opportunities**

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system.

Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

We appreciate that the words ‘climate change’ are on page 5 of the Future Direction document under ‘Global challenges’ – ‘the health and social consequences of climate change’.

However, we are concerned that there is no other mention of climate change throughout the Strategy Future Directions or Road Map. The Strategy fails to make the connections between long-term health conditions and well-designed climate action which can reduce the prevalence of these conditions, and fails to consider the profound threat of already committed climate changes to New Zealanders’ health, health equity and our health services.

Climate change threatens to be so pervasive in its impacts on the social and environmental determinants of health that it has been identified as *“the biggest global health threat of the 21st century”* by the Lancet Commission.[1] The Lancet Commission has also suggested that *“tackling climate change could be the greatest global health opportunity of the 21st century”.*[2]

Our health sector, led by the Ministry in partnership with other agencies governmental and non-governmental, must rapidly get up to speed with both the health opportunities and threats posed by global and local climate changes. This requires much more sophisticated analysis than simply looking at the implications of already committed extreme weather events and sea level rises as local government is starting to do. As an example, we note that the draft strategy projects government health spending as a percentage of GDP as far ahead as 2060; even predicting GDP is fraught with difficulty as both NZ and the world (including our trading partners) grapple with loss and damage from climate changes.

These are not business-as-usual times and complexities of interactions globally, within our economy and society, and even within health service delivery, cannot be underestimated or ignored. OraTaiao’s experience to date in interactions with various central and local government agencies is that the dots are not being joined yet. Any further delay in starting to understand the connections between climate changes and health means missed opportunities at considerable economic loss and unnecessary suffering by New Zealanders.

**Opportunities**

Moving from treatment to prevention is one of the *aligning behaviours* desired by the Strategy. One of the greatest “healthy choices”, and preventative interventions is to modify climate change. Examples of co-benefits to health of addressing climate change are described in the appendix. As previously stated, in many instances, healthier lifestyles and diets will modify both the current overwhelming burden of long term conditions, and reduce greenhouse gas emissions, with economic and health benefits realised long before the benefits to climate change are apparent.

Well planned measures to address climate change can have substantial health (and health equity) co-benefits. This fortnight, the UN Climate Change Summit meets in Paris to determine emissions reductions targets to keep our world from warming above the internationally agreed limit of 2’C. There is increasing support for reducing the world’s emissions to close to zero by mid-century and agreeing upon a new warming limit of 1.5’C in the existential interests of both small island states such as our Pacific Island neighbours and making a liveable future more likely for our children and grandchildren. The likely direction of emissions reductions offers unique opportunities to make significant and immediate improvements to the growing prevalence of long-term non-communicable diseases – *carpe diem*.

The Climate and Health Council would like to see cross-sector research completed in 2016 that quantifies the health co-benefits (including fiscal savings) from climate actions – such as increasing New Zealanders’ activity levels as a part of their daily travel, insulating all New Zealand homes, and widespread dietary change to substantially reduce meat and dairy intake in favour of lower emissions plant-based food. There is already a substantial body of overseas and local literature available, and the Council offers support to the Ministry of Health in establishing this project.

We refer the Ministry to the NZ Medical Association (NZMA)’s position statement on Health and Climate change,[3] as well as a number of submissions to the Ministry for the Environment by health NGOs on New Zealand’s Climate Change Target.[4] The Royal Australasian College of Physicians recognises the urgency of action by doctors and health care systems to address Climate Change in its campaign, Doctors for Climate Action ([http://doctorsforclimateaction.org](http://doctorsforclimateaction.org/?doing_wp_cron=1449194377.6446399688720703125000) ).

Combatting both long term conditions and climate change requires another recommended aligned behaviour: moving from fragmented health sector silos to integrated social responses. OraTaiao urges the Ministry of Health to provide leadership in addressing the health and equity impacts of climate change. The Council encourages collaborative work with other agencies to rapidly reduce greenhouse gas emissions, while transitioning to a healthier, renewables-based economy.

OraTaiao believes that the Strategy could be instrumental in raising awareness of the adverse impacts of climate change on health, and the substantial health gains of mitigation and adaptation. Increased awareness of health professionals, management, governments and communities, must lead to action in order to ensure that the health, economic, and climate opportunities are grasped.[5]

The Health Strategy should encourage the health sector, particularly DHBs, to rapidly reduce its own emissions towards carbon neutrality.

The Health Strategy and the Ministry of Health should have a role in:[5]

* Increasing awareness amongst health professionals, governments and communities about the health implications of climate change and the need for health promoting mitigation and adaptation
* Making sure Climate change policy improves population health, accords with Te Tiriti o Waitangi, and that creates a more equitable, just and resilient society
* Placing public health and equity at the centre of climate change policy
* Including climate change as a consideration in all Health Impact Assessments and ‘Health in All Policies’ approaches
* The health sector leading in climate change mitigation and adaptation
* Priority for populations who are most at risk of climate change health impacts globally and in New Zealand

(refer to sections 3.3.2, 3.3.3 of the NZ College of Public Health Medicine's climate change Policy Statement [5])

**Challenges**

The 2015 Lancet Commission described Climate Change as a “Medical Emergency”.[2]. Climate Change will aggravate many of the Global Challenges listed in the draft Strategy, it undermines the social and environmental determinants of health, and as such, deserves more prominent consideration in the Strategy.

Climate change is a serious, potentially catastrophic emerging risk to public health, sustainable development and equity. Projected climate change health impacts include malnutrition, deaths and injuries from extreme events, vector-borne disease such as dengue fever, cardio-respiratory effects from air pollution, and diarrhoeal disease. More diffuse effects include mental health problems, migrant health issues and the health issues resulting from civil tension and conflict. Well-planned action to reduce greenhouse gas emissions can bring about substantial health co-benefits and will help New Zealand address its burden of chronic disease.[6]

Climate Change will aggravate many of the stated Global Challenges:[6]

* Older people and those living with long term conditions are particularly susceptible to heat waves, air pollution, food insecurity, and damage to health care infrastructure.
* Climate change increases existing infections, whether water, food, or vector-borne, and contributes to the emergence of new infections.
* Mental health sequelae are significant in children as well as adults.
* Outdoor workers and sportspeople will be exposed to excess heat, light, and pollution, causing health issues, but also limiting productive capacity.
* Climate change also increases exposure to UV light and thus we can expect increasing rates of skin cancers including malignant melanomas.
* Not only the global (health) workforce, but also our patient population will be highly mobile as changing environmental conditions drive people out of their current habitation both within New Zealand and from overseas, such as the Pacific Islands.

Extreme weather events, such as heatwaves and flooding, cause injury, disease, damage to health infrastructure, and potential deaths. They also lead to exacerbation of chronic health conditions, mental health sequelae, and put extra stress on health and social care professionals.

An important example of unforeseen effects of climate change-enhanced extreme weather events impacting health and health services in New Zealand itself, is from the flooding which hit the Hutt Valley in May 2015. There was one death, but we are also aware of at least three ‘near misses’. One near miss concerned a patient with chronic respiratory disease (under the care of a specialist OraTaiao member) who was discharged from hospital that day, with arrangements for domiciliary oxygen to be delivered the same day. The patient had to divert to a family home for several hours before reaching the intended discharge destination. The patient’s oxygen did not make it through the flood waters and arrived the following day. Additionally, Wellington Hospital was unable to admit from, or discharge to the Kapiti Coast that same day. Some healthcare communication systems were down over subsequent days.

The health sector itself, is a high emitter of greenhouse gases, and therefore adds to the burden of ill health which it subsequently treats. The Strategy should direct health services to reduce greenhouse gas emissions as a matter of urgency. Carbon neutrality is the goal.

**The future we want**

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

We suggest:

(i) a whole-of-life approach to health so that all New Zealanders ‘start well, live well, stay well, get well, end well’ and

(ii) that we will be ‘people-centred’ which is more inclusive and suggestive of health as an experience of well-being by people (rather than relating to buildings and equipment).

We note that there appears to be an undue emphasis on “getting well” and inadequate reference to both “living well”, and “staying well”.

The definition of ‘health and wellbeing’ appears to be missing.

We assume this is te whare tapa whā (the four cornerstones of health):

taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health).

Guiding principles: a set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

We support the refreshed guiding principles, but note that these will be challenged by climate change as elaborated below:

1. *The best health and well being possible for all New Zealanders throughout their lives*

Climate change poses significant risks to physical and mental health throughout life, but those at the extremes of age are particularly vulnerable.

1. *An improvement in health status of those currently disadvantaged*

Climate Change will further disadvantage those currently disadvantaged in New Zealand society. The vulnerability include those living with long term conditions and socioeconomic deprivation.

1. *Collaborative health promotion and disease and injury prevention by all sectors*

Extreme weather events, such as heatwaves and flooding, cause acute trauma, damage to health infrastructure, and potential deaths. They also lead to exacerbation of chronic health conditions, mental health sequelae, and put extra stress on health and social care professionals.

1. *Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi*

Maori have particular sensitivity to climate impacts for a variety of reasons including their traditional bonds to the natural environment, and frequency of socioeconomic deprivation. Tackling climate change to improve population health thus helps to build a more just, equitable and resilient society in keeping with Te Tiriti o Waitangi.

1. *Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay*

Note that our research indicates that climate change is likely to widen existing inequities.[6]

1. *A high-performing system in which people have confidence*

Yes.

1. *Active partnership with people and communities at all levels*

Yes.

1. *Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing*

This principle needs to be reflected in wider government policy for it to be meaningful. We support the addition of this principle, leading to a ‘Health in All Policies Approach’ throughout government departments. Thus policy makers in all sectors would automatically consider the health and equity implications of any public policy developed, through routine Health Impact Assessments.

The Ministry must lead, promote, and take ownership of a ‘Health in All Policies Approach’ across all of government. This WHO-espoused approach to public policies across sectors systematically accounts for the health implications of all policy decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.[1]

**Five strategic themes**

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

OraTaiao welcomes the opportunity to discuss this in detail when presenting our oral submission.

**Roadmap of Actions**

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

OraTaiao welcomes the opportunity to discuss this in detail when presenting our oral submission.

**Turning strategy into action**

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

OraTaiao welcomes the opportunity to discuss this in detail when presenting our oral submission.

**Any other matters**

7 Are there any other comments you want to make as part of your submission?

Firstly, we append the previous letter of 10 September 2015 to the Minister of Health by OraTaiao: The New Zealand Climate & Health Council outlining our original recommendations regarding the NZ Health Strategy. We hope that this can be seriously considered in developing a Health Strategy that responds to the challenges and opportunities NZ faces from now on.

Secondly, OraTaiao is cautious about the Strategy’s inclusion of links with those “in industry” as a feature of the “one team approach”. The World Health Organization has drafted guidance which may be helpful for the Ministry to consider, “*WHO will exercise particular caution….when engaging with private sector entities or other non-State actors, which are negatively affecting human health or affected by WHO’s policies, norms and standards.”*

We are disappointed that the Strategy does not refer to the excessive production and consumption of unhealthy foods and tobacco promoted by commercial interests. These activities drive some of the great health challenges of our century, namely obesity, cardiac and respiratory diseases, cancer, tobacco and alcohol-related morbidity and mortality. Antibiotic resistance has become a major cause of morbidity, mortality and cost in our hospitals, and is largely due to the overuse of non-therapeutic antibiotics in livestock agriculture. These same excesses of production and consumption also change our climate.

