**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**315 – 326**

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| Submitter organisation | Cochrane New Zealand |

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on behalf of a group or organisation(s)

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*(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)*:

## 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 background should include an explicit statement about utilising proven evidence based methods employed by researchers in the health and education sectors. These methods should be implemented nationally and continually evaluated to ensure the best delivery of health opportunities for all New Zealanders. |

### 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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| 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 evidence-based system**. |

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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| One missing component from the principles was a lack of reference to the evidence underlying policy and health care decisions. The evidence should be generated via well designed research.  Goal 3 change to  3. Collaborative evidence based health promotion and disease and injury prevention by all sectors  Goal 6 change to  6. A high-performing evidence based system in which people have confidence |

### 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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| Themes 3, 4 and 5 all refer to the use of information, collaboration with researchers and evidence based decisions. These are all key concepts to deliver an effective health system. However, in the “what great might look like in 10 years” there is not enough clarity around how this interaction with the research and health evidence production will happen. The themes instead suggest that the system will be relying on identified leaders. We suggest that in addition the strategy should incorporate the identification and support of potential evidence production partners that would play a key role in achieving the themes. These partners should involve researchers and policy makers who might be external to the health providers. |

### 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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| The action items as laid out are very broad. The items that we would like to comment on are part of themes 3, 4 and 5.  Theme 3 Value and high performance  Action item 11  This discusses the health investment approach. There needs to be more clarity around how the standards and guidance will be developed and if they are going to have longer term investment for NGO’s based on which are offering the highest potential health returns. There is a tension between organisations offering a long term view compared with those focussing on short term gains. A transparent process is needed, conducted by an independent group looking at the evidence supporting proposed population based interventions.  Developing and disseminating practices is an excellent action goal but only if those practices have been shown to be effective.  Action item 12  We would like to see an additional action item here to discuss the development of national evidence based guidance, pathways and advice. At the moment there are many disjointed efforts to improve the quality of healthcare delivery throughout the DHB sector. A health strategy aiming to bring the country together as a whole highlights the need for a national evidence group to collect and appraise evidence and inform health system decision making.  Theme 4 One team  Action item 16  In addition to clinical leadership we would like to see an emphasis on the need for a comprehensive evidence based program led by a national team with expertise in assessing evidence available around health strategies and interventions.  Action item 17  In this statement we would like to see the change   * Share best practices and identify, publicise and spread examples of innovation that have been shown with best evidence to demonstrate improved equity of health outcomes, efficiency, quality and safety, and reduction of harm.   Theme 5 Smart system  Action item 20  This item discusses the impact of health research  We would like to add an item here to promote the establishment of a New Zealand based evidence capability to inform all health services as to the most effective new technologies by rigorously assessing all the available evidence to determine efficacy and applicability. |

### 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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| Measures need to be auditable and this process needs to be made part of the road map of actions when it is finalised. |

### Any other matters

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

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| The vision promoted in this document is admirable. However, we need to careful to avoid the trap of listening to a limited range of opinion leaders about what is best for the country (top down approach). The health system needs an evidence based approach as a fundamental principle in order to identify and deliver health improvements. We want to make sure our health system is not only supported by extraordinary people but also by organisations that that work together as ‘One Team’ to provide the best, most effective healthcare interventions and systems. At the moment the document lacks clarity on how the vision will be supported by the wealth of evidence available and produced internationally and nationally. |

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| **316** | Submitter name | [redacted] |
| Submitter organisation | Public Service Association |

**Submission on the Draft New Zealand Health Strategy**

**December 2015**

**Introduction**

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| *Who we are*  *Our membership*  **General Comments**  *The strategy lacks detail …*  *… in particular, on funding issues*  *… and fails to state how a fragmented sector will be brought together in an effective ‘system’*  **Responses to the questions**  *Two further principles are proposed*  *There is a place for telehealth, but those unable to access it must not be left behind*  *Health workers must be trained and supported to use technology*  *Individualised funding must be backed up with good employment practice, preferably through providers*  *The in between travel case shows the way forward for regularising the care and support workforce*  *People in rural and remote areas must not be disadvantaged*  *More clarity is needed about how the Maori and Pacific peoples health needs will be met*  *Contracted services must maintain skills, specialisms and service quality*  *There are particular concerns in mental health*  *The strategy is light on innovations to deliver better value and high performance.*  *Underfunding of $1.7 billion since 2009 is ignored*  *Large scale private provider are becoming ever-bigger players, putting downward pressure on wage and service levels*  *Our community services members give examples of what this means.*  *Do they leave the client’s dishes in the sink?*  *What the investment approach means in practice is unclear.*  *PSA has experience of high performance work practices*  *Involving the workers who do the jobs, and harnessing their ideas is the way to deliver high performing services*  *Sustainable Work Systems is the PSA’s high performance programme*  *Kaiser Permanente in the USA is a model*  *The one team approach must value and use the skills of all health workers*  *Ministry of Health staff must be supported to develop the capability to position the Ministry as the system leader*  *Data systems must be designed around people*  *The challenge of integrating systems must not be under-estimated*  *NGOs, and their workers, must be supported to develop IT capability*  *Unions must be involved in the impact of technology on jobs* | The New Zealand Public Service Association : Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand, representing 62,000 members who are taxpayers and users of the health system. We are a democratic organisation with members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities, state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.  Of these members, around 17,000 work for DHBs as allied health, mental health and public health professionals and support workers, and as administration and clerical support. We also have around 6,000 members who work in community-based public services, providing home support to elderly and disabled people, providing mental health and drug and alcohol services, and residential disability support services. They are employed by not-for-profit and private providers who are funded through contracts to DHBs and, in some cases, directly by the Ministry of Health.  Through the New Zealand Council of Trade Unions : Te Kauae Kaimahi (the CTU), we work closely with other affiliated health sector unions on matters of common interest. We support the submissions of the CTU, NZNO, ASMS and E tū. We are an associate member of AHANZ, the peak body for allied health professional associations, and maintain close links with organisations and consumer groups in disability, home support and mental health. We participate in the Health Sector Relationship Agreement (HSRA) and the National Bi-partite Action Group (BAG), which are national health forums.  In developing this submission we have spoken with groups of our members in DHBs and community public services to ascertain their views, as well as sharing these views with other health sector unions and organisations.  **General comments on the proposed Draft New Zealand Health Strategy**  The document acknowledges that it is intended to be high-level, to set principles, and to indicate preferred directions and approaches. It also emphasises the need to move to a view of the health system as a whole, including primary care and community-based services, as well as a citizen / user-centred focus. All of which is useful, and we can in principle agree, but there is a worrying lack of detail and concreteness about the roadmap actions, the links between the strategy and the roadmap, and how the desired state will be achieved.  Additionally, there is little or no reference to funding, and considerable vagueness – presumably deliberately – about the ‘investment approach’ and what this will actually mean in practice and what the likely impacts on current funding arrangements will be. The supporting reviews commissioned by the Director-General of Health on Capability and Capacity and Funding have plenty to say about funding issues, and recommendations, but very little has been carried through to the draft strategy document. For example, both reviews find that the current provider contracting model works against innovation and workforce development and they recommend multi-year contracts with providers to provide certainty and support forward planning – but the strategy is silent on this. This does not give us confidence, especially when the challenges section notes that Treasury considers that New Zealand cannot afford to keep providing services as we do now.  Funding is not the only ‘elephant in the room’ not addressed by the strategy: we have a highly fragmented health system with 20 DHBs and hundreds of NGO and private providers, including PHOs. Having all these elements functioning as a coordinated and aligned health system is a good goal, but the strategy and roadmap do not provide any concrete information about how this desired state will come about, other than vague references to ‘improved coordination’; ‘clarify roles and responsibilities’; ‘improve governance and decision-making processes across the system’.  *Are there any additional or different challenges or opportunities that should be part of the background for the strategy?*  In general we agree with the challenges and opportunities, but there are some gaps. The paragraph on p7 on workforce needs to identify the challenge of ensuring we recognise the contribution, and fully utilise, the skills of the entire workforce, not just doctors and nurses but also allied health, technicians, clerical and administrative support people who are integral to the ‘one team’ approach that is part of the vision of the strategy.  The opportunities should include the opportunity to reorient our health system away from a traditional western model to one that is centred on the needs of individuals, families and communities – a whole of New Zealand approach that can fully reflect and support the range of ethnicities in the country, particularly Māori.  We have already noted the fragmentation of the current health system – but the challenge of integration should be included.  **The future we want**  *Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?*  In general, we can agree with the vision statement which is at a very high level. The Health Sector Directions Forum proposed amending ‘live well, stay well, get well’ to ‘start well, live well and end well’, which we support. Other parts of the statement are more problematic – ‘people-centred’; ‘one team’, ‘smart system’ are imprecise, and capable of different interpretations depending on the context. They essentially mean all things to all people – and in effect therefore mean nothing very much. Clarity is needed, and we have more to say below on this in the section on the five themes.  *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?*  The refreshed principles are generally satisfactory, and we are glad to see that seven are retained from the 2000 document. We propose two additions to the principles:   * A principle on the determinants of health is needed (e.g. housing, income, employment, social services). Alongside this the need for integration with other services and agencies (WINZ, Housing NZ etc) should be explicit. Principle 8 does include ‘collaborating with others’ but this needs more precision. * A principle on utilising all the skills and attributes of the entire health workforce would underpin the system-wide approach envisaged in the strategy and ensure that all parts of the workforce, including allied health, clerical and administrative workers, and care and support workers see their contribution as part of the whole. It would also reinforce the elements of the strategy that deal with workforce development.   **Five strategic themes**  *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?*  ***People-powered***  We support the focus on people as individuals and as co-producers and co-designers of their health and well-being. However, yet again, this section is long on vision and short on detail of what will actually happen, and how it will happen.  There are two assumptions that concern us in particular:  There is a heavy emphasis on telehealth and technologies, assuming that people will in future engage with health services through technology. There is no doubt that technology developments offer significant opportunities, and for some people this will provide benefits. But others will struggle; they will not be able to afford to buy and run the devices so will be disadvantaged vis-à-vis the tech savvy, assertive and affluent sections of the population (who will be predominantly Pakeha). Others will be disadvantaged by age, lack of literacy or disability, so supports must be in place for them. The other side of ‘people-powered’ telehealth is the need to ensure that health practitioners are supported with up to date technology for their jobs, and are fully trained and supported in its use to maximise its benefits. Protocols to maintain the security of personal health information will be important.  Our members who work in mental health have commented that it is important that people who are in acute crisis are seen face-to-face by qualified practitioners and not directed to telehealth approaches. Getting the right balance – for service users – between telehealth and primary and secondary care will be important.  Our members who work in home support expressed concerns about technology being used for surveillance purposes – for example, GPS on cars or phones to track location and the time spent with a client.  Individualised funding (IF) is seen as one way forward for ‘people power’. It can enable people with disabilities to gain a greater measure of personal independence, and direct their own services. Research[[1]](#footnote-1) supports the proposal that it provides better outcomes for people with disability. For the PSA the problem with individualised funding is not with the concept or the ambition, but with the lack of consideration of the workforce required to provide independence for the person with disabilities. These concerns centre around employment relationships, wages and conditions, training and qualifications, and health and safety.  Under the New Zealand model of IF, many disabled people will directly employ their support staff. There is no doubt that many will be good employers, but generally small employers struggle with the capacity and capability to deal with employment matters well. From a worker perspective it is best that support workers under IF are employed by providers. This would provide them with greater employment security, access to training and health and safety support, and probably make it easier to ensure regular hours.  Care and support work is often seen as ‘women’s work’, done by family members, neighbours or friends and is not valued for the skills, knowledge and responsibilities that are required. Having a provider employ the worker means that there is more scope to negotiate fair wages and conditions that are consistent across the sector. There is a growing realisation that better training and higher level qualifications are required for the care and support workforce and this was part of the in-between travel case settlement reached by the PSA and the Ministry of Health, where work is underway to regularise the workforce. The changes are significant and when achieved will ensure guaranteed hours for the majority of the workforce, paid training to enable support workers to gain level 3 qualifications, wages based on the required levels of training, and fair and safe workload allocations.  ***Closer to Home***  Again, we support this theme in general, and we know that it is what people and their families want. Members however have questions about equitable access for people in rural and provincial areas, and it would be good to see more detail on how the strategy will ensure that they do not miss out. In effect this theme is a challenge to the DHBs about where services are best delivered and how they are configured.  Māori and Pacific peoples have a greater degree of health inequalities; and accessible and affordable community, primary and whanau services are important in supporting better outcomes. The strategy does note Māori and Pacific health as a priority, which we agree with. However by not addressing the social and economic determinants of health (unemployment, low wages, child poverty, bad and costly housing etc) the strategy misses the point. The emphasis on ‘collaboration across government’ is once again vague and imprecise.  We have concerns about moves to further contracting out of services to community and primary health organisations. If this happens it must be balanced with measures to ensure that skills, specialisms and service quality are maintained. For example, one member from a remote area reported that emergency services are being run by aged care nurses, which may be adequate for low-level emergencies but may well also carry risks for the public and for the health workers. The other issue in more contracted services is more fragmentation of services.  Members who work in mental health have raised concerns that the provision of secondary mental health care has been restricted over recent years, often in response to DHB financial constraints, and people with significant mental health issues, as well as those with less severe problems, being directed into the primary sector. They see people who cannot afford to pay for primary care being deprived of early intervention when symptoms are less severe, so that personal suffering builds up until they meet the threshold for secondary mental health care. While ‘closer to home’ is a good goal, it is important that mental health care is accessible when and where it is needed and that affordability barriers for primary care are removed.  The vision for ‘great in 10 years’ refers to workforce capability and capacity in primary and community services that provide high-quality care as close to home as possible. We fully support this, but the strategy needs to recognise the community services workforce requires training to raise qualification levels, fair pay and conditions, job security, and adequate health and safety. It must also be respected and valued for its important contribution to peoples’ well-being and health, and not just seen as low-value ‘women’s work’.  ***Value and high performance***  This section is where the direction for funding is more transparent than elsewhere (though still very opaque); but the strategy is light on any real innovations to deliver better value and high performance, nor does it deal with the issue that, in real terms, the health budget has been underfunded by around $1.7 billion since 2009/10 according to research[[2]](#footnote-2) undertaken by the CTU and ASMS. There is no acknowledgement of this shortfall, just an assumption that the funds must be stretched even further. We do, of course, support getting value for money and better performance but continued underfunding is not the answer. The removal of the ring-fence for mental health funding has meant that they are now under-resourced, so that should be remedied.  As they struggle with their own deficits, DHBs have consistently underfunded contracted providers through mechanisms such as increasing service levels within the same (or decreased) funding, or dropping services. Given the emphasis in the strategy on the shift to primary and community services, it is crucial that any shift is properly funded. We note that, over time, community and NGO providers are often taken over by large, for-profit organisations with puts even more pressure on the wages and service levels. The experience of the early childhood education and residential aged care sectors, where large scale foreign owned companies attracted by the guaranteed government funding have entered the New Zealand market, are germane here. The private sector is focussed on maximising the return to its owners and shareholders; the risk to public value is that the government has to step in in case of service failure, as we have seen in the private prisons debacle with Serco.  To illustrate this point, our community public service members have many examples of provider management solutions to dealing with funding shortages: for example, a client who previously had an hour for home management being cut back to 45 minutes – ostensibly as part of the restoration model encouraging independence, but not taking into account the importance of the relationship with the client and the fact that the client may not be capable of some tasks. Should the worker leave the client with a tub full of dishes because the 45 minutes is up?  Members also point out times where one home support worker is expected to use a hoist on their own, where in a rest home or hospital situation, two workers would be assigned. Qualified workers are trained not to use hoists on their own. Not sending a second worker is a cost saving to the provider.  Much is made in the strategy of the need for the investment approach; what this looks like in practice is not clear. It seems to be about closer collaboration between departments, DHBs and agencies which all makes sense. But it is a narrow focus on cost reduction, with the hope that better health, economic and social outcome will eventuate. It is very much about managing risk, partly by shifting it to contracted providers and the voluntary sector. The funding review commissioned to support the draft strategy is clear about the proposed direction, and it envisages a greatly increased role for the private sector in competition with DHBs for contestable funding; much of the detail has not been carried through to strategy or the road map of actions. The private sector will not be interested in the difficult and intractable issues; they will cherry pick the easier and more profitable services, reinforcing health inequities.  The PSA is also committed to high performing workplaces in both the community sector and the public sector with a view to creating a climate and culture where frontline workers, including those who might qualify as public entrepreneurs, can flourish. We have two principal objectives:   * Enabling PSA members to have good jobs, within a workplace culture of meaningful and substantive engagement of workers and their union with the employer on how the work is organised and carried out * Supporting the delivery of high quality public services that provide value for money and good outcomes for New Zealanders.   A high performing workplace is one where our members can mobilise their knowledge to improve the efficiency and quality of services and embed positive and productive workplace relationships and practices with a view to creating sustainable services, sustainable jobs, and productive workplaces.  The PSA believes that high performance workplaces can be achieved through a culture of engagement and collaboration by direct, meaningful and regular engagement with the workforce on all matters over which the workforce directly influences performance. This is essential for sustained high performance and for achieving the productivity gains that employers (and members) seek in a time of scarce resources. In the highly unionised public sector the union is central to improving productivity and innovation and the PSA wants to be involved.  For example, we have developed Sustainable Work Systems (SWS) as a programme for putting the high performance workplace agenda into practice. SWS sits within our wider agenda, and is an important and effective tool for realising high performance in workplaces where the conditions are right for it. We have a number of projects underway with employers to implement this programme. It has been running with bookers and schedulers at Bay of Plenty DHB since 2009, where the introduction of SWS reduced (and sustained) the time taken for scheduling acute appointments from 5 hours to 1.5 hours, significantly reduced the need to rebook appointments at short notice and allowed patients to choose their appointment times so that they are much more likely to turn up.  We have visited Kaiser Permanente in the US, where the health company and a coalition of unions have a long-standing formal partnership based on a shared commitment to high performance through employee involvement[[3]](#footnote-3). This has delivered significant benefits and savings to the company, to the workers – and to their clients and patients. If the government is serious about high performance, it needs to work with unions to promote and participate in such approaches.  ***One team***  Our members support the principle of working together in local teams and across the system. However, there is a real problem about how the clinical professions view the contribution of the full range of health workers. The submission from AHANZ has useful points about allied health professionals, which we support. Allied health and technical workers need to be seen as integral and equal participants in multi-disciplinary care teams; and clerical and administrative workers and home support workers need to have their roles and ideas respected and valued.  This goal has a focus on workforce development, including the skills necessary for integrated care. We support this, and expect that unions will be fully involved in implementation. Adequate support for training and qualifications must be part of this. There must be a clear understanding – from all parties – that the health workforce is wider than the clinical workforce, and includes the non-regulated workforce which is be a key component of the ‘closer to home’ objectives. This should be more explicit in the strategy, as well as the role of unions in supporting workforce development.  We agree that the Ministry of Health, where we have members, needs additional capability to realise its proper role in system leadership. If there is to be any reorganisation of the Ministry, staff must be assured that their jobs are safe and that they will be supported to transition to new roles through best practice change management and the PSA will expect to be fully engaged from the outset.  ***Smart System***  Much is made throughout the document about the need to improve data analytics and collection, as well as the transformative potential of technology. However, the systems need to be designed around people – both clients and service users and the staff who use and operate them. We have made points above about the currently fragmented DHB / provider system and this is starkly shown up in the proliferation of incompatible IT systems.  Health Benefits Ltd (HBL) was set up to deliver national programmes for ‘back office’ shared services between DHBs, including IT procurement and integration. It failed to deliver, and was disestablished. The Auditor-General’s report into HBL makes for salutary reading; she notes[[4]](#footnote-4) that:  *‘The change required had been underestimated … The (IT) programme’s goals were ambitious, requiring creating a single system that could replace 20 systems and different ways of operating. It appears that HBL underestimated the health sector’s fragmentation. This made achieving the programme’s objectives in the time allotted particularly challenging.’*  The draft strategy needs to be realistic about the challenges that must be overcome to deal with the fragmentation and achieve the goal of integrated and smart systems. The strategy also glosses over IT and capacity and capability deficits in NGOs and providers – if they are to be part of an integrated national information and data system, they will need considerable capacity and capability building, as well as training for staff.  This section is silent on the potential impact of technology on jobs and changed work practices. Good planning and communication with workers and their unions must be part of the ‘smart system’ implementation, as well as ensuring that any changes to jobs are done with – and not to – the workers, so that they are supported into new areas of work and new roles as needed.  **Roadmap of actions**  *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?*  The roadmap is a curious mix of detail and small-scale actions; of large and sweeping statements and high-level ambitions; of what is currently happening and what a desired future looks like. It is therefore difficult to comment on it. Getting the strategy right is the first step. |

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|  | For further information about this submission contact:  [redacted], Policy Advisor  [redacted][www.psa.org.nz](http://www.psa.org.nz) |

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| **317** | Submitter name | [redacted] |
| Submitter organisation | The Royal New Zealand College of General Practitioners |

3 December 2015 Our ref: HMB329-15

New Zealand Health Strategy Update Consultation

New Zealand Health Strategy Team

Ministry of Health

PO Box 5013

WELLINGTON 6145

To the New Zealand Health Strategy Team,

# Draft Health Strategy

Thank you for providing the Royal New Zealand College of General Practitioners (the College) the opportunity to comment on thedraft *New Zealand Health Strategy*.

# Executive summary

The College supports the introduction of the new Health Strategy, and the accompanying Road Map, and largely agrees with the approach taken by the Ministry in both documents.

Our key message to the Ministry is that the changes envisaged by the Strategy cannot be achieved without the introduction of appropriate investment mechanisms – mechanisms that are capable of shifting funding towards new models of care and which ensure that care is delivered to those most at need. These models need to ensure that investment follows the patient, rather than the health service or health practitioner. Critical to this new investment approach will be flexibility to enable innovation, and local autonomy to ensure that models of care are the best fit for the communities that they serve.

As a general comment, the College’s view is that the Strategy must also take a much stronger position on issues related to health equity. Our view is that equity needs to be incorporated into the opening statement, perhaps as “…New Zealanders **equitably** live well, stay well, get well.”

Our vision is for a health strategy that encourages and requires providers to focus on equity as well as improving the health of the total population. We therefore recommend that a new strategic theme be added that focuses on equity.

The remainder of the College’s submission considers how the Strategy is relevant to general practice – and what a Road Map for Primary Care might look like. We recommend that this Road Map include:

***Theme 1 – People-powered***

* A focus on general practice interventions that encourage patients to make positive lifestyle choices. The College already provides training and tools to GPs to assist them in health promotion activities, and can support this activity.
* Emphasis on the importance of care co-ordination in the management of patients with complex needs and long-term conditions, and on the central role that that general practice plays as the patient’s healthcare home.

***Theme 2 – Closer to home***

* Funding mechanisms that allow better use to be made of GPs with advanced competencies or advanced training to provide high quality care closer to home, in particular in the management of patients with complex needs and long-term conditions.
* Guidance on when role expansion is appropriate, which makes clear that it should be introduced only when: it frees up other practitioners, and allows them to practice at the top of their scope; the substitute practitioner has appropriate skills, knowledge and expertise; continuity of care is maintained, and relevant information about the patient is passed to their usual health provider (who will usually be their GP). The guidance should also advise that it is strongly preferable that role expansion should only occur when a practitioner with an expanded role is practising within primary care, as part of a team that includes the patient’s usual health provider.
* A plan to improve retention of primary care nurses, and recruitment of GPs – and to encourage more Māori to train as health practitioners. The College appreciates the recent increase in funding to support the training of more GPs, and has set a target to increase the number of Māori entrants to our training programme from 7.7% to 22%.
* Consideration of the sustainability of the primary care workforce, to ensure that any change is accompanied by appropriate support for all practitioners affected by that change. Pastoral care of GPs is a key function of the College, and we can provide support around this action.
* An action, within Action 6, on providing pregnant and postnatal women who smoke with support to be smokefree by means of ready and free access to nicotine replacement therapy and support to quit services. This action should be supported by a Health Target that measures the percentage of hospitalised pregnant women who smoke and who are provided with cessation support.

***Theme 3 – Value and high performance***

* Acknowledgement of the important role that primary care has to play when undertaking an investment approach – in particular in terms of early identification of patients where early investment in their healthcare will have the greatest benefit.
* Mechanisms that allow high performance to be recognised, to support the role that the College plays in ensuring quality.
* A target to lift the proportion of Vote Health and ACC funding that goes into primary care from 7.8% of the total, and put in place a primary care investment plan to deliver this. This will build on the commitment made in the Health Strategy to see a wider range of services delivered in primary care. It should also result in a significant reduction in other health sector costs, and therefore savings for Government.
* A recommendation that the Ministry of Health begin to publish statistics monitoring how DHBs allocate their funding, including what proportion of their funding is invested into general practice and community care. This will provide a national picture of how initiatives are achieving the shift in service delivery envisaged in the Health Strategy.
* A review of current general practice funding mechanisms in light of the feedback provided by GPNZ, and that steps be taken to ensure that funding for general practice is not just increased – but that it is also allocated in a way that is fair, streamlined and needs based.
* Provision for a new five year transformation fund to build the primary care infrastructure needed to meet current and future needs.

***Theme 4 – One team***

* A recommendation that the Ministry’s health advisory structures continue to maintain a high degree of independence.
* A recommendation that the role of co-ordinating services in the community should be undertaken by PHOs.
* A greater focus on health and social services working together in a more integrated way. In particular, the Road Map should recognise the importance that social determinants have on health – and advocate for policy approaches to address these. For example, attempts to reduce the incidence of rheumatic fever would be greatly facilitated by the provision of warm and dry social housing.
* A focus on integration that extends beyond health and social services and includes commitments from Government and Government agencies.
* A focus on learning together, as well as on working together. Collaboration and integration can only be encouraged when different health practitioners learn alongside one another.
* Detailed guidance on actions, starting at the governance level, that health sector and other organisations should be taking to achieve equity.
* An amendment to Action 13 to reflect the advice provided in the Ministry of Health’s *Intervention Framework to Improve Health and Reduce Inequalities in Health.* This Action should be reworded to state: “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 outcomes.”
* A further amendment to Action 13 that requires governance bodies to self-audit against the Ministry of Health’s *Intervention Framework to Improve Health and Reduce Inequalities in Health*.
* An amendment to Action 14 to ensure that this Action includes a greater equity focus. We recommend that this should state: “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 performance.”

***Theme 5 – Smart system***

* A focus on the development of a shared electronic health record.
* A focus on opening up data-sets to allow improved identification of illness in primary care. Implementing this recommendation will require support to increase the capacity and capability of practitioners to undertake this work.

