**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**327 – 345**

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| **327** | Submitter name | [redacted] |
| Submitter organisation | Kidney Health NZ |

4 December 2015

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

**Wellington**

Dear Colleagues

**Consultation Submission: Update of the New Zealand Health Strategy**

Thank you for the opportunity to participate in the consultation process on the draft of the Update of the New Zealand Health Strategy. We wish to make the following observations regarding the draft document – some general; others referenced to specific material within the document:

1. In general, we are encouraged by the document’s emphasis upon health outcomes rather than inputs – and, in particular, the apparent willingness of the Ministry for health service users to be involved in the identification and development of outcomes measures that they themselves will find meaningful.
2. We are also encouraged by the document’s emphasis upon the role that IT has to play in improving health provision and therefore health outcomes. While the Ministry’s renewed commitment to rolling out single electronic patient records is particularly encouraging, we are concerned that this project not be further delayed by linking it to the concept of patient access to that record via a patient portal. The development of a single patient record approach has already taken well over ten years. We would recommend that the use of this technology be made available to all health professionals involved in a patient’s care as soon as possible – with the patient portal concept flagged as a separate project. We see the latter concept in the ‘nice to have’ category, while health professionals’ access to a single electronic patient record we would categorise as an urgent ‘must have’.

In terms of increased use of telehealth technology, we would observe that that a significant proportion of New Zealand’s health consumers may not have either the means or the ability to access such technology – limiting its use, and standing somewhat at odds with the Ministry’s stated commitment to ‘equity of access’ in terms of health services.

1. The document also refers to better use of data – using

*“data to better understand people and populations, know what works for people and why, and continuously adapt service and funding approaches.”* (p.12)

Our concern is in relation to who effectively ‘owns’ that data. We are conscious that a lack of effective data sharing has, in the past, represented a significant but perpetual barrier to improved health outcomes.

1. We thoroughly endorse the document’s commitment to increasing the focus on wellness and prevention of long-term conditions through both population-based and targeted initiatives (p.14), and commend the Ministry’s current initiative in the area of chronic kidney disease. Even further improvement in health outcomes could be potentially achieved if the strategy were to emphasise a more ‘joined up’ approach to the prevention of long-term conditions – i.e. recognising such long-term conditions as diabetes, kidney disease, heart failure, obesity, etc. as often related, and addressing them together, rather than solely through separate health strategies.

For example, Action 1.b (p.34) recommends the use of social media to provide information on early stage diabetes. Why only diabetes? Why would social media not similarly be used to provide information on the prevention and early-stage management of other long-term conditions?

1. While the ongoing relocation of health services from a secondary to a primary setting (reflected throughout the document) is to be encouraged, past history suggests that a different funding strategy to that currently in place will be required if the potential of such an approach is to be fully realised. So long as District Health Boards are left to contract (and therefore fund) primary health services, there is no guarantee that the past pattern of DHBs devolving secondary services to the primary setting without devolving the funding necessary to ensure those services’ ongoing viability will not be repeated. Unless that funding anomaly is addressed, DHBs will continue to prioritise the funding of secondary services over primary as they have done in the past.

Thank you again for the opportunity to provide feedback on this draft document. Our final observation would be that, in its current form, the draft strategy is heavy on principles and rhetoric, but very light indeed on detailed action – who will be responsible for initiating and facilitating the changes foreshadowed, the milestones to be met (that will give us the confidence that progress against the strategy is actually being made), and, of course, how such initiatives will be funded within an already overstretched health budget.

Nga mihi nui

[redacted]

**Chief Executive Officer**

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| **328** | Submitter name | Kathryn Maloney |
| Submitter organisation | Age Concern New Zealand |

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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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| Age Concern New Zealand (ACNZ) would like to see more democratisation around health knowledge to empower people and support them to take responsibility for their own health. However, it takes more than just health literacy to change behaviour – support is key.  Language needs to be simple and straightforward. Communications between consumer and health practitioner have to be clear and plain and the practitioner needs to ensure the consumer understands the messages. |

### 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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| “Live well, stay well” aligns well with ACNZ’s mission statement: “Age Concern promotes wellbeing, rights, respect and dignity for older people”. It is vital the health promotion is at the heart of living well and staying well.  However the concept “that *all* New Zealanders live well, stay well, get well” is just not possible as people will die. ACNZ suggests the omission of the word “all”. |

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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| ACNZ is very pleased to see that health and wellbeing is the primary principle. We are also pleased that the third principle incorporates health promotion and injury prevention, both of which are crucially important in keeping older people as well as possible for as long as possible.  Health and wellbeing, health promotion and injury prevention are all areas where NGOs can play a large part and we would like to see more support and resources given to the NGOs who work in these areas. |

### Five strategic themes

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

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

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| “People-powered” aligns well with the work ACNZ does around health promotion – to give older people the tools to help them remain healthy and well. The example given that “older people … can require more support to obtain and use the information they need for their health” is relevant to the work we do to empower older people to be more involved in their health and wellbeing. We feel that across the health sector, good customer service, providing reliable information is key to helping people make informed choices.  “Closer to home” also aligns closely with ACNZ’s work to ensure people age well in the place they want to be – that they experience quality ageing.  “Value and high performance” focusses on outcomes which again, match well with ACNZ’s view of contractual services –we need to aim for good outcomes to ensure that the work we do is of value to the community and to ensure that our work remains of high quality.  “One team” empowers NGOs such as ACNZ to work within the whole health system. However, it is crucial that the NGOs are fully supported to be able to carry out this work to the best of their abilities, with the right amount of resource, and investment to enhance capability and capacity of the NGOs.  “Smart system” works for many populations that are connected to the internet via home computers, work systems, phones and tablets. However the majority of the population group that ACNZ works with – older New Zealanders – are not “connected” in a way in which they would feel comfortable with dealing with any health issues via online systems. Therefore, while smart systems are developed, there is a need to keep other, more traditional systems available for older New Zealanders. There is also the need to build health literacy via ensuring equity of IT access, i.e. continuously building the capacity of people to engage on an IT platform. |

### 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** – self-management of health through a range of digital technologies must be user-friendly for older people and alternatives must be offered.  **Action 1 d** – how will an older person have access to their information?  **Action 3 a** – where specialist services are in just one location, careful consideration needs to be given to those older people who live in rural communities, on a fixed income who will struggle to get to the main centres for treatment and check-ups. Older people must have cost-effective access to services.  **Action 5 e** – ACNZ’s health promotion programme can play a part in preventing long-term conditions for older people.  **Action 11 b** – ACNZ welcomes the possibility of longer-term contracting of NGO providers. As a contracted NGO provider, we understand how constraining short contracts can be, with no assurance that services we are currently funding will be funded into the future. However, we also understand the need to ensure consistently high quality services is provided through longer-term contracts.  **Action 16 b** – ACNZ welcomes the development of a system leadership and talent management programme to develop the workforce, and particularly welcomes the use of these principles to strengthen skills and capability and expand support for the NGO/primary and volunteer sector.  **Action 19 b** – as mentioned previously, patient portals are innovative and work for many population groups. However, ACNZ is concerned that those people who do not have online access (which is particularly prevalent within the older communities), will be unable to access their records and so suitable alternatives must also be offered.  **Action 19 d** – again, mobile “health apps” work well for those people who have access to tablets and smart phones but many in the older age groups do not have access to these and so will be unable to access the “Health App Formulary”. We would welcome other ways for people to access the same information in other ways. |

### 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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| A yearly stakeholder survey could be used to measure perceived progress on the Roadmap of Actions.  Continuous dialogue with all stakeholders is important if the strategy is to be an organic strategy. |

### Any other matters

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

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| ACNZ sees health promotion as key to ensuring older New Zealanders live well and stay well for as long as possible wherever that is practical. Empowering people to take responsibility for their own health and supporting them to do so is essential. |

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| **329** | Submitter name | [redacted] |
| Submitter organisation | Otago Regional Council |

Our Reference: A865500

**Otago Regional Council Submission**

**to the Ministry of Health**

**on the**

**Update of the New Zealand Health Strategy**

**‘*All New Zealanders live well, stay well, get well*’ Consultation draft**

This is a submission to the Ministry of Health on the Update of the New Zealand Health Strategy ‘*All New Zealanders live well, stay well, get well’* consultation draft.

The Otago Regional Council does not wish to be heard in support of this submission.

Signature of submitter (or person authorised to sign on behalf of submitter):

[redacted]**Director of Policy, Planning and Resource Management**

4 December 2015

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**Full Submission**

# Summary

## Otago Regional Council (ORC) supports the proposed update of the New Zealand Health Strategy (the Strategy) and requests the strategy recognise the importance of the roles of other agencies, such as regional councils, and work with those agencies in achieving the health vision.

# Proposed Regional Policy Statement and Human Health

## The Otago Regional Council (ORC) is reviewing its Regional Policy Statement for Otago (RPS).

## The Proposed RPS is a high level policy framework for the integrated management of Otago resources. It identifies regionally significant issues and the objectives, policies and methods to achieve integrated resource management within the region.

## The Ministry of Health (the Ministry) Health Strategy consultation draft (the Strategy) discusses the Ministry view on the current New Zealand health and disability system and a future direction to address challenges and opportunities.

## A component of the Strategy future direction is identifying ‘the future we want’. Similarly, the ORC Proposed RPS is an outcome driven strategy document that aims to deliver a better future for the Otago region and its communities.

## ORC notes the synergy between the outcomes its Proposed RPS provides and those of the strategy. ORC requests that the strategy recognises the importance of managing the natural and physical environment in which our communities live for health. The role of agencies, such as ORC, should be identified in the Strategy as contributing to the Strategy vision.

# Human Health Provision in ORC Plans

## The Proposed RPS recognises the importance of human health throughout the document in relations to the management of the natural and physical resources.

## Chapter 2 of the proposed RPS proposes objectives and policies recognising the importance of natural resource values. It sets out how these should be managed to maintain and enhance qualities in order to support human health and reduce the potential for adverse effects, in particular;

## Water, Air and Soil

## Objective 2.1, Policies 2.1.1, 2.1.3, 2.1.4 and 2.1.5

Integrated Resource Management

## Objective 2.36 and its suite of policies

## Chapter 3 of the Proposed RPS proposes objectives and policies to achieve resilient, safe and healthy communities. In respect to human health, these objectives and policies include provision for:

## Natural Hazards (Objective 3.2 and its suite of polices)

## Climate change (Objective 3.3)

## Urban design (Objectives 3.7 and its suite of policies)

## Infrastructure (Objectives 3.4 and 3.5 and their suite of policies)

## Hazardous substances (Objectives 3.9 and Policies 3.9.2 and 3.9.4)

## Adverse effects and sensitive activities (Objectives 4.5 and Policies 4.5.1, 4.5.2, 4.5.3 and 4.5.5)

## For reference, the Proposed RPS document can be accessed at the ORC website[[1]](#footnote-1).

## The Proposed RPS recognises, and provides for, clean air and warm homes being important factors in positively affecting human health. For example, warmer homes contribute to air quality by reducing the need for heating, particularly those using solid fuel, which in turn reduces particulate emissions.

## Policy 4.5.1 of the Proposed RPS requires that discharges of hazardous or noxious substances are avoided in close proximity to sensitive activities such as residential areas and educational services.

## The Regional Plan: Air for Otago contains provisions, including rules in respect to domestic heating appliances meeting emission and thermal efficiency standards.

## Access to good quality drinking water is provided for in the Regional Plan: Water for Otago, both for surface water bodies and groundwater aquifers. Objectives and policies recognise managing both water resources and activities which may affect the quality of these resources is important to retaining reliable, safe drinking water, along with contact recreation and source of food.

## The combined Otago/Southland Regional Land Transport Plans 2015 - 2021 provides for active transport modes, such as pedestrian and cycling networks, to achieve benefits of connectivity and integration with public transport. Provisions for active transports modes in urban and transport network design also have health related benefits for our communities.

**End.**

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| **330** | Submitter name | [redacted] |
| Submitter organisation | New Zealand College of Public Health Medicine |

4 December 2015

**Update of the New Zealand Health Strategy**

**Submission to the Ministry of Health**

#### Introduction

1. The New Zealand College of Public Health Medicine thanks the Ministry of Health for the opportunity to make a public submission on the draft New Zealand Health Strategy Update (the Strategy).
2. The New Zealand College of Public Health Medicine (NZCPHM) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 226 members, all of whom are medical doctors, including 194 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine.
3. Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM strives to achieve health gain and equity for our population, reducing inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.
4. The NZCPHM would like to thank the Ministry for the huge amount of time and effort that has gone into creating this draft Update of the New Zealand Health Strategy. Communication about the NZHS from the Ministry has been thorough and frequent, and we have appreciated the varied opportunities to contribute through regional consultation meetings and the online forum.
5. Overall the Strategy has many strong aspects. However, the NZCPHM has two overarching concerns: firstly, the emphasis given to population level approaches to improve health, social determinants and health equity is severely inadequate. Secondly, although the Strategy begins well, looking at health in the widest sense, this quickly deteriorates into a narrow focus on delivery of health services to individuals. These two issues mean that the Strategy misses the opportunity to reach its full potential in terms of supporting all New Zealanders to be healthy in the context of a country with rapidly changing demographics and facing global health challenges.

#### Vision Statement

1. The opening phrase of the vision statement “that all New Zealanders live well, stay well and get well” is commendable. We think it needs to explicitly include the start of life[[2]](#footnote-2) and quality at the end of life, and suggest the addition of ‘start well’ and ‘end well’ to the statement.
2. Throughout the remainder of the Vision statement, the Strategy and the Roadmap, the focus appears to be primarily on ‘getting well’. It is concerning that there is minimal emphasis on living or staying well; the focus is on what health services are required (designed for value and high performance) and how they should be delivered (people powered, closer to home, by one team, in a smart system). This, in effect, changes the vision for the Health Strategy into a Health Care Services Strategy. With the Strategy being focussed only on the health system, it will be unable to deliver on its stated intent of living and staying well.
3. We are disappointed that the government’s disability strategy has been separated from the health strategy. The Strategy talks about ‘the health and disability system’ but barely mentions people with disabilities or impairments and how they will be supported.

#### Health equity

1. We acknowledge the use of the word ‘all’ in the vision statement, noting that “the word ‘all’ was chosen to reflect the important need for this Strategy to reduce disparities in health outcomes, and make sure the health system is fair and responsive to the needs of all people — young and old, from all ethnic groups, and wherever they may live”. The NZCPHM considers that the use of “all” is insufficient to generate the level of attention that the current disparities deserve.
2. Compelling health inequities exist in New Zealand by ethnicity and socioeconomic status. These inequities are large, pervasive, and persist across the lifespan and over time. The NZCPHM is committed to a vision of a fair and just society where action is taken to remove the avoidable differences in health outcome. Reaching this vision will require national commitment to achieving equity in access to the determinants of health such as income, education, housing and access, timeliness and quality of health care.
3. It is imperative that an explicit focus on health equity for all groups, but particularly for Māori, is included in the Strategy and the Roadmap.
4. Health equity means having equal opportunity to stay healthy, not just equal access to health care services once people are sick. That is, ‘health’ should be equitable, not just ‘health care outcomes’ as a result of being in the health system. In order to reduce avoidable inequalities in health, the Strategy must take account of conditions in our wider society that contribute to health inequities and activate the levers that can make a difference.
5. “Action taken to reduce health inequities through action on the social determinants of health will benefit society in many ways. It will have a profound effect on the quality and longevity of life for everyone, and not just those at the bottom of the gradient, those who suffer the most from material deprivation, or those who are exposed to negative life course events. There is also a profound effect for the economy. Productivity losses through illness, societal costs associated with effects of mental illness, violence, including the costs of law enforcement and incarceration, numbers of people receiving benefits should all be decreased.

The ever increasing costs of healthcare are, in part at least, a result of increased treatment costs for conditions that could have been largely prevented through action on the social determinants of health. Addressing the social determinants of health is not just a way to achieve better health equity, but a critical measure to ensure the financial sustainability of the health system. Action on the social determinants of health should therefore be a major focus for the health sector.

However, most of the social determinants of health lie beyond the mandate of the health sector. Actions are required in many non-health sectors, including local government, social development, transport, finance, education and justice. The health sector has a role in advocating for and actively encouraging inter-sectoral approaches to addressing the social determinants of health and the whole of society needs to be involved along with the whole of government.[[3]](#footnote-3)”

The NZCPHM strongly urges the Ministry to include a far greater emphasis on the above aspects of health equity in the final version of the Strategy.

#### Treaty of Waitangi

1. We note that that the principle “Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi” has moved from being principle no.1 in the original 2000 strategy[[4]](#footnote-4) to now being principle no.4. It is unclear whether these principles are in order of importance and this should be clarified in the document.
2. We recommend that ‘a commitment’ to honouring the Treaty is made, rather than just an ‘acknowledgement’. The NZCPHM recommends that this commitment includes prioritising improving Māori health and achieving equity in health between Māori and non-Māori in the Strategy.[[5]](#footnote-5)
3. It is noteworthy that the 2000 Strategy has a much greater explanation of the Treaty and what it means in reference to the Strategy. The 2000 Strategy identifies the ‘3 P’s’ (partnership, participation and protection) and identifies “other goals based on concepts of equity, partnership, and economic and cultural security must also be achieved”. None of this is mentioned or referred to in the updated Strategy and it is not clear whether the old strategy still applies. The Māori Health Strategy, He Korowai Oranga[[6]](#footnote-6), is briefly mentioned in the Update but it is not stated specifically that it will be used alongside the Strategy or that its concepts will be incorporated into this Strategy.

#### Wider approach needed

1. There needs to be considerably more emphasis on the social determinants of health and the importance of constructive working relationships with other government departments such as Education, Housing, Transport, Social Development and Employment. It is clearly apparent to those working in the public health sector that solutions to complex health issues will only be solved through a whole-of-government approach.
2. The NZCPHM recommends that the Strategy adopts a ‘Health in All Policies’ (HiAP) approach across all of government, with the Ministry of Health leading and promoting this approach. The WHO defines HiAP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.[[7]](#footnote-7)"
3. It could be **argued** that the inclusion of the new **eighth** principle of “thinking beyond narrow definitions of health and collaborating with others” would have negated our concerns that the Strategy was taking a ‘siloed’ approach to health. However this principle has inadequate attention throughout the rest of the document. The ‘Closer to Home’ theme makes some mention of collaboration across social agencies but in reality a collaborative approach at the highest level is required in order to provide the infrastructure for inter-sectoral collaboration to bear fruit.
4. Similarly, advocating that there should be ‘one –team’ is positive but unfortunately it focusses only on the health care team, other than a brief mention of collaborating with researchers. The team members could include iwi representatives, local government officials and councillors, school teachers, police officers and social workers. There are wider teams such as these already established in NZ.

#### Strategic Themes

1. People-powered is a term which has unclear meaning. The Roadmap describes the aim of having people-centred health services where people are partners in their health care. It is unclear where or how the ‘powered’ part of the term will be applied. We prefer use of the term ‘people-centred’ or ‘people and whānau-centred’.
2. In the Roadmap, the 5 year goals for a people-powered health strategy include people having access to information to assist them with choices and taking greater responsibility for their own health. This is commendable, but in order to have real control over their health, people need to be unhindered by physical, social, commercial and political environments that promote unhealthy practices, e.g. where it is easier to take the lift than the stairs at work because the stairs have security locks, or where the sugary drinks are cheaper and closer to the checkout in the supermarket than the milk. The Strategy should include how people will be supported to be healthy through policies and environments which promote healthy behaviours.
3. The NZCPHM agrees with the collaborative and supportive ethos behind the ‘one team’ theme but, as stated in para 20, the Strategy and Roadmap needs to go beyond a narrow definition of health and collaborate with other sectors to achieve wellbeing.
4. It is important to note that health care that is ‘closer to home’ does not necessarily result in better health outcomes.
5. The NZCPHM proposes that the five strategic themes should be amended to:
   * People and whānau-centred care
   * Reducing inequity
   * Working across sectors
   * High performing teams
   * Smart systems

#### Population health priorities

1. The original 2000 Strategy included 13 population health priorities. These are not restated in this updated Strategy so it is unclear whether there remains a commitment to these. Currently, there is minimal inclusion of specific actions to address the major preventable causes of poor health and premature death, which the NZCPHM considers to be a serious omission.
2. A significant example of this is the lack of mention of the current government goal of Smokefree Aotearoa by 2025[[8]](#footnote-8). Although it is declining, tobacco smoking is the number one preventable risk factor for health loss in NZ[[9]](#footnote-9) and is also a major contributor to health inequalities. The Roadmap does not include any plans on how to achieve the smokefree goal (e.g. higher tobacco taxes, restricting outlets, intensifying mass media campaigns etc.). Early in the Strategy document the need for a behaviour shift at system level ‘from treatment to prevention’ is identified, but this is not adequately followed through into the Roadmap.
3. The Roadmap refers to “implement a package of initiatives to prevent and manage obesity”. The NZCPHM suggests that the Childhood Obesity Plan[[10]](#footnote-10) be specifically stated if this is what is being implied, but suggests that this obesity plan is an insufficient package of initiatives to have an impact on obesity.
4. Climate change is inadequately addressed in the Strategy, only being mentioned as a global challenge without addressing the impact of climate change on New Zealanders. The NZCPHM considers that climate change is a serious, potentially catastrophic emerging risk to public health, sustainable development and equity. Projected climate change health impacts include malnutrition, deaths and injuries from extreme events, vector-borne disease such as dengue fever, cardio-respiratory effects from air pollution, and diarrhoeal disease. More diffuse effects include mental health problems, migrant health issues and the health issues resulting from civil tension and conflict. Well-planned action to reduce greenhouse gas emissions can bring about substantial health co-benefits and will help New Zealand address its burden of chronic disease.[[11]](#footnote-11)
5. The NZCPHM proposes that both the Strategy and the Ministry of Health have a role in increasing awareness amongst health professionals, governments and communities about the health implications of climate change and the need for health-promoting mitigation and adaptation.
6. The increasing emergence of antimicrobial resistance is an international health concern. It has been described by the World Health Organization as the third greatest threat to human health, ranking alongside terrorism and climate change.[[12]](#footnote-12) Reviews of the growing burden of antimicrobial resistance in this country have noted that resistance to many common antimicrobials is now endemic in New Zealand, in both community and healthcare settings.[[13]](#footnote-13) Therefore, the NZCPHM recommends that this significant health threat be included in the Strategy and appropriate actions included in the Roadmap.
7. Finally, additional significant challenges that are not included in the Strategy are health literacy, child poverty and end of life care.