OraTaiao is also concerned about the potential pervasive impacts on health and on climate change responses, of international trade and investment agreements. The Council believes it to be appropriate that the Strategy acknowledges these concerns, and that the Ministry commits to mitigating the potential threat. It is imperative that New Zealand retains the ability to directly protect the health of its population in the future, and indirectly protect health and health equity, by responding promptly to mitigate climate change. It is particularly concerning as international authorities, including the WHO, World Medical Association, and the UN Special Rapporteur on the right to health, have expressed their concerns regarding the potential risks to public health which could arise from trade and investment agreements.[7]

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* NZ Medical Association<http://www.nzma.org.nz/__data/assets/pdf_file/0003/42843/NZMA-Submission-to-MFE-on-New-Zealands-Climate-Change-Target.pdf>;
* The NZ Nurses Organisation<http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/3_2015-06%20MFE%202020%20Climate%20Change_NZNO.pdf>
* The NZ College of Public Health Medicine<http://www.nzcphm.org.nz/media/85832/nzcphm_submission_on_nzs_post-2020_climate_change_target__03062015_.pdf>,<http://www.nzcphm.org.nz/media/85324/2013_11_22_2._nzcphm_climate_change_supplement_1__final2_.pdf>
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**APPENDIX: ORATAIAO LETTER TO MINISTER OF HEALTH 10 SEPTEMBER 2015**

[unformatted text of OraTaiao letter, 10 September 2015]



[www.ortaiao.org.nz](http://www.ortaiao.org.nz)

10 September 2015

Hon Dr Jonathan Coleman

Minister of Health

**Dear Minister Coleman**

Thank you for involving the health sector in your review of the New Zealand Health Strategy. We commend you for the timely refresh of the Strategy acknowledging that both the major health issues, and the health sector operating environment have changed significantly over the last 15 years. We were encouraged to hear that the strategy incorporates the wider environmental context of health and wellbeing, as well as the notion of a “sustainable health system”. In considering the draft Strategy you will no doubt be grappling with many competing issues.

Climate change is a “high level” health issue that will potentiate other high level health issues (including obesity), with increasing impacts over time, for the children of today and coming generations. On the other hand, health-centred climate action offers us an unprecedented opportunity to address the underlying causes of New Zealand’s largest health problems – including cancer, heart disease, diabetes and injury. Considering climate change in the revised Strategy fits with three of the Strategy’s themes: Living well in healthy communities; a great start for children and families; fostering and spreading innovation and quality improvement.

The Ministry of Health already undertakes some work in two climate and health areas: preparedness for locked in changes in infectious disease patterns (particularly through enhanced mosquito surveillance); and providing nominal support to DHBs to undertake carbon footprinting activities.

However, there are multiple benefits to a carbon neutral/climate-protective health system that span the domains of financial sustainability, quality, health and health equity gain, and health protection that the revised Health Strategy could recognise and harness:

**Significant Financial Savings for Health Sector**

Analysis shows that most carbon reduction initiatives in health save money as well as cutting emissions. For example, the East Midlands NHS Carbon Reduction Project resulted in savings of £1.5 million and 2,556 tonnes of CO2e per annum.1-3 Some of these savings require little or no investment and result in short term financial gain (for example changing procurement decisions and behaviours), while others require greater capital commitment with longer pay-back periods (for example new energy sources for heating).

Several New Zealand DHBs have employed sustainability or energy officers and/or are undertaking CEMARSTM (Certified Emissions Measurement and Reduction Scheme). This includes Counties-Manukau, Auckland, Waitemata, Nelson-Marlborough, Capital and Coast, and Canterbury DHBs. However many other DHBs are not responding to calls from their staff and community for carbon reduction and environmental sustainability – and are unlikely to unless these are mandated by the Ministry of Health.

**Quality Improvement**

Carbon reduction initiatives can improve the quality of healthcare.3 The process of measuring the carbon footprint of healthcare pathways can highlight system inefficiencies and can be used to drive leaner, more productive pathways. For example prioritisation of disease prevention, improved integration of primary and secondary care, and better use of information/communication technology. The UK’s Royal College of Physician’s report ‘Leading for Quality’ recommended placing sustainability at the heart of all health service decision-making.4,5

**Health Gains**

Policies to cut greenhouse gas (GHG) emissions can strongly influence the determinants of health, and have a large impact on non-communicable diseases and the chronic disease burden.6-8

• Infrastructure and policy to encourage walking/cycling cuts motor vehicle emissions and air pollution, and increases physical exercise, allowing health gains for obesity, diabetes, cancer, heart disease, respiratory disease and mental health.9-12

• A healthier diet across the population (more fruit/vegetables, less red meat, less saturated fat) would cut agricultural emissions, and lower risks for many diseases, including cancer and heart disease.13

• Well insulated homes, with clean and efficient heating, cuts energy emissions as well as reducing illnesses associated with cold, damp housing.14-16

The direction of the NZ Health Strategy could stimulate health promoting climate action across Government sectors. The Ministry for the Environment has expressed a desire to work more closely with health experts on climate change mitigation health co-benefits, to assist the design of climate policy.

This fits well with the sector feedback from the Health Strategy Expert Advisory Group workshops that suggested a greater emphasis on prevention and wellness; early actions on priority conditions such as childhood obesity and mental health; and greater links with other sectors.

NZ healthcare itself has the opportunity to take a leadership role by integrating health-promoting carbon reduction into its own operations. For example, promoting active transport amongst hospital/clinic staff, service users, and visitors could reduce transport emissions and increase levels of physical activity.17 Renewable energy for hospitals would cut energy emissions and reduce health damaging air pollution.

**Health Equity Gains**

Environmental sustainability concepts are well integrated into Māori world views and models of health. Equity gains could be made if cost savings from carbon reduction in the health sector were re-invested into healthcare and preventative health initiatives for high need populations (e.g. fuel savings from transport planning could be reinvested into enhanced outreach services). Evidence shows that low carbon initiatives across other sectors can improve the health of low income populations (e.g. policy to increase cycling and walking brings health benefits to low income groups).9,18,19

**Population Health Protection**

Health-care has a very large carbon (and other GHG) emissions footprint.20 Thus the health sector is inadvertently contributing to climate change – one of the biggest health threats of the 21st century.6,7 By reducing emissions the health sector can play a part in global efforts to protect people’s health and wellbeing from the damaging effects of climate change. Additionally, cost savings from well designed, progressive carbon reduction policies can be reinvested into prevention and priority conditions.

In addition to these benefits, we note the legal mandate in the NZ Public Health and Disability Act 2000 requiring that DHBs ‘exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations’. Other health systems around the world are already well ahead of New Zealand in committing to services that are climate-friendly; and to being part of the all-sectors, all-countries efforts to address climate change and protect health.21 We note from the lists of attendees at the revised Health Strategy consultation workshops an absence of climate and health expertise, or wider expertise in the important links between local and global physical environments and health. We are therefore contributing outside the consultation process as we consider there to be significant health opportunities and efficiencies that would otherwise be missed.

**Recommendations:**

**1. That the New Zealand Health Strategy set a high level goal for a carbon neutral and climate-protective health system, in line with leading health systems internationally.**

**2. That the New Zealand Health Strategy commits to cross-government action that places health and health equity at the centre of climate policy making**

We look forward to a response from you and would like to meet with you at the earliest opportunity to discuss further how climate change can be incorporated into the revised Strategy.

We wish you well with the completion of the revised Strategy.

**Yours sincerely,**

[redacted]

**Public Health Physician and Co-Convenor of OraTaiao: NZ Climate & Health Council**

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4 December 2015

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

Wellington

**Re: Auckland DHB feedback on the draft New Zealand Health Strategy**

Thank you for the opportunity to provide feedback on the draft New Zealand Health Strategy. Auckland DHB is providing the attached submission as part of a Northern Region submission.

We have been involved in the consultation process on the refreshed strategy throughout 2015, including the most recent opportunities with the release of the draft Strategy. We have provided input into the consultation along these various stages, at different levels and in different forums. We are pleased to provide further feedback on this final draft Strategy.

The Strategy refresh is a significant opportunity to provide leadership and direction in health. Overall the strategy is simple, concise, and easy to read. It acknowledges that there have been challenges in delivering on the principles articulated in the 2000 Health Strategy, and that broad examination systems and funding are important in order to recommit to those high level principles while stretching them further to add collaborative interagency working. Some key areas we are very supportive of, and which align to DHB direction of travel, are the focus on people-centred services, co-design, system thinking, and priority areas of children and whanau and long term conditions.

We note and support the increased focus on collaborating across government (examples given include the Social Sector trials and Children’s Teams) and the indication of expansions of these approaches and new funding approaches to support this. We also support the commitment to the development of a national electronic health record and sharing of health information to support targeted intervention, integration and monitoring of outcomes.

We believe the strategy could be further strengthened. The focus on prevention, early intervention, long term conditions, children and families are important and supported. Focused evidence based actions, supported by the signalled health investment approach, are not clearly visible in the roadmap of actions. The actions appear to be a continuation of current activity. In our submission we have provided suggested ways to improve the link between the sections, and clarify the actions themselves, to meet the vision of equitable population wellness articulated in the document. Key areas could include population level strategies for long term conditions (including obesity, alcohol, tobacco control, cardiovascular disease, cancer and mental health); a focus on improved outcomes key population groups (ethnic-specific but also key groups such as older people and mental health); and an empowered and enabled workforce and population able to navigate conversations and care delivery in the most appropriate way.

We appreciate the opportunity to provide commentary and look forward to the release of the final strategy.

