**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**85 - 113**

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| **85** | Submitter name | Mark Shanks |
| Submitter organisation |  |

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| This submission was completed by: *(name)* | Mark Shanks |
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on behalf of a group or organisation(s)

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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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| Big opportunity to provide whole of life health and education outcomes for people with a disability This will involve a multi-disciplinary approach and a far better connection between education and health because the best results will be obtained by providing the support early to develop the independence of a person with a disability. Of particular importance are the periods of transition, especially when leaving the school system. This is not managed well at the moment. People with a disability are high risk and this is exacerbated by a lack of meaningful vocational and educational outcomes. Disengagement leads to physical (obesity, lack of personal care) and mental health (feelings of unworthiness) problems. |

### 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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| Yes it is a good general statement |

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 principles are sound and they would be very useful in guiding the strategy |

### 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 and the definitions of what great looks like gives solid direction. Interactive fantasy based computer games are not a panacea however. It will come down to empowering the family and the community to take ownership of their own health. |

### 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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| All good but…Fund those organisations who will deliver physical activity for all ages and abilities, encourage health eating by taxing junk food and making whole food cheaper, strictly control advertising of harmful products |

### 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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| More vigilant monitoring of health and social outcomes by contract managers. Don’t continue to fund non-achievers. Ask the community how well a provider is delivering a service. |

### Any other matters

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

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| Instigate a powerful and engaging disability awareness campaign to educate the public that people with a disability want to be a part of society – work, play and social interaction. Provide incentives to employers to provide employment opportunities. |

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| **86** | Submitter name | Kate Grundy |
| Submitter organisation |  |

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

on behalf of a group or organisation(s)

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X Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| Provision of end of life care and palliative care is completely missing from this update. This is an enormous challenge to our health system and our society – as the population ages and the number of deaths increases, particularly in the old and the very old. See below.    Most people would love to suddenly become very ill and die over a short period but this is almost always not the case. Death is preceded by often a long period of deteriorating health requiring a high level of input from health services. Unless we accept the inevitability of death the best choices regarding what treatment is appropriate and where it will be delivered are unlikely to be made in a timely way. |

### The future we want

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

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

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

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| The glaring omission in this section is to die well.  *Live well, stay well, get well, die well.*  Health systems are best measured by how we care for the most vulnerable – and the dying are totally vulnerable and at the mercy of the services provided for them. Palliative care services must be comprehensive, competent and well-coordinated. This is not currently the case in all locations in NZ. Work still needs to be done in order to ensure a good death for everyone.  I totally agree that “working as one team” is very important – specifically so at the end of life where secondary care, primary care (including ARC) and Hospice (ie the NGO sector) must work together for the patient and also for the family/whanau. This requires smarter applications re IT system and ARC and Hospices must be included (over 30% of NZ’ers die in ARC and this number is rising).  See below – the outcomes framework for the South Island Alliance. One of the bubbles (at 11 o’clock) is “People die with dignity”. Dying can and must be included in this Health Strategy.  http://www.sialliance.health.nz/UserFiles/SouthIslandAlliance/Image/Outcomes%20Framework_020715.jpg |

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

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

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| These are fine – but I suggest amending 1 as below;  *The best health and wellbeing possible for all NZers throughout their lives, including at the end of their lives.*  It is possible to live well until the end of your life – ignoring it in health policy doesn’t help achieve this goal. |

### 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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| With the amended centre, these 5 themes work really well.  Regarding “Closer to home” – this is extremely important for people at the end of their lives – “living in place, dying in place”. It is requires having expertise at that local level – this is contingent of access to education and support, both would be provided by comprehensive palliative care services.  If people are to die in their place of choice (generally not in acute hospital), a plan needs to be developed to make this a reality for as many people as possible. This will require palliative care expertise in all NZ Hospitals so that symptoms can be stabilised and discharge planning into an appropriate environment can be expedited. |

### Roadmap of Actions

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

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

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| There should be an action around ensuring that all NZers have quality care at the end of life.  Maybe this should sit in the improve quality and safety section….. |

### Turning strategy into action

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

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| No specific comments. |

### Any other matters

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

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| The word map is a very poor reflection of what our health system should look like. It makes me wonder where the palliative care voice was at the workshops.  There is no reference at all to 5 key elements that I would have expected to see;  Dignity, compassion, collaboration, communication, competence.  These are vital components for all care, not just at the end of life.  I draw your attention to the 6 C’s of nursing care in the NHS – they sum it up for me. |

Kate Grundy, November 2015

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| **87** | Submitter name | Flora Gilkison | | |
| Submitter organisation | New Zealand Orthopaedic Association | | |
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|  | | | New Zealand Orthopaedic Association |
| Position (if applicable): | | | CEO |

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### 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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| There should be a better acknowledgment of the importance of musculoskeletal health which underpins all other aspects of health by allowing individuals to remain physically active leading to a reduction in the obesity burden and contributing to the New Zealand Economy through work in the under 65 age group. This is important aspect to fit in with the vision of live well, stay well and get well where wellness strategies range from childhood through to the older person. |

### 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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| --- |
| Yes it does in a sense. Please see response below. |

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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| ‘People powered’ is empowering people to look after their health and educate them about how to do this which should be part of the curriculum of our schools.  Closer to home health services are not always possible and can lead to duplication and high cost and poor quality. New Zealanders will require to travel more in the future particularly for accessing high tech interventions but should have primary health services delivered at or close to home and avoid unnecessary hospital admissions.  Value of health services will be essential and a fresh look at healthcare costs related to the last year of people’s lives will be a good start. Some cancer treatments with very expensive drugs only prolong the life of patients by days or weeks. A number of medical and surgical interventions are of very low value. The Health Strategy should focus on interventions which are evidence based and of value to patients  ‘One team’ basically means better coordination of healthcare avoiding duplication and inefficiencies. The GP and patient should be the one team in charge of buying and coordinating the healthcare of individuals.  ‘Smart’ of course and the modern technology will allow healthcare to be delivered completely differently from the traditional face to face patient doctor consultation. |

### 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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| Care must be taken that the “statement on the benefits of technology will help solve health issues” is not seen as the solution to all health problems. Technology will only be an enabler not “the solution”. The quality of the interpretation of the data generated by these new technologies is essential when it comes to appropriate healthcare delivery. It is possible that all this will generate more inappropriate and low value care! Relying on self-management of health is asking a lot of the NZ public at this stage and will require a significant investment in raising the health literacy of the majority of our population. Most of the time clinical decisions are made by the health practitioner in partnership with the patient rather than the patient making the decision.  Closer to home care especially for long term conditions and the elderly preventing hospital admissions and rest home care is very important in the future as our population ages. Reducing the cost of rest home care should be a crucial part of any health strategy in a world where the ageing population is going to grow exponentially over the next decade or two.  Coordination of care is another very important aspect of future healthcare delivery to avoid duplication and unnecessary cost.  Health interventions have to be of value to individuals and society. It is all about outcomes! If the intervention does not improve the patient’s wellbeing or health then the quality of this particular intervention is zero and should not be funded by the tax payer.  High performance means a very effective team which obtains results which can be measured.  One team is about quality people. We want to achieve a well trained work force which makes the right decisions and obtains the right result. This might require investment in training of good quality health practitioners.  Smart system yes but information and data systems do not automatically lead to better health. You need smart people rather than smart technology. |

### 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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| Yes they are but the themes have to be integrated and not developed in parallel to be able to achieve the 2021 goals. There also need to be a change in the funding formula of health, including the primary sector, otherwise no progress will be made. Having 20 different DHB’s and many more PHO’s will be a big challenge!!! |

### 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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| Empower and trust those who have responsibility to put the strategies into practice. The Ministry of Health can track and report so much that they constrict health improvements. The value added from many reports and performance markers are just not evident and so a good hard look at what is required and keep it simple.  Disinvestment is hard to do but is necessary to be able to move forward. |

### Any other matters

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

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| Prevention of osteoporosis by encouraging people to remain physically active, prevention of falls in the elderly, prevention of harm from alcohol and prevention of obesity through exercise and healthy eating will have a positive impact on the musculoskeletal health of New Zealanders and should be an important part of the Strategy. This will require an integrated approach involving agencies across the government sector and better alignment of those agencies.  There is very little in this document about musculoskeletal health and the socio economic impact of arthritis, osteoporosis, injuries, back pain etc. The growing burden of long-term conditions has to include musculoskeletal diseases, obesity and the effect of alcohol on musculoskeletal injuries and health in general.  Currently unmet need is affecting mainly musculoskeletal conditions and is likely to grow as a result of the ageing of our population. This requires investment in the future and should be an important part of the New Zealand Health Strategy.  Timely and equitable access to orthopaedic surgery before patients have reached a state of permanent and severe disability should be part of this 10 year vision. Keeping people at work and elderly independent in their own homes will benefit the overall health and wellbeing of our population and save money. |

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| **88** | Submitter name | [redacted] |
| Submitter organisation | Allied Health Aotearoa New Zealand |

4th December 2015

New Zealand Health Strategy Consultation Ministry of Health

PO Box 5013

Wellington

**RE: Submission on NZ Health Strategy and Roadmap of Actions Introduction**

Allied Health Aotearoa New Zealand (AHANZ) is the incorporated society of 24 professional associations which work together to promote, advocate for and support allied health professionals. AHANZ is the connected voice of approximately 30,000 allied health professionals across New Zealand.

Thank you for the opportunity to provide feedback on the proposed NZ Health Strategy and Roadmap of Actions. We acknowledge what has been a considerable amount of work to get it ready for consultation.

We have opted not to answer your specific questions but provide you with over-arching feedback and specific feedback relating to the Allied Health Science and Technical workforce.

**Some Overarching Concerns**

The Ministry of Health (MOH) has acknowledged in the document that many of the recommended actions do not deviate far from the existing strategy. Whilst we acknowledge the difficulty in proposing solutions that are overly prescriptive, we would argue that there is a fundamental lack of detail in how the strategy is going to be resourced and implemented and we may well find that in five years’ time we are no better off.

Furthermore, until there are significant changes made to the way in which capitated primary care services are purchased and funded, the type and location of services delivered and the health outcome measures expected we will not realise any effective change from what we currently have.

There are a number of examples where the Roadmap of Actions document refers to solutions being delivered ‘over time.’ This is not a measurable outcome, does not provide healthcare providers with a blue print for expectations around timely outcomes, what it is expected they deliver or how they should interface with other providers and this lack of connectivity we believe will once again result in siloed and inefficient health care delivery.

Furthermore, ‘Promoting to service users and clinicians the benefit of having access to a patient portal’ we would argue is not sufficiently robust if we are going to realise the health outcomes that we aspire to. Such an initiative needs to be more than promoted, but mandated by the MOH, sufficiently resourced and uptake regularly measured as General Practitioners become more IT savvy.

We wholeheartedly agree that the obligations under the Treaty of Waitangi should be a fundamental principle in guiding the general direction of the strategy. However where the document refers to the Treaty of Waitangi underpinning the design of training for health workers and ‘board members’, it is not clear who these board members are, whether they be District Health Boards, Regulatory Authorities, or both.

We totally support self-management of healthcare through the use of digital technologies and the use of social media particularly in the area of Type 2 Diabetes Mellitus (T2DM). However, it has been raised with the MOH before that many of the high needs populations that are most at risk of chronic long term diseases, such as T2DM do not have access to smartphones or know how to use social media apps.

**Closer to Home**

The members of AHANZ are concerned that there is a fundamental lack of reference to Allied Health professionals in the Roadmap of Actions document who we believe are pivotal to the MOH fulfilling the principle of services being delivered ‘Closer to Home’. The Roadmap of Actions talks about health professionals [namely nurses] being trained in tasks that they have not traditionally performed and altering their scope of work. Whilst we agree in principle to this happening, particularly in rural areas where there is a definite need; there is currently already a 30,000 strong allied health workforce who are skilled and qualified to carry out a lot of these tasks but to date have not been utilised even close to their full potential.

The Roadmap of Actions document also refers to the need to ‘fully utilise health skills and training by removing legislative barriers to allow health practitioners such as ‘pharmacists and nurses’ to prescribe. It is disappointing that the MOH has not considered utilising the many other professional groups such as optometrists, dietitians and psychologists who already have or who are in the process of working towards prescribing scopes of practice.

There is no doubt that an integrated ‘wrap around’ approach to dealing with chronic health conditions such as diabetes could significantly benefit from the expertise of a number of health practitioners other than Doctors many of whom have not just prescribing rights but are highly skilled in their particular field of expertise.

**Tackle Long Term Conditions and Obesity**

The Roadmap of Actions document refers to the need for health professionals to reorient planning guidance and performance management to either diabetes or mental health or cardiovascular disease. Allied health professionals would strongly assert that these conditions are connected, multi-factional and driven by social factors that cannot be siloed.

The document also refers to health providers implementing a package of initiatives to prevent and manage obesity in children and young people up to the age of 18 years. There is, however, no reference to how these programmes will be resourced, supported and managed and as there are currently a number of initiatives that are working very successfully around the country, how existing programmes that have been evaluated and have international credibility could be compulsorily rolled out across the country to prevent reinvention of the wheel.

**Value and High Performance**

The 50 different allied health professional groupings could bring a myriad of services and professional, regulated skills to primary care services teams who want to increase the value they bring to their community. Allied Health professionals are able to deliver a wider range of core services, develop more integrated care plans, better co-ordinate with specialists and hospitals, increase access and work in a raft of different community environments.

We are pleased that the MOH has acknowledged the need to ensure funding and information systems support providers to improve their services and it is encouraging that a health investment approach is being considered. However, we are concerned that the document does not provide enough of a mandate for providers to invest in systems that are for the good of the nation and will assist health delivery services to be joined up across both care sectors and professional groupings.

We would also argue that purchasing from non-government organisations (NGOs) and commissioning services at a local level requires sound contract management to ensure deliverables are clear and outcomes are met.

**Improve Performance and Outcomes**

We are pleased to see referenced in the document that a health outcome focused framework will be developed that will link to the Integrated Performance and Incentive Framework (IPIF) work already carried out. Unfortunately, despite trying on several occasions, AHANZ was unable to have any input into the IPIF measures agreed to date which we believe remain medically focussed and not particularly patient centred.

AHANZ is keen to reinforce that if the MOH want to increase and improve equity of health outcomes, quality and value, allied health services must be incorporated into the primary care delivery model and for this to work there needs to be a health investment approach that is supported by a complete overhaul of the funding model. As long as Doctors remain the financial gatekeepers to the way services are devolved, we will continue to get the same outcomes for patients.

**One team**

The Roadmap of Actions document references the need to develop an established, integrated, advisory framework that supports the shared future direction. To date, the MOH has not provided a formal avenue for the allied health sector to provide feedback and policy advice and to develop such an advisory framework without the allied health voice would be a retrograde step.

**Summary of Interventions where allied health service would be well utilised**

Allied Health professions are pivotal to the delivery of a number of the actions outlined in the Roadmap of Actions Document. We urge the MOH to consider how allied health services may be better utilised in the development of future primary care models and future funding arrangements.

Thank you for the opportunity to provide feedback, we ask that our comments be given due consideration as part of the consultation process. AHANZ is happy to be consulted further.

[redacted]

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| **89** | Submitter name | [redacted] |
| Submitter organisation | Blind Foundation |



Blind Foundation Submission

# Update of the New Zealand Health Strategy

This is the Blind Foundation’s submission on the New Zealand Health Strategy

The Blind Foundation is the main provider of rehabilitative, support and advocacy services for blind and low vision New Zealanders. The Blind Foundation has approximately 12,000 clients throughout the country.

**Our Purpose**

To enable people who are blind or have low vision to be self-reliant and live the life they choose.

**Our Vision**

Life without limits

Kahore e Mutunga ki te Ora

**Four Key Priorities**

1. Independent living
2. Access for all
3. Reach more people
4. Building a Foundation for the future

The Blind Foundation advises government, business and the community on inclusive standards to ensure that the people we represent can participate and contribute equally. We have four major contracts with government. We value our relationships with officials and Ministers. We seek to act as a trusted advisor and specialist on the blindness sector. We are a long serving and expert provider of services to the sector.

The Blind Foundation has a long standing and valued relationship with the Ministry of Health and we welcome this opportunity to comment on the draft strategy and to offer our support in its implementation.

The Blind Foundation has recently completed a five yearly strategic review which shares a similar approach to that being proposed by the Ministry. In addition, the Blind Foundation is in the final stages a research project examining the prevalence of blindness and low vision in New Zealand. This study has involved sector wide cooperation and the use of multiple data sources. The project has been an object lesson in many of the Health Strategy’s five strategic themes and will be used as an example in the comments to follow.

**Consultation Questions**

**Challenges and Opportunities**

The key background issues for the Blind Foundation that are addressed in the strategy are the increasing rates of age related disability and the need to maintain peoples independence. Our research indicates there is already an unmet need for vision rehabilitation services so that increases in age related vision loss will be in addition to that base. The age related health impacts of the baby boomer generation will not impact fully on the Blind Foundation services until probably the early 2020’s but by that stage there will be a need for major development of the health workforce and related infrastructure.

Indications are that the impacts of age related disability will not simply be a linear extension of the current types of demands. The requirements will change and as yet there is insufficient research into emerging trends and needs. We note with concern the possibility of NZ Statistics to reduce the collection of disability statistics to a ten year interval.

**The Future We Want**

The Blind Foundation is in broad agreement with the vision set out in this section and there is a need to “shift behaviours” (Health Strategy Draft page 8). We welcome the shift of emphasis toward greater support for prevention and independence. However the strategy does not indicate how these value changes will be effected and what incentives for change will be used? *(This general theme is quite pervasive and is dealt with in detail later in this submission)*

**Are these the right principles?**

The Blind Foundation concurs with the principles set out on page 8. The area we have concern with is Principle 5, “Timely and equitable access regardless of ability to pay”. The Blind Foundation notes the relationship between disability, health status and income. (NZ Statistics Disability Survey 2013 Social and economic outcomes for disabled people). The Blind Foundations own research (BF Client Needs Survey 2014) concurs with the Disability Survey. Only 24% of Blind Foundation clients consider they have good health compared to 35+% of the non-disabled population

The typically low incomes of people who are blind or have low vision (average less than $30k per year) contribute to access problems. Also information on health services has to be available and accessible. Health programmes will need to be structured in ways to overcome these inherent disadvantages.

**The Five Strategic Themes**

**People Powered**: The Blind Foundation agrees with the proposed customer centric, more individualised approach to care and to the tailoring of programmes to particular segments. The blind and low vision population have health needs that generally mirror the mainstream population but the disability adds particular features to how those programmes might be explained (with accessible information) and delivered.

The actions proposed (page 34) rely heavily on information provision therefore accessibility, particularly of digital information is central. The Blind Foundation is willing to explore collaborations with DHBs in reaching high need priority populations.

**Closer to Home:** The Blind Foundation supplies many of its services within the users own home or in close by communities and is equipped to do this nationwide. Often these types of delivery modes will be more expensive than services concentrated in locations at a distance from the customer base. The Blind Foundation research (BF Client Needs Survey 2014 and Recreation and Volunteer Survey 2013) indicated cost and transport options made a very significant differences how well services were utilised.

The Blind Foundation is in full agreement with the focus on early intervention prevention and rehabilitation and is happy to contribute its experience with domestic and small community service delivery. (Health Strategy Draft pages 35).

The Blind Foundation notes that 40+% of its clients use digital devices and this rate is increasing. This will increasingly enable tele-health type applications.

The approach to more proactively manage long term conditions proposed (page 37) includes rehabilitation. The Blind Foundation believes early rehabilitation and possibly a lower threshold for people to obtain disability support could be cost effective in the long run and reduce the need for residential care. This area requires further research.

**Value and High Performance:** The health sector is extremely varied in its constitution and capability. The following comments reflect the Blind Foundations observations about the disability sectors contribution in three key areas:

**Strong performance measurement culture:** The Blind Foundation observation is that parts of the sector lack the systems and the application of consistent data collection practices to enable effective performance management. We note the Action 10 d (Health Strategy Draft page 40) which indicates that information technology projects will be "prioritized".

Disability sector planning is often lacking in specific and measurable outputs and outcomes for clients this inhibits objective evaluation of programmes that work and those that do not.