## How will we know that the Road Map for Primary Care has succeeded?

We will know that the Road Map for Primary Care has achieved its aims when:

* All New Zealanders have access to high quality primary care, when they need it.
* The number of New Zealanders enrolled with a PHO rises from 96.1% to near 100%.
* More patients are seen and treated in a primary care setting, and less in hospital Emergency Departments
* The number of unnecessary ambulance call-outs is reduced.
* The length of hospital stays for patients aged over 65 is reduced.
* There is increased case management in general practice of ambulatory sensitive conditions.
* The burden of lifestyle illness is reduced through interventions in primary care that encourage patients to make healthier lifestyle choices
* The burden of diseases that arise through social determinants of health is reduced by health and social services working together in tandem.
* There is a reduction in the health disparities that exist between different patient populations.
* The number of nurses, doctors and Māori choosing to work in primary care increases.
* The rate of rise in Vote Health and ACC funding decreases, and the proportion of this funding that goes into primary care increases.
* Patients and health practitioners have easy access to the health information they need, at the time they need it and in a way that they can understand it. This means that New Zealanders make regular and effective use of their patient portal to better manage their own health, and an electronic health record allows practitioners in primary, secondary and allied care to access all the information they need when a patient consults them.

# General practice in the New Zealand health system

General practice has a proud history in New Zealand. It is not only the largest clinical specialty, comprising almost 40 percent of New Zealand’s specialist workforce, it is also the broadest. The former chair of the Medical Council, Professor John Campbell, once described it as:

”…the specialty, the vocational scope of practice, which treats patients with the widest variety of conditions, with the greatest range of severity (from minor to terminal), from the earliest presentation to the end, with the most inseparable intertwining of the biomedical and the psychosocial, and treats patients of all ages, from neonates to elderly, over a lifetime”.[[5]](#footnote-5)

GPs form the core of the primary health system – committed to improving the health of all New Zealanders through high quality, personal, family, whanau and community-oriented, comprehensive general practice and primary care.

## The value of general practice

General practice in New Zealand has proved a remarkably effective way of delivering high quality health care. 96.1% of the population is enrolled with a PHO[[6]](#footnote-6) and half of all adults report that they had visited their GP in the past three months[[7]](#footnote-7). General practice provides first-contact care, and all the care needed for more than 90% of health problems that GPs encounter[[8]](#footnote-8).

The New Zealand community values the role that GPs play in their health care, and patients report a high level of satisfaction and trust with their GP – with 93% rating the care provided by their GP as good or very good, and 84% reporting that they definitely had trust and confidence in their GP[[9]](#footnote-9). Practice nurses experience even higher levels of trust and satisfaction[[10]](#footnote-10).

There is good evidence internationally of the value that GPs bring to the health sector. Work by Barbara Starfield and others has found that health is better in areas with more primary care doctors, people who receive care from primary care doctors are healthier regardless of their initial health or various demographic characteristics, and the characteristics of primary care are associated with better health[[11]](#footnote-11).

Through providing greater access to needed services, better quality of care, a greater focus on prevention, early management of health problems, reducing unnecessary and potentially harmful specialist care, systems that support primary care services are more equitable, more effective and cheaper to communities. There are benefits in the comprehensive and continuous care that an identified single general practitioner responsible for the oversight and management of a patient’s health care experience brings.

GPs have an important role in integrating both primary and secondary care and are knowledgeable about common medical conditions:

“Specialists become knowledgeable about rarer variants of disease because they are selected for them by generalists. Generalists become knowledgeable about the common conditions that rarely reach the specialist.”[[12]](#footnote-12)

There is an emerging body of research revealing that a greater breadth of services provided in primary care is associated with lower costs and fewer hospitalisations[[13]](#footnote-13), and also improved health outcomes[[14]](#footnote-14). Evidence also demonstrates that care for illnesses common in the population (e.g. community-acquired pneumonia) is more expensive if provided by specialists rather than generalists, with no difference in outcomes[[15]](#footnote-15).

## Why a new Health Strategy is important to general practice

General practice has undergone considerable change since the introduction of the Primary Health Care Strategy (PHCS) in 2001. Population registration, capitation and primary health organisations (PHOs) have all arrived and made fundamental changes to the landscape of general practice.

The PHCS had two key aims – to improve health and to reduce inequalities in health. While there has only been limited evaluation to assess the impact of the strategy, we do know that some things have changed substantially since its introduction. We know that many New Zealanders pay lower fees for primary health care than they used to, and we know that consultation rates have increased over time[[16]](#footnote-16). We also know that there has been evidence of improvement of health outcomes in New Zealand, together with better rates of immunisation and a reduction on inequalities associated with ethnicity[[17]](#footnote-17).

In short, we know that over the past 14 years general practice has succeeded in not just responding to a growing population, an ageing population, and a sicker population – but is now providing New Zealanders with greater levels of care, and more effective care, than ever before.

However, general practice now faces new challenges:

* The population continues to grow, age and develop more complex health needs and multiple morbidities. Treating long-term condition is costly, and it is expected that these costs will increase in the future[[18]](#footnote-18).
* Changes in technology that transform our ability to communicate and treat disease. Some of these new technologies will provide new models of working that will break down the traditional barriers between primary and secondary care. This will challenge the traditional divisions between hospitals and general practice, between health and social care, and between generalists and specialists.
* Changes in health services funding growth. Like most western countries, New Zealand will continue to experience budget pressures over the next few years.

# Feedback on the Health Strategy

The College supports the introduction of the new Health Strategy, and the accompanying Road Map, and largely agrees with the approach taken by the Ministry in both documents.

The College has considered how the Strategy is relevant to general practice – and our submission provides some guidance to the Ministry about what a Road Map for Primary Care might look like.

Our key message to the Ministry is that the changes envisaged by the Strategy cannot be achieved without the introduction of appropriate investment mechanisms – mechanisms that are capable of shifting funding towards new models of care and which ensure that care is delivered to those most at need. The model needs to ensure that investment follows the patient, rather than the health service or health practitioner. Critical to this new investment approach will be flexibility to enable innovation, and local autonomy to ensure that models of care are the best fit for the communities that they serve.

In relation to the last point, we note that current funding models in primary care are generally at a practice level – rather than at a patient level. For a practice that works under the Very Low Cost Access (VLCA) contract, care to all patients within that practice is subsidised regardless of actual need. Similarly, for a practice that does not work under a VLCA contract there is no mechanism available to subsidise services to patients in need of care that they are unable to afford.

We also note that “investment follows the patient” means that if an elderly patient is discharged from hospital care with a recommendation that follow-up is provided in primary care – then the funding for the provision of that care should follow the patient from the hospital and into general practice.

As a general comment, the College’s view is that the Strategy must also take a much stronger position on issues related to health equity. Our view is that equity needs to be incorporated into the opening statement, perhaps as “…New Zealanders **equitably** live well, stay well, get well.”

Our view is also that the proposed “focus on improving health for those currently disadvantaged” does not go far enough. The focus should instead be on reducing, or better eliminating, health disparities and on ensuring that all people have an equal opportunity to stay healthy. Merely focusing on “improving health for those currently disadvantaged” may result in improvements, but this could be at a slower rate than those in a more advantaged position – resulting in health disparities actually becoming worse. 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.

Our vision is for a health strategy that encourages and requires providers to focus on equity as well as improving the health of the total population. We therefore recommend that a new strategic theme be added to the Healthy Strategy that focuses on equity.

## Theme 1 - People-powered

The College agrees with this theme. General practice already plays a key role in delivering care that is patient-centred and people-powered. Practices are located in the community, and are often integral to the life of that community. GPs also play a key role as patient advocates, care navigators and care co-ordinators. They provide care that is holistic and looks at the whole of the patient, and aim to help patients to manage their own health.

Our view is that to achieve the aims of this theme, proactive primary care must become even more central to interventions that encourage patients to make positive lifestyle choices. It seems to make very little sense that “a record number of Kiwis are undergoing weight-loss surgery on the public purse”[[19]](#footnote-19) (with each of those procedures costing between $17,000 and $35,000) when, for the past six years, the Ministry of Health’s *Clinical guidelines for Weight Management in New Zealand Adults[[20]](#footnote-20)* have toldus that the evidence for the effectiveness of much cheaper interventions focused on diet, physical activity, behavioural strategies and pharmaceuticals is all “strong”[[21]](#footnote-21).

To support this theme, the College recommends that the Road Map should provide a focus on general practice interventions that encourage patients to make positive lifestyle choices. The College already provides training and tools to GPs to assist them in health promotion activities, and can support this activity.

Our view is also that general practice should have greater involvement in care co-ordination, and that the Strategy should focus on the central role that general practice plays as the patient’s healthcare home. We note that a major international study on patients with complex care needs found that their care was often poorly co-ordinated[[22]](#footnote-22). However “…adults seen at primary practices with attributes of a patient-centred medical home—where clinicians are accessible, know patients’ medical history, and help coordinate care—gave higher ratings to the care they received and were less likely to experience coordination gaps or report medical errors.”

As the New Zealand health sector faces a future that contains a rising number of patients with complex and long-term conditions, the care co-ordination role filled by general practice will become increasingly critical. Care co-ordination ensures that patients receive high-quality, timely and appropriate services in the most convenient way, and provides continuity of patient care.

To support this theme, the College recommends that the Road Map should place emphasis on the importance of care co-ordination in the management of patients with complex needs and long-term conditions, and on the central role that that general practice plays as the patient’s healthcare home.

The College also agrees that patient portals will become an increasingly important tool for empowering patients to manage their own health more effectively. We will continue to provide support and guidance to GPs to increase uptake.

## Theme 2 - Closer to home

General practice is embedded in the community, and is often an integral part of that community. It already plays a key role in providing care to patients close to their home.

## A multi-disciplinary workforce for primary care

It is well-recognised that a strong primary healthcare system is fundamental to safe, quality, patient-centred and cost-effective care. It is the College’s position that continuous and comprehensive care is best provided by a collaborating multidisciplinary team of health professionals with oversight, delegation and leadership by the patient’s usual health provider (who is usually a GP).

There appear to be considerable advantages in aiming to make better use of practitioners within the existing primary care team – and also in expanding that team to include new players whose skills complement those of GPs and nursing staff. For example:

* Making better use of GPs with advanced competencies or advanced training to provide high quality care closer to home, in particular in the management of patients with complex needs and long-term conditions.
* Putting a greater emphasis on the care coordination role played by general practices. This is likely to have particular benefit for patients with long-term and complex conditions, where they are required to interact with a variety of health practitioners working in a range of different health services.
* Clinical pharmacists, working within a general practice, might play a more significant role in the management of patients on long-term medication and people in rest homes.
* New models of working allow GPs to spend more time with those patients who have the greatest need. Telephone triage, electronic analysis of health records and other models all allow GPs to work more effectively and efficiently.

## GPs with advanced competencies

The College agrees that new skills and technologies will allow some services to be shifted from the hospital to the community. GPs are already able to provide the care needed for more than 90% of the health problems that they encounter[[23]](#footnote-23). GPs with advanced competencies or advanced training are able to provide an even broader range of services and evidence demonstrates that care for illnesses common in the population is cheaper if provided by generalists rather than specialists, with no difference in outcomes[[24]](#footnote-24).

In our view, one critical area where GPs should be playing a much more significant role is in helping patients to manage complex needs and long-term conditions. General practice in New Zealand has already moved well beyond the model of “one GP, one patient”, and we strongly support new models that make use of GPs with advanced competencies or training – and also non-governmental organisations in their community.

One example of a model that is worthy of consideration and expansion is the GPSI Diabetes[[25]](#footnote-25) model that has been successfully operating in Hawkes Bay, and has now expanded into Auckland. The GPSI Diabetes service is a community-based service, run by a general practitioner with a specific interest (GPSI) in diabetes, and a practice nurse. Adults with diabetes are referred to the service by their GP and care is provided using a set of loosely structured diabetes-specific patient-centred approaches. Following a series of visits, patients are discharged back to their GP.

An audit of this programme published in the Journal of Primary Health Care[[26]](#footnote-26) found that New Zealand Europeans and Māori with Type 2 diabetes and Type 1 diabetes experienced immediate and sustained (two-year) improvements in HbA1c, and that ethnic disparities in HbA1c were reduced by a small – but statistically significant - amount. In addition, a survey of GPs and patients found strong support for the programme – with 72% of patients also indicating an increased understanding of diabetes and better self-management.

To support this theme, the College recommends that the Road Map should support initiatives intended to make better use of GPs with advanced competencies or advanced training to provide high quality care closer to home, in particular in the management of patients with complex needs and long-term conditions.

Making better use of general practitioners with advanced competencies will also help to address concerns about the lack of career pathways in primary care. The career structure in general practice is currently largely flat, with very little opportunity for career development once a GP obtains Fellowship. A primary reason for this is that there is no recognition of experience in general practice, and little incentive for GPs to develop advanced skills. Funding structures are flat, despite evidence that a greater breadth of services provided in primary care is associated with lower overall healthcare costs and fewer hospitalisations[[27]](#footnote-27), and also improved health outcomes[[28]](#footnote-28).

## Role expansion in the wider context

However, we also suggest that some care needs to be taken when considering any form of role expansion – whether it be in the context of GPs taking on advanced competencies, or role expansion for another practitioner such as a pharmacist, nurse or physiotherapist.

It should be a given that role expansion should only occur when a practitioner has sufficient skills, knowledge and expertise to complete the task required. It is important to note that even a small knowledge gap might create risk or result in a considerable rise in the overall cost of care. For example, a relatively unskilled worker who is triaging requests for after-hours care is likely to prioritise in a more conservative manner than a better trained colleague, leading to a higher number of call-outs and unnecessary urgent hospital referrals.

There are therefore some services that should not be shifted away from their current providers. Neurosurgery should continue to be performed by neurosurgeons, and diagnosis should continue to be undertaken only by those practitioners who have comprehensive training in assessment and diagnosis.

However even when a practitioner has appropriate proficiency, role expansion has the potential to have a negative impact on patient care. This is because of the potential impact on both continuity of care, and on the comprehensiveness of care.

## Continuity of care

Continuity of care is a cornerstone of high-quality health care in New Zealand and there are clear risks to patients where continuity of care does not exist. A fundamental requirement of good medical practice is to adequately assess the patient’s condition, taking account of the patient’s history[[29]](#footnote-29). General practitioners put care in the context of the whole person, including knowledge of home-life and social circumstances. Without continuity of care an elderly and frail person may be discharged after treatment for one of many illnesses, without support and into an inappropriate home environment[[30]](#footnote-30).

While continuity of care is clearly easier to achieve when the same practitioner provides the same care to the same patient over time, it can also often be achieved by ensuring that practitioners who provide care to a patient share comprehensive information about that patient with the patient’s usual health provider in a timely manner.

## Comprehensiveness of care

There is also an emerging body of research revealing that more comprehensive primary care is associated with lower costs and fewer hospitalisations[[31]](#footnote-31), and also improved health outcomes[[32]](#footnote-32). “More comprehensive” in this context refers to the breadth of services that are delivered. Much of this benefit can be attributed to opportunistic interventions. For example, a GP might take the opportunity provided by a consultation for a repeat prescription of the oral contraceptive pill to remind a patient that it is time for a cervical smear test or to discuss lifestyle choices and conduct a diabetes check.

Role expansion that reduces the comprehensiveness of primary care limits the opportunity for opportunistic interventions and over time this will result in: a rise in overall health costs; an increase in the rate of hospitalisation; and a decline in health outcomes.

## Integration

In our view, role expansion works best in primary care when the practitioner with an expanded role is a member of the primary care team. In this context, care coordination and continuity of care are much easier to maintain – and for the patient there are not the risks associated with being passed from one service to another, and then back again.

## When role expansion is appropriate

As a general rule then, the College supports role expansion when:

* The substitute practitioner has appropriate skills, knowledge and expertise.
* It frees up other practitioners, and allows them to practice at the top of their scope.
* Continuity of care is maintained, and relevant information about the patient is passed to their usual health provider (who will usually be their GP).

It is also strongly preferable that practitioners undertaking a task substitution role be practising within primary care, as part of a team that includes the patient’s usual health provider.

To support this theme, the College recommends that the Road Map should provide guidance on when role expansion is appropriate, which makes clear that it should only be introduced when: It frees up other practitioners, and allows them to practice at the top of their scope; The substitute practitioner has appropriate skills, knowledge and expertise; Continuity of care is maintained, and relevant information about the patient is passed to their usual health provider (who will usually be their GP).

The College further recommends that this guidance state that it is strongly preferable that role expansion should only occur when a practitioner with an expanded role is practising within primary care, as part of a team that includes the patient’s usual health provider.

Whenever services are shifted from one group to another, standard-setting is important to ensure that quality is maintained. The College provides an important role as a standard-setter for general practice, despite considerable professional resistance, and therefore should be central to the development of any standards that relate to service delivery in primary care.

Critically, role expansion in general practice will rely on there being a sufficient number of well-trained primary care nurses available to support GPs. A plan therefore needs to be made to improve retention of primary care nurses and recruitment of GPs, and to ensure that the demographics of our health workforce reflect the demographics of the New Zealand population.

To support this theme, the College recommends that the Road Map must include a plan to improve retention of primary care nurses and recruitment of GPs - and to encourage more Māori to train as health practitioners. The College appreciates the recent increase in funding to support the training of more GPs, and has set a target to increase the number of Māori entrants to our training programme to 22%.

While GP recruitment has risen in recent years (172 registrars entered the general practice training programme in 2015 – up from 69 in 2007), we are also aware that the workforce is ageing – with 41% of GPs intending to retire in the next 10 years[[33]](#footnote-33). There is a risk that in shifting greater services into the sector without also providing GPs with appropriate support could result in higher workloads, and therefore higher levels of stress and burn-out.

To support this theme, it is recommended that the Road Map consider the sustainability of the primary care workforce, and ensure that any change is accompanied by appropriate support for all practitioners affected by that change. Pastoral care of GPs is a key function of the College, and we can provide support around this action.

In terms of specific actions within this theme, the College’s view is that there would be relatively great gains through relatively little cost by including a focus on providing smoking cessation support for pregnant and postnatal support for women who smoke. An audit of hospital services (who are meeting the >95% Hospital Brief Advice to Quit Target), found that only 21% of hospital admitted pregnant women who smoke were charted nicotine replacement therapy (NRT) and only 8% were referred for smoking cessation support. Cost is a big barrier for pregnant women and providers have reported having had trouble accessing the NRT inhalator and spray for pregnant women in the community. Evidence suggests that incentives to quit for pregnant women are more effective than any other[[34]](#footnote-34). Quit rates of 70% have been achieved with $250 worth of vouchers (3 months Co2 validated quits, Maori women)[[35]](#footnote-35); however incentive based smoking cessation services for pregnant Maori women are not mandated nationally.

To support this theme, it is recommended that an action, within Action 6, be included which focuses on providing pregnant and postnatal women who smoke with support to be smokefree by means of ready and free access to nicotine replacement therapy and support to quit services. This action should be supported by a Health Target that measures the percentage of hospitalised pregnant women who smoke and who are provided with cessation support.

## Theme 3 – Value and high performance

There is good evidence internationally of the value that GPs bring to the health sector. Work by Barbara Starfield and others has found that health is better in areas with more primary care doctors, people who receive care from primary care doctors are healthier regardless of their initial health or various demographic characteristics, and the characteristics of primary care are associated with better health. An increased supply of primary care doctors is also associated with lower total costs of health services.[[36]](#footnote-36)

## An investment approach

The College supports the suggestion that an investment approach be taken to health. High-needs patients place a considerable cost burden on the health system, and in many cases these costs could have been averted through intervention at an earlier stage of illness. General practitioners already play a critical role in early identification of need, and their involvement will be critical in implementing an investment approach.

To support this theme, the College recommends that the Health Strategy include acknowledgement of the important role that primary care has to play when undertaking an investment approach – in particular in terms of early identification of patients where early investment in their healthcare will have the greatest benefit.

## Performance management in general practice

The College plays a key role in performance management for general practice. We set practice standards, through both the Cornerstone and Foundation standards, and also provide assessment and moderation to measure performance against those standards. However, mechanisms that recognise high performers are also needed. We note that there has been a proposal that greater access / financial incentives be incorporated into the Integrated Performance and Incentive Framework (IPIF), and the College strongly supports this approach. The College submits that if the IPIF does not go ahead in this form, then some other positive incentive framework must be introduced.

To support this theme, the College recommends that the Road Map include mechanisms that allow high performance to be recognised, to support the role of the College in ensuring quality.

## Measuring value and high performance in primary care

Much of the value of general practice has been hidden because it is hard to measure. It is relatively straight-forward to measure how many hip transplants have been performed in a hospital, but it is difficult to measure improvements in the general health of a community attributable to high quality general practice. The College therefore supports the introduction of more nuanced metrics.

However, while the College supports the use of data, such as outcome data, to measure performance – we do note that arriving at a meaningful, intelligible and fair system is extremely complicated and carries the risk of unintended consequences.

In our view, greater use of metrics may have real benefit in general practice if used as a tool to improve quality. Already bpacnz prescribing reports and the Health Quality and Safety Commission’s *Atlas of Variation* provide powerful sources of information that allow GPs to reflect on their own practice, and to identify areas where that practice may not be in accordance with the practice of their colleagues.

However, we would counsel caution in interpreting such data to measure performance. By way of example about “interpretation”, data on polypharmacy in older people in the *Atlas of Variation* is very useful when viewed at a regional level. But, if taken at the level of an individual practitioner, it is likely to be misleading. A skilled practitioner who takes on more complex cases in a residential care facility is likely to be dealing with polypharmacy on a far more regular basis than a colleague who provides care to a healthier population in the community. Therefore, according to the raw number of “patients receiving five or more long-term medications”, a skilled practitioner may be perceived as being “worse at managing polypharmacy” than his or her colleagues. In such cases, data may need to be normalised to allow for a fair comparison to be made (for example, by comparing only the treatment provided to patients with a similar health profile).

In our view, the principles that should be followed when collecting, analysing and publishing performance data are that:

* The cost to health services and practitioners of data collection and administration must be minimised[[37]](#footnote-37).
* Data must be:
  + Reliable
  + Valid and comparable (in that any comparison recognises differences such as the diversity in the health profile of different practitioners’ patient populations)
  + Comprehensive (in that they compare across a large population of services and health practitioners).
* Data must be presented in such a way that they:
  + Genuinely represent quality
  + Are readily understood
  + Enhance public understanding.
* Data should be provided to health services and practitioners in a form that will help to drive quality improvement.

We are also conscious that there is a risk that because some measures of quality are easy to measure, then those measures will become more “important”. Healthcare systems are driven by data, and the means could easily become the end. For example, because prescribing data is relatively easy to collect and analyse, there is a risk that the quality of general practice will start to be measured by the quality or amount of prescribing. This could mean that a GP who prescribes within specified parameters but who is unable to develop a relationship of trust with his patients will be perceived as a “better” GP than one who has developed a relationship of trust with his patients and whose prescribing reflects the needs of individual patients as a whole, including social circumstances and the patient’s informed choice, rather than simply complying with what might be considered “best practice”.

## Shifting the focus of investment

As identified earlier, general practice is highly utilised, trusted by patients and effective. It is also relatively inexpensive. For the 2013/14 year, the New Zealand Government allocated $13,862 million for the funding of health and disability services through the Ministry of Health[[38]](#footnote-38). Of this, $5,824 million (42% of total health funding) went to district health boards for the provision of hospital services[[39]](#footnote-39), while $1,204 million (8.7% of total health funding) made it to PHOs and general practices[[40]](#footnote-40). A similar proportion exists in the money distributed by New Zealand’s other major health funder, ACC. In 2013/14 ACC spent approximately $2,981 million on health services, financial compensation, rehabilitation services, care and support and injury prevention[[41]](#footnote-41). Of this, $123 million (4% of ACC’s health spend) went to general practice[[42]](#footnote-42).

In total then, it appears that approximately 7.8% of Health and ACC funding goes into general practice. Although a direct comparison cannot easily be made, it does seem that New Zealand’s investment in primary care – as a proportion of total health spending – is at the lower end when compared to the investment made in both Australia and the UK. In Australia primary care accounts for around 10% of per capita expenditure on health[[43]](#footnote-43), while in the UK it accounts for around 8.5%[[44]](#footnote-44).

Although the level of investment is relatively low compared to the investment in hospital care, 96.1% of the population is enrolled with a PHO[[45]](#footnote-45) and half of all adults report that they had visited their GP in the past three months[[46]](#footnote-46). GPs provide all the care needed for more than 90% of health problems that they encounter[[47]](#footnote-47).

There is a developing body of evidence that increased investment in the GP workforce will reap significant benefits for New Zealand. We now have evidence that: health is better in areas with more primary care doctors[[48]](#footnote-48); an increased supply of primary care doctors is associated with lower total costs of health services[[49]](#footnote-49); and there is an emerging body of research revealing that a greater breadth of services provided in primary care is associated with lower costs and fewer hospitalisations[[50]](#footnote-50), and also improved health outcomes[[51]](#footnote-51).

Research conducted by Deloitte in the UK[[52]](#footnote-52) revealed that increased spending on general practice by £72 million each year could lead to short-term savings of £447 million annually through:

* Diverting patients away from Emergency Departments (the cost of seeing a patient in primary care is estimated to be around £45, while the cost of a comparable appointment in a hospital is estimated to be between £61 to £82).
* Reducing the number of unnecessary ambulance call-outs.
* Reducing the length of hospital stays for patients aged over 65, by providing greater primary care support at home.

Over the medium- and long-term, additional savings of up to £333 million were also predicted through:

* Increased case management in general practice of ambulatory case sensitive conditions.
* Interventions that encourage patients to make healthier lifestyle choices.

Despite the strong case for increased investment in general practice as a way to reduce total health costs, Government investment in general practice has actually decreased in recent years. The value of capitation (the primary funding avenue for general practice within Vote Health) has decreased in real terms by $47 million since 2006[[53]](#footnote-53). In 1999 there were 84 FTE GPs per 100,000 New Zealanders, in 2012 this ratio had fallen to 74 per 100,000[[54]](#footnote-54). NZ Health survey results in 2014 show that 14% of the NZ population (over 500,000 people) chose to forgo attending a GP because of cost. Even more worryingly, 21% of Maori and Pacific People reported an unmet need for GP services because of cost[[55]](#footnote-55).

Some steps have been taken to help reverse this trend. With an ageing workforce and a population with increasingly complex service demands, the Government has recognised the need to train more GPs and has increased the level of funding for training. This allowed the College to place 172 registrars in the general practice training programme’s 2015 intake – up from 69 in 2007.

While investment in training GPs has increased, there is a strong case for direct investment in general practice to also increase – and in particular for an increase in the proportion of Vote Health and ACC funding that goes into general practice.

The College recommends that the Road Map should set a target for increasing the proportion of Vote Health and ACC funding that goes into primary care, and put in place a primary care investment plan to deliver this. This will build on the commitment made in the Health Strategy to see a wider range of services delivered in primary care. It should also result in a significant reduction in other health sector costs, and therefore savings for Government.