Thank you for the opportunity for the NZCPHM to submit on the New Zealand Health Strategy Update. We hope our feedback is helpful, and would welcome the opportunity to assist the Ministry in any way.

Yours faithfully,

[redacted]

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| **331** | Submitter name | [redacted] |
| Submitter organisation | Alcohol Healthwatch |



4 December 2015

**Submission to the Ministry of Health**

**UPDATED NEW ZEALAND HEALTH STRATEGY**

**Introduction**

In responding to the update of the Health Strategy and the two documents - ***1) Future Directions*** and 2) ***Road Map of Actions*** - we are drawing on over 20 years experience addressing one of this country’s most pressing but marginalised and neglected health and social issue – alcohol-related harm.

We also draw on our experience in health sector more broadly, as a long term provider of health promotion services under contract to the Ministry of Health, members of the Public Health Association of New Zealand, Injury Prevention Aotearoa, and the Health Promotion Forum, and our participation in the discussions to-date on the review of the Health Strategy including attendance at two sector workshops.

Together with our ongoing multi-agency collaboration within other sectors provides us with a depth and breadth of knowledge and experience on which to comment on the draft Health Strategy.

1. **General Comments:**

We thank the Ministry of Health for the opportunity to comment on the updated Health Strategy. We wish to acknowledge the work that has gone into the review and consultation processes to date, and the role the Ministry of Health has played.

We acknowledge the many positive elements expressed in the **Future Directions** and **Road Map of Actions**.

Please note that our comments are not intended to be critical of the Ministry of Health or any of our valued colleagues in the Ministry. We also hope that our comments and recommendations assist in strengthening the next Health Strategy and wish to support this process as far as able.

However, it has to be said upfront that we are deeply concerned about the lack of clarity and specificity of the draft Health Strategy. We don’t believe that it a) clearly articulates the desired health and well-being outcomes and b) effectively respond to the needs or expectations of those working to achieve improved health outcomes or the communities they serve. Having two documents is in itself a barrier to understanding the strategy as a whole.

We believe that this will ultimately make it difficult to achieve the integration and cross-sector engagement desired.

The Draft Strategy doesn’t inspire. It talks about ‘change’ and ‘shift’ yet does not clearly articulate the actual change that we’re seeking. In order to do this we believe an honest and robust appraisal of progress against the existing health strategy needs to have been conducted. To our knowledge this hasn’t been done, and therefore the process undertaken hasn’t served the sector or health well. Undertaking a funding review and capability and capacity review without first establishing clear goals seems illogical.

If the Health Strategy is to be successful, and achieve integration across sectors it must clearly and concisely articulate:

* its aims, goals and objectives
* the health outcomes desired
* the strategic approaches and actions that will be taken to achieve these
* how activity will be co-ordinated
* what will be done to mitigate risks associated with achieving the goals
* what outcome indicators will used to monitor and measure progress
* how the delivery of the strategy will be resourced

Instead we see a set of “*principles*” largely the same as the previous Health Strategy, and broad “*strategic themes*” that require extensive explanation even to those within health. Outcomes aren’t clearly specified, most are vague and system oriented e.g. In 10 years *“we are good at identifying key health problems”.*

***The Future Directions*** is essentially a ‘pick and mix’ collection of ‘health-speak’ resulting in confusion rather than articulating a clear future direction, and the ***Road Map of Actions*** is essentially a limited list of unspecific (largely unmeasurable) actions towards a rather unknown destination. We don’t believe the documents will assist those of us in the Health sector to articulate our hopes and aspirations to others.

While the two documents contain many words, concepts and actions that we fully adhere to and support, they fail to articulate these in a way that will invigorate a largely disillusioned, tired and overwhelmed workforce, or encourage engagement and participation by other sectors, or provide a clear pathway to improving health and achieving equity.

We are not convinced the draft Health Strategy actually adds any value or improves the existing New Zealand Health Strategy (2000). Rather the existing Health Strategy provides a much simpler and clearer strategic framework. We would like to see the new strategy build on the strengths of the existing strategy and address its weaknesses and gaps. If we haven’t effectively implemented the existing strategy or its parts, or haven’t been able to, then understanding this and articulating this is paramount. Only then will be able to properly identify the challenges and risks to health in a changing environment, and how we will respond to these.

If alcohol-related harm was a marker of the success of our previous Health Strategy however, its implementation clearly demonstrates our incapacity to respond to a serious health issue. We suggest it also offers great learning for achieving better health outcomes.

As a participant at both sector workshops on the new Health Strategy we picked up several clear themes:

* Firstly, **frustration** – this was expressed in comments such as “I was here 15 years ago and had these same discussions, and are experiencing the same issues now”

Numerous restructures of the Ministry of Health, a focus on achieving “targets”, funding and programme cuts, challenges to our sector’s right to and desire to advocate for health, constantly dealing with the urgent and not having the time or resources to deal with the important.... are just a few of the reasons why many in the health sector are feeling tired, hopeless, and undervalued.

* Secondly, that **prevention** was seen as a priority, and a public health model was needed to enable this and achieve more equitable health outcomes, and to reflect the broader role of health. The report presented by Francesca Colombo, Health of the Health Division (OECD) indeed called for a “stronger emphasis on prevention” as her first response to what’s needed.

While prevention and public health were deemed very important by the sector, the sector itself clearly finds it difficult to lift its gaze from the “urgent” pressing issues of service delivery confronting front-line services. Conversations at workshop tables quickly reverted to front line service at hospitals, and the focus on individuals already experiencing ill-health. It was as if we didn’t have the language or the head space to remain prevention focussed – the sector hasn’t been supported to do this.

* Thirdly**, under resourcing** - most of the people at the workshops were people who have dedicated their careers and a significant part of their lives to caring for people, promoting and supporting better health. Yet there is a feeling that can best be described as fear or guilt when it comes to asking for the resources we need to do the job properly, and avoid the stress and burn-out that threatens many in the health sector.

The two documents talk about ‘investment’ yet are silent on where this investment i.e. money/resource will come from, and the necessary political and long term commitment to investment in order to reap longer term gains.

Public health is the model that can encompass health in its broadest sense, and support better health outcomes across the lifespan. However, taking a public/population health approach requires us to not just think about “service delivery” and “systems” in isolation but rather as means to achieve better health outcomes.

Neither of the two documents articulate the desired health outcomes – thereby missing the all important step between the broad concepts – such as the “guiding principles” and “strategic themes”, and the actions.

Utilising a public health approach would require us to consider and prioritise the promotion of health and well-being and equity first and foremost, and then to consider the risks and challenges to health and mitigate these.

Concepts such as prevention and the precautionary principle are core to public health approaches, as is achieving equity. A public health approach would challenge us towards re-orienting public services and building health public policy in order to achieve and sustain health gains.

In our view ***The Future Directions*** fails to acknowledge the significant risks to health or barriers to health that we have experienced or are experiencing, such as bird and swine flu, climate change and global warming, ebola, and the potential loss of health control measures through Free Trade Agreements; and how we intend responding to these. It’s not clear that we are learning from our experiences to date responding to these risks and threats, and planning to improve our capacity to respond to these. Subsequently the **Road Map** **of Actions** fails to adequately address these risks.

***The Future Directions*** most definitely fails to fully recognise the significant risk alcohol consumption poses to health. We have included a summary, which is by no means exhaustive list of the global and New Zealand burden of harm in the appendix.

***The Future Directions*** fails to acknowledge our international commitments such as United Nations Convention of the Rights of the Child, Sustainable Development Goals, Global Monitoring Framework for Non-communicable disease, or international agreements such as the Framework Convention for Tobacco Control, or international guides and strategies such as the Global Strategy to Reduce Alcohol-related harm.

The New Zealand Health sector cannot operate or thrive in a vacuum, and needs to genuinely respond to both the challenges and opportunities for health and well-being in a global context. The draft Health Strategy appears rather insular in this regard.

***The Future Directions*** fails to build on the **evidence base** that has already been established.

We recently attended the Global Alcohol Policy Conference 2015, Edinburgh Scotland, where the latest evidence and best practice on preventing alcohol-related harm was shared. Key themes from this event which was attended by over 400 people from over 60 nations include;

* The need to bring a **rights based approach** to our harm reduction efforts
* The need fora **binding legal framework** and that **the Governments of member states** will need to direct this.
* The need for **international alliances to be built and grown** – in NZ, trans-Tasman, Pacific and connecting Globally.
* That **“Best buys**’ are still the best buys
  + Reducing availability and accessibility
  + Increasing price (through taxation and minimum unit pricing)
  + Reducing exposure to alcohol marketing through comprehensive enforceable restrictions.
* That Free Trade Agreements are a significant threat, and require collective action to ensure they don’t undermine our efforts to minimise alcohol-related harm.

In New Zealand there is significant **political resistance** to implementing these evidence-based policies, despite strong public support and rigorous reviews recommending them.

In contrast political leadership was evidenced by Scotland’s First Minister Ms Nicola Sturgeon in her address.

“*No responsible government can ignore an issue that has such devastating consequences for the population that it serves*.”

“*The first responsibility of any Government is to the health of its population*.”

“…*I believe it is the duty of politicians and Government to lead by example*…”

***The Future Directions*** ascertains that our health system is performing well, with the measures tending to focus on demand driven service delivery outcomes to people already experiencing ill-health. We believe these forms of measurement give limited insight and represent an “ambulance at the bottom of the cliff” mentality. Continuing to focus on these types of measures will only serve to keep us stuck in “overwhelm”.

If we were to look at health outcomes in relation to alcohol, even just a tiny peak under the surface identifies significant deficits.

The Global Monitoring Framework for Non-communicable Diseases (NCDs) includes the voluntary target of a 10% relative reduction in harmful use of alcohol by 2025 measured against a 2010 baseline.

New Zealand’s National Drug Policy (2015 to 2020) indicates that in the six years to 2013/14 hazardous consumption of alcohol decreased from 18% to 16%.

While sitting firmly in the health domain, alcohol-related harm also sits across almost all other social domains yet it is not fully recognised by any. This has resulted in;

* The healthy choices are made most difficult by a failure to address alcohol availability, accessibility, marketing and other evidence-based policies.
* Responses are knee-jerk and reactive rather than planned and preventive.
* Evidence based policies and interventions are consistently rejected, and the focus is on the policies and strategies least likely to reduce harm.
* Information is not systematically collected and/or reported, so policies and strategies to address alcohol-related harm are poorly informed, not able to be properly evaluated.
* The work-force is splintered and uncoordinated.
* Alcohol harm prevention efforts experience gross under-investment.
* No clear policy leadership within the Ministry of Health.

We don’t believe these issues are specific to only to alcohol, rather that similar issues are experienced by those attempting to address other health issues which collectively contribute to a massive avoidable burden.

A “Better public services approach” while sounding good in theory can lead to a narrow systems view rather than a broader social determinants perspective where we would identify the real reasons people are in need of these services in the first place, and addressing these in order to identify prevention measures and implement those.

1. **Specific comments and recommendations for the next Health Strategy to more effectively reduce alcohol-related harm.**

Like any health and/or social issue alcohol-related harm requires a strategic and comprehensive response, and a long term commitment.

The **Road Map to Action** includestwo actions relating to addressing alcohol-related harm.

1. Increase support to pregnant and post natal women experiencing mental health and alcohol and other drug conditions.
2. Lead the development ofa plan to improve the health system’s response to children and families who are living with Fetal Alcohol Spectrum Disorders.

While we support these actions, they fall well short of a comprehensive response to alcohol-related harm. Below we give three examples where HEALTH is impeding rather than supporting efforts to reduce alcohol-related harm.

* **Addressing Fetal Alcohol Spectrum Disorder**

Both the **Road Map** and the **National Drug Policy** identify a commitment to **publish** a plan for **FASD,** something we have been calling for many years. However we note a) that this plan was called for by the Health Select Committee in 2013, and the development of the plan has already progressed, therefore publishing a plan hardly represents a major strategic commitment b) publishing of a plan is only the beginning, without a commitment to the effective implementation of the plan it is nothing but words on paper.

We also note that families living with FASD and other experts on this matter have had to demand engagement in the planning process to-date. While individuals within the Ministry have worked diligently to strengthen connections and relationships with key stakeholders, we believe this has been hampered by the having no allocated resources for developing the FASD plan from the start, and that reflects poorly on Government commitment to act on its own words.

The **“Call to Action”** developed by participants at a national symposium on FASD in 2014 maps out the needs of families and those in the health and social sectors. It presents an opportunity for Health to acknowledge existing experience of those working to address this issue, and demonstrate a commitment to a shared approach to planning.

* **Sector driven planning and collaboration**

In Auckland we have lead the collaborative development of an Action Plan to address alcohol-related harm. This has been developed without the support of a national alcohol strategy and without the guidance of an up-to-date National Drug Policy.

We are now working to implement the plan with our planning partners including NZ Police, Auckland Council, Hapai Te Hauora, Auckland Regional Public Health Service, Community Alcohol and Drug Service, Health Promotion Agency and a wider group of regional stakeholders.

We have established an outcomes indicator framework with support from our research partner Dr Taisia Huckle, Massey University, and published our first report on these. We have employed two interns from the University of Auckland to progress two special projects 1) information development and 2) equity framework development. This has all been achieved without any additional resources.

One of our plan’s priorities is to establish a comprehensive and sustainable programme of screening, brief intervention and referral to treatment (SBIRT) - one of our evidence-base outcomes. However, attempting to do this without additional resource is proving extremely challenging. We have a dedicated and committed Working Group established but progress is hampered.

Alcohol is not considered a priority, and there is a focus on other health “targets”. Despite willingness by a number of health professionals to progress SBIRT, the systems and processes are not there, and resources cannot be drawn from other aspects of their service. While other districts have been able to get SBIRT programmes in place, Auckland has additional challenges including having three DHBs, three Police districts and a larger population.

Some PHOs are delivering SBIRT but it is piece-meal and very difficult to get useful information about the reach and practice of this.

We are aware the Ministry of Health is undertaking a pilot to “screen” for alcohol involvement in five DHB emergency departments (not including Auckland), however this appears to be an information gathering exercise. Our group is concerned that a) it is at best a “pre-screen” and b) that there are no plans or resources to ensure that individuals who might present with problematic alcohol use are given the information and help that they have a fundamental right to.

* **Effective implementation of alcohol legislation and inequity**

Earlier this year we co-hosted three regional forums with the Health Promotion Agency. These provided the sector with on opportunity to discuss how the **Sale and Supply of Alcohol Act 2012** was working.

The report on these forums identifies significant issues with the Act’s implementation. It identifies significant deficits in Health’s capacity and capability to ensure the Act’s effective implementation. There are also serious issues in relation to the level of protection the Act is actually offering to communities and their health. In fact, the requirements on already disadvantaged communities to oppose licence applications, provide a level of evidence that they simply do not have access and attend hearings (for sometimes days without any support) raises more serious issues of further inequity.

These are just three areas of work that we are actively engaged in where HEALTH’s response to a significant health issue is exposed as wanting. We could provide numerous other examples such as lack of action on warning labels, alcohol marketing, price controls etc.

**Recommendations:**

We strongly recommend that the new Health Strategy

1. Includes explicit aims to improve health outcomes and reduce inequities.
2. Reflects a wellness /Pae Ora model (mauri ora/whānau ora/wai ora) as opposed to a ill-health model
3. Utilises a public health framework to establish goals, objectives and strategies including improving public policy, creating safer environments, re-orienting services – with the prevention of ill-health and promotion of health and wellbeing as its primary goals.
4. Identifies specific health outcomes and indicators on which to monitor and measure progress against these.
5. Clearly articulates strategies and specific objectives to improve responsiveness, build capacity and capability of the workforce and the communities they serve, mitigate risks, and improve service performance towards achieving the outcomes.
6. Specify the actions that will be taken to advance these strategies and achieve the objectives.
7. Explicitly and transparently enable sector and community input into planning and policy development and include actions to enable this.
8. Explicitly include the reduction of alcohol-harm prevention as an objective
9. Explicitly commit to an evidence-based approach – for alcohol that would mean including strategies to
   * Reduce accessibility and availability of alcohol
   * Restrict alcohol marketing
   * Increase the price of alcohol
   * A comprehensive programme of Screening, Brief Intervention and Referral to Treatment.
10. Explicitly commit resources to enable the effectively delivery of the actions identified, including the plan to address FASD.
11. Identifies a set of national indicators for alcohol-related harm, and allocates the necessary resources to monitor these.
12. Commits resources to a comprehensive and co-ordinated research strategy to ensure we have the necessary data and information to report on alcohol-related harms and to properly evaluate the effectiveness of policies and programmes.

**Contact:**

[redacted]

Director

Alcohol Healthwatch

Ph [redacted]

**Appendix**

Globally, harmful use of alcohol causes approximately 3.3 million deaths every year (or 5.9% of all deaths), and 5.1% of the global burden of disease is attributable to alcohol consumption. Alcohol is a leading risk factor for global burden of disease,[[14]](#footnote-14) and the single leading risk factor for death and disability in young people.[[15]](#footnote-15) It is a causal factor in 60 types of diseases and injuries (intentional and unintentional) and a contributing factor in 200 more.[[16]](#footnote-16)

Alcohol is attributed to a myriad of harms such as cancer, liver cirrhosis, cardiovascular disease, dependence, depression, suicide, family disruption, family violence, sexual violence, child neglect and abuse, injuries, vandalism, crime, public disorder, financial problems, educational and work related issues, loss of work productivity and broader social harm.[[17]](#footnote-17) The range and magnitude of harm extends beyond the drinker and the harm experienced by an individual from others’ drinking is more significant than previously thought.[[18]](#footnote-18) Alcohol use is linked to the incidence and clinical outcomes of infectious diseases such as tuberculosis, HIV/AIDS and pneumonia.

Alcohol has been identified as one of the main risk factors for Non-Communicable Diseases (NCD), and as such a target of reducing the harmful use of alcohol by at least 10% has been agreed by World Health Organisation Member States as part of the Global Action Plan for NCDs 2013-2020.[[19]](#footnote-19)

The World Health Organisation also recognises that it is often afforded a low priority in public health policy.

“ ...*harmful use of alcohol can also have serious social and economic consequences for individuals other than the drinker and for society at large (e.g. Anderson et al., 2006; Sacks et al., 2013).* ***Despite the large health, social and economic burden associated with harmful use of alcohol, it has remained a relatively low priority in public policy, including in public health policy.”***

*From the World Health Organization’s Global status report on alcohol and health 2014.*

In New Zealand:

* New Zealanders consume more alcohol per capita than the world average.[[20]](#footnote-20)
* One in five past year drinkers have a hazardous drinking pattern.[[21]](#footnote-21)
* Alcohol consumption is responsible for 5.4% of deaths and 6.5% of disability-adjusted life years lost by New Zealanders under 80 years of age.[[22]](#footnote-22)
* Between 800 and 1000 New Zealanders die from alcohol-attributable causes every year and many thousands more experience physical, emotional, health, disability, social and economic harms from their alcohol use.[[23]](#footnote-23)
* More than half of alcohol-related deaths are due to injuries, one quarter are due to cancer and one quarter are due to other chronic diseases.[[24]](#footnote-24)
* In one year, an estimated 83,000 New Zealanders – meet the diagnostic criteria for alcohol use disorder. Of this number, more than 53,000 are aged between 16 and 24 years of age, comprising just over 7 per cent of the total population in this age group. Over the course of a lifetime an estimated 11.4 per cent of us will have met the criteria for alcohol abuse.[[25]](#footnote-25)
* Alcohol is implicated in a third of all violence,[[26]](#footnote-26) a third of all family violence[[27]](#footnote-27) and half of all sexual assaults[[28]](#footnote-28) and homicides.[[29]](#footnote-29) Young adults with alcohol dependence symptoms are four to twelve times more at risk than others to be involved in violence, whether as offender or as victim.[[30]](#footnote-30)
* Between 20 to 50% of young New Zealanders who commit suicide are intoxicated at the time of their death. Twenty five per cent of young people presenting to general hospitals following a suicide attempt have some level of harmful or dependent use of alcohol. [[31]](#footnote-31)
* Alcohol accounts for almost one-fifth of intentional self-harm hospitalisations and unintentional poisoning fatalities.[[32]](#footnote-32)
* Alcohol is the second biggest contributing factor to road crashes in New Zealand.[[33]](#footnote-33) Alcohol-related deaths as a percentage of all road fatalities have increased since 2000.[[34]](#footnote-34)
* Alcohol is a direct or indirect factor in approximately 45% of fire fatalities each year.[[35]](#footnote-35)
* Alcohol consumption on boats is a direct cause of around three deaths each year.[[36]](#footnote-36)
* Between 20 to 25% of workplace injuries involve intoxicated workers.[[37]](#footnote-37)
* One in four New Zealanders are negatively impacted due to someone else’s drinking.[[38]](#footnote-38)
* About 40% of those injured and 25% of those killed in alcohol-related traffic crashes are harmed due to others drinking.[[39]](#footnote-39)
* Between 2005 and 2007 an average of 61 children and young adults aged between 4weeks and 24 years died because of their or someone else’s drinking.[[40]](#footnote-40) Almost all injuries to children in alcohol-related crashes are attributed to someone else’s drinking.[[41]](#footnote-41)
* Alcohol is also considered to be a factor in poor supervision of children, in child abuse and neglect.[[42]](#footnote-42)
* It is estimated that at least 600 children are born with Fetal Alcohol Spectrum Disorder (FASD) every year.[[43]](#footnote-43) Alcohol consumption during pregnancy is the leading preventable cause of intellectual disabilities and birth defects in the developed world.[[44]](#footnote-44)
* Alcohol abuse is 2.3 times more prevalent than drug abuse and alcohol dependence is 1.8 times more common than drug dependence.[[45]](#footnote-45)
* Alcohol-related harm is strongly linked to the availability and accessibility of alcohol.[[46]](#footnote-46)
* Harm from alcohol is estimated to cost New Zealand $4.9 billion a year.[[47]](#footnote-47)

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| **332** | Submitter name | [redacted] |
| Submitter organisation | Pegasus Health (Charitable) Ltd |



3 December 2015

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

Wellington

**Subject: Update of the New Zealand Health Strategy**

Thank you for the opportunity to submit on the Consultation document of the Update of the New Zealand Health Strategy. It is timely that the New Zealand Health Strategy of 2000 is updated to help guide New Zealand’s health systems into the future.