Yours faithfully

Ailsa Claire, OBE

**Chief Executive**

Update of the New Zealand Health Strategy

All New Zealanders live well, stay well, get well

Consultation draft

Submission form

**Auckland DHB Submission**



### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| The strategy justifiably emphasises a number of strengths of New Zealand’s health system. We believe however that there are some key areas which pose significant challenges that are not presently addressed, and some key opportunities to address them that relate to the principles and themes in the document. While we understand that this is a high level strategic document we believe that the articulation of some additional elements strengthens the ‘intervention logic’ translation of principles and strategic themes to the roadmap of action. There is not currently a clear correlation between the two sections of the Strategy and this could be a way to achieve more continuity. * There could be clearer articulation of the financial challenges of growth in our older population (driving significant health expenditure), the impact of long term conditions, and demand for access to high cost targeted drug therapies. Some DHB stakeholders felt that the need for change (working differently and funding differently) does not appear to have a clear basis in this section. The document does not clearly articulate how to resolve the financial tension between doing more cross-sectoral and prevention/early intervention work (which we support) and still managing to provide treatment services (with substantial population growth and continuing to ‘do more with less’).
* The challenge of long term conditions is noted; however the road map does not clearly address how to continue to accelerate progress in the key conditions of cardiovascular disease and cancer. We recommend providing several key well defined initiatives or agreed actions in the roadmap to address these key drivers of morbidity and early death (with a focus on groups disproportionately burdened).
* End of life care and advanced care planning are important challenges related to an aging population and long term conditions. Workforce development is a key opportunity in these areas. Patients need to be guided through often overwhelming information; and clinicians need further and focused training to navigate these conversations. Empowering our workforce and our population, and refocusing on *care* and our co-produced DHB values are concepts which stakeholders felt could provide opportunities to address some of these challenges. *Care* for both our workforce and our population was a theme highlighted by DHB stakeholders.
* Technology is important enabler and is rightfully included in the document however there is a disproportionate focus on technology without acknowledgement of workforce development (including appropriate use of multidisciplinary/multiservice/multisectoral team members), communication skills and cultural competency. The same skills are needed for long term condition management discussions and facilitating self-managed care as for advance care planning and end of life care. This involves different ways of communicating and new skills for all health professionals, and for ensuring our workforce is equipped to work at the top of their scope.
* The challenge of delivering equitable outcomes across population groups is mentioned once in this section and yet does not translate well to key opportunities or to the roadmap of actions. There are significant opportunities in prevention, early intervention, targeted resources and primary care access that can address inequitable outcomes. We believe that consideration of ‘all New Zealanders’ does not address this well.
* Ensuring we have the appropriate level of health services for the local population and how these are structured in the most appropriate way to be effective are important elements to DHB planning that could be reflected in the document. DHB involvement in planning better for the most appropriate primary care access in specific locations is an important opportunity that could be addressed. By that we mean working with our primary care providers (including private providers) such as general practices, pharmacies and NGOs in the community on what the appropriate place, number, and level and mix of service delivery is (‘right sizing’) to ensure primary care is accessible and delivers appropriate and equitable health outcomes. The Strategy does acknowledge issues for Māori and Pacific populations in accessing primary care services; however the opportunities to address these access barriers are not further addressed in the remainder of the document or in the actions.
* There is a need to ensure the strategy has a clear and explicit focus on equity to achieve Māori health gain. Initiatives that promote equity invariably lead to improved health for all. But initiatives aimed at improving health for all customarily either maintain or increase inequities. The health inequities experienced by Māori in our region include barriers such as access to and through services, service design, quality and safety and data quality. Opportunities in this area include increasing our Māori clinical workforce, Clinician and whānau health literacy, service redesign and improving cultural competency and responsiveness. There is a requirement to consider the needs of Māori exclusively from other high needs and vulnerable populations given the expectations as a Treaty of Waitangi partner.
* A key challenge in the wider Auckland region is reflecting Asian population growth and super-diversity within our services. The health disparities experienced within Asian subgroups due to barriers such as accuracy of ethnicity data, access and utilisation of health services (in particular primary care) are important. Opportunities in this area include language and progress towards a culturally competent health workforce. There is a real and emerging need to focus on Asian health as a key priority group alongside Māori and Pacific, rather than consideration under ‘Other populations.’ We also note that there is no reference to ‘refugee’ populations throughout the document, given their high needs and barriers to access and utilisation of services, language and complex health needs.
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### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| The focus on system alignment towards a shared vision and outcome of wellness is one shared by DHBs, articulated through our Outcomes Frameworks (DHB Outcomes Framework and Māori Health Outcomes Framework *Nga Painga Hauora* developed with Sir Mason Durie). The strategic themes articulated in the statement are supported by DHBs. We would like to see more clearly identified actions to operationalise this vision through the strategic themes and roadmap.Many DHB stakeholders felt that the term ‘all New Zealanders’ reduced the emphasis on equity rather than enhanced it. Particularly because the Strategy retains three key principles related to equity, including its commitment to the Treaty of Waitangi, the statement ‘all New Zealanders’ appears to undermine this position. If actions to address equity were a more prominent feature in the roadmap actions this issue may be less prominent. Several stakeholders would prefer equity to be explicit in the vision. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| The original New Zealand Health Strategy 2000 principles remain sound. There is broad based DHB support for the addition of the new principle providing a broader definition of health and cross-sector working to realise the impacts of the health system on social outcomes, but also the impact of the wider socioeconomic determinants on health outcomes (eg housing, education, employment, poverty). * We are supportive of the new principle and indeed have made progress in these areas with inter-sectoral collaboration at a number of levels for example in the Auckland Social Sector Leaders Forum, Healthy Auckland Together, the Rheumatic Fever Prevention Programme and in the vulnerable pregnant women and vulnerable children’s work programmes. These forums and ways of working are still in development and many are working towards collaboration rather than achieving it yet.
* Genuine partnership and collaboration takes a lot of energy and resource and at times remains elusive despite significant goodwill and passion. We would like to see much clearer activity in the roadmap to indicate how this will be resourced and enabled (for all partners) and how this will be measured, evaluated and appropriately strengthened.
* Evidence of genuine collaboration at all levels (from the Minister and Ministries down) was an important element noted by many DHB stakeholders. The ability for other sector partners to understand and articulate (‘speak for’) health is an important element of the success of health system interventions with benefits for other sectors (eg the Better Public Sector targets), and the impact of other sectors on health outcomes (eg housing quality on preventable hospitalisations).
* Local ability to influence and facilitate action (and accountability) in the key areas outlined in the draft Strategy could be enabled in a range of ways including moving some services currently held nationally to a regional/district approach eg disability services, mobility teams, Plunket and Lead Maternity Carers. DHBs should be held accountable for the delivery and stewardship of the local health system to achieve government policies, under clear and concise Ministry standard setting, but with considerable freedom to delivery those achievements as appropriate for our populations.
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### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| The five themes are acceptable although some DHB stakeholders felt that they appeared more as a collection of ‘good ideas’ rather than a coherent approach. Some stakeholders felt that they could be stated in a more inspirational way. * **People-powered** addresses co-design, individual responsibility for health and health literacy which are all important elements to consider including funding implications. We are already working on these elements in the DHB and appreciate the technological enablers of this approach. The workshop consultation sessions suggested that equity could be considered under the people-powered section (it is not currently and this would strengthen the section). One possible way to do this is to change the theme to **People-powered, Equity focussed** We need to also ensure that patient empowerment and engagement approaches (which we support) are not only taken up by those with the most resource as this provides potential to increase inequalities. The section on People-powered could also address the workforce eg (a) populations and patients and (b) health professionals, providers and inter-sectoral workforce. Further connections between leveraging data and population segmentation approaches under Smart System could be linked to People-powered through improved and consistent offer of services/interventions to the ‘right’ people to improve access and self-management of their health would also strengthen the section. **Community -centred** rather than People-powered was felt by some DHB stakeholders to encompass the key NGOs, community groups, and other providers (including cultural and disability associations) as key players in their ability to ensure the needs of diverse groups are incorporated into the co-design of interventions, programmes and services, particularly those where language is a barrier.
* **Closer to home** was an area where DHB stakeholders had divergent opinions. Some felt that this was ‘business-as usual’ with ongoing efforts to reorient the system towards improved access to primary services, prevention and early intervention including progress with Whānau Ora centres, Healthy Village Action Zone and Enua Ola. Overall DHB stakeholders voiced strong support for a greater focus on primary and community services (including selected secondary services as is underway in a number of initiatives such as Whānau Ora centres and the Tamaki Regeneration Project), however expressed concern that funding reorientation needs to follow system change. There was universal support for the need to focus on children and whānau and long term conditions. However prevention, early intervention and broader government policy drivers (noting the inclusion of the recently released obesity strategy) were not addressed in this section or in the roadmap. Some stakeholders felt that there was not enough evidence for why closer to home should be a key focus above other areas. The section does not mention that there are some instances where improved efficiency can be gained from regionalisation or centralisation of some high cost or specialised services. Stakeholders also note that there is likely to be a trade-off between providing more services locally and making other investments such as prevention, improving equity or providing access to drugs and interventions that prolong life such as advanced pharmaceutical therapies (eg for Hepatitis C and melanoma). **Convenient and timely access** was felt by some stakeholders to conceptualise the range of best access points across population groups and services.
* The outcomes focus of **Value and High Performance** was felt to be in alignment with DHB direction. Information drivers and performance measurement were well supported but stakeholders did not believe that the roadmap addressed how this was to be operationalised in enough detail given how much work has already gone into these areas. Again equity was noted here but this appeared to be limited and had no associated roadmap actions. This appears to be a missed opportunity to ensure that equity of outcome is consistently applied as part of the value/investment /performance equation (as DHBs are legislatively mandated to do to address health inequality). There is opportunity here to include equity as a key health and wider system performance measure and to refocus funding to achieve this. DHB stakeholders considered responsive services (culturally responsive and responsive to patient experience and to people with disabilities) to be a key performance measure in itself.
* The components of the **One Team** theme were generally agreed noting that true integration remains a challenge and opportunity for DHBs in many areas. The term ‘flexible use of the workforce’ was challenged although and a related concept was suggested in preference: that new models of care enable all members of the workforce (including the emerging area of care navigation) to work to the top of their scope. It was noted that health navigators (a workforce that is not-well-defined) are becoming ‘the answer’ in many parts of the system. How we train, resource and utilise this new workforce, who are working with some of the most vulnerable and complex patients, still needs much more consideration. The Ministry could provide the leadership in the roadmap on appropriate training pathways, skillset development and cultural competence if navigators are to become core to the One Team approach.
* **Smart System** is again a technology heavy section. We agree that technological solutions are an important element of focus; however Smart Systems should also be linked to multidisciplinary team approaches and to integrated care. Technology also need to be seen as more than enabling patients to make their own appointments and review tests online (although this is important); the potential of technology application to drive more efficient, faster, safer and more accurate care is a broader conceptualisation.
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### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| As noted previously there was felt to be a lack of connection between the generally agreed principles and themes and the roadmap. Part I of the strategy offered potential new ways of working together and suggested a new ‘health investment’ funding approach. * Most of what is in Part II, the roadmap and actions, appears to represent a continuation of current approaches. For example the roadmap does not contain large scale or new actions to match the approaches signalled in the Strategy itself; including in the areas of prevention, technology and people-centred care which are key principles of the document (eg a National Bowel Screening Programme).
* Many of the actions did not have enough detail to determine the potential to contribute to population wellness (the aim and vision of the Strategy), most notably in areas where the Ministry has already undertaken considerable work and where key initiatives could be articulated (eg cancer control, cardiovascular disease, mental health, disability, Māori Health). As noted previously enablers and measurement of cross-sectoral working are not well described.
* Although population based strategies are mentioned there is no activity indicated at this level. Our population is one of the most obese in the world and we have very high rates of alcohol-related harm and domestic violence and well documented issues with inadequate housing and continued and significant burden of ill health from smoking. These are key areas that impact on health and the social sector where there is opportunity for high level policies, population health interventions and interagency collaboration in this area.
* Partnership is mentioned but meaningful partnership with Māori (to achieve equitable health outcomes), a retained core principle of the draft Strategy, appears to be missing from the roadmap.