While some District Health Boards (DHBs) have developed strong relationships with general practice within their regions, many have not. Despite Ministerial directives to this effect, some DHBs have been very slow to shift the delivery of services away from hospitals and into primary care. The lack of support has made it very difficult for GPs to provide care to their patients in an integrated way, or to develop new and more effective models of care. Our view is that one solution to this issue is to start monitoring and reporting DHB performance in this regard.

The College recommends that the Ministry of Health begin to publish statistics monitoring how DHBs allocate their funding, including what proportion of their funding is invested into general practice and community care. This will provide a national picture of how initiatives are achieving the shift in service delivery envisaged in the Health Strategy*.*

There is currently a perception in primary care that current general practice funding formula and co-payment rules fail to ensure the sustainability and equity of access to general practice. In particular, a number of issues with very low cost access (VLCA) funding have been identified by general practice across the country[[56]](#footnote-56). The College is pleased that the Ministry of Health has asked General Practice New Zealand (GPNZ) to provide informed feedback on ensuring affordable, equitable access to sustainable general practice – including on the sustainability of VLCA funding.

The College recommends that the Ministry of Health review current general practice funding mechanisms in light of the feedback provided by GPNZ, and ensures that funding for general practice is not just increased – but that it is also allocated in a way that is fair, streamlined and needs based.

Increasing the proportion of health sector funding that goes into primary care will allow practices to employ more GPs, nurses and other health workers – but further investment is also needed to build general practice infrastructure. In particular, funding is needed to improve: the uptake of new communications technology in general practice; institute new models of care; build the primary care infrastructure needed to provide a wider range of health services; and to support more GPs to work in areas of need.

The College recommends that the Road Map should include provision for a new five year transformation fund to build the primary care infrastructure needed to meet current and future needs.

## Theme 4 – One team

The College supports changes to the structure and organisation of the Ministry of Health intended to improve its performance. In this context we note that:

* Health Workforce New Zealand has provided a place where open and honest conversations about workforce can be held. That has been invaluable, but the performance of this body must be measured and transparent.
* The National Health Committee has a role to play in taking on tough issues, and independence is an important part of that role.
* The Health Quality and Safety Commission has done a considerable amount of good work in the short span of its existence, and seems to have genuinely benefited from its structural independence from the Ministry of Health.

The College’s overall view is that a “one size fits all” approach to the restructure of Ministerial bodies would not be appropriate. The bodies listed above have demonstrated the value of independent management and governance, even if performance has not been all that it could be. For this reason, we recommend that the Ministry’s health advisory structures continue to maintain a high degree of independence.

In the College’s view, effective implementation of change in the health sector is best achieved when it harnesses clinical leaders. Clinical leadership is needed at all levels of the health system, including at a national, regional and practice level.

40% of the specialist workforce is made up of general practitioners, and for most patients their first presentation with an illness or injury is to their GP. For this reason, clinical governance – particularly at the national and regional level – should include sizeable GP input.

The College also supports the focus on reducing fragmentation and on health practitioners developing new or stronger skills. As discussed above, there is considerable potential for the health system to make better use of GPs with advanced competencies or advanced training to provide high quality care closer to home, for example in the management of patients with skin cancer. A transformation fund, to build the GP infrastructure needed to provide a wider range of services is necessary to support this change.

In our view, there should be a focus on learning together, as well as on working together. Collaboration and integration can only be encouraged when different health practitioners learn alongside one another.

The College also strongly supports integration. There are two key types of health service level integration that the College considers vital to comprehensive and continuous patient care:

1. Integration of services – this improves patient access and can help bring services closer to home. In the College’s experience, the greatest successes with integration have started at the local level as a result of clinical leadership and teamwork in a well-organised system.
2. Integration of health professionals – It is the College’s position that continuous and comprehensive care is best provided by a collaborating multidisciplinary team of health professional with oversight, delegation and leadership by the patient’s usual health provider (usually a GP).

Barriers to health service level integration need to be identified and minimised. Barriers can include: inadequate funding mechanisms; a lack of appropriate infrastructure, such as IT interoperability; a silo mentality; and systems that create more work for clinicians, rather than less.

Integration is increasingly common in general practice. The College’s 2015 workforce survey included questions around integration, and revealed that the majority of GPs already work in an integrated way with at least one colleague who is not a doctor or nurse. The most commonly reported relationship was with pharmacists (31% of GPs reported that they worked with pharmacists in some way), closely followed by physiotherapists (28%) and counsellors (26%). The survey also investigated the degree of integration, and found that the highest degree of integration is found when GPs reported that they work alongside nurse practitioners, practice assistants, physician assistants and social workers.

It is also important to note that there are already bodies that play a contracting and co-ordinating role in the delivery of services in the community – PHOs. If a wider range of services are to be delivered in the community, then it appears logical that PHOs should take the lead in co-ordinating those services.

The College recommends that the Road Map make clear that PHOs should have a central role in the co-ordination of services in the community.

The College also recommends that the Road Map include a greater focus on health and social services working together in a more integrated way. In particular, the Road Map should recognise the importance that social determinants have on health – and advocate for policy approaches to address these. For example, attempts to reduce the incidence of rheumatic fever would be greatly facilitated by the provision of warm and dry social housing.

Addressing the social determinants of health will require national coordination. Therefore, in our view, the focus on integration needs to extend beyond health and social services and include commitments from Government and Government agencies.

The Ministry of Health’s *Intervention Framework to Improve Health and Reduce Inequalities in Health* provides detailed guidance on actions, starting at the governance level, that health sector and other organisations should be taking to achieve equity.

In our view, Action 13 of the proposed Road Map needs to reflect the advice provided by the Ministry in this document and should be reworded to state:

“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 outcomes.”

Action 13 should also require governance bodies to self-audit against the Ministry of Health’s *Intervention Framework to Improve Health and Reduce Inequalities in Health*.

Similarly, we recommend that Action 14 be reworded to include a greater equity focus. This should state:

“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 performance.”

## Theme 5 – Smart system

IT is a key enabler for a future health care system based on integration and collaboration, and also as a tool to better enable patients to better manage their own health. The College supports the introduction of a national electronic health record and the statement that uptake of patient portals should be supported.

We also note the important role that Patients First has played as a broker between the Ministry of Health and IT vendors. That organisation has been successful in implementing a number of major projects that have improved the ability of health services to share information electronically.

The introduction of a shared electronic health record is particularly critical as a support for other focus areas of the Health Strategy which look at greater integration of health practitioners. Integration will require that all members of a multidisciplinary team have appropriate access to a patient’s history (e.g. their long term medications list).

The College recommends that to support this theme, the Road Map includes a focus on the development of a shared electronic health record.

As discussed above, the College also supports the better of use of data and analytics to improve services – although with some caveats around how such data is interpreted and used.

In the future data and analytics will also play a key role in the assessment and identification of illness. We are already aware of the use of search algorithms to examine patient records in general practice that have been able to identify patients with asthma with a high degree of accuracy, and which have enabled improved care[[57]](#footnote-57).

The College recommends that to support this theme, the Road Map includes a focus on opening up data-sets to allow improved identification of illness in primary care. Implementing this recommendation will require support to increase the capacity and capability of practitioners to undertake this work.

# How will we know that the Road Map for Primary Care has succeeded?

We will know that the Road Map for Primary Care has achieved its aims when:

* All New Zealanders have access to high quality primary care, when they need it.
* The number of New Zealanders enrolled with a PHO rises from 96.1% to near 100%.
* More patients are seen and treated in a primary care setting, and less in hospital Emergency Departments
* The number of unnecessary ambulance call-outs is reduced.
* The length of hospital stays for patients aged over 65 is reduced.
* There is increased case management in general practice of ambulatory sensitive conditions.
* The burden of lifestyle illness is reduced through interventions in primary care that encourage patients to make healthier lifestyle choices
* The burden of diseases that arise through social determinants of health is reduced by health and social services working together in tandem.
* There is a reduction in the health disparities that exist between different patient populations.
* The number of nurses, doctors and Māori choosing to work in primary care increases.
* The rate of rise in Vote Health and ACC funding decreases, and the proportion of this funding that goes into primary care increases.
* Patients and health practitioners have easy access to the health information they need, at the time they need it and in a way that they can understand it. This means that New Zealanders make regular and effective use of their patient portal to better manage their own health, and an electronic health record allows practitioners in primary, secondary and allied care to access all the information they need when a patient consults them.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College’s policy team at [policy@rnzcgp.org.nz](mailto:policy@rnzcgp.org.nz).

Yours sincerely

[redacted]

**Chief Executive Officer**

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| --- | --- | --- |
| **318** | Submitter name | Michael Howard |
| Submitter organisation | Patients First |

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| --- | --- |
| This submission was completed by: *(name)* | Michael Howard |
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| Organisation (if applicable): | Patients First |
| Position (if applicable): | National Operations Manager |

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

as an individual or individuals (not on behalf of an organisation nor in a professional capacity)

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)*: IT Integration

### 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 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 sentence has a lot of words and is full of slogans, but it is very generic. It could equally apply to any health system in the world. Can we have something aspirational, easily remembered, meaningful, clear and engaging for New Zealand? Healthy New Zealanders for example. |

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 document is light on how these will be measured. They may be guiding principles, but it is unclear how the rest of the document and the actions link into these. |

### 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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| Yes, but the action items are light. How will the ‘what great look like be measured’? What are the baselines? The ‘what great might look like’ is in some instances very generic. Health is becoming increasingly driven by people’s expectations. The need to invest in technology solutions to support new and emerging models of care is under stated. This is much more than patient portals, which is the main point made regarding technology.  We would suggest a set of statements that make it a NZ document. The current statements are mostly generic, broad and open to interpretation. For example we could have: “a smokefree New Zealand by 2025”, “eliminate childhood obesity by 2025” etc. The statements should be inspirational, engaging, clear and precise. This is a “New Zealand” Health Strategy, and those who read it should be saying – “yes I want to be part of making that happen”. It reads far too bureaucratic.  The whole philosophy on how care is delivered will need to change to support these goals and combat the stated challenges. Otherwise we will just be supporting an outdated transactional model of care that will not deliver what is needed for the future. This seems to only lightly be touched on in Closer to Home (eg minor surgery in the community) and only on an individual service basis rather than how the system is strategically configured. |

### 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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| *Specific Suggestions:*  Action 1: Inform and Involve People  It is suggested that a stocktake be undertaken as the first step. Stocktakes often take a while to develop and are only current to a point in time. It will quickly go out of date unless it is maintained, which we doubt will happen for the long term. We recommend this action be deleted.  Instead of the Ministry having a specific social media action on diabetes, we recommend that the Ministry enable greater use of mobile technologies, eg through the Health App Formulary proposed in Action 19 (d).  Action 2: Know and Design  Dissemination of information is important (eg through conferences), but it does not lead to consistent service implementation. The proposed action is just to ‘showcase’ three examples, rather than do anything with them. It is recommended that a second part of this action could be to consider these for a funded national rollout. Action b. discusses ‘support clinician-led collaborations’, however, it is unclear what ‘support’ means. Is the Ministry considering funding these collaborations with service planning, implementation and service delivery to their high need patients?  Action 3: Shift Services  “The Ministry of Health, with input from the system, will ensure the right…” Although it is laudable and high level, we are not sure this is achievable. We recommend more emphasis be placed on addressing the known barriers for shifting services. This is particularly regarding DHBs’ sunk costs in their hospital assets, change costs for DHBs (particularly those with deficits that are reluctant to invest in spending more in the short term), Union issues, etc. It is relatively easy to develop the service pathways, but nothing will change unless the DHBs are able to address these issues. We strongly recommend this action be reframed to addressing these barriers.  Action 4: Shift Services  Although part of the care team, pharmacists do not provide continuity of medical care to patients. We recommend caution in extending pharmacists’ prescribing rights, and acknowledge that this is a controversial issue.  Action 5: Tackle Long-Term Conditions and Obesity  This action only discusses the role of “the Ministry of Health and DHBs”. It is recommended that the Ministry acknowledge the role of service providers. The Ministry and DHBs cannot implement the NZHS by themselves.  Although we acknowledge the risk obesity poses, there are no actions on reducing the prevalence on smoking. Although obesity is the new government target, we do not consider the Ministry loosing sight of the risk that smoking poses to be appropriate within the NZHS. It is unclear if it is still the government’s intention to aim for a smokefree New Zealand?  We recommend the NZHS more strongly indicate the need for an increased focus on preventative health to address avoidable long-term conditions. The statistics regarding childhood obesity and obesity in general for example reflect a disappointing failure as a system.  Consistency in some of the goals across elections (or individual Ministers) would help provide stability and clarity for the system.  Sub-action d. Successful partnerships cannot be “required” as stated. Partnerships are built on a foundation of trust and respect. We recommend this be re-worded to state “the Ministry will help foster successful partnerships to develop between organisations”.  Action 6: A Great Start for Children, Families and Whanau  This action places a focus on “at risk” children, however the document does not state what the children at risk of. This could be interpreted as poor oral health, poor hearing, poor educational achievement, witnessing family violence, poverty, depression, obesity, abuse etc, etc. This could be defined to include a very large part of the New Zealand population with its wider definition. We recommend this be defined to provide clarity (for example with a footnote or a reference to another document that has an appropriate definition).  Sub-action b. It is unclear whether ‘promoting healthy nutrition’ will be enough to change deep lifestyle habits and therefore lead to reduced prevalence of obesity. The Ministry could work with the Ministry of Education on policy requirements regarding sugar and fat content in food for schools and tertiary institutions. The Ministry could also work with District Health Boards, local Councils and other government-owned entities to do similar.  Sub-action f. There is an opportunity for the Ministry to work with the Department of Corrections in ensuring that prisoners are enrolled with a general practice as part of their release plan.  Action 8: Improve Performance and Outcomes  Although the loss of traction on the Integrated performance Incentive Framework (IPIF) is very disappointing, it is positive that a health outcome-focused framework is still a goal. We strongly recommend that this includes a co-designed and co-governed approach with the sector (rather than “with involvement from the health and disability system”. The idea behind IPIF was generated from the primary care sector and passed to the Ministry. May be as an alternative, the approach could be turned around and the Ministry could contract with the primary care sector to deliver a working model?  Action 10: Align Funding  Sub-action d. “Agree on IT project funding priorities” reads as an after thought. It may be better to integrate IT solutions to support new service pathways and models of care throughout the document. We would suggest that “agreeing priorities” does not go far enough. We recommend that this be re-written to have IT systems implemented as the goal. The current goal would not result in any IT system being implemented, which would be inappropriate.  Action 11: Target Investments  We recommend this action could include developing and using a health and social investment approach.  Action 13: Clarify Roles, Responsibilities and Accountabilities  It appears this action relates to the Ministry of Health, DHBs and any Ministerial Advisory Committees. We recommend that the leading sentence be re-worded from improving decision-making “across the system”, to be “within the Ministry of Health and DHBs”. If it is intended that the governance arrangements and decision-making processes of providers is included, then we recommend this is explicitly stated.  Action 14: Clarify Roles, Responsibilities and Accountabilities  Sub-action a: Recommend this action be re-worded to be review “and implement changes as necessary”.  Action 15: Integrate Health Advice  It is unclear what “incorporates or takes into account relevant existing national committees” means. Does this mean those committees will be absorbed into the new Integrated Health Advisory Structure? If it is, then that would be very helpful. However we would question the need for this new structure to have its own governance board. This could be with the Ministry of Health’s internal staffing structure. We question what return on investment the creation of these types of structures (NHB Board for example) has provided to the system.  Action 18: Strengthen National Analytical Capability  Recommend a new action be included on working with other Government departments to electronically determine eligibility to health and disability services. This would particularly include the Departments of Corrections and Internal Affairs. This could then be integrated into the National Enrolment Service (and potentially the NHI for hospital and other 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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| As stated above many of the actions and “what great would look like” don’t appear to be very measurable. They are not SMART actions. There are no baselines provided. Some of the language is “improve” – but by how much should the target be stretched?  Full public reporting should be completed annually. Data should be made available so true progress can be measured. Too much reporting is redacted by the Ministry, so the true picture remains unknown. “You can’t manage what you don’t know”, and the system needs full disclosure to support healthy New Zealanders. |

### Any other matters

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

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| One of the key areas that needs to be extended is sharing of information inter-sectorally. This will require a number of privacy issues to be addressed. This continuously proves difficult within health with the Office of the Privacy Commissioner detailing complaints about data breaches. However, we do not consider that addressing these types of issues to be impossible. Patients First for example will be releasing a free secure email service for the health sector before Christmas 2015 called hMael.  The ability to match data across sectors would be hugely beneficial for the Government, but not all sectors have unique identifiers, so this cannot be done. A good example is education. The ability to track educational performance with health need. Some small items would make a significant difference for this, for example having clear common definitions that are used across sectors.  The emerging space new technology (eg genomic profiling with 23 and Me, and health apps) is likely to create information overload on the system. Future information needs will need to be sorted, prioritised and integrated.  Managing the mountain of future information will likely see a need to increase the investment in primary care IT. We note that the spend on primary care information technology is low when compared to secondary care, and also non-health industries. We recommend the NZHS provide actions that address the barriers for IT investment.  We also recommend that there be a single source of truth for patient information. This could be developed as a ‘Patient Health Record as a Service’ that lives in the cloud, with individual vendors being able to access it. |

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| **319** | Submitter name | [redacted] |
| Submitter organisation | Te Ara Hā Ora |

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**1 December 2015**

### Re: Submission on the Update of the New Zealand Health Strategy

To Whom It May Concern:

This submission is on behalf of Te Ara Hā Ora, the National Māori Tobacco Control Leadership Service based in Tamaki Makaurau. The purpose of Te Ara Hā Ora is to work with Māori to take action to eliminate tobacco from Māori communities. To achieve this goal we grow local, regional and national leadership, increase communication and enhance collaboration across the country. Te Ara Hā Ora is dedicated to ensuring that Māori are strongly represented in local, regional and national tobacco control initiatives, especially in regards to policy development opportunities.

We would like to take this opportunity to acknowledge the many strengths of the proposed update of the New Zealand Health Strategy. The focus on strengthening the health care system, the need to improve the health status of Māori, whānau ora, reducing harm to young people, housing, climate change and the role that changing technologies will have in the future health of New Zealanders is commendable.

However, from the perspective of population health, prevention, and cost effectiveness, the draft Strategy could be strengthened particularly around smoking, which from our reading, is scarcely mentioned in the draft.

Tobacco smoking remains the number one preventable risk factor for health loss in NZ. It is also a major contributor to health disparities between Māori and non-Māori. In 2011, the New Zealand government committed to the Smokefree 2025 Goal. The New Zealand tobacco control sector have also developed a “roadmap of actions”, which sets out a detailed plan for reaching 2025. Furthermore, the Government recently committed to developing a comprehensive strategy for achieving the 2025 goal. From our reading, neither of the aforementioned are acknowledged in the draft Strategy. Given the governments commitment to the 2025 goal and that cost-effectiveness and substantial economic benefits are key elements of this strategy, the lack of strong actions around the major causes of preventable illness and disease, like smoking, is of concern.

Key Recommendations:

Prevention

* A stronger focus on preventative measures is needed, especially initiatives to address tobacco smoking, New Zealand’s major cause of preventable illness and death. Stronger preventative measures in this area have been shown to be cost effective in that they lead to reduced health care costs over time and deliver the best health outcomes in the long term.
* A stronger focus on population health goals, like Smokefree New Zealand 2025, with more concrete actions and commitment are needed. Existing strategies and frameworks for reaching 2025, namely the “Roadmap of Actions” developed by the New Zealand tobacco control sector, and the Te Ara Hā Ora Strategic plan for Māori also deserve acknowledgement.

Priority Populations

* A stronger focus on priority populations like Māori and Pacific, and reducing health disparities are needed. Initiatives that address the wider negative determinants of health (poverty, education, employment) and improve access and “user experiences” in the primary care and cessation/treatment setting have been seen as key factors to addressing the high smoking rates amongst Māori.
* Targeting priority populations through prevention or stop smoking support makes fiscal sense, as Māori experience the greatest level of harm from tobacco smoking and associated long term conditions like heart disease and cancer.
* Based on the principles of the treaty and the current health status of Māori, we believe that the guiding principle “*Acknowledging the* ***special relationship*** between Māori and the Crown *under the* ***Treaty of Waitangi”*** should be given higher priority and consideration in the updated Strategy.

Justification and evidence for recommendations:

Prevention

**What the Strategy says:**

Like many other health systems around the world, our system faces the challenges of an ageing population and a growing burden of long-term conditions, such as heart disease, diabetes and mental health conditions. Issues such as obesity can also lead to longer-term health problems.

**Our response:**

The Update of the New Zealand Health Strategy identifies our “strong primary care focus with a widely supported focus on wellness” as a key strength of the current New Zealand health system.  However, focussing on the urgent, and devoting the majority of our resources to urgent matters, has the potential to ignore opportunities to reduce need in the future, and also may be unethical. If we keep spend solely on immediate need and neglect public health initiatives, then it is possible that more people will die prematurely (Woolf, 2007).

Many countries now recognise that increasing the resources allocated to public health initiatives, especially initiatives to reduce the prevalence of smoking, combat obesity, and reduce the harms associated with alcohol, is essential to better long term health outcomes (Swinburn, 2008; Wilson & Thomson, 2007).

**What the Strategy says:**

The Treasury considers that New Zealand cannot afford to keep providing services as we do now. It projects that, without significant change, government health spending would have to rise from about 7 per cent of GDP now, to about 11 per cent of GDP in 2060

**Our response:**

Research also shows that investing in prevention and other public health measures is cost effective. Such investment saves considerable clinical treatment costs, and maintains the health of the workforce - which is a prerequisite for economic prosperity (Ahmad, 2005; Ahmad & Billimek, 2005; Wilson & Thomson, 2007).

Priority populations

**What the Strategy says:**

Some of New Zealand’s population groups receive unequal benefits from the health and disability system. This can be seen in life expectancy statistics; while New Zealanders overall are living longer, Māori and Pacific peoples still have a lower life expectancy.

**Our response:**

Tailored public health measures are critical to population level efforts to reduce health inequalities, and have more reach and impact at a population level than interventions in the secondary and tertiary health sectors.

Literature documenting the status of Māori health in Aotearoa/New Zealand overwhelmingly confirm that Māori are poorly represented in positive health and wellbeing outcomes (Pomare, 1995; Robson & Harris, 2007). Māori have significantly higher mortality rates than non-Māori; lead in almost every major disease category (e.g. asthma, ischemic heart disease; breast and lung cancer); have a higher prevalence of chronic diseases than non-Māori; and experience higher mortality rates as a result of a chronic disease (Pomare, 1995; Robson & Harris, 2007).

Currently 32.7 per cent of Māori identify as being regular smokers – more than double the smoking rates of non-Māori.[[58]](#footnote-58) Among Māori men the regular smoking rate is 30.5 per cent and among women it is 34.7 per cent.[[59]](#footnote-59) 40.5 per cent of Māori women of childbearing age (20- 44 years) smoke regularly.[[60]](#footnote-60) In 2014, Māori girls were more than three times more likely to be a regular smoker than non-Māori girls.[[61]](#footnote-61) Māori boys were also more than three times more likely to be regular smokers than non-Māori boys.[[62]](#footnote-62) Māori girls have consistently had the highest daily smoking rates of Māori and non-Māori boys and girls since 2000.[[63]](#footnote-63) Although data is limited, it is estimated that 33 per cent of all cigarette equivalents are smoked by those with a mental illness.[[64]](#footnote-64) Figures from the Ministry of Health also show that in 2010/11 Māori had the highest rate of mental health and addiction service use (4938 people seen for every 100,000 Māori) when compared with Pacific people and other ethnicities.[[65]](#footnote-65)

The relative lack of information on ‘what is effective’ for Māori has been a major concern in Māori health promotion. While a number of programmes have been shown to be effective with non-Māori, less impact has been shown on Māori health (Barwick & others, 2000).

**What the Strategy says:**

Stronger partnerships and changing approaches will allow us to do even more.

**Our response:**

The Bangkok Charter for Health Promotion in a Globalised World (World Health Organisation 2005), an international forum that built on the Ottawa Charter (World Health Organization 1986), highlighted as one of the key issues to be addressed, at both local and global levels, the links between inequalities being faced by indigenous people and their health status. Mason Durie, a prominent Māori researcher also concluded that the preferred path to goals of Māori development should be based on ‘Māori social structures, Māori delivery systems and a Māori cultural context’.

**What the Strategy says:**

The principle that acknowledges the Treaty of Waitangi should guide the design of training for health workers and board members to ensure they have appropriate knowledge about the Treaty, its implications for the participation of Māori in the health system, partnership approaches to services, and the need to improve the health status of Māori.

**Our response:**

The 1980s saw a growing challenge by many Māori health providers and consumers of the shortcomings of western-based models of health. This coincided with a resurgence in aspects of Māori culture, a greater awareness of the impact of colonisation and increasing understanding of the relevance of the Treaty of Waitangi to contemporary New Zealand society. In the health sector, the Treaty of Waitangi has often been interpreted in terms of the right of Māori to make decisions about their own health care, and attainment of equity of health status. Thus many Māori argue for increased delivery of services ‘to Māori by Māori’ and for control of the resources to facilitate this (Huriwai, 2002).

**What the Strategy says:**

New Zealand’s Māori Health Strategy, He Korowai Oranga, uses the concept of mauri ora to reflect its focus on individual people. It says that people using health services need pathways to care that meet their immediate needs as well as their future needs, across all stages of their life. This Strategy similarly acknowledges that need.

**Our response:**

The last 30 years has seen the development a number of tīkanga and kaupapa Māori based paradigms and models – many of them now ‘common place’ in the Māori health sector –as a way to address the aforementioned issues and concerns of Māori.

**What the Strategy says:**

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.

**Our response:**

Targeting priority populations through prevention or early detection initiatives makes fiscal sense as these groups are more likely to be affected by long-term conditions such as heart disease and cancer.

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| **320** | Submitter name | [redacted] |
| Submitter organisation | Public Health Association, Auckland Branch |

**1 December 2015**

### Re: Submission on the Update of the New Zealand Health Strategy

To Whom It May Concern:

This submission is on behalf of the Public Health Association, Auckland Branch. The Auckland Branch has recently undergone a process of ‘revitalisation’ with its incoming executive committee and a renewed focus on lifting the public health profile of Tāmaki Makaurau. The branch adheres to the directives of the national body, the Public Health Association of New Zealand Inc.

We would like to take this opportunity to acknowledge the many strengths of the proposed update of the New Zealand Health Strategy. The focus on strengthening the health care system, the need to improve the health status of Māori, whānau ora, reducing harm to young people, housing, climate change and the role that changing technologies will have in the future health of New Zealanders is commendable.