The Blind Foundation has a strong interest in the use of subjective and objective outcome measures.

**Use of investment approaches:** The application of the Ministry of Social Development investment approach may have only a limited application in the health sector. The health sector does not have an equivalent of MSD's "Future Welfare Liability" as a proxy for calculating changes in forward expenditure. Rationing treatment based (in part) on the expectation (or not) of future expense will be difficult to apply. We have a yet to see a convincing economic case except in very particular and generally small applications. Expenditure on disability support may be closer to the MSD model.

The ethical case also requires development. It is ethically easy to treat a patient who will obtain the short term benefits of treatment and lessen the probability of future expenditure. It is ethically much harder to withhold treatment on the basis it will not have a similar long term payoff.

That being said the Blind Foundation does see opportunities to achieve long term changes to the economics of vision health care through selected types of early intervention in vision rehabilitation. The aim for example will be to reduce hospital admission rates for falls and residential care for the elderly. The Blind Foundation is currently planning a research project in this area.

**Removal of infrastructural and financial barriers to delivering care:** This is a commendable objective (Health Strategy Draft page 18) but the actions indicated on pages are still at a high level of generality. We note the Strategy's references to the Productivity Commissions work on purchasing effective social services. We agree particularly with the Commission's recommendation that government's purchase of services from NGO be fully funded and sufficient to provide a return on investment.. (Productivity Commission Final Report Effective Social Services page 12 and recommendation 6.6). The ROI is essential if NGO suppliers are to be able to fund the changes and developments in service delivery, management process and workforce development the strategy requires. In other areas the Commission's recommendation have a potential to encourage fragmentation and duplication of functions at national and regional levels.

**One Team**: The Blind Foundation agrees with the thrust of this section and is working with the National Health Committee on developing integrated pathways for specific types of vision health care. In many areas the health and disability sector has seen proliferation of specialist agencies and service providers and integration and collaboration across organisational and service boundaries have become essential but costly activities. The Blind Foundation thinks there are significant benefits to encouraging the development of national service providers who have scale and capability. Conversely the type of changes proposed by the Productivity Commission need to be weighed against a tendency to absorb valuable management staff into elaborate commissioning and purchasing structures and fragmentation of suppliers at a regional and local level.

**Smart System:** The Blind Foundation agrees with the approach to make better use of data across the sector. Our recent experience however is there are institutional barriers to the sharing and use of data. These are such things as multiple layers of ethical approvals (national, at DHB level and by Iwi), poor use of National Health Index (NHI) numbers. There is a high level of suspicion about data sharing in the lay community. Also our observation is that there is still considerable work to be done to ensure consistent standards of data capture even within highly specialised areas such as vision care.

**General Comments**

The Strategy makes little or no mention of the private sectors contribution or to the extent to which the public and private sectors are interdependent. We note for instance that in our area of vision care a very large proportion of the medical resource is private.

The Strategy requires service providers to make incremental changes but over time these shifts in capacity capability and process will be significant. The Strategy is largely silent on the issues of the incentives and cost of change.

END

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| **90** | Submitter name | Tira Albert |
| Submitter organisation | Mana Wahine |

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| This submission was completed by: *(name)* | Tira Albert |
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Are you submitting this *(tick one box only in this section)*:

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

on behalf of a group or organisation(s)

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

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

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

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

x Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| **1) Add the challenge of real and meaningful actioning of Te Tiriti o Waitangi in the Health system.**  Currently the different relationships and mechanisms in place to action Te Tiriti o Waitangi in the NZ health system are variable in their effectiveness.  As tangata whenua we acknowledge the whole Tiriti document and emphasise the First Tiriti in te reo Maori – preamble and all articles.  However we are aware that the Crown does not at this time acknowledge or entertain conversation and exchange on the basis of the full TOW instead has substituted the Principles of the Treaty. As such we will base this submission on the full Tiriti but converse with the MOH using the principles of Te Tiriti.  **2) Demonstrate your acknowledgement of Te Tiriti from start to finish within document.**  This requires that every section and strategy of the document is explicit in providing the tangata whenua viewpoints and themes. This includes specific tangata whenua actions and strong alignment with He Korowai Oranga.  **3) Refer to Māori as tangata whenua within the document.**  We are ethnically Mäori and from our world view we are **tangata whenua**. This recognises our unique position as the indigenous people of Aotearoa New Zealand and the partner to Te Tiriti.  This document should not replace He Korowai oranga but should aim to improve the conditions within the NZ health Sector so that He Korowai Oranga can be implemented effectively. |

### 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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| **Te Tiriti o Waitangi as founding document of Aotearoa is missing**  **The whole person is missing from this direction**  **The whānau is missing from the direction and from the whole document**  **Life Course approach is needed so that all of the attention is not on older people with little flow of resources to young people and prevention.** |

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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| On reading the updated version of the strategy, we notice that the Te Tiriti o Waitangi principle has dropped from first to nearly last in the list of principles. This strongly signals a reduced priority that the Ministry of Health has for Te Tiriti o Waitangi and its special relationship with tangata whenua.  In order to provide a more balanced document with adequate priority and meaningful engagement with Te Tiriti O Waitangi and tangata whenua we recommend:   1. **Return the principle for Te Tiriti o Waitangi to its position as the first principle of the Strategy as it was in its predecessor.** 2. **Change the wording of the principle referring to Te Tiriti o Waitangi to:**   ***Acknowledge and action the special relationship between tangata whenua and the Crown under the Treaty of Waitangi*** |

### Five strategic themes

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

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

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| 1. **Add one more Strategic theme called Actioning Te Tiriti o Waitangi in the New Zealand Health Sector.** |

### 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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| Currently Tangata whenua are largely not included in this roadmap. To make the point again - his action plan should not replace He Korowai oranga but should provide the necessary conditions and developments so that He Korowai Oranga can be implemented in the New Zealand Health Sector.   1. **Select 5 – 10 vital actions that will make the biggest difference to bringing to life Te Tiriti o Waitangi in the health sector and make a difference to tangata whenua wellness.**   Suggestions to be included as actions   * An honest evaluation is required to ascertain how well Te Tiriti o Waitangi is being acknowledged and actioned in the New Zealand Health sector. Partnership, Participation and Protection of tangata whenua health in many areas is being eroded and diminishing. Just look at this strategy and ask yourself if this document is a true reflection of the intention of Te Tiriti o Waitangi? There are many threads to this work and much of it is sitting ready to be brought together in a single picture. Other areas may need some work. * Develop an investment Plan for tangata whenua health * Create a regular monitoring report to measure and disseminate information on progress on actioning Te Tiriti o Waitangi in the New Zealand Health system utilising RBA and info graphics that are meaningful to the sector and to tangata whenua. |

### 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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| See section above to create a Te Tiriti o Waitangi in action report and add case studies and vignettes about the reality for tangata whenua. Not only have the feel good stories as the reality is many tangata whenua had negative experience and outcomes. Show true leadership by being willing to learn from reality. |

### Any other matters

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

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| We cannot see ourselves in this document – save for the disparity statements which talk about Māori inequalities. Consider Sharing our innovations and evidence of Māori health gains.    There is no proactive response to improving Māori health. Draw upon and recognise traditional Māori wisdom and frameworks as valued as part of the body of knowledge of wellness in Aotearoa/New Zealand. |

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| 1 December 2015 | S15.32 |

**Submission to the Ministry of Health on the Update of the NZ Health Strategy**

The National Council of Women of New Zealand, Te Kaunihera Wahine o Aotearoa (NCWNZ) is an umbrella group representing 288 organisations affiliated at either the national level or to one of our 20 branches. In addition to our organisational membership, about 260 women are individual members of branches. NCWNZ’s function is to represent and promote the interests of New Zealand women through research, discussion and action. This submission has been prepared by the NCWNZ Health Standing Committee and its contributing members across the country

NCWNZ welcomes the opportunity to participate in this consultation process regarding updating of the New Zealand Health Strategy. In 2000, NCWNZ also made a submission to the Ministry of Health’s New Zealand Health Strategy Document.

**Challenges and opportunities**

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

1.1. Providing health services to rural / isolated communities in provincial New Zealand is a challenge which should have a greater emphasis in the background for the Health Strategy. Currently there are some population groups receiving unequal access to health services they need.

1.2. Technological changes have been rapid in recent years. There must be regular training of staff at all levels to ensure technology is used efficiently and effectively and most importantly SAFELY. The system is only fully efficient when operated properly, when information retrieved is accurate and when information is delivered when and where it is needed. For example: In Accident and Emergency departments where people are presenting with high needs.

1.3. Spreading the strategy wider than merely for the health industry will be challenging and yet vital if the health of New Zealanders is to improve. Expecting individuals to take responsibility for and to improve their own health is a worthy ideal but expecting people to eat healthily through education alone is flawed. Education will not be enough. It is too simplistic to make assumptions that citizens will do what is good for them. They will only do what they can afford. People need to have sufficient income to ensure they are able to feed, accommodate and clothe themselves adequately. It may be

that government regulation has to be considered. (for example: allow only healthy foods available in schools, fluoridation of water) The downstream adverse health effects from obesity are too serious to simply leave the solution over to people to make “healthy choices”. Expecting companies to regulate sugar and fat laden foods and reduce sugar and salt in processed foods on a voluntary basis may not be enough and regulatory steps might also be necessary.

**The future we want**

*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 this statement capture what you want from New Zealand’s health system? What would you change or suggest instead?**

2.1. Whilst our members consider the statement is a well-crafted statement, we are concerned that some of the very good concepts in this document are diminished by insincere sounding jargon. A much simpler statement such as “**All New Zealanders will have fair access to services for their health and well-being**” would be preferred. Health is not a commodity, yet terms used such as: ‘smart system’; ‘people powered’ and ‘high performance’ sound rather like commercial advertisements for ‘things’ or consumer goods.

2.2. What is needed is a medical service that delivers when and where it is needed, without long delays, cancelled appointments, wrong records tabled at appointments and with the opportunity to discuss treatments and patient future needs and requirements.

*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*

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

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

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

**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?**

3.1. These principles will be helpful as a guide for the New Zealand health system and they will be helpful as a guide for the implementation of the health strategy. The challenge for the Ministry of Health will now be the expectation of all New Zealanders that the health services do deliver on this strategy. As long as these principles are acted upon and underpin the implementation of this strategy, there should be good outcomes.

**Five strategic themes**

*1. People powered*

*2. Closer to Home*

*3. Value and high performance*

*4. One team*

*5. Smart system*

**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?**

4.1. The present system for health delivery certainly needs to be refocused.

4.2. While the five strategies are worthwhile, our members dislike the use of the word “theme”, which in our opinion is rather weak and infers a story or fairy-tale – not an image you would wish to project. Because we believe there is urgency in implementing aspects of the strategy, our suggestion is to replace “theme” with “**focus for action**”.

4.3. Our preference is for a “**people centred approach**” rather than a “people powered approach”. While not disagreeing with the general concept and appreciating that technology tools such as mobile devices, smartphones and wearable devices will be options into the future, personal attention from well trained and knowledgeable health professionals will continue to be the preferred choice for most people.

4.4. We agree with the direction outlined in the ten year vision that will encourage people to be more in control of their health through better access to relevant information when they need it and by making informed choices.

**Roadmap of Actions**

**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?**

5.1. The action areas covered in these documents are comprehensive. Our greatest concern is the delivery of health services to all New Zealanders. There are alarming gaps in the delivery of services which must be addressed in order to ensure all New Zealanders do have access to health services.

5.2. Barriers to service delivery which currently exist in rural communities and remote areas must be addressed and service upgraded and improved.

5.3. There is a need for more flexible hours and ease of access to health services for working parents who face difficulties in attending clinics and getting themselves and children to medical appointments within current open hours.

5.4. Accessing up to date digital communications might actually increase the gap between the well- off who have good digital access and those who have limited incomes. This is likely to be a particular issue for single parent families.

5.5. There is a gender gap with women retirees which needs to be considered. Women are living longer and because most women have had lower earning capacity during their working lives, many female retirees have access to a limited retirement fund. Their ability to access health services may be compromised because of their limited income. For example – transport and access to digital communications

**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?**

6.1. For the health strategy to succeed there must be clear understanding of the “Strategies”, “Roadmaps”, “Actions”, and “Improvements” and there must be buy-in from all sectors. The staff at every level must understand the whole concept, be willing to accept the proposed changes and be willing to work together including also with non-Government organisations and volunteer organisations. At present there are groups who prefer to work in silos, are unwilling to compromise and not willing to accept change. Everyone must **work together as a team** to safely deliver the best services possible to each and every person who presents for treatments, information, care and support.

6.2. Page 3 of “Future Directions” states that; “Increasingly, Government agencies are working together in coordinated and effective ways to respond to priority issues.” We support government focus on “improving the lives and well -being of all New Zealanders” and cannot emphasise strongly enough the importance of Inter-departmental communications and co-operation. It will be imperative if the Health Strategy is to succeed. Providing healthier homes is one example which demands Inter-departmental communications and co-operation and where protections, processes and regulations may have to be introduced to ensure people are not made ill because of poor living environment.

**Any other matters**

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

7.1. The Ministry of Health will need “buy in” from all health professionals for this strategy to succeed.

7.2. Our responders consider on-going staff development is essential. Well trained, fully informed, professionally supported staff, whose work and contribution are **valued**, appreciated, encouraged and appropriately remunerated, are the best tools of the health system. Whilst recognising that health professionals are mostly a credit to their various professions, we consider close supervision is essential in order to raise the standards and attitudes of some. Appropriate training, peer support, professional development, internal assessment and monitoring, external monitoring and auditing of performance standards will all contribute to achieving and maintaining higher standards, improved service delivery and personal pride in their professions and in the health system which they work so hard for.

7.3. NCWNZ’s function is to represent and promote the interests of New Zealand women through research, discussion and action. The right to health is an international human right for all women and children. While health outcomes for New Zealand women have continued to improve over recent decades, health disparities still exist. Health policy must recognise key issues in women’s lives, risks associated with socio/economic status and barriers to accessing health care such as transportation, location and cultural appropriateness.

7.4. There is significant work to be done to ensure co-operation between all strata of the health system and that the provision of an outstanding health service is paramount, rather than protecting one’s patch and fighting to keep their share of the health dollar

7.5. The strategy seems to be light on future issues of health. While obesity requires urgent consideration, it is not the only issue which should be targeted. Innovations in the ability to detect inherited cancers, inherited conditions and health research are all important and requiring consideration. There are ethical issues concerning treatment when less money is available - obesity leads to kidney failure – there are issues around transplanting of various body parts.

**Conclusion**

The National Council of Women is pleased to have had the opportunity to contribute to the consultation about updating the New Zealand Health Strategy. We consider the health of all New Zealanders to be of paramount importance. The Roadmap of Actions which accompanies the Health Strategy must be regarded as a living document. The proposal to upgrade the Roadmap annually, for the Ministry of Health to lead an annual forum to share practice, develop a system overview and inform, and for the Health Strategy to provide guidance for annual planning will be a good basis for future planning and finding ways to deliver services within the resources available.

The intent of the Health Strategy is to improve the quality and safety of service delivery and improved access to health services for all New Zealanders. NCWNZ believes that the delivery of health needs of women and children are encompassed in this statement.

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| Rae Duff  National President | Ailsa Stewart  Convener, Health |

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| Submitter organisation |  |

**Feedback on the draft NZ Health Strategy December 2015**

Great strategy. We need one.

I like:

* The **focus on people**, especially engaging with stakeholders and patients
* **Empowerment**: we recognise the whole person and respect their ability to determine their health and healthcare
* **Cross sector work** that addresses social determinants, especially where the sectors partner strategically at government level: e.g BPS targets
* It acknowledges and affirms the position and importance of **the Treaty** to the country’s health (and for everyone, not just for Māori).
* **It’s concise** – based on a few themes and a few high level actions. Memorable.

Priority areas where I’d advocate for change:

1. More on health sector leadership: developing and retaining our workforce. Underscore the importance of vocation as the backbone of the health system. Care, compassion, quality and going the extra mile, all rest on staff engagement. This is getting lost/subsumed in the drive to boost IT. I’d put our workforce under People-powered. The whole system is all about people. Put people in the centre of the circle in figure 1.6 (as opposed to the vison)
2. Boost the empowerment approach. This sets the system up for respectful (as opposed to paternalistic) partnerships with people and communities. It also opens the door on community development – empowered communities driving their own solutions.
3. Cross sector work that addresses social determinants needs to happen at central government level. We need more actions planned here, especially to drive Māori and Pacific health gain.
4. We need to orient services and actions towards those with the highest need. Get clearer on the equity approach and spell out what this looks like. A call to equity on its own won’t achieve anything.
5. We seem to have lost ‘disability’ as in ‘health and disability’ system. Don’t separate disability off into a separate document. These two areas belong together. It’s unclear where disability belongs.
6. The diagram in figure 1.6 is critical. It needs to be the one thing we remember and identify with. It needs people in the centre. The graphic could be re-drawn so we remember each theme (closer to home sits inside a house shaped symbol). Soften the whole look of it; it looks too corporate. Don’t number the themes; not a hierarchy. Please make the themes bi-cultural. We talk about the importance of the treaty so let’s model that in the diagram – each theme in English and Māori. And the vision.
7. Prefer the vision to firmly grasp the empowerment message: *People empowered to determine health and healthcare throughout their life, including end of life. A workforce empowered to make a healthy difference.*

| **Area of interest** | **Feedback** |
| --- | --- |
| 1. **Health workforce and leadership** | What’s missing is a focus on enhancing the vocational aspects of health ie caring and compassion. Health is already becoming more technical and must be balanced with retaining its heart and soul.  Staff need more and training to keep up with changes ie new technology and how to share information with patients in a way that is empowering, safe and useful.  The health system leadership could be more specific. And the imperative to support those in the system who doing the caring. An aging workforce requires more flexible work practices, and mentoring for new graduates.  Also making sure that our practice is based on commonly held values. |
| 1. **Boost the empowerment approach** | Empowermentsets the system up for respectful (as opposed to paternalistic) partnerships with people and communities.  It opens the door on community development, empowered communities driving their own solutions. |
| 1. **Cross sector work and social policy** | We can drive down rates of lifestyle related conditions through good policy. Would be good to have more specifics about the central government policy areas that would make the biggest difference.  Agencies need to model to collaboration at the very highest level and line up policy to drive these changes home.  We need to develop our own policies in NZ and not just use ones from overseas that won’t work for our country, especially for Māori.  We talk about clinical leadership but our clinicians don’t get enough chance to influence policy, nor do they have a voice in the media.  Similarly, board members need to be able to speak out and stir up debate. We should welcome an engaged population who want to discuss health in the open. Anything that moves us away from the *‘trust us! we know best’* mentality.  Our best brains in the country, and our key experts on health and disability are silenced. We seem terrified of entering into a debate. |
| 1. **Equity** | Get clearer on the equity approach and spell out what this looks like. A call to equity on its own won’t achieve anything. We need to orient services and actions to assist those with the highest need.  We need bold actions to address equity. MoH leadership would help here. Set a clear message with targets. |
| 1. **The vision** | The vision could be the main headline in the document. It seems lost.  The empowerment message needs to be in the vision.  Vision could be: *People empowered to determine health and healthcare throughout their life, including end of life. A workforce empowered to make a healthy difference.*  ‘The future we want’ needs refining. Muddles this with the vision. It’s better to have ONE memorable vision. Otherwise the key messages get messy and forgettable. The strategy will have legs of its own if we can remember it.  We need something about end of life care. The period of time between a terminal condition and when you die is important and needs a special approach ie the whole Advance Care Planning discussion. |
| 1. **Refreshed guiding principles** | Add:  **Empowerment** needs to be central here. It’s the only way to establish that we are working respectfully with people and breaking the paternalistic mould. No more ‘doing to’ people. The key is *doing the things that matter to each person*.  **Engaged and highly skilled workforce.** There is no health and disability system without a dedicated workforce. And this requires staff (and volunteers) who bring their hearts and souls to the job. |
| 1. **People powered** | People powered needs to be people **Em-**powered ie give more attention to people who are dis-empowered, dis-advantaged. Equity discussion needs to go in here. And have a higher profile. Get specific.  Add **community development** here ie communities of interest empowered to drive their own solutions (with health in the support role)  Add **empowered workforce**. An empowered workforce means staff speaking out, and board members speaking out, and people coming forward with ideas. This will drive the kind of leadership we need in the system. We need ‘health’ to be the best career choice for ‘people’ people. |
| 1. **Closer to home** | This theme seems redundant. Closer to home is best subsumed under People Powered. Doesn’t warrant being a key theme. Services closer to home is not an end point, only one of many variables that may help along the way.  We want to give the best care, but closer to home doesn’t always mean better. We need to provide as much as we can in the least intensive environment. It’s more about the right person, the **right place** and the right approach for each person. And choice. |
| 1. **Value and high performance** | This section is not clear to me. Too many things are crammed in here and they are not all compatible. Value for money doesn’t seem to sit well with equity. I think equity sits best under people powered. |
| 1. **Smart system** | Need to emphasise that a smart system is **responsive** to patients. The expectations of consumers to ask questions and interact with professionals will accompany technology development. Answering patient calls is already a struggle, let alone having free-flowing e-conversations with patients and family about the specifics of their care.  The document has a technology focus. The big challenge will be helping people to understand all the information. We’ll need to train clinicians to help with conversations with patients. The risk is that we just fire more and more information around.  The biggest gaps re being ‘smart’ is making sense of the vast amount of data we have on hand. Data’s no good to us if it’s not being analysed. Health intel seems the weakness, not the mechanisms for generating or sharing data. |
| 1. **The document itself** | Document could be improved by jumping straight to the strategic direction. The preamble and forewords, and why we need a strategy, seem to deflect from the power of the message.  Start with the vision and move from there.  Too many things are in the mix at the moment.  Watch the language. Some phrases feel tired; like padding rather than strategy:   * Rising to the challenge * Ensure equitable access * New ways of working * Direction of travel * Going forward * High performing system * Opportunities and challenges   We could strip this kind of language out and go for a fresher approach. If we have to use these terms then terms then use an everyday example. Make it real. What exactly is a high performing system? I can’t picture it. Is it like google? Is it like raising a family? |

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| **93** | | Submitter name | | [redacted] |
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Workforce development - the people in the system need to understand consumer needs and they need to bring their professional skills as well as strong interpersonal skills to the job.