**Commentary on some of the specific actions:**Action 1: Inform and involve peopleIn the area of self-management education, where technology is very important, there is opportunity to focus on reorientation of the system to support self-management skills and person-to-person approaches enabled by technology rather than focus exclusively on technology.Action 2: People-led designWe support this activity, and indeed patient experience is valued highly in terms of DHB focus. However the action proposes three projects rather than a comprehensive approach or system reorientation which is where the opportunity is. Action 3: Shift servicesGiven that this has been an emphasis of the Ministry and DHBs for a number of years this section appears to lack definition and concrete activity.Action 5: Tackle long-term conditions and obesityd. An important risk was noted under Action 5(d); requiring partnering with only with strong/best performing partners. We are comfortable working with high performing organisations and providers and sharing the learnings across the system as is proposed here, however there is a risk in *requiring* partnerships with those best performing/most equitable providers. Some of our providers have high performance because they deliver services to well-resourced populations. We see significant learnings to be had from providers and organisations working in areas of deprivation or high need and still managing to achieve reasonable performance or more importantly to maintain or improve their performance. We are concerned that requiring partnership only with top performers would risk our support for smaller or poorer performing providers in key localities or populations of interest to the DHB. Losing DHB focus or support could mean that some providers (eg Māori or Pacific providers) services are unsustainable and this would risk our ability to improve equity, choice and patient experience. .e. With regards to population segments, greater effort must be directed to Māori and Pacific ) population groups in targeted prevention, promotion and early interventions for diabetes and cardiovascular disease. Targeting interventions to some high risk Asian subpopulations (eg Chinese and South Asian) will become increasing important in Auckland. Actions in this area should support sound moved from risk assessment to appropriate management. The Diabetes Service Level Alliance in Auckland DHB and Waitemata DHB is an example of planned activity to make this shift.Action 6: A great starta. This action needs to include tobacco (the health target of reducing smoking at two weeks post partum would support this addition).Action 8: Improved performance and outcomesDevelop and implement a health outcomes framework. We have DHB outcomes frameworks and a Māori Health Outcomes framework *Nga Painga Hauora* among other service level outcomes frameworks developed or in progress. We are aware of the importance of measuring outcomes to determine whether we are meeting need, however determining/attributing contribution of an intervention or programme to that outcome remains challenging. We note our position that it is important that we continue to report intermediate outcomes/outputs that we can be confident are linked to outcomes (by evidence) and are clear about our contribution to these. We are happy to work with the Ministry on reducing the administrative burden of our current performance reporting and reconsider selected outcomes and programme outputs in terms of ongoing monitoring. We have begun such a process in our integrated contracting approach with Pacific and Māori Providers under the Māori Health Outcomes Framework *Nga Painga Hauora*.Action 11: Target investmentsThis action appears to suggest that investment approaches are not currently undertaken by DHBs. We are open to understand more about the proposed health investment approach; however the information provided in this action is not clear about what this would entail. We understand and welcome the need to look wider than health benefit from health interventions, and support new investment to explore and robustly evaluate this approach. This approach, however, does not appear to be an appropriate basis for all wider health funding.Action 12: Quality and Safetya. This action refers to rest homes and we note that this should be residential care. Quality in residential care is important area but the Roadmap action does not have enough clarity on this point.Action 16: Build system leadership, talent and workforceWorkforce development needs to include a focus on empowering providers of care and the population (as noted above) and to enable inclusive approaches to addressing inequalities (including the range of disabilities). Health literacy, in its broadest sense (organisational literacy and patient literacy) is a useful mechanism to facilitate this development and the DHBs have health literacy approaches in progress to begin this work.Action 18: Strengthen national analytical capability People are increasingly able to interact with the health system online – this requires online functionalities to provide information to users in their preferred language with funding earmarked for ongoing support. English should not be the only language option available to individuals who wish to access information about the health system online.Action 20: Strengthen health research and technologyIt is important to acknowledge that a lot of useful health services analysis, research and evaluation is conducted in DHBs and within providers. This can be usefully strengthened, rather than the singular focus on the Health Research Council suggested in this action.  |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| There is a growing call for equity focussed health reporting. An approach that mandates equity focussed reporting will best support an ongoing focus on achieving health equity. Currently, service providers can reach health targets for ‘all New Zealanders’ while failing to reach the same target for Māori or other priority populations. For example a breast screening provider may ensure that 80.9% of New Zealand Europeans access a service, but only 61.5% of Māori, resulting in a total population result that nearly reaches the 70% target. There are a number of ways to require, provide and enable equity focussed reporting across the sector and we recommend leadership and investment in this area. |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| **310** | Submitter name | [redacted] |
| Submitter organisation |  |

1) People are living longer with increasing impairment, many are not treatable as such but cause a number of access issues, to the built environment, to communication channels.

2) Information and communication, the Ministry needs different forms of media for all their publications and communications ie plain/simple language with pictures, videos with sign or captions. MOH needs to ensure websites can be accessible from different forms of digital technology i.e can people zoom in on text or convert it to grayscale for black text on white background.

3) Need more research, preferably led by disabled people into what harm has been done ie sentinel events involving disabled people and what health and disability services can learn from these incidents, also research into disabled people in the workforce particularly the health and disability workforce, disabled people want to see more people like them who understand their conditions

4) With regard to the therm about services closer to home, it is more about how easily accessible it - ie services that are 5 mins away but not easy journey to get there or bad parking etc is worse that a half hour but easier more "accessible" journey. Factors include public transport, parking journey from where transportation ends to where services are i.e carpark to buildings uncovered can be a problem for many people with disabilities, sign-posting attitude of staff.

5) Need much more representation of disabled people at all levels of governance across the health and disability sector.

6) Individualised Funding: the idea is sound but it doesn't guarantee that there will be options to choose from, the purpose of IF is so that people can choose new services but in many places rural especially there are not any choices to be had.

7) Always engage and consult with disabled people.

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| **311** | Submitter name | Donna Matahaere-Atariki |
| Submitter organisation | Te Rūnanga ō Ōtākou Inc |
|  |  |
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| Organisation (if applicable): | Te Rūnanga ō Ōtākou Inc |
| Position (if applicable): | Chairperson |

Are you submitting this *(tick one box only in this section)*:

[ ]  as an individual or individuals (not on behalf of an organisation)

[x]  on behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

[ ]  I do not give permission for my personal details to be released.

(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[x]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[x]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [x]  Other professional association

[ ]  Professional association

[ ]  Academic/research [x]  Other: Ngāi Tahu Runanga

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| Te Rūnanga ō Ōtākou agree that funding arrangements contribute to stubborn disparities in access to services, and widen the gap in unmet need. We also note that the system on a whole works very well for most other population groups. The challenge remains to go forward with a clear purpose and uncompromising focus on inequity across all populations groups. Inroads achieved here would lift NZ’s health status as an exemplar. The role of local hapū and iwi is not very clear and represents a lost opportunity for building responsible and self-determining individuals, whānau and communities. Investment in local Hubs that are community and iwi partnerships with clinical expertise is the way forward to ensure that services are culturally and clinically sound and that communities are having a greater say in their health.Evidence suggests that the primary care environment is central to diminishing the rapid growth of inequalities for population groups. The leadership role of hapū and iwi with the primary care sector in partnership with MSD, CYFs, Justice, and Philanthropy, Universities including schools of Medicine, Sciences and Dentistry is an example of the potential for locally driven Hubs focused around solving some of our most endemic social problems.Te Rūnanga ō Ōtākou look forward to the implementation of the NZH Strategy and the role that we might play in its success.  |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| Great statement, it would benefit by noting that the *system* is not singular but part of the broader eco-system that we all live in. We particularly applaud the recognition of the need to focus on wellbeing and how all the other systems contribute to this. Issues of equity for vulnerable population groups such as Maori, Pacific and Older people tend to fade into the background against the needs of our under 5s. This is unfortunate and it is not about competition but rather how each of these groups can contribute to the increased health. This is because vulnerable populations can often live in the same house deepening inequalities and overlooked in the current approach and allocation of resources.Te Rūnanga ō Ōtākou have a broad vision of health that does not separate or define whanau in relation to their prevalence for disease but rather as an integral component of overall wellbeing. This requires that each part of our larger systems is focused on the active participation and engagement of people.  |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| These are great principles what we would suggest is that the principles are merely the logic and value that we might attach to people’s lives. Te Rūnanga ō Ōtākou believe that principles are only relevant insofar as they reflect the collective value of humanity. We suggest that more emphasis is placed on articulating how these principles express a desired outcome for people. |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| Te Rūnanga ō Ōtākou view a great system as being responsive and long-sighted. It is a system where people are at the heart of everything we do and that this is our measurement. Not waiting times or elective surgeries or numbers of Diabetes measures and immunisations, These are merely expectations that a system is operating. A great system would provide a number of mechanisms for commissioning care. A great system would not invest all its resource into underperforming and wieldy institutions it would trust that the community and that iwi would provide an alternative mechanism for allocating resources to meet identified needs.  |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| Te Rūnanga ō Ōtākou is supportive of the roadmap and the emphasis on people. It is a fitting and appropriate acknowledgement that wellbeing must be both people-led and dependent on the level of their agency in making good decisions based on evidence based information. |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| Te Rūnanga ō Ōtākou believes that community and iwi-led initiatives that seek to create Hubs of Wellbeing and integrated provision can support turning strategy into action. Local responsibility and partnered approaches that are supported by local stakeholders is integral to activating and producing buy-in for the strategy. |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| Te Rūnanga ō Ōtākou consider the strategy as a whole to be a vast improvement on the former strategy that focused too heavily on building institutional capability. This strategy acknowledges the complex array of systems that impact wellbeing and importantly the role of people in determining their level of wellness.We hope that the Minister and his government consider the role of commissioning noted in the report of the Productivity Commission on Social Services and the potential for innovative purchasing models to some of our most enduring social problems.We commend the Minister and his Executive Team for what we perceive as a roadmap to an extremely fabulous health system. |

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| **312** | Submitter name | [redacted] |
| Submitter organisation |  |

[redacted]

[redacted]

**1. CHALLENGES and OPPORTUNITIES**

I would have liked to see some quantification of how near to the goals of 2000 the present strategy has brought us:

e.g. one goal was to reduce the number of suicides - which I believe have risen dramatically just recently.

This update is the opportunity *'to work together to create a better system'* but unless there is a long hard scrutiny of all the **'sacred cows'** we will continue to see rising rates of conditions such as obesity, heart disease, cancer, mental illness etc.

It is disturbing to read that in fact this update does nothing to address the root causes of many of these health problems.

which lie in the inadequate and inappropriate 'treatments' themselves.

There is little point in working more closely with Police & Courts by providing mental health and addiction 'treatment' when these often make the problems worse for the individual involved.

The '*new technologies and drugs'* are likely to not only overburden the health system financially, but also impose an ever increasing toxic overload to the individual, who is already struggling with the exposure to toxic chemicals through land sea and air, contaminating food and water, and even from local authorities and health professionals who continue to dowse us all with pesticides, including herbicides, and even insisting many people ingest them without even being informed of their dangers.