However, from the perspective of population health, prevention, and cost effectiveness, the draft Strategy could be strengthened. There is scope for the draft Strategy to better consider the benefits of public health approaches in terms of health loss, and to set out a more coherent set of priority population health goals and actions to achieve them. Given that cost-effectiveness and substantial economic benefits are key elements of this strategy, the lack of strong actions around the major causes of preventable illness and disease, and top ten risk factors (e.g. high blood pressure, high blood cholesterol, high sodium intake) is a concern.

Key Recommendations:

Prevention

* A stronger focus on preventative measures is needed, especially initiatives to address the major causes of preventable illness and death like smoking, obesity, and the harms associated with alcohol. Stronger preventative measures in these areas have been shown to be cost effective because they reduce health care costs over time and deliver the best health outcomes in the long term.
* A stronger focus on population health goals, like Smokefree New Zealand 2025, with more concrete actions and commitment are needed. Population health goals for addressing the rising obesity epidemic should also be developed.

Priority Populations

* A stronger focus on priority populations like Māori and Pacific, and reducing health disparities are needed, especially initiatives that 1) improve access and “user experience” for “low access New Zealanders” in the primary care setting and 2) address institutional racism in the health system and the wider negative determinants of health (poverty, education, employment) for Māori and Pacific populations.
* Targeting priority populations through prevention or early detection initiatives makes fiscal sense, as these groups are more likely to be affected by long-term conditions such as heart disease and diabetes.
* Based on the principles of the treaty and the current health status of Māori, we believe that the guiding principle “*Acknowledging the* ***special relationship*** between Māori and the Crown *under the* ***Treaty of Waitangi”*** should be given higher priority and consideration in the updated Strategy

Justification and evidence for recommendations:

Prevention

**What the Strategy says:**

Like many other health systems around the world, our system faces the challenges of an ageing population and a growing burden of long-term conditions, such as heart disease, diabetes and mental health conditions. Issues such as obesity can also lead to longer-term health problems.

**Our response:**

The Update of the New Zealand Health Strategy identifies New Zealand’s “strong primary care focus with a widely supported focus on wellness” as a key strength of the current health system.  However, focussing on the urgent, and devoting the majority of our resources to urgent matters, has the potential to ignore opportunities to reduce need in the future, and also may be unethical. If we keep spend solely on immediate need and neglect public health initiatives, then it is possible that more people will die prematurely (Woolf, 2007).

Many countries now recognise that increasing the resources allocated to public health initiatives, especially initiatives to reduce the prevalence of smoking, combat obesity, and reduce the harms associated with alcohol, is essential to better long term health outcomes (Canberra, 2006; Cobiac, Vos, Doran, & Wallace, 2009; Swinburn, 2008; Wilson & Thomson, 2007).

**What the Strategy says:**

The Treasury considers that New Zealand cannot afford to keep providing services as we do now. It projects that, without significant change, government health spending would have to rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060

**Our response:**

Research also shows that investing in prevention and other public health measures is cost effective. Such investment saves considerable clinical treatment costs, and maintains the health of the workforce - which is a prerequisite for economic prosperity (S. Ahmad, 2005; Sajjad Ahmad, 2005; Chisholm et al., 2006; Cobiac et al., 2009, 2009; Grosse, Teutsch, & Haddix, 2007).

Priority populations

**What the Strategy says:**

Some of New Zealand’s population groups receive unequal benefits from the health and disability system. This can be seen in life expectancy statistics; while New Zealanders overall are living longer, Māori and Pacific peoples still have a lower life expectancy.

**Our response:**

Tailored public health measures are critical to population level efforts to reduce health inequalities, and have more reach and impact at a population level than interventions in the secondary and tertiary health sectors (H. Came, 2011; Heather Came, 2012, 2013, 2014).

Literature documenting the status of Māori health in Aotearoa/New Zealand overwhelmingly confirm that Māori are poorly represented in positive health and wellbeing outcomes (Pomare, Keefe-Ormsby, Ormsby, & others, 1995; Robson & Harris, 2007). Māori have significantly higher mortality rates than non-Māori; lead in almost every major disease category (e.g. asthma, ischemic heart disease; breast and lung cancer); have a higher prevalence of chronic diseases than non-Māori; and experience higher mortality rates as a result of a chronic disease (Pomare, 1995; Robson & Harris, 2007).

The relative lack of information on ‘what is effective’ for Māori has been a major concern in Māori health promotion. While a number of programmes have been shown to be effective with non-Māori, less impact has been shown on Māori health (Barwick & others, 2000).

**What the Strategy says:**

Stronger partnerships and changing approaches will allow us to do even more.

**Our response:**

The Bangkok Charter for Health Promotion in a Globalised World (World Health Organisation 2005), an international forum that built on the Ottawa Charter (World Health Organization 1986), highlighted as one of the key issues to be addressed, at both local and global levels, the links between inequalities being faced by indigenous people and their health status. Mason Durie, a prominent Māori researcher also concluded that the preferred path to goals of Māori development should be based on ‘Māori social structures, Māori delivery systems and a Māori cultural context’ (Barwick & others, 2000).

**What the Strategy says:**

The principle that acknowledges the Treaty of Waitangi should guide the design of training for health workers and board members to ensure they have appropriate knowledge about the Treaty, its implications for the participation of Māori in the health system, partnership approaches to services, and the need to improve the health status of Māori.

**Our response:**

The 1980s saw a growing challenge by many Māori health providers and consumers of the shortcomings of western-based models of health. This coincided with a resurgence in aspects of Māori culture, a greater awareness of the impact of colonisation and increasing understanding of the relevance of the Treaty of Waitangi to contemporary New Zealand society. In the health sector, the Treaty of Waitangi has often been interpreted in terms of the right of Māori to make decisions about their own health care, and attainment of equity of health status. Thus many Māori argue for increased delivery of services ‘to Māori by Māori’ and for control of the resources to facilitate this (Huriwai, 2002).

**What the Strategy says:**

New Zealand’s Māori Health Strategy, He Korowai Oranga, uses the concept of mauri ora to reflect its focus on individual people. It says that people using health services need pathways to care that meet their immediate needs as well as their future needs, across all stages of their life. This Strategy similarly acknowledges that need.

**Our response:**

The last 30 years has seen the development a number of tīkanga and kaupapa Māori based paradigms and models – many of them now ‘common place’ in the Māori health sector –as a way to address the aforementioned issues and concerns of Māori.

**What the Strategy says:**

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.

**Our response:**

Targeting priority populations through prevention or early detection initiatives makes fiscal sense, as these groups are more likely to be affected by long-term conditions such as heart disease and diabetes.

**What the Strategy says:**

Māori organisations are uniquely placed to contribute to the goal of closer-to- home health care. They are geared to be responsive to their Māori owners, often the very community they serve, and are inherently people-centred. This is important as Māori (and also Pacific) adults are more likely than the adult population as a whole to say that they are unable to access primary health care services due to cost (Table 1.1)

**Our response:**

Similarly, initiatives that improve health service access for Pacific peoples will be vital moving forward. One in five Pacific children and three in five Pacific adults are obese. One in four Pacific adults smoke. Diabetes disproportionately affects Pacific adults. One in ten Pacific adults have been diagnosed with diabetes. One in ten Pacific adults experienced psychological distress in the past four weeks. Cost prevented 17% of Pacific adults, and 7% of Pacific children, from visiting a GP when they needed to, in the past 12 months. Over one in ten Pacific adults and children did not collect a prescription item in the past 12 months due to the cost. Only one in three (33%) Pacific adults (with natural teeth) had visited a dental health care worker in the past 12 months. Pacific adults and children were more likely than other people to have had a tooth removed due to poor oral health in the past 12 months.

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**Empowering People with Myalgic Encephalopathy/Chronic Fatigue Syndrome, Fibromyalgia & Related Conditions**

**Health Strategy 2015 Consultation Document**

**Refreshed guiding principles for the system**

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

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

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

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

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

***This is a crucial guiding principle. Currently access for, people with ME/CFS to clinical and community based services, including appropriate respite care and home support services is inconsistent across DHBs.***

***While the illness affects people of all ages, the majority of our members are in the middle age group. Those who qualify for youth or older age group services have better access to community based support services. In the Wellington Region, access for people in the middle age group is rare, even for those who are severely disabled by ME/CFS and living alone. Age related priorities for home help services needs to be removed to provide much needed help.***

***There is also a need nationally for respite services for families caring for severely ill people with ME/CFS. There needs to be adequate training of staff in respite facilities involved in caring for individuals with ME/CFS, about their charges overall needs, particularly sensitivity to sensory stimulation and physical activity.***

***The prevalence of ME/CFS in the community is higher than that of other chronic illnesses such as Multiple Sclerosis and Parkinson's Disease. Those with ME/CFS can be more disabled than those with these conditions yet can be denied access to specialist services, community and home help services.***

***Time is a crucial factor in diagnosing and treating ME/CFS. An early diagnosis leads to a better prognosis. If qualifying for access to specialist services, a person with ME/CFS can find the waiting lists are extremely long. They may be put as a very low priority, often superseded by those whose conditions are deemed more urgent. Keeping in mind the need for early intervention, poor access to hospital based tests undermines their wellness process.***

***It has been proven that being able to visit a specialist every 6 weeks for the first 6 months of being diagnosed with ME/CFS brings better outcomes for the patient. The***

***shorter the span of the illness, the greater the likelihood of full or partial***

***recovery, enabling a greater chance of being able to return to the workforce.***

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

***While some people with ME/CFS have had a positive experience with the health system, unfortunately some with ME/CFS have been traumatised through incorrect diagnosis, accusations of malingering, inappropriate psychiatric/psychological assessment and exercise regimes that worsen their condition. Many severely ill people with ME/CFS are simply left to family to care for them with little or no help from the health system for their symptom or personal care management.***

***In the MoH report to the Select committee in 2012 it was acknowledged that anecdotal evidence pointed to inconsistencies across the country in the way CFS/ME is managed; that there was considerable scope for improvement; and that much greater consistency in the skills, knowledge and attitudes of General Practitioners was needed. It was suggested that a stronger effort could be made here under the government’s “Better, Sooner, More Convenient” approach to primary health care in New Zealand.***

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

***WellMe is a member of ANZMES and represented on the committee. WellMe appreciates that the measures the Ministry of Health has undertaken to coordinate discussions between the MOH, RNZCGP’s and ANZMES on the issues confronting those working to help the ME/CFS population and plan a way forward.***

***At WellMe, we welcome interaction with local clinicians and provide a forum for them to impart their knowledge to our members who may otherwise not have access.***

***It is crucial that momentum is maintained on these important issues***

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

***We encourage more collaboration with the national support groups who often have the latest information on illness research, management and treatment. We encourage clinicians and health care workers to refer patients to national and local support groups for information and social support, thus equipping patients to be informed about and involved in their own health.***

***WellMe employs a Community Based Support worker to provide one to one support for our members, and to facilitate support group meetings for social interaction and the sharing of information and strategies for managing symptoms. We also accept people with similar chronic conditions such as Fibromyalgia and Sjogrens where there is no local support group of their own.***

***We produce information pamphlets, provide public information through radio interviews and events and disseminate expert national clinical information material supplied by ANZMES.***

***Given inequity of access of people with ME/CFS to information due to cognitive impairment visual disturbances, limited concentration and energy, the health***

***sector needs to expand its view of workforce and utilise services provided by the social sector such as Community Support/Field Workers trained in ME/CFS to go into homes of those with ME/CFS to help, inform and advise on what help and resources are available to those with ME/CFS.***

***Funding national and/or local support groups to provide this service can lead to a cost effective outcome.***

**Health Strategy 2015 Consultation Document**

Part II: Road Map of Actions

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| **Inform and involve people** | |
| **Action 1** | Improve coordination and oversight and expand delivery of information to support **self-management of health** through a range of **digital technologies**.  ***Being able to access to information on-line is very enabling for people with chronic illness or disability. However, there are some groups******of people with cognitive impairment who have difficulty reading screens and/or written material.   In addition, people with ME/CFS can experience worsening of symptoms with mental activity and visual problems causing difficulties in the eye scanning screens or reading material.***  [***http://www.eurekalert.org/pub\_releases/2015-11/uol-vsc112415.php***](http://www.eurekalert.org/pub_releases/2015-11/uol-vsc112415.php)  ***Many people on low incomes don't have access to new technologies, this includes the chronically ill and disabled. There needs to be a strategy for providing free information to these groups.***   1. \* Start with a stock-take of current provision and consider different innovation and information channels relevant to people’s needs when growing the available information network.   ***At present we see a lack of medical and clinical expertise in dealing with ME/CFS in some areas. Doctors lacking confidence or willingness to diagnose. This leaves patients are in limbo. Having a diagnosis does provide a base from which to commence management.***  ***There is a slightly higher risk of deaths from suicide (we had one recently in our support group) and we would again highlight the need for good clinical, supportive, well informed, unbiased care which respects the patient's perspective of their illness listens to what they say and involves them in the decision when choosing treatment options.***   1. Use social media to provide information on early stage diabetes.   ***Social media is a good health promotion/illness prevention and management tool. However, for many older age groups do not use social media as they are not willing to expose themselves to privacy issues, invest the time into staying connected or are unable to operate or afford smart phones.***  ***Phone apps may be more useful for those that can own and operate smart phones.***  ***Advertising campaigns through radio, television and print media may be necessary for those who cannot or do not wish to use social media, as is using national and local support group networks to disseminate information.***   1. \* Continue to strengthen the National Telehealth Service by providing more support for self-management of people’s health and conditions.   ***Self management is effective in groups who are able to self manage,***  ***there will always be those who need support and we would stress that***  ***alternative options always need to be available***   1. Create partnerships for better health services by giving everyone on the health team, including the person, access to the same information.   ***This would ensure a more streamlined process and ensure the***  ***information being given is standardised* .**  i. \* Promote to service users and clinicians the benefit of having access to health information accessible via a patient portal.  ***Hospital based specialists are not able to access test results done through some agencies because of the way the District Health boards and contracts are set up. This is ridiculous in a technological age.***  ***Being able to access your own information on-line is very enabling for people with chronic illness or disability. However, there are some groups with cognitive and visual impairments, or poor access to***  ***technology due to poverty, that will need more traditional methods of accessing information.***  ii. \* Expand the number of early adopter DHBs using an integrated health record for pregnant women and children (as part of the Maternity Information System) from five to ten. |
| **Know and design** | |
| **Action 2** | **Promote people-led service design** by collecting and sharing good examples of it from design laboratories and practices; focus especially on those examples that effectively reach and understand high-need priority populations.  ***Those with ME/CFS are a high need but underserved population and***  ***therefore should be a high priority for improved overall care. There***  ***are some good examples of care from ME/CFS Field Workers around***  ***NZ which can be modelled for regions lacking in this level of support.***  ***A recent meeting of ME/CFS Field Workers in the upper North Island***  ***proved highly successful. The sharing of information is vital to get the***  ***maximum benefit from it nationally.***  ***Feedback from those with ME/CFS is also vital to maintaining the***  ***integrity of the system.***  a. \* Identify and showcase three high-quality, people-led service designs at the annual forum (links to action 17).  ***See Action 17 for comment of health forums***  b. Support clinician-led collaborations to engage with high-need priority populations on key health issues.  ***Input from clinicians and researchers with an active interest in the illness should be sought. National bodies who pay for overseas specialists and researchers to visit and share their knowledge should be actively encouraged and supported.*** |
| **Shift services** | |
| **Action 3** | To maximise value for people and achieve the **best health outcomes**, the Ministry of Health, with input from the system, will ensure the **right services are delivered at the right location** in an equitable and clinically and financially sustainable way.   1. \* Engage with DHBs in establishing service configuration design principles (recognising that some services, such as primary care, need to be available locally, while other specialist services, such as heart transplants, need only be in one location).   ***Support for those with chronic illnesses needs to be of a consistent***  ***standard throughout NZ.***  ***How will MoH ensure that those living with ME/CFS have the right***  ***services delivered at the right location in a clinically and financially***  ***sustainable way? Historically many living with ME/CFS have been***  ***unable to access such services as Need Assessment Service***  ***Coordination (NASC) as they “fall between the cracks” in this and***  ***other services. Some have commented on the lack of informed health***  ***providers/carers and the lack of services that take into account the***  ***particular needs of those suffering from an***  ***autoimmune/neuroinflammatory condition which ME/CFS has been***  ***shown to be coming under by recent research findings.***  ***At present anecdotal evidence is showing us, access to the public***  ***hospital networks does not produce effective results for some with***  ***ME/CFS, therefore denying them 'best health outcomes'. We would***  ***welcome a high performing system in which those with ME/CFS have***  ***confidence. A percentage also need access to providers that will visit***  ***them in their homes due to the post exertional worsening nature of the***  ***illness.***  b. \* Agree design principles for the approach.  c. Collaborate on the approach to implementation and timing. |
| **Action 4** | Enable all **people working in the health system** to add the greatest value by making sure they are providing the right care at the earliest time while **fully utilising their health skills and training**.   1. \* Remove legislative barriers to allow health practitioners, such as pharmacists and nurses, to prescribe under limited circumstances.   ***Many social/volunteer sector agencies and support groups employ field workers to educate people with chronic illness about treatment and management of their condition. However funding is inconsistent across DHBs and often gained only through donations and grants from trusts which is limiting and unreliable. Government funding directed at this sector could strengthen this service and cost effectively take pressure off clinical services.***  b. \* Increase the use of telehealth approaches, including telemedicine and telemonitoring, to provide services to people closer to their home.  ***How will the MOH enable people working in the health system to add 'the greatest value' to those living with ME/CFS while 'fully utilising their health skills and training' when there is little or no training or information on ME/CFS in the current curriculum.  At this point in time the medical profession is largely ignorant of the multi systemic and severe nature of this disease.*** |
| **Tackle long-term conditions and obesity** | |
| **Action 5** | The Ministry of Health and DHBs will increase the effort on **prevention, early intervention, rehabilitation and wellbeing** for long-term conditions such as diabetes, cancers, cardiovascular disease, chronic respiratory conditions, mental health conditions, musculoskeletal disorders, and for obesity, addressing common contributors or risk factors of these conditions and focusing efforts on points in the lifecourse with the greatest opportunity for success.  ***ME/CFS (Myalgic Encephalopathy/Chronic Fatigue Syndrome) needs to be included in the strategy to tackle long term conditions.***  ***In NZ, there are more sufferers of ME/CFS than Multiple Sclerosis, yet attracts fewer resources and reduced access to services.***  ***The Institute of Medicine (IOM) Report 2015 : ‘Beyond Myalgic Encephalomyelitis/Chronic Fatigue syndrome: Redefining an Illness’ stated that “patients have been found to be more functionally impaired than those with other disabling conditions including type 2 diabetes mellitus, congestive heart failure, hypertension, multiple sclerosis and end-stage renal disease” .***  ***This supported findings in a 2014 research study conducted by Massey University, NZ into the impact of ME/CFS on the daily lives of sufferers.***  [***http://www.massey.ac.nz/massey/about-massey/news/article.cfm?mnarticle\_uuid=8689D1E6-DD19-C2AD-390E-FC170EEF020C***](http://www.massey.ac.nz/massey/about-massey/news/article.cfm?mnarticle_uuid=8689D1E6-DD19-C2AD-390E-FC170EEF020C)    a. \* Agree the outcomes framework for setting expectations and judging success.  b. \* Reorient planning guidance and performance management to outcomes for long-term conditions, starting with a focus on one of these; for example, diabetes or mental health conditions or cardiovascular disease.  c. \* Make greater use of new and existing clinical networks to strengthen collaborative approaches to long-term conditions that span DHB boundaries.  d. Support the spread of best practice over time, by requiring partnerships between those producing the best and most equitable health outcomes and others.  ***There needs to be an openness to embrace the new research that has shown some of the old ways of managing ME/CFS are not best practice and to work together to improve outcomes for those with ME/CFS.***  e. Over time, progressively target other aspects of long term condition prevention and management – perhaps population segments, or weaker segments of the end-to-end journey; perhaps emerging conditions.  ***ME/CFS is a chronic condition spanning DHB boundaries with no current performance expectation or management action plan in place.  MOH designating ME/CFS as an 'emerging condition' would help people with this complex and debilitating condition access the DHBs.***    f. Capture the service user’s care plan in an electronic form for access by all health providers who make up the care team.  g. \* Collaborate with other government agencies to implement an evidence-based programme of vocational rehabilitation to maintain employment for people with long-term conditions.  h. \* Implement a package of initiatives to prevent and manage obesity in children and young people up to 18 years of age that combines targeted interventions for those who are obese, increased support for those at risk of becoming obese, and a broad base of population-based strategies to make healthier choices easier for all NZrs. |

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| **A great start for children, families and whānau** | | |
| Action 6 | | The Ministry of Health will continue to **collaborate across government agencies, using social investment and lifecourse approaches**, to improve and make more equitable the health and social outcomes for all children, families and whānau, particularly those at risk.  ***An evidenced placed programme, encouraging and respecting input from the patient is vital to achieving success. Good communication with a respect for the patients lived experience of the illness in determining school/work capacity.***  a. \* Increase support to pregnant and postnatal women experiencing mental health and alcohol and other drug conditions.  b. \* Promote healthy nutrition and activity for pregnant women and children to reduce the prevalence of childhood and adult obesity.  c. \* Support families, especially those with newborn babies, to have healthy housing (warm, dry and smokefree) and address crowding issues, to reduce transmission of infectious diseases and family stress.  d. \* Improve collaboration between early childhood services and health services for preschoolers to improve early childhood education attendance and better address unmet health and development needs.  e. \* Be a strong participant in the Government’s programme of work to improve social outcomes for children and young people, with initial focus on:  i. \* leading the Government’s programme of work to ensure all children, at the age of six, turn up to school regularly, are ready to learn, are well fed and healthy, and live in a safe and nurturing environment  ii. \* supporting Ministry of Education’s lead on the Government’s strategy for at-risk 15- to 24-year-olds, which includes working towards improved health outcomes for these young people.  ***Collaboration with the Ministry of Education needs to include children and young people with chronic illness/disability. Children as young as 4 years of age have been recorded with the diagnosis of ME/CFS***  ***There are many young persons living with ME/CFS who because of their condition are unable to sustain school based education instead opting to be home schooled or distance learning.  At times the school has been unwilling to work with those young persons to ensure their education is not comprised and to accept they are living with a severe medical condition****.*  ***A longitudinal study conducted by Dr Kathy Rowe, Paediatrician, at the Centre for Adolescent Health at Melbourne’s Royal Children’s Hospital, on Young People and CFS, highlighted the importance of early intervention in children and young people and the importance of education and social adjustment. Her longitudinal study concluded that a collaborative approach between the clinician, school and family are crucial in the long term health outcomes for children and young people with CFS.***  ***In what ways will the Ministry of Education and the MOH partner to ensure improved outcomes for those young persons and to ensure the education, career and life choice options of those young persons are not comprised?***  f. \* Connect children and families of offenders to health services.  g. \* Work with the Accident Compensation Corporation (ACC) and other partners to build on a range of programmes that support young people to make healthy relationship choices with the aim of reducing the incidence of sexual and family violence in the future.    h. \* Lead the development of a plan to improve the health system’s response to children and families who are living with fetal alcohol spectrum disorders. |
| **Improve performance and outcomes** | | |
| **Action 7** | \* The Ministry, working with the HQSC, will develop and implement **service user experience measures**. This could build on the HQSC’s existing work with online patient experience surveys.  ***What measures will the MOH put in place to ensure that those living with chronic illness and disabilities who have difficulty accessing, or are unable to use on-line technology, can participate in the online patient experience surveys or 'service user experience measures'?***  <http://www.massey.ac.nz/massey/about-massey/news/article.cfm?mnarticle_uuid=8689D1E6-DD19-C2AD-390E-FC170EEF020C> | |
| **Action 8** | \* Develop and implement a **health outcome-focused framework**, with involvement from the health and disability system, service users and the wider social sector. The framework will reflect the links between people, their needs, and outcomes of services and will shift the focus from inputs to outcomes. This work will build on the Integrated Performance and Incentive Framework work to date, and aims to increase equity of health outcomes, quality and value.  ***Any health outcome focused framework that reflects the links between people, their needs and outcomes of services is welcome.***  ***There is currently no consistent framework in the NZ health system for the treatment of those with ME/CFS, a complex and challenging chronic condition. The result is inconsistent or poor quality outcomes, ineffective and sometimes harmful treatment/management plans and inequity of access to services.***  ***ANZMES acknowledges that the MOH is working to address this issue. A greater focus on outcomes would focus DHBs on early interventions and effective management protocols.*** | |
| **Action 9** | \* Work with the system to develop a **performance management** approach that makes use of streamlined reporting at all levels, to make the whole system publicly transparent. This will draw on service user experience results (developed through action 7), operate within the outcomes framework (developed through action 8) and involve approaching planning, monitoring and continuous improvement in a tight–loose–tight way (ie, setting specific target outcomes, making service delivery options flexible, and being tight on achieving health and equity outcomes) and supporting innovation.  ***The current lack of flexible service delivery options needs to be addressed as current contract arrangements between the DHBs and service providers are often population targeted and do not take into consideration the needs of emerging chronic health conditions, particularly home help and personal care for people under the age of 65 years.*** | |
| **Align funding** | | |
| Action 10 | Align funding better **across the system** with a rolling programme focused on getting the best value from health investment (including incentives where relevant to support Strategy direction).  ***The MOH's strategy to align funding across the system so as to ensure access to those most in need is welcome.***  ***The majority of the 22,000 plus New Zealanders living with ME/CFS are unable to work or able to work only part-time, leaving them unable to pay for private medical treatment.  People with ME/CFS are often unable to access specialist clinical services as ME/CFS is given low priority. This is despite the Health Select Committee recommendation in 2013 that people with ME/CFS receive Specialist care.***  ***A large majority of people with ME/CFS live alone with little or no family/whanau support. 25% are severely ill leaving them housebound or bedridden requiring personal care services. Despite high support needs, these severely ill people are often unable to access home support services.  Access appears to be denied due to age ineligibility or lack of knowledge or empathy about the cause of the disability.***  a. \* Ministry of Health will provide advice on the best way to ensure access to **health services for those most in need through financial support** (eg, very low-cost access).  b. \* **Embed the partnership approach between Ministry of Health, Treasury and DHBs for major capital expenditure**, providing additional support from people with expertise in major capital expenditure to strengthen governance, planning and delivery.  c. \* **Improve commissioning** by using a wider range of service delivery models, expanding the use of contracting for health and equity of health outcomes, and build capability to lift the quality of commissioning (as suggested in the New Zealand Productivity Commission’s More Effective Social Services’ review recommendations).  d. Agree on **information technology (IT) project funding** priorities with input from across the system. | |
| **Target investments** | | |
| Action 11 | Develop and use a **health investment approach** with DHBs. This could be used to target high-need priority populations to improve overall health outcomes, while developing and spreading better practices. This will increase knowledge about population segmentation, drive collaboration, build skills in developing investment cases in the system, improve visibility of value for money, and build on the New Zealand Productivity Commission’s recommendations around a learning system.  ***A health investment approach that would target ME/CFS (a high need priority population with inequitable access to the health system and inequitable health outcomes) is welcome. Initiatives to develop and spread better treatment/management protocols and knowledge, understanding and empathy with people living with ME/CFS is crucial***  a. \* Develop the techniques, standards and guidance for health investment cases.  b. Trial the approach by targeting services for population segments offering the highest potential health and fiscal returns. Funding will be awarded on the basis of the strongest investment cases for a three- to five-year period to enable longer-term contracting of NGO providers where relevant*.*  c. Review results and learnings and consider extending the scope to cover the country for the selected population outcome and segment, and/or other outcomes and segments.  ***.*** | |
| **Improve quality and safety** | | |
| Action 12 | **Continuously improve system quality and safety**. The Ministry of Health will achieve this by:  a. \* partnering with other organisations on quality and safety initiatives in primary and rest home care  b. \* working with ACC and the HQSC to strengthen initiatives to reduce patient harm, in particular where services have high volumes or high costs  c. \* working with ACC and HQSC to analyse data on treatment injury, making continuous improvements to solutions to the problems identified  d. \* reviewing and streamlining annual reporting to incorporate relevant quality performance reporting.  ***Initiatives to reduce patient harm are welcome.*** ***There is a need for greater education across the health sector with relation to ME/CFS and quality outcome performance based reporting. While there are some good teams working in some DHBs, quality services are not widespread and sometimes services within DHBs are inconsistent. Many people with ME/CFS referred to hospitals and clinics are offered psychological counselling, and exercise/rehabilitation programs without understanding of the latest internationally accepted treatment protocols. The result is that patients are left feeling their progress through the hospital system was either futile, or resulted in a deterioration of their condition.*** | |