Communication and access to communication is the key for everyone.  There is a particular need for migrants to understand the health sector and how they can access appropriate services.

There needs to be a common system across all DHBs so that records and information are available regardless of location.

We need to demystify the health system, particularly DHB services so that access to services and support are available at the right time, in the right place for the right people.

Better connections to other social sector agencies eg: WINZ could greatly benefit patients, eg: those whose sickness has implications for employment, eg: Housing where that threatens people’s recovery and/or wellbeing, g: Education for health eating, how bodies work, obesity

Connections between social agencies – and social support – works better for people with injuries than sickness

A former staff member noted: Burn-out, disengagement with change, change fatigue. Strategy, leadership and action plans need to address this. Need to focus on what change will deliver to the end-user/patient benefit. That is a point everyone can agree on.

Clarify responsibility: doing what is whose job? Make that clear to avoid confusion, patients and stakeholders being passed from pillar to post

MOH to help transfer successes across the country, learn about what’s working and bring every service up to that standard.

Need much more care planning: discussions up-front could greatly improve delivering what patients want, before it’s too late.

Regards,  [redacted]

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| **94** | | Submitter name | | [redacted] |
| Submitter organisation | |  |
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Thank you for the opportunity to respond and provide feedback on the NZ health Strategy.

Overall I am very supportive of the principals and themes outlined in the Health Strategy.

* I would like to reinforce the focus and need for the Health strategy, systems and our health services to have a much greater focus on “living well” (this is for people without illness and also for those with illnesses / long-term conditions, those who have a palliative diagnosis or those with a disability).  We have moved a long way from defining wellness as “having no illness” – this is no longer the picture and it is critical services and communities are set up to support living well / supporting quality of life.   Along similar lines due to an increase in long-term conditions and people living longer with health conditions it is critical health and social services are in place to support this.  For example; Survivorship for cancer is much greater now – though support to help people reintegrate and move forward with their lives is not a big focus (i.e. rehabilitation post cancer, support back into school, work, home roles, volunteer roles) – we must have a greater focus than just on “healing” or “curing”.   This is similar for how do we support someone who has had a life threatening or altering health event i.e. a Stroke or Heart Attack.  We don’t readily have access to psychological support to help acceptance, manage the fears and changes to lifestyle that this event has led to.  (How many people following a stroke are offered counselling or psychological support?)
* Also the focus on integration is critical, though we need to ensure barriers are removed to enable this to happen – as examples are often presented of “good ideas” but due to funding silos etc. people don’t feel they can make the change.  An example of where looking at funding and systems would be appropriate would be Child Development Services and Special Education.   Health Professionals work in both systems, and have “criteria” for who they will and won’t see.  There is a very small pool of health professionals working in this space, and it “just makes sense on so many levels” that we should be pooling this valuable and small resource to support best value for money and more importantly to remove any gaps in services.

Another example where integration could be improved is with health and welfare – how could health professionals work more closely with those on sickness and invalids benefits to support them into work.   I have seen the opportunities for this having worked in a Pain Management service where if the health service and the welfare services were better connected shared goals could be worked towards that would benefit the individuals health and support them directly with gaining employment.

* Another area we can do better with is  support for people with Obesity.  A great start is occurring with the focus on Child Health Obesity.   To support the rise in Diabetes etc. we need to have supportive programmes in place (from community based programmes led by communities) through to Health system programmes where people can be supported holistically (i.e. through Multidisciplinary approaches – Psychology, Exercise Physiology/Physio, Dietititans etc. – all working together in an integrated approach and using best practice) – similar to how Pain management services work in an MDT approach.  We need to be more proactive in supporting people.
* As an Allied Health professional – I would like planners and funders and the Ministry to be fully aware of the contribution of Allied Health, Scientific and Technical professions.  The documents clearly talk of Nurses and Doctors, though it is critical other Health professionals are part of integration, leadership and talent development and are at the table when looking at options of service delivery and new ways of working as the perspective of Allied Health provides another expert and diverse perspective.  Therefore it is a lost opportunity and the focus on “value and high performance” will not be realised unless the Allied Health potential is untapped.

The Allied Health, Scientific and Technical (AHS&T) workforce encompasses over 50 professional groups working across all health and disability services, and employed in both the public and private sectors, comprising over 30,000 individual professionals.

There are examples across the world where Allied Health are being used in Advanced roles to enable earlier access, diagnosis and management, where previously or currently they would sit on a waiting list (several examples to illustrate this are: Speech language therapists and Audiologists being used more upfront in ENT clinics, Hand Therapists being used as first contact/referral from GPs for carpal tunnel symptoms, Physiotherapists being used as first contact in Emergency Departments for Musculoskeletal injuries/presentations – able to order x-rays and triage those needing to see medical staff).

Many thanks for opportunity to provide feedback.

[redacted]

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| **95** | | Submitter name | | [redacted] |
| Submitter organisation | | National Diabetes Services Improvement Group |
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**National Diabetes Services Improvement Group – feedback on the draft NZ Health Strategy**

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| **Date:** | 19 November 2015 |
| **Time:** | 10.00am – 12.00 noon |
| **Location:** | Teleconference |
| **Chair:** | [redacted] |
| **Attendees:** | [redacted] |
| **Apologies:** | [redacted] |

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|  | **KEY POINTS/DECISIONS** |
| Initial Comments | * The draft is very high level. * The closer to home section could benefit from additional information on food. The current section on ‘closer to home’ includes comment on ‘initiatives with industry to support… health-appropriate food product information’ (pg 17). It should at least consider exploring other healthy food options. * Good focus on cross government and social sector work * The draft lacks information on the environment and needs more on food, this is currently largely ignored * The concept of people power does not grasp the principle of people centred care. * It doesn’t reflect the changes underway in patient centred care and actions need to be more real. * The key concepts are not well defined. The lack of definition made the actions difficult to interpret * The draft makes lots of assumptions. * On page 7 the draft does not clearly articulate what is broken. What we are doing well and what we need to fix. * There is confusion on people power and what that means * The focus on wellness will mean different things to different people without a definition. For some feeling well means not attending primary care for preventative services. * Like the concept of a smart system and one team * The draft is broad then has some very specific actions in the roadmap. It needs to look across broader groups/disease states |
| What action has the greatest potential to improve health or the health system? | * The strength is that it is multi-faceted, one single action would not provide the level of improvement desired * Need to be able to see the consumer in the development of services. ‘People power’ does not demonstrate this. It should be able partnership * The draft could include the concept of ‘knowledge exchange’. * The preventative space is the most important. The draft is missing an indication of gaining knowledge on how we can make healthy choices. * The principals need to be evidence based * We need to benchmark health literacy. Aim for basic literacy in the first instance to ensure we don’t create complexity that causes accessibility issues * Making sure guidance is usable for people and accessible * Live the idea of maximising skills * Good to see the focus on funding – could strengthen the flexible funding * While it is good to see services closer to home the draft is silent on the secondary service and the role it plays and how it will be supported. * Good to see strong secondary care support to primary care and building workforce capacity in primary care. * Where is the focus on the Māori workforce, especially nursing * Clinician and consumer leadership need to be strengthened in the document * The plan needs to be clear on what is already there and working well so we don’t replicate * It is vital that people have access to their online health record * The draft needs to be more clearly defined so we can see where it fits * Prioritisation of actions is implied in the plan but a process approach may be better. Showing that the sector will be responsive, and how it will do that * ‘Closer to home’ – does this raise an equity issue? What about the homeless? * The quote on pg 13 about people having the power could be seen as inflammatory * If there isn’t a basic understanding then you can’t achieve what we want to achieve. |

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| **96** | | Submitter name | | [redacted] |
| Submitter organisation | | School of Population Health |
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School of Population Health,

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**HEALTH SYSTEMS**

26 November 2015

New Zealand Health Strategy Consultation

Ministry of Health

PO BOX 5013

Wellington

**RE: Submission on New Zealand Health Strategy Consultation**

To Whom It May Concern:

Thank you for the opportunity to provide comment on the recent update of the New Zealand Health Strategy. There are a number of important strengths of this document including the focus on patient-centredness, cross-government collaboration, the central role of information systems and the importance of the Treaty of Waitangi in shaping our current and future health system. Overall, the document presents a clear direction about what needs to improve. We also think the sections outlining what to expect from the system in 10 years time are very successful in articulating this vision and how it will be achieved in practice. There are some aspects which we think require further consideration:

**1. Confusion around principles, themes and specific actions**

We believe there is some confusion between articulating basic principles and strategic themes and identifying specific actions. The five strategic themes seem more like core principles and it is unclear how they differ from the eight principles set out at the beginning of the document. We also felt that the Strategy document could be more strategic by focusing less on the detail of specific implementation programmes (for example, patient portals and telehealth) and more on basic principles. For example, people accessing and using their health records for self-care purposes (and give portals as an example), and leveraging information and communications technologies to facilitate care delivery at a distance (telehealth).

**2. The presence of equity in the document**

We are concerned by the lack of focus and prominence of equity in the document especially when compared to the previous version of the NZ Health Strategy. The inequity that exists in New Zealand can become invisible in goals of achieving “the best health and wellbeing…*for all*”. Our health system works very well for some people and not so well for others. With respect to equity we should be emphasising the need to act for those most disadvantaged by our system as a priority. We also want to highlight the negative rather than aspirational language used to discuss equity in the document (see “stubborn disparities” on page 7).

**3. Patient Centredness and People-Powered**

While the language around ensuring a patient-centred and people-focused health system is very encouraging, we are concerned that some of the language in the document signals a greater onus on patients/individuals rather than the health system to act as the agents for change. The term “people” may also be too vague and generic and may make it difficult to distinguish between the people using the services and those providing it and who is ultimately accountable for ensuring a high quality, accessible system.

**4. Treaty of Waitangi**

We question how the New Zealand Health Strategy will give effect to the Treaty in practice. This should be made more explicit.

**5. Cross-Sectoral Collaboration & Accountability**

While we are very pleased to see cross-sectoral collaboration in health being central to the new strategy, we question how these sectors are involved/engaged in the development/implementation of the strategy and how accountability across sectors will be ensured/promoted.

**6. Consultation Process to Update the Strategy**

Finally, while the document indicates that a “wide range of people contributed” to developing this updated version of the Health Strategy, it is unclear who these individuals were, what communities and interests they represented and the process that facilitated the development of the revised strategy. Documenting this is good practice in contemporary policy development. Many thanks again for the opportunity to contribute to your consultation process.

Kind regards, Health Systems Section, School of Population Health

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| **97** | | Submitter name | | Ruth Robson | | |
| Submitter organisation | | Canterbury Clinical Network Programme Office | | |
|  | |  | | | | |
| This submission was completed by: *(name)* | | | | | Ruth Robson |
| Address: *(street/box number)* | | | | | PO Box 741 |
| *(town/city)* | | | | | Christchurch |
| Email: | | | | | Ruth.robson@ccnweb.org.nz |
| Organisation (if applicable): | | | | | Canterbury Clinical Network Programme Office |
| Position (if applicable): | | | | | Programme Manager |

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

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

🗸 on behalf of a group or organisation(s)

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research

🗸Other *(please specify)*: Health Alliance

### 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 CCN Programme Office is in agreement with the challenges and opportunities identified. We suggest four additional challenges:   1. The need to break down the barriers at a government level to enable cross-sector initiatives at a local level. CCN recommends that to enable collective impact through alliancing at a local level requires government to foster cross agency engagement at a national level. One suggestion is the development of a National Wellness Strategy that is overarching across all Government health and social agencies and that provides the mandate at a national level for local cross sectorial responses. 2. Demand on our Mental Health Services across the country particularly for our children and youth and particularly in Canterbury as a result of the ongoing effects of the earthquake is a challenge that CCN suggests should be articulated in the strategy. 3. The population is ageing and people need to be supported to die well as per their own preferences. The need for advanced care planning and good palliative care services should not be overlooked in the strategy. 4. With the country’s focus on keeping people well and in their own homes, more people will be cared for by family and other carers in the future. CCN recommends that the strategy addresses the important need to ensure carers are supported to do their job /stay well so they can support more people in the community. |

### 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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| CCN Programme Office supports the statement of “live well, stay well, and get well”, however suggest the use of “all” is a little unrealistic and that the use of “New Zealanders” would be sufficient.  “People powered” is also not supported as it does not feel inclusive of those vulnerable populations that can’t for whatever reason “power” themselves to access services or take a more proactive role in their health. Suggest “people centered” or “focusing on people, their families and communities” would be more inclusive.  Dying well is also important. We encourage the Strategy writers to work in something that is about ‘end of life’ planning.  In terms of workforce, we support the principle of alliancing and clinician led stakeholders working collaboratively and so in this context “people powered” is appropriate.  For us the sentence is missing some important elements. We suggest the following would be better…  That New Zealanders **live well, stay well, get well and die well**, through the provision of services that are **focused on people, their families and communities** and are delivered **closer to home**, by providers working as **one team** in a **smart system** designed for **value and high performance.** |

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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| CCN Programme Office supports these eight principles and agrees that they will help guide us to the implementation of the Strategy.  Further we suggest Alliancing enables patient-focused services that are clinically led and integrated in the way service responses are designed. In Canterbury we have demonstrated transformational health services delivered to our population through an alliance approach and would be eager to see the country achieve the same benefits for the people on New Zealand through alliancing. |

### Five strategic themes

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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| Again CCN Programme Office suggests “People powered becomes “**People centered”.** As stated above, to empower people to take responsibility for their own health and to be partners in their own health is one aspect, but in addition to this the whole system needs to buy into the concept of being ‘people centered’ from facility design to service design to process design. From this people are empowered to be involved in their own health. For this reason CCN suggests that “people powered” is limiting in its scope.  CCN Programme Office supports the “Closer to Home” theme. This has been a major focus for CCN’s alliancing activity through local initiatives such as Falls Prevention Services, Medicines Management Services and CREST to name just a few.  CCN Programme Office supports the “Value and High Performance” theme where smart investment ensures best value for the dollar spent. We also support the sharing of successful innovations across the whole health system and collaborative approaches that enable standardised approaches to common challenges or needs.  We suggest the “One Team” theme could be strengthened to empower the whole system toward alliancing and cross sector responses. While this is mentioned in the People Powered theme, the One Team theme is where it is best demonstrated. Alliancing principles enable cross sector engagement and locally driven responses to locally identified challenges. Health alliancing or inter-sectorial alliancing where health takes a lead needs to be included in the One Team theme.  CCN Programme Office supports the “Smart System” theme. Collaborative care through shared care planning and telehealth enable the delivery of “patient centered” health services. Technology such as patient portals provides the tools to empower people to be partners and be self managing their own health and that of their families. |

### Roadmap of Actions

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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| CCN Programme Office recommends an additional action under the One Team theme that supports an alliancing approach where the client is the common denominator i.e. vulnerable children, pregnant women etc. By promoting alliance approaches where there is a common vision supported by data, local communities are empowered to respond with locally lead initiatives through cross sector engagement between health, social, education and law enforcement agencies. |

### 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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| CCN Programme Office agrees that the annual forum would be a good way for the Ministry to engage with local health providers. For it to work well it does need to foster two way exchange and real partnership. |

### Any other matters

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

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| Thank you for opportunity to make this submission. CCN Programme Office compliments the Ministry on the Saturday consultation on the Health Strategy recently held in Christchurch. The open space methodology was refreshing and engendered participation. It was also good the way the Ministry staff sat in and participated in the discussion stations. Well done. |

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| --- | --- | --- | --- | --- |
| **98** | | Submitter name | | Andrew Bary |
| Submitter organisation | | Pharmacy Council of New Zealand |
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File ref: P4

1 December 2015

Ministry of Health

PO Box 5013

Wellington

Sent by – email nzhs\_strategy@moh.govt.nz

To whom it may concern

On behalf of the Pharmacy Council of New Zealand (Council), I would like to thank you for the opportunity to provide feedback on the draft New Zealand Health Strategy.

Council acknowledges the importance of the strategy and has appreciated the invitation to participate in the sector engagement sessions.

As requested, we have provided feedback on the attached form. You will appreciate that our feedback is not exhaustive however, we believe it provides clear insight into our thinking.

Should you wish to discuss any aspect of our submission, please contact David Simpson (Chief Executive) on 027 270 0236 or 04 495 0330.

Yours sincerely



Andrew Bary

**Chair**

Pharmacy Council Feedback 1 1 December 2015

**Challenges and opportunities**

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

The Pharmacy Council (Council) believes the challenges for the New Zealand health system are captured at a high level, in particular, the importance of addressing health disparity. We also want to emphasise that prevention is a significant opportunity across the health and social systems. Examples include maternity/antenatal, mental health and cardiovascular amongst many more.

We note that the intention may be covered in the challenges section, through the following statement “some funding arrangements contribute to stubborn disparities in access to services, and sometimes they widen the gap in unmet need”.

Notwithstanding, what could be made more explicit is that, in order to improve system performance in reducing health disparities and improving safe and effective outcomes for people, we must adopt a more integrated approach to the provision of patient centred services. This is both a challenge and opportunity. There are good examples across New Zealand where this already occurs, however, funding models and resources must be better aligned to support this type of practice to become the norm.

**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?

The statement reflects a holistic perspective of what New Zealand requires from its health system and interface with the social system. Taking a pharmacy specific perspective, Council is of the view that pharmacists have a number of unique characteristics that differ from many others i.e. high levels of accessibility, broad clinical knowledge, expertise in medicines management and importantly wellness (prevention).

The statement aligns well to our own strategy which puts significant importance on integrated (one team) patient centred services which are accessible (smart system), effective and safe (high performance).

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?

The principles are flexible, holistic and empowering. They recognise New Zealand’s health needs across generations, operating environments and the special relationship with Māori. There is also a strong correlation between the principles and the delivery of safe and effective health services which, of course, are the primary focus of Council.

**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?

Generally speaking, Council agrees with the five strategic themes. Our specific comments relate to the five themes as follows:

**People powered**

This is critical to the effective provision of safe, effective health care. It is not clear how the system as a whole will facilitate this. Customer focus must not only happen in silos but instead, must occur across the patient journey. Maybe this could be included?