In June 2015 the 100millionth! chemical was registered and there has been an exponential growth in this industry since WWII with many, if not most, not having adequate safety testing for their active ingredients, let alone the 'adjuvants', which can be even more toxic, and very rarely in conjunction with other substances they are commonly used with or applied to, and certainly there are never any studies of seeing how they work synergistically with any of the other 999,999,999 already registered - and presumably in use.

The USA alone churns out trillions of tonnes per year and yet this Health Strategy fails to mention what impact this may be having on all our lives or how it may affect our health and happiness.

It's not surprising to me to find that approximately 40% of hospital admissions are from iatrogenic illnesses; and yet the Ministry of Health continues to promote:

adding highly toxic hydrofluorosalicic acid to out drinking water - despite evidence on their own web site that teeth in non-fluoridated areas have improved more than those in the fluoridated areas - note the word 'improved', because bare statistics that are bandied about in this 'debate' never tell the whole story:

vaccinations that inject ever more toxic substance directly into younger and younger little human bodies despite it being known way back in the '60's that this Original Antigenic Sin sets up the immune system to respond inadequately, deficiently and even inappropriately, no doubt contributing to the increasing incidence of 'allergies':

even the obvious disasters of swine 'flu and gardasil have not waned this obsession and Big Pharma no doubt will keep coming up with ever more cash cows with 'convincing evidence' to add them to the schedule:

to have a virologist recommending dodgy 'flu vaccines to young and old, sick or pregnant is entirely irresponsible considering even the 'safety testing' is never done on theses groups:

the Ministry of Health stands by and lets DOC, TB FreeNZ and local councils drop highly toxic sodium monofluoroacetate directly into waterways, i.e. water supplies, and even backs them up by testing for parts per billion and declaring water 'safe', knowing full well that endocrine disruptors can do their damage at parts per trillion:

it took 40 years for WHO to offer guidelines on mercury toxicity after the disaster in Japan in the '70's;

and this year the IARC committee of WHO declared glyphosate, the active ingredient in many formulations such as Roundup, to be a probable human carcinogen.    How long will it be before the Ministry of Health protects the public from this health hazard?

There is no excuse to blame the problems of obesity and dementia on ethnic difference or an ageing population - or even climate change! - when the facts reveal, that although they may affect some ethnic groups more than others, they are problems that cut right across race and age.    Dementia is affecting younger and younger people, not just those who make it to 'old age'.

There needs to be acknowledgement of not just Maori and Pacific health providers, but also providers who cater to those of us who prefer not to undergo invasive and risky procedures but still need access to and support from health professionals who can help us regain, maintain and improve our health and well being.

**One of the challenges that needs to be added here is to reduce the exposure of the population, and indeed the environment to as many of those 100 million chemicals as we can**.

**One of the opportunities is to make sure that all of us have equality in accessing the health care of our choice - if indeed the Ministry of Health wants us all to be more in control of our own destinies.**

**2. THE FUTURE WE WANT**

'*The exciting vision for the best system in the world - and to reduce disparities in health outcomes and make sure the health system is fair and responsive to the needs of all people - young and old, from all ethnic groups, and wherever they may live*' etc., sounds great.

However until the system acknowledges the basics to human health and well being lie in providing nutrition as close to what nature provides as possible, and 'treatments' that support what the natural defence mechanism is already trying to do - to bring the individual to the best possible state of equilibrium -  the dire health statistics we already have can only get worse.

Case in point:

I have an old friend was in a dire state a few months ago (despite having 2 visits every day from home 'carers' ) but improved markedly when I could take him fresh, organic fruit and vegetable vitamised drinks and spring water every day, and leave him with nutritious meals to augment the Meals on Wheels.    When I could only visit him twice per week, and despite him having 3 carer-visits per day, he ended up in hospital and then has had to go to a resthome and now dementia unit.

For the cost of approximately $60 per week he was kept in good health but is now costing the health system $12,000+ per week.

The *'fit for the future'* system needs to encompass our evolutionary past of which we are products of.   A few hundred years of 'medical 'research' can never replace the wisdom of millions of years of nature's trial and errors, and the closer to natural that we can live and eat, the better health and well being we will enjoy.

Honouring what that difference is between a live body and a dead body must be central to any health system that seeks to maximise the benefits to 'all' - '*not just long life, but also quality of life, which maximises years of wellness*.'

R&D needs to go into delivering the freshest most nutritious and affordable organic produce to 'all':

not pouring ever increasing funds into Big Pharma's latest cash cow.

For a better future we need to heed the past:

remember radium, thalidomide, DDT, smoking, Agent orange, mercury, lead, arsenic, fluoride,swine 'flu vaccines:

and now even statins, calcium supplements, paracetamol, Gardasil and mammograms!

Look at the recent research done in NZ on vitamin C - while many of us have been enjoying the benefits of megadoses for years!   Now with super-resistant bugs it is imperative that megadoses of IV vitamin C are made widely available and accessible to all who wish to employ this safer and more effective measure - to my knowledge the bugs don't develop resistance to vitamin C.

I want the health system to provide for my needs, rather than Big Pharma's greed, by offering natural health treatments and support for my choices rather than the dogma of the day - which clearly changes every decade at least.

Preferring to rely on improving my nutrition, homeopathic, vitamin C,  and other natural remedies, and refusing what I considered bizarre procedures like mammograms has often put me outside sympathetic responses from certain health providers and I think I deserve better than that!

They have tried to make me look foolish but I can only say now "Who is the foolish one now?"   - the one that swallowed all the pills, got the mammograms and vaccines and believed they ate a 'balanced diet' of devitalised, contaminated and aldulterated food, and drank highly toxic industrial waste from their taps - or myself who experienced a wonderful improvement in health and well being when I stopped drinking the fluoridated tap water on 20th October 2012 and have continued to improve as I delete more and more toxins from my diet and home and consume an increasing percentage of organic produce as I can afford?

The shame is that not only the people who could benefit most from such changes are least likely to be able to afford them, but also they are given false assurances that by following Ministry of Health guidelines they will have optimal health and well being:  so even those motivated to improve their lot are not getting the guidance they need, and flog themselves on various fitness regimes whilst drinking ever more contaminated tap water, and thinking there is no nutritional difference between organic produce and the chemicalised alternative 'non-food', because the Ministry of Health says so!

**What I would like changed here would be:**

the acknowledgement that medical knowledge and research only scratches the surface of the complexities of nature and that any system of medicine, attempting to heal, maintain or improve the health of human beings needs to **First Do No Harm** - do nothing that would stand in the way of the millions of years of evolution that had gone into our basic defence mechanisms that are designed to keep us in optimal homoeostasis:

and find ways to work with them, rather than merely trying to stomp out symptoms in the false belief that that will 'cure' the condition - as is presently being acknowledged in the latest strategies for cancer, and in the problems with statins which has left doctors scratching their heads as to why certain people are affected more than others:   even the latest fad of inoculating with faeces from healthy guts harks back to the work that Dr Edward Bach did on bowel nosodes in homoeopathy before he refined his approach even further by developing the Bach Flower Remedies:

have a 'smart system' that utilises **every** team, to tailor the delivery to the individual and supports their choices in health care.

A smart system that is pro-active in minimising exposure of the population to harmful substances and influences:

and promotes healthy options such:

removing the GST on fresh, raw, unprocessed organic produce:

banning all unnecessary toxic chemicals such as fluoride, 1080, glyphosate, cholecalciferol, brodifacoum:

promoting non-toxic alternatives to air fresheners, microbeads, cleaning agents, vaccines, drugs etc:

and offering multiple choices to people rather than just "'toe the party line' or get no help at all" - as for mammograms etc.

3. **EIGHT PRINCIPLES**

It would be difficult to fault these eight principles as they stand:

but the devil is in the detail.

The system is driven by well meaning but misguided 'professionals' who simply follow the rule book

and never question the assumptions or dogma it is based on, and therefore can do inordinate harm:

e.g.my grandmother was as sharp as a tack until about 96 when she went into hospital for a cataract operation.

and had always avoided pills and 'interference' whenever she could:

however, understandably she became a bit disoriented away from home ,and instead of phoning family to settle her in,  they pumped her full of Melleril and she declined mentally quite dramatically following that.

Similarly with my friend, now in a dementia unit, when he went to hospital he set off a number of code oranges and got BDs pumped into him, again despite not being one for taking drugs:

at least they did start to phone me, after I complained, and as a familiar voice I was able to settle him down after a few minutes, and once he was in a room of his own, and didn't have the people moving around the ward in the middle of the night, which he mistook for intruders or 'unwelcome visitors', he caused no further problems.

However they still failed to consult over other things that could have been tried to avoid an invasive procedures which has adversely affected the quality of his life and limited his options:

and in the rest home they once again failed to phone me when there was a problem to prevent it escalating;

I begin to suspect that there is a hidden agenda to hold back until the person falls over and then get more money by having an excuse to put them in the dementia unit.

There appears to be a mindset that sees drugs as a first line of action rather than the last resort - why would you use something potentially harmful and toxic in preference to non-toxic, gentle, natural methods?   To make profits for Big Pharma of course!

**All while this is the dominating paradigm there is little hope of these 8 principles resulting in any real improvements in     our collective health status.**

4.  **FIVE STRATEGIC THEMES**

***1***

***People-powered***

It's a sad commentary as  to where our society has got to when the health system talks about

 *people taking greater control of their own health*;

when those of us who have always sought to do so have had an uphill battle and suffered much scorn

 and indignities in the process.

From a GP warning that I might turn my children orange by giving them carrot juice - he has since died of cancer and maybe could have done with some himself?

to the doctor challenging my claim of feeling so much better from not drinking the fluoridated tap water when it turns out he didn't even now where the fluoride came from - was unaware that it was toxic waste from the filthy scrubbings of the fertiliser factory chimneys and not even pharmaceutical grade poison:

and my own (now ex-) GP who failed to support my efforts in seeking answers and redress from Watercare by saying that now I didn't have symptoms there was nothing to write and besides they all drank the water at the Medical Centre and none of them were sick!

this is after years of trying to keep myself fit and healthy and wondering what on earth was wrong with me:

going on organic raw food diets,  punishing keep-fit regimes, fasts even, and worst of all trying to drink 8 glasses of water a day when in reality it was poisoning me.

Many of my symptoms that have cleared up in the past 3 years since not drinking the artificially fluoridated tap water are of relevance to what older people suffer from:

gastric distress, especially on bending down to pick things up - very uncomfortable - and the feeling of being 'waterlogged after drinking just 1/2 a glass:

unable to close my eyes in the shower whilst washing my face because of losing my balance - and often having to cling to the bannister going down stairs, and blurry vision after reading not much at all:

painful tingling in my big toes on stretching then:

most of all the inertia, like walking through treacle, impeded, lifeless, trying to 'conserve energy' to do the simplest of everyday task - dishes, walking upstairs even.