In preparing this, we look to our own experience as a partner in the Canterbury Health System and the body of literature that supports health systems transformation.

There are aspects of the Draft Strategy that we are supportive of. We support the retention and expansion of the principles on which the Draft Strategy is based and broadly agree with the five themes and in particular that we must have a health system that is people-centred. However, we believe there are areas in the Draft Strategy that need strengthening and/or reorienting.

## Overall

There is little to no referencing to the literature around health system transformation, including from New Zealand related literature.[[48]](#footnote-48) The guiding principles that are outlined are not well reflected in the document or the action areas.

The Draft Strategy purports to have a people focus. However, the focus of the document is almost exclusively on the health system. The overview diagram of the NZ Health and Disability System (Fig 10) appears to be a funding and contracting model. This would be better represented if the diagram depicted the systems and services from the people’s perspective.

We would expect in a people-focused health strategy to:

* Look at health outcome improvement from a big picture point of view, recognizing more strongly the wider determinants of health and effective strategies
* A strong population health focus as per the Triple Aim. This would include identifying highly effective health promotion strategies to address health outcomes at system level, for example taxation, regulation and policy approaches. Only less effective strategies have been identified. This is particularly important as obesity has been made a priority area and this is one area that the health system has little to no impact on improving. Personal interventions have limited impact and a system wide, health promotion approach is required.
* We recognize the impact that the social determinants of health have in keeping people well eg education, housing, employment, therefore we fully support initiatives aimed at integrating the health and social sectors.
* Represent equity of access and equity health outcomes strongly throughout the document, not only in the principles. When considering equity, we support the concept of proportionate universalism[[49]](#footnote-49) – actions must be universal, however to reduce health inequities, scale and intensity should focus on the disadvantage proportionate to the level of disadvantage
* Use clear terminology that is not open to misinterpretation. We find the term people-powered ambigious
* A strong focus on groups with poorer health status – Māori, Pacific and low socioeconomic
* Recognition of the needs of all health services to services that are responsive Māori and Pacific rather than only Māori and Pacific providers. This is because most Māori and Pacific people use mainstreams
* Identification of Culturally and Linguistically Diverse Populations (CALD) and their specific needs, in particular interpreter services, as this is a growing group within New Zealand
* Identification of people with disabilities or older people

## Primary Health Care and access

Primary health care services are vital to maintaining and promoting the health of our populations. The strength of a country’s primary health care system is associated with lower rates of premature death (all-cause and from long term conditions) and improved health outcomes. Quality primary health care is also able to reduce the adverse association of income inequality with general health and reduce health inequalities. [[50]](#footnote-50)

Noting this, we feel that the Draft Strategy has a limited emphasis on the pivotal role that primary health care takes in keeping people well and managing long term conditions. We suggest an increased emphasis on primary health care. In addition, we suggest that there should be an emphasis on access to primary health care services. The Draft Strategy states as a strength, that we have a universal health care system. However, despite increased investment in health care over the years and improvement in access, there is still considerable evidence that many people have poor access to health care services, most problematically, primary health care services.

Poor access to primary health care services can exacerbate inequities in health outcomes. Ensuring primary health care services are accessible across all groups is a critical part of ensuring that health services are effective for all population groups. In identifying access as a focus area, we suggest that a systems based approach is needed to address access.

We support a clinically lead, patient focused primary care health sector and we believe in the value that sustainable general practice brings to the NZ healthcare system. Therefore we support maintaining the value of funding for primary care and the ability to charge appropriate co-payments. The practice based VLCA model of funding for general practice should be transitioned to a more patient focused funding model.

The IPIF framework was developed to encourage system wide integration and quality improvement within the health sector. We support the continued implementation of this framework as it was originally conceived.

In our view, it is important that a significant degree of regional autonomy is maintained within the health system. This will allow for improved responsiveness to the needs of local populations.

## Leadership and health systems transformation

Leadership is critical to successful health systems transformation. The model that has been successful in Canterbury is a diffuse, systems wide leadership model that is based on high level of trust and low bureaucracy. Everyone is encouraged to take their role in making the Canterbury Health System operate as one system.

The model that is presented in the Draft Strategy is a centralised one. It identifies the Ministry of Health as the key leader without an emphasis on the importance of leadership across the system. While New Zealand looks to Ministry of Health to identify outcomes to achieve, it is counterproductive to be prescriptive and have an overly centralised model of leaderships. The Ministry of Health has a role as leader, but also very importantly an enabler of leadership.

## Māori

Māori are Tangata Whenua and therefore we would fully expect Māori to feature strongly in the NZ Health Strategy. We believe this should be greatly strengthened and a strong link made to the recently updated He Korowai Oranga: Māori Health Strategy and its principles and action areas.

## Action Areas

### Action areas 1 and 19

We support the use of social media for people with all long term conditions as an effective means of managing behaviour and lifestyle changes and not just those with diabetes.

We strongly support the development of a national electronic health record. The HealthOne system in Canterbury has been instrumental in improving access to health information for individuals by the entire healthcare team which in turn has also improved patient outcomes. We suggest that HealthOne be used as a model for the national EHR.

Patient portals are useful tools to allow people access to their health information. While we are supportive of these, we believe that patients should be able to access all their health information via one portal rather than multiple portals. Therefore the action to expand the number of users of the integrated health record for pregnant women and children is not supported as this would increase the fragmentation of health information.

### Action area 3

The concept of moving secondary care services into primary care is strongly supported. Canterbury has a long history of successfully realigning health services in this direction. More recently it has used the alliancing model to achieve this in a system wide approach. We support this model being used nationally.

### Action area 4

We support removing the legislative barriers to allowing a broader range of health practitioners to prescribe in limited circumstances.

### Action area 5

Primary care has a significant role to play in the management of long term conditions. In this endeavor, it needs to be supported by strategies that reduce barriers to accessing healthcare; encourage cross sectorial collaboration and effective health promotion strategies.

### Action area 6

The principle of a great start for children, families and whanau is strongly supported. We believe that primary care is the point of continuity of healthcare for most people and therefore should be integral to these strategies; either in the provision of the initiatives or closely aligned.

### Action areas 8 and 9

We strongly support the development of a health outcomes framework and would like to work collaboratively to achieve this.

### Action area 11

The use of an investment approach for targeting the health needs of high need populations is supported.

### Action area 18

We support the strengthening of the national analytical capability and believe that Primary Health Organisations are well placed to make a significant contribution in this area. Removing barriers to appropriately access national data on their enrolled populations would be beneficial. The Canterbury model of HealthSafe, where with the appropriate governance, patient data from a variety of sources, is able to be linked together, de-identified and used to inform clinical and system improvements, is recommended for consideration nationally.

Kind regards

[redacted]

CEO

Pegasus Health (Charitable) Ltd

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| **333** | Submitter name | [redacted] |
| Submitter organisation | National Maternity Monitoring Group |

19 April 2016

Chai Chuah

Director-General of Health

Ministry of Health

PO Box 5013

Wellington

Dear Chai,

**New Zealand Health Strategy consultation**

Thank you for taking the time to attend the National Maternity Monitoring Group’s (NMMG) meeting on 26 November to discuss the review of the New Zealand Health Strategy.

We were interested to hear about the challenges and opportunities for the health system, and the five strategic themes: *people-powered, closer to home, value and high performance, one team* and *smart systems*. It was good to have the opportunity to discuss how these themes impact maternal and child health services.

* The *People-powered* theme is related to health literacy and helping the population to understand what they can realistically expect from maternity, labour, birth and neonatal services. Once work has started to take effect in the Maternity Information Systems Project, the sharing of health care information (between providers and consumers) via a maternity portal will assist this to be achieved. The use of technology can also help ensure that health consumers are directed to reliable information sources to help them take control of and better understand their health condition. Such resources can also provide information on what consumers can realistically expect from those health services.
* The *Closer to home* theme sits well with the work we are currently doing around investigating access to, provision and use of rural and primary/community maternity facilities and services.
* The *Value and high performance* theme reaffirms the current systemised approach already demonstrated in maternity services with the use of guidelines and a quality focused approach. As noted below, this theme in particular resonated with the NMMG because of the Maternity Standards, the Maternity Quality Initiative (MQI) and the Maternity Quality and Safety Programmes (MQSPs) that are already embedded in DHBs. These existing programmes involve not only maternity health practitioners but also the women to whom they provide the services.
* The *One team* theme states the importance of leadership and mentoring as identified in the MQSP.
* Lastly, the *Smart systems* team will promote cross sector engagement across maternal and child health services.

The NMMG were concerned to hear that *quality* is not identified in the strategic themes but reassured that you noted it should be there and we concur. We feel that this could be captured by changing the third theme to ‘*Value and high quality performance’*. We have identified through our work that the quality of maternity care can be inconsistent nationally which has the potential to impact equity within and across regions. The MQI is a good example of how we have noted the importance of quality through the Maternity Standards, from both national and local leadership. The combined support provided by the Ministry and the NMMG for the MQSPs nationally has helped the creation of, and support for, leadership and mentoring roles in DHBs. Undertaking the development of the Maternity Standards, and aligning these with MQSPs, achieves both a national and regional understanding of how to achieve an improvement in quality of care provided to women and their babies. Whilst the DHBs were slow initially, their enthusiasm now for the MQSP is a model that perhaps could assist with the roll out of the revised strategy. Many DHBs and practitioners can now see the positive results that this focus on quality has had to the maternity services they offer within their DHB.

The *Value and high performance* theme also recognises the need to make better use of funding. The NMMG discussed with you the importance of disinvesting from treatments that are no longer the best option based on current evidence. The National Screening Units recent decision to disinvest in the HIV Screening Programme is one example. The other aspect of this issue is direct to consumer advertising which creates consumer demand through private providers. This can then quickly impact on publicly funded health services sometimes with little or minimal evidence. A recent example is the Non-Invasive Prenatal Testing. Investing in evidence that treatments are either no longer appropriate, or should not be funded by the public heath dollar due to the lack of evidence, could result in significant financial saving if funding for those ineffective treatments, tests or investigations were better managed or ceased.

Thank you again for attending our meeting. We look forward to meeting with you again in 2016.

Kind regards,

[redacted]

**Chair, National Maternity Monitoring Group**

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

|  |  |  |
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| **334** | Submitter name | [redacted] |
| Submitter organisation | The Australian and New Zealand College of Anaesthetists (ANZCA) |

December 7, 2015

Mr Chai Chuah

Director-General of Health

Ministry of Health

PO Box 5013

Wellington 6145

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

Dear Mr Chuah

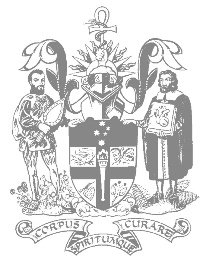
**Update of the New Zealand Health Strategy: consultation draft**

Thank you for the opportunity to provide feedback on the draft update of the New Zealand Health Strategy. The Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine, is the education and training body responsible for the postgraduate medical training programs and continuing professional development in anaesthesia and pain medicine for New Zealand and Australia. ANZCA’s mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine. The New Zealand National Committee (NZNC) of ANZCA has considered the update of the New Zealand Health Strategy, as well as the Capability and Capacity Review that informed the update of the Health Strategy.

Overall, the revised Health Strategy sets a positive aspirational direction for the health sector. The NZNC supports and commends a number of the espoused themes embedded in the strategy, in particular: collaboration and team work; fostering a culture of quality improvement; developing stronger clinical leadership in the health sector; people-centred healthcare; prevention of chronic conditions such as obesity; investment in information and communication technology to improve electronic health records and foster better health data collection and analysis; and an investment approach to healthcare.

Specific comment and feedback to improve the revised strategy further is set out below. This feedback also takes the Capability and Capacity Review into account.

*1. Health equity*

Inequity of health outcomes is still a major issue in New Zealand. In the 2013/14 New Zealand Health Survey, it was clear that priority populations including Māori, Pacific peoples, and those living in the most socioeconomically deprived areas in New Zealand had higher rates of unmet need in terms of access to primary care. Similarly, these populations had higher rates of long-term conditions such as obesity, diabetes and hypertension. Māori and people living in more deprived areas were also more likely to experience chronic pain, and inequitable access to specialist services (such as Pain Medicine) is a real issue, due to a shortage of specialists.

The revised Health Strategy refers to health equity and access issues, and the NZNC commends the Ministry for retaining equity issues as a component of the strategy. However, there is an apparent decrement in equity emphasis from that expressed in the 2000 Health Strategy despite little apparent resolution of equity issues. The NZNC recommends strengthening the equity components of the revised strategy and including more explicit acknowledgement of the social determinants of health and the need to achieve equity in health outcomes. The Health Strategy is an important document for guiding the health sector, offering an opportunity to keep equity of health outcomes front and foremost as the sector develops over the next ten years.

*2. End of life care*

The title of the revised Health Strategy includes the phrase “All New Zealanders live well, stay well, get well,” referring to health care and quality of life across the whole life course. This concept is commendable, however, end of life care is an important part of health and well-being across the life course, and is missing from the strategy. The NZNC recommends that end of life care should be included as a key component of the health strategy, particularly the right of terminally ill patients to dignity and comfort at the end of life, and access to expert palliative care. There is a great deal of public interest in end of life care issues currently, as demonstrated by the petition to parliament for the health select committee to investigate public attitudes towards medically assisted dying. ANZCA’s professional document *PS38 Statement Relating to the Relief of Pain and Suffering and End of Life Decisions* outlines ANZCA’s position on end of life care, and is available here:

<http://www.anzca.edu.au/resources/professional-documents>

*3. Choosing wisely*

The “people powered” theme of the revised Health Strategy talks about understanding people’s needs, empowering people to be more involved in their health, and building health literacy. The NZNC recommends including another component to this theme about clinicians and patients having conversations to facilitate wise decision making about the most appropriate care for the individual, including questioning whether or not various tests, treatments and procedures are necessary. This is a key aspect of the “Choosing Wisely” campaign that has gained traction internationally, and that the medical profession in New Zealand is beginning to consider.

*4. Developing leadership within the health sector*

The NZNC commends the focus in the revised Health Strategy of developing pathways to foster clinical leadership and talent development in the health sector. To develop better clinical leadership within the health system, pathways will need to be created to make leadership a viable career option for clinicians.

*5. Collaboration between District Health Boards*

“One team” is a theme of the revised Health Strategy, with the vision of having a health system that “is more than the sum of its parts.” Better collaboration and sharing of best practice between District Health Boards would fit under this theme, and would have major benefit to the health sector. However, the Capability and Capacity Review identified that currently District Health Boards are fragmented and siloed, and work in a divisive and competitive system that limits collaboration and cooperation.

The Capability and Capacity Review states that new incentives and capabilities are needed to work across the arbitrary boundaries of District Health Boards. Incentivising collaboration may have some success, and should be explored. However, a key factor that fragments the health sector is the absolute number of District Health Boards with respect to the size of the New Zealand population.

With the revision of the New Zealand Health Strategy, and reviews into funding arrangements and capability and capacity gaps in the health sector, it would be timely to consider reducing the number of District Health Boards to facilitate the healthcare sector to collaborate as a New Zealand-wide system. Indeed, in the absence of such a review we suspect that the proposed incentivisation will be of limited penetrance and is likely to be largely ineffective.

*6. Information Technology*

The draft Health Strategy and the Capability and Capacity Review both have a strong focus on information and communication technologies. The NZNC sees huge value in a nationalised information technology system that can reduce both fragmented care and duplication by facilitating health practitioners to have better access to patient records and medical data across primary, secondary and tertiary care, and across District Health Board boundaries. The current approach to acquisition and management of these technologies would appear to be hampered by the aforementioned siloed nature of the multiple DHB model of healthcare delivery.

*7. Data collection*

The “smart system” theme of the revised Health Strategy discusses better collection and utilisation of data to improve evidence-based decision making and clinical audit. The NZNC strongly supports collecting and analysing health outcome data at the team level to benchmark practice; drive continuous improvements in safety and quality; improve transparency; and enable clinicians to better discuss the risks of interventions with their patients. Isolated areas where this has already been done (such as the Australasian Vascular Audit Program and the New Zealand Joint Registry) have great potential.

However, overall, existing data is of poor quality and cannot meaningfully be used to assess outcome variation or the performance of teams. As such, the NZNC considers that significant investment is likely to be necessary if useful data is to be gathered, analysed and used to direct policy and practice.

*8. Uptake of new technologies*

Action 20 in the roadmap refers to developing capability for effective identification, development, prioritisation, regulation and uptake of knowledge and technologies, as well as developing a regulatory scheme to support the assessment and uptake of medical devices and therapeutic products.

The NZNC strongly supports implementing a standardised and efficient way of evaluating new technologies that takes into account evidence of efficacy as well as safety/lack of harm. Currently, new technologies may enter the country at substantial cost not necessarily supported by robust evidence. Loose governance of this domain may foster unwise spending of the healthcare dollar and offers potential for substantial harm. As such, the NZNC would welcome improved capability and regulation for evaluation and uptake of medical devices and therapeutic products.

We also suggest that processes for the evaluation of new knowledge and technologies should define those terms in a broad sense to include not only medical devices and therapeutic products but also to encompass novel techniques and models of care.

*9. Clinician-led research*

Action 20a of the roadmap outlines that the Ministry of Health, the Ministry of Business, Innovation and Employment and the Health Research Council will work together to better align and strengthen the impact of health research in New Zealand.

It is unclear what “better aligning” the impact of health research in New Zealand means, and we recommend clarifying this action further. If the intention of this action is to direct research funds to align with government priorities, the NZNC urges some caution. Although such an approach is not without merit, insofar as there is a place for research that aligns directly with government priorities (for example, recent research around rheumatic fever), the NZNC would like to emphasise that this should not be to the exclusion of independent clinician-led research. To drive dynamic innovative healthcare research that will benefit the sector, it is essential that contestable funds are available for original ideas not yet conceived by policy makers. Individual clinician-led research offers dynamism difficult to emulate even by well aligned Ministries.

The NZNC would, however, welcome government involvement in strengthening the impact of clinician-led research in the New Zealand health sector, in terms of disseminating results and helping to implement practice change as a result of research. A good example of this is the support the Health Quality and Safety Commission has provided to promote surgical safety checklists, as a result of clinician-led research across multiple countries (including New Zealand) into a surgical safety checklist to reduce complications and mortality following surgery.2-4

*10. Shifting focus to primary care*

The revised Health Strategy includes the theme “closer to home” encompassing a focus on preventing long-term conditions, taking an investment approach to health, and better access to primary care and community services. The Capability and Capacity Review supports this, suggesting that a significant amount of activity provided in the secondary and tertiary sector needs to be redistributed to non-hospital based settings.

The NZNC commends the focus of preventing long-term conditions, and agrees that more investment in the primary care sector is needed. However, increasing investment in the primary care sector should not be at the immediate expense of investment in the secondary and tertiary sectors. Certainly increased focused primary care has potential to delay the onset, or prevent the development of a variety of serious conditions and increase quality adjusted longevity, which is of significant value to the population. However, an inevitable time lag will exist between the implementation of preventative strategies and realisation of their benefits. During that interval full support to secondary and tertiary services will need to be maintained if a decrement in quality is to be averted. Longer term funding balance between hospital-based and primary care will require good data to inform the efficacy of preventative interventions.

Thank you once again for the opportunity to provide feedback, and we look forward to seeing the revised health strategy evolve further following the consultation period. You are welcome to contact us if you would like to discuss any aspects of our submission. If you have any questions, please contact [redacted] (Senior Policy Adviser) in the first instance, at [redacted]

Yours sincerely

[redacted]

Chair, New Zealand National Committee

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2. Hannam J.A, Glass L, Kwon J, Windsor J, Stapelberg F, Callaghan K, et al. A prospective, observational study of the effects of implementation strategy on compliance with a surgical safety checklist. BMJ Quality & Safety 2013: 22: 940-7.