**Closer to home**

Council strongly supports this principle and as outlined above, believe pharmacy has a very important role to play in providing health services that are locally accessible, relevant to a specific population’s needs and supportive of preventative approaches.

**Value high performance**

Strong performance is critical. Healthcare providers must ensure the services they deliver are efficient, of high quality and delivered safely. There must also be a focus on continuous improvement in performance and this must be used to maintain professional accountability.

**One team**

This is a very important principle, and one that we strongly endorse, particularly as it relates to providing safe and effective patient care. In order for a step shift to occur, it will require a culture change across the system. Although not directly related to our mandate, it is important that funding models facilitate and do not create barriers to more effective integrated health service models.

**Smart system**

Smart systems are imperative to the delivery better patient care. Technology is a key enabler to increasing connectivity across health disciplines. Seamless information flows will reduce errors, create improvements in managed care, increase patient autonomy and engagement in the management of their own health. This must be encouraged.

**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?

Council appreciates that the strategy is still at an early stage and is high level, therefore making it difficult to provide specific recommendations. Notwithstanding, we note that it may be advantageous to prioritise and identify under the “value and high performance section” what the “system measures” are earlier than proposed. This may help to drive, incentivise or give further traction to other initiatives such as obesity reduction initiatives.

**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?

The key to any strategy’s success is to ensure the goals, targets and tactics occur. Therefore, accountability for action needs to be made clear from the outset. This will require setting expectations with stakeholders and gaining commitment to the long term goals rather than focussing on short term tactics. In Council’s view, this will require frequent and targeted engagement which is appropriately supported and resourced.

We are highly supportive of the Ministries strategy and would be happy to provide any input that may be of use.

**Any other matters**

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

Council believes it would be beneficial for the Ministry to consider being more specific on the actual actions or activities that will come from the strategy. We appreciate it is a high level strategy and the roadmap will be part of phase two development. However, in our view, the strategy would benefit from more measurable and action oriented statements, which would take it more tangible for the sector and New Zealand public.

Council strongly support the Ministry’s view of the importance of prevention. We don’t believe this goal is well articulated both in theme nor action. This is critical if this is to be a collective goal for the health and social sectors. Moreover, without a change in the fundamental and linear way our health professionals are taught – we will never maximise the benefits of “prevention as a cure”. We must therefore re-examine how we educate students and health professionals to expand their learning, thinking and creativity as it relates to the rapidly expanding health need.

The strategy starts well but, loses its way a little. By way of example, the strategy states “there is an opportunity that comes from an aging population” but stops short of really naming what that opportunity is.

As Council has outlined above, we believe there is an immense opportunity for the use of technology to assist with information sharing, gathering of health data, identifying trends in performance which feedback into whole of system improvements. We appreciate the complexity of the health and social systems, however, the infographic (figure 10.) loses its impact by trying to illustrate too much information in a single page. You may wish to consider breaking it down into layers to better show the system interactions.

What is not clear is what input has been sought from health consumers. We assume this occurred as part of the engagement process, however, it may be worth considering making it explicit.

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| **99** | | Submitter name | | [redacted] |
| Submitter organisation | | Family Whanau Leadership Network |
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**Midland Regional Feedback – NZ Health Strategy Feedback on Roadmap to Action**

**Family Whanau Leadership Network (Te Ao Whanau) Feedback**

**People Powered**

* Invest time into people to learn their story and link them to appropriate services – people led
* Create easy to use smartphone Aps with user friendly software
* Person centred individual - personalising care (recognising that one person’s ‘package of care’ will look different to others)
* Online questionnaires – will it be accessible to every New Zealander 0-150?
* ‘Proof of Outcome’
* Follow up attending support groups, peer lead groups – ask questions - what did/didn’t work in order to improve actions 1 & 2
* What has greatest impact on New Zealand’s healthcare system
* Moving away from being service centric
* Has been difficult to use family/whanau feedback
* Who identified that you needed a Youth Action Teams and did they go out to the sector to ask?

**Closer to Home**

* Good health begins at home
* Services close to home
* Table 1.1 scary
* DHB staff could travel more and work alongside local groups
* Primary provider skill and confidence needs raising
* More education about what closer to home means
* Cross sector collaboration
* Influence mechanisms locally and regionally (rural broadband too weak for Telehealth, minor stuff able to be done in smaller centres, some mobile services, after hours limited)
* Statistically 80-90% at Tairawhiti don’t access their GP because they can’t afford to (and can’t afford to pick up their prescriptions)
* Marae-based services in rural areas
* Change the language – ‘high potential’ not ‘high risk’

**Value and High Performance**

* Working smarter for better outcomes that are measurable
* A7 - Families would agree to having services that are informed by Service User and Whanau experience
* A8 – Families would be keen to hear what these outcome measures are going to be
* A9 – Families would be in favour of a robust performance management approach. It would ensure best practice is delivered (consistent high level service delivery)

What will families notice?

* A better connectedness across services
* More affordable access for high needs in more remote areas
* Nationwide standardised of care/service
* Sue - Change language – stop calling us ‘Carers’ we prefer Family or Whanau or both

**One Team**

* Competitive
* Contract environment - funding structure
* Biggest organisation growth period could be pre contract/DHB/plan and fund
* RHa. H7a. T.H.a funding ability to work toward organisations/contract boundaries has noticeable
* 1. Operating as a team in high trust system with better cohesion – funding structure, co-design; community driven, integration
* 2. Making the best, most flexible use of our health and disability workforce – generalist and specialist, reflective of community needs and demographic, holistic approach
* 3. Strengthen the roles of people, families & whanau and communities as carers – information/education that is culturally preferred
* 4. Collaborating with researches – explore indigenous paradigms

**Smart Systems**

* Improving technology and communication – health system
* Online – health records, accurate, available to other government agencies and sectors, efficient and faster, improve communication, sharing information, user-friendly language
* Rural Areas – disadvantaged, link up with the necessary services, track progress of share goals, can have access to specialist cares, by use of safe and secure video link
* Decrease hospital admissions
* Reduce travel costs
* Benefits to the elderly – palliative care
* Change Title – ‘Get Well, Live Well, Stay Well’

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| --- | --- |
| Brian Thomas, Western BOP, (Chair) | Jim Dickinson, Family Advisor Taranaki DHB |
| Tau Moeke, Tairawhiti, Whanau Worker | Lisa Baty, Family Lead, Tairawhiti DHB |
| Anne Grennell, Director Rostrevor Hours, Hamilton | Kathleen Wright, COMPIA Worker, Western BOP |
| Hine Moke-Murray, Manager, Te Kupenga Net | Shelley Martin, Family Worker, Linkage Rotorua |
| Libby Moeke, Board Member, Te Kupenga Net | Sue Philipson, AOD Family Advisor, Taranaki DHB |

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| Submitter organisation | |  |
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**Midland Regional Feedback – NZ Health Strategy Feedback on Roadmap to Action**

**Maori Leadership Network (Te Huinga o Nga Pou Hauora) Feedback**

**People Powered**

Potential gaps for Maori

Health literacy/education

Access to health in rural communities

IT in rural communities is a challenge e.g. broadband

Some Whanau do not have computers/phones

Marae Health Clinics/mobile services

Education among Iwi groups and their circle of influence

**Close to Home**

Services Tui Ora Med Team, take it to them

Townships urban and rural

Ngati Porou Hauora – Take it to the people

West meets East

Early intervention – housing, womb to tomb

Build on Gaps

Policies – Manamotuhake I Te Kainga - technology, communication – systems - Roro, relationships, practices, education, early intervention/prevent

Iwi Kaupapa Maori

**Value and High Performance**

Value/High Performance

Outcomes focus – RBA, integrated contracting (more from widgets)

Sector Services – In the Picture

Definition of value for money needed – this assumes we are all on the same page

Proportionate Universalism

Funding flexibility

**One Team**

Take services to our people – in the Marae

1. Bigger than just Health and Disability

Multi Agency

Individual providers with multiple contracts managing as a continuum/system

2. Integrated systems advice for those that have vested interest

Does take time to build to get benefit

3. Integrated Ministry’s/as demonstrated in the SST

Influence mechanism

Iwi has to sit at the table

4. Imitation (he iwi kotahi) – pan tribalising as opposed addressing the need

Outcomes focused which enables Maori to determine the outcomes

**Which action will be the most significant for Maori?**

Being involved in design of outcomes - at the beginning.

Developing Leaders (that we choose) around that.

Then workforce in a wider sense.

**How is it going to be funded?**

Shift some from children’s team

Moving out of non-Maori services into Maori services

* Change Title – ‘Get Well, Live Well, Stay Well’

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| Hine Moeke-Murray, Manager Te Kupenga Net, (Chair) | Donna Blair, CE Te Utuhina Manaakitanga Trust, Rotorua |
| Hera Matanga, EI Nurse, Tui Ora, Taranaki | Terry Huriwai, Te Rau Matatini |
| Lybby Moeke, Board Member, Te Kupenga Net | Kiri Pieta, Portfolio Manager, BOP DHB |
| Te Rau Oriwin-Daley, Kui, Tui Ora, Taranaki | Tau Moeke, Kaumatua, Tairawhiti |

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| **101** | | Submitter name | | [redacted] |
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**Midland Regional Feedback – NZ Health Strategy Feedback on Roadmap to Action**

**Consumer Leadership Network (He Tipuana Nga Kakano)**

**Closer to Home**

4. Final Actions are okay but not operationalised

How will MOH support this mahi to happen within communities?

Equity for rural, high Maori populated areas is harder, how will MOH support this?

POVERTY, HOMELESSNESS etc and then things like the digital divide

Mobilise services – DHBs cant sit in their offices anymore, need to integrate ‘tack on’ to primary rural services

Outcome focused! It it’s not working, chuck it

Co-location! OR send the money out and get rid of the DHB

Psychiatrists can stop prescribing and help GP’s prescribe that ‘push it out’

HBT

Marae based services

Indigenous health first, prioritise Maori

Get rid of population based funding. The real thing here is EQUITY! Deprivation based services!

Grow our own - support our Rangatahi to go away, get skills and COME HOME

Bind them with love for their people. Provide assistance to help “grow your own”

Be creative using people from these rural areas

Whanau ora – make it bigger, individual/whanau

Packages of Care – rather than more service

Stop funding services by the DHB door

$180k for Wellington bed! That’s 2-3 FTE’s and home! That can work in the home!

Generalists rather than Specialists – WFD – What it takes approach

Telehealth access (don’t replace Face to Face though)

**People Powered**

Access to interpreters for all language

Training for people to be an effective consumer participate

More peer roles that are trained in health literacy - need consumer advisor positions funded in physical health

Portals in waiting rooms – look up medical information; webhealth, health apps

RTF – embedded all services

Must ensure youth, Maori, Pacific, deaf etc are represented in all aspects of service delivery

1. Agree. Co design

2. Agree. HQSC – start good consumer consultation work

**Value & High Performance**

7. Yes this is a vital component

– establish networks of service users

– co designing service user experiences

– “Nothing about us – without us”

Gaps –

- funding

- more education to invite the service user and whanau

- educate service users

8. Yes, ensure we become outcome-focused orientated (not numbers)

- establishing service user and aftercare frameworks

WHOQOL / HoNOS / training / ADOM

9. Yes – there needs to be accountability

– include bigger picture

Tap – perspectives, funding, framework

10. Yes – having localised services

Gap – achieving required capital for local investment

**One Team**

13. Avoid Isolation

- Multi skilled workforce

Language

Tools

Partnership

Shared skill base

Clear terms of reference

Flexible resources

14 Teamwork

15 Ease of Access

- establish a clear directory of how to get to “One Team”

16. Refer to 13 (it supports 13)

- workforce stocktake

17. Services users need to be part of that team

- quarterly forum until it matures

**Smart Systems**

18. Is there any value placed on anecdotal? (data quality) RFT

Get rid of MOH yearly survey

19. Imperative. National Health record – see all medications

Security? Different levels of access i.e. front page

* Change Title – ‘Get Well, Live Well, Stay Well’

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| --- | --- |
| Guy Baker, Consumer Lead, Tairawhiti DHB, (Chair) | Nic Magrath, Consumer Advisor, Taranaki DHB |
| Noeline Kuru, Consumer Team Leader, Taupo / Waikato | Chloe Fergusson, Consumer Lead, Te Kupenga Net |
| Arana Pearson, Consumer Lead, BOP | Reima Kolose, Consumer Lead, Emerge Aotearoa |
| Susan Freeman, Consumer Advisor, Linkage, Rotorua | Brendon Doleman, Consumer Advisor, Waikato DHB |

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**Midland Regional Feedback – NZ Health Strategy Feedback on Roadmap to Action**

**Midland Addictions Leadership Network**

**People Powered**

*Action 1, additions*

1B – use social media to provide information/promote responsible alcohol and drug use

1C – understand and reviewing alcohol and drug helpline inclusion in national Telehealth service – does it work? What parts need strengthening; gap analysis

di – need NGOs who are the primary addiction providers to be involved in the patient portal - problem gambling, cessation – shaping health information

ii – reference COPMIA guidelines (supporting parents – healthy children)

*Action 2: Know and design*

a) important to have high quality people led addiction designs – showcase addictions priorities within MH&A

b) high needs priority population often involve addictions/HM issues - so want to see involvement of partnership between clinicians **and whanau who use service**

**Closer to Home**

*3. Communication* – robust – honest -clear (two way)

Number 3: agree, NGO’s not funded (equitable) – rural, access for workforce, limited services, Maori need one day a week services does not meet the needs of the community

Iwi exceptions competes against government lead ideas – hapu integrated service

4. Number 4 – health promotion – awareness, financial support so meets the needs for Maori/Pacific peoples

Training Pacific people (developing our own expertise with your people)

5. Involvement with all aspects of community eg: shopkeepers, clubs, churches, marae’s, schools, community boards, funding options to support innovations

Mainstreaming working more collaboratively with NGO – adding values, expertise, sharing resourcing, funding appropriately

Ministries need to understand what collaboration means to them collectively and then devolve to various providers (lead by example). Reduce duplication, expectation for providers more realistic, clearer messages received across Ministries and down therefore reducing confusions

Comment made by Lesley Watkins made reference to work through Te Pou (not to angle out one health issue when clients have multiple issues)

**Value and High Performance**

1) Policies are recognising the need to work collaboratively

Can Providers take on board directives? E.g. rising to challenge COPMIA docs, stock takes, audits

Midland forums – strengths – connectedness amongst providers i.e. Te Whare Oranga Ngahau

2) Services delivered in community setting – DHB

Services should look at eternal funding opportunities i.e. workforce warehouse trusts, sponsorships

Less duplicating

High trust contracting. Bulk funding in advance

3) Primary Care – ongoing but improving = communication

4) Secondary Service – Assistance with transport example

5) Clinical workstation – technology

**Smart Systems**

Look beyond health systems to also include education, social etc,

Ensure access to quality information – ‘health apps’ - but who decides what’s an approved programme – different folks need different approaches

Apps in development but may have proven efficacy – yet

Challenges of current patient portals e.g. IRD/WINZ. If you are not a regular user they are challenging to navigate; how do we learn from these?

Resilience, strengths base

MOH working in other government agencies /ensure better information and analysis for effective cross sectorial action at all levels

Patient Portals – clients may have opportunities to correct their information that is not correct

Uptake of knowledge and technology service effectiveness

Promote healthy behaviours self management

Common provider portal

Relationships communities

**One Team**

Clarity needed – what is the system? E.g. Primary Health Maternity; need to be at the table, need addictions as part of these etc

*Action 13* – Board Governance – where is clinical governance across sector for addictions – is this what is meant?

*Action 14* – Addictions needs to be given fair acknowledgement across and system and strategy implementation – not Add on/marginalised

*Action 15* – Another Advisory structure – clarity of role and responsibility needed

*Action 16* – workforce – needs to be for across the system including non-specialist addiction workforce

*Action 17* – Communication – not one national forum – need live communications – social media/new technology

* Change Title – ‘Get Well, Live Well, Stay Well’

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| Dr Graeme Judson, Medical Lead, Taranaki DHB, (Chair) | Donna Blair, CE, Te Utuhina Manaakitanga Trust, Rotorua |
| Klare Braye, Matua Raki | Rachel Poaneki, Portfolio Manager, Waikato DHB |
| Lesley Watkins, Portfolio Manager, BOP DHB | Rose Taylor, Team Leader, Taranaki DHB |
| Sally Whitelaw, Clinical Team Leader, BOP DHB | Terry Huriwai, Te Rau Matatini |
| Dona Leger, Waikato | Tina Winikeri, Manager, ARC Taupo |
| Pania Hetet, Manager, Tuhoe Hauora, BOP | |

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| **103** | | Submitter name | | **[redacted]** |
| Submitter organisation | |  |
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**SUBMISSION ON ACTION ON FASD PORTION OF THE NEW ZEALAND HEALTH STRATEGY**

**[redacted]**

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| **104** | | Submitter name | | Tim Roper |
| Submitter organisation | | New Zealand Self-Medication Industry |
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| 27 November 2015  New Zealand Health Strategy Update Consultation  New Zealand Health Strategy Team  Ministry of Health  PO Box 5013  WELLINGTON 6145  Email: nzhs\_strategy@moh.govt.nz |

Dear Sir / Madam

**Submission form NZSMI on New Zealand Health Strategy**

NZSMI (New Zealand Self Medication Industry Association) is pleased to be able to respond to the above consultation with our submission. We have taken cognisance of the report and also the options for consideration with our response below.

NZSMI is the premier body in New Zealand representing companies that are involved in the manufacture, distribution, marketing of consumer healthcare products. We represent approximately 85% of the companies who trade in over the counter (OTC) medicines in New Zealand.

Yours faithfully,

**Tim Roper**

*Executive Director*

New Zealand Self-Medication Industry

**Executive Summary**

* The New Zealand Self Medication Industry Association (NZSMI) supports the updated New Zealand Health strategy documents, both the *Future Direction and Roadmap of Actions.*
* NZSMI endorses the vision that all New Zealanders ***“Live well, stay well, get well”.***
* NZSMI supports the **five** key strategy strategic themes which are:

1. People powered;
2. Closer to home;
3. Value plus high performance;
4. One team;
5. Smart system.

* NZSMI will focus its comments on three of the key themes being:

1. People powered;
2. Closer to home; and
3. One team.
4. **People Powered**

Understanding people’s needs and wants and partnering with them to design services to meet their requirements and encourage and empower people to be more involved in their health, is one of the key objectives of NZSMI’s “Advancing the notion of self care”.

To this end, NZSMI has led the establishment of the **Self Care Alliance NZ** which was formed on 22 October 2015. **Attached** to this submission is a document (Appendix 1) that explains the purpose and objectives of the **Self Care Alliance NZ.** In addition (as Appendix 2) is the rationale document to encourage organisations to *“join the conversation”* and align themselves with the goals of SCA.

The establishment of this organisation is a perfect example of embracing the theme of *“people power”* as promoted in the NZ Health Strategy. Many of the points highlighted *“what great might look like in 10 years”*, can be seen as long term objectives of the Self Care Alliance.

NZSMI encourages those charged with implementing the health strategy to communicate directly with either the writer or Dr Janine Bycroft of Health Navigator at [janine@healthnavigator.org.nz](mailto:janine@healthnavigator.org.nz) so that assistance can be provided to drive this theme forward.

The concept of people powered health also aligns with our health agenda aims of driving responsible reclassification of medicines to widen access via pharmacists and pharmacies. This needs to be supported by the provision of and availability of relevant information to make self care decisions, of which responsible advertising is key. The current regulatory environments support this, with NZSMI’s Code of Conduct ensuring members promote and advertise in a responsible manner.

1. **Closer to Home**

Focus on wellness and prevention of long-term conditions through both population based and targeted initiatives, sit well with the work NZSMI has been doing, particularly within the New Zealand pharmacy network. Initiatives that include a Self Care week and promoting awareness of long-term conditions, including Arthritis week and Gout month, endorse and support the notion of promoting education and awareness of these debilitating conditions. NZSMI would welcome opportunities to further work with the Government to advance these themes.

Investment in early life and a focus on education in schools for young children to change behaviours around lifestyle, diet and exercise again fit neatly with the NZSMI vision of ***‘better health for New Zealanders through the development of responsible self medication’.***

The idea of integration and collaboration between health professionals to provide for a closer to home service, shifting the health focus from secondary to primary care is again a theme we endorse.