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| **Clarify roles, responsibilities and accountabilities** | | |
| Action 13 | Improve **governance** and **decision-making processes** across the system, through a focus on **capability, innovation and best practice**, in order to improve overall 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. | |
| Action 14 | The Ministry of Health will work with leaders in the system to improve the cohesion of the health system, including by **clarifying roles and responsibilities/accountabilities** 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 and legislative/regulatory advice, and monitoring of performance.  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. | |
| **Integrate health advice** | | |
| Action 15 | \* The Ministry of Health, with input from the system, will establish a simplified and **integrated health advisory structure** that oversees health system changes and incorporates or takes into account relevant existing national committees (eg, the National Health IT Board, the Capital Investment Committee, Health Workforce New Zealand, the National Health Board, and the National Health Committee).  ***WellMe is a member of ANZMES and represented on their committee. We support ANZMES’ offer to contribute its 25 year skills and experience of ME/CFS to the MOH and the proposed integrated health advisory structure.  As New Zealand's national ME/CFS organisation with a strong national Support Group network and an international renowned reputation for excellence ANZMES has access to the most recent research results and an ongoing relationship with international ME/CFS researchers and clinicians.*** | |
| **Build system leadership, talent and workforce** | | |
| Action 16 | Put in place a **system leadership and talent management programme** and **workforce development** initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.   1. \* Develop a system-wide leadership and talent management programme aligned with the State Services Commission framework.      1. Use the same principles to strengthen skills and capability and expand support for the NGO/primary and volunteer sector.   ***Expanded support for the NGO/primary and volunteer section is welcome***   1. \* Develop and roll out governance training programme bespoke for the system.     d. \* Work with the HQSC to equip clinical networks to lead quality improvement, emphasising clinical leadership.   1. Working with other social sector agencies, the Ministry of Health will identify areas of workforce capacity planning that it can lead on behalf of the social sector and accelerate workforce development actions for the carer and support workforce.   ***Given inequity of access of people with ME/CFS to information due to cognitive impairment and visual disturbances and limited concentration, the health sector needs to expand its view of workforce and utilise services provided by the social sector such as Field Workers trained in ME/CFS to go into homes of those with ME/CFS to help, inform and advise on what  help and resources are available to those with ME/CFS***   1. The Ministry of Health will identify and use workforce data to inform workforce planning and development where a workforce is not sustainable and initiate a remedial work programme to address this.   ***Workforce development initiatives in the form of more doctor education are crucial for people with ME/CFS to create greater health outcomes. Rising levels of engagement between the medical profession, MOH, DHBs and national information, education and advocacy groups is an important aspect of increasing workforce knowledge of ME/CFS patient’s health needs.***  ***Community nursing training would also be beneficial for those severely ill with ME/CFS whom are bed-bound or housebound.*** | |
| **Lead whole-of-system forums** | | |
| **Action 17** | To create a **‘one-team’ approach for health in New Zealand**, the Ministry of Health will **facilitate whole-of-system forums annually** (in advance of DHB planning), to discuss government priorities, share international and New Zealand best practices and build leadership. Forums will inform advice to the Minister of Health on system priorities on an annual basis and contribute to a culture of trust and partnership.  \* Communicate yearly to share progress on the implementation of the Strategy.  \* Share best practices and identify, publicise and spread examples of innovation that demonstrate improved equity of health outcomes, efficiency, quality and safety, and reduction of harm.  ***This is crucial to enable more collaboration with Health and Disability information/education and advocacy groups. However, thought should be given to enabling people with chronic illnesses such as ME/CFS to participate equitably with other Forum groups. Representation of our group in the last major disability forum held in Wellington was not possible as we were too ill to attend. Despite the high prevalence of our illness, we often lack a voice in health and disability service planning due to the difficulties of participation caused by our illness. It should be noted that national and local advocacy groups can be made up of individuals who suffer from chronic illness and disability themselves.*** | |
| **Strengthen national analytical capability** | | |
| **Action 18** | Increase New Zealand’s **national data quality and analytical capability** to improve transparency across the health system.  a. The Ministry of Health will work with other government agencies to ensure better information and analytics for effective cross-sectoral action at all levels of the system.  i. \* Progress analytical and research networks to inform decision-making, working with Superu.  ii. \* Work with Statistics New Zealand’s integrated data infrastructure to inform prioritisation of health and social investment programmes.  ***Relying on Statistics NZ data collection for setting health investment programmes further marginalises people with ME/CFS where data collection has previously been overlooked. National Support Groups often have statistics related to illness prevalence based on international studies. Longer term, Statistic NZ needs to be more responsive to emerging diseases that have significant prevalence in NZ.***  iii. \* Increase Ministry of Health capability (links to actions 14 and 15). | |
| **Use electronic records and patient portals** | | |
| **Action 19** | The Ministry of Health will establish a **national electronic health record** that is accessed through certified systems including: **patient portals**, health provider portals, and mobile applications.    a. \* Design and implement a national electronic health record, with appropriate standardisation to ensure high-quality data is accessible by certified health applications.  b. \* Continue to drive uptake of patient portals so that over time all New Zealanders will be able to access their health information electronically.  ***This can be very enabling for many people with chronic illness or disability. However, a strategy needs to be put in place for making information available to people who cannot access information electronically***  c. \* Public hospital-based health providers will use a common provider portal to access medical records, standardised to enable effective sharing of medical records, and with appropriate privacy safeguards.  ***This is an important step in creating efficiency and effectiveness of health service delivery and meaningful and timely information for patients.***  d. Establish a list of certified mobile ‘health apps’ that service users and health providers can use with confidence (to be known as the ‘Health App Formulary’).  ***An effective tool for those who like to play with their phones. This is used effectively for people with heart disease while shopping for groceries and can be useful for encouraging people to take personal responsibility for their health management.***  ***Care needs to be taken that the apps are appropriate for the illness and consultation with national advocacy groups is important where knowledge of the illness is developing such as ME/CFS*** | |
| **Strengthen the impact of health research and technology** | | |
| **Action 20** | | Develop capability for **effective identification, development, prioritisation, regulation and uptake of knowledge and technologies**. This action area seeks to improve the health system’s service effectiveness, reduce cost, improve engagement with people who access health services, promote healthy behaviours and self-management, and aid people-led design. It includes use of new technologies (medicines, medical devices from dressings to robotics, cell and tissue therapies), service design/models of care, and information technology.    ***The NZ Health system has been slow to respond to international research and best practice guidelines for people with ME/CFS. This has led to poor outcomes for people with this chronic and debilitating illness. In many cases it has led to misdiagnosis, mistreatment, worsening of symptoms and longevity of the illness, poor or no access to support services, psychological trauma, mistrust of clinicians and the Health system in general.***  ***While we note that in the past 5 years there has been an improvement in the experience of many of our members accessing the health system, we are still very concerned about the use of harmful and outdated symptom management protocols and the lack of community based support services. Any initiative to improve the engagement between the medical profession and those with ME/CFS to improve the quality, safety, experience and equity of their health outcomes is welcome.***   1. \* The Ministry of Health will work with the Ministry of Business, Innovation and Employment and the Health Research Council to better align and strengthen the impact of health research for New Zealand.   ***International Research on ME/CFS is expanding rapidly. It is being described as “The last major disease to be understood”. The NZ Parliamentary select committee on ME/CFS in 2011 noted ‘We recognise the need for greater public awareness and further research”. It is estimated that 22,000 people are affected by the illness in NZ, of which 25% are unable to work, with more able to work only part-time. The wider economic impact of which affects not only the individual but their families, communities and the tax payers of New Zealand. Continued research funding is needed to find a diagnostic test and to develop best practice guidelines to ensure people can improve their quality of life and that of their families and ultimately recover from the illness and return to the workforce. We welcome any attempts to strengthen the impact of health research, particularly the ability to respond to emerging diseases.*** |

**Summary of Actions**

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| **People- powered** | 1. Improve coordination and expand delivery of information to support self-management in health through digital solutions.   ***What provision will be made for those unable to access the online patient portal or support/information systems?***   1. Promote people-led service design including for high-need priority populations   ***How will MOH ensure that those living with ME/CFS have the right services delivered at the right location in a clinically and financially sustainable way?*** |
| **Closer to home** | 1. Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way.   ***How will the MOH ensure equitable access to services by people with ME/CFS?***   1. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions and for obesity ***Early intervention is critical to improved outcomes for people with ME/CFS*** 2. Collaborate across government agencies, using social investment approaches, to improve the health outcomes and the equity of health and social outcomes for children, families and whānau, particularly those at risk   ***In what ways will the Ministry of Education and the MOH partner to ensure improved outcomes for children and young persons to ensure the education, career and life choice options of those young persons are not comprised?*** |
| **Value and high performance** | 1. Implement service user experience measures.   ***What measures will the MOH put in place to ensure equitable access to experience measures for those unable to participate in on-line surveys***   1. Implement a health outcome-focused framework to better reflect links between people, their needs, and outcomes of services. 2. Work with the system to develop a performance management approach with reporting that enhances public transparency.   ***How will the MOH ensure that this information is made available to individuals and advocacy groups***   1. Align funding across the system to get the best value from health investment, starting with better access to those most in need, improved delivery of major capital expenditure, and more effective commissioning by contracting for outcomes.   ***How will the MOH improve service delivery to those most***  ***in need when severely ill people with ME/CFS who have high needs are currently unable to access services?***   1. Develop and use a health investment approach with DHBs and consider using this to target high-need priority populations to improve overall outcomes while developing and spreading better practices. 2. Continuously improve system quality and safety ***What focus/priority will be given to improve quality and safety of service delivery for people with ME/CFS*** |
| **One team** | 1. Improve governance and decision-making processes across the system, through a focus on capability, innovation and best practice, in order to improve overall outcomes.   ***How will the MOH ensure that advocacy groups are consulted on decision making and best practice guidelines?***   1. Clarify roles and responsibilities and accountabilities across the system as part of the implementation of the Strategy. 2. Establish a simplified and integrated health advisory structure. 3. Implement a system leadership and talent management programme and workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility. 4. Create a ‘one team’ approach for health through an annual whole of system forum, sharing best practice and contributing to a culture of trust and partnership   ***How will the MOH ensure that people with chronic illness and disability and their advocacy groups have equitable access to such forums?*** |
| **Smart system** | 1. Increase New Zealand’s national data quality and analytical capability to improve transparency across the health system. 2. Establish a national electronic health record that is accessed via certified systems including patient portals, health provider portals, and mobile applications.   ***Again, very enabling for individuals with access to and cognitive ability to use electronic systems. Care needs to be taken to ensure those who cannot access electronic systems can participate***   1. Develop capability for effective identification, development, prioritisation, regulation, and uptake of knowledge and technologies.   ***Open communication and collaboration with national advocacy groups is critical to the success of this action.*** |

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4 December 2015

New Zealand Health Strategy Update Consultation  
New Zealand Health Strategy Team  
Ministry of Health  
PO Box 5013  
**Wellington 6145**

**Submission on the New Zealand Health Strategy**

**Introduction**

Family Planning welcomes the opportunity to provide feedback on the update of the New Zealand Health Strategy. We acknowledge the importance of the strategy providing overarching direction and focus for the New Zealand health system.

Family Planning is New Zealand’s largest provider of sexual and reproductive health services and information. We operate 30 clinics throughout New Zealand as well as school and community-based services. We provide over 164,000 consultations, with forty-three per cent of our clients aged under 22 years. Our health promotion teams run professional training and workshop programmes in schools and the community for parents, teachers and other professionals. We are a registered private training establishment offering clinical training and development courses and workshops for doctors, nurses, midwives and other clinicians working in sexual and reproductive health.

Family Planning works to enable people to make informed choices about their sexual and reproductive health and well-being. Our services are confidential, high quality, free or affordable. We play a significant role within the health system delivering preventative and essential health care and information.

Overall, Family Planning supports the Strategy, particularly the guiding principles and the focus on prevention, partnership and collaboration. We raise the following points below for consideration.

**Summary of key points:**

* Family Planning recommends that sexual and reproductive health feature in the Health Strategy.
* Family Planning recommends that the Strategy have a stronger focus on health equity.
* Family Planning supports removing legislative barriers to enable a broader range of health practitioners to prescribe, and recommends nurse prescribing be a priority (*action 4a*).
* Family Planning recommends that the Ministry of Health improve and make more equitable the health and social outcomes for all New Zealanders (*action 6*).
* Family Planning supports efficiency and innovation in health care. However, we raise a number of issues for consideration for developing a health outcome-focused framework to drive health sector performance (*action 8*).
* Family Planning supports aligning funding better across the system and improving commissioning, (*action 10 and 11*). However, we want to ensure that the wider sector, including NGOs, be included as part of the approach and that there is a level playing field for seeking funding.
* Family Planning strongly supports an integrated health advisory structure (*action 15*).
* Family Planning strongly supports the Ministry hosting “whole of system” forums annually (*action 17*).
* Family Planning recommends prioritising data collection and analysis around a broad range of health equity indicators so progress can be measured (*action 18*).
* Family Planning is not opposed to national electronic health records in principle, but recognises that in practice there will be a number of key considerations (*action 19*).
* Family Planning questions whether patient portals for everyone offer good value for money and whether, with limited funding, they should be limited to those with complex medical problems requiring care from several services (*action 19*).

**General comment**

* Family Planning recommends that sexual and reproductive health feature in the Health Strategy.

*The starting point for this review is that critical aspects of the sexual and reproductive health of the people of New Zealand are lagging well behind other similar countries.*

– Value for Money review of Sexual and Reproductive Health Services Final Report[[66]](#footnote-66)

The government has prioritised supporting vulnerable children and whānau through its Better Public Services targets. This government focus is evident throughout the draft health strategy. Sexual and reproductive health care plays an important role promoting positive outcomes for children and whānau and should feature in the health strategy as an area for focus. Improving the sexual and reproductive health of all New Zealanders, particularly those currently experiencing poor outcomes, will support healthy, planned pregnancies, healthy women, children, whānau and communities.

The *Growing Up in New Zealand* longitudinal study found that 40% of pregnancies are unplanned.[[67]](#footnote-67) While declining, New Zealand has the second highest rate of teenage pregnancy among OECD countries,[[68]](#footnote-68) and there are significant disparities in sexual and reproductive health outcomes, particularly among Māori. For example, teenage birth rates at age 16 “are 37 per 100,000 Māori women, 20 per 100,000 Pasifika women, and 10 per 100,000 New Zealand European women.”[[69]](#footnote-69) Māori and Pasifika young people are over-represented in sexually transmitted infection (STI) statistics.[[70]](#footnote-70)

Ensuring access to confidential, culturally appropriate sexual and reproductive health services and information supports young people to make informed, healthy choices, reducing vulnerabilities and enabling opportunities to participate in educational and economic opportunities. Sexual and reproductive health services should sit alongside other univseral services referenced in the strategy such as maternity, immunisation and Well Child / Tamariki Ora. This fits with the intention expressed in the Closer to Home theme of Future Directions: “*investment early in life and a focus on children, young people and families and whanau”.*

It also aligns with the Ministry of Health strategy, *Better, Sooner, More Convenient Health Care* which emphasises providing more health services in the community, and an approach that “supports people to stay healthy”.[[71]](#footnote-71)

In addition to contributing to national targets, ensuring that reproductive and sexual health is visible in the New Zealand Health Strategy supports New Zealand meeting international obligations. In September this year, all member states of the United Nations, including New Zealand, signed up to the Sustainable Development Agenda[[72]](#footnote-72). The 17 goals at the centre of the agenda are universal, applicable to both developed and developing countries. Goal 3 is specifically focused on health and well-being. Target 3.7 under goal 3 states: “By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.”

* Family Planning recommends that the Strategy have a stronger focus on health equity.

Health inequity is a significant problem in New Zealand. There are many types of equity, including equity related to sexual orientation, gender identity, ethnicity, geographic location, income and disability. Government and publicly funded services have obligations under the Treaty of Waitangi to prioritise addressing health inequity among Māori.

Social and economic factors, like education, income, gender, heterosexism and racism, are key drivers – or determinants – of health. Uneven distribution of such determinants means some groups in New Zealand have a disproportionate burden of health risk and ill-health.

One of the guiding principles of the health strategy broadly references health equity as an improvement in health status of those currently disadvantaged. This statement should be strengthened and adequately reflected throughout the Future Directions document and action steps. The Strategy discusses equity in the context of improving health system performance and cost-effectiveness. Addressing health equity requires examining systems, policies and practices through an equity lens to assess impact on health outcomes. It is unclear how the strategy and action plan will challenge the underlying social and economic determinants of health inequity including poverty and violence.

**Comment on Roadmap of Actions**

* Family Planning supports removing legislative barriers to enable a broader range of health practitioners to prescribe, and recommends nurse prescribing be a priority (*action 4a*).

Family Planning believes prescribing medicines assists health professionals in providing care; it is not inherent to any particular medical profession. Nurse prescribing has been shown to be a high quality and safe option for patient care, particularly in sexual and reproductive health settings where the focus is on maintaining wellness, not managing complex health issues.

Nurse prescribing is a systems level change that will help address health inequities by improving access to medicines particularly among groups that currently experience barriers to accessing health care. Nurses work within and across diverse communities, including communities of high need. Nurses are highly skilled and trained in clinical assessment, an important component of safe prescribing.

Family Planning supports the increased use of telehealth approaches as a way to reach out to those with poor access to clinical services. This has the potential to contribute to improving health equity. (*action 4b*).

Family Planning notes that government should consider a more comprehensive review of outdated health legislation as an action step. Health care laws should be fit for purpose and should not create barriers to accessing health care or contribute to inequitable health outcomes. For example, the current abortion law is out of date, creates barriers to accessing services and wastes public funds on unnecessary consultations. The current abortion law inappropriately exists under the Crimes Act. Abortion is a health issue not a crime. Abortion law in New Zealand should be modernised to reflect women’s autonomy and promote equitable access to the full range of safe, legal abortion services available to women.

* Family Planning recommends that the Ministry of Health improve and make more equitable the health and social outcomes for all New Zealanders (*action 6*).

Family Planning is supportive of action 6. However, we recommend broadening the focus of prevention work or life course approaches. There should also be a focus on structural and systems changes alongside initiatives to change individual behaviour. The Future Directions document highlights our publicly funded, universal health system as a strength. Investments in long-term, public health prevention measures should focus on creating healthy environments that make it easy for all people to make healthy choices. While it makes sense to target some prevention initiatives to specific communities through action plans, the national strategy should retain a broad, holistic focus on multiple determinants of health and improving the health of all New Zealanders.

A Canadian policy institute, The Wellesley Institute writes:

*If we want to reduce the gap that exists in health between the wealthy and the poor, then we need to look at health promotion activities and programs through an equity lens. In the literature on reducing health disparities through health promotion, there is a consensus that such programs need to target the fundamental causes of disadvantage and be participatory in nature (see Frohlich et al, 2008; Phelan and Link, 2005; Themessl-Huber et al, 2008; Capewell et al, 2010). Equity focused programs would not just seek to address individual disease or behaviour, but would look for solutions outside of a traditional health model (Williams et al, 2008).[[73]](#footnote-73)*

Targeting initiatives to specific groups runs the risk of missing out others who currently have poor health outcomes such as LGBTI (lesbian, bisexual, transgender, intersex) youth. It also misses the opportunity to support healthy behaviour “upstream”. For example, promoting good nutrition among all New Zealanders, increases the likelihood that all women will eat well including those who may become pregnant. Structural changes – such as working with food producers and industry to ensure healthier food is available to everyone – enables all people to make healthier choices.

The Growing Up in New Zealand longitudinal study points to the broad and complex range of factors impacting children’s vulnerability, including whether a pregnancy is planned:

*the pregnancy characteristic most likely to be associated with children experiencing clusters of risk factors and being in higher risk groups for vulnerability was whether the pregnancy itself was planned or unplanned. The likelihood of children being exposed to stably high vulnerability risks compared to stably low (between pregnancy and infancy) was greater for this characteristic than any other[[74]](#footnote-74).*

Initiatives that focus on ensuring all people are empowered to make healthy choices - including healthy choices about their reproductive and sexual health - supports healthy children and whānau and healthy communities.

* Family Planning supports efficiency and innovation in health care. However, we raise a number of issues for consideration for developing a health outcome-focused framework to drive health sector performance (*action 8*).
  + How will outcomes be determined? Will outcomes support ethical and effective practice?
  + How will identified outcomes reflect the multiple factors impacting health outcomes?

Kate Frykberg, consultant and chair of Philanthropy NZ explains challenges around an outcomes focused framework for health and social sectors:

*Who gets the credit? If Sienna stops getting in trouble with the police, is the youth programme responsible for her improved behaviour, or as it the alternative education provider? Or perhaps it was the touch rugby team she recently joined. Or her supportive uncle and his family. Or maybe she just did some thinking and changed herself. In all likelihood, the behaviour change is a complex interplay of all of the above. Who then, deserves the funding?”[[75]](#footnote-75)*

* + How will an outcomes-focused framework reflect outcomes realised in the long term?
  + What safeguards will be in place to prevent outcomes driving practice (e.g. unnecessary investigations, over-prescribing, cherry-picking patients)?
* Family Planning supports aligning funding better across the system and improving commissioning, (*action 10 and 11*). However, we want to ensure that the wider sector, including NGOs, be included as part of the approach and that there is a level playing field for seeking funding.

For example, at the moment RFPs are time consuming, costly and applied inconsistently across the health sector. There shouldn’t be different rules for different parts of the sector. The tension that exists as a result of DHBs being both funders and providers of health care services should be a consideration when thinking about the best value use of resources and effective commissioning.

We support high trust models of commissioning where there is a proven track record. Organisations that can effectively and efficiently provide high quality services at the local level should partner with government to achieve desired outcomes.

Competitive commissioning should be balanced with support for collaboration across the health sector. How will integration and collaboration be supported in a competitive environment? Will the Ministry of Health provide leadership for collaboration and sharing knowledge and best practice? How can funding opportunities be structured to promote cross-agency and cross-sector collaboration?

* Family Planning strongly supports an integrated health advisory structure (*action 15*).

We understand that there were legitimate reasons for establishing separate advisory groups initially, however, in the current environment is makes sense to integrate these groups as a mechanism to support a cross-Ministry approach to our health system and move away from operating in silos. We support this positive step forward and other work around integration within the Ministry.

* Family Planning strongly supports the Ministry hosting “whole of system” forums annually (*action 17*).

We appreciate the wide consultation that has occurred around this strategy, including the face-to-face meetings across the country and the inclusion of NGOs. This provides a great model; we support a similar level of consultation with the sector in future. The Ministry should consider ways to expand exposure and bring new voices around the table to widen the range of views. Family Planning applauds the Ministry’s intent to consult and the use of a systematic approach.

* Family Planning recommends prioritising data collection and analysis around a broad range of health equity indicators so progress can be measured (*action 18*).

Family Planning supports increasing New Zealand’s national data quality and analytical capability, however, recommends that the focus of data collection should not just be on the Better Public Services targets, but a broad range of health equity indicators.

While the Social Policy and Evaluation Research Unit (SUPERU) provides useful information about a number of issues (e.g. teenage pregnancy reports) to support effective planning and delivery of services, its scope tends to be specifically family-focused reflecting its origins as the Families Commission. SUPERU should ensure that its scope is sufficiently broad to include other target groups (e.g. single, LGBTI) particularly in light of changing demographics such as an aging population and greater numbers of couples or single people without children.

* Family Planning is not opposed to national electronic health records in principle, but recognises that in practice there will be a number of key considerations (*action 19*):
  + How NGOs in particular will acquire the resources to build the infrastructure and capacity necessary to use electronic health records , given that this has so far been channelled through Primary Health Organisations (PHOs)?
  + How privacy will be balanced with information sharing to ensure effective health care delivery and continuity of care?
* Family Planning questions whether patient portals for everyone offer good value for money and whether with limited funding, they should be limited to those with complex medical problems requiring care from several services (*action 19*).

Patient portals are useful in certain circumstances, such as where a person has complex health needs requiring access to the system at multiple levels and across services. However, for well people and the general population, patient portals may not be cost effective and may exacerbate health inequities. There is a danger that there will be unequal access and relevance of these systems across populations. The Ministry should prioritise value for money investments in technology and consider technology initiatives through a health equity lens.

Thank you for the opportunity to provide comment.

Ngā mihi

[redacted]

Chief Executive

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| **323** | Submitter name | [redacted] |
| Submitter organisation | New Zealand College of Midwives |

4 December 2015

**The New Zealand Health Strategy**

FEEDBACK FROM New Zealand College of Midwives

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The New Zealand College of Midwives is the professional organisation for midwifery. Members are employed and self-employed and collectively represent 90% of the practising midwives in this country. There are around 2,900 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to on average 60,000 women and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the woman and her baby. It provides women with the opportunity to have continuity of care from a chosen maternity carer (known as a Lead Maternity Carer or LMC) throughout pregnancy and for up to 6 weeks after the birth of the baby, and 92% of women choose a midwife to be their LMC. Primary maternity services provided by LMC midwives are integrated within the wider primary care and maternity services of their region or locality. The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and well-being.