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| **335** | Submitter name |  |
| Submitter organisation | Green Cross Health |

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| This submission was completed by: *(name)* | Green Cross Health |
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| Organisation (if applicable): | Green Cross Health |
| Position (if applicable): |  |

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

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

on behalf of a group or organisation(s)

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

## 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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| One of the challenges, also an opportunity, is the need to address the alignment of incentives and funding across providers. If there is a desire to expand the roles of primary care providers to have them operate at the top of their scope this will be critical to enable this change.  If we are serious about having people choose where they have their healthcare delivered, then funding needs to follow the patient. It needs to be an enabler not a barrier. Silos need to be broken down. If real change is to be effected funding discussions have to occur hand in hand with any changes to the strategy.  It has already been noted in the draft that the amount of financial resource required to fund the models of care is significant and current models are not sustainable. There still appears to be no appetite to explore a user pays mechanism. Surely freeing up funding for those who can pay and are willing to should be explored? There are a number of different examples where people see value in accessing certain services and care and will fund that accordingly themselves. Merely shifting the same pot of funding around is not the way to address the growth in care and support requirements.  One of the key challenges is balancing the funding to support preventative health and the ability to show outcomes. Not resourcing preventative health appropriately, particularly in at risk populations before the disease presents is key to reduce spend on illness and allows the focus to switch to wellness. |

### The future we want

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

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

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

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| We would like to see a system that is focussed on delivering people centred care, providing services where people want to and are able to access them from whom they choose and how barriers to achieving this can be removed. We strongly support collaboration across a number of sectors in a system that uses data and technology to drive health services, care & support so people are able to tell their story once and we need to enable personal responsibility for being well, living well and staying well. Value is referred to but a focus has to be on delivering efficient sustainable services and support systems. |

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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| While 7 of these principles remain in place from the strategy developed in 2000, we question what measurement and outcomes have been realised from these to determine if they are correct moving forward? We agree with the addition of thinking beyond narrow definitions of health and working across a number of sectors collaboratively that impact health and wellness. However, it does seem to be what we have focussed on over the last 15 years and it has been highlighted that the current system is not sustainable - the principles need to include how we better use the health dollar. The document highlights the workforce issues being faced and while the principles talk about a high performing system, there needs to be an expansion of the roles of health professionals to be able to deliver on this.  The principles don’t mention being outcomes focussed, measuring, monitoring and reporting. |

### 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, these do provide the right focus but the wording “get well” indicates ongoing focus on treatment and not preventative care and could be replaced with Be well.  The development of a Smart system needs to be a priority. Reduction in fragmentation of care is referred to and IT is the critical enabler to deliver on this and create a health system in which the person should only have to tell their story once. This is an area where efficiencies can be realised but does need significant investment. An example is Test Safe. Clinicians point to evidence where this system has been successful in determining the care and support people receive from a number of different health care providers, the document also talks about building on areas where there is evidence and putting them to work.  The silo approach that is currently experienced is reducing the opportunity to succeed in delivering these “Best Ideas” and until these are addressed improvement and outcomes will be not be seen. We need to focus on introducing innovation and reviewing and measuring current systems and services that are in place.  Aligning incentives and funding across providers needs to be addressed and funding needs to follow the person. This will open up a more people centred approach where people choose where they want to receive their care and support. This will support the expansion of healthcare providers scopes of practice and is where sustainable value can be realised. Until this occurs it will be more of the same that we have now and this has clearly been identified as not being sustainable. |

### 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 question around these important actions is more around the prioritisation of them. Developing information systems, patient portals and technology that can complement achieving the other 19 actions will be critical, IT has been identified as playing a major role in reducing fragmentation of care, of being able to provide care where the person chooses it and from whom they choose. This will not be realised unless a robust platform that has all information shared amongst the different providers of care is developed and delivered. There needs to be significant investment in this area.  We have spoken often in this document of the need for the person to be able to tell their story once and an IT framework is required to support this. The ability for all providers to access these systems to refer people into other services and accept referrals is a pivotal part of people care. Investment appears to be made on funding systems but not on the implementation or monitoring of outcomes of those systems. |

### 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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| Linked to provider performance targets, measured, documented and shared. These performance targets need to be owned and shared across all disciplines where all providers are responsible for the outcomes. It is important to get feedback as to what value communities see in the progress and include that in the tracking.  The timeframe from development to implementation of key actions needs to be tightened, reviewed frequently and reported on at regular intervals and shared and people held accountable for the process.  What can realistically be achieved and what is going to give the health system the biggest gains. Is it 20 different actions? We would suggest not. We would prefer to see a focus on fewer key priorities which could unlock a number of the other positive actions. |

### Any other matters

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

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| Align funding and incentives across providers. Re-align contracts that do not enhance the ability for efficiencies to be realised.  Invest in implementing IT not just development of it  Measure and share outcomes and performance  Focus on sustainability for providers and funders |

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| **336** | Submitter name | [redacted] |
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4 December 2015

New Zealand Health Strategy Consultation Ministry of Health

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# Submission: Update of the New Zealand Health Strategy

Thank you for the opportunity to comment on the draft health strategy update.

We agree with the Director General’s statement that strategy should emphasise the need “*for integration of our framework, methodology and approach, as well as coherence so that we are all clear on the role we each have to play in making our desired future a reality.*” Having the right framework is critical, as is policy coherence. More important than structure is the trust that is needed between the participants in the system that is collectively working to have a positive impact on the health of all New Zealanders.

Much of the draft strategy content aligns well with established human rights principles such as the importance of involving and empowering people in decision–making that affects them and improving the status of those who are currently disadvantaged. This submission focuses on three key areas which we believe would strengthen the strategy further.

* The need for explicit recognition of the human right to health.
* The importance of recognising the 2030 Sustainable Development Agenda in the strategy document.
* A systems approach and the need for trust

# Health as a Human Right

From a human rights perspective, part of the framework for health is the obligation of the State to enable the progressive realisation of the right to health of all New Zealanders. This State obligation to the people of New Zealand needs to be part of the foundation of the strategy along with other relevant rights that affect the right to health, such as the right to adequate housing.

The Commission’s view is that the current draft strategy could be further strengthened and enhanced by including explicit recognition of the human right to health. The right to health is a fundamental human right that has been recognised in a number of international treaties and conventions that New Zealand has ratified. It does not mean that everyone has the right to be healthy. The right encompasses access to timely, acceptable and affordable health care of an appropriate standard and requires the State to generate conditions in which everyone can be as healthy as possible. The right is also a component of the right to an adequate standard of living and extends to underlying determinants of health such as access to food and water, healthy housing and sanitation.

A good explanation of the right to health can be found in the World Health Organisation Fact Sheet available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

# Sustainable Development Agenda

New Zealand has very recently endorsed the 2030 United Nations Sustainable Development Agenda. This agenda sets 17 globally agreed goals each supported by detailed targets and indicators.

SDG Goal Three is “Good Health and Well-Being – Ensure healthy lives and promote well-being for all ages”. This goal and related targets and indicators, global and national, will be of particular relevance to the performance and systems components of the health strategy and should again be explicitly reflected in the thinking and commentary in the strategy document.

All States will be required to disaggregate the collection of data in relation to this goal so that there is clear information about progress of marginalised and vulnerable groups as well as the population as a whole. We have attached analysis of the Health and Wellbeing goal prepared by our colleagues at the Danish National Human Rights Institute. We have discussed this analysis with them, with WHO and with acknowledged international experts like New Zealander Paul Hunt. We believe it will serve as a means to report on New Zealand’s progress in relation to the right to health at relevant United Nations human rights reviews and in the UN High Level Political Forum that will monitor New Zealand’s progress on the SDGs.

Speaking on the adoption of the Agenda by the UN General Assembly Foreign Minister McCully said: “*New Zealand welcomes the adoption of the SDGs. But we also know that this marks the beginning not the end of the process. Ahead lies the serious challenge of attempting to meet these Goals. If we are to succeed in the way in which the MDGs did not, we will need to learn from the significant lessons of the recent past. These are lessons about hard work and hard decisions, about choosing the right priorities and focusing on practical outcomes. Above all they are about strong partnerships that deliver positive, timely results.”* New Zealand is well placed to meet this challenge. As the Strategy covers 10 of the 15 years in which the Agenda is to be implemented the strategy needs to recognise the Agenda.

Transparency of the underlying rights based frameworks will also assist in enhancing community and sector understanding of the scope, and limitations, of these rights and corresponding State obligations. This may simply require a short additional paragraph in the draft document and/or some strategic footnotes or additional content. The Commission is happy to work with you to develop brief and appropriate content along these lines

# A Systems Approach and the Need for Trust

The health system (and we mean the whole system not just the Ministry and the DHBs) is the only part of the State that touches New Zealanders from before they are born to after they die. It has incredible potential to meet the social services challenge outlined in the recent Productivity Commission report and the opportunities for the good use of big data that the Government and other sectors have identified through recent projects. However, it needs to operate as a system serving the people not as silos or hierarchies.

We notice that on page 22 the strategy emphasises the need to “foster increased trust and collaboration” but nowhere is it explained how that is to be achieved or what great would look like in regard to trust. David Albury has long observed New Zealand state sector strategy and he has noted that in many strategies structural solutions are proposed to cultural problems. Building trust

amongst the community and those within the sector will be a key component to implementing the strategy successfully. Developing trust is a cultural issue and needs a cultural response.

The trust issue was recently summarised well in the Stanford Social Innovation Review it was noted that “Creating the formal structures that make up an ambitious, multi-sector change initiative is one thing. But forging the intangible interpersonal connections that result in authentic bonds among participating leaders is something quite different. Indeed, it is notoriously difficult’ in our view the Health Strategy must confront this challenge and have a realistic plan to address it.

As indicated above we would appreciate the opportunity to meet and discuss these suggestions with you in more detail and can assist with drafting content that would incorporate these matters into the current draft document. There are also some specific areas where we would like to find out more detail about the Ministry’s proposed activities, such as some concerns about what is not in the roadmap, which we do appreciate is illustrative. These include issues relating to adequate housing and the primary health care of intellectually disabled people.

Yours sincerely

[redacted]

Chief Commissioner

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| **337** | Submitter name | [redacted] |
| Submitter organisation | Worksafe |

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Wellington

4 December 2015

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

Kia Ora

**New Zealand Health Strategy consultation**

Thank you for the opportunity to provide a formal submission on the New Zealand Health Strategy consultation.

We are pleased to see that the Health Strategy broadly aligns with the Worksafe vision:

*Everyone who goes to work comes home healthy and safe*

Our submission on the Health Strategy is focused on the following areas:

1. Whether it is appropriate for the Strategy to more directly reference the relationship between the workplace and health.
2. How the Ministry of Health will partner across government to complete the Health Strategy in early 2016.
3. The evidence and data that supports the Heath Strategy.

**The Workplace and Health**

Worksafe would like to discuss with the Ministry of Health whether more specific reference of the relationship between the workplace and health is appropriate in the Strategy.

Worksafe promotes the philosophy that “a good workplace leads to good health” and that “good health leads to a good workplace”. The Strategy does briefly mention the workplace and references a wider context (pg 3), which is positive from our perspective as it starts to integrate the Ministry of Health’s strategies and inventions designed to address the government’s health priority areas. We believe the workplace emphasis should be more specific, including both response and preventative interventions, to make the overall context of the Strategy clearer.

**Partnering across Government**

The Strategy clearly states the need for partnering across government for development and implementation of the strategy and interventions. We are in agreement with you that it will take a whole of system approach. There are a number of engagements already occurring or proposed (action point 20 - engage with the [Ministry of Business, Innovation and Employment](http://www.mbie.govt.nz/)). Worksafe welcomes direct engagement and involvement where relevant to ensure workplace health and prevention measurements are integrated in the strategy.

**Evidence and Data supporting the Strategy**

There is some strong evidence and data referenced in the Strategy and you rightly state there is a need to create a whole of system approach across government. The Strategy would be strengthened by articulating how the system will operate e.g. how data will be gathered and measurements reported upon where several agencies are involved.

We noted that the final updated Health Strategy is expected to be released in the first half of 2016. As previously stated, Worksafe would welcome the opportunity to engage during your finalisation of the Strategy.

We note that all submissions will be published on the Ministry’s website with personal details removed.

[redacted]

Manager, Occupational Health

Worksafe

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| **338** | Submitter name | [redacted] |
| Submitter organisation | Royal Australasian College of Surgeons |



11 December 2015

New Zealand Health Strategy Consultation  
Ministry of Health

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

To the New Zealand Health Strategy Team

Updated New Zealand Health Strategy

The Royal Australasian College of Surgeons (RACS) wishes to make a submission on the above document.

**Introduction**

The Royal Australasian College of Surgeons is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. It represents nine surgical specialties in New Zealand and Australia being: Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head-and-Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery.

RACS commends the Ministry of Health for its work so far in updating the New Zealand Health Strategy and broadly supports the direction that the Strategy is taking. We believe that the overarching vision, that *all New Zealanders live well, stay well, get well,* is a suitable goal for New Zealand moving towards the future, and that the five themes, with some revisions, will provide a sound platform for this vision to be achieved.

The guiding principles at the core of the Strategy remain largely untouched from the original New Zealand Health Strategy in 2000 and we believe that they can continue to provide a solid foundation for the health system. The addition of the eighth guiding principle - *thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing* – is an appropriate expansion to the principles, effectively conveying the Strategy’s holistic approach towards health and wellbeing. Given the wide reaching nature of this principle however, it can only be meaningful if it is adopted across all relevant Government departments/ministries.

RACS considers that the ‘Future Direction’ outlined in Part I of the document demonstrates in general a positive direction for health in New Zealand.

**Strategic Themes**

***People Powered***

RACS agrees with the overarching direction of this strategic theme, with the aim to ensure that each individual is in the best possible health. However, the title “people powered” suggests that the primary focus of the theme may be to leverage the population as a resource. RACS considers that “people focused” or “people centred” may resonate better.

Individual choices regarding health are highly personal, occur in a constantly changing environment, and are influenced by a wide variety of factors. We commend the Strategy for recognising this latter point by *thinking beyond narrow definitions of health*. However, this theme takes a rather homogeneous view of the New Zealand population and fails to reflect the subjective environment in which health decisions are made.

As an example, Action 1 supports “self-management of health through a range of digital technologies”. Self-management of health is complex, and individuals have varying preferences for being proactively involved in their healthcare. A shift of responsibility to the individual may result in a shift to blame, should their health deteriorate. This is likely to be most prevalent in vulnerable populations; safe-guards need to be in place to ensure individuals are not compromised.

Those people that often most need healthcare - such as the elderly or those with limited incomes - may be the least able to manage their healthcare or access digital technologies.

We support the use of digital technologies to empower individuals; and over time it is likely that the population will move to increased use of such technology. In the interim, the Strategy needs to be more receptive to the limitations of digital self-management.

***Closer to Home***

RACS cautiously supports the principle of role expansion as a means of delivering care “closer to home”, but believes that the Action Map needs to provide more specific guidance regarding the circumstances in which such expansion will be appropriate.

We recommend that role expansion be limited to instances where practitioners are enabled to practice at the top of their scope, and that any delegated provider has the appropriate training, skills and expertise – and the provision of the necessary resources - to safely fulfil their expanded role.

RACS believes that role expansion must be considered in the context of comprehensive care which is best provided by a collaborating multidisciplinary team of health professionals with oversight, delegation and leadership by the patient’s usual health provider.

***Value and High Performance***

RACS believes that existing Ministry of Health operational performance measures, without appropriate outcomes measures, serve to undermine the strategic theme of ensuring a quality and cost-effective health service.

At present, health targets are too rigid and focussed on process measures; this reflects a disconnect between the Ministry and clinicians. The inflexibility of such process-measure targets does little to promote the actual provision of quality outcomes.

RACS recommends that the Ministry redevelop health targets in closer collaboration with clinicians and DHBs, with the aim of promoting high performance in a more flexible environment for success.

**Other Concerns**

***Prevention and the wider social determinants of health***

The prevention of ill health is a strong theme running through Part I of the Strategy. A move “from treatment to prevention” is also identified as one of the markers of the Strategy’s success. This focus on prevention fits well with the proposed “investment approach” and has the potential to create a solid foundation for lifelong health. RACS strongly supports these concepts and believes that the prevention of ill health is an extremely cost-effective method of healthcare investment. However, there is almost no reference to any of the wider social determinants of health which would enable New Zealanders to *live well,* and *stay well*.

As such, the current Actions place undue focus only on New Zealanders *getting well*, and fail to provide any focus on disease or injury prevention. RACS therefore recommends that the Action Map in Part II be reworked to better represent the prevention and investment approach promoted in Part I. For example, Tobacco use is identified as the leading preventable individual risk factor for ill health in New Zealand.[[51]](#footnote-51) Despite the New Zealand Government’s world leading commitment to a “Smokefree Aotearoa” by 2025, there is no mention of tobacco in any of the actions proposed by the strategy. Other determinants of health such as alcohol, obesity, high blood pressure and / or cholesterol, and high saturated fat intake are also absent. All of these are in the top 10 risk factors that contribute to health loss in New Zealand, yet receive no mention in the Action Map.

***Measure of success***

As referred to above, measuring outcomes is an important aspect of ensuring that a system is succeeding and operating cost-effectively. The Strategy provides illustrations of what successful implementation of the updated plan will look like upon competition of the actions. However, there are insufficient interim measures that can indicate whether the strategic plan is on track. We recommend that metrics are added to the Action Map as a means of measuring success.

RACS appreciates the opportunity to comment on this important document.

Yours sincerely,

[redacted]

Chair, New Zealand National Board

Royal Australasian College of Surgeons

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| **339** | Submitter name | [redacted] |
| Submitter organisation | Johnson & Johnson |



**Submission to the**

**New Zealand Health Strategy**

**Consultation**

**December 2015**

# Our Credo

We believe our first responsibility is to the doctors, nurses and patients, to mothers and fathers and all others who use our products and services. In meeting their needs everything we do must be of high quality. We must constantly strive to reduce our costs in order to maintain reasonable prices. Customers’ orders must be serviced promptly and accurately. Our suppliers and distributors must have an opportunity to make a fair profit.

We are responsible to our employees, the men and women who work with us throughout the world. Everyone must be considered as an individual. We must respect their dignity and recognise their merit. They must have a sense of security in their jobs. Compensation must be fair and adequate, and working conditions clean, orderly and safe. We must be mindful of ways to help our employees fulfil their family responsibilities. Employees must feel free to make suggestions and complaints. There must be equal opportunity for employment, development and advancement for those qualified. We must provide competent management, and their actions must be just and ethical.

We are responsible to the communities in which we live and work and to the world community as well. We must be good citizens - support good works and charities and bear our fair share of taxes. We must encourage civic improvements and better health and education. We must maintain in good order the property we are privileged to use, protecting the environment and natural resources.

Our final responsibility is to our stockholders. Business must make a sound profit. We must experiment with new ideas. Research must be carried on, innovative programs developed and mistakes paid for. New equipment must be purchased, new facilities provided and new products launched. Reserves must be created to provide for adverse times. When we operate according to these principles, the stockholders should realize a fair return.

# A Tātou Whakapono

I te tuatahi, he kawe i ngā takuta, ngā nēhi, ngā tūroro; ngā whaea me ngā matua, me ērā katoa e whakamahi ana i a tātou taonga me a tātou ratonga. Kia tutuki ai ō rātou hiahia me pai ake te katoa ō a tātou mahi. Me anga nui tātou ki te whakaheke i ngā utu kia noho ngāwari ai. Ko ngā tono a ngā kaihoko me wawe me tika te whakarite. Me whai wāhi, whai hua hoki a tātou kaiwhakarato, a tātou kaitohatoha.

Huri noa i te ao, ko te mea nui, he kawe i ngā kaimahi, ngā tāne me ngā wāhine. Me whakaaro anō ki ia tangata o roto i te mātotoru. He mana anō, he painga anō kei tēnā me tēnā ō rātou. Me whakapūmau hoki rātou i roto i ō rātou mahi. Kia rite, kia tōtika te tahua utu; kia mā, kia tōtika kia haumaru te wāhi mahi. Whakaarohia me pēhea te āwhina i a tātou kaimahi me ō rātou whānau. Kia āhei ngā kaimahi ki te tuku whakaaro, ki te whakahē hoki. Mō ērā whai tohu ana, kia wātea te ara whakawhanake, whakapiki ake i te mahi. Mā tātou e tohu ngā ritenga whakahaere, ā, kia tika hoki ngā urupare.

Herea ai tātou ki ngā hapori e noho nei, e mahi nei tātou, huri noa i te ao. Kia kīa tātou, he hunga pono - tautokona ngā mahi pai me ngā mahi atawhai a te hapori, ā, me kawe a tātou wāhanga o te taake. Ākina ngā mahi whakapai ake i te nōhanga a-iwi, te hāpai i te hauora me te mātauranga. Kia pai te mau i ngā rawa i waimarie te riro mai, tiakina te taiao me ngā rawa tuturu.

Ka mutu, ko te wāhi ki ngā kaipupuri hea. Me whai hua tōtika te mahi umanga. Me torotoro ngā whakaaro hōu. Me haere tonu te rangahau, te whakatinana i ngā kaupapa hōu me te utu i ngā whakahē. Me haere tonu te hoko taputapu hōu, te hanga wāhi hōu, me te tuku tāonga hōu. Hangaia he putunga rawa mō ngā wā o te uaua. Ki te haere tātou i raro i ēnei whakapono, ka whai hua tōtika ngā kaipupuri hea.



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# Submission information

This submission is feedback to the New Zealand Health Strategy Consultation undertaken by the Ministry of Health: Update of the New Zealand Health Strategy.

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# Who we are

The Johnson & Johnson Family of Companies in New Zealand is the country’s leading broad-based health care supplier, dedicated to helping solve major and everyday health care challenges for the people of New Zealand.

Our Companies are the market leader in infection prevention, joint reconstruction, trauma, wound closure, prostate cancer, multiple myeloma, schizophrenia and ulcerative colitis. Our businesses also contribute significant investment toward three key public health programmes:

* research on the management of metastatic prostate cancer and inequities in care in New Zealand;
* Tōu Ake Oranganui, a mental health workforce relapse prevention development programme; and
* an Employment programme in Secondary Mental Health Services.

We operate three businesses in New Zealand:

* **Johnson & Johnson Pacific**, known for its portfolio of leading consumer health brands;
* **Johnson & Johnson Medical**, a medical devices and technology business; and
* **Janssen**, the pharmaceutical companies of Johnson & Johnson.