The themes of prevention and wellness, as opposed to treatment and sickness, are principles that NZSMI supports. A concerted effort to change behaviours and improve people’s and families’ viewpoints around health status is one NZSMI advocates for.

Reclassification of medicines to make these available from pharmacies helps bring self care options closer to home by increasing the access opportunities, whilst also allowing pharmacists to fully utilise their health skills and training.

1. **One team**

The focus of the ***Self Care Alliance NZ*** is around the belief that no one organisation can address the health inequalities of the population alone. Having an overarching organisation that is inclusive, rather than exclusive, is one that sits well with the “one team” concept. We support:

* Operating as a team in a high trust system with better cohesion;
* Strengthening the roles of people, families and whanau and communities as carers;
* Collaboratively working with researchers is part of NZSMI’s modus operandi around the fact that evidence needs to be provided to promote the value of Self Care from an economic perspective. Only then will change be supported and driven in the health system.

By joining together as a team as opposed to operating in silos, will bring about improved communication and empowerment to individuals, families and whanau.

Although NZSMI will not comment in detail on the other two themes of *Value and* *High performance* and *Smart System*, we do support and embrace the ideas promulgated under these two headings.

**ROADMAP OF ACTIONS**

**People Powered:**

* **Action 1:** Improve coordination and oversight and expand delivery of information supporting self-management of health through a range of digital technologies is a concept that NZSMI is involved in by partnering with Health Navigator to provide an ideal platform for advancing this particular action. We would encourage those involved with the implementation of this action to again contact either the writer or Janine Bycroft at the earlier email address.
* **Action 2:** Promoting people-led service design is again one that NZSMI would be delighted to be a part of to showcase a high quality people-led service.

**Closer to Home**:

* **Action 3:** As part of this action includes involvement with DHBs and the three Auckland DHBs have indicated a willingness to be part of the Self Care Alliance, this provides an ideal platform for trialling initiatives around this concept. NZSMI would be willing to be involved in this particular action.
* **Action 4:** NZSMI endorses this particular action of fully utilising the skills of health professionals at the top of their scopes of practice and the launch of a Minor Ailment Scheme (which NZSMI has been promoting) would fit well under this action. We fully support and encourage further reclassification and development of protocols to allow pharmacist supply of medicines for self care.
* **Action 5:** The theme of prevention and early intervention, rehabilitation and wellbeing fits with the principles of the Self Care Alliance.

**One Team:**

* **Action 13, action 14 and action 15:** These actions speak of greater clarity of roles, responsibilities and accountabilities and NZSMI, as the organisation representing the consumer healthcare products industry would like to be involved in deliberations around these actions.

**Smart System:**

* **Action 19 (a) and 19(b):** NZSMI is supportive of these particular actions as we contend that as individual patients avail themselves of electronic health records and access the information via a health portal with their GP, more accurate information will be available for all healthcare professionals which can only improve outcomes for patients.

In addition the ability to record OTC (over the counter) medication taken in conjunction with prescription medicines will provide a holistic picture of the treatments patients /consumers are receiving. There is no doubt that when a patient’s medicine record is only partial the risk of misadventure is increased.

**SUMMARY**

NZSMI supports the thrust of the New Zealand Health Strategy in principle and would want to be involved specifically in the areas highlighted in this submission.

NZSMI aims to encourage healthy, informed prevention and wellness habits amongst the wider New Zealand population which we anticipate will be of assistance in reducing the burgeoning funding issue that is envisaged if no change is made.

NZSMI believes that encouraging the re-classification of certain medicines to allow the New Zealand population to confidently self- medicate, addressing the issues of self- limiting and chronic conditions, will assist in reducing the burden of cost on the health system

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| **105** | | Submitter name | | Lee Tempest |
| Submitter organisation | | FASD-CAN Incorporated |
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FASD-CAN Inc.

C/- Secretary Lee Tempest

1 Rawhiti Road

Manly Whangaparaoa

0930

2 December 2015

**FASD- CAN submission re the New Zealand Health Strategy Action 6:** The Ministry of Health will continue to collaborate across government agencies, using social investment and life course approaches to improve and make more equitable the health and social outcomes for all children, families and whānau, particularly those at risk. **H. Lead the development of a plan to improve the health systems response to children and families who are living with fetal alcohol spectrum disorders.**

FASD-CAN Incorporated [FASD-CAN] is a New Zealand based, non-profit incorporated society made up of parents, caregivers, extended whānau and professionals. We are united in our passion to improve the lives of those living with Fetal Alcohol Spectrum Disorders. We are well placed to contribute to the New Zealand Health Strategy’s development of a plan to support children and families living with fetal alcohol spectrum disorder. Indeed we believe strongly that full representation of the affected families experience should be mandatory in all strategic planning and decision making.

**Executive Summary**

We are concerned at the current lack of lack of support for parents and caregivers from across all Government sectors.  By way of remedy and recommendation, we draw your attention to the ‘Call to Action’ Consensus Statement 2014 which was formulated as a result of information shared at the Fetal Alcohol Spectrum Disorder Symposium and the FASD Policy and Research Roundtable hosted by the University of Auckland’s Centre for Addiction Research and Alcohol Healthwatch. FASD-CAN advocate for the following recommendations to be implemented into policy to ameliorate the current inequity:

**FASD Prevention Policy and Practice**

* Reduce the environmental influence of alcohol known to increase harm including reduction in availability, increase in price and restriction of promotional marketing.
* Strengthen consistency and effectiveness of non-stigmatising messages to not drink preconception, during pregnancy or when breastfeeding, including on the product and point of sale.
* Require screening and brief intervention with women of childbearing age by primary health and addiction services, and referral to specialist services for those at increased risk.
* Ensure FASD prevention is taught across the education curriculum and in specialist courses.

**FASD Screening, Assessment and Diagnostic Training and Practice**

* Direct health funding to support FASD training in integrated diagnosis and car planning with child health, mental health and other services across the lifespan.
* Provide for the establishment of a Centre of Excellence where expertise can guide and maintain consistency of evidence-based practice and continuing education across services.
* Together with FASD experts, develop guidelines and referral pathways for children and youth with FASD similar to that for Autism Spectrum Disorder.
* Screen children for FASD at point of entry into Children’s Teams, Gateway or other child health programmes.
* Ensure children in care who are at very high risk of having FASD are screened and if positive, receive timely diagnosis, care and education adapted to their special needs.
* Provide for Specialist FASD Advisor in schools.
* Screen for FASD in youth justice, care and protection residences and alcohol and drug services and provide appropriate intervention pathways to reduce the risk of recidivism.

**FASD Intervention Policy, Training and Practice**

* Ensure that the parent/caregiver voice is included and heeded in regard to FASD specific policy around health, education and justice.
* Prevent discrimination by recognising FASD is a lifelong disability with significant unmet need that is not explained by poor parenting practice or other circumstances.
* Recognise the fiscal, emotional and time-consuming demands on those caring for a child or adult with FASD by ensuring their eligibility for financial and respite care support.
* Ensure those diagnosed with FASD are eligible for disability and education supports that are not predicated on IQ alone but equally consider deficits in executive and adaptive function.
* Fund and mandate experts to deliver integrated intervention training and support programmes in mental health, justice, addictions, education, police etc. that will assist individuals with FASD to reach and maintain their potential.

**FASD Research**

* Build a research network to guide and conduct FASD-related research.
* Fund a World Health Organisation national prevalence study which New Zealand has been invited to participate in to ascertain the scale of FASD.
* Conduct a Youth Justice FASD prevalence and intervention study.
* Develop a national database for the collection and analysis of FASD clinical data.
* Conduct a cost benefit analysis to determine the cost of FASD in New Zealand.
* Research the outcomes of FASD and the cost-benefit of intervention strategies.

**Rationale why MoH need to deliver comprehensive service provision for individuals and families living with FASD.**

The above recommendations are based on our concerns at the current lack of support for parents and caregivers from across all sectors – education, health, justice and social development. In a recent survey carried out by our organization, we asked parents what was the most difficult aspect of raising a child with FASD. Their responses can be summarized as follows:

*“Parents also note the severe impact of FASD on their own ability to cope. The stress, 24/7 supervision, no ‘down-time’, feelings of isolation from family and friends, depression and chronic grief. It is no surprise that parents and caregivers are overwhelmed at times, with FASD causing many behaviors that would test even the most calm, tolerant and loving parent. Behaviors such as: aggression, violence, abuse, impulsivity, poor decision making, addictions, criminal activity, rigid thinking, sensory issues – all wrapped up in one very unpredictable package.”*

FASD is a lifelong condition that a child does not outgrow. Our organization emphasizes that all plans need to incorporate services to support those affected throughout their life span and not just during childhood as there will be an on-going need for supervision, support and intervention. Of equal importance is the criteria upon which services can be accessed.

FASD is diffuse brain damage caused by prenatal exposure to alcohol and only diagnosed when there are deficits and not merely areas of weakness. This precaution rules out delay that may result from other factors such as postnatal disadvantage and lack of educational opportunity. Features of autism are common in children with FASD due to their wide-ranging underlying brain damage. FASD is considered an invisible disability that is expressed through learning and behaviour.

Thomas, Warren and Hewitt (2010) discussed the effects that prenatal exposure to alcohol had on the fetus. Alcohol is a teratogen which crosses the placenta causing neurological damage and birth defects. This is presented through a wide range of impairments including behavioural issues, central nervous system damage, emotional dysregulation and sensory processing issues. In addition, deficits can be found in motor co-ordination, attention, adaptive and executive functioning, learning and memory. FASD children often look “normal” but their brain injury can manifest itself in disruptive, challenging, and destructive behaviour.

**Primary Symptoms that can occur in FASD**

* Attention and memory deficits
* Hyperactivity
* Difficultly with abstract concepts (math’s, time, money)
* Poor problem solving skills
* Difficulty learning from consequences
* Poor judgement
* Immature behaviour
* Poor impulse control

Further issues facing children and families often include:

● Performance at lower levels than tests scores would indicate

* Resistance to change in the environment
* Limited traditional problem solving skills Impaired ability to generalize information
* Limited predictive ability
* Visual/auditory processing impairment
* Inappropriate affection towards strangers
* Frequent temper tantrums
* Rage or emotional shut-downs
* Impulsivity
* Inability to learn from their mistakes
* Inability to see patterns
* Poor grasp of ownership/stealing
* Frequent lying and blaming of other people
* Extreme responses to minor stimuli
* Fine/gross delays in motor skills development
* Low self-esteem
* Few, if any, friends
* Trouble in maintaining focus to complete tasks.
* Fear of new situations, and changes in routines and environments
* Immaturity
* Disorganization
* Picky about clothing/food
* Poor understanding of social norms
* Limited ability to control their emotions
* Dangerous, unsafe and destructive actions

(Adapted from “I don’t have a PROBLEM CHILD … But my child *DOES* have a *PROBLEM*”, Fetal Alcohol Support Trust, Hamilton)

Adaptive function is known to be affected the most in those with FASD who may at first glance appear more able but cannot function independently in their daily lives. The usual pattern is for adaptive function to be significantly lower than intellectual function. It is the executive dysfunction that results in the greatest functional difficulties in those living with FASD. Their disability is not under pinned by IQ, but rather their ability to learn, plan ahead, and understand consequences before acting or reacting impulsively. Due to this, we strongly believe that services should be available based on a diagnosis of FASD regardless of intellect.

FASD children have a hard time coping with stimulating environments. They do not have the ability to filter out noise, light, and movement. This makes a trip to the mall or a family birthday party very difficult for them to tolerate. Often they have sensory problems which make them hypersensitive to sound (soft sounds can seem loud and vice-versa) and/or light. Their sense of touch may also be affected and they may not be able to tolerate tags or seams in clothing, yet they may play in an aggressive and rough manner. They may be viewed by others as mean, picky, lazy, or defiant. Often friends and family will give the parents advice on “how to make their child behave.” However, traditional parenting techniques may not work for these children. Instead of “trying harder” we have … [to learn] … to “try differently….

Research has established that there is a high correlation between FASD and mental health problems with Fryer, McGee, Matt, Riley and Mattson (2007) finding that 97.44% of FASD sufferers have a comorbid diagnosis such as depression, oppositional defiance disorder, bipolar, attention deficit hyperactivity disorder and conduct disorder. Streissguth et al. (2004) advocated for better interventions to ameliorate the emergence of these secondary disabilities which arise due to a poor fit between environment and need. This stance is backed up by Phung, Wallace, Alexander and Phung (2011) who stated that literature in the FASD field has consistently maintained that early interventions predicates successful outcomes. Given the complex behavioural patterns displayed by those affected their caregivers are often exhausted requiring wrap around access to services to provide necessary support.

Astley, Bailey, Talbot, and Clarren (2000) describe FASD as the leading known cause of mental impairment in the western world. Prevalence rates in New Zealand are unknown. However in 2013 the Ministry of Health Select Committee’s report *Inquiry into improving child health outcomes and preventing child abuse, with a focus from pre-conception until three years of age* admitted that given our binge drinking culture up to 3000 New Zealand babies could be born with this disability per annum. This pandemic presents a huge social problem in our nation that currently remains unaddressed. Despite international research highlighting the importance of early interventions, FASD continues to remain invisible in service provision within New Zealand. In 2013 Bagley reported that gatekeeping was occurring and families were being denied access to services as either FASD did not fit their funding criteria, or lack of professional knowledge meant that if FASD was suspected clients would be referred elsewhere creating a revolving door scenario.

Rogan and Crawford (2013) discussed how Alcohol Healthwatch secured a grant to train a core group of clinicians using internationally accepted guidelines for diagnosing FASD. Whilst multi-disciplinary teams have been successfully implemented in some areas of New Zealand, access to diagnosis using internationally accepted guidelines remains patchy and non-existent in many areas. The adage ‘it takes a village to raise a child’ is a worthwhile sentiment expressing the value in supporting parents raising their children. Parenting children with FASD has been likened to using a road map of Wellington to find your way around Auckland.

The aim of social policy is to enhance the wellbeing of individuals, with the principle goals of justice, equality, freedom, need, risk and citizenship incorporated at both a national policy level and through international Human Rights obligations which our country has ratified. Until the New Zealand Government develop, implement and fund a strategic plan to address FASD, families will continue to be discriminated and marginalised within service provision and FASD will remain invisible. This is not acceptable and compromises the Human Rights of individuals and their families. Therefore we welcome the opportunity to engage with the Ministry of Health in the development of evidence based services to support individuals and their families.

Bruce Ritchie summed up the situation facing, not only the families of children with FASD, but the whole of New Zealand society, when he wrote about the Canadian situation.

*“An individual’s place, and success, is almost entirely determined by neurological functioning. The largest cause of brain injury in children is prenatal alcohol exposure. Often the neurological damage goes undiagnosed, but not unpunished. This major health issue creates enormous personal, family, social, educational, social service and justice consequences.*

*Prenatal alcohol exposure has been linked to more than 60 disease conditions, birth defects and disabilities. Damage is a diverse continuum from mild intellectual and behavioural issues to profound disabilities or premature birth. Prenatal alcohol damage varies due to volume ingested, timing during pregnancy, peak blood alcohol levels, genetics and environmental factors.*

*There are very few physicians who are trained, or inclined, to diagnose Fetal Alcohol Spectrum Disorders (FASD) and there is no national diagnostic data collection mechanism for FASD or mandatory reporting of FASD and its subset diagnoses. As such the true incidence of FASD is not precisely known and appears to be grossly under-diagnosed. Therefore, it is necessary to approach the subject from other avenue.*

*Many prenatally alcohol exposed children are diagnosed with other conditions that do not carry the social baggage of an alcohol related condition. This can result in inappropriate treatment protocols, years of frustration for the child, the family, educators, and eventually the courts. Failure to confront the elephant in the living room results in multi-generational FASD and enormous social and financial costs. Massive denial is the hallmark of alcohol issues in our society.”*

There are many aspects of FASD mentioned here that are negative and can be the cause of devastating long-lasting outcomes. However, it is also important to remember that with informed support, evidence shows that outcomes can be different. With a focus on strengths, an understanding of individual areas of challenge and what those with FASD ‘CAN’ do, then, together, we can help create happy productive members of society. Again, in the survey of parents, the following is a summary of strengths:

*“Examples of positive attributes are: Artistic or musically talented, sporty, creative, humorous, enthusiastic, resourceful, loving, generous and compassionate. Parents all reported some of these aspects for their children. Some also highlighted how having to confront FASD and live with someone with a disability has helped shape who they are and how they have learned to be more tolerant and understanding of those with differences.”*

As an organization, we believe that investment in supporting families, caregivers and individuals living with FASD is justified and worthwhile and will contribute to positive outcomes for this cohort and society as a whole. The cost of support is far less than the alternative, that is, to do nothing and effectively ‘write off’ a large group of people who have the potential to do much better given appropriate support. The knowledge gained also provides the seeds of opportunity for preventing future children from being similarly affected by alcohol. Without this support, the evidence points to the Justice system carrying much of the burden and incurring the costs.

We include as part of this submission:

1. The FASD in New Zealand: A Time to Act; Call to Action Consensus Statement 2014 which was formulated as a result of information shared at the Fetal Alcohol Spectrum Disorder Symposium and the FASD Policy and Research Roundtable hosted by the University of Auckland’s Centre for Addiction Research and Alcohol Healthwatch. It identifies areas of priority to prevent FASD and to address the gaps in service delivery.
2. ‘A Parents Wish List’ which provides valuable information into what parents have identified as needs within service provision.

FASD-CAN has the largest collective knowledge base and experience of FASD within New Zealand. We welcome opportunities of engagement with the Ministry of Health and other service providers who are seeking to develop their services to support individuals and families living with this complex and currently marginalised disability.

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| **106** | | Submitter name | | Dr Stephen Child |
| Submitter organisation | | New Zealand Medical Association |
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**Update of the New Zealand Health Strategy**

**New Zealand Medical Association**

**Submission to the Ministry of Health**

**November 2015**

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| *“Why treat people and send them back to the conditions that made them sick?”*  – Sir Michael Marmot in ‘The Health Gap’ 2015 |

**About the NZMA**

1. The NZMA is New Zealand’s largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback by our Advisory Councils and Board. We have also appreciated the opportunity to participate in Ministry-led meetings that preceded the release of this draft.

2. The key roles of the NZMA are to:

• provide advocacy on behalf of doctors and their patients

• provide support and services to members and their practices

* publish and maintain the Code of Ethics for the profession
* publish the *New Zealand Medical Journal*.

**General Comments**

3. We congratulate the Ministry on leading the development of this important document. We are broadly supportive of the five strategic themes, though with some caveats and concerns that are elaborated on below.

4. We consider the strategy’s overarching vision – “All New Zealanders live well, stay well, get well” – to be commendable. We also welcome the strategy’s strong and repeated emphasis on viewing health as an investment.

5. We applaud the addition of the eighth guiding principle: “thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing”. However, this principle will need to be reflected in wider government policy to be meaningful. We suggest that the Ministry lead, promote, and take ownership of a ‘Health in All Policies Approach’ across all of government.[[1]](#footnote-1) This is an approach to public policies across sectors that systematically takes into account the health implications of all policy decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.

6. We have some concerns that the strategy’s overarching vision, though admirable, becomes increasingly disconnected from the proposed strategy as the document progresses. It appears that the strategy and roadmap of actions are weighted toward all New Zealanders “getting well” but somewhat light on all New Zealanders “living well” and “staying well”.

7. Personal responsibility is a vitally important part of improving health, and one on one interactions between patients and their trusted health practitioners can be a key driver for health improvements. However, these aspects need to be supported by changes to the environment that help make the healthy choice the easy choice. We are concerned that there is no acknowledgement of the environment in which health choices are made.

8. We expand on our concerns in the following paragraphs, and also provide specific responses to some of the questions in the consultation document.

**Specific Concerns**

***Health equity is framed in overly narrow terms***

9. We welcome the repeated acknowledgement of health equity throughout the document. However, we are concerned that health equity is framed almost exclusively in terms of providing equal access to healthcare when people become ill. While the Minister’s forward acknowledges “the drivers of ill health that sit outside the health system”, the environmental and social determinants of health scarcely get any subsequent mention in the document.