4 December 2015

New Zealand Health Strategy Update Consultation  
New Zealand Health Strategy Team  
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The New Zealand College of Midwives (the College) has provided this response to the New Zealand Health Strategy document. Thank you for including the College in the consultation process. The College supports the updating of the New Zealand Health Strategy and welcomes the opportunity to provide input and feedback. It is important to have an overall strategy and consistent principles to support future direction of resources.

1.0 Introduction

1.1 An issue of concern for midwives is that the health strategy consistently presents a focus on ‘limited resources’, ‘rising to the challenge of achieving more with the resources we have’ and ‘finding new ways of working’. These terms could also be grouped as an expectation of ‘more for less’ principle or strategy.

1.2 This ‘more for less’ strategy within the health sector is problematic and can result in poor quality health systems. Retention of a qualified, specialist, high quality and regulated workforce is one of the keys to ensuring a quality health service for the population. Alongside this is the need for public health initiatives, preventative health measures and a focus on staying well.

1.3 The strategy of ‘more for less’ has been consistently applied within maternity with a continued and consistent lack of increase in the Section 88 payments for midwives for more than a decade. At the same time there has been a continued increase in expectations and workload.

1.4 This ‘more for less’ strategy is counterproductive to the well-being and retention of the workforce and is resulting in a midwifery workforce crisis. Midwives are leaving the profession resulting in shortages of midwives within both the community and in many of our tertiary hospitals.

1.5 This has an effect on the health and wellbeing of women and their families when they cannot find a midwife to provide their maternity care in the community. A crisis of recruitment and retention of quality staff leads to a decline in quality health services and subsequent deterioration of population health.

1.6 The continued and sustained undervaluing of midwifery services, when midwives provide a comprehensive high quality personal and public health model has to stop. Midwifery is a key to ensuring that parents are supported to parent well and effectively and that babies and infants get the best start in life.

1.7 Midwives provide a cost effective service in the community and within the hospital. They are the only group of health professionals who work and integrate community care and hospital care. They have been providing the majority of care when the woman is in hospital during labour supported by hospital midwives. Providing continuity of care supports cost effective care as women are less likely to go to hospital in early labour and have better health outcomes (Tilden et al, 2015). It is surprising that despite this there has been no recognition or increased funding for the work of community midwives.

1.8 If the midwifery workforce was fully resourced and funded adequately then it is likely that significant and positive changes in many health targets could be achieved and women and families who receive midwifery care would be ‘better off’ on many of the health parameters. Midwives are achieving good outcomes despite the ongoing challenges and they do play a critical but undervalued role in a spectrum of health care initiatives. Pressure to constantly do ‘more for less’ is not a strategy for success in health initiatives. All strategies must be adequately funded to be effective.

**2.0 Overall health strategy**

2.1 We support the statement that ‘All New Zealanders live well, stay well, get well’ which is described as central to the NZ health strategy with the intention to reflect the health context and population needs of all New Zealanders.

2.2 We are concerned though that there has been insufficient attention on addressing the drivers of ill health that sit outside the health system. There is a need to consider and address the important aspects of ‘living well’ and ‘staying well’ with a focus on achieving equity of health outcomes across populations. The environment as determined by socioeconomic factors has a major influence on an individual’s health and is largely outside the influence of health care providers.

2.3 There is now clear evidence on the social gradient of health, which links increasing socioeconomic deprivation with poorer health outcomes across the spectrum (Marmot, 2007). Improved health outcomes and life expectancy occur with higher incomes and resources. In order to achieve equity of health outcomes, action is required to reduce inequalities in society in general, at an economic level.

2.4 This strategy does not appear to address this foundational principle in any way. Furthermore, equity needs to be considered not just between the populations named in the Strategy (Māori, Pasifika, disabled people) but also between those of high and low socioeconomic status, and between men and women. The health strategy needs to look beyond health and take steps to regulate the environment so that healthy options are provided, easy to access and supported universally.

2.5 In addition, we recommend that any and all health strategy goals should have a clear and obvious benefit to public health, that they be embedded in a scientific and evidence-based approach, that any new programmes of potential interest should be evaluated thoroughly before being introduced into the New Zealand Aotearoa context, that all policies and strategic health plans should be independent of industry; protected from industry influence and conflicts of interest; and be transparent and accountable.

2.6 The UK Faculty of Public Health defines public health as, “The science and art of promoting and protecting health, well-being, preventing ill-health and prolonging life through the organised efforts of society” (UK Faculty of Public Health, 2013). Midwifery care is an excellent example of an effective public health initiative.

**3.0 Feedback directly linked to the Health Strategy** document content

Page 2: NZ health system markers

3.1 We are uncertain of the meaningfulness of these positive statements about health in New Zealand when we recognise ongoing crises in areas such as poverty, unhealthy housing situations, under and over nutrition, obesity, diabetes, and rheumatic fever for example.

3.2 We suggest that the statement about life expectancy be changed from boys and girls to women and men as the ages mentioned are 79.7 years and 83.2 years.

Page 3: Health in its wider context

3.4 We agree that the “health and mental well-being of parents supports the social development, educational outcomes and lifelong experience of their children, and of their wider families and whānau”. It would be good to see some indicators that these issues of parental mental health are being addressed in a meaningful way within the health strategy.

3.5 For example, midwives often find that there are inadequate mental health services for the mothers that need them. We need to have a better understanding of the volumes of women who may requires mental health services and ensure that these services are available to all women wherever they live.

Page 4: Health system initiatives with other agencies

3.6 We are pleased to see the statement about provision of healthier homes and addressing overcrowding to reduce illness. It is important that these issues are addressed especially in light of recent reports about the poor state of housing in New Zealand, the lack of sufficient social housing and that landlords do not maintain their properties to a minimum standard to avoid ill health for their tenants (The Salvation Army, 2013: Te Puawaitanga ki Otautahi Trust, 2014).

3.7 Midwives are frequently working with women and their families who are living in poor conditions and severe deprivation. Optimising health is difficult for health professionals in these circumstances and needs the involvement and commitment of social and housing services.

3.8 The College supports the intention to use ‘investment funding’ to give providers ‘an incentive to focus on [these] long-term impacts and value them alongside immediate, short-term gains’.

Page 5:

3.9 Strengths of the current system: We agree with the strengths as listed, and would like to see our world-class, midwifery-led, maternity care system included here.

Page 7:

3.10 ‘Some funding arrangements contribute to stubborn disparities in access to services…’. While maternity care is free of charge in NZ and improves health outcomes through screening, education, support and intervention where there is clinical need, there is lower engagement for women of lower SES early in pregnancy.

3.11 Midwifery has demonstrated a model which delivers individualised care directly to the woman in her community, and has the particular strength of achieving engagement with the health service at a critical juncture (Dixon et al. 2014). However, due to ongoing under-resourcing of midwifery there has been little ability to improve the reach of midwives to women living with significantly increased needs in some situations, whether social or remote rural.

3.12 Opportunities: ‘a focus on prevention and making healthy choices easy, through approaches at both population and individual levels, can help stop or slow some health conditions’. There is strong evidence to back up such a statement by taking action on the social determinants of health (for example, Marmot, 2007), however this strategy only looks at individual access to health care and linking with a limited number of other agencies (MSD, Corrections). It also expects that by providing health information, people will make better health choices.

3.13 Baum and Fisher (2014) have explored the issue of behavioural health promotion in depth, and found it to be ineffective in achieving its aims, which are to improve health and reduce disparities. Problematically, it often has the opposite effect of actually increasing health disparities as those who are better resourced are more likely to take up the behavioural health changes that are recommended by health promotion messaging.

3.14 ‘Making healthy choices easy’ is only achievable when the circumstances in which people make their decisions are conducive to such choices, which necessitates a change in the environment by reducing inequalities and regulating unhealthy products (alcohol, tobacco, sugar).

Page 9:

3.15 ‘Refreshed guiding principles for the system’. We agree with all 8 of the principles, but question the ability of this strategy to achieve some of these principles, particularly point 2 and point 5.

Page 11:

3.16 People-powered.

We draw to your attention the NZ midwifery model of care as a working example of all three of the main points of this theme.

Page 13:

3.17 ‘*What might great look like in 10 years: People access practical evidence-based health advice that makes it easier to make healthy choices and stay well’*.

Unless this is backed up with environmental and social change as outlined above, this is a clear example of what Hunter et al (2010) describe as ‘lifestyle drift’, where governments begin the policy making process with a commitment to addressing social determinants, but ultimately move ‘downstream’ to interventions directed at individual behaviour change, which has been clearly shown to be ineffective, especially in the context of deprivation (Baum & Fisher 2014).

3.18 We would like to see a commitment on this page that our unique no-fault ACC provision is retained.

Page 14:

3.19 Once again, we draw your attention to the example of the NZ midwifery model of care as a service that already works in the capacity of care provision ‘closer to home’.

Page 15:

3.20 Table 1.1 only acknowledges a small selection of the data on unmet need. According to the NZ Health Survey (MoH 2012), women of childbearing age (15-44 years old), especially in the most deprived areas, had the highest unmet need for primary healthcare, at far greater levels than men. GP visits and prescriptions were foregone due to factors including cost and lack of transport (MoH 2012), both of which stem from lack of disposable income and material hardship.

3.21 Profiling the initiative called *‘Key tips for a warmer, drier home’* is an example of how individualised, behavioural messages are being used in place of investment in adequate social housing, which was alluded to at the beginning of the document but not elaborated on subsequently.

3.22 An example of how housing links with other social determinants is as follows: Inadequate housing is strongly linked to poverty with several downstream negative health effects. Poorer households are more likely to spend >30% of their income on accommodation, the level at which the Ministry of Social Development (MSD) defines housing affordability (MSD 2010).

3.23 Housing quality and security of tenure are compromised in the rental market (Baum 2008), where excess cold and damp is less able to be mitigated due to high rent, which reduces disposable income for other basic necessities such as heating (MoH 2014) and clothing. This exacerbates the disproportionately high levels of asthma for those in deprived areas (MoH 2012).

3.24 Cost also drives household crowding (Baker et al. 2013; MoH 2014). Several close-contact infectious diseases (CCIDs) are attributable to household crowding and CCIDs may be rendered more severe through the other effects of poverty, including poor diet and reduced access to healthcare (Baker et al 2013). The goal on page 13 of providing health advice to help people make their own healthy choices is extremely unlikely to lead to effective health improvements in this context.

Page 16:

3.25 Obesity is rightly acknowledged as a major source of health problems which contributes to the increased demand for health services and funds. Obesity must be tackled at both an individual and a structural level, by dealing with the obesogenic environment.

3.26 The Strategy goes some way to acknowledging the wider contributors to obesity with the statement, *‘Population-based strategies can also make healthier choices easier for all New Zealanders and help prevent and manage long-term conditions. They include things such as smokefree areas, safe sport programmes, public education initiatives, and initiatives with industry to support workplace safety or health-appropriate food product information’*.

3.27 However experience and evidence tells us that this is not adequate. Regulation is required to make healthy choices the most accessible, desirable and therefore easiest choices. Healthcare and behavioural messaging alone cannot solve the obesity problem.

Page 17:

3.28 *What might great look like in 10 years*

We recommend that another point is added, with a statement about a Health in All Policies approach to legislation in NZ, to address the impact of other sectors on health.

Page 18:

3.29 *‘striving for equity of health outcomes for all NZ populations’*. We agree with this aim but are concerned that this Strategy will struggle to achieve this outcome, for the reasons already explained.

3.30 ‘New Zealand’s health system needs to do better for the populations that do not enjoy the same health as the country as a whole. These include Māori and Pacific populations and people with disabilities’. To this statement we recommend adding, ‘women and those living in the most deprived areas of NZ’ (MoH 2012).

Page 21:

3.31 One team*: ‘operating as a team in a high-trust system with better cohesion’*. We very much support this point but contend that under-resourcing is antagonistic to this goal.

Page 23:

3.32 ‘*There is a culture of enquiry and improvement throughout the health system, and seamless links to the NZ and international science communities’*. We support this 10 year goal, which needs the addition of a statement requiring that health professionals being studied and relevant to the research are included in any health research team. For example, midwifery researchers must be involved in all publicly funded research and audit on maternity, as they have crucial insights into the sector.

3.33 The profile of Healthy Auckland Together acknowledges the crucial importance of food environments and marketing as one of its 5 areas on which to focus to improve health and reduce obesity. This needs to be incorporated into the rest of the Strategy, as outlined above.

Page 24:

3.34 ‘*Data and smart information systems can support evidence-based decisions on treatments, options and interventions.’* We agree with this goal and add that clinicians (such as midwives for maternity) are involved with data analysis of their sector, for the valuable insights they can provide.

3.34 *‘Fragmentation makes technology overly complex and expensive. To share new ideas or innovations, we must have sufficient scale and similarity to roll them out across our system.*’ We add to this that all health care providers, including community midwives, have access to adequate IT and are funded for these.

Page 25:

3.35 We would like to point out that not all members of the population can afford or have access to modern communication technologies such as smart phones and computers for use with telehealth initiatives.

Page 28:

3.36 To figure 10, we suggest adding a much broader range of government agencies and departments to the box of ‘other government agencies’, with the goal of achieving a focus on Health in All Policies.

3.37 Also figure 10, health could be improved by local government if the 2012 amendments to the Local Government Act were reversed to once again include the mandate ‘to promote the social, economic, environmental and cultural well-being of communities in the present and for the future (LGNZ 2003 p. 15, as cited in Kessaram 2013).

Page 34:

3.38 Action 1.D.ii. Add to this ‘and fund interfacing IT capability for the community midwifery workforce’.

**4.0 Summary**

In summary the College supports the majority of principles within this health care strategy. We have reservations about striving for ‘more for less’ and consider that the NZ model midwifery care, which takes place at the beginning of life, must be supported, adequately funded and publicly endorsed by the Ministry of Health as the first step towards long-term good health (Sandall et al. 2013). In spite of the value of midwifery from an investment perspective, it has been underfunded and undermined in NZ for the last several years.

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| Submitter organisation | Southern District Health Board |

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**Southern District Health Board Feedback on the New Zealand Health Strategy**

**4 December 2015**

# Challenges and Opportunities

The Strategy overall is heading in the right direction. The concept of ‘investment funding’ and cross government focus is good to see.

However, we think that the DHBs should be taking a leadership function in the integration of social services for a population. Evidence is strong that local determination of service delivery in a public sector is more effective at reducing inequity. DHBs have roles: to support the most vulnerable; leveraging their organisational capability in commissioning (Planning and Funding); and the reality that DHBs are the only Government agency accountable for every person from before birth to death. “People powered” as a concept risks excluding people who are not in a position to participate in their own health care and need the support of the system, it sounds individualistic rather than a partnership and loses the quality focus of “person centered” which guides how a system needs to be designed and function.

The strategy doesn’t reflect the need to use data to design the system in a flexible way that can respond to the needs of individuals. The increased use of data appears to be more about providing information for clinical care rather than using that data to design and plan systems. There is a risk in the strategy and the action plan that we will continue to function in silos rather than an integrated person centered system. There is little recognition in the document of the capability that already exists in DHBs and regions that can be leveraged to create local responses with true community engagement. The Productivity Commission Report was quite clear about the opportunities available using a collaborative approach built around DHBs and their alliances. The MoH’s role is to provide leadership and enable the DHB to deliver to their populations. The MoH needs to take a leadership role with other Government agencies on health and social service integration as health has the largest workforce, already functions in an integrated way, has the best access to data about populations and people, and the most to gain given the known impact of the social determinants on health outcomes .

Financial pressure in health has shown that the DHBs are capable of delivering significant efficiency gains, in real terms delivering more with the same. Stepping into the social service integration space really helps DHBs as the opportunity exists to get ahead of demand and reduce long term impacts on the system.

Noting there should be recognition of the challenges:

* Balancing resource allocation at a national level for growing urban and declining rural populations
* providing services over distance to rural areas;
* providing for multimorbidity and the generalist approach required for this;
* the poor person and family/whānau experience, and often high costs, when people’s end of life isn’t in their place of choosing.

There should also be recognition that we are a well-educated nation with great opportunity to increase health literacy.

# The Future We Want

## 2.1 Future Direction Statement

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.

The ‘Live well, stay well, get well’ by-line doesn’t include dying well, as noted above. Suggest ‘Live well, stay well, get well, end well’.

## 2.2 Principles

### **2.2.1 The best health and wellbeing possible for all New Zealanders throughout their lives**

Agree

### **2.2.2 An improvement in health status of those currently disadvantaged**

Agree

### **2.2.3 Collaborative health promotion and disease and injury prevention by all sectors**

Agree but this is too limiting as a principle. We would be seeking a collaborative approach to all parts of health and social services including the care and support of people with ill-health and disabilities including disability due to aging. The principle is to support people to live the best possible lives.

### **2.2.4 Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi**

Agree

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

Suggest ‘timely and equitable *access* for all New Zealanders to a comprehensive range of health and disability services, regardless of WHERE PEOPLE LIVE OR THEIR ability to pay ‘. Access however is a poor measure for equity we need unequal access to support equitable outcomes. Access should be according to need and ability to benefit.

### **2.2.6 A high-performing system in which people have confidence**

Good aim – hard to measure, this is about how the people working in the system feel about working in the system. If they feel enabled and trusted they will work in a way that instils confidence.

### **2.2.7 Active partnership with people and communities at all levels**

Good principle, should be expanded to include other organisations and agencies.

### **2.2.8 Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing**

Agree

A further principle needs to be added reflecting the core values of health professionals, something like “Caring for people as individuals with respect and compassion”

## 2.3 Aligning Behaviours

The core behavior trait required is trust. The Ministry of Health needs to move from a monitoring and regulator role to an enabling role. Adaptive leadership is required and the role of the leader in this model is to clarify the problem and support the solutions created by the people.

*Dot point 4* – suggest changing – from fragmented health sector silos to integrated HEALTH AND social service responses.

# Five Strategic Themes

In general, the following are missing: good end of life care; a recognition that multimorbidity requires more than better disease specific care pathways; and the need for a generalist approach to providing care for these people are missing. Taking into account the aging population there is limited focus on the needs of older people and how we might provide support that is holistic and targeted at keeping people as well as possible, in their own homes and communities and out of institutions (including age residential care and hospitals). This will take a whole of system response and is not disease specific. Without this focus a significant amount of resource will be expended on services that the people themselves would prefer to avoid. It is quite clear that no society can afford to institutionalize its aging population at the rate we currently are so without this focus healthcare in New Zealand will become unaffordable.

We also note the triple aim (Population health, Experience of care and Sustainability) has been 'demoted' to within one of the 5 high level themes rather than the overarching high level outcomes.

## 3.1 People Powered

The term ‘people powered’ is interesting wording but we would like to suggest this theme reflects the partnership with the person/family/whanau/carer/and health professional. We recognise that this theme is designed to put the emphasis on people owning and engaging in what is important to them / their needs and goals for their healthcare (along the lines of Advanced Care planning approach) and ensuring those needs are an integral part of the equation and not the health professionals determining the best outcome.

The patient’s journey is now articulated strongly throughout the document. There is, for example, under the heading ‘People Power’ strong emphasis towards technology and infrastructure. The strategy needs to balance itself between IT being made available to support clinical needs versus people under the heading of ‘People Power’ still accessing health care in a traditional manner (walk ins or pre-booked appointments) of which there is little or no mention.

It should also be recognised that there are a group of people who will continue to need support to access healthcare at the level which meets their need. These people miss out if the system does not actively seek to engage and support them.

### 3.1.1 People powered 10 year view

This focuses entirely on individual level care, misses community based aspects of health promotion, illness prevention and patient empowerment. The view is largely casting people as passive rather than active partners in decision making. This also links to a preventative model.

Health literacy is missing and technology is only one way to empower people. We need a broader multi-channelled approach that starts before school that empowers people to understand (in whatever way works for them) what will keep them well and how to access the support they need.

The core advantage that health has is the population approach which enables the delivery of services in a way that is aligned with the specific needs of the population and the resources of the community.

## 3.2 Closer to Home

The notion of ‘Closer to Home’ is a good however this strategy needs to be forward thinking in its projections

What this section should do is explore whether the existing community models of care are the right type of services to be offered in a changing world and where population behaviours are different. It’s good to see there is a focus on Maori and Pacific models and approaches, however, ownership of improved health outcomes for these communities must be seen as the responsibility of all health services and Maori/Pacific NGO being seen as key contributors towards population and service performance. “Closer to Home” should also mean focusing on building primary and community capacity and capability to support people to stay in their own home even when unwell so we can reduce the demand on the most expensive part of the health system. Managed correctly a strategy of people only being in hospital when they need hospital level care will ensure that we make best use of scarce workforce resources and avoid large future capital expenditure.

### **3.2.1 10 year vision**

Palliative care is missing, integrated care for multimorbidity not single disease approaches missing. Could add a bullet ’People die in their place of choosing’ or something similar.

How does the ‘Closer to Home’ 10 year view look for communities? The description is more about systems and infrastructure. What specific actions will address the early onset and advancement of long term chronic conditions for Maori and Pacific? We know that these conditions are starting 10 years earlier and in some cases these conditions are intergenerational.

## 3.3 Value and High Performance

The fundamental key driver to a ‘Value and High Performance’ will depend on the types of models that are in play across the sector and the measurement of their performance. What we do have is national health targets. What we don’t is a very clear focus on measurable outcomes, a set of measures reflecting system performance and a service improvement culture rather than a win/lose punitive target driven culture. Although Triple Aim gives a basis for moving this forward, we need to get serious about right sizing existing services gradually to show better performance over time. That may mean disinvestment and reinvestment in activities that show benefit realisation over time. Many things look good on paper, but how do we know changes have been great for our community/people?

## 3.4 One Team

There is a great deal to support in this section however the overall focus becomes one of the Ministry’s role as leader rather than reinforcing the concept of organising around the needs of the people and the multiple roles required in a team. The one team concept needs to be more person centred and less organisational centric in its articulation.

Although Whanau Ora, Integrated Family Care and other ideas have come forward, many cars up a person’s drive still happens. The strategy should be bold and set out a clear direction on what a One Team should be. This part of the strategy talks about IT and infrastructure - these are big investment calls and the resources spread across the section are very thin now.

Need to include a focus on generalism to meet needs of future multimorbidity. It is becoming clearer that a disease focus is not the solution to the challenges faced by the health system as the real challenges are with the combination of complex medical and social issues that prevent people from living well. This is even more support for an integrated approach that is tailored to meet the needs of the person in the context of their whanau and their community.

The box at the bottom of p.22 should include: need for generalist integrated approach for multimorbidity management and support.

### **3.4.1 10 year vision**

Add - ‘We invest in the capability and capacity of our workforce, including the NGOs and the volunteer sector, and make sure that it fosters leadership, A GENERALIST APPROACH, flexibility and sustainability’

## 3.5 Smart System

Integration can be enabled by sharing data within the local ecosystem. National systems can act as a backbone but local integration of data and observation is required to create that insight that enables innovation. There is a lack of recognition in the document of using information to plan and design services and to underpin a culture of continuous service improvement.

Shared care plans box – Shared care plans do not have to involve a health navigator. Integrated/coordinated care CAN involve a health navigator but depends on individual circumstances.

We must avoid using technology for technology’s sake we need to design our services and use technology to support.

### **3.5.1 10 year vision**

10 year vision – electronic health pathways agreed; and overcoming distance with technology so same quality of care regardless of location missing

# Turning Strategy into Action

Overview of NZ health and disability system – district Alliances’ role, 4 regional DHB groupings role, and PHOs existence in the system, all with accountabilities (and funding flows) not mentioned.

# Roadmap of Actions

Note: we have not included any actions based on the changes suggested earlier in this feedback document.

In general the lack of mention of Alliances and PHOs is concerning. We acknowledge that this document is to be taking a strategic view, but significant work has gone in to alliances over the last couple of years and they are the key entities for delivering transformation under the One Team theme.

## 5.1 People Power

Action 1 – improving people’s ability to be informed and therefore self-manage better is not just about digital technologies. What actions will promote health literacy?

## 5.2 Closer to home

Need to promote career choices that are generalist in nature, e.g. GPs, rural hospital medicine doctors, generalist and community based nurses, general allied health roles.

This theme should also recognise that allowing people to die in the place of their choice improves the quality of their terminal phase of life, the experience for their loved ones, and can reduce costs.

Need an urgent focus on reducing hospital and aged residential care admission or we will run out of resource before the strategy is implemented.

Shift services

Action 3a - need to engage with health alliances, regional structures, not just DHBs.

Action 4 - could speak more to promoting/enabling service integration more.

Tackle LTC and obesity

Action 5b - is disease silo based, rather need to embed a generalist based multimorbidity approach, rather than disease specific approaches, to cope with the health needs of the future (approaches such as self-management support, life coaching and navigation). Needs to include Advance Care Plans being widely in place by 5 years time for end of life care.

## 5.3 Value and High Performance

*Second sub bullet point of final main bullet point –* providers use a health investment approach – FUNDERS also need to have a health investment approach

Align funding

Equity model - funding model issues. There is so much more that can be offered in the community that is “free” when you access the hospital system and therefore reinforces the care away from home (not closer to). Under the ACC funding model people can access physiotherapists (and many others) directly for early intervention and prevention strategies ongoing. Others wanting access for early (non-accident) education/ advice / rehabilitation are required to pay (not subsidised). Cost is a barrier to preventative healthcare for many from an equity point of view. An exception to this would be the Pharmacists whereby people can walk in off the street and seek advice as a first step for straight forward ailments etc. The pharmacist ensures that pathway to the GP or other health professional is clear to the person should something change or not improve.

Target investments

Action 11 b – this should be approached with caution. It risks competition that destabilises core services, potentially allows cherry picking and fragmentation of service provisionExperiences in UK would suggest caution is required.

## 5.4 One Team

Clarify roles, responsibilities and accountabilities

Action 14 b – this casts the DHBs in the passive role. Wording should reflect active involvement of DHBs in development of changes.

Build system leadership, talent and workforce

Action 16e and f – these two points are the main ‘workforce’ parts of the actions. Given the issues facing health workforce, regulated and unregulated, this seems light. Also could include promoting focus on generalism.

## 5.5 Smart system

Paragraph 2 – not everybody will want/be able to have online access. The system should not become so focused on digital solutions that alternatives aren’t available, as risks designing in inequities.

There are three aspects to health information”

* Health information that the patient holds
* Health information that the health professional holds
* Health information across agencies / government

Smart technology will likely be an important enabler going forward for consumers and we also need to keep sight of equity issues with $ costs in terms of any IT devices (phones / apps etc).