We are dedicated to addressing and solving the most important unmet medical needs of our time, within areas such as arthritis, cardiovascular, infection control, immunology, metabolic, neuroscience, oncology and osteoporosis. Driven by our commitment to patients, we develop sustainable, integrated health care solutions by working side-by-side with health care stakeholders, and investing in partnerships based on trust and transparency.

We supply to all District Health Boards (DHB), pharmacies, consumer outlets and private hospitals in New Zealand. We provide education materials to health care professionals throughout the country – from student doctors and nurses through to registrars and consultants. Johnson and Johnson Pacific business has a broad range of products in baby care, skin care, oral care, wound care and women’s health care, as well as nutritional and over-the-counter pharmaceutical products.

As part of activities supporting our Credo our businesses donate around $200,000 annually and our staff volunteer more than 1,200 hours to support organisations like Shine (working with children of families with family violence), Women’s Refuge, New Zealand Blood Cancer and Leukaemia Foundation, Variety (Bikes for Kids), Books in Schools, Red Cross, Making Smiles – Changing Lives (cleft palate surgery in the Pacific), Kids Can, Brothers in Arms and the Salvation Army.

# Our Feedback: Making the most of what we all have

We support the proposed vision for the future of the New Zealand health system captured by the ‘live well, stay well, get well’-statement and we agree with the general direction outlined in the draft strategy contained in the Future Direction statement and the Roadmap of Actions.

We offer the following observations, based on our long experience in health care in New Zealand, to assist in the further development of the strategy.

The goal of collaboration, including partnering, within the health system, with the community and across the government sector, is clearly articulated within the draft strategy. We believe that there are significant opportunities that are available from collaboration with the innovative health care focussed private sector. Ensuring that all relevant parties are included early in the decision-making process helps ensure that all issues and potential opportunities are available for consideration.

**Sharing data**

The health system functions on data. Data informs decisions about the relative merits of Government priorities, actions plans, health strategies, individual health choices and treatments. There are many sources of data not least that of country-wide health care systems and global health care companies. Ensuring that data is widely shared, subject to appropriate safeguards, amongst all parties to the health system can benefit everyone.

From our perspective, better health care data will assist us to: better shape our research priorities, to meet patients’ needs, more precisely describe the benefits that our innovation can provide, more accurately detail the cost-effectiveness of what we do and better determine outcomes.

More broadly, data will lead to greater efficiency, including cost control, and effectiveness, comparability of health interventions in a ‘Whole of Government Approach’, and the right choices for the right patient.

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| The Johnson and Johnson Family of Companies in New Zealand are investing and co-developing a Diabetes Health Economics model with a New Zealand trade and enterprise health technology group.  This economic modelling and future projects in other high priority diseases will help to identify cost effective solutions that support culturally appropriate early intervention, treatment adherence, health literacy education, health sector navigation, data analysis and patient empowerment to improve health outcomes for some of New Zealand’s most problematic diseases. |
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| The Johnson & Johnson Family of Companies in New Zealand are also exploring partnerships to analyse and invest in productivity improvement for young New Zealanders affected by rheumatology accidents and disorders such as trauma recovery, back pain and other inflammatory disorders which impact an individual’s ability to return to work. |

**Sharing innovation**

Innovation is critical to our role. This innovation can extend beyond what is expected of a traditional health care company. An example is that of the community-based programmes to support mental health patients undertaken by our pharmaceutical business, Janssen.

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| Everyone involved with mental health care recognises that mental illnesses present unique challenges for consumers, their health care providers and caregivers. These include: high costs, complex risk profiles, fragmented care, potential involvement with social services and law enforcement agencies and sub-optimal treatment adherence. Recognising this, we have worked closely with interested stakeholders, looking for additional solutions to enable coordinated care ‘closer to home’.  Janssen has developed several community-based programmes around the world to support improved outcomes for people living with schizophrenia and other complex mental illnesses. These programmes have been developed in partnership with public mental health facilities with the goal of introducing a more integrated and holistic approach to treatment.  One of these programmes, MAP, was developed in partnership with a major British NHS Foundation Trust with an aim to improve the management and care of people with mental health issues, including recognising early signs of relapse in individuals with schizophrenia. Where implemented, the programme has led to reduced hospitalisation, increased staff and consumer satisfaction, reduced cost and improved the overall quality of care.  We have partnered with health services in Australia to pilot programmes that support improved transition from Community Mental Health to Primary Care for people living with schizophrenia. These programmes seek to address one of the critical challenges to achieving successful long-term outcomes for people living with schizophrenia, which is the lack of an integrated care pathway between public specialist care and primary care.  One pilot programme is designed to support health care professionals and consumers to be better prepared for transition and improve communication between all stakeholders. Key programme components include:   * education resources and services to support primary care treating teams with the management of people with schizophrenia; * appointment reminders and medication dispense and delivery services to help consumers adjust to receiving their care in the primary care setting; and * online resources and programme coordinators to support improved communication and coordination of activities between community and primary care teams.   Outcomes of the pilot programme are currently being reviewed with a view to expansion of the programme to other interested services.  Locally, Janssen supports a workforce development programme in relapse prevention at the Waitemata DHB Mental Health and Addictions Services which was recently expanded to include Non-Government Organisation (NGO) staff.  The programme consists of evidence-based education workshops supporting relapse prevention for all staff. The success of the programme in Waitemata and Capital and Coast DHBs has provided evidence for further expansion in Primary Care workforce development. Programmes like this could further support expanded integrated care between Secondary and Primary Health care services, with appropriate clinical interventions. |

Our innovation is aimed at better meeting the needs of those patients and consumers who use our products and services. There are many examples for health care solutions that we have developed for the increasing number of people living with chronic health conditions. We believe that sharing the outcomes of our innovation, the insights and opportunities that it creates will help achieve the New Zealand Health Strategy vision.

**Sharing how we resource health**

As part of our broader innovation focus, the Johnson & Johnson Family of Companies is participating in, and closely following New Zealand’s foray in social impact investing. We share the belief that bringing together capital and expertise from the public, private and non-profit sectors can deliver better outcomes for patients, consumers and society. Focusing on specific outcomes, sharing experiences across different groups and providing the discipline of financial incentive offers the opportunity to do more with less and then to share those benefit.

The areas of social impact opportunities which we have identified in New Zealand include: Mental Health Employment Support (IPS), productivity improvements following skeletal trauma or rheumatology inflammatory disorders, mental health forensic recidivism and mental health re-hospitalisations, Hepatitis C eradication programmes and diabetes management.

**Sharing our insights and activities on training and community support**

We collaborate broadly across the health care sector – we supply all District Health Boards, pharmacies, consumer outlets and private hospitals in New Zealand. We provide education materials to health care professionals throughout the country – from student doctors and nurses through to registrars and consultants. We have a legacy of experience in working with these stakeholders and in developing and supplying educational materials and services.

Similarly, we work closely with and actively support the patient and community sector.

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| As a major New Zealand health care supplier, the Johnson & Johnson Family of Companies is deeply concerned about the disparities in health outcomes between Māori and other New Zealand population groups.  We are working collaboratively with Māori Iwi and health sector leaders to uncover information and gain deeper insights into the elements that cause or contribute to these disparities and associated poor health outcomes for Māori, and to help design, develop and implement culturally appropriate, practicable solutions to address them.  Over recent years we have undertaken a number of projects that have contributed to improving health care outcomes for Māori, including supporting major research studies in mental health and prostate cancer, engaging Māori Health experts and advocates, sponsoring Māori-led community organisations, and engaging in community partnerships. We have also begun training and supporting our staff to develop a better understanding of Te Reo Māori.  The Johnson & Johnson Family of Companies are currently consulting with Health Sector leaders and Māori Iwi on the development of a Johnson & Johnson Māori Responsiveness Strategy, Mahitahi - Working as One, to contribute to better health outcomes for Māori. |

# Our summary of actions

We share the vision of ‘live well, stay well, get well’ and we have extensive experience in helping individual New Zealanders achieve just that.

We believe that there are significant opportunities that are available from collaboration with the innovative health care focussed private sector. We have insights and expertise that can contribute to ensuring that New Zealand has a health care system that will deliver on the outlined vision.

We can achieve this by working with you: sharing our insights and experience into making the best use of data, partnering to drive patient-focused and evidence-based innovation, health education and support for the community sector.

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| Submitter organisation | Association of Salaried Medical Specialists |



**Submission to the Ministry of Health on the Draft Updated New Zealand Health Strategy**

**3 December 2015**

Background

The Association of Salaried Medical Specialists (ASMS) is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members. We now represent more than 4,000 members, mostly employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all public hospital senior doctors and dentists eligible to join the ASMS are in fact members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

## Summary

* Much of the substance of the draft updated health strategy lies in a number of other documents, including the Productivity Commission report, the Capability and Capacity Review and the Health Funding Review. They cover a broad range of sometimes complex and controversial issues. The Health Funding Review, for example, proposes radical changes that resemble policies of the failed health ‘reforms’ of the 1990s. To allow little more than a month for consultation on the draft strategy is insufficient time to enable a proper analysis of what is being proposed. This is made worse by the fact that the status of the above documents remains unclear. This consultation therefore feels rather like an exercise in shadow-boxing.
* Those comments aside, the ASMS supports the proposal to retain the seven principles of the original New Zealand Health Strategy. We also support the proposed additional *principle* of collaborating across sector to improve New Zealanders’ wellbeing. However, there is much in the substance of the draft strategy, assuming the recommendations of the documents mentioned above are adopted, which we do not support and have serious concerns about.
* While the draft updated strategy is presented as representing “the common view of where we want to go” (Minister’s foreword), it is in fact largely a reflection of current government policy. As such, the ‘update’ is an exercise in reframing the original New Zealand Health Strategy within the Government’s policy agenda.
* If the essential aim of the draft strategy is to progress from the current state to a desired state in 10 years’ time, it is vital that the current state – the starting point – is well defined. It is not well defined in this document due to its use of highly selective information. It fails to acknowledge the efficiency and quality of our health system relative to comparable countries, it fails to acknowledge the extent of New Zealand’s current health need compared to other like countries, and it fails to acknowledge significant health inequality that is due to poverty.
* A Commonwealth Fund report shows the main weakness of New Zealand’s health system is access to it – both in primary and secondary care.
* The challenges relating to future health spending are overstated to the point of being alarmist and are being used as the rationale for introducing ‘significant change’ to the current health system model. Government health spending has in fact been falling as a proportion of gross domestic product (GDP). It is a trend that is likely to continue under current policies, in line with a planned reduction in overall government expenditure as a proportion of GDP.
* We agree in principle that the health New Zealand system must continue to perform as efficiently as possible. As mentioned above, it is doing relatively well in this respect when measured against comparable countries. We therefore do not support the stated rationale for ‘significant change’ in the current model.
* If New Zealanders’ health needs are not met by public health services, the costs do not disappear; they still have to be borne by the economy. The important question then becomes whether it is more efficient and equitable to pay for health needs privately or publicly. There are good reasons to conclude that it is more efficiently and equitably provided publicly.
* **There is a significant opportunity to improve the cost-efficiency and effectiveness of our health services by giving a stronger commitment to distributive clinical leadership. This is policy which is supported across political parties because it has proven to** significantly improve the effectiveness and efficiency of health services while managing the increasing costs of health care. Despite this, it has been ignored in the draft strategy. The ASMS considers this a critical oversight and calls for it to be remedied in the final document.
* The draft strategy acknowledges challenges such as the aging workforce, but no responses or potential responses are suggested. Unpublished MCNZ workforce survey data indicated that on recent trends, about 19% of the specialist workforce will be lost within the next five years due to the drop-off of specialists from the age of 55. A report prepared for Health Workforce New Zealand (HWNZ) offers solutions to improve retention of older doctors. However, the draft strategy is silent on the ‘opportunities’ to mitigate the effects of an aging medical workforce.
* The draft strategy acknowledges New Zealand’s medical workforce is highly dependent on overseas recruits, many of whom do not stay long. However, its suggested solution – ‘we need to continually invest in training’ – is inadequate. It is only part of the solution and, for the medical specialist workforce, will have little or no impact for another 15 to 20 years. The challenge with regard to this workforce is here and now.
* Health Workforce New Zealand acknowledges: *“The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.* Accordingly, the draft strategy needs to recognise the importance and urgency in addressing senior doctor shortages.
* Research shows there are potentially significant gains to be made in the quality, effectiveness and cost-efficiency of health services by adopting a genuine patient centred care approach to service delivery. Despite these benefits, this approach has not been well established in New Zealand’s District Health Boards (DHBs) because to a large extent it requires an upfront investment in services, especially in the health workforce.
* New Zealand’s demographic trends point to a continuing rise in the number of people dying each year. However, our services are not taking the opportunity to help people plan to die well. In the last year of life, many experience a disconnected, confusing and distressing array of services, interventions and relationships with health professionals. Many do not get enough palliative care. A good death gives people dignity, choice and support to address their physical, personal, social and spiritual needs. So while the draft strategy focuses on people ‘living well, staying well, and getting well’, ‘dying well’ is also of critical importance and needs to be included in the document as part of the patient centred care approach.
* At the other end of the lifespan, a greater investment in ‘starting well’ is sorely needed as part of a long-term strategy and commitment to ‘patient centred care’. This is where a genuine whole-of-government ‘investment approach’ (not the false ‘investment approach’ of the draft strategy discussed below) focuses on a woman being healthy when conception occurs, being healthy throughout the pregnancy, and the newborn being healthy for its first two to three years because of the significant physical, mental and emotional development that occurs in those early years. Young children are most vulnerable to the impacts of poverty, abuse and neglect, which have life-long impacts and costs. As such, effective public investment in the early years will deliver the best return on investment. Reaching young children requires investment in their parents/caregivers and family. In short, whole-of-government policy should ensure every baby should be born to a healthy mother and grow up in a healthy home.
* ASMS suggests ‘Start well, live well and end well (or go well)’ would be a better title for the strategy reflecting a better range of priorities.
* The proposed ‘health investment approach’ – based on the ‘investment approach’ currently used by the Ministry of Social Development (MSD) – may be used to ‘target high-need priority populations to improve overall health outcomes’. The approach uses techniques from the insurance industry to calculate long-term costs to the government of health and social services. However, it focuses only on costs and benefits to the government and not at the benefits to individuals and the community. Even the Productivity Commission has noted that “slavish application of an investment approach based purely on costs and benefits to government might lead to perverse outcomes”.
* An ASMS *Research Brief* has identified considerable risks and uncertainties associated with the proposed use of Social Impact Bonds (SIBs). There is a lack of evidence that SIBs actually work as intended, especially given uncertainties surrounding how well they are likely to function in the New Zealand context. SIBs carry high risks of perverse incentives, with funding for SIBs programmes being dependent on measures of long-term health outcomes which will be influenced by multiple factors beyond the programmes themselves.
* The draft strategy highlights the need for ‘trust, cohesion and collaboration’. However, the proposed new approach recommended in the Director-General of Health’s commissioned Review of Funding contradicts this. If implemented, it would be a fundamental departure from the evidence-based collaborative, integrated model underlying current government policy and a return to the market-based policy of the 1990s. It would open up DHB services to competitive tendering, short-term funding, short-term planning, fragmentation of services and clinical teams, barriers to integration of clinical services, disruption to continuity of care, uncertainty for DHB employees and patients alike, lack of transparency due to commercial sensitivities (especially where private providers are involved), and increases in user charges for some (including, potentially, patients opting to travel for elective surgery).
* The draft strategy’s aim to have a smart system depends largely on capital investments. However, whereas unmet health need is a sign of under-resourced clinical services, there is also increasing anecdotal evidence of DHBs accumulating a ‘capital deficit’ to attempt to balance their books. This is resulting in health professionals having to work with poorly functioning equipment and information technology which is vital for providing a safe and efficient service.

## General comments

Much of the substance of the draft updated health strategy (the draft strategy) lies in a number of other documents, including the 400-page Productivity Commission report, the 40-page Capability and Capacity Review and the 40-page Health Funding Review. They cover a broad range of sometimes complex and controversial issues. The Health Funding Review, for example, proposes radical changes that resemble policies of the failed health ‘reforms’ of the 1990s. To allow little more than a month for consultation on the draft strategy is insufficient time to enable a proper analysis of what is being proposed.

This is made worse by the fact that the status of the above documents remains unclear. As far as the ASMS is aware they are at this point proposals which have yet to be decided on by the Government. This consultation therefore feels rather like an exercise in shadow-boxing.

Notwithstanding these comments, the ASMS supports the concept of a long-term strategy in health. We support the proposal to retain the seven principles of the original New Zealand Health Strategy. We also support the proposed additional principle of collaborating across sector to improve New Zealanders’ wellbeing. However, there is much in the substance of the draft strategy, assuming the recommendations of the documents mentioned above are adopted, which we do not support and have serious concerns about.

One of the fundamental challenges of producing a 10-year strategy is to reconcile short-term political realities with a desire to plan in the longer term in a comprehensive way. In an ideal world there would be a process to produce broad public consensus, including cross-party agreement, on not only the principles of a health strategy but also the priorities, the challenges and the opportunities, leaving successive governments to implement the strategy in their own way, guided by their respective policies. In fact we believe there would be potentially huge health benefits if political parties could, to begin with, agree on policies to address the challenges at the ‘start of life’ and ‘end of life’ care. Without such agreement it cannot be assumed that current government policies will be continued by later governments over the next 10 years. This 10-year strategy, therefore, should not be dependent upon the policies and approaches of current government policies, especially where these are known to be contentious.

In the ASMS’ assessment, while the draft strategy is presented as representing “the common view of where we want to go” (Minister’s foreword) – it is in fact largely a reflection of current government policy.

It may be reasonable to promote government policy in the draft strategy where it happens to also be “the common view”. However, there are aspects of government policy here that are controversial, such as the “investment approach” to services provision, the use of public-private partnerships, approaches to health funding, and parts of the government-commissioned report of the Productivity Commission, such as “social impact bonds”. These do not represent the common view.

The political nature of the document is also evident in its less-than-candid perspective on a number of issues and omission of some notable inconvenient truths, which are discussed further below.

The current state

New Zealand has much to be proud of, including the health and health system indicators included in the draft strategy. But it is highly selective in the information it presents. The text box on page 2, for example, provides a number of positive indicators relating to our health system and New Zealanders’ health status, but nowhere in the document is there a more comprehensive range of indicators, including the negative as well as the positive, to give a more balanced perspective.

If the essential aim of the draft strategy is to progress from the current state to a desired state in 10 years’ time, it is vital that the current state – the starting point – is well defined. It is not well defined in this document.

**New Zealand has a relatively efficient, good quality health system**

A Commonwealth Fund report comparing 23 health system performance indicators across 11 countries[[52]](#footnote-52) shows New Zealand’s performance on efficiency and quality of care is among the best, being ranked 3rd and 4th respectively. This has been achieved despite New Zealand being ranked bottom on health expenditure per capita. We note that while the draft strategy refers to this report, it overlooks these achievements, which are especially relevant given the repeated message in the document and some of the referenced documents that the system must undergo significant changes to become more efficient and affordable

The fact that the Commonwealth Fund gives New Zealand’s health system an less-impressive overall ranking of 7th out of 11 is due to relatively poor performance indicators for access to services (7th), and equity (10th). And on a measure of ‘healthy lives’ (infant mortality, healthy life expectancy and mortality amenable to health care - that is, deaths that could have been prevented with timely care) New Zealand was placed 9th.[[53]](#footnote-53)

Another measure where New Zealand ranks lowly is in physician numbers. According to the OECD, in 2013 New Zealand was 30th out of 32 countries on a measure of hospital specialists per population. We were above Chile and Turkey. (The figures include trainee specialists.) For primary care specialists, New Zealand ranked 20th. Physician numbers alone do not necessarily determine access to services – there are a range of factors – but it is reasonable to assume it is a key measure.

All of this indicates New Zealand’s health system is performing comparatively well on what it actually *does*, but there are significant issues with what it *does not* do due to a lack of service capacity.

Poor access to diagnostic tests (11th out of 11 in the Commonwealth Fund report), long waits for treatment after diagnosis (10th), long waits to see a specialist (9th), cost barriers to primary care (9th), and long waits for elective surgery (8th) have all contributed to a growing, hidden unmet need.

Even in the Government’s high priority services such as elective surgery, there have been numerous reports from around the country of increasing barriers to accessing treatment. It appears patients have to be in more pain to access elective surgery now than ever before. As the New Zealand Medical Association has put it, the gap between the patients who meet the clinical threshold for surgery, but fall short of our hospitals' financial threshold, is widening.[[54]](#footnote-54)

So while it must be acknowledged that the numbers of operations have been steadily increasing, New Zealand’s access to elective surgery (and waiting times for specialist appointments), as the Commonwealth Fund report shows, still lags behind many other comparable countries.

The health service indicators outlined above point to unmet health need which exists across a range of health care services, such as primary health care, dental health, mental health, sexual health, disability support and primary services for disadvantaged communities, as well as medical and surgical specialties.

**New Zealanders’ health status is poor in some key areas**

In a number of common health status indicators (Table 1), New Zealanders’ state of health tends to fall in the bottom half of OECD countries. New Zealand also ranks poorly in comparisons with Australia, Canada and the United Kingdom (UK).

Health status indicators are of course influenced by a number of factors, including social, environmental, economic and lifestyle factors. (Though focusing on education campaigns to tackle issues such as obesity misses the point that they are often a result of social, commercial and political decision-making much more than individual decision-making.)

Of course poverty (not mentioned in the document) has a major effect on health. Access to and the effectiveness of the health system is also crucial. The importance of the health system in improving health status has tended to be understated in the past.[[55]](#footnote-55) Indicators such as high suicide rates and high mortality amenable to health care indicate unmet need in both preventive and treatment services.