10. It is our strong view that health equity is much more than just having equal access to healthcare. While this is indeed important, it also encompasses having an equal opportunity to stay healthy. We draw attention to the NZMA position statement on Health Equity,[[2]](#footnote-2) as well as the report by the WHO Commission on the Social Determinants of Health which states: *“…avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces”.*[[3]](#footnote-3)

11. The strategy’s failure to acknowledge the structural drivers of health inequity mean there is also no discussion about the policy levers available to address the “political, social, and economic forces” that drive health inequities. In particular, there is a conspicuous absence of any discussion about the wealth of epidemiological research showing a strong positive correlation (and very likely partial causal relationship) between income inequality and a wide range of key health and social problems in OECD countries.[[4]](#footnote-4) We contend that the draft strategy should place a greater emphasis on the environmental and social determinants of health, and include the use of policy levers to address the political, social and economic forces that drive health inequalities.

***Many key health challenges of the 21st century are not given sufficient acknowledgement***

12. We are concerned at the cursory manner in which the strategy addresses climate change. Climate change threatens to be so pervasive in its impacts on the social and environmental determinants of health that it has been identified as *“the biggest global health threat of the 21st century”* by the Lancet Commission.[[5]](#footnote-5) The Lancet Commission has also suggested that *“tackling climate change could be the greatest global health opportunity of the 21st century”.*[[6]](#footnote-6) Well planned measures to address climate change can have substantial health (and health equity) co-benefits. We refer the Ministry to our updated position statement on Health and Climate change.[[7]](#footnote-7)

We note that the draft strategy projects government health spending as a percentage of GDP as far ahead as 2060. We believe that any strategic planning document on health that looks forward as far as 2060 must take into account climate change, and should consider adaptation/mitigation strategies as well as opportunities to realise significant health co-benefits. We also recommend that the health strategy should encourage the health sector, particularly DHBs, to adopt measures towards greater environmental sustainability, including carbon neutrality.

13. We are disappointed that the strategy does not acknowledge the links between commercial incentives to maximise production/consumption and major 21st century health problems such as the obesity epidemic, tobacco and alcohol-related harms, cancer, respiratory and cardiovascular disease caused by air pollution from the burning of fossil fuels, and antibiotic resistance (particularly due to the overuse of non-therapeutic antibiotics in agriculture). Other issues that we believe the strategy could acknowledge include excessive pharmaceutical company monopoly rights, harmful off-label promotion, and the marketing of pharmaceuticals (to both patients and prescribers) in ways that promote overuse, which is costly and exposes populations to unnecessary harms.[[8]](#footnote-8)

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| *“Efforts to prevent noncommunicable diseases go against the business interests of powerful economic operators. In my view, this is one of the biggest challenges facing health promotion… it is not just Big Tobacco anymore. Public health must also contend with Big Food, Big Soda, and Big Alcohol. All of these industries fear regulation, and protect themselves by using the same tactics.”* [[9]](#footnote-9)  – Dr Margaret Chan, Director General of the WHO |

14. Because the conflicts between public health and private commercial interests are scarcely acknowledged in the document, there is no discussion about the possibility of strengthened regulation of industry as an effective policy lever to ensure that “all New Zealanders live well and stay well”. We refer the Ministry to our policy briefings on tackling obesity[[10]](#footnote-10) and reducing alcohol-related harms,[[11]](#footnote-11) both of which call for strengthened regulation of industry as part of a suite of measures to improve population health. Both the above policy briefings are also clear that when there are conflicts between protecting the public health of New Zealanders and protecting private commercial interests, public health considerations should prevail.

15. We are particularly concerned that the strategy refers to a “one team approach” that “encompasses links” with those “in industry”. While few would argue that health practitioners and policy makers should collaborate with those in the tobacco industry, we believe that self-regulation has failed for many other industries that are linked to health harms (eg, the alcohol and unhealthy food industries). We suggest the Ministry adopt the approach proposed by the WHO in its draft framework of engagement with non-state actors,[[12]](#footnote-12) expected to be approved in December 2015: *“WHO will exercise particular caution….when engaging with private sector entities or other non-State actors, which are negatively affecting human health or affected by WHO’s policies, norms and standards.”*

16. Tobacco remains the leading preventable risk to health in New Zealand, yet the draft strategy is relatively weak in this area. For example, there is no acknowledgement of the Framework Convention on Tobacco Control, or of the government’s commitment to achieve a “Smokefree Aotearoa” by 2025, including the implementation of standardised packaging. We suggest that the draft give more emphasis to tobacco control, including specific actions that are designed to help achieve Smokefree Aotearoa.

***The “people powered” strategic theme fails to acknowledge the role of the environment in which choices are made***

17. We share in the goal of making healthy choices easy choices, and strongly agree with the statement that “Population-based strategies can make healthier choices easier for all New Zealanders and help prevent and manage long-term conditions”. However, the document offers little of substance that is likely to help achieve this goal. Notably absent is any mention of investment in active transport infrastructure (to both reduce pollution / greenhouse gas emissions, and improve physical activity). Urban environments that support physical activity and active modes of transport are an important component of a suite of measures to address the obesity epidemic, and improve respiratory and cardiovascular health.

18. Effective policy levers to improve the environment in which health choices are made include strengthening regulations on the marketing of unhealthy food to children, a key recommendation in our policy briefing on tackling obesity,[[13]](#footnote-13) and stronger restrictions on the marketing and availability of alcohol, key recommendations in our reducing alcohol-related harm policy briefing.[[14]](#footnote-14)

19. As there is no acknowledgement of the environment in which health choices are made, the “people powered” strategic theme could degenerate into little more than a series of targeted educational campaigns, coupled with calls for those at the raw end of intergenerational inequities to take “personal responsibility”. As we have already alluded, personal responsibility needs to be supported by changes to the environment that help make the healthy choice the easy choice.

20. We strongly support the strategy’s emphasis on health literacy and empowering people to manage their own health. However, in order to realise optimal health outcomes, we believe that it is just as necessary to address the fundamental social and environmental determinants of health. Most patients want to be healthy and to take control of their own health but often face socio-economic or other barriers to doing so.

21. We are not comfortable with the term “people-powered” as the first action area. We suggest that this be changed to “people-centred” or “people-focussed”. The action should relate to empowering individuals to take responsibility for their own health management, not to create an approach or a system that is run by them (as the term “people-powered” implies). Health practitioners undergo extensive training to become experts in their fields. This expertise is distilled to a level that an individual can understand and use to manage their own health problems. This doesn’t mean that what health practitioners do is simple.

**Other comments**

*Targets*

22. While the use of targets may be useful in contributing to achieving some of the actions in the roadmap, we request that they be developed in close collaboration with the sector. We have concerns that targets can lead to perverse outcomes,[[15]](#footnote-15) and that using financially punitive approaches to enforce targets can lead to the further detriment of the services already in question. We encourage the Ministry to engage meaningfully with DHBs and other Crown entities to ensure that there is buy-in from frontline staff in order to support the development of the roadmap. Making reporting simple and quick to peruse by frontline staff and the public may help build engagement and buy-in from both staff in the health sector and tangata whaiora.

*Value from health investment*

23. With respect to aligning funding to get the best value from health investment, we suggest that the Ministry consider explicitly committing to an approach known as ‘proportionate universalism’. This concept describes a service that is delivered to all, because of evidence that all will benefit, but provides additional assistance to those who need and will benefit from more. Targeted services are thus embedded within a universal system. Proportionate universalism has been developed to help overcome the challenges faced by universal and targeted approaches.[[16]](#footnote-16)

*Electronic records and mobile applications*

24. While we are strongly supportive of the establishment of a national electronic health record, we are concerned at the plan’s assumption that all New Zealanders will be able to access their health information electronically and use ‘health apps’. There is a ‘digital divide’ in New Zealand.[[17]](#footnote-17) Furthermore, not everyone can be assumed to be able to access their health information electronically or to use mobile health applications (eg, the elderly). Greater use of technology should not exacerbate existing health inequities or exclude particular population groups.

*Additional feedback*

25. The following points were raised during recent workshops to discuss the strategy:

* We recommend that the strategy address the importance of enabling clinical research and innovation.
* We suggest that the strategy include discussion on ensuring that there is good support for end of life care.
* We recommend that the strategy identify the importance of enabling elderly people to live independently for as long as possible.
* While the strategy has national goals, we suggest that it should enable the regions to find and implement the solutions that best suit their populations.

We hope that our feedback has been helpful and look forward to continued engagement with the Ministry as it progresses the development of this important strategy document.

Yours sincerely



Dr Stephen Child

NZMA Chair

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| **107** | | Submitter name | | [redacted] |
| Submitter organisation | |  |
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RE: MENTAL ILLNESS

I am extremely concerned that the MOH re: both docs above, are tending far too much to define mental illness in behavioural/phenomenological terms rather than biological causation. The former, renders mental illness almost discretionary - able to be "talked away" by psychotherapeutic intervention, job training etc whereas the reality of the biological causation model requires the very best psychopharmacological expertise. Mental illness is no different from eg cardiac or oncological sickness - none of these can be "talked away", meditated away or ended by techniques such as "mindfulness". The MOH is in some danger here - it seems to be missing the meaning of biological mental illness, may be under-resourcing for it and dislocating its provision at community rather than specialist level, unless of course PHO skills are up to the measure of the requisite medication skills.

This is a significant worry and I would welcome the MOH's response to this vital matter.

Kind regards, [redacted]

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| **108** | | Submitter name | | Catriona Godbert | | |
| Submitter organisation | |  | | |
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| This submission was completed by: *(name)* | | | | | | Catriona Godbert |
| Address: *(street/box number)* | | | | | |  |
| *(town/city)* | | | | | | Napier |
| Email: | | | | | |  |
| Organisation (if applicable): | | | | | |  |
| Position (if applicable): | | | | | | Community Dentist |

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

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

on behalf of a group or organisation(s)

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*: Individual submitter (can’t get the tick boxes to work on my computer), Community dentist currently working for Maori Health provider

### 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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| I especially agree that our strengths are:   * Publicly funded, (reasonably) universal, committed work force. *But point out that this largely falls down for dental care for adults which is mostly private and by no means universal.* * ACC extremely valuable for health and social reasons. * Strong desire for better integration of health and social services*, the evidence of the need and potential benefits are there, need to get on with this.* * Maori and Pacific health providers connected to their communities are modelling integrated approaches to health *despite the challenges of being at the mercy of piecemeal contract based funding*.   Opportunities:   * Oral health disease is largely preventable * Evidence shows there is an inextricable link between good oral health and good general health, and people with chronic conditions are at risk of poor oral health * Integrating dental and medical is an opportunity to minimise poor oral health outcomes and maximise health gains * Inter-professional collaboration and making oral health an essential part of primary care has real potential to improve individual health care, improve population health, and lower costs   Challenges: I especially agree that challenges are:   * Increasing numbers of older people with associated need*, especially from my perspective dentate older population with co-morbidities causing increased difficulties in maintaining dental health.* * Obesity and diabetes increasing problem. Both of these have strong links with oral health, Diabetes exacerbates periodontal disease and periodontal disease and other oral infections make diabetes much harder to stabilise. The same factors that cause caries, poor diet high sugar intake are major factor in obesity. * Some of NZ’s population groups receive unequal benefits from health and disability system. Unacceptable that these inequalities persist. * Lack of visibility of results. Some of the oral health data required to be provided to ministry of health by contractors seems to disappear into a black hole. Let’s make better use of the data collected. * Funding arrangements can stifle initiative and flexibility. * Sharing information, this is a big one. Even within the organisation that I work for that employs 200 plus people providing a variety of health and social services we do not yet have an integrated system so people can expect all the kaimahi who work with them to have access to the relevant data from other services within same organisation. It is inefficient for service providers around the country to individually be trying to find a patient management system that provides the flexibility and depth of detail to be suitable for use across the social /health spectrum. If we could crack this nut it would be a huge advance in truly coordinated prevention and care. * Children, adolescents, and adults of Maori and Pacific ethnicities, and people of low socio-economic status have worse oral health outcomes, greater unmet need. * The effectiveness and efficiency of general medical care will be undermined if the health system fails to invest and provide medically necessary dental care to those at risk of poor health outcomes. * Oral health has been silo-ed out from medical health for far too long * Prevalence, severity and cost of this mostly preventable disease does not get the attention it deserves |

### 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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| Yes as long as we maintain the focus on all and equity. |

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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| Yes and I agree with the behaviour shifts hoped for:   * From treatment to prevention and support for independence. * From service centred delivery to people centred services. * From competition to trust, cohesion and collaboration * From fragmented health silos to integrated social responses*. Oral health especially has been separated out for too long.* |

### 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 good categories for focus |

### Roadmap of Actions

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

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

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| Action 1:  Ensure dentistry is included in any development of digital technologies that facilitate interdisciplinary coordination and cooperation and communication with patients.  Action 3:  Don’t underestimate the value of having different health and social services co-located (under one roof) not only for patient convenience but to facilitate inter service cooperation and collaboration. The lunch room and’ heads around doors’ currently does a lot of what we hope a shared patent management system will do for shared care in the future. Ensure dental services are considered/included when designing community health hubs.  Action 5:  a new action about oral health and diabetes is needed because:   * About one third of people with diabetes have severe periodontal disease * Evidence demonstrating relationship between periodontal disease and diabetes * Among patients with diabetes, periodontal disease appears to accelerate many side effects * Oral Health care can help reduce the risk of developing complications for those with diabetes * Effective diabetes management and good oral health are impossible to attain without self-management skills * Inter-professional collaboration between dental and medical health will help reduce the incidence and adverse impact of diabetes on the quality of life of their patients   Action 6:  a new action about oral health and tamariki is needed because:   * Dental caries is the one of the most common chronic diseases of childhood * Oral health disease and infection has a profound negative impact on children’s lives and compromises their learning and healthy development * ASH and hospitalisation rates show high and disproportionate rates for tamariki being admitted to hospital for dental treatment. Dental being about first equal with respiratory conditions as most common cause of hospital admissions for children despite being mostly preventable. |

### Turning strategy into action

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

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### Any other matters

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

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| My main points are:   * Concern that there is no specific mention of oral health in this strategy, despite oral health previously being a health priority. * Our mouth is part of us and good oral health is essential for good general health. * Poor oral health is early indicator of factors that contribute to obesity and diabetes. Initiatives that target and prevent oral disease will be early intervention and prevention for diabetes and obesity. Childhood caries should be the trigger for appropriate support and intervention. * Cost is more of a barrier for oral health care than our other health care that is largely publicly funded and universal. Certainty around funding for provision of essential and preventative (not just emergency) dental care for low income adults would reduce the burden of oral disease and be a big step forward. Work needs to be done to link with ministry of social development who currently fund some of this treatment. * Oral health needs to become an essential part of primary care and be included with other performance indicators and included in care plans. |

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| **109** | | Submitter name | | [redacted] |
| Submitter organisation | | Eastern Bay Primary Health Alliance |
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Hi there. Please find below feedback from a range of roles to include clinicians within the Eastern Bay Primary Health Alliance.

**Principles**

Collaborative health promotion and disease and injury prevention by all sectors

* Health promotion needs proactive overall leadership for collaboration to occur as is highly fragmented and diverse across sectors, providers and areas. Needs to be led nationally and/or regionally (an overarching Health Promotion strategy with priorities).
* Disease and injury is too broad – requires a purely preventative approach

**Strategies and Actions**

**Overall**

Actions need to specify more about effective tailored solutions, improved access and improved health literacy rather than clinically or technology driven responses  

**People-powered**

* The strategy has the potential of excluding those without access to digital technology i.e. high deprived, rural and ‘high need’ populations who are heavily effected by socio-economic determinants.  Propose to change the emphasis slightly to enable people to access whilst facilitating greater support and **empowering people** with no or low access so inclusive of deprived population with poorer health outcomes.
* Action 1 supports those with access but it needs to reflect an equal action for those without access, see above

Point B propose the focus is more than clinician-led collaboration – what about community or organisational led collaboration? Also need a focus on prevention of key health issues?

**Closer to home**

The Strategy is too vague and ambiguous. Emphasis seems largely secondary in context.  This is about devolvement.  The emphasis is on upskilling existing health workforce to take on more outside of their roles, which is good however the resources need to move with the “taking on more outside of the roles”. Support the focus on shifting services from secondary but needs clarification on mechanism (action 3) as to how this will be done and who will lead the process.

* Action 3 – agree in principle but needs greater emphasis on PHO consultative involvement and needs to stress greater transparency and dissemination around service delivery requirements, actual performance and costs and associated funding between DHBs and PHOs.  Propose the use of the DHB/PHO Alliances model as it favours transparency, better dissemination and implementation of agreed i.e. the right services being delivered at a preventative level.
* Action 4 – agree however actions A and B only recognises clinical staff and technology approaches when often administrative, reception or community health workers or health care assistants when trained or upskilled can have a great impact on barriers, patients  and ultimately health outcomes. Technology point as above.
* Action 5 – agree but health issues seem confused as the long term conditions from obesity are diabetes, cancers, CVD, musculoskeletal disorders and some mental health issues. This action probably needs greater separation on age groups rather than being combined for long term conditions and preventative obesity approaches.
* Preventative obesity approaches whilst good that aim at those up to 18 ignores preventative approaches or addressing obese patients especially those at risk of developing long term conditions related to obesity i.e. young adults 19+, middle aged people at risk etc.
* References to elderly patients largely missing as well as references to those with multiple long term conditions
* Action 6  - needs to include primary and secondary health sectors, not just MoH.
* The secondary health sector particularly LMCs and Midwives are missing in a, b, c, d where they may have a positive and great impact

**Value and high performance**

* Action 9 –  Need to capture and address DHB funding and contractual arrangements as is restricting in the current environment
* Action 11 – Capture the application of existing tools such as HEAT tool  / health inequality lens / equity of health care framework  / RBA

**One team**

* Needs to be linked to the impact on patients or health outcomes.
* Needs a focus on principal players I.e. DHB to DHB – DHB P&F – PHOs and health sectors.
* Needs reference to health sectors primary, secondary, community, etc and the DHB/PHO Alliance models.
* What are the operational benefits, to DHB,  PHOs, patients, health outcomes, inequalities and equitable service delivery i.e. how is this going to benefit the workforce at the ground level and patients?
* Need to capture the removing of silos, streamlining governance structures and empowerment of operational management

**Smart system**

* Need to capture shared care records, integration i.e.  sharing of patient data across primary and secondary interfaces.

**Anything missing?**

* Increased Primary care related preventative approaches and health issue prevention strategies and associated service and/or funding devolvement from Secondary
* Have a more people focused approach
* Have a focus on Social Determinants of Health
* There is an imbalance between wellness and illness
* The actions need to specifically address the independent review findings around the New Zealand health sector having:

1. lack of visibility of results;
2. service mix and design slowness to changes and demands caused by overly prescriptive funding and contracting arrangements;
3. funding arrangements contributing to unequal access and unmet need.