Use of electronic records and patient portals

Action 19a – assume they are meaning create the ability for existing systems to talk to each other, rather than developing a whole new national system?

*Action 19c* – why wouldn’t primary care providers be included in this action as well?

# Any Other Matters

* The plan about access and actions to improve the health and wellbeing of Maori, Pacific and vulnerable populations like the Asian community.
* The plan has a five and ten year focus. How is the planning building in a natural decline in populations in 10, 20 or 30 years? What we do know from demographers that there will be real pressures on all government services if we don’t plan for the bubble burst for those aged 70 years plus and non-Maori. There is a significant concern about this strategy which is more about meeting the demand now and this leaves population like Maori, Pacific and Asian in a vulnerable situation where their population demographics are younger and fertility/birth rates are higher to non-Maori.
* Throughout the document there is sparse reference to workforce development and changing requirements. For example page 5-6 talks of the issue of the ageing workforce but not the growing demand on the health system that will also lead to an increased need in health workforce numbers.
* It would be good to see markers that include education recruitment to tertiary centres, prioritisation about investment strategies and managing the transition points from a youthful workforce to a maturing/ aging workforce through to their exit or retirement.
* The type of health care professional we need is evolving and we need to ensure that we are growing and training the appropriate workforce to provide appropriate care. The mix and range of specialist vs. generalist is key to this, particularly in the rural sector.

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| **325** | Submitter name | [redacted] |
| Submitter organisation | Roche Products (New Zealand) Ltd |



Update of the New Zealand Health Strategy

All New Zealanders live well, stay well, get well

**Consultation draft**

**Roche Products (New Zealand) Ltd’s Response**

Compiled by:

[redacted]

Director, Access and Public Policy

[redacted]

New Zealand Health Strategy Submission

# **Introduction**

Roche New Zealand is part of the global pharmaceutical Roche Group. Headquartered in Basel, Switzerland. Roche is a leader in research-focused healthcare with combined strengths in pharmaceuticals and diagnostics. Roche is the world’s largest biotech company, with differentiated medicines in oncology, immunology, infectious diseases, ophthalmology and neuroscience. Roche is also the world leader in in vitro diagnostics and tissue-based cancer diagnostics, and a frontrunner in diabetes management.

The local office was established in 1975. Roche maintains a full-service headquarters in NZ, meaning that medical, commercial, regulatory, drug safety and finance support are all staffed locally.

As well as providing New Zealanders with funded access to innovative medications, Roche participates in the New Zealand health environment in the following ways:

Since 2012 Roche has run a Patient Access Program for the supply of unfunded medicines utilising a cost-sharing model with rebated cycles and a cost capping scheme:

○ More than 80 active patients on the Patient Access Program;

○ More than 220 patients enrolled since its inception in 2012;

○ More than $3.0M support for this initiative by providing rebates and caps.

Roche is currently running 40 clinical trials in New Zealand, involving 278 patients. Roche’s clinical trial investment for FY 2014 including cost of medicines, Roche personnel, investigator grants and fees, and Clinical Research Organisations was in excess of $5M.

Roche was a founding partner and provided significant seed funding to two major Phase I Clinical Trial Units in New Zealand (CCST & ACS). Leveraging these facilities, Professor Ed Gane (Auckland University, ADHB, and Auckland Clinical Studies) has played a lead role in the development of drug treatments for hepatitis culminating in Gilead’s sofosbuvir, effectively a cure for up to 96 percent of people with hepatitis C, and firmly establishing his international profile.[[76]](#footnote-76)

Roche’s personalised healthcare strategy aims at providing medicines and diagnostics that enable tangible improvements in the health, quality of life and survival of patients.

## Roche is grateful for the opportunity to comment on the draft New Zealand Health Strategy. We support the review of the NZ Health Strategy, especially since the previous Strategy was published in 2000 and there have been huge technological advances and quite different health challenges to overcome.

## Roche supports the drive and focus in the new Strategy to think and work differently. We also support the goal of achieving equitable outcomes for all New Zealanders with particular reference to the needs of our Māori, Pacific and Asian populations.

## Roche accepts the health sector must focus on the Return on Investment that the country receives for the $16 billion dollars it invests in health and we believe that good data and analysis is key to achieving improved outcomes and more cost-effective health spend.

## Roche believes the pharmaceutical industry is rapidly developing new and improved therapies and we consider the draft Strategy does not sufficiently take into account the technological advancements, such as immunotherapies, that could positively impact the health system. Technology advancements still appear to be viewed as a cost rather than an investment in improved health outcomes. Generic medicines are really just cheaper, older technologies that offer less than optimum outcomes for patients and yet are celebrated as part of our health strategy (page 19 of Strategy).

## In our response we have focused on the Five Strategic Themes and the Roadmap of Actions outlined in the draft, and we have highlighted a few key actions below that address the Strategic themes.

# People-powered

## To expand delivery of information to support self-management in health through digital solutions, Roche recommends engaging with creative agencies to discover workable solutions around the challenges of cultural nuances when patients engage with doctors and nurses. We need to find tools to help patients communicate simply, swiftly and more accurately without being under-diagnosed and misunderstood. For example, perhaps a patient could illustrate on a diagram where their pain was in their body by marking the area on a picture of a human body and including their type and level of pain on a sliding scale in a similar way to the paper used by hire car companies to describe the damage on a car. This could also work on a telehealth basis.

## IT systems and technology need to be more nimble and more easily adapted for changing technologies and consumer behaviours. The pace of change is rapid. Increasingly, consumers expect to be able to access information across a range of digital platforms and equally, provide information back to their carers through digital means.

## The reference in the text box on page 11 of the Strategy identifies a funding model that gives people choice and control. Choice means there needs to be a mechanism where those with insurance can have real choice with their medications. Currently this is very limited. Solution: Pharmac approve pricing for insurance-funded medications. This would provide an incentive for insurance companies to fund and an incentive for New Zealanders to be insured.

## 

# Closer to Home

## Roche supports the decentralizing of services and creating the opportunity of services closer to home where appropriate. This is also applicable for some tertiary services. For example, to enable more remote communities to access oncology treatment, we would support the establishment of Oncology Buses through a public-private partnership and more regional and tele-health clinics.

## Roche supports the use of new technology to enable treatment closer to home. The ability to deliver Herceptin subcutaneously is an example of this. A new time and motion study by New Zealand researchers shows that an innovative subcutaneous (SC) formulation of Roche’s Herceptin® (trastuzumab), which could be delivered by simple injection at a doctor’s surgery or potentially at home or work, reduces the time women spend receiving chemotherapy treatment by up to 75 percent.[[77]](#footnote-77) This targeted breast cancer therapy avoids the need for women to go to a clinic for 30-90 minutes to receive intravenous Herceptin® chemotherapy. International studies show that the Herceptin® formulation is preferred by more than 86 percent of patients. [[78]](#footnote-78) Early adoption of technology has the ability to bring healthcare closer to home in addition to empowering people (i.e. people-power).

# Value and High Performance

## Roche supports a collaborative project to support the development and maintenance of more health registry databases. Roche believes that measuring health outputs and health outcomes is key to making better decisions and to delivering better health outcomes for patients. The initiative should focus on driving the uptake of efficacious medical products, leveraging efficiency, durability and tolerability.

## Roche supports the action of continuously improving system quality and safety through centres of research excellence such as the work conducted by Professor Ed Gane that we outlined in our introduction.

## Roche believes there is an opportunity to expand the clinical trial programmes in New Zealand and unite the medical companies behind the patient focus and benefits (One Team). We suggest setting up DHB KPIs for involvement in clinical trials (similar to the National Health System NHS scorecards in the UK) to optimize the known benefits of having a robust clinical trial focus within the health system.[[79]](#footnote-79)

## Bring together the country’s health economists and business analysts to delve into the details of the healthcare system and analyze the Big Data. By working on projects together they could help everyone in the sector to better understand the healthcare landscape and enable researchers the opportunity to drill down into greater detail than working in isolation and specific areas.

# Smart System

## Roche agrees that data and smart information systems will support evidence-based decision-making with treatments, options and interventions. Roche would be prepared to pool the financial resources that it currently spends on ‘Patient Apps’ with those of other companies. The intention would be to create better Apps that address wider needs and benefit the entire healthcare system. This co-operation could tackle the big-picture needs to the NZ healthcare system and encourage ‘One Team’ working together.

# Key actions

## *Health Registry Databases.* As previously outlined in Clause 4.1, Roche believes there is an opportunity for New Zealand to lead the way in creating registry databases, similar to the Orthopaedic Joint Registry and the Trauma Registry, to enable the sector to identify which treatments and technologies work most effectively and which do not work. Currently, everyone is working in isolation. There are DHB databases, Ministry databases and company databases. They are collated in different ways for different purposes. This information needs to be centralised, consistently collated and shared across the sector, including with private companies. Such databases would benefit patients in many ways including identifying the most effective treatments faster. At this point, we do not know how the screening registries link with current disease databases, if at all, to streamline information across the New Zealand health sector. Roche recommends the amalgamation of these sources of information to benefit clinical decision making and patient treatments and ultimately outcomes.

## *Clinical Trials.* As previously outlined in Clause 4.3, Roche considers New Zealand should support and expand access to clinical trial programmes. Clinical trials deliver better treatment outcomes[[80]](#footnote-80); retain the specialist workforce; create an income stream and increase the country’s capability on ethical research practice and continuous improvement. In 2011, Cranleigh Health estimated that by 2020 New Zealand could generate revenue of $250 million annually from clinical trials for basic medical research, and attract $50 million from other sources. We believe there is a role for pharmaceutical companies to work with Government and institutions in attracting more investment in clinical trials that could not only provide New Zealand with breakthrough therapies but also export revenue. Separate business units should be set up in DHBs to ensure that clinical trials are seen as a core function and are fully supported. A recent British Medical Journal paper quotes Jonathan Sheffield, chief executive of the National Institute for Health Research (NIHR) Clinical Research Network, as saying, “It is the duty of every doctor to get involved in research.”[[81]](#footnote-81) This paper also highlights:

### The NIHR has 1 percent of the NHS budget with the vision to improve the health and wealth of the nation through research

### The Clinical Research Network provides support for research in the NHS, most of which is funded by industry in a collaborative model

### Staff are attracted to and retained by hospitals with research units

### Biggest beneficiaries are the patients who are taking part in trials of the latest treatments.

### Another recent UK paper shows that research-active Trusts appear to have key differences in composition than less research active Trusts. Research-active Trusts had lower risk-adjusted mortality for acute admissions, which persisted after adjustment for staffing and other structural factors.[[82]](#footnote-82)

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| **326** | Submitter name | [redacted] |
| Submitter organisation | New Zealand Council of Trade Unions |



Submission of the

New Zealand Council of Trade Unions

Te Kauae Kaimahi

To the

Ministry of Health

on the

Update of the New Zealand Health Strategy

P O Box 6645

Wellington

December 2015

1. Introduction
   1. This submission is made on behalf of the 31 unions affiliated to the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU). With 320,000 members, the CTU is one of the largest democratic organisations in New Zealand.
   2. The CTU acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through Te Rūnanga o Ngā Kaimahi Māori o Aotearoa (Te Rūnanga) the Māori arm of Te Kauae Kaimahi (CTU) which represents approximately 60,000 Māori workers.
   3. The CTU is involved in various health sector forums including the Health Sector Relationship Agreement (HSRA) and the National Bi-Partite Action Group (NBAG).
   4. We welcome the opportunity to make a response to the draft update of the New Zealand Health Strategy (Draft Strategy). Accessible quality health services are critical to the hundreds of thousands of workers we represent and to their families and whanau. There are many thousands of health sector professional and workers who are part of unions. We endorse the submissions of our affiliates: E tū, the Association of Salaried Medical Specialists (ASMS), The Public Service Association (PSA) and the New Zealand Nurses Organisation (NZNO) on this Draft Strategy.
   5. The Consultation Documents asks a number of questions on the Draft Strategy. This submission addresses those questions. However, there are additional issues that we have raised which fall outside the feedback form questions.

*Draft Update of the New Zealand Health Strategy – Concerns*

* 1. The Health Strategy must deliver a robust, resilient and fair future focused Health Strategy for those who access health services, those who work in and deliver health services and for the wider population. As written, the Draft Strategy does not raise our trust or confidence for an accessible and equitable future-focused health system.
  2. We are concerned about the lack of detail and evidence base supporting the Draft Strategy, the over-use of jargon with little definition or clarification of what lies beneath the generic language in the Draft Strategy. The terms “shared goals” and “partnership” are repeated throughout the Draft Strategy without an explanation of what these terms actually mean in practice e.g. “Partnership” - what does this mean? What are the benefits? From whose lens? Who are the partners? Do they have equal influence? And what are the “shared goals” so often referred to in the Draft Strategy?
  3. We are concerned that the Draft Strategy is silent on key issues such as universal access to quality care and health services; achieving a fair and equitable public health system; outcomes that a future focussed Health Strategy should achieve; how these will be measured and how the Health Strategy and its actions are resourced and funded.
  4. There is a noticeable absence of the role of social determinants and factors leading to good health. While there is reference to health disparities of Māori and Pacific people, there is no reference to the health disparities faced by low-income people. There is a lack of any reference to the role of public health measures in improving population outcomes other than in relation to obesity.
  5. If service users are able to access health services early (particularly vulnerable groups), health problems are identified, monitored and addressed early then the impact downstream on the health system is more favourable in terms of cost, likelihood of complex problems arising and better health outcomes. However, this is noticeably absent throughout the Draft Strategy. Furthermore, there is no reference to the Primary Health Care Strategy (2001) which raises the question of what is the role and status of the Primary Health Care Strategy in the Draft Strategy?
  6. The Draft Strategy refers to the “investment approach” many times throughout the document without any explanation of what this would mean for the health sector. Investing in people is an attractive concept but the only example of this approach in New Zealand is the Forward Welfare Liability model that is currently being implemented in the social welfare sector. The suitability of this model has been criticised for social welfare[[83]](#footnote-83),[[84]](#footnote-84),[[85]](#footnote-85) and is highly questionable for the health sector. There is no evidence provided as to how an investment approach would work in the health sector and how it would improve overall health outcomes. This is discussed further in this submission.
  7. The Draft Strategy implies through several actions and statements the likelihood of privatisation of public services and infrastructure and increased use of the third sector through contracting out of services. These could have significant impacts on the workforce such as increased insecurity of employment and the problems of lack of workforce development, poor working conditions and cost-cutting that have been all too evident in the residential care sectors. This is of serious concern to the CTU. If this is not the case, the Strategy should provide assurances to this effect. But if this is the case then the Strategy ought to directly communicate this in the interests of openness and transparency with unions and the wider sector.
  8. The Draft Strategy has a strong technology focus. Although technology is already important and will play a strong role in the future, it raises a number of concerns for unions including the impact on jobs, services, infrastructure and costs. In addition not everyone has access to technology. In particular, people with low incomes, the elderly and people with disabilities may have limited access or difficulties in using technology. Recent examples in the health sector (e.g. Health Benefits Limited) and wider State Sector highlight an increasing trend of poor and rushed planning, excessive costs resulting in little or no benefit and ill-informed decisions regarding technology solutions. The health sector can ill afford to continue making these costly mistakes.

*Consultation*

* 1. A Health Strategy is a significant piece of work for which there must be adequate time for submitters to analyse the issues and provide recommendations. The short consultation process and ad-hoc coordination of engagement meetings with the sector (on several occasions key groups including unions were not aware of meetings) has made it difficult to make an informed submission on the many far reaching issues which must be considered in a limited timeframe. The limited time-frame has also impacted on submitters’ ability to provide alternatives to what is contained in the Draft Strategy.
  2. We urge caution in finalising and rushing implementation of the Draft Strategy without full and proper public consultation. It is clear that further work is still required before a final Strategy can be agreed upon. Without this information and input there is a high risk of ill-informed decisions and poorly developed actions and roadmap.
  3. Given the complex nature of the health sector, the CTU strongly recommends continued involvement of forums such as the HSRA Steering Group and the NBAG for engagement in further discussion of the Strategy. A more coordinated approach to consultation and open lines of communication will assist in information sharing, dialogue and building confidence in workers, the wider health sector and public on the credibility of the development of a Health Strategy.

1. Consultation Questions: (Update of the Health Strategy: Submission Form)

### Challenges and opportunities:

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 importance of health inequalities and how they affect health outcomes needs to a much stronger part of the Draft Strategy. There is an almost complete absence of the role of social determinants and factors leading to good health. Given the substantial work and research done on the importance of the social determinants of health, their absence from the Draft Strategy is inexplicable. The social determinants of health drive health inequalities. As the WHO Director General, Margaret Chan states:  *Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."*  Though there is recognition of the disparities that Māori and Pacific Island people face, the health disparities faced by low-income people in general do not feature as areas of attention or focus of work in the Strategy, the five themes or the action plan.  There needs to be more emphasis on the critical role that primary health care services play in improving health outcomes and the principles that effective primary health care services are based upon: the concept of “Health for All” which is well known and understood at a local, national and international level.  The document talks about “how to meet the needs of New Zealand’s most disadvantaged”. The document refers to one of our strengths being a publicly funded universal health system and yet there is a move reflected in the document on more targeting rather than sustaining universal services. The move to a more targeted health system will result in a shift away from a universal health system. This is in spite of the increasing evidence that the best health outcomes are from universal services. It will also undermine public support for the publicly funded health system as fewer people benefit from it, and it will create poverty traps. |
| The health disparity of people with intellectual disabilities is of serious concern and the failure of the Draft Strategy to actively address these disparities is disappointing. The poor health status of people with intellectual disabilities continues to exist even though there is comprehensive empirical evidence of the health inequalities affecting this vulnerable group. Despite this information, there is no comprehensive or systematic response to the health needs of New Zealand children and adults with intellectual disability.  Additional challenges not addressed in the Draft Strategy include the impact of International Trade and Investment Agreements on the health sector. For example, the provisions of international agreements such as the Trans-Pacific Partnership Agreement (TPPA) may affect the ability of the government to change or modify contracts, utilise policy and regulatory levers to combat health issues such as tobacco or sugar control, and maintain access to affordable medicines. The impact of TPPA being ratified by the New Zealand Government needs to be considered in respect of the health sector.  We are concerned at the absence of issues related to Climate Change and future implications for population health, services and infrastructure. Climate change is already affecting, and will continue to have an effect on social and environmental determinants of health including clean air, safe drinking water, sufficient food and secure shelter. It will affect some of our nearest neighbours in the Pacific, in turn impacting New Zealand’s population. The effects of Climate Change cannot be ignored and must be considered as part of a future focused Strategy for the health system. |

### 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 concerned at the use of jargon language in the document e.g. “people-powered” or “one team”. It is cynical to use a term like “people-powered” when the intention is increasingly to devolve control of the system to private contractors who individuals find difficult to hold to account because the relationship with them is at bottom a commercial one controlled by remote holders of the purse strings, and frequently individuals requiring services are those who are least in a position – often because of their health condition – to hold anyone to account. If the reference is to voucher-like systems where funding is effectively in individual hands, that has other well-known problems including loss of the bigger picture of the public good.  These matters should be explicit and in the open in a Strategy. Using terminology like “people-powered” is sloganeering in order to be able to claim public support on the basis of obfuscation of real intentions. These phrases mean little in themselves, can mean quite different things to different people, and have different interpretations according to context. This statement should clarify direction; instead it will mean quite different things to different readers.  The central statement of “All New Zealanders live well, stay well, get well” does not adequately capture the issues affecting the sustainability and future focus of the health system. We support the suggestion at the Health Sector Direction Forum on 19 November 2015 that the central vision statement be rephrased to “start well, live well, end well”. The start of life, living well and ending well all represent pertinent issues and resonate with statements throughout the Draft Strategy such as “…starting and finishing in homes…”. This would be more helpful in forming the basis for a future focused Strategy.  Ideally the final Health Strategy and its actions would be linked to each part of the central vision statement “start well, live well, end well”. These are broad terms but can possibly link and guide the Strategy more clearly in comparison to the current draft. |

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 retention of the 7 principles from the 2000 Health Strategy and the addition of one more are supported. They provide continuity and stability in the health care system beyond political cycles. However, though the principles are retained, they are not embedded and do not translate into the narratives of the five themes or into the road map. |