Table 1: New Zealand’s position in the OECD’s health status indicators, 2013\*

| Health Status Indicator | Position among 33 OECD countries  (1 being best) | NZ position relative to Australia, Canada, UK  (1 being best) |
| --- | --- | --- |
| Life expectancy at birth | 10= | 2= (behind Australia) |
| Premature mortality | 26 (females)  18 (males) | 4  4 |
| Mortality from ischemic  heart disease | 23 (females)  25 (males) | 4  4 |
| Mortality from cerebrovascular disease | 24 (females)  17 (males) | 4  3 (above UK) |
| Mortality from all cancers | 28 (females)  13 (males) | 4  3 (above UK) |
| Suicides | 27 | 4 |
| Infant mortality | 29 | 4 |
| Obesity prevalence (adults) | 27 | 2= (behind UK) |
| Diabetes prevalence  (adults aged 20-79 years) | 24 | 3 (above Canada) |

Source: OECD Health Statistics, 2015; International Diabetes Federation. IDF Diabetes Atlas, 6th Ed. 2014; Global Health Observatory Repository, WHO 2015. \*Or latest year where data are available

**The challenges**

Challenges to meeting health need tend to be understated, whereas challenges relating to resourcing the system are overstated.

**Health status indicators**

New Zealanders’ health status indicators such as those listed in Table 1 show the challenges facing our health services challenges are much greater than is suggested in the draft strategy. New Zealand’s health system not only faces the ‘global’ challenges of an aging population and, with it, an increase in long-term conditions (called a growing ‘burden’ in the document) such as heart disease, diabetes, depression and dementia, we are facing those challenges from a poor starting point compared with other countries.

**Inequality**

Further, although the draft strategy acknowledges health inequality as a key challenge, it only does so in relation to Maori and Pacific peoples. While we agree a concerted effort is needed to address Maori and Pacifica health inequalities, the same must be said for health inequalities related to socioeconomic status, which are well recognised in the health sector but are ignored in the document. Poverty – a word overlooked – must feature highly in the strategy as a major factor in health disparities and health outcomes, especially for children.

We note also an anomaly in the ‘word map’ where ‘inequality’ is under-emphasised due to being included twice.

**Aging workforce**

Other valid challenges are identified, such as the aging workforce and the effects of climate change, but no responses or potential responses are suggested. On the former, the Senior Medical Officer Commission of 2008/09 identified a sharp drop in numbers from the age of 55, which it considered “seems likely to reflect a loss of [specialists] to the system through early retirement and emigration”.[[56]](#footnote-56) Unpublished MCNZ workforce survey data indicated that on recent trends, about 19% of the specialist workforce will be lost within the next five years due to the drop-off of specialists from the age of 55.

A report prepared for Health Workforce New Zealand (HWNZ) acknowledges that “older doctors are working fewer hours and many are retiring earlier… Concern about earlier retirement of doctors and the aging of the medical workforce has been noted by commentators and many of the specialist colleges, as it is considered this will exacerbate current workforce shortages.”[[57]](#footnote-57)

The report suggests that “if doctors can be encouraged to work longer, albeit for fewer hours per week, in different specialty areas and/or in different roles, workforce supply may not decrease as fast as predicted”. It identifies a number of potential ‘solutions’, including suggestions for improving career satisfaction (including interventions to reduce stress), changing work roles, introducing more part-time and job-share positions and more flexibility in work hours, retraining in other specialties, and career and succession planning.

However, the report notes limited New Zealand research about doctors’ intentions with respect to retirement, and what would keep them in practice. It calls for more research and information to enable longer term workforce modelling and to align the needs of younger doctors wanting work-life balance and ‘portfolio lifestyles’ with more flexible working conditions for older specialists.

It is hugely disappointing that the draft strategy is silent on the opportunities to mitigate the effects of an aging medical workforce.

**High dependency on overseas recruitment**

The draft strategy acknowledges New Zealand’s medical workforce is highly dependent on overseas recruits, many of whom do not stay long. However, its suggested solution – ‘we need to continually invest in training’ – is inadequate. It is only part of the solution and, for the medical specialist workforce, will have little or no impact for another 15 to 20 years. The challenge with regard to this workforce is here and now.

International workforce indicators point to an increasingly competitive market for medical specialists which, as an OECD report warned, “would make the New Zealand trained health professionals harder to retain, and the potential pool of foreign recruits more difficult to attract”.[[58]](#footnote-58)

In 2011, HWNZ’s Executive Chair Des Gorman acknowledged “the key issues that are germane to the number of doctors in our workforce are recruitment, migration and retirement, and all three require address”.[[59]](#footnote-59) However, to date there are no significant measures in place that address these issues with respect to the specialist workforce.

In 2014, HWNZ’s report *Health of the Health Workforce 2013 to 2014*, stated:[[60]](#footnote-60)

*While the [Medical Workforce] Taskforce initially focused on the immediate postgraduate period, a whole-of-career perspective has now been adopted. The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.*

Accordingly, the draft strategy needs to recognise the importance and urgency in addressing senior doctor shortages.

For further information on the issues facing the medical specialist workforce, two reports, *The Public Hospital Specialist Workforce* (2013) and a follow-up publication *Taking the temperature of the public hospital specialist workforce* (2014), are available electronically via the following links:

<http://www.asms.org.nz/wp-content/uploads/2014/07/The-Public-Hospital-Specialist-Workforce-web.pdf>

<http://www.asms.org.nz/wp-content/uploads/2014/09/Taking-the-temperature-of-the-public-hospital-specialist-workforce-August-2014-FINAL.pdf>

Health system funding

The draft strategy includes an unchallenged Treasury view – and we consider it an alarmist view – that “New Zealand cannot afford to keep providing services as we do now” and that “without significant change, government health spending would have to rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060”.

There are several points to make about this.

First, it is accepted internationally that there is no ‘right’ level of funding for health care. It is not the role of Treasury to determine what is ‘affordable’. That is a political decision.[[61]](#footnote-61) [[62]](#footnote-62) It may be that the current Government agrees with Treasury’s view. But, again, while it would be reasonable for current government policy to guide the way the strategy is implemented, it should not form the platform to shape the strategy itself.

Second, Treasury data show actual Vote Health expenditure has been falling as a proportion of GDP over recent years – an intentional policy move flagged by Treasury in a document dated June 2012.[[63]](#footnote-63) Treasury data, including recent GDP adjustments, show that while Vote Health’s total operational and capital expenditure was close to 7% of GDP a few years ago, it is now closer to 6% (Table 2).

**Table 2: Total Vote Health expenditure as a proportion of GDP**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Year*** | ***2009/10*** | ***2010/11*** | ***20011/12*** | ***2012/13*** | ***2013/14*** | ***2014/15*** |
| Vote Health ($m)\* | 13,128 | 13,753 | 14,160 | 14,449 | 14,849 | 15,009 |
| Nominal GDP for the year to June ($m) | 195,399 | 203,791 | 212,307 | 216,585 | 234,027 | 240,571 |
| % of GDP | **6.72%** | **6.75%** | **6.67%** | **6.67%** | **6.34%** | **6.24%** |

Sources: Treasury: *Financial Statements of the Government of New Zealand for the Year Ended June 2015*, October 2015.

\* $49 million has been subtracted from the funding allocations for 2012/13 onwards to account for estimated health provider superannuation contributions such as to Kiwisaver, previously paid for by the State Services Commission.[[64]](#footnote-64)

The drop in health funding as a proportion of GDP is largely a result of significant funding shortfalls in Vote Health’s operational funding since 2009/10. Data are not available to enable an accurate assessment of how much money has been saved over those years through genuine efficiencies and how much has been ‘saved’ through service cuts and increases in user charges. With that qualification, taking into account actual expenses, consumer price index (CPI), population and average wage increases, Vote Health’s operational funding shortfall has accumulated to an estimated $0.8 billion between 2009/10 and 2014/15. This year’s estimated funding shortfall would make that more than $1 billion.[[65]](#footnote-65)

Similarly, core government expenditure has been falling in recent years, having peaked in 2011, and is forecast to drop to 29.2% of GDP in 2019. The intention according to Finance Minister Bill English is to see it drop to 25% within the next six to seven years. The continued under-resourcing of our health services, then, is not owing to unaffordability; it is a policy decision to give priority to a policy of reducing government expenditure overall and introducing tax cuts.[[66]](#footnote-66),[[67]](#footnote-67)

In line with those policy priorities, the Government’s trajectory is one of continuing cuts in health spending. Treasury’s Budget 2015 data[[68]](#footnote-68) and the Ministry of Health’s demographic growth rate data[[69]](#footnote-69) show Vote Health’s operational funding is forecast to drop by approximately 4% each year, allowing for inflation and demographic changes. The extent to which that forecast funding is adjusted upwards depends on how much is allocated to Vote Health from the Government’s general budget operating allowance. However, in the past, the additions to Vote Health from the operating allowance have not been enough to keep up with rising costs, population growth and new programmes.

The Treasury graph used in the draft strategy (p 6) projecting a steep rise in government health spending as a proportion of GDP over the next 40 years is not consistent with recent trends or stated government intentions for the coming years, so at the very least it needs explanation.

Thirdly, notwithstanding the points made above, the draft strategy implies that government health and disability services spending of 11% of GDP by 2060, as projected by Treasury, is excessive. In fact government health spending in some OECD countries is already between 9% and 10% of GDP. In England, where the public-private expenditure mix is similar to New Zealand’s, an independent commission recently recommended to the English Treasury that public spending on health and social care (ie, including disability services and aged care) should be increased to 11%-12% of GDP by *2025*.[[70]](#footnote-70) [[71]](#footnote-71)

Fourthly, if New Zealanders’ health needs are not met by public health services, the costs do not disappear; they still have to be borne by the economy. The important question then becomes whether it is more efficient and equitable to pay for health needs privately or publicly. There are good reasons to conclude that it is more efficiently and equitably provided publicly. As Treasury itself has noted:

*We do not currently see a clear case for moving away from a predominantly single-payer, tax-financed health system. Systems like ours are typically better at containing health spending and there is no one system that presents a clearly more efficient alternative.[[72]](#footnote-72)*

If we add considerations of equity to cost-containment, private provision is not likely to be better for people, the country and the economy, and that is well illustrated by the costly and inequitable situation in the United States.

This is important because the argument that current levels of funding are ‘unstainable’ are used as the rationale to introduce ‘significant change’ in the model of our current health system (p6).

We agree in principle that the health New Zealand system must continue to perform as efficiently as possible. As discussed above, it is doing relatively well in this respect when measured against comparable countries. We therefore do not support the stated rationale for ‘significant change’ in the current model.

**Opportunities**

**New Zealand has much to be proud of, including a largely publicly funded, universal health system; a no-fault accident compensation scheme; and a committed and highly trained workforce, as acknowledged in the draft strategy.**

**Distributive clinical leadership**

**There is a significant opportunity to improve the cost-efficiency and effectiveness of our health services by giving a stronger commitment to distributive clinical leadership – a policy which has cross-party support and therefore would be appropriate to include in the long-term strategy.**

There is now a strong body of evidence showing comprehensive clinical leadership can do what New Zealand’s successive attempts at health reform have failed to achieve: significantly improve the effectiveness and efficiency of our public hospitals across the whole spectrum of services (not just the selected few targeted by Government) while managing the increasing costs of health care.

Indeed, given the health indicators for the coming decade, the ability of our health system to meet the growing demands may well rest on the extent to which comprehensive clinical leadership is established in practice.

*Quite simply, the reforms we need are only likely to be successful if clinically led.*

– Professor Des Gorman, Executive Chair, HWNZ[[73]](#footnote-73)

Successful clinical governance, as envisaged by the Government’s *In* *Good Hands* policy statement and by the *Time for Quality* agreement between the ASMS and the country’s DHBs requires distributive leadership, embedded at every level of the system.[[74]](#footnote-74) [[75]](#footnote-75)

Some of the many specific benefits of distributive clinical leadership include:

* effective and efficient development of new innovative service models
* quality training and supervision
* sustainable achievement of government health targets
* improved safety and quality of services and outcomes.

For this to succeed in any meaningful way, financial investment is needed to develop the capacity of the specialist workforce to enable ‘time for quality’.

Despite the many benefits of distributive clinical leadership, and support by successive governments, it has been ignored in the draft strategy. We strongly recommend that this is rectified in the final document.

**Patient centred care**

In the context of the draft strategy, ‘time for quality’ is needed to provide ‘patient centred care’. For example, for:

* “understanding people’s needs and wants and partnering with them to design services to meet these;” and
* “encouraging and empowering people to be more involved in their health by engaging with them about their wellbeing and helping to make health choices” (p 11).

This is especially important given our health services are facing increasing numbers of patients with chronic and complex needs and for enabling patients and families to make informed decisions about end-of-life care.

New Zealand’s demographic trends point to a continuing rise in the number of people dying each year. However, our services are not taking the opportunity to help people plan to die well. In the last year of life, many experience a disconnected, confusing and distressing array of services, interventions and relationships with health professionals. Many do not get enough palliative care.

A good death gives people dignity, choice and support to address their physical, personal, social and spiritual needs. So while the draft strategy focuses on people ‘living well, staying well, and getting well’, ‘dying well’ is also of critical importance and needs to be included in the document as part of the patient centred care approach.

This should involve three reforms. First, we need more public discussion about the limits of health care as death approaches, and what we want for the end of life. Second, we need to plan better to ensure that our preferences for the end of life are met. Third, services for those dying of chronic illness need to focus less on institutional care and more on people’s wishes to die at home and in homelike settings. [[76]](#footnote-76)

At the other end of the lifespan, a greater investment in ‘starting well’ is sorely needed as part of a long-term strategy and commitment to ‘patient centred care’. This is where a genuine whole-of-government ‘investment approach’ (not the false investment approach of the draft strategy, discussed below) focuses on a woman being healthy when conception occurs, being healthy throughout the pregnancy, and the newborn being healthy for its first two to three years because of the significant physical, mental and emotional development that occurs in those early years. Young children are most vulnerable to the impacts of poverty, abuse and neglect, which have life-long impacts and costs. As such, effective public investment in the early years will deliver the best return on investment. Reaching young children requires investment in their parents/caregivers and family.[[77]](#footnote-77) [[78]](#footnote-78) [[79]](#footnote-79)

In short, whole-of-government policy should ensure every baby should be born to a healthy mother and grow up in a healthy home.

More broadly, research shows there are many benefits from patient centred care when it is properly implemented. When healthcare administrators, clinicians, patients and families work in partnership, the quality and safety of care rises and provider and patient satisfaction increase. Recent research indicates that a patient centred approach can also make health service delivery more efficient.[[80]](#footnote-80)

Specific benefits include decreased mortality, decreased emergency department return visits, fewer medication errors, lower infection rates, and reductions in both underuse and overuse of medical services. In the care of patients with chronic conditions, studies indicate that patient centred approaches can improve disease management, increase both patient and doctor satisfaction, increase patient engagement and task orientation, reduce anxiety, and improve quality of life.[[81]](#footnote-81)

A patient centred care approach has also been linked to improvements in long-term outcomes in cardiac patients and is seen as integral to preventative care.[[82]](#footnote-82)

Further, it has been acknowledged that, to succeed, a patient centred care approach must address staff needs, because the staff’s ability to care effectively for patients is compromised if they do not feel cared for themselves. Once the patient centred care approach is firmly established, a positive cycle emerges where increasing patient satisfaction increases employee satisfaction, and this, in turn, improves employee retention rates and the ability to continue practising patient centred care.[[83]](#footnote-83)

Limited resources in the form of underfunding, low staffing levels and low morale in already overstretched systems are a perceived barrier to the practice of patient centred care.[[84]](#footnote-84)

An underlying reason why a comprehensive patient centred care approach has not been well established in New Zealand’s DHBs, despite all of these benefits and more, is that it requires an upfront investment in services, especially in the medical specialist workforce.

Good patient centred care also requires more active participation from elected DHB board members. If the desired approach is to “understand how health fits into people’s lives, and how it relates to the common needs, interests and priorities,” (p11), then one obvious avenue for this, aside from health professionals, is through the elected members of the district health boards. However, while currently most board members are elected by the public, all board members (both elected and appointed) are directly responsible and accountable to the Minister of Health.[[85]](#footnote-85)

In the ASMS’ experience, the result has been that, with a few exceptions, elected board members have been politically managed and community engagement and representation has fallen well short of what was expected when DHBs were established. The extent to which elected board members are able to advocate on behalf of their communities would be further diminished if boards are reduced to nine members, with six appointed by the Minister, as recommended by the Capability and Capacity review.

**Quality and safety**

We support the draft strategy’s aim to improve the safety and quality of health services, which could potentially have a significant positive impact on the efficiency and effectiveness of the service. One frequently referenced study has estimated that adverse events in our health services could cost New Zealand $870 million per year, of which $590 million is due to potentially preventable events – mostly occurring in the hospital system.[[86]](#footnote-86)

While a range of factors contribute to this, there are many examples indicating specialist staffing levels is an important factor, especially given the increasing complexity of health care delivery is placing greater demands on the expertise of doctors and teams of healthcare professionals. However, increasing heavy clinical demands have meant many specialists are unable to find the recognised professional minimum standard of time for non-clinical duties, including time for continuing education, research, quality improvement activities and, not least, training other doctors.

An Australian survey of quality and safety practitioners found, “The single proposal judged by survey respondents to have the highest potential effect on reducing adverse events was that the supervision and support of junior doctors be improved.”[[87]](#footnote-87)

**‘Smart system’**

The draft strategy’s aim to have a smart system depends largely on capital investments. However, whereas unmet health need is a sign of under-resourced clinical services, there is also increasing anecdotal evidence of DHBs accumulating a ‘capital deficit’ to attempt to balance their books.[[88]](#footnote-88),[[89]](#footnote-89)

One of the most recent examples is the privatisation of the Wellington region’s hospital laboratory services, which occurred after the Service Integration and Development Unit (SIDU) for Capital & Coast, Hutt Valley and Wairarapa DHBs reported that “upgrading the Wellington Hospital laboratory has been deferred for several years due to capital restraints” and “Hutt laboratory has had very little capital investment for many years”. Some laboratory equipment was described as being “held together by bits of wire” and potential failure placed patients at risk. Privatisation of the hospital laboratories “allows for private capital investment to upgrade the facilities which the three DHBs have not been able to match”.[[90]](#footnote-90)

The short-term financial fix, however, comes at a cost in the longer term given the bottom line for private financial investment is to make a profit.

In the United Kingdom, where private capital investment has been widely used by successive governments to avoid short-term public expenditure in the NHS, some regional services ended up facing such crippling repayments that the Government needed to inject (pounds)1.5 billion in ‘emergency funding’ so that services were not cut to pay the bills.[[91]](#footnote-91)

The draft strategy highlights the importance of “information being reliable, accurate and available at the point of care” (p24). But again there is much anecdotal evidence that DHBs are not investing in information technology sufficiently to enable this to be a reality.

We agree it is important that the health workforce’s activities are supported by up-to-date and functional information technology. Clinicians increasingly rely on information technology to deliver day-to-day services. This includes but is not limited to accessing patient information, electronic medical records, results of investigations, etc. Systems to enable electronic prescribing and electronic requesting of investigations further add to health professionals’ reliance on IT for the management of patients. The ASMS raised with the Capability and Capacity Review team the frustration and time wasted, reported by our members, in dealing with unreliable systems and outdated software. Furthermore patient care can be severely compromised when access to IT is interrupted.

The National Health IT Board is pushing ahead with its work programme and vision of the shared medical record across providers and we fully support this. However, the National Health IT Board seems to have very little or no influence on individual DHBs’ Information Services departments. Some basic functionality is lacking at the coal face. Outdated web browsers, difficulties in accessing email on different work stations, and system down-time adds to frustration and risk.

Patient expectations of what hospital information technology can deliver far exceed reality. Patients increasingly want to communicate with their doctor by means of email, text message and have access to their laboratory results, etc. They are willing to share their health information via insecure IT systems to expedite their care. We urgently need to find a secure solution.

Greater investment in technology, however, is not necessarily a cost-saver, as is suggested in the draft strategy. Technological change could potentially reduce demand for health services and lower costs or, just as easily, generate increased demand on the health sector and raise costs.[[92]](#footnote-92) [[93]](#footnote-93)

We note a government-commissioned review of New Zealand’s Electronic Health Records Strategy[[94]](#footnote-94) suggests more investment in technology could improve ‘productivity’ and lower costs but its arguments are based on fundamentally flawed ‘productivity’ measurements, which the ASMS critiqued in 2013.[[95]](#footnote-95) The review also showed a lack of understanding of our health system by claiming New Zealand’s costs and staffing levels per hospital bed were relatively high without recognising that our hospital bed numbers per population are among the lowest in the OECD. If the draft strategy’s aspirations for greater cost-effectiveness through great use of technology are based on such advice, the potential for improvement will be less than expected.

We also caution that while greater investment in electronic health records and advanced access scheduling may be necessary to move medical care into the 21st century, this should not be conflated with achieving patient centred care. Simply implementing an electronic health record in itself is not patient centred unless it strengthens the patient-clinician relationship, promotes communication about things that matter, helps patients know more about their health, and facilitates their involvement in their own care. Similarly, advanced access scheduling would have limited value, in terms of patient centred care, if it simply leads to greater access to an overworked health professional workforce.[[96]](#footnote-96)

**‘Action areas’ with high risk of unintended consequences**

**‘Health investment approach’**

The health investment approach – based on the ‘investment approach’ currently used by the Ministry of Social Development (MSD) – may be used to ‘target high-need priority populations to improve overall health outcomes’ (p 41). The approach uses techniques from the insurance industry to calculate long-term costs to the government of health and social services.[[97]](#footnote-97)

However, it fails the test of being an investment approach. A true investment approach should take a long-term view of both the costs and the benefits of public services in order to reduce costs while maintaining or improving effective services and benefits. It is the idea of spending now to reduce future costs.