Cheers

[redacted]  
[redacted]

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| --- | --- | --- | --- | --- | --- | --- |
| **110** | | Submitter name | | Katie Milne | | |
| Submitter organisation | | Federated Farmers of New Zealand Inc. | | |
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|  | | | | | | |
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| Organisation (if applicable): | | | | | | Federated Farmers of New Zealand Inc. |
| Position (if applicable): | | | | | | National Board Member |

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)*:

### hallenges 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?

|  |
| --- |
| Federated Farmers are concerned that rural communities, comprised of farmers and those in supporting industries, are not identified as a high need priority population. On searching the Consultation Draft of the New Zealand Health Strategy, there is only one reference to the term “rural”. That being, that “telehealth approaches can help give people in rural locations access to specialist health care”, which is recognition of the unique challenges that rural communities in New Zealand are facing (page 31). In contrast, the challenges identified within the Health Strategy discuss ethnicity and the challenge of catering to an increasing ethnically diverse population.  It is generally accepted that rural people have poorer health outcomes than their urban counterparts. Given the health status of rural populations, it is imperative that rural communities are equipped with the appropriate resourcing and skills to respond to these unique challenges.  When our24 Provincial Presidents were surveyed on the areas of concern for them, some of the common themes included many citing a lack of stability in GPs in their community due to continual locum doctors. One respondent had not seen the same doctor twice in five years. Only just this week, we have heard of new Fijian and Pilipino workers in the Ashburton area requiring travel to Christchurch to visit a GP, because books are full in the Ashburton area. While these are daily struggles for our members, the challenge for the rural population is not limited merely to access to services, but it is a unique combination of ensuring these services are appropriately targeted for the rural population.  Federated Farmers believes that the challenge is as much one of health services and access to General Practice and specialist medical services, as it is of wellbeing. Health in this sense is about ensuring that our rural communities are empowered, through the funding of community led and driven public health initiatives that improve the resilience of our rural communities to respond to challenges that are presented by adverse events, commodity prices and the pressure of increased regulation.  Relief Sought:  Federated Farmers seeks that rural communities are identified as a unique community of interest in the background to the strategy, and that the challenges of improving the health of rural communities are identified and further worked through within the New Zealand Health Strategy. |

### 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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| Federated Farmers supports the sentiments expressed in the statement, particularly the acknowledgment that health is about wellbeing – live well, stay well, get well.  While recognising the similarities that exist across our whole population, the statement risks understating the need to respond to the individual needs of different communities of interest, including rural communities. It must be ensured that, in future, our health system is able to respond to these challenges. |

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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| Federated Farmers supports the eight principles identified within the Consultation Draft, with the following amendments.  We support the goals of timely and equitable access. From our knowledge of the rural community, when farmers reach out for help, they are in often urgent need of assistance. We agree that all people living in New Zealand are entitled to receive the same quality of health care no matter where they live.  We support the acknowledgement of active partnerships with people and communities. We are supportive of the Ministry’s intent to work beyond the narrow definition of health, collaborating with others for the wellbeing of the population. There is significant opportunity for organisations whom are embedded within rural communities to have a more active role working with health professionals and organisations to engage the hard to reach rural population, should this opportunity be recognised by District Health Boards. Even simple decisions around where to host a preventative health event, and the time of year and day has a significant impact on whether it will be attended by those that most need the support.  If these principles are to underpin the work programme of the Ministry and inform strategy and policy development, it is critical that rural communities are recognised within the principles.  This requires an equitable share of the health resources (i.e. on a per capita basis); flexible funding models that support collaboration and which recognise the extra costs of providing services closer to the “rural” home. Outside of the health sector, improving the “liveability” of our rural towns needs to occur. For example, high speed broadband, good quality schooling and safe roading are all important factors. People need to live within communities which support healthy lifestyles.  Relief Sought:  Federated Farmers submits that principle 5 is amended to read “Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services regardless of ability to pay or where they live”. |

### 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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| Federated Farmers supports the five themes identified within the Strategy. We believe that they provide the right focus for action. In particular the goal of ensuring “all New Zealanders live well, stay well, get well” suggests to us an acknowledgement that this refers to people no matter where they live in New Zealand. However we are concerned that the vision for the future lacks acknowledgement of the specific needs of rural communities. The Closer to Home theme provides an opportunity to cater for the needs of rural communities. The Strategy touches on the opportunity for trialling other approaches, including vans, telehealth and outreach, in remote locations. Federated Farmers seeks further attention to other opportunities to provide for rural health care and community wellbeing in the rural and remote context.  Relief Sought:  Federated Farmers submits that the strategic themes are further developed to provide for rural communities interests and needs. |

### Roadmap of Actions

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

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

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| The actions need to acknowledge the extra challenges that will need to be overcome if rural communities and the health providers who look after them are not to be further disadvantaged. Some specific comments:  **Action 1 & 19: digital technology, patient portals and telehealth.** Many rural people still do not have adequate broadband access & speeds to take advantage of these technologies, neither do they have adequate cell phone coverage. The higher costs of these services in rural & remote regions is also a barrier. Rural communities have the most to gain from being able to access digital technologies yet they currently have the poorest access to them. Infrastructure that supports the digital link between a community and their rural health centres is critical. Importantly, it is also a mechanism for: bringing secondary care into rural communities; recruitment and retention of health professionals and for their training and education (both undergraduate and postgraduate). This digital divide needs to be addressed across Government as a top priority.  **Action 3 &4: shifting services**. High quality services have to be within reasonable travelling distances for rural communities otherwise they will not use them. Flexible funding models which also encourage collaboration between rural health professionals and enable rural health professionals to work at the top of their scope are important here. As are sufficient technologies to support telehealth approaches such as telemedicine and telemonitoring. However, it should not be assumed that expanding these services to rural communities will be a cost saving activity. First and foremost, they need to be seen as an important mechanism for improving rural health outcomes.  **Action 11: health investment.** Providing services to rural communities will always be more expensive than urban communities due to the twin challenges of distance and time. Assessment of the “strongest investment cases” needs to acknowledge this and DHBs need to ensure that their health providers get out into rural regions on a regular basis rather than expecting rural people to travel unreasonable distances to access services - services which often run 9am to 5pm which are impractical for many rural people who derive their living from the land.  **Action 12: quality and safety**. Rural communities have much higher rates of injury than urban communities, largely due to the nature of rural industries such as farming, mining and forestry. The important linkages between “good health” and “good safety” in the rural workplace and home needs to be better recognised e.g. happy and well people make better decisions and are much less likely to have an accident.  **Action 13 & 14 & 15: roles, responsibilities, accountabilities and integrated health advice**. The bodies providing advice to the MoH need strong rural voices. These people need to be living and working in rural NZ. We strongly believe the MoH should reinstate its “Rural Desk” so as to provide it with a national view on rural health. This has been eroded and fragmented with 20 DHBs.  **Action 16: leadership, talent and workforce**. There is a critical need for an in-depth rural health workforce plan and one of the first steps in this is an in-depth workforce survey across all the health professional groups (regulated and non-regulated) working in rural communities. This action needs to be at the very top of HWNZ’s agenda. Also, the way in which our rural health professionals are trained needs to change. International evidence is clear that the best way to retain our rural health professionals is if they grew up rural and received most of their professional training within the rural setting. We would like to see a national rural health training school established to oversee this – which in turn would provide a good base for conducting rural health research.  **Action 17: whole of systems forums**. This is a commendable action and will provide a mechanism for assessing the impact of proposed Government policies on overall health and wellbeing of the population, and in particular rural populations. A recent example of where one Government department’s strategic goals won’t work without the alignment and support from other departments is MPI’s goal of doubling the value of our exports in the next 10 years. As we understand it, an extra 50,000 agricultural workers alone will be needed if this goal is to be achieved. However, there seems to have been little work done on how these people will be accommodated or their health needs taken care of given the rural health workforce shortage. Also, without 21st century technologies such as high speed internet & cell phone coverage it is hard to see how our rural towns will be desirable places to live. These factors are critical to address if our young people are to relocate to the country.  **Action 12& 18 & 20: quality & safety, health research and analytical capability.** There is an urgent need to get some robust rural health research and reporting underway. We believe that where you live (and work) has a significant impact on your health outcomes and we would like to see routine rural/urban analysis of health-related data across Government. As a starter we would like to see a rural vs urban comparison within the six health targets. |

### 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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| To achieve the goal ensuring all New Zealanders live well, stay well and get well, the shifting of strategy into action requires robust data and measures to track the health status of the rural population and rural health outcomes. At present, there is limited data that distinguishes rural from urban, making it difficult to have a complete picture of the health status and challenges of our rural communities.  If the system does not take into account the difficulties of accessing health care from a distance explicitly and comprehensively it will fail.  For example, utilising the current collected data associated with National Health Index number, service utilisation can be measured and reported based on place of residence. The argument is made that numbers are small and differences in outcomes and service utilisation across different DHBs is therefore unreliable. The collection of data at a national level is possible as demonstrated by the Health Quality and Safety Commission.  Federated Farmers acknowledges that the Rural Health Alliance Aotearoa New Zealand is in a unique position through its network of members that represent consumers, providers, professional groups and industry bodies across rural New Zealand, to provide guidance on how to track and report on these outcomes. We would hope that RHAANZ can be engaged to provide input into the furthering of measurable standards for rural health outcomes.  Further, it is imperative that reporting to the Ministry from those organisations with the authority for delivering on health outcomes better reflects the need to cater to the rural population. For example, we are concerned that at present there is no requirement, for District Health Boards in the preparation of their Suicide Prevention Strategy to consult with or feedback to the Ministry on their engagement with the rural population. This leaves a significant gap in the strategy for those that could be said to need it most; farmers who are regularly exposes to stresses and pressure that can lead to grave outcomes.  Relief Sought:  Federated Farmers submits that in order to achieve the goals of the Strategy, specific measures must be developed for reporting on the status and outcomes of the health of the rural population. Further, regional health care organisations must be required to engage with the rural community in the preparation of strategies for their regions. |

### Any other matters

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

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| Federated Farmers acknowledges the last time a national health strategy was developed a further piece of work was undertaken to develop a rural health strategy. Federated Farmers is concerned that the rural health strategy was never implemented.  It could be said that this provides an impetus as for the need to embed within the national Health Strategy an acknowledgment of rural communities, and the unique challenges and opportunities for the rural population. The philosophy of a focus on equity outcomes no matter where one lives is a step in this direction, however we believe that more needs to be done to embed rural within the strategy, to ensure that the policy direction of the Ministry will adequately respond to the challenges of our rural communities’ wellbeing in the future.  Relief Sought:  Federated Farmers submits that further work is completed to embed rural health needs within the New Zealand Health Strategy. |

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| **111** | | Submitter name | | Sue Domanski |
| Submitter organisation | | New Zealand Dietitians Board |
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Chai Chuah

Director General of Health

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

Wellington

[nzhs\_strategy@moh.govt.nz](mailto:nzhs_strategy@moh.govt.nz)

1 December 2015

Dear Chai,

I am writing on behalf of the Dietitians Board in response to your request for feedback on the draft **New Zealand Health Strategy 2016** and the roadmap of actions. The Board was grateful to Deborah Woodley from the Ministry for presenting the draft strategy to our Board meeting in Wellington on 19 November.

We had wide-ranging discussions with Deborah, the key points of which I set out below relating to the five strategic themes:

**1. People-powered**

The document seems to be focused on the ‘younger generations’. There are many references to social media and other technologies as means of delivering information, records and consultations. In our experience as practitioners and lay people, different generations bring to consultations different expectations – older generations might wish to be ‘told’ what to do, younger generations might prefer ‘options’. There is not a ‘one-size-fits-all’ solution through technology.

**1. People-powered** and **4. One Team**

The Board urges more consultation with health practitioners on the impact of patient portals on the way in which health records are recorded by practitioners.

**1. People-powered** and **5. Smart System**

The Board considers there is too much reliance placed on the future of ‘telehealth services’ in the document. In our experience as practitioners and lay people, there is suspicion of telehealth and strong preference for face-to-face contact. In some cases this is generational but it is also cultural. In addition, many small providers do not have the financial capacity or personnel to introduce smart technologies. It is not a replacement for well-resourced primary healthcare provision

**4. One Team**

The Board believes the strategy document should be more focussed on the development of the workforce that will be required to deliver the health services and less focussed on technology and systems. As one of the 16 regulatory authorities for New Zealand Health Professions under the HPCA Act 2003, we would like to see more evidence of a willingness to engage with Boards and practitioners on the development of the allied health workforce. Clinical advisers from the allied health professionals, and community champions, will be crucial to the success of the strategy particularly in key areas such as obesity and diabetes. Our Boards also offer a wealth of expertise in leadership within the allied health professions.

**5. Smart Systems**

The Board hopes that the final strategy document will commit to greater engagement between the regulatory authorities and Health Workforce New Zealand for workforce planning. Our Boards have a wealth of information about the current state of the workforce, its movement and its training needs. We can also support the development of practitioner skills through our scopes of practice and continuing professional development programmes.

In conclusion, we hope that the final document will be truly ‘people-powered’, not through technology but through recognition of the vital role that can, and should, be played by allied health professionals in the delivery of your health aspirations for New Zealand.

As the regulatory body for New Zealand’s dietetic workforce, we would very much wish to be closely engaged in advisory work on key strategies such as obesity and diabetes. As practitioners and lay people, we find it hard to recognise the claim that ‘90% of all New Zealanders report they are in good, very good or excellent health’ especially when other statistics illustrate a lack of unmet needs in primary health care and significant numbers of New Zealanders with chronic health issues such as diabetes and obesity .

The Board believe that a well-crafted strategy, utilising to the full the skills of allied health professionals, can greatly improve the health outcomes for New Zealanders.

Thank you for the opportunity to comment on the New Zealand Health Strategy.

Yours sincerely,

Sue Domanski

**Registrar**

New Zealand Dietitians Board

Te Mana Tohunga Matai Kai

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| **112** | | Submitter name | | **[redacted]** |
| Submitter organisation | | Rural Health Alliance Aotearoa New Zealand |
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**Update on the New Zealand Health Strategy – high level feedback from the Rural Health Alliance Aotearoa New Zealand (RHĀNZ)**

Submitted by email: [nzhs\_strategy@moh.govt.nz](mailto:nzhs_strategy@moh.govt.nz) Date: 4 December 2015

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| --- | --- |
| This submission was completed by: *(name)* | [redacted] |
| Address: *(street/box number)* | [redacted] |
| *(town/city)* | [redacted] |
| Email: | [redacted] |
| Organisation (if applicable): | Rural Health Alliance Aotearoa New Zealand |
| Position (if applicable): | [redacted] |

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

✓ on behalf of a group or organisation(s)

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

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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)*: umbrella organisation of rural health providers, rural industry and community groups

### 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 and actions need to specifically reference rural populations as being high-need priority populations. There is no mention of rural anywhere in the summary documents. We know that rural people have poorer health outcomes overall, especially in regard to higher depression rates, injury rates and cancer survival rates, as well as higher rates of animal borne diseases, and higher smoking and alcohol consumptions rates. (National Health Committee, 2010). The suicide rates for rural people is consistently higher than urban people (between 20% -50% higher depending on the year) and we know that rural Maori have the poorest health outcomes of all. The reasons for these disparities are complex and many sit outside of the health system. A joined up approach across Government is needed to solve these problems and we would like to see a “rural lens” being applied across all policy development in much the same way an “ethnicity lens’ is currently applied. We strongly believe that where you live in NZ has a significant negative impact on your health outcomes and we would like the NZ Health Strategy to better reflect and address these concerns. |

### 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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| --- |
| Yes, as a high level aspirational statement we agree with it.  However, in order for people to live well and stay well they need “equal opportunity” to stay healthy and this requires an across Government approach if this is to be achieved for rural communities. |

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 8 principles are sound. We agree that all people living in NZ should receive the same quality of health care no matter where they live and we agree that health services should honour the Principles of the Treaty of Waitangi.  However, if the principles are the basis upon which the MoH will make its health policy and implementation decisions then it is critical that improving the health and wellbeing of rural populations is seen as a priority from the outset. This requires an equitable share of the health resources (i.e. on a per capita basis); flexible funding models that support collaboration and which recognise the extra costs of providing services closer to the “rural” home. Outside of the health sector, improving the “liveability” of our rural towns needs to occur. For example, high speed broadband, good quality schooling and safe roading are all important factors. People need to live within communities which support healthy lifestyles.  We reiterate: Given rural NZ’s contribution to our economy, and in particular, the meat, bread, milk, fruit and vegetables we eat, keeping rural NZ healthy is the best way to keep all NZ healthy. |

### 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?

|  |
| --- |
| Yes, the five themes provide the right focus for action, in particular the goal of ensuring “all New Zealanders live well, stay well, get well” suggests to us an acknowledgement that this refers to people no matter where they live in New Zealand. In general the vision for the future lacks acknowledgement of the specific needs of rural communities and we would suggest that the fifth of the eight guiding principles be slightly modified to say “Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay **or where they live.** “ |

### 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?

|  |
| --- |
| The actions need to acknowledge the extra challenges that will need to be overcome if rural communities and the health providers who look after them are not to be further disadvantaged. Some specific comments:  **Action 1 & 19: digital technology, patient portals and telehealth.** Many rural people still do not have adequate broadband access & speeds to take advantage of these technologies, neither do they have adequate cell phone coverage. The higher costs of these services in rural & remote regions is also a barrier. Rural communities have the most to gain from being able to access digital technologies yet they currently have the poorest access to them. Infrastructure that supports the digital link between a community and their rural health centres is critical. Importantly, it is also a mechanism for: bringing secondary care into rural communities; recruitment and retention of health professionals and for their training and education (both undergraduate and postgraduate). This digital divide needs to be addressed across Government as a top priority.  **Action 3 &4: shifting services**. High quality services have to be within reasonable travelling distances for rural communities otherwise they will not use them. Flexible funding models which also encourage collaboration between rural health professionals and enable rural health professionals to work at the top of their scope are important here. As are sufficient technologies to support telehealth approaches such as telemedicine and telemonitoring. However, it should not be assumed that expanding these services to rural communities will be a cost saving activity. First and foremost, they need to be seen as an important mechanism for improving rural health outcomes.  **Action 11: health investment.**  Providing services to rural communities will always be more expensive than urban communities due to the twin challenges of distance and time. 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These people need to be living and working in rural NZ. We strongly believe the MoH should reinstate its “Rural Desk” so as to provide it with a national view on rural health. This has been eroded and fragmented with 20 DHBs.  **Action 16: leadership, talent and workforce**. There is a critical need for an in-depth rural health workforce plan and one of the first steps in this is an in-depth workforce survey across all the health professional groups (regulated and non-regulated) working in rural communities. This action needs to be at the very top of HWNZ’s agenda. Also, the way in which our rural health professionals are trained needs to change. International evidence is clear that the best way to retain our rural health professionals is if they grew up rural and received most of their professional training within the rural setting. We would like to see a national rural health training school established to oversee this – which in turn would provide a good base for conducting rural health research (another top priority for us).  **Action 17: whole of systems forums**. This is a commendable action and will provide a mechanism for assessing the impact of proposed Government policies on overall health and wellbeing of the population, and in particular rural populations. A recent example of where one Government department’s strategic goals won’t work without the alignment and support from other departments is MPI’s goal of doubling the value of our exports in the next 10 years. As we understand it, an extra 50,000 agricultural workers alone will be needed if this goal is to be achieved. However, there seems to have been little work done on how these people will be accommodated or their health needs taken care of given the rural health workforce shortage. Also, without 21st century technologies such as high speed internet & cell phone coverage it is hard to see how our rural towns will be desirable places to live. These factors are critical to address if our young people are to relocate to the country.  **Action 12& 18 & 20: quality & safety, health research and analytical capability.** There is an urgent need to get some robust rural health research and reporting underway. We believe that where you live (and work) has a significant impact on your health outcomes and we would like to see routine rural/urban analysis of health-related data across Government. As a starter we would like to see a rural vs urban comparison within the six health targets. |

### 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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| To achieve the goal ensuring all New Zealanders live well, stay well and get well the shifting of strategy into action requires robust data and measures to track rural health status and rural health outcomes.  If the system does not take into account the difficulties of accessing health care from a distance explicitly and comprehensively it will fail.  The Rural Health Alliance Aotearoa New Zealand is in a unique position through its network of members that represent consumers, providers, professional groups and industry bodies across rural New Zealand, to provide guidance on how to track and report on these outcomes.  For example, utilising the current collected data associated with National Health Index number, service utilisation can be measured and reported based on place of residence. The argument is made that numbers are small and differences in outcomes and service utilisation across different DHBs is therefore unreliable. The collection of data at a national level is possible as demonstrated by the Health Quality and Safety Commission.  We would be very happy to engage in further discussion around what to track and how to track the reporting of progress of the health strategy. |

### Any other matters

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

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| The last time a national health strategy was developed a further piece of work was undertaken to develop a rural health strategy. We think the lack of implementation of this strategy reflected the lack of priority placed upon rural people in New Zealand at that time.  We think by incorporating into the national strategy a clear focus on equity of outcomes wherever people live we will steer the providers who implement the policy in a direction that will ensure the goals of the strategy are met.  This approach should clearly be embedded in this document.  The concept of “rural proofing” policy has been shown internationally to be an effective way of ensuring that services are developed that takes into account the evident differences in access that affect people living at distance from services. In order to ensure the “people powered’ strategy works for people in rural communities, the Rural Health Alliance Aoteroa New Zealand would be keen to see further developments of this strategy and the actions following on from it are put through a process of “rural proofing.”  We would be happy to demonstrate how this would work. |