### 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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| **Five Themes**  The Five Themes should be connected and provide a clear, evidence based analysis of the issues and appropriate actions to progress a future focused Strategy. The Draft Strategy does not provide us with confidence or assure us of the future of the health system given the lack of clarity and detailed information on several actions identified under each theme. Instead it raises a number of risks and disconnection between what needs to happen - addressing health needs and health inequalities - and actions for addressing these needs. The lack of emphasis on population health priorities will affect the sector if the Draft Strategy is implemented in its current state. It will give rise to a number of unintended consequences and most worryingly lose focus of people and the role public health system.  Given the gaps in detail and lack of clarification on themes and several actions it is difficult to support the Five Themes or the actions under each theme. A summary of the high level issues are identified below under each theme but the CTU and affiliated health sector unions welcome the opportunity to discuss these and other issues in greater detail further with the Ministry of Health.  **People-powered**  The People-Powered theme promotes a people-centred approach to health services and having service users as partners. Whilst we encourage a health system taking into account the perspective of the service user we also urge caution regarding the actions proposed and seek greater clarity on these actions and details of the theme.  *Acknowledging the special relationship between Maori and the Crown (principle)*  The Draft Strategy needs to show more awareness of New Zealand’s social and cultural context - in particular tangata whenua and tikanga based principles in healthcare. The principle acknowledging the *“special relationship between Māori and Crown”* in the Draft Strategy must be reflected in a meaningful, credible and continuous way to achieve better outcomes. Māori must be given solid recognition in policy and health development planning. There are specific reasons why Māori have some of the poorest health outcomes of any group. There is plenty of research and evidence that highlights health inequalities and social determinants of health for Māori (indigenous health). Whilst access to services can be affected by cost, access can also be affected by the cultural connection to the system, services and practices that do not align with Māori. These issues must be examined and *relevant, culturally appropriate* approaches for addressing health problems affecting Maori identified with solutions led by Māori.  Māori naturally have a people-centred approach and this must align with the Closer to Home theme in that Māori must lead in the design and implementation of actions aimed at addressing Māori health issues. However, Closer to Home actions must be well resourced and supported by the Ministry of Health and other agencies to enable Māori to achieve better outcomes. Similarly, there are specific cultural settings for other vulnerable groups such as Pasifika, immigrant communities and also refugees who often arrive from displaced backgrounds. There are specific issues and backgrounds that need to be examined urgently and *relevant, appropriate and culturally sensitive* solutions identified for these groups (from a cultural perspective) to help reach better health outcomes.  *Cultural Settings*  New Zealand’s population is culturally diverse with many ethnicities and with this comes a number of challenges including trust, confidence, accessibility to quality services and engagement in the health system. The Draft Strategy lacks evidence on the issues affecting these populations in terms of engagement in the health system, or an examination of why these issues exist. For example, does the Draft Strategy, system and current structures contribute towards people’s trust and confidence in the system or does it act as a barrier for positive engagement? If people do not have trust and confidence in the system, the Draft Strategy is unlikely to meet expectations of the people-centred approach.  The Draft Strategy discusses the connection Pasifika communities have to churches and the opportunity this provides in access points for health care. This is encouraging but it should be happening *already* so the question must be asked why this is not happening? What are/will be the barriers and what must be done to overcome these barriers from a structural and cultural perspective? The Draft Strategy lacks meaningful discussion on these issues.  *Digital Solutions*  The Draft Strategy discusses digital solutions aimed at providing greater access to information and evidence based health advice for service users. This is encouraging, however, it is not clear, how “access” to information and services will best be achieved through digital solutions or if in fact the digital solutions which enable remote access to patient health information is secure. The Roadmap discusses the use of telehealth in delivering timely and responsive services. Whilst, telehealth and the use of technology is useful particularly for the younger population there are also a number of limitations associated with digital solutions. For example, not everyone has access to technology particularly those who live in low-socio economic areas or some people with disabilities. In some instances it may not even be about access but more about technology literacy. Is the Ministry of Health confident that with a rollout of telehealth and other technology services people will have access, knowledge and be able to use these services?  Whilst technology provides a channel for accessing services and information, it is only useful if the person is able to understand the information, navigate patient portals and connect to telehealth services. Health literacy plays an important role in improving the health perspective of the service user therefore it is important in changing behaviours and understanding information that is relevant to improving health outcomes. Any digi-health solution will require a high standard of health literacy for successful uptake and implementation – has this and associated challenges been considered?  The Draft Strategy does not mention whether there will be trials to assess the effectiveness of the digital solutions, or whether the digital solutions will be available in various languages reflective of communities in New Zealand e.g. Māori, Chinese, Samoan, Indian etc or those with specific disability needs. If these issues have not been explored, we recommend further analysis on the effectiveness of digital solutions for health services, including uptake in low- socio economic areas, by people with English as a second language, or by people with disabilities who are limited in accessing technology, and the level of technology and health literacy required to fully utilise the tools.  Whilst there may be benefits for the service user in accessing health information and improving health literacy through digi-health solutions there is a risk that this could lead to less face-to-face time with health professionals, possibly complicating health problems further (if left untreated). The process and engagement through digi-health solutions needs to be managed carefully and have input from the health workforce some of whom will be required to spend more time entering information online for the patient as opposed to doing other clinical work.  *Individualised funding*  We are concerned about risks related to Individualised Funding and the lack of balanced discussion on the model in the Draft Strategy. The wish for people to be autonomous and in charge of their own care needs is appreciated but there are major employment and health and safety issues which need more attention.  The issues that are raised by turning dependent citizens into employers of their carers have not been confronted. Such arrangements can move people into the responsibility of an employer without the necessary training or adequate cognisance of the employment responsibilities which may become complicated by the dependency of the relationship and the high degree of trust that is required. This can lead to much more than the usual (and often difficult) problems when an employment relationship breaks down.  We support the concept of the consumer having choice in the employment of their support worker but advocate for it to be managed through an organisation that is accountable for managing the employment and the health and safety requirements (which are significant) to the level of the Home and Community Support Standards and other relevant legislation.  **Closer to Home**  The theme, ”Closer to Home” is focused on the shifting of services and care being delivered close to where people live. The notion behind people being able to access health services close to home is unassailable. And the vision laid out in, “what great might look like in 10 years“, is also unarguably a good one. But there are components missing in how Closer to Home services will translate into the delivery of accessible, effective, quality health care services for all people.  *Primary Health Care Services*  A central component of close to home must be the role that primary health care services play in improving health outcomes and the established values of primary health care services: the right to health for all; people centred care; a central role for communities in health action; prevention and health promotion as integral part of the health response; and local action.  The identification of primary health care services as the basis of improving health outcomes is essential because of the strong evidence that primary care is associated with a more equitable distribution of health in populations and can improve overall health and reduce differences in health across major population subgroups.  For some people health services need to be close to where they work. And they also may need to be close to the communities that people associate with e.g. Iwi associating with discrete Māori health services.  *Health Inequalities*  Effective primary health care improves the health of groups who face health inequalities. The Draft Strategy acknowledges health inequalities for Māori and Pacific peoples. Addressing the health inequalities of Māori and Pacific people is a recognised major health priority. Missing, however, in the Draft Strategy are the health inequalities caused by low socioeconomic status and the health inequalities and challenges caused by lack of access to social determinants which affect good health: adequate income; quality housing, decent employment. While the importance of these factors are recognised by health professionals and workers, and also in some of the current funding arrangements e g. Very Low Cost Access scheme; in refugee health contracts, the omission of the health inequalities faced by people with lower socioeconomic status is a crucial and inexplicable missing component.  *The Investment Approach*  It is a concern that the theme Closer to Home includes reference to the investment approach given it is unclear what is meant by this approach for the health sector. The investment model that is currently being applied in the Ministry of Social Development (MSD) uses techniques from the insurance industry to calculate long-term costs to the government of welfare services. This approach only focuses on costs to the government and ignores the benefits to individuals and the community from welfare services. It is ill-advised and we suggest potentially dangerous, to suggest an investment approach in the health sector when there is no agreement about what is meant nor any evidence that it will improve health outcomes.  *The Health Workforce*  The demand in providing services Closer to Home has impacts for the workforce and is an essential consideration in delivering services Closer to Home. There has been a substantial growth in the non-regulated workforce providing services to people in their home but without the commensurate funding needed, the employment arrangements needed for decent working conditions nor the training required. Workforce requirements are an essential but missing consideration in the Draft Strategy of delivering services Closer to Home.  **One team**  The theme “One Team” is unclear. Several areas identified under the theme lack detail, future focus and is silent on what is meant by a number of actions which leaves it open for misinterpretation.  *Health Workforce*  The One Team theme largely refers to the clinical health workforce but there is little reference in the Draft Strategy to the wider health workforce. The health workforce is wider than the clinical workforce and entails both the regulated and non-regulated workforce which are intrinsically linked in the delivery of health services.  The theme Closer to Home is focused on the shifting of services and care to the home. This requires an emphasis on the skills, conditions and sustainability of the home support workforce as well as its growth to meet demand – yet there is little discussion around the challenges of meeting workforce requirements for the delivery of services and care closer to home. This approach to care and service provision has more complex requirements of the workforce, both in the nature of work and the workplace, and in the requirements of health workers who are physically or professionally isolated in people’s homes. Over recent years the sector has had to address problem after problem arising from the non-regulated workforce: the sleepover case, in-between travel case and equal pay case are symptoms of numerous problems in the sector. It demonstrates that leaving it to ‘the market’ to resolve these problems does not work. A strategic approach is required to providing a sustainable workforce that has the training and skills required, addresses workplace health and safety challenges, and provides attractive careers that enable retention of experience in this growing sector.  We recommend the One Team theme is redrafted to encapsulate all parts of the Health workforce so as to “reflect a whole of workforce approach” which recognises the importance of each workforce in the delivery of health services and the challenges and benefits for workers in both a qualitative and quantitative way for the future.  The generic reference to workforce development does not provide assurances that the Draft Strategy has identified the direction and priorities for the health workforce in the future. This is of serious concern. The Health Strategy should clearly identify the challenges, opportunities and priorities for workforce development including workforce shortages and training pressures that need to be addressed to assist implementation of a Health Strategy in future.  The health sector workforce is highly unionised therefore input from health sector unions is critical in understanding workforce issues and developing a response to these issues.  *Who is the One Team?*  The One Team refers to NGOs but there are a number of other groups that contribute to health outcomes. The health workforce, whanau and community is and should be at the heart of the One Team but the theme requires a broader view that includes the role of Iwi, Unions, DHBs, wider health sector providers, other Government agencies (e.g. housing, corrections, MSD, Local Government), health groups, education providers, representative and advocacy bodies in working together to improve coordination, health services and outcomes for New Zealanders. One Team must be inclusive of all people in New Zealand, and who participate and connect with the health system. This is lacking in the Draft Strategy. If the Draft Strategy refers to collaboration in actions and the Roadmap then One Team must be inclusive of all participants who can enable collaboration, particularly at community level.  *Roles and Responsibilities for the Workforce*  The actions for One Team refer to clarifying roles and responsibilities for the workforce. It is unclear what is meant by this action. We strongly encourage union consultation on the One Team theme and clarification of the actions regarding roles and responsibilities. Similarly, the term “flexibility” is often used throughout the One Team theme (and Draft Strategy) yet it is unclear what is meant by *“flexibility and full use of skills …. continuing to reduce barriers that currently prevent this, including legislative barriers”.* This statement is of serious concern as it not clear what it means and more specifically what is meant by legislative barriers or *“flexible use of the health and disability workforce.”* The Health Strategy needs to clarify what is specifically meant by this action and statement.  *Volunteers*  The need to support families, whanau and individuals in communities in their roles as carers of people close to them is highlighted in the Draft Strategy including the need for *“…tailored information and training for volunteers….opportunity to contribute to design choices …..”* The Draft Strategy, however, is silent on how this training would occur, what it would involve, by whom, the incentives and expectations on unpaid carers/volunteers, and implications for employment and health and safety. The Draft Strategy needs to clarify the statement above and specify details for unpaid carers/volunteers, expectations and implications for the sector.  *Reliable Workforce Data*  The Draft Strategy refers to the use of workforce data to inform workforce planning, however, this assumes that there is a reliable workforce collection data system in existence. There is a large gap in reliable and robust data collection of both the regulated and non-regulated workforce for the health sector. This is a well-documented issue that has been raised on several occasions previously by unions and sector organisations. In order to provide a true and reliable picture of New Zealand’s health care workforce, there must first be a system in place for workforce data collection. We consider that either the Ministry of Health or Health Workforce New Zealand (who have been specifically tasked this role) should play a more active role in collating reliable workforce data to better inform workforce planning.  **Value and high performance**  The Value and High Performance theme lacks detail and clarity on the intent behind actions, and raises a number of concerns regarding sustainability, accountability and transparency. The actions (without saying specifically) can be interpreted to also mean greater use of the private sector in the delivery of services, Public Private Partnerships and Social Investment Bonds.  We oppose actions which are short-term in focus, will result in privatisation of services and infrastructure, affect quality care and services, lead to insecure employment, deterioration of pay and employment conditions, lack of transparency and impact adversely on smaller communities. Instead, we recommend the Draft Strategy’s focus should be on improving the effectiveness of current infrastructures, strengthening contract management and monitoring processes, building existing alliances in the sector and putting effort into greater collaboration. There should be reviews of whether current private provision by contracting out or outsourcing are in fact working in terms of sustainability and outcomes.  The CTU and affiliated health sector unions are keen to participate and play a part in initiatives that improve the overall function of the health sector and promote sustainability.  *High Performing Workplaces*  We support the action around implementing/dissemination of best practice initiatives. There are opportunities for less disruptive incremental changes to be made in comparison to contracting out services and infrastructure. Such changes can contribute to cost savings, add value, improve efficiencies, build trust and confidence in the sector, and minimise disruption to the sector which would otherwise occur through more significant and risky “transformational” changes.  The CTU supports a high-trust system with better cohesion. The CTU-affiliated health sector unions have played a strong collaborative role in helping to create high performing workplaces. This role has included working in partnership with DHBs to facilitate change, innovation and identify better ways of working *together*.  There are opportunities for Unions, DHBs and other stakeholders in the health sector to work collaboratively on developing a high trust working environment and sharing best practice initiatives. The CTU and its affiliated unions are keen to play a part in fostering constructive relationships and innovative workplace practices.  *The Investment Approach*  The term, “the Investment Approach” is now strongly associated with the Forward Welfare Liability (FWL) Model and with the form that is being applied in the Ministry of Social Development (MSD) towards welfare beneficiaries. Analysis of the MSD Investment Approach shows that it is fundamentally flawed in that it does not consider benefits, only costs, and then only looks at the costs to government[[86]](#footnote-86). The Productivity Commission state that the MSD Investment approach is not a cost- benefit analysis and recommend that “it should be further refined to better reflect the wider costs and benefits of interventions”. They state that “slavish application of an investment approach based purely on costs and benefits to Government (like the FWL) might lead to perverse outcomes. For example if the health system were to seek only a reduction in future health costs then there might be little done if anything, to discourage obesity as early deaths from obesity would reduce future fiscal liability”.[[87]](#footnote-87) Because of the lack of clarity and different interpretations around the Investment Approach it should not be included as a direction or policy in the final Health Strategy without further in-depth clarification, discussion and agreement.  *Expanding the Use of Contracted Out Services*  Expanding the use of contracting for health and equity of health outcomes is an action identified under the theme. We view increased use of contracting out services and infrastructure as detrimental to New Zealand’s economy and public health system. In particular, greater risk of private sector commercially driven behaviour will seriously weaken and undermine the public health sector and affect the ethos of the wider public sector.  We believe that outsourcing and wholesale use of contracting out services will allow the private sector undue influence over services in the public health system. Contracting out services or a national outsourcing approach are said to enable the transfer of risk regarding delivery failure to the private sector. In fact the state can never remove itself from risk because the public expects it to provide these important services. Instead (as with the recent Novopay and Serco cases) the state finds itself shouldering the risk and with added costs to retrieve the situation.  The Draft Strategy leads to this way of thinking. International (e.g. the United Kingdom’s National Health System) and local examples such as the centralisation of food production in the 1990s e.g. Tempo which had negative consequences for service delivery resulting in liquidation of the provider and more recently the problems arising from the privatisation of Wellington region’s hospital laboratory services. These examples highlight the risks and failures of outsourcing and privatisation of public services, infrastructure and associated issues including fragmentation of the health service, lack of democratic, accountable and transparent processes, changes to services and increased costs. These examples show that the outsourcing approach has been hugely controversial and fiscally there are more and more questions emerging about the financial viability and quality of contracting out services and infrastructure.  We hold serious concerns regarding the nature of work if contracting and outsourcing approaches were to progress e.g. prevalence of contractors, casualised workforce and deterioration in pay and conditions for workers. The CTU holds serious concerns regarding this development and the continued negative effect contracting out will have on employment and the hollowing out of public services.  Ownership of facilities and equipment by a third party for the delivery of services poses great risks for DHBs particularly their ability make most efficient use of the assets, control the cost of them and to buy back assets in future. The desire to expand the use of contracted-out services introduces competition and profit-driven motives into the delivery of public services, which is in stark contrast to the collaborative and service orientated approach of the public sector. The proposed approach inevitably leads to the health sector being increasingly privatised, posing major risks that threaten patient safety, equity, quality of care, services and capacity of the health sector.  We are also concerned where the expanded use of contracted services an outsourcing may result in the shifting of services and jobs to larger Centres, privatisation and the subsequent pressure on smaller communities who are already struggling in terms of economic development and job growth. It is disappointing to see the Draft Strategy not provide any evidence, information or analysis on the impact of contracting out and outsourcing services, including on smaller/ regional communities.  Maintaining and building the capacity and capability of DHBs to provide services should be the long-term strategy of government and DHBs. Use of the private sector as a short-term solution for “quick wins” is short sighted, irresponsible and not a sustainable approach to addressing problems. We believe the focus should be on improving the effectiveness of current infrastructures, contract management and monitoring processes.  The CTU opposes contracting out of services and infrastructure under an outsourced provider arrangement.  *Transparency and Accountability*  We support the comments under the theme around transparency of information and accountability. However, the theme contradicts itself in terms of the focus on contracted out services and private sector role in the delivery of services. Accountability is affected where private sector involvement increases in the delivery of public services and infrastructure. The lack of accountability mechanisms and impact on transparency if services are contracted out and outsourcing approaches are undertaken concerns us. Under an outsourcing approach, public spending is more difficult to scrutinise as private sector providers are not covered by official information requests.  There is also a risk of hollowing out the expertise and capability of the health sector, so that monitoring of services cannot be effectively carried out, and the ability to resume provision of services is lost. Any proposal to nationally outsource the provision of services and infrastructure encourages a commercial profit-driven approach. Given the small size of New Zealand’s health sector and the specialities required, private provision frequently has few if any competitors.  If prices are driven down by government contracting requirements that aim to reduce Crown costs and achieve accountability through short term contracting, the results are too frequently short term positions taken by contractors with regard to improving systems (including technology and record systems) employment, pay, training of staff and ongoing staff development.  We are also concerned about the recommendation arising from the Capability and Capacity review that the number of Board members on each DHB Board be reduced to nine members (from the current 11) with six of the nine members appointed by the Minister of Health. We have strong concerns regarding democratic representation and decision-making processes on DHB Boards. The proposed increase in Ministerial appointees on DHB Boards is in direct contradiction to the people-powered theme and patient-centred care approach in the Draft Strategy. If the Draft Strategy has an emphasis on transparency of information and accountability of decision-making we do not see this recommendation as promoting either of these but rather it diminishes democratic representation and processes. The Capability and Capacity review recommendation does little to increase trust and confidence in the system by service users, whanau, workforce, community advocates and wider health sector.  *Technology costs*  The Draft Strategy signals significant technology changes which will have cost and resource implications for the sector. The action regarding technology costs will need to consider many facets of technology improvement and be well connected to implementation of digital health solutions and actions highlighted under the Smart System theme. We are concerned, however, that the Draft Strategy has a high technology focus yet there is no information to clarify viability or how the actions will be funded.  Increasingly the complexity of technology projects means increased risks of failed projects (such as Novopay). It also makes it more difficult for low-capitalised contractors, especially NGOs, to take part in it. This is likely to mean contractors will be large, often overseas-controlled multinationals with even less connection to local communities undermining themes such as “Closer to Home”.  There is a strong likelihood that the demand on Information Technology (IT) infrastructure and future ongoing maintenance will require increasing levels of investment by DHBs. This adds further financial pressures to DHBs if this is not known, or costed appropriately and will inevitably have an adverse effect on funding for service delivery and workforce implications. Further information is required and analysis disclosed before a well-informed decision can be made particularly given the likelihood of high technology project costs.  *Quality and Safety*  We support the action around strengthening relationships to continuously improve system quality and safety particularly around reducing patient harm. However, as mentioned already it is unclear which other organisations are seen as part of the partnership or which quality and safety initiatives are identified in terms of primary and rest home care – how will these initiatives be identified and who will have input into identifying them? The workforce often plays a significant role in promoting the culture of quality and safety and as such must have the opportunity to participate in the continuous improvement system.  **Smart Systems**  The “Smart System” theme has a strong technology focus aimed at accessibility of information, data and smart systems that improve decision making, reporting and gaining efficiencies from emerging technologies. Whilst it is inevitable that technology will play a greater role in the health system in the future we are concerned at the impact of these changes if they are not carefully planned, the impact on jobs, and duplication with other areas of work. For example, there are other IT programmes being undertaken in the sector such as through Health Partnerships Limited which may potentially overlap with actions outlined in relation to the people-powered theme (digital solutions) and smart systems.  The CTU urges caution in finalising the Draft Strategy too quickly in this regard. Instead we encourage a thorough analysis of other work in relation to technology that may be underway already in the sector and detailed analysis of any proposal to progress the Smart System actions including assurances around funding and resourcing and whether the sector has the foundations to withhold such solutions e.g. a capable, high speed broadband service that is accessible in all areas of New Zealand.  *Technology Platforms*  To implement a smart system across all DHBs, there must be a robust and reliable IT platform to launch smart information systems and promote timely access to health information. The National Infrastructure Platform (NIP) project conducted by HBL highlighted the fragile state of the current ICT platform and systems used by DHBs. The demise of HBL has seen the NIP project transferred to the new DHB owned entity Health Partnerships Ltd but the status of the project remains unclear.  We are concerned that without a full understanding of the current state, implementation challenges and costs, the sector risks developing infrastructure solutions which are costly, not fit for purpose, affect timely access to information, privacy and security considerations, risks duplication with other programmes, risks business continuity and adversely affects the integrity of the health system.  Greater investment in quality infrastructure to underpin the longevity and sustainability of IT and other support services in the health sector is required. However, the Draft Strategy is silent on the issue of cost and resources required to implement the actions for Smart System or who will fund this initiative. One of the actions under the Value and High Performance theme alludes to IT project funding but does not specifically identify who will address the costs or any evidence of the budget for IT. We seek assurances that funding from DHB funding streams is not relied upon to meet implementation costs.  It is likely there will be many hidden costs (such as implementation, resourcing, upgrades, ongoing maintenance and infrastructure costs) associated with initiatives under Smart System as has been the case with similar large scale IT-related projects in the State Sector.  The technology solutions identified under Smart System need to be carefully considered and all relevant information made transparent to Unions, workers and DHBs. In New Zealand, there have been several examples of State Sector agencies undertaking IT initiatives (e.g. Novopay) which have been poorly planned, managed and implemented resulting in excessive costs which were unnecessary, avoidable and ultimately resulting in project failures or significant re-planning.  Technological solutions can be difficult to understand due to complexity and is an area which is foreign to many people due to its technical nature. This is a risk as it makes it easier to push through a proposal which is poorly developed or not understood by the workforce or the sector and poses implications for service delivery and costs.  Further information is required and analysis disclosed before a well-informed decision can be made on whether to progress any IT related initiatives given the likelihood of high implementation costs as has been proven by the Finance Procurement Supply Chain (FPSC) programme undertaken by Health Benefits Limited (HBL). The Office of the Auditor General in October 2015 released findings into the performance of HBL and in particular the FPSC programme. The analysis was critical of a number of factors that contributed to the difficulties of the programmes including an ambitious and complex programme, which was risky with poor management and inadequate communication. The FPSC programme was not only expensive with no benefit to the sector but created unnecessary stress and anxiety for staff, and loss of institutional knowledge which the sector cannot afford to lose.  *Standardisation of Approaches*  There is reference to Standardisation of approaches in several parts of the Draft Strategy including under Smart System. It is unclear what is meant by standardisation in the context of the Draft Strategy, however, recent examples show that the quest for standardisation in various areas of the health sector have frequently not been successful and have resulted in budget blowouts. For example, the FPSC programme conducted by HBL which financially was a disaster and caused unnecessary stress for staff, loss of institutional knowledge and job losses. The CTU seeks further details on the Smart System and clarity of goals such as *“standardisation of approaches”.*  *Privacy Considerations – Information Sharing*  The Draft Strategy must ensure the public have trust and confidence in safe, accessible and relevant health services. We are concerned about potential issues associated with confidentiality and privacy surrounding the accessibility of patient information. Mental-health information is a particularly sensitive instance. For example, there is a risk that people who are engaging in illegal substance abuse may not be so forthcoming with their issues if they know the information will be recorded and available to all health professionals. We strongly urge caution where the rights of patient/service user may become compromised through the wide and easy accessibility of patient records.  Greater emphasis on information sharing and data matching across DHBs and government agencies is of concern if not undertaken properly. The Privacy Act 1993 makes specific considerations for information that is shared and data matching across agencies. Although there are merits to global access to information there are also a number of issues that could arise as to how this information is managed, accessed and distributed if requested between DHBs and by other agencies.  Concerns surrounding centralisation of patient information such as access, confidentiality and privacy of patient information is also heightened given the number of privacy breaches due to IT failures by State Sector agencies over the past few years (e.g. ACC, MSD, MoH, EQC, NZ Post). Patient’s private information must be protected first and foremost - protection must not be undermined or devalued in pursuit of efficiencies and cost savings.  Finally, patient data and application support must remain with and managed by DHBs. It is important DHB’s maintain ownership of patient and hospital information. There are many details lacking in relation to the Smart System theme including who will be involved, how this will work and how will it be resourced. In any case we hold concerns about private and confidential information being held by another facility (third party) and the risk of data mining as has been the case previously in New Zealand and internationally with the privatisation of such services in the IT area. |

### 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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| The Roadmap is not evidence-based and is unclear in several areas. Some actions are too prescriptive (micro-management) such as the “*number of people able to access patient portals*” or too targeted. For example, actions addressing obesity are identified but are targeted towards certain population/age groups. Obesity is problem that is affecting the whole population and likely to have a big impact on the sector therefore it would be more effective to have a national response to obesity that has a future focus for the long-term.  In other areas, actions are either too broad or represent current activities already happening such as “*obesity reduction initiative in place”* and other actions represent what should already be occurring but are not such as *“partnerships between DHBs in the management of long-term conditions.”* The Strategy and Roadmap does not identify why this is the case - what are the barriers to these actions not occurring already? How can the barriers be overcome and by whom?  The Roadmap needs to be informed by what the Draft Strategy is aiming to achieve but the actions and connections are unclear on how this will occur as the Draft Strategy itself is unclear on what will be achieved. As mentioned earlier, the Draft Strategy is not well connected, balanced or reflective of the challenges, opportunities, expectations or goals for the sector. If the themes in the Strategy itself do not interconnect then it does not bode well for a Roadmap of actions which is likely to be underwhelming and off the mark for the sector. |

### 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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| The Draft Strategy needs to be guided by the principles that are meant to underpin the Strategy. The Strategy needs to include the perspective of the service user – this requires actively engaging with not only the sector but population groups on the challenges, opportunities and most importantly what people want for the public health system and identify the goals collectively. The Draft Strategy takes a selective approach to health issues which avoids a universal approach to goals and outcomes.  In order to develop a future focused Strategy, the past must be understood (from all perspectives) to inform future actions. The final Health Strategy must include the narrative (stories) from the perspective of a service user, their whanau and the wider community – what do health outcomes/strategy look like to a service user? What has been their experience and what do they want for future experiences?  The Health Strategy is a significant document. Therefore an evaluation and monitoring programme examining the implementation, effectiveness of actions and experiences of users must be built into the roadmap and its actions.  The lack of information on outcomes in the Draft Strategy is concerning. For example what are the outcomes the Strategy is seeking to achieve? What will it look like, how will this be determined and how will it be measured? Is this long-term or only in tune with the proposed life of the Strategy (which broadly coincides with the political life cycle)? To have a national Health Strategy there needs to be a national measure. Unfortunately the national measure is absent from the Draft Strategy and related documents. Without this information those implementing the Strategy will not know what it is aiming to achieve or how it should continue into the future. |

### Any other matters

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

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| We strongly recommend a wider strategic response towards the development of a Health Strategy that is based on equity, access, protection, and transparency. The absence or lack of focus on the Draft Strategy on population health priorities is deeply concerning and raises the question – do these priorities even matter and are they a priority for the Ministry going forward? Many of the priorities do not feature in the Draft Strategy such as mental health which is having a profound effect on people and the health system yet markedly absent. We would have expected population health priorities to be the cornerstone of the Draft Strategy and effort given to addressing these issues. Instead the Draft Strategy is unbalanced, and prioritises cost and health expenditure over quality care and services, meeting the health needs of people, improving health outcomes and addressing health inequalities.  Health cannot be seen in isolation from other social issues – there is a domino effect between health and employment, social welfare, education and other services. For these reasons and those raised in this submission, the draft Strategy must take a more strategic analysis of the challenges affecting the sector now and into the future (beyond the political cycle and beyond the sector itself). A Health Strategy that does not address drivers of health from outside the “health system” is doomed to fail. |

Summary of CTU Recommendations: Draft Update of the New Zealand Health Strategy

* 1. The CTU and affiliated health sector unions welcome the opportunity to discuss the issues raised in this submission in greater detail further with the Ministry of Health. This could extend to discussion at forums such as the HSRA Steering Group and the NBAG for engagement and discussing the Draft Strategy in future.
  2. That the guiding principles are supported and provide continuity and stability beyond political cycles.
  3. That the final Strategy shows more awareness of New Zealand’s social and cultural context - in particular Tangata Whenua. Māori must be given greater recognition in policy and health development planning including design and implementation.
  4. That because the unions are the means by which the workforce is represented there should be input from health sector unions in understanding workforce issues including workforce development and developing a response to them.
  5. That the CTU and affiliated unions continue to play a part in fostering constructive relationships in the health sector and innovative workplace practices that improve the overall function of the health sector and promote sustainability and high performing workplaces.
  6. That further work is required before a final Strategy is agreed upon and caution is urged in finalising and rushing implementation of the final Health Strategy.
  7. The central statement of “live well, stay well, get well” should be rephrased to “start well, live well, end well”. However, this statement requires further work and clarification so it is well understood.
  8. That there is a greater emphasis on addressing health inequalities, how they affect health outcomes, the social determinants of health and the actions needed to eliminate health disparities.
  9. That the value of universal services in promoting optimal health outcomes is promoted and the critical role that primary health care services play in improving health outcomes.
  10. That the Health Strategy avoids language and jargon which is unclear and open to different interpretations. The Health Strategy must reflect in accessible and understandable language the goals of the health systems.
  11. That the Investment Approach is not included as a direction or policy in the Final Strategy because of the significant faults in its current implementation in the MSD and the ambiguity surrounding its meaning.
  12. That the perspective of the service user be taken into account and caution be applied regarding the actions proposed under each of the five themes with greater clarity on these actions.
  13. That there is better clarification and connection between the five themes, actions and Roadmap: currently this is unclear.
  14. That there is further analysis on the effectiveness of digital solutions for health services including uptake by people with low incomes, with English as a second language, or with disabilities who are limited in accessing technology, and the level of technology and health literacy required to fully utilise the tools.
  15. That the process and engagement through digital health solutions is managed carefully with participation from the health workforce.
  16. That the concept of consumer choice in the employment of their support worker is generally supported but it is managed through an organisation that is accountable for managing the employment and the health and safety requirements (which are significant) to the level of the Home and Community Support Standards and other relevant legislation.
  17. That there is a reliable system in place for workforce data collection in order to provide a true and reliable picture of New Zealand’s health care workforce.
  18. That the “One Team” theme is redrafted to encapsulate all parts of the Health workforce so as to “reflect a whole of workforce approach” (regulated and non-regulated workforce).
  19. That “One Team” is inclusive of all people and groups in New Zealand who participate and connect with the health system.
  20. That there is clarification of statements and actions proposed under “One Team”: for example, what is meant by reducing legislative barriers or *“flexible use of the health and disability workforce”* and similarly - the incentives, expectations and implications for employment and health and safety for volunteers as carers.
  21. That the technology solutions under “Smart System” are carefully considered and all relevant information made transparent to Unions, workers and DHBs and that further information analysis required and disclosed before a well-informed decision can be made on whether to progress any IT related initiatives given the likelihood of high implementation costs and risks of failure.
  22. That there is more explanation and detail on the “Smart System” and clarity of goals such as *“standardisation of approaches”.*
  23. That the implementation costs and resourcing of actions are not dependent on constrained DHB funding streams.
  24. That as a national Health Strategy it should contain national measures of success. The evaluation and monitoring programme examining the implementation, outcomes, effectiveness of actions and experiences of users must be built into the roadmap and its actions.

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