Even basic biological chemistry text books show fluoride inhibits the citric acid cycle -the main energy producing pathway in the mitochondira:

and it is acknowledged as the primary action of 1080 poison with the creation of fluorocitrate, delivering animals a prolonged and painful death that we should all be ashamed of;

and people affected by it find it near to impossible to have their complaints recognised:

( like the 2 women picnicking in the drop zone) - very much like the Vietnam vets and the people in New Plymouth exposed to the Ivan Watkins Dow factory and it's products.

The *'healthy choices'* must not be limited to those approved by Big Pharma and the health professionals that they may have bribed - like in China where the government fined GSK $400M being the sum it used to get doctors there to prescribe their products.

***Individualised Funding Allocation*** must include choice and control  to get the services that most suit the person' needs even to securing a safe water supply, natural health products and advice, and fresh organic produce, to have any real meaning and impact:

'*to encourage more self-management and shift power back to the people'*

- **& not to take it away from them to begin with!**

***2 Closer to Home***

This is sad reading to me.

Seeing the people most at risk are also the people who have been shown to be more susceptible to the adverse effects of certain public health measures such as fluoridation and vaccination;

and compounded by poor nutrition that will not be alleviated by school breakfast and lunch programmes  which deliver empty calories and faulty advice:

and in communities that can ill afford the fresh raw organic, uncontaminated, unadulterated and unprocessed food so favouring the cheaper chemicalised non-food and paying the price in health costs.

If IV antibiotics can be made available in primary and community care settings as an alternative to hospitals, then surely IV vitamin C could be made available on the same basis giving people a real choice, so they can truly take control of their own health and well being, and cut down the risk of antibiotic resistance that has become a global problem from them being the first port of call rather than the last resort . . .  and vitamin C would be much more affordable - less profit for Big Pharma though!

**It is good that Maori and Pacific Islanders cultural needs are being catered to, but it must not be forgotten that there are strong cultural traditions in families such as mine, who wish to work with nature more than with cut, burn and poison mentalities, and deserve to have their share of the health dollar allocated to meet their needs also.**

Despite the 2000 Health Strategy aiming to cut rates of obesity,

'*it is now expected to overtake tobacco as the leading risk to health':*

It is very telling that *children living in deprived neighbourhoods are more likely to be obese.:*

*and that obesity if a preventable risk factor for diabetes, cardiovascular problems, dementia, some cancers, mental illness and chronic pain  . . .  and attention problems that affect their ability to learn*.'

THis is a vicious circle whereby families cannot afford foods of high nutritional value such as fresh raw organic produce;

their poor nutrition then makes them less able to resist the toxic effects of the chemicalised non-food as well as other exposures to toxic chemicals through pesticides, fluoride and vaccines etc:

e.g. fluoride exaggerates the uptake of lead in hispanic and negroid populations and quite likely Maori and Pacific Islanders:

it also suppresses thyroid function and this alone can predispose the individual to inactivity and obesity:

it has been shown to lower IQ by a significant number of points - despite the Gluckman Review claiming it was 'insignificant' - that has now been admitted by him - and hopefully corrected???

the lack of minerals in low cost food can exacerbate these problems and even contribute to chronic pain.

My Grandmother lived to over 100 years old and loved to go barefoot whenever she could:

I have found an earthing or grounding sheet to make most aches and pains disappear overnight and this simple measure may well obviate the need for expensive operations to relieve chronic inflammation such as carpal tunnel.

Being in Auckland I should have no trouble accessing high quality care - but as my friend, now in a dementia unit found, if your needs don't match the system protocol you are worse off than ever.

***3 Value and High Performance***

THe same faulty reasoning is evident here.

There is no point in '*striving for equity of health outcomes for all New Zealand populations': and*

*'To achieve this, our focus must be on removing the infrastructural, financial, physical and other barriers to delivering high-quality health services that exist within the health sector and between our sector and other sectors.'*

when what exists within the health sector not only doesn't meet the needs of Maori and Pacific populations:

 nor those of us who do not wish to be cut, burned or poisoned:

but actually adversely affects out health and well being when we may be bullied into accepting drugs and procedures because they are the only ones on offer in the 'system', and we cannot afford to access better treatments.

It is fitting here that you only provide the example of PHARMAC's approach since that is usually the only one on offer when visiting a GP - and that is what makes such prescriptions the 3rd leading cause of death in the USA, behind heart disease and cancer.

I will never know whether megadoses of IV vitamin C would have saved my mother or my son 3 weeks later because even when I requested it, it was refused, despite there being nothing else on offer, and despite the farmer recovering from swine 'flu just a month or so previous in the neighbouring ICU!

This is not 'value' or 'high performance' - it is arrogance, dogma and neglect!

***4 One Team***

This section makes me want to run for cover before this **'One Team'** get their hooks into me!

It's not about *'strengthening the roles of people, families, whanau and communities as carers':*

it's about supporting them:

*'Getting rid of fragmentation*' sounds more like suppressing any opinions or treatments that don't fit your dogma:

and yes, you will need strong leadership to try to pull this one off - to pull the wool over all of us!

*'Collaborating with researchers'* runs the risk of influencing them to get the results that support the dogma or they don't get further funding?

If the Health Research Council was genuine in wanting to improve the overall health of the population where is the epidemiological studies to unravel the actual effects of fluoride, vaccinations etc - two sacred cows that continue to graze in the protected fields of the Ministry of Health, and should have been kicked out long ago to fend for themselves in the real world - and stand up to true public scrutiny without being cushioned by the ministry's extensive PR machine everytime someone points a finger at them.

It is surely easy enough to compare the overall health of fluoridated populations with non-fluoridated ones - rather than just dmf stats or % caries-free:

(and even here Ministry of Health's own stats already indicate that teeth have improved more in non-fluoridated areas than in fluoridated ones):

others have compared the health of vaccinated v. non-vaccinated children;

where's the data on communities level of exposure to pesticides and any association with health problems

 - as was finally recognised in New Plymouth with the Ivan Watkins Dow factory

or organic nutrition v. chemicalised non-food - overseas studies suggest a great improvement in health as I have experienced.

Have they continued the research on vitamin C?

*'There is a culture of enquiry and improvement throughout the health system, and seamless links to the New Zealand and international science communities.'*

If the first part of this statement was true then we wouldn't have the ever increasing rates of diabetes, obesity, heart disease and cancer etc because most of these things are avoidable:

 but instead our health has been sacrificed to the international non-science communities - otherwise known as Big Pharma.

Case in point:

I have lived in Auckland for the past almost 40 years and have never heard of Healthy Auckland Together:

this despite being very active in the public health field;

and once again exposes the lie contained in this vision:

*'New Zealand and international research, best practice and local innovations are shared freely and used to roll out improvements nationally.'*

Does the 'Regional Action Plan' involve ridding our city of carcinogenic glyphosate?

If anyone disagrees with any of the dogma they are shut out of everything, and this is sad because it means sacred cows are never challenged and the strategies and policies that emerge from all these discussions and workshops never address the total picture and therefore never perform as well as if they were subjected to robust scrutiny - see vaccinations, fluoridation, 1080 etc:

very good example being the weed control in Auckland City where the policy was adopted in 2013 and it was to be included in the Unitary Plan - and even when there was 'higher level check-in', and AC had a knee-jerk reaction to set up working parties and committees galore, they made sure that our community group, that has more experience than any other in this field, was shut out - yet again - because they don't want to hear anything that contradicts their intention to save a few cents in fact they merely shift the cost from their weed control budget to the health system - so the Ministry of Health should be concerned and pro-active in protecting public health in this area!

AND TAKE ACTION!

***5 Smart System***

Dr Google has indeed forced your hand on this and used wisely could be of great benefit:

however there are some pitfalls:

Nothing can replace the personal touch - as I found out from a series of anaesthetics where I recovered far better when someone held on to my arm 'going under' - never found out if it would have been better again if someone had done the same when I was emerging from the 'sleep' because they never did!!!

Information can be used against a person when it puts the in a box and they are thenceforth never given proper appraisal because of the preconceived opinions contained in their files - it can happen even without our 'advanced technology' as I found out in 1993 when North Shore Hospital registrar simply decided I must be a neurotic housewife when I took myself to hospital after realising that I was in no state to even attempt to find an appropriate homoeopathic remedy, and failed to take me seriously, almost costing my like, and resulting in losing almost a metre of valuable intestine.

Thirdly, it must be remembered that there are a significant number of people sensitive to emfs - even if banks make fun of them - then the health system needs to be able to accommodate who don't want 'high-tech' interventions - a job for the 'health navigator'?

***TURNING STRATEGY INTO ACTION***

I am sure by now anyone reading this will realise how disappointing  this Health Strategy Update is to those New Zealanders who have already chosen to take responsibility for their own health, but, find when they need a bit of support, unless they agree to invasive procedure or toxic drugs etc, they are left out in the cold.

We pay, and pay, and pay, through taxes, rates and donations, and get nothing in return:

except government led derision and scorn.

I may be a '*barking mad'* or '*whacko'* Classical Homoeopath, as the Minister of Health and his master claim:

but I am healthier than many of my peers, from reducing toxins as far as possible and using  pure water, high quality nutrition and natural treatments where I can:

indeed the Queen relies on her homoeopathic remedies also and appears to enjoy exceptional good health despite age and a very heavy work load - maybe Coleman and Key could do more 'research' whilst around the royal dinner table or cosy fireplace?

The Ministry of Health does need to take urgent action but this 'Update' is a blueprint for disaster.

Doing what you've always done, but even more so, can only result in accelerated rates of the obesity, diabetes, heart disease, cancer, dementia, allergies - the list is endless - and includes the iatrogenic illnesses as well!

***II. ROADMAP OF ACTIONS***

If the Ministry of Health is going to take the *'investment approach'* to health funding and services then it needs to break free from the stranglehold of Big Pharma and earnestly investigate the basis for good health and well being - happiness even - most of which are already known and pursued by those 'in the know'.

Supporting rather than interfering, manipulating and bullying people who are facing already difficult health choices.

The best investment in mental health is giving support to families where their primary and most important connections for the individual lie.

The present system actually breaks up those connections and invalidates them in many cases.

I am still wading through the records of my sons 'treatments' at a variety of institutions and clinics and am horrified at the approaches by the majority of them.   It was glaringly obvious that the 'disconnection' with myself (through no fault of my own and in exceptional circumstances) was pivotal to his situation, but instead there was constant erosion of it from 'highly qualified' idiots.

There was a refusal to even consider different approaches even when his condition was deteriorating.