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

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

√ **on behalf of a group or organisation(s)**

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

√ **Non-governmental organisation**  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

## 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 challenges and opportunities as outlined on pages 5-7 provides a good description of the most obvious issues facing our health system and our society. However, these are factors that are already well recognised, well documented, researched and highlighted across virtually all global health systems, especially in the western world e.g. largely stating the obvious.  They describe those health related factors in our society that are the “symptoms rather than the cause”.   * This is evidenced by the fact that, for example, the increase in obesity has been well known and understood for quite a long period of time yet its incidence continues to rise at alarming, almost epidemic levels. Similarly, the growth in dementia related illnesses has been well known for at least the past 10-15 years. * The future numbers are so large that this draft strategy and actions will struggle to establish the platform that will address the impact across the health sector and society in the coming 15-20 years.   Hence, we feel that there needs to be more understanding of the underlying lifestyle, cultural and wider societal influencers that inhibit some people from making healthy choices whilst others do this almost instinctively. We feel that a focus on the modern health consumer is missing.   * There is a broad and growing body of evidence that describes the patient-related factors that influence health outcomes, and we believe these should be understood and addressed as part of health service provision and modelled for their impact on lifetime health costs.   There is much to be learned from the disciplines of Health Psychology – how people’s beliefs drive health related behaviours and Behavioural Economics – designing systems and services that make the right choice the easy choice for the consumer.  We unfortunately intervene too late when beliefs and habits have become the persons new normal. We also make it very difficult for people to choose the healthy option and interact with the services on offer.   * A good example of this is the poor uptake to Cardiac Rehabilitation and Diabetes Self-Management Programmes. We need to more deeply understand the drivers for this poor uptake and redesign our systems and services to increase adoption and engagement.   Additionally, there are opportunities available to us as a society, and to the health sector in particular to identify the behaviours that determine whether individuals, families/whanau and communities make healthy or unhealthy choices that affect their health and wellbeing as a result.   * In other words, this health strategy needs to contain a focus on recognising and understanding the **cause** rather than only trying to respond to the **symptoms**.   Of course, key enablers such as IT/technologies, workforce, etc are all very important right across the health environment. Additionally, these enablers must connect across, and interoperate with, other government departments so there is a holistic approach to assisting people to be healthy, well and productive (both in a spiritual and physical sense).   * The use of effective IT systems will be a key determinant of the success of this strategy and a long-term (20 years) view must be taken rather than the current 3-5 year cycle. Systems that are in use now will be redundant or at least significantly changed in 5 years’ time. IT enablement that straddles sectors will be the most significant driver of change at pace.   We strongly believe in considering the person as a whole, their health in context with their environment, social support, education, housing, etc is fundamental to ‘shifting the needle’.   * Therefore, we need to determine what the “health system and its models of care” will look like in 20 years’ time then establish the way in which IT will support and enable this. * For example, providing care closer to the home will mean a significant shift in the way technology is used and will need to become embedded into the daily lives of every citizen based on a “cradle to grave – or (better still) a generational “cradle to cradle” model embracing all of family/whanau in the change and using the power of the family social construct as a networking or enlisting effect. * Once this long-term view is established then we can work back to the present time with the knowledge there is a vision for the future. We should be making more opportunity from the systems that we have already developed to support this such as; before school health checks, immunisation registry, government targets e.g. heart and diabetes checks – if one person in the family has been identified to be at risk then we need to create a system that supports the entire family/whanau and friends circle?   We also strongly believe that far more focus has to be given to the unpaid carers and the paid carers in the unregulated health workforce. Fundamentally, these people make a huge difference to the lives of the people they care for yet go relatively unrecognised.   * They can (and will be expected to) do more to alleviate the “pain points” especially when it comes to providing care closer to home. The use of IT and technologies will be essential to assist this workforce (and all of the health workforce) to be as effective and efficient as possible.   Failure to do so not only means we lose a huge opportunity to maximise the support for people receiving care in their own homes but will also have a significant impact on our country’s productivity and economic viability.   * For example, an unpaid carer is typically removed partially or fully from the workforce during the time they’re providing care to their loved one. Often they then struggle to return to the paid workforce when their unpaid caring duties come to an end.   The well understood false economy here is, that if we intervened up-stream to prevent people from reaching end-stage disease states, then both the person with the condition and the impact on their family would be lessened. This then allows funding to be redirected into more programmes of change that target people earlier. Again this requires a cross sectorial view and funding models that support that.   * Currently, 1 in 8 NZ workers are family carers and this is set to increase especially as the population ages and the prevalence of long-term conditions increase. Also, family carers are estimated to have a 5% impact on the country’s GDP ($10 billion per annum). * Another way to look at it is that the typical carer devotes 1,500 hours per year to caregiving. This is equivalent to 30 hours per week and 0ne-quarter of their waking time every week (calculated using 2009/10 Time Use Survey and 2013 Census).   The reason why the above factors are so important is simple – the country’s demographics clearly show us that many thousands more people will need to be cared for in their own homes (and at much higher clinical levels of care). Similarly, community-based facilities such as aged residential care, disability care providers, etc must be looked at as very important contributors to their local communities’ health and wellbeing.   * In other words, everyone and everything is viewed as being in a connected system and are valued for the contribution they make as long as they do it in a collaborative, integrated and person-centred/people-powered way. |

### The future we want

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

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

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

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| The essential role of any strategy is to provide leadership through describing a vision of an outcome that will capture the minds and hearts of all those people involved. Any strategy for the health of a population is challenging to develop as the sheer volume of people and their own particular world views are difficult to encompass fully.  Therefore, the question needs to be – “does this statement describe a future state that captures minds and hearts”?   * It is our view that this test is not met by the current statement and encourage more work to be put into this before it is finalised. As individuals we all want to be able to identify ourselves living in this future state and having some control over our place within this system.   Hence, we believe there needs to be more emphasis on “enablement, empowerment and partnerships” that places the emphasis on individuals, families/whanau and communities doing “for themselves rather than having it done to them”.   * This does mean a move away from the medical model, hospital-centric view of the health system and a focus placed on taking personal responsibility, self-management and being enabled to do more for themselves rather than have the State decide how, what and where their health services will be provided.   The use of the phrase “people-powered” seems more of a marketing catch phrase than something that people will be able to identify with in the way it is intended. It will depend on how people are interacting with the health system whether they view this as a good thing or not.   * Most will say that this is already the case so what is going to be different in real terms. Similar to the test above will this phrase capture minds and hearts, and will leaders be able to articulate it in a way that prevents confusion?   This strategy and statement is going to require quite a substantial shift in approach by the key health sector leaders particularly within the Ministry of Health construct. The strategy describes a “brave new world” where people will be trusted to do the right things and supports will be in place to enable risk taking whilst recognising that the biggest gains will come from innovation that can no longer happen as an isolated event.   * Linked to this is the need to determine a very clear definition of innovation itself so that it is clearly understood, recognised when it happens and rewarded accordingly. * So often, basic quality and continuous improvement is labelled as being innovative when it fact these things should be the standard expectation of a progressive, learning organisation. * Innovation needs to be recognised as something that completely changes the way something is done from what has become known as the norm. In other words, a game changer that creates a new paradigm rather than simply improves an existing process.   Critically important health and wellbeing related factors that cannot be ignored such as quality systems, research-based clinical models of care, standards, etc are fundamental building blocks to the health system.   * However, these can also be used as constraints to prevent innovation, risk taking and doing what’s right for the end-user rather than what’s right for the next manager up the line or keeping the politicians out of the headlines.   Calculated risk takers, such as Dr Lance O’Sullivan must be encouraged and supported to do the best they possibly can for their local population groups. As their success grows then further support and resources must be provided so their particular solution can gain scalability for use in other parts of the country.   * The current mind-set of “not built in my backyard, patch protection” has got to be addressed as it is a major inhibitor of progress. True collaboration, integration and working in the best interests of the consumers of health services (i.e. all New Zealanders) no matter where they may live must be held up as the basic expectation and rewarded (not only in monetary terms) accordingly.   Along with this, the local champions of these types of innovative solutions that align with the strategic direction must become the national champions of that solution as well. All too often, a highly successful local solution fails to gain national traction because the real driver/champion finds themselves on the side-lines and the original solution becomes watered down to meet a bureaucratic requirement rather than a person-centred/people-powered outcome.   * There is obviously a fine line involved with this. The mark of the new style of leadership required to implement this strategy will be to keep people safe from harm whilst enabling a system that forges a truly new way of delivering health and social services to New Zealanders. One that is no longer driven from the top-down and is fully enabled from the bottom-up.   One Team and a Smart System are very large statements – currently the building blocks and behaviours are not in place to enable the provider, vendor or funder communities to realise this.   * This needs to be a key focus of the strategy – what fundamentals have to be in place, mandates to interoperability standards and a philosophy of sharing and openness to ensure an open flow of data between sectors, systems, etc. Otherwise we will continue to be many isolated teams all being purchased separately with no mandate, funding or scope to connect. |

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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| Yes, as guiding principles these are excellent as long as they become embedded right across the health sector and beyond into other government departments.   * Additionally, the leaders throughout this connected system (including politicians) will need to demonstrate understanding and acceptance of these principles (beyond the usual 3-yearly cycle) otherwise there will be obvious challenges that could undermine the overall strategic direction.   A good example of this is in the first principle – to achieve health and wellbeing throughout their lives requires a health system that knows and connects with people at every touch point, not just when they are sick or disadvantaged.   * This fundamentally changes the way services are currently structured and funded. Intervening with people when they are already on poly-pharmacy regimes, with multi-comorbidities is unacceptable when we have systems that can identify people many years before this. We need to build a Health and Wellness System (not continue to deliver to a sickness system). |

### Five strategic themes

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

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

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| These strategic themes capture the essence of what the majority of people would like our health system to aspire to be involved with. They are optimistic and support the overarching vision of “wellness for all”. We would encourage an even bolder and braver step being the renaming of the Ministry of Health to the **“Ministry of Wellbeing”**.  In reference to our previous comments relating to the phrase “people-powered” this would be the only theme that we encourage further thought be put into whether it is the correct phrase to use.   * We need a phrase that individuals can almost instinctively relate to and see it as capturing their wants, needs and emotional attachment to health and wellbeing. People powered may lend itself to ‘work hard, work harder with no more money’ – people are already working very hard and in many cases over-worked to the point of cracking.   The concept and principles of a **“person-centred”** model are well researched, documented and understood. We believe this is a better phrase to use as we all see ourselves first and foremost as a “person” rather than a “people”.   * For example, the former (person) is about me as an individual versus the latter (people) being about others (i.e. “those people as a group” vs “me as a person”). This speaks to co-design and involving users early on to be involved in designing effective models of care.   This is important when looking to capture minds and hearts, being able to describe a health environment that is aware of ‘me as a person’ and that also considers those factors that enable individuals to be healthy and well whilst understanding the importance of family/whanau and community.  Regardless of what this theme is eventually called we certainly agree that the use of IT/technology based solutions is an absolute prerequisite to enable people-powered/person-centred health and wellbeing models of care.   * The growth of technologies that support the “consumerisation of healthcare” will make a considerable contribution to the effectiveness and efficiency of health service delivery. These will also aid the development of preventative solutions and empower greater levels of self-awareness and self-management.   Essentially, this is occurring now and will only grow bigger as the population demands more focussed care delivered to the place they are most comfortable receiving it; with seamless interoperability across the health and social continuum.  Value and high performance – there are many examples across health of wasteful re-creation of what is already working well elsewhere. Sharing of best practice and the spread of innovative solutions needs to be the default position for all DHBs, PHOs, Health Providers, Vendors and so on.  Each delivery of any funded project must be a new innovation or significantly improved process that takes the NZ Health system to a better place and advances health and wellness outcomes. There is so much duplication and stand-alone systems that are costly and limiting the pace of change.   * For example, no public tender should be allowed to proceed if other regions have already delivered the service/products/systems/processes unless there is an overwhelming reason for doing so i.e. to ensure anti-competitive practices are prevented from occurring.   Successful, existing work should be leveraged and advanced with this being role-modelled through effective leadership. We are a small Nation of $4.2million people and we should be capable of greatness that is exportable and leading the world stage.   * Effective governance and leadership is at the core of unlocking the potential to achieve an aspirational, visionary and far-reaching strategic direction. |

### 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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| Firstly, it must be recognised that turning a strategy into a set of actions is a challenging process and we applaud the efforts that have clearly been put into this roadmap.  As such, we understand that it is difficult to achieve a level of granularity that will satisfy everyone involved in the health ecosystem.   * We also believe there will need to be more detailed plans developed that include key performance measures that can be tracked and adjusted to account for changes in the system as well as keep people on track to deliver on expectations.   No matter how this is described or laid out in the plan there definitely needs to be a clear set of priorities and timeframes by which these must be achieved. Anything else then becomes secondary to these high priority actions in order to avoid confusion or loss of focus.   * This includes a clear line of responsibility that pushes the priority areas out of the hospitals and into the communities to where the needs are most urgent and the biggest gains can be made.   The primary and community care sectors must be enabled to take a lead role in the health and wellbeing of New Zealanders. With this comes a reconfiguration of the funding models based on a “risk and rewards” model that recognises efforts to keep people out of hospitals and as well as they can be in their homes and communities (this includes facilities located in communities that provide essential care services for those most in need i.e. aged residential care).   * Both secondary and primary sectors have to work more positively toward achieving a “connected system” that is interdependent rather than isolated in terms of outcomes for the population.   In 5 years’ time we definitely must have a sustainable solution in place based on “a system that measures what matters to people, and people’s involvement improves quality, safety, experience and health and equity of outcomes”. This factor is now well understood across most health services and outcomes are becoming clearly defined.   * Exactly **how** this will be achieved is less defined in this strategy particularly in a way that better manages ever constrained resources such as funding, human resources and infrastructural requirements.   To be really effective any solution must be built from the patient/person back into the health, social, education and justice systems if a truly holistic, wrapped-around environment is to be achieved. |

### 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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| IT/technology-based solutions are available now and will increasingly become embedded throughout the health and social systems to enable tracking, monitoring and reporting on virtually all areas required.   * This will require high levels of integration and interoperability supported by funding and resources to create, implement and sustain the system. * Co-design of systems must become the norm rather than these happening in isolation then pushed out to the providers, vendors, etc to implement whether they are the right solution or not.   In terms of overall measurement, tracking and reporting – transparency in all areas is going to be paramount. Everyone has to know the expectations and whether they’re being delivered or not. Leadership of this is essential so that people are aligned to the outcomes and working on doing the right things to achieve them.   * If people are fearful of their job security or working in a constrained, difficult working environment then the desired outcomes will not be achieved.   We must have a cost-effective health system that utilises its resources as effectively and efficiently as possible. NZ’s population base and changing demographics will not sustain the current system so it is essential to optimise health outcomes whilst managing the resources carefully.   * This is why we need clear outcome measurements with risk and reward funding models that support outcomes, not outputs.   The repetitive nature of the health system needs to be replaced with a “centres of excellence” approach that would see certain DHBs/PHOs (for instance) establish themselves as experts in specific areas of the health system. These DHBs/PHOs then lead the implementation of their programmes on a national basis.   * For example, Northland DHB becomes the centre of excellence for the delivery of services to remote rural areas using enhanced technology solutions. Their knowledge and expertise is then used to replicate the model into other DHBs with similar demographics i.e. Southern, Wairarapa, Whanganui, etc.   Regardless, the specific models of care required for the future health system need to be much better understood so that key enablers, such as IT and workforce, can be configured now. If not, the models won’t be able to be implemented as the infrastructures are not in place to support them.  We agree that a stocktake needs to be undertaken as mentioned in the strategy. This definitely needs to be broadened to include key sector groups such as NZHIT, MTANZ, HiNZ and so on plus the likes of Callaghan Innovations and NZ Trade & Enterprise. This will enable the collation of the systems and solutions that are in the market now and are coming to market that will be important in supporting the health strategy to be delivered.   * Hence, we support a broadened stocktake that identifies what is in place now, what else is available and how systems could be integrated to provide a greatly enhanced solution.   Absolutely critical to any pathway is to build and generate a coalitions/collaborative based model that encourages and recognises effective teamwork regardless of hierarchies and bureaucratic structures.   * The likes of secondments across the whole sector must be encouraged so that we develop a “best and brightest” pool of governors, thought leaders, change managers and implementers who have a wide understanding of the whole construct.   Change management methodologies and resourcing has to be built into the health system so that it is seen as being just as important as a quality system or the setting of standards. We can no longer support the implementation of systems that do not fully cater for the change management processes that will make them successful.   * By its nature strategy describes a new state that means the current way of doing things are fundamentally different (changed). Therefore, any strategy is nothing without effective execution and change management that successfully governs and manages the implementation processes.   As such, we do not have the level of change management expertise in the health sector to support the success of this strategy.   * Best practice programme management office systems and change management processes have to be positioned at the highest possible levels of all organisations and effective change managers attracted into the sector. * The current model of under-resourcing the change management processes results in higher costs through low adoption levels, poor uptake and minimal cultural changes that result in the “old way of doing things” being retained.   **Hence, technology and change management needs to be viewed as an investment not a cost. On this basis we strongly believe that more resources have to be put into these with a very clear understanding of the return on investment this will generate.** |

### Any other matters

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

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| New Zealanders are currently fortunate to be able to enjoy a **good** health system that in many cases is envied by other countries. This strategy is our opportunity to describe a course of travel that will create the **best** health system that we could possibly have.   * To do this means taking some risks, being prepared to be visionary, establishing truly stretch targets and growing our leaders to drive the strategy into action over the coming 10 years. * Nothing of real substance will be achieved if we continue to do it the way it’s always been done.   From an IT/technology perspective we have concerns relating to a constrained marketplace that does not necessarily encourage true innovation and where transparency is not always in place. Any move to creating a closed system would constrain innovation, limit the achievement of key priorities within required timeframes and lead to an exodus of some of our “best and brightest” people and organisations.  Governance and leadership across the health sector (public and private) needs to be strengthened so that the delivery of the strategic direction and the empowerment of people to carry this out are at their optimum levels. Being able to establish the strategy and align everyone towards its achievement requires special skills and the building of these capabilities must go hand in hand with any other actions described in the draft strategy.  The current structures across the health sector need to be addressed as these create unnecessary complexity, don’t work well together, not aligned and lead to anti-competitive behaviours. Technology has the ability to change this by creating a connected system that doesn’t rely on physical boundaries.   * For example, we could be using the best minds that are located across the globe to solve some of our health issues, and vice versa, on a virtual basis that is highly cost efficient and effective. * A boundary-less health system that makes the most of the best people and services on a national and global scale plus feeds back into the global system, which then enables a self-funding model, is an aspirational vision that should not be overlooked in the development of this strategy. * This means that multiple organisations (especially in the public space) creating same or similar solutions for their own use disappears and ‘best of class’ systems are selected for consistent use right across the NZ health sector.   For example, through the use of technologies NZ could become the global centre for the monitoring of people with congestive heart failure (CHF), identify those most at risk and work with their local care teams to put in place services that help them to be as well as possible, remain in their own homes and reduce the rates of re-presentation to emergency departments and hospitals.   * In other words, an “Uber” model that would see New Zealand as the global provider of CHF services without owning the high cost labour and infrastructure inputs.   In any case, we will see changes in traditional structures that are driven by consumer’s uptake of technology in much the same way as we’ve seen sectors such as banking, travel and education change in recent times.   * For example, the growth of virtual GP services will challenge the traditional primary practice models as consumers utilise technology to access consultations on-line and when they need them rather than making an appointment and going to a physical location.   These changes won’t be led by the Ministry, DHBs or PHOs – consumers will determine the way they access health services especially in the community setting and it will be the innovative, fast moving service providers who will gain early advantage. We will soon see this on a smaller scale as patients start to change their GPs because they want access to their patient portals. |

1. WHO national framework for Health in All Policies is available at <http://www.who.int/healthpromotion/frameworkforcountryaction/en/> [↑](#footnote-ref-1)
2. Available from <http://www.nzma.org.nz/__data/assets/pdf_file/0016/1456/Health-equity-2011.pdf> [↑](#footnote-ref-2)
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