Instead, far from being an investment approach to social welfare, MSD focuses only on costs and benefits to the government and not at the benefits to individuals and the community. Even the Productivity Commission recommended that the investment approach “should be further refined to better reflect the wider costs and benefits of interventions” and called for independent evaluations. It noted that “slavish application of an investment approach based purely on costs and benefits to government might lead to perverse outcomes.

For example, some studies suggest that obesity might reduce future health costs as obese people die more quickly. A health system that sought only a reduction in future health costs might therefore do little, if anything, to discourage obesity.” (p231, *More Effective Social Services*)

Council of Trade Unions economist Bill Rosenberg’s analysis of the ‘investment approach in social welfare concluded:

*It treats citizens as liabilities [the draft strategy call chronic health conditions a ‘burden’] unless they are employed, and even then they are not regarded as assets. This is the logic of the approach and is being demonstrated in harsh, poorly conceived welfare policy which ironically is short-sighted because it ignores human need. Based on commercial insurance actuarial methodologies, it confuses public services with private insurance. It places no value on the purpose for having public services such as social security. It promotes an impoverished approach to public policy which can be dangerously wrong.[[98]](#footnote-98)*

**Social impact bonds**

Social impact bonds (SIBs) are a newly developing form of ‘results-based’ contracting between the Government, private social service providers and investors – which may be financial institutions, charities or individuals.

An ASMS *Research Brief* has identified considerable risks and uncertainties associated with SIBs. In our submission to the Productivity Commission we raised concerns about the lack of evidence that SIBs actually work as intended, especially given uncertainties surrounding how well they are likely to function in the New Zealand context. We further highlighted our concerns at the risks associated with the likelihood of achieving rates of return to investors, potential savings to the Government and being able to accurately measure the success of a SIB programme.

Perhaps the most complex feature of SIBs both for potential investors and governments interested in using SIBs is the ability to generate accurate metrics, both in terms of what will be measured and how outcomes will be attributed and identified. There are also unknown but potentially large costs in developing accurate metrics. Debates around measurement feed into broader issues around the amounts of risk that investors are willing to shoulder, issues around attribution of outcome and factoring in the broader social context of individuals and how outcomes will be linked to payments for investors. There are clearly high risks of perverse outcomes emanating from perverse incentives.

It remains unclear who has responsibility if and when things go wrong. It is not clear whether there will be a gap in service provision if the SIB fails, and who has responsibility for defining and assessing outcomes which will have key ramifications for both the social group involved and future service provision under a SIBs model.

Yet the Productivity Commission maintains SIBs can stimulate innovation by sharing risk and linking payment to performance while leaving the providers (as opposed to the Government) free to determine how to achieve the agreed outcomes.  Accordingly, it sees a role for them in encouraging experimentation and testing the effectiveness of new approaches, though it acknowledges “they may not be suitable for wide application across social services”.

**Proposed changes to the ways services are funded**

New Zealand faces particular challenges in providing an effective and efficient health service, with its small and largely widely dispersed population and an over-stretched medical specialist workforce subject to the pressures of international shortages. The approach to addressing these challenges by successive governments over recent times, following the disastrous competitive market experiment of the 1990s, has been a policy emphasis on collaboration and integration.

The draft strategy highlights the need for ‘trust, cohesion and collaboration’ (p9). However, the proposed new approach recommended in the Director-General of Health’s commissioned Review of Funding contradicts this. If implemented, it would be a fundamental departure from the evidence-based collaborative, integrated model underlying current government policy and a return to the market-based policy of the 1990s. The structure may be different, but the effects would be the same: opening up DHB services to competitive tendering, short-term funding, short-term planning, fragmentation of services and clinical teams, barriers to integration of clinical services, disruption to continuity of care, uncertainty for DHB employees and patients alike, lack of transparency due to commercial sensitivities (especially where private providers are involved), increases in user charges for some (including, potentially, patients opting to travel for elective surgery), and so on.

The funding review goes further and suggests “a separation of DHBs’ planning and funding from their provider arms should be considered”.[[99]](#footnote-99) Such a move would reintroduce a key structural element of the 1990s’ policies which would open the way for a change to a more commercially oriented health system.

Even in much larger countries, market-based health policies (including those using the so-called ‘internal markets’) have been shown to be far less cost-effective and more difficult to manage than collaborative-based models because the complexities of delivering health services do not fit with basic market principles.

As one prominent health policy expert put it, anyone who believes competition works in health just as it works elsewhere “displays an ignorance of a literature stretching back 50 years”.[[100]](#footnote-100)

One of the outcomes of the policies of the 1990 was a loss of public trust in the health system; the same could very well happen if these proposals were adopted which, again, would work against the stated aims of the draft strategy.

The recommendations introduce a great deal of uncertainty for DHB services, with indications that funding will be dispensed only if planned ‘milestones’ are achieved. If they are not – and there may be various legitimate reasons why they may not – their funding would go to another provider. This could have a profound effect on DHB services as a whole.

If some elective surgical services are denied funding in one DHB, for example, presumably necessitating clinicians moving to a different employer, the negative flow-on effect for that DHB could include the effective delivery of acute surgical services, A&E, intensive care, and obstetrics, among possible other areas. For provincial DHBs especially, the impact would undermine the viability of the hospital services with a further downstream impact on primary care.

We note also that these sorts of moves would be in the context of proposed changes to national prices, though it is unclear what these changes would entail. A leaked document of the review explained they would “reflect lowest cost DHBs”, which has been edited from the official document.[[101]](#footnote-101) There is a high risk of perverse incentives where the primary goal of providing low-cost services takes precedence of quality and safety, especially considering we are still a long way from having a robust, comprehensive system of monitoring and evaluating quality and safety. As incentives to cut costs intensify, so too must the emphasis on ensuring quality and safety. This would involve more resources than are presently made available.

Indeed there is much contained within the recommendations that suggest increased administration and technology costs. When health funding is falling in real terms, including funding of the Ministry of Health, it is difficult to see where the resources are going to come from to implement these often complex arrangements.

Exacerbating the effects of a competitive approach to funding and providing services is the idea of splitting DHB funding into four pools. This does not correspond at all to the way services are provided to patients. Cancer treatment services, for instance, are provided right across community-based and hospital-based services. It is the same patient throughout, and to carve up the funding would seriously risk fragmenting the services and potentially causing patient harm.

We note that “at least to start with” the DHBs and the Ministry of Health will manage these multiple funding pools. There is no acknowledgement of the additional administrative costs involved in that task. Presumably there is a plan to shift this task to some other body in the future, again harking back to the 1990s.

We note also that the Funding Review’s recommendations are at odds with those of the ‘Capability and Capacity Review’. For example: “The revised [operating] model should … provide DHBs with funding certainty so that they in turn can lengthen downstream contracts with providers beyond the current one-year lengths.”[[102]](#footnote-102) As discussed above, it seems clear that if the Funding Review recommendations were adopted, DHB funding would be anything but certain.

It is important to recognise that the Funding Review recommendations are the result of a secretive process. They impose changes from the top. It is an approach that has a poor record in health systems internationally, not least in New Zealand. Time and again the opposite, bottom-up approach has been found to be more successful. Distributive clinical leadership is a prime example.

As Des Gorman has said:

*Quite simply, the reforms we need are only likely to be successful if clinically led.[[103]](#footnote-103)*

And the Ministerial Review Group:

*The past is peppered with reforms, designed along varying philosophical lines, and implemented by various government agencies. These reforms have generally been top-down and have had mixed levels of success. None, however, have been led by clinicians, even though the resulting changes have often had significant effects on clinical practice. This was particularly the case during the 1990s, when reforms were occurring against the background of the need for a substantial reduction in public expenditure. Health managers have also been asked to implement reforms without the mandate or co-operation of the clinicians who would be key to making them successful.[[104]](#footnote-104)*

Whether in the context of ‘reform’ or ‘review’, the above observations apply equally when the changes being imposed affect the way clinical services are delivered. Our reading of the proposed recommendations is that they certainly do impact on decisions concerning clinical services and on the way those services are delivered. The result, therefore, may well be the same scenarios where health managers are required to implement measures without the mandate or agreement of the clinicians who are key to making them successful.

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| **341** | Submitter name | [redacted] |
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4 December 2015

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

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

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

1. Thank you for the opportunity for the Auckland Regional Public Health Service (ARPHS) to provide input into the draft update of the New Zealand Health Strategy.
2. The following submission represents the views of ARPHS and does not necessarily reflect the views of the three District Health Boards it serves. Please refer to **Appendix 1** for more information on ARPHS.
3. Once again, thank you for this opportunity to submit on this issue. We would be happy to supply further information.

Yours sincerely,

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| [redacted]  **General Manager**  **Auckland Regional Public Health Service** | [redacted]  **Clinical Director**  **Auckland Regional Public Health Service** |
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**SUMMARY AND KEY RECOMMENDATIONS**

1. The review and update of the New Zealand Health Strategy (the Strategy) provides an opportunity to take stock of the challenges of today and tomorrow. These challenges are substantial and the pace of change is fast. How New Zealand’s health system (through all its participants) anticipates or reacts to these challenges will be vital for setting a successful foundation for populations to live well, stay well and get well.
2. The updated Strategy is focussed primarily on health system improvements and efficiencies rather than on population health gain priorities. To ensure population health gains are maximised more strategic development will be needed in areas such as reducing the incidence and impact of cancers, heart disease and obesity.
3. As the World Health Organisation has long established, many determinants of health lie outside the health sector. It will be important that the Strategy acknowledges and, where appropriate, aligns with other initiatives and plans to improve health outcomes from a range of sectors, specifically with local authority planning tools and the urban development sector.
4. ARPHS main comments and recommendations are:

* We support the review and revision of the Strategy.
* Continuing with the status quo will not be enough to address many of New Zealand’s significant health challenges for today and tomorrow.
* The Strategy provides an opportunity to communicate widely the role of the Ministry as a steward. This is an important role in shaping and lifting health outcomes over a long period – to marshal and direct, cohesive and coordinated effort.
* Prevention is key. Effective and appropriate early intervention can lead to significant health gain across the population. We recommend the level of prevention actions within the road map is strengthened to improve quality of life.
* We support the Strategy’s focus on collaborating across government agencies, and have suggested amendments to strengthen this theme from a public health perspective.
* ARPHS encourages integrated planning between District Health Boards and local governments as urbanisation and population growth continues to play a significant role in contributing to people’s wellbeing.

**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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| **Communicating the Ministry of Health’s Role**  The Strategy provides an important opportunity for the Ministry to clarify its role in a large, complex and devolved system. The Ministry’s role in safeguarding, protecting and enabling the health system is likened to stewardship.  Clarifying roles and responsibilities in an explicit manner can help the Ministry stimulate coordinated action and effort as intended.  *\* Note: We have identified several opportunities that will be discussed later on in the submission form. We consider these opportunities should be embedded across the Strategy, rather than simply identified.* |

**The future we want**

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

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

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

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| This statement links in the Strategy’s vision and strategic themes, and we are supportive of this. Population health contributes to New Zealanders living well and staying well.  We consider the “providing services closer to home’ phrasing within the statement comes at the expense of other key concepts and actions captured under the Strategy’s ‘closer to home’ theme, which is also about focusing on wellness and prevention. A different title to represent the principles and actions of this theme may be warranted. |

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

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

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| We welcome the retention of the guiding principles from the 2000 New Zealand Health Strategy.  We strongly support the addition of principle 8 – *thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing -* because it acknowledges that other sectors beyond the health sector influence health outcomes. |

**Five strategic themes**

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

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

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| **One Team Theme – could be expanded**  We support the “one team” theme. However, this tends to acknowledge only those participants in the health sector. This theme could be expanded to apply a “*whole of society focus*” as there are many government agencies, business and community groups whose successes influence health outcomes. Examples include education, employment, justice, environment, transport, infrastructure, finance, charities, and community groups.  Partnering across government is a real opportunity and strength of the Strategy to advance public health action. We are encouraged that collaborative actions are highlighted in the Strategy, but believe the concept of collaboration could be elaborated on further under the ‘One Team’ theme, with specific focus on identifying opportunities where the Ministry can lead collaboration across sectors to achieve potential health gains.  Auckland’s growing population of 1.5 million people creates the need to collaborate with agencies inside and outside of the health sector.  Healthy Auckland Together is an exemplar of collaboration in the Auckland region, and we are delighted to see its inclusion as an example of integrated planning. We believe this type of collaborative model could be implemented in other regions to improve health outcomes. |
| There is an opportunity for the Strategy (particularly within the Roadmap of Actions) to promote/guide the creation of such collaborative models across New Zealand. The World Health Organisation’s Health in All Policies Framework[[105]](#footnote-105) is another example.  **Smart System**  We are supportive of the Strategy’s recognition that we need to increase New Zealand’s national data quality and analytical capability to improve transparency.  Development of new technologies for service users as part of a ‘Smart System’ should take into account accessibility for people with disabilities and the elderly. This is an area that could be explicitly strengthened within the Roadmap actions.  **Addition of a new theme – Measuring Success**  Measuring progress and effectiveness are important activities that are often under resourced and unplanned.  We would recommend an evaluation framework be considered as another theme with a series of specific and tangible actions underneath. The Strategy must be capable of monitoring progress and specifying accountability. |

**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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| **Strengthen preventative actions**  We consider there is an opportunity for the Strategy to place greater emphasis on upstream preventative measures in order to achieve significant gains in the overall health and wellness of New Zealanders. |
| The Strategy as currently drafted, particularly at the Roadmap action level, seems weighted towards the provision of health services, while limited attention is paid to promoting actions that will address the wider determinants of health and inequalities. With our aging population, demands on the health system are potentially overwhelming unless sound investment in prevention is made.  The Roadmap actions also lack specificity as to how the overarching principles of the Strategy and the primary goal in each work area will be delivered. Clear, bold and direct action points should be established.  There are several key healthy life choices that should be promoted in the strategy to support the ‘live well, stay well, get well’ vision.   * + Stop smoking.   + Eat good food.   + Physical activity.   + Moderating alcohol use.   These are decisions that should be encouraged at a system level and ought to be adopted throughout the Strategy to help healthy life choices become easier choices.  **Include a separate work area to focus on broad based population-based strategies to address long-term conditions and obesity.**  Further to our comments above, we recommend the inclusion of a separate work area in the Roadmap to focus on broad based population-based strategies to address long-term conditions and obesity.  Apart from Action 5(h), most of the sub-actions under Action 5 – Tackle long-term conditions and obesity appear to relate to the health system and managing the care of the individuals with chronic conditions, rather than focusing initiatives at a population level and towards the prevention of long term conditions.  Action 5(h) acknowledges that a package of initiatives will be required to prevent and manage obesity in children and young people up to 18 years of age, including “a broad base of population-based strategies to make healthier choices easier for all New Zealanders”.  We consider the underlined action should be a separate work area in its own right, and the subsidiary actions contributing to it need to be elucidated, so there is greater clarity on how obesity and other long-term conditions will be addressed. |
| **Action 20 – Strengthen the impact of health research and technology**  We note the Ministry will work with the Ministry of Business, Innovation and Employment (MBIE) and the Health Research Council to better align and strengthen the impact of health research for New Zealand. Following the recent review of the Health Research Council, it has been recommended that a new 10 year health research strategy be developed to focus and align the economic and health goals of the health research sector and maximise the contribution of science to New Zealand’s economic growth and wellbeing of New Zealanders.  This provides an opportunity to reassess the benefits of various research fields, the model for funding this research, and how research opportunities may be identified and screened to better meet the needs of research end-users.  In Canada, under the Applied Health Research Question model[[106]](#footnote-106) a portion of funding awarded to health service researchers by the Ontario Ministry of Health and Long-Term Care can be accessed by the broader health care sector to pose their own research questions. Findings are made public and must be relevant to other organisations in the health sector. This allows government-funded researchers to better meet the current and future research needs of the provincial health system, and increases the uptake of research findings. It also fosters ongoing relationships between researchers and decision-makers.  We believe a similar type of model could be established and administered through the Health Research Council. |

**Turning strategy into action**

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

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| As noted above, an additional theme on measuring success should be included. |

**Any other matters**

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

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| **Environments – Planning and Health**  Making healthy choices easier is a concept promoted in the Strategy. Exploring this concept further, the Strategy should recognise that population health outcomes and the quality of the urban environment are intrinsically linked. The nature of the urban environment we live in can influence our behaviour and contribute to making healthy choices easier, or harder.  The Strategy rightfully identifies obesity as a key challenge. However, it is “obesogenic” urban environments that discourages physical activity and encourages dependence on cars for daily functions. It also encourages easy access to high energy/low nutrient food products. The current urban environmental settings contribute to the increase in obesity and diabetes with the serious consequences for health, wellbeing and productivity. A strategy focusing on underlying causal factors, as well as individual choices, is needed.  The way a suburb, town or city is developed can impact on factors such as:   * Social exclusion and segregation;   + Housing (affordability and quality);   + Disparities in environmental hazard exposure (such as where factories and other industrial production facilities are located);   + The ability of people to engage in active transport (walking and cycling);   + Access to healthy food environments.   Greater integration between the health and local government sectors could be strengthened in the Strategy. For instance, there is unrealised potential within New Zealand’s planning framework to improve public health outcomes and support other preventative health measures via spatial planning interventions.  In the last year ARPHS has been engaged in the planning process for the Proposed Auckland Unitary Plan (PAUP); the new rule book for Auckland. To help combat obesity rates, we suggested that zoning restrictions be adopted to control the proliferation of fast food outlets in the Auckland region. |

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| We were particularly concerned that the current Auckland planning settings had allowed fast food clustering to occur in lower-socio economic areas. The most deprived neighbourhoods in Auckland are seven times more likely to have fast food premises than grocers within a five minute drive.[[107]](#footnote-107) This illustrates clearly that under these conditions unhealthy choices are an easy choice.  Planning is not the silver bullet to address obesity, but could be part of a coordinated regime of effective policies, programmes and interventions that together, address obesity outcomes. However, we need greater recognition at a national level (and through the Strategy), that the built and physical environment plays an important role in addressing long-term conditions such as obesity and diabetes.  The Strategy provides an excellent opportunity to provide the national narrative and promote the development of healthy urban environments. This is particularly appropriate considering the government’s present discussion around:   * RMA reform work currently underway by the Productivity Commission. * Ministry for the Environment’s National Policy Statements on Urban Development.   The Strategy can identify spatial planning as a potential lever for improving health outcomes.  **Use of the term ‘public health’ vs. ‘population health**  Throughout the Strategy the term ‘public health’ is predominantly used to refer to the public provision of health services rather than as a population and health promotion response. The distinction between these two concepts should be clear. A glossary of terms is recommended so definitions are clear. |

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| **342** | Submitter name | Liz Stockley | | |
| Submitter organisation | Health Hawkes’s Bay Te Oranga | | |
| This submission was completed by: *(name)* | | | | Liz Stockley and Health Hawke’s Bay Te Oranga |
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| *(town/city)* | | | |  |
| Email: | | | | Liz@healthhb.co.nz |
| Organisation (if applicable): | | | | Health Hawke’s Bay Te Oranga |
| Position (if applicable): | | | | CEO |

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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| **On behalf of the Board and team at Health Hawke’s Bay – Te Oranaga:**  In general the challenges and opportunities as stated are accurate.  One additional challenge (or symptom of the challenges we face) is the sheer volume of initiatives, priorities and targets that require focus – some of which are not always the most important focus for our local population here in Hawke’s Bay.  The strategy should clearly articulate that some of the issues we are facing including obesity are already overwhelming the system – this is not just a looming problem it is a current problem that we do not have the immediate capacity to resolve.  The workforce issue needs to encapsulate the challenge of encouraging young people – especially Māori and Pacific into a career in health – particularly the primary and community health sector. We need to make improvements in how we support, mentor and fund their development.  The documentation identifies the need for us to learn better from each other. We also need to invest in learning from our communities. We do not support the evaluation of successful projects that are not Health system owned projects – a local example is Iron Māori – a programme which has done a significant amount for Māori health with little support from public funds. We need to hear stories from successful community initiatives, and review some of their data to learn what has made them a success. |

### The future we want

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

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

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

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| **On behalf of the Board and team at Health Hawke’s Bay – Te Oranaga:**  In general the future direction statement captures the right essence although the terminology is clumsy and would not necessarily appeal to the general public.  It would be good to incorporate the commitment to **empowering** people - in partnership with whanau/family and communities for a Healthier New Zealand. We need to give individuals the tools they need to self – manage and make good decisions. Not necessarily make the decisions for them.  The statement should also encapsulate the need for us to ‘die well’ at the right time in an appropriate environment. |

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 behalf of the Board and team at Health Hawke’s Bay – Te Oranaga:**  Health Hawke’s Bay – Te Oranga would like to congratulate the Ministry of Health for the explicit inclusion of the special relationship between the crown and Māori and acknowledgement of our responsibilities under the Treaty of Waitangi. As we move into the era of co-design and community involvement in the design at both the systems level and at the individual level it is vital that we do so with respect to the treaty.  We are pleased that there is consistency maintained in the direction through the conservation of the guiding principles from the original strategy and feel that these are still relevant and appropriate. |

### 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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| **On behalf of the Board and team at Health Hawke’s Bay – Te Oranaga:**  The Five strategic themes are good but they do not provide for the prioritisation of **equity** and **giving children the best start in life** which need to be the focus of a sustainable action plan for the future.  **People-Powered:**  The phrase “we will be people powered’ suggests that we are not now. People are currently and need to continue to be the centre of the system. We believe the essence of the ‘people powered’ statement is to bring in the notion of self-management, empowered health literate population and a capable workforce. We do not believe the phrase reflects this level of empowerment.  **Smart Systems:**  Health Apps and patient portals are mentioned a number of times – care must be taken not to lose sight of the people in our community who will not (for numerous reasons) engage in this way. There also needs to be very strong advocacy for those who cannot advocate or self-manage. We need to be careful not to overestimate the mileage we will achieve through this area of health service development |