**MY ROADMAP - INVEST IN GOOD HEALTH RATHER THAN DRUGS!**

1 FAMILY FIRST - people centred - individual in context of whatever 'family' they identify with or identifies with them.

2 SYSTEM SUPPORTS rather than dictates - provide choices people actually want - within a fair budget

3 NATURAL FIRST over and above chemicalised water and non-food, and using drugs;  as preferred treatment.

4 CREATE WELLNESS through:

warm, secure, well fed families - eliminate poverty

pure water

high quality natural nutrition

accessible and affordable to all - remove GST off unprocessed organic produce

uncontaminated air, food and water

quality open space for all - no poisoning with 1080, glyphosate, brodifacoum, cholecalciferl etc;

opportunities for activites - especially in the now clean open air

social equity

5 PROTECT THE POPULATION from - a small list of example:

undue influence of Big Pharma - that is the 3rd leading cause of death in the USA after heart disease and cancer

and is set to get even worse with the introduction of GE vaccine trials for liver cancer

Keep NZ GE-Free!

profit-driven market influences pedalling drugs, sugar, adulterated, contaminated, degraded non-food & alcohol

ban all unnecessary toxic chemicals -

permits under strict conditions for any pesticides, drugs etc deemed absolutely necessary

limit all toxic drugs to prescription - and as a last resort -

the alcohol industry

greedy politicians

6 RESEARCH & DEVELOPMENT & FUNDING - AND TRACKING PROGRESS

Big Pharma and chemical corporates, such as Monsanto have far too much influence in our lives;

Need to counter this with government driven R&D into what constitutes good health and how to achieve, maintain or improve it.

how to make high quality, fresh raw, unadulterated, uncontaminated, unprocessed food and water accessible and affordable to ALL

what natural therapies have to offer

integrate natural therapies properly into the health system to ensure they are accessible and affordable to all of us

continue research into vitamin c, and extend to homoeopathy, nutrition, and other natural therapies and products etc

comparative studies on populations:

vaccinated v. unvaccinated

fluoridated v. non-fluoridated

organic v. chemicalised non-food

history of allergic v. non-allergic families - to unravel factors

same with heart disease, cancer, diabetes, dementia etc - lifestyle factors, exposure to toxic chemicals, use of drugs &/or vaccines, medical histories etc.

plastics, microbeads, sugar substitutes, butter substituts, non-food, microwaves, emfs, smart meters, fracking, GE,

**REFERENCES - from Dr Google!**

**100 Million Chemicals!**

Neurobehavioual Effects of Developmental Toxicity - The Lancet - Neurology

[http://www.thelancet.com/journals/laneur/article/PIIS1474-4422(13)70278-3/fulltext](http://www.thelancet.com/journals/laneur/article/PIIS1474-4422%2813%2970278-3/fulltext)

<http://www.motherjones.com/tom-philpott/2015/11/usda-researcher-claims-harrassment-and-retaliation-pesticide-research>

UN Experts urge phase-out of hazardous pesticides

<http://www.un.org/apps/news/story.asp?NewsID=52002#.VmT9XygoobC>

<https://www.cas.org/content/chemical-substances/faqs>

**Unnecessary toxic chemicals**

Fluoride Officially classed as neurotoxin

<http://eatlocalgrown.com/article/13130-fluoride-classified-neurotoxin.html>

1080 for Beech Mast Unnecessary

<http://www.stuff.co.nz/environment/74695030/1080-drop-by-doc-for-beech-mast-unnecessary>

New neonicotinoid studies ring alarm bells

<http://www.radionz.co.nz/news/rural/290371/new-neonicotinoid-studies-ring-alarm-bells-greens>

**Vaccines**

Unvaccinated are Healthier than Vaccinated Populations:

<http://www.omsj.org/corruption/cfrmap>

Infant Immunity - Pregnancy

<https://www.youtube.com/watch?v=ElI5q0BWKv0&list=PLgH2vCx5TOgWuQtnPkwtwgrn5D-2pjhgc&index=2>

'Flu shot most compensated for vaccine.

<http://vaccineimpact.com/2015/flu-shot-remains-most-dangerous-vaccine-based-on-injuries-and-deaths-compensated-by-government/>

Cancer, Simian Virus 40 and Polio Vaccine Fact Sheet

[http://web.archive.org/web/20130522091608/http://www.cdc.gov/vaccinesafety/updates/archive/polio\_and\_cancer\_factsheet.htm](http://web.archive.org/web/20130522091608/http%3A/www.cdc.gov/vaccinesafety/updates/archive/polio_and_cancer_factsheet.htm)

Vaccination Affects kids Adversely

<http://www.newindianexpress.com/cities/kochi/Vaccination-Affects-Kids-Adversely/2015/07/12/article2915265.ece>

**Homoeopathy**

The Swiss Government's Remarkable Report on Homeopathic Medicine:

<http://www.huffingtonpost.com/dana-ullman/homeopathic-medicine-_b_1258607.html>

<http://www.homeopathyheals.me.uk/site/latest-news/4473-dana-ullman-s-testimony-to-the-fda-on-homeopathic-medicine>

**Obesity**

Overuse of antibiotics is making kids fat, destroying gut flora and hindering child development, study suggests.

<http://www.naturalnews.com/050576_gut_microbiome_antibiotics_childrens_health.html>

**SOCIAL EQUITY**

<http://www.actionstation.org.nz/wedontstopcaring?utm_campaign=cyfs_kids&utm_medium=email&utm_source=actionstation>

**GENETIC ENGINEERING**

<http://www.gmoseralini.org/seralinis-team-wins-defamation-and-forgery-court-cases-on-gmo-and-pesticide-research/>

MONSANTO

Triumph of "Digital Toxicology":  Why the US won't Regulate Deadly Chemicals

<http://www.globalresearch.ca/triumph-of-digital-toxicology-why-the-us-wont-regulate-deadly-chemicals/5492390>

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| **313** | Submitter name | [redacted] |
| Submitter organisation | Te Pou Matakana |

“Update of the New Zealand Health Strategy

**All New Zealanders live well, stay well, get well**

Consultation draft” (MoH)

**Feedback from Te Pou Matakana**

Te Pou Matakana aims to drive better outcomes for whānau across the North Island by adopting a ‘commissioning for outcomes’ approach. It is anticipated that this approach will lead to the collaborative and innovative behaviours needed to achieve the best outcomes for whānau. With this in mind, we are pleased to provide feedback on the draft update of the New Zealand Health Strategy.

The draft document is well structured and provides important insight into the current challenges in regards to health provision and measurement, as well as looking towards a more innovative approach towards addressing priority areas, as well as outcomes measurement.

It is pleasing to see that the Treaty of Waitangi has been used as a guiding principle during the development of the draft document, and that issues surrounding current disparities have been highlighted. While these are of significant concern, the ongoing gap in life expectancy between Māori (particularly males) and the rest of the population remains an issue and requires direct and considered investment. Theme Three makes specific reference to the issue of disparities and in particular gaps between Māori and the general population. Consideration is given to addressing these concerns, however, this Theme places no particular emphasis on Māori. For these issues to be addressed, Theme Three must be more focused in terms of investments which specifically target Māori.

Alternatively, a broader recommendation is that the strategy includes a NEW THEME. This would be a consistent with the rest of the strategy, but focus specifically on reducing disparities and have investments which directly align with this. If not, it is doubtful that the objectives of the strategy which specifically relate to vulnerable populations, those most in need (and especially Māori) will not be met, and will undermine the purpose of developing an innovative new action plan that can make new, meaningful and sustainable changes to health disparities.

The focus on developing an outcomes focused approach (as opposed to outputs approach) is a timely and appropriate development. The importance on making this development actionable is well captured in the draft strategy, it would be good to see what kind of indicators will be developed to capture the proposed outcomes. It will be important here also to consider what specific outcomes/indicators will need to be seen to advance Maori health status (across the board, and in specific priority areas).

Ngā mihi

[redacted]

**Director, Wai-Atamai**

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| **314** | Submitter name | Tony Blakely |
| Submitter organisation |  |

# NZ Health Strategy Consultation Draft – are the big prevention programmes really in there?

*Tony Blakely, Nick Wilson*

In this blog we comment for a second time this week on the consultation draft of the NZ Health Strategy, focusing this time on preventive interventions that actually would make a meaningful difference to health in Aotearoa NZ. The draft Strategy has many strong aspects, but by having a ‘people centred’ approach it gravitates to IT system and individual-level actions, and drifts away from population-level prevention activities that would have the biggest health impact (a goal of strategy), reduce health inequalities (another goal of the strategy) and be best value for money (yet another goal of the strategy). We recommend that the word ‘prevention’ needs to be more than a garnish sprinkled through the document, but rather an actual substantive item on the menu of offerings. We conclude by offering up some interventions for comparison persons, and note that the population-wide interventions not highlighted in the Strategy can have an impact on health gain and costs (savings) far in excess of those implicitly in the Strategy’s focus.

The current Health Strategy is 15 years old; time for a refresh. Minister Coleman says many good things in his foreword to the just released Consultation Draft, including:

*“... there is an emerging consensus that working intersectorally will help address those drivers of ill health that sit outside the health system.”*

And:

*“Engagement with the sector to develop a picture of what the future might look like resulted in a greater emphasis on health education and prevention to reduce future demands.”*

But by the time the draft Strategy has traversed its five organising themes (1. People powered, 2. Closer to home, 3. Value and high performance, 4. One team, 5. Smart system), the gravitational pull of a focus on health service systems and people-centric approaches leaves the 20 identified Action Areas at the conclusion bereft of actions that actually have a big impact on population health – in our view, and as we also commented on earlier this week. More on that in a bit.

There are definitely some good bits in this Draft Strategy. It should, and does, consider how to embrace and maximise use of IT systems, smart thinking, health services coordination, and such like. All good and necessary stuff. The problem is that the big drivers of ill health (obesity, tobacco, income-adequacy, etc) fall off the table. Why? We do not know. It could be that it is just too hard in a Strategy document to tackle the elephants in the room (sugary foods, the Food Industry, tobacco) when the most important policy actions on these items are issues of Politics (with a capital ‘P’). Or it could be that the – generally sensible – five organizing themes naturally lead to ‘within the health system’ actions, activities for DHBs and citizens – not activities for the state through ‘collective action’.

So what is missing? Well, as per our previous blog there are plenty of key causes of health loss that are not adequately covered, including some that have no mention at all. The lack of any mention of the Smokefree 2025 goal is particularly surprising.

So lets look a bit more at what should be more to the forefront in the Strategy. First, note that the Minister in his Foreword emphasizes prevention, and that the document talks (at length) about health gain, productivity and value for money. So, below we present just a handful of the (growing list of) interventions we have modelled in the BODE3 Programme (University of Otago), estimating health gains (as quality adjusted life years) and costs for interventions. We have ranked them by health gain, or quality adjusted life years (QALYs), for the remainder of the 2011 NZ population’s life.

Many of the health service interventions are not even visible in the figure above, so we plot them graph again on a log scale – now giving a relative comparison of QALY gains. The gains from interventions such as population-wide salt reduction and tobacco tax dwarf those for Herceptin and cancer care coordinators. (To put these numbers in perspective, the mandatory 25% reduction in salt levels in all processed foods gains 110,000 QALYs, which is equivalent to a gain of 0.6% in the expected QALYs left to live among all 35+ year olds alive in 2011.) But we need to be careful in the comparisons. Most importantly, the preventive interventions are for the whole 2011 population followed to death or age 110 years, with the QALY gains often occurring decades into the future (although the QALY gains are discounted at 3% per annum). In contrast, the treatment interventions are just on the cases diagnosed in 2011. This is a function of the modelling, so to try and make for a ‘fair’ comparison, we scaled up the treatment-type (and HPV vaccination which is just for girls age 12 in 2011) by 20-fold, which allowing for a 3% discount rate is roughly similar to modelling that treatment intervention on the 2011 population every year into the future. Even with this scaling, the population-wide interventions stand out.

There are many nuances to consider in the above graphs. For example, how interventions differ in their ‘benefit’ and ranking if, say, one limits the time horizon for benefit to the next 10 to 20 years (favouring treatment interventions), what discount rate one uses, and so on. We will visit these considerations in future blogs and publications. But for now, the point is that the current Draft Health Strategy is excluding mention of interventions with the biggest impact – on a long timeline at least.

What about cost-effectiveness? Or the cost per QALY gained? The graph below shows the incremental cost-effectiveness ratios (ICERs) for the same interventions above. First, for completeness we show as negative ICERs those interventions that are cost saving; one may elect to just consider these interventions as ‘cost saving’ or ‘dominant’. Why are some of the interventions (massively) cost saving? (E.g. see this blog on dietary salt reduction interventions.) Because they prevent disease, preventing future health system expenditure – or perhaps more accurately allowing health expenditure to move to other areas (e.g. dementia care). But from an economic perspective, a perspective included in the current Draft Health Strategy, (massive) cost savings – even if decades into the future (not unlike the projected benefits of other major Government expenditure, e.g. roads) – are hard to ignore.

Considering the positive ICERs, Trastuzumab (Herceptin) appears to be on the cusp of cost-effectiveness. (However, cost-effectiveness varies enormously by age and receptor subtype – paper under review.) Cancer care coordinators might be deemed a good buy, and this is indeed an area that the NZ Government has been investing in. HPV vaccination of girls is also a good buy (and is current practice in NZ) by usual criteria – albeit not cost saving like population-wide salt and tobacco interventions. Notably, not all salt interventions are cost saving – dietary advice costs money per QALY gained, an example of how personalised interventions are often (not always) less likely to be cost saving than population-wide interventions through regulation or other means.

Yes, there is plenty of nuance to consider in the above comparisons – and we will explore these more in the future. The unavoidable point here though, and in light of the draft Health Strategy Consultation, is that it seems erroneous – and poor economic sense – to not forefront population-wide prevention more.

To conclude, we recommend the following revisions of the Health Strategy:

* Include a more explicit – not just a diffuse lip-service – articulation of prevention options. This could be achieved by adding ‘Prevention’ as a theme, making six themes in total.
* Articulate the need under ‘intelligent systems’ for (cost-effectiveness) evaluation of health policy options, beyond what Pharmac does for drugs and devices, to inform policy development.
* Name an agency to oversee such provision of advice to Government; we note that the Public Health Advisory Committee of the National Health Committee exists on statute, but has been inactive in the last 7 years.

**BLOG Submission source:** <https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/>

**The Draft NZ Health Strategy: Will it enable New Zealanders to “live well, stay well and get well”?**

Posted on [December 1, 2015](https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/) by [Kate Sloane](https://blogs.otago.ac.nz/pubhealthexpert/author/sloka05p/)

*Prof Nick Wilson, Prof Richard Edwards, Prof Tony Blakely*

The new draft NZ Health Strategy is strong on strengthening the health care system and has some strong population health aspects, at least rhetorically. It includes phrases like a system moving “from treatment to prevention”. But how does it fare when considering the science around burden of disease and interventions to address the 10 top risk factors for health loss in NZ? Unfortunately not well at all. There are no population health goals and minimal evidence of concrete action to address the major preventable causes of poor health and premature death. In summary, there seems plenty of scope for upgrading the draft Strategy if it is going to enable New Zealanders to “live well, stay well and get well”.

See graph online here <https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/>

The draft NZ Health Strategy (1) has a strong focus on strengthening the health care system. As such it addresses the “Get well” part of the “Live well, stay well and get well” goal that it espouses for New Zealanders. It also appears to have some strengths from a population health perspective, at least in its use of language and terminology. Phrases like a system moving “from treatment to prevention” are used and the word “prevention” is mentioned 13 times. It also describes an investment approach focused on long-term benefits. One of its eight principles is “Collaborative health promotion and disease and injury prevention by all sectors”. It also stresses the theme of “value and high performance” with the word “value” appearing 28 times. It even mentions “inequalities” (albeit just once). But here we look at the draft Strategy document from mainly just one perspective – the degree to which it acknowledges the 10 top risk factors for health loss in NZ, sets out population health goals and proposes strategies to reduce their impact (2) (see Table below).

The number one preventable risk factor for health loss in NZ is tobacco smoking (see Table and Figure). It is also a major contributor to health inequalities. Neither is apparent in the draft Health Strategy, which scarcely mentions tobacco. The Government’s world-leading Smokefree 2025 Goal (3) is not mentioned in any form. Nor does the draft Strategy’s “Roadmap of Actions” include any plans on how to achieve the Smokefree Goal (e.g., via higher tobacco taxes (4), restricting outlets (5), revising regulation around alternative sources of nicotine (6), intensifying mass media campaigns (7) etc). The Government recently committed to developing a comprehensive strategy for achieving the 2025 Smokefree Goal. This too goes unmentioned. These omissions are difficult to understand given the Government’s commitments to Smokefree 2025 and the rhetoric in a Strategy that claims to be moving ‘from treatment to prevention’. From a value-for-money and investment approach perspective this also seems unfortunate – given NZ modelling work suggesting that tobacco control interventions are highly cost-effective and that higher tobacco taxes, for example, would save health dollars (8) and would probably have other substantial economic benefits (9).

The challenge of increasing levels of obesity is at least acknowledged and described. The word “obesity” gets 13 mentions, and the “Roadmap of Actions” states the intention to “implement a package of initiatives to prevent and manage obesity in children and young people up to 18 years of age”. However, once again there is no population health goal for reducing obesity and the proposed actions do not include any substantive plans to tackle the obesogenic environment (e.g., the words “marketing”, “outlets” and “tax” are not mentioned). Even physical activity only gets one mention with the word “exercise”.

Brief mentions are given to the high blood glucose risk factor (in terms of diabetes), and also the word “alcohol”. But there are no population health goals or substantive primary prevention plans outlined for these risk factors. The lack of focus on alcohol is of note given that this is an area where there is ready scope for large health gains – while also saving health system costs (10).

Top 10 risk factors which are not discussed at all include: “high blood pressure”, “high blood cholesterol”, “high sodium intake”, “high saturated fat intake”, and “adverse health care events”. From an investment approach and value-for-money perspective this also seems unfortunate – given the NZ modelling work that suggests that population-level dietary salt interventions would generally produce large health gains while also saving health dollars (11). Similarly, for NZ work on the benefits of taxing high salt foods (12), and sugary drinks (13).

**Where to from here?**

In summary, from the perspective of population health and prevention, the draft Strategy is highly inadequate. There is plenty of scope for the draft Strategy to be upgraded to be better based on the science of health loss and to set out a coherent set of priority population health goals and actions to achieve them. Given the clear indication of the cost-effectiveness and substantial economic benefits of such measures, including the benefit of constraining rising health care costs (identified as a major long-term funding issue in the challenges section of the draft Strategy), it is puzzling that the draft Strategy is so bereft in these respects. The final version of the Strategy needs to take a more balanced approach in which key causes of health loss are fully acknowledged and addressed by an appropriate range of strategies and actions to ensure that New Zealanders do indeed “live well, stay well and get well”.

**Risk factors for the top 10 causes of health loss in NZ (from the NZ Burden of Disease Study (2))**

| **Risk factor (top 10)** | **DALYs (disability-adjusted life-years) lost in 2006** | **Mentioned in the draft “Health Strategy” (word search terms used)** |
| --- | --- | --- |
| **Number** | **%** (of all health loss) |
| 1) Tobacco use | 86,900 | 9.1% | “smokefree” (n=2), “tobacco” (n=1), “smoking” (n=0), ***All nil for:*** “tax”, “outlets”, “campaigns”, “mass media”, “warning labels”, “2025” (the latter is the year for the Smokefree Nation goal”). |
| 2) High BMI | 75,100 | 7.9% | “obesity (n=13). ***All nil for:*** “overweight”, “BMI”, “diet”, “obesogenic”, “marketing”, “tax”, “outlets”, “campaigns”, “mass media”. (See also “physical inactivity” below). |
| 3) High blood pressure | 61,000 | 6.4% | ***All nil for:*** “blood pressure”, “hypertension”, “salt”, “sodium”, “unhealthy” (food) |
| 4) High blood glucose | 43,800 | 4.6% | “glucose” (n=0); “diabetes” (n=12) – but the latter contexts do not seem to address the obesogenic environment (see above under “high BMI”). |
| 5) Physical inactivity | 40,000 | 4.2% | “exercise” (n=1), “inactivity” (n=0). But the obesogenic environment is not considered (see “High BMI” above). |
| 6) Alcohol | 37,000(net of benefits & harms) | 3.9% | “alcohol” (n=4), “binge” (n=0). ***All nil for:*** with regards to: “marketing”, “tax”, “outlets”. |
| 7) High blood cholesterol | 30,900 | 3.2% | ***All nil for:*** “cholesterol”, “lipid”, “dietary fat”, “fatty acids”, “diet” |
| 8) Adverse health care events | 30,300 | 3.2% | ***All nil for:*** “adverse”, “adverse events”, “hospital acquired”, “health care events”. |
| 9) High sodium intake | 16,300 | 1.7% | ***All nil for:*** “sodium”, “salt” |
| 10) High saturated fat intake | 11,400 | 1.2% | ***All nil for:*** “saturated fat”, “cholesterol”, “lipid”, “dietary fat”, “fatty acids”, “diet” |

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**2 thoughts on “The Draft NZ Health Strategy: Will it enable New Zealanders to “live well, stay well and get well”?”**

1. Robert Beaglehole on [December 1, 2015 at 12:44 pm](https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/#comment-223908) said:

Congratulations. This is a very important blog. We should all make a brief submission on the strategy by this coming Friday. We should call, for example, for selected population health goals, endorsement of the SF2025 goal, and key interventions to achieve this goal and others.

[Reply ↓](https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/?replytocom=223908#respond)

1. Sidd Mehta on [December 2, 2015 at 8:52 am](https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/#comment-223952) said:

Great post. Glad you have pointed out the disconnect with the investment approach (value per dollar spent) and the long term structural interventions that would to increase the value received per dollar spent. If the initiative is all about savings and personal responsibility than why are structural interventions such a blank spot in the strategy? Often, modelling and real observations have showed the need for environmental interventions in order deliver value of money at a population level. Sustainable Development Goal number 4 articulates that health system (or system) interventions are more likely to produce better health outcomes. This strategy is not for NZ population, it is only for those assigned as most vulnerable, at the cost of ignoring the wider social determinates of health affecting all New Zealanders.

[Reply ↓](https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/?replytocom=223952#respond)

1. Documented in each DHB’s Annual Plan, 2015/16. [↑](#footnote-ref-1)
2. Atul Gawande’s “Being Mortal: Medicine and What Matters in the End” [↑](#footnote-ref-2)
3. Presentation to DHB Chairs and CEs, November 2015 [↑](#footnote-ref-3)
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