### 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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| **On behalf of the Board and team at Health Hawke’s Bay – Te Oranaga:**  **Prioritisation of Resources**  The Board and staff of Health Hawke’s Bay – Te Oranaga believes the Ministry could be braver in the prioritisation of resources in two specific areas: 1) equity – prioritising resources on those populations most underserved; and ii) giving children the best start to life.  In terms of return on investment and long term impact the action plan needs to provide a specific focus on the prioritising of children and improving their start in life. There are significant risks to the sector in not focusing our resources on getting a healthy start in life.  An emphasis on prioritising investment of resources on Māori, Pacific and those living in the poorest conditions would benefit all of us, not just economically but through the strengthening of our most vulnerable communities.  **Clinical Leadership**  The roadmap identifies mechanisms for improving system leadership and the management of key talent. Clinical leadership is also an area that needs to be supported with specific development activity, particularly in the primary care space.  **Workforce development**  There is a need for workforce development activity to be focused on primary care, particularly in the rural communities where the sustainability of workforce is a critical issue.  **Dental Care**  Dental care is mentioned briefly, however, not really reflected in the roadmap. Bad teeth and gum disease affect all aspects of health care, most especially in long term conditions. The cost of dental health care for those on low incomes needs to be addressed. |

### 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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| **On behalf of the Board and team at Health Hawke’s Bay – Te Oranaga:**  The Board of Health Hawke’s Bay – Te Oranga felt that the roadmap was weak, particularly from a primary care point of view. The actions identified are not significantly different from the activities currently being worked on at a local level and it is hard to see how this roadmap will enhance what we are already doing locally.  **One Team**  The road map for one team needs to be strengthen with incentives for organisations to work more closely – beyond the boundaries of the health system. It would also be good to see engagement with communities specifically incorporated into the action plan. If we are asking communities, whānau and individuals to step up as equal partners in their health care we need to properly engage with them and provide them the tools to support this.  **Smart Systems**  One specific area of concern is the focus on systems development for secondary care with no immediate improvements suggested at the primary level. Improvements at the primary care level will positively affect a greater number of people and might reduce downstream demand for secondary services.  There is an immediate need for the National Health IT Board to be supporting the primary care sector better in terms of IT. Small organisations are individually investing too much for little return. Economies of scale are vital and need to be achieved at national level in such a small country. Too much health money and human resource is being invested for too little return. |

### Any other matters

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

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| **On behalf of the Board and team at Health Hawke’s Bay – Te Oranaga:**  As a general comment, the Board and staff of Health Hawke’s Bay – Te Oranga expressed a concern that whilst the themes of the strategy are good, the strategy documentation is not written in a way in which people can engage easily with it. It would not be understandable to the general public. It does not paint a picture of how the future will look different for the individual or whānau.  Further to this, whilst the strategy makes sense, it is felt that the strategy lacks energy and inspiration. This is not a tool through which the sector will find additional motivation or inspiration. The strategy will not encourage the people of New Zealand to buy into taking better care of themselves.  Our final comment is that we have been working on these strategies and more over the last years and that there has been “incremental” change; is “incremental” enough? Could creating a sense of urgency be appropriate? Given the challenges ahead. |

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| **343** | Submitter name |  |
| Submitter organisation | APEX Association of Professionals and Executive Employees |

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**Update of the New Zealand Health Strategy**

New Zealand Resident Doctors’ Association (NZRDA), Association of Professionals and Executive Employees (APEX) & the New Zealand Medical Laboratory Workers Union (NZMLWU) Joint Submission

This joint submission to the NZ Health Strategy consultation is on behalf of the New Zealand Resident Doctors’ Association (NZRDA), the Association of Professionals and Executive Employees (APEX) and the New Zealand Medical Laboratory Workers Union (NZMLWU). Collectively, these three unions represent the interests of more than 6,400 health employees. The NZRDA is the only organisation in New Zealand solely representing the interests of Resident Medical Officers (RMOs). NZMLWU represents laboratory workers employed in both the private and public sector and provides a democratic inclusive environment in which Medical Laboratory Science can be promoted. APEX represents allied, scientific and technical health professions including the following:

Anaesthetic Technicians

Audiologists

Clinical Physiologists

Dental Therapists

Dietitians

Medical Physicists

Medical Radiography Technologists

Opticians

Perfusionists

Pharmacists

Physiotherapists

Psychologists

Radiation Therapists

Scientific Officers

Social Workers

Sonographers

**Executive Summary**

We would like to thank the Ministry of Health for providing us with the opportunity to comment on this consultation document. There is much to commend in the new health strategy, such as the placing of patients at the centre of everything we do (patient empowerment) and the utilisation of advances in technology and infrastructure to automate routine task, share information and improve patient interaction (patient portals). The numerous benefits contained in this document are obvious and as such they have not been commented on in our submission. The focus of this submission is on identifying the various risks and deficiencies contained in the health strategy that are evident to us.

Thank you in advance for taking the time to read and consider our submission. If you have any questions or require clarification or further information please do not hesitate to contact Luke Coxon (Advocate) at [support4@apex.org.nz](mailto:support4@apex.org.nz) and we will endeavour to assist you where possible.

The main points of our submission are summarised below:

* We are supportive of the measure to consolidate specialist/tertiary services into a smaller number of services delivering specialised care for a defined population base.
* We recommend that the statement of NZs health strategy should be changed to *‘*All New Zealanders, live well, stay well, get well *and end well*’. This would recognise that the health system is also about providing end of life care.
* While agreeing with the need for an expansion of early intervention and prevention programmes we are concerned about possible deficiencies in existing programmes and the accepted premise that this in itself will reduce future health expenditure.
* The ‘one team approach’ aims to contribute to a culture of trust and partnership. In doing so it we hope that the strategy will put in place effective strategies to confront the endemic culture of workplace bullying.
* Underfunding and a policy to restrict the wage growth in the public health sector have resulted in wages dropping below the inflation rate and the rate of wage growth in the private sector. This is unsustainable and will inevitably lead to a less efficient and effective service.
* The new health strategy lacks clarity around what its direction actually is, what needs changing and what it purports to change, how it will be implemented and by whom and is deficient on identified and measurable outcomes/objectives.
* While the strategy recognises that the health sector workforce is ageing and dependent on the overseas recruitment of health professionals to maintain it, it fails to propose any adequate strategies/policies to mitigate this and ensure the future sustainability of the professional health workforce
* The new strategies future direction points towards a gradual slide towards the privatisation of health care. We are highly concerned about its bias towards contracting out of services and the possible expansion of social bonds programmes.
* Due to a lack of detail on what is actually being proposed a number of questions arise regarding what the actual impacts/outcomes will be of the reforms/programmes that are implemented.
* The new strategy will continue the underfunding of the health sector and we fear that any expansion of new services will come at the cost of the funding of existing services and the secondary sector.

**Centralisation of the provision of specialist / tertiary health services**

The strategy stipulates that specialist/tertiary services should be consolidated into a smaller number of services delivering specialised care for a defined population. We are supportive of this measure.

Under the slogans of competition and community control, DHBs can become beholden to local vested interests and pressure leading to waste and inefficiency. An illustration of this is the provision of neurosurgery services in the Southern DHB. It is not a necessary or life preserving service, patients in the Otago region could access neurosurgery in Christchurch and then recuperate ‘closer to home’.

The Southern DHB is currently bankrupt and is paying out of its budget for a speciality service it doesn’t need to provide out of necessity. While a decision to close down its neurosurgery service would not be politically popular, the expenditure could be better utilised on providing other necessary services (such as orthopaedic surgery), reducing waiting lists and increased staffing. Despite the DHB Board being dismissed and a caretaker commissioner being appointed, no hard decisions have been made as to what are the appropriate and necessary services for a mid-sized regional DHB to provide.

We hope the new strategy is able to overcome vested political interests and pork barrel politics to genuinely ensure the appropriate, clinically sustainable and efficient delivery of specialist tertiary services in appropriate centres that are available to all of those who need them.

**All New Zealanders should be able to end / die well**

The statement that ‘All New Zealanders live well, stay well, get well’ misses out a central component of what health is also about and that is our mortality and end of life care. New Zealanders want the ability to end their lives in an environment of theirs and their families choosing and that requires being able to prepare for death.

It is likely that the strategy fails to recognise this due to the political sensitivity concerning debates around euthanasia. While being able to ‘end well’ could also include the right to euthanasia, it doesn’t have to out of necessity. When we refer to being able to end well, we mean about living a life in a way so that it ends well and a death occurs. We all generally want to have a good death that occurs at the proper time and the proper place. It means recognising that many people do not want to have their lives unnaturally prolonged in hospitals. Such deaths are financially wasteful to society and cruel to the individual and their loved ones.

We propose as such to change the statement of NZs health strategy to *‘All New Zealanders, live well, stay well, get well and end well*’. If this was adopted it would as give greater substance to the ‘closer to home’ and ‘people-powered’ themes of the heath strategy.

**A focus on preventive strategies and early intervention services**

The Health Strategy proposes to mitigate projected future expenditure increases through adopting an investment approach in which long term impacts are valued alongside immediate short-term gains. In doing so, the strategy places a greater emphasis on an expansion of prevention and early intervention services, through an expansion of primary, community and home-based health care. It is envisioned that this would enable people to manage their own health, and help prevent and mitigate health conditions that occur later in life. While agreeing with the need for an expansion of such services and programmes we do have the following concerns/ comments:

* There is little evidence that such approaches will in fact result in reduced costs in the future. In the short term the expansion of these services will result in new and unidentified expenditure increases.
* While these new services are being rolled out, we still have a sizeable proportion of the population that have long passed the stage of early intervention and are dependent on secondary health care to manage their conditions and provide for their care. If funding is diverted from the secondary to primary sector they will be the ones that pay the price in a reduced and/or inferior care.
* There is at the present time little evidence of the effectiveness of existing programs such as Whanau Ora. The public needs access to evidence based assessments/reviews that expound what has and has not worked.
* The view point that Maori and other ethnic minorities are best treated by clinicians and health professionals of the same ethnicity is problematic. A Maori or Pacific patient, like any other patient, if given the choice would want to receive the best possible care, from the best available physician/professional. What is also needed is cultural sensitivity training to enable *all* health clinicians/professionals to care for patients of different ethnicities, in the most culturally appropriate manner.
* Existing prevention and early intervention programmes have failed to alter the current trajectory of NZs growing obesity epidemic. The hard questions such as ‘why is this the case?’ need to be asked, analysed and answered.

**Confronting endemic bullying in hospitals and the one team approach**

The health system has an endemic and entrenched culture of workplace bullying that is based on false hierarchies of and within the medical professions. Resident doctors have recently highlighted the abuse they suffer from senior doctors as a result of teaching by humiliation. The trainee apprentice model results in senior doctors using the hierarchy of disparity in authority amongst doctors to abuse their power. Unfortunately, bullying is not only restricted to the RMO and SMO workforce. Rather, it is endemic throughout the health system and impacts on the entire workforce. Bullying results in the victim losing confidence and impairing their performance. Ultimately this can have a negative impact on patient safety.

The ‘one team approach’ aims to contribute to a culture of trust and partnership. In doing so we hope that the strategy will put in place effective strategies to confront the culture of bullying in the public health system. The health workforce will never operate genuinely as a team as long as a culture of bullying and false hierarchies prevails.

**Underfunding and the health workforce**

In the background to the new strategy are the fiscal considerations that guide it. The strategy quotes and by default agrees with the position of Treasury that “considers that New Zealand cannot afford to keep providing services as we do now. It projects that, without significant change, government health spending would have to rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060”.

We are concerned that the new health strategy fails to address the pressing needs of the secondary hospital health sector and its professional health workforce. We fear that any expansion of new services will come at the cost of the funding of existing services. The prevailing view that health funding is tracking at an unsustainable rate, has resulted and justified successive years of underfunding. Vote Health’s operational budgets have been decreasing as a proportion to GDP, from 6.56% of GDP in 2009/2010 to an estimated 5.99% in the 2014/15 budget allocations. If Vote Health’s budget had matched the same proportion of 2009/10 it would have received an additional 1.4 billion dollars (Reality Check ASMS 2014).

The CTU and Association of Salaried Medical Specialists estimated that the 2015 Health Vote was $245 million behind what is needed to cover new services, increasing costs, population growth and the effects of an ageing population. The DHBs funding was deficient by $133 million. We are concerned that there is no indication that the new strategy will change this trajectory. The provision to align funding and embed the partnership between the Ministry of health, Treasury and the DHBs for capital expenditure signal that underfunding will continue to the detriment of the provision of quality public health care. Successive years of underfunding have resulted in the following outcomes:

* Understaffing and employees working excessive and unsafe hours of work to the detriment of theirs and patient safety.
* A failure to reward productivity and performance. Despite provisions in our collective agreements to reward merit and performance, few staff are actually rewarded for high performance. The need and pressure to keep budgets in check override this.
* A serious erosion of clinical standards. This has manifested itself in that last year with four DHBs having training accreditation for doctors either being lost or threatened.
* A focus on getting patients out of the hospital as quickly as possible can come at the detriment of care.
* Workforce profession shortages and a failure to adequately rectify/mitigate shortages.

Underfunding and a policy to restrict the wage growth in the public sector has resulted in wages dropping 2.5% below the inflation rate between March 2010 until March 2015 and 3.2% below the rate of wage growth in the private sector. Treasury, the Ministry of Health and the DHBs Shared services, have effectively collaborated to ensure wages and other conditions of employment do not increase beyond what is an agreed % cost amount (referred to as the annualised cost of settlement).

Every year unions are told this is all you can have; regardless of the peculiarities of a professional workforce group (shortages, recruitment and retention, private sector market rates etc.). This trend of deliberately restricting wage growth is unsustainable and inevitably leads to a less efficient and effective service. Low morale and the recruitment and retention of staff suffer. It results in inflexibility when it comes to addressing the unique situations of particular professions and hinders the ability for unions and the DHBs to work collaboratively together to address the needs of the whole health system.

The health strategy recognises that the health sector has an ageing workforce and is now part of a highly mobile global workforce and dependent overseas recruitment of health professionals to maintain it. It however fails to propose any adequate strategies to mitigate these factors and ensure the future sustainability of the workforce. Nearly all medical professions are included on NZ Immigrations skills shortage list and we currently have the highest dependency on overseas recruitment (42 per cent of the medical specialist workforce) of any country in the OECD.

Many health professions are either facing or about to face international shortages placing the long term sustainability of the NZ heath system at considerable risk. The strategy merely reiterates existing policy/strategies to continually invest in training and to work with Health Workforce New Zealand (HWNZ) to identify and fill workforce shortages. HWNZ have in recent years identified that sonographers, medical physicists and radiation therapists are experiencing “critical shortages”, however little has been done to rectify and reverse this situation. In the case of Medical Physicists, the failure of the Ministry of health and DHBs to act on their ‘critical shortage’, led to a prolonged industrial dispute this year. If we look at the data concerning the Medical Physicists workforce we get an understanding of the challenges we are up against;

* 66% of Medical Physicists are overseas trained.
* 54% of New Zealand trained Physicists work overseas. Mostly in Australia where wages are 30 to 50 percent higher. Few of them plan to return to NZ due to this substantial pay differential and many currently here are contemplating leaving.
* There is a current 24% deficit in DHB staffing levels.
* Increased cancer registrations in the next five years will double the number of certified Medical Physicists required. It takes 9 years to complete the requisite training (including 5 years of post-graduate training) to practice.

Despite this substantiated recruitment and retention workforce crisis, short term cost implications have driven the position of the DHBs, at the expense of the long term sustainability of cancer treatment in NZ. Such a short sighted position results in greater financial costs and inefficiency in the long term. There is a need to take the necessary measures to ensure NZ has a sustainable and highly skilled professional health workforce. The strategy as it stands fails to take up this challenge.

**A foreseeable slide towards the privatisation of health care**

The strategy points to a renewed focus on the private sectors role within healthcare provision and a continued policy of favouring the contracting out of health services. The strategy proposes a health-focused investment approach that would entail inviting the private sector and non-profit sector to bid for contracts. While it refers to expanding the use of contracting for health equity outcomes, such assertion is driven more than ideological bias rather than based on actual evidence of the benefits of contracting out.

The contracting-out business model is fraught with problems; contracts can tend to be awarded on the basis of cost rather than on the ability to deliver an effective service. A race to the bottom ensues with providers, competing to outbid each other through providing the cheaper service. The private sector is driven by the pursuit of profit and this will often take precedence over the provision of quality healthcare services, patient needs and the interests of the New Zealand health system. A case in point is the private sectors failure to invest resources into the training/education of the future health workforce.

The focus on contracting out of service delivery to non-profit community organisations and NGOs can also lead to patients gaining an inferior service due to the limited capacity (skilled employees, experience and resources) of these community organisations to deliver the service. The health strategy justifies the contracting out model on the basis of community empowerment; however this model of service delivery is primary guided by financial considerations, community organisations are able and prepared to provide these services at a lower cost than the government can.

Though not explicitly stated, we have a concern that in the background to the strategy is the future introduction of bulk funding of health care providers and an individualised voucher system for accessing healthcare. Its focus on performance management, health investment and consumer (patient) empowerment also point towards utilising social bond programmes. Social bonds programmes have already been introduced this year with a focus on mental health, cutting prisoner offending rates and managing long term health conditions.

Social Bonds are a kind of interest-bearing IOU, just like financial market bonds and have the following characteristics:

* Government contracts out social services to non-government or private organisations. Time-frames and targets are set for them to meet
* Investors buy social bonds to fund their services
* Investors buy social bonds issued by the Government to fund the ser­vices.
* If the targets are reached, the Gov­ernment pays back the investors, plus a return on the investment (to a maximum amount).

Putting aside the ethical questions about the morality of applying market principles to the delivery of social services to vulnerable groups, we are left to wonder: are Social Bonds even based on sound science in the first place?

One of many commentaries against the Social Bonds is from Associate Professor Michael Anthony O’Brien from the School of Counselling, Human Services and Social Work at Auckland University. He sees Social Bonds as a dangerous tool that runs substantial risk of very serious harm. The most serious problem, in his view, is that the services will be based on investment returns, not on the needs of those receiving services. The most vulnerable will be dependent on the willingness of investors, who want a return on their capital - in some instances quite a significant return. Those whose needs don’t meet the investors’ interests will be left behind and will get, at best, less services, often of an inferior standard. They will be the most vulnerable, with the greatest needs, from, for example, the most deprived and disadvantaged backgrounds.

While proponents of Social Bonds say their implementation would create more competition between providers, broaden the range of services available and save taxpayer money, since the Government only pays for what works (when targets are met), these benefits are far from proven.

In Professor O’Brien’s words: “Social bonds allow government to do less and underfund critical services and programmes. They also create a great opportunity for social engineering based on investor decisions. If additional funding is going to create the possibility of better outcomes for vulnerable children and families then those outcomes should be available for all, not just those who are acceptable to investors. Vulnerable children and families should not be the subject of another unfortunate experiment.”

If the further roll out of privatisation, contractualisation and social bonds is indeed on the agenda, it would be a massive step in the wrong direction. The health strategy needs to come clean on what it is actually proposing to do and not hide its intentions behind buzzwords and management change rhetoric. The public deserves to know what is actually being proposed and afforded the right to be consulted. Without this ‘transparency’ any talk about a people powered health system is merely empty rhetoric.

**A lack of clarity and measurable outcomes**

The new health strategy seeks to address the various challenges facing the health system with a renewed clarity of direction. Unfortunately the strategy offers little clarification on what this new direction is, what needs changing and what it purports to change, how it will be implemented and by whom, and what measurable outcomes and objectives it seeks to achieve.

Whilst the strategy does propose extending preventive and early intervention services and programmes and on utilising advances in technology and infrastructure to automate routine task, share information and improve patient interaction (patient portals), beyond this there are few tangible objectives/outcomes presented. The secondary health workforce are notably absent from the strategy and there is little understanding gained on what the new strategy would mean for ourselves, our professions, the hospitals we work in and the public and patients we serve.

The strategy is deficient when it comes to implementation details and measurable, evidence based outcomes. For example, under the theme of ‘value and high performance’ it speaks about secondary hospitals improving their core services and strengthening their partnerships with regions to address workforce and quality pressures. There is however no explanation or evidence presented as to how core services will be improved and how these improvements will actually be realised. The strategy merely accepts that this is what will happen and asks us to trust that it will deliver.

There is also an overemphasis on rolling out abstract change management/processes and systems of governance (decision making, accountabilities, system leadership etc.) without identifying what currently needs to be changed in the system. The strategy seems to elevate process above achieving tangible evidence based objectives/outcomes/outputs. It seems to say that if we get the fundamentals of the process/governance right then the benefits will automatically follow and the system will correct itself. If anything the strategy raises more questions than it answers, as to what is actually being proposed, what will be implemented and what the actual and not stated impacts/outcomes of the reforms/programmes will be.

Given past (recent) history, strong leadership and support from the centre will be needed.  We doubt "stewardship" will be sufficient in the face of political reality.  We are also concerned that "leadership" appears to being used in the same manner as "management".  Management is not the same things as leadership and we need both.  Whilst managers can be leaders, many are not.  We are rich in bureaucracy and poor in good management: less management but more good management is required.  Leadership is distributive: many people can be leaders.  Amongst other things effective support for clinical governance is essential if we are to get this element functioning well in health.

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| Submitter organisation | Brewers Association |





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***Introduction to the Brewers Association of Australia and New Zealand***The Brewers Association of Australia and New Zealand represents major brewers with the core purpose to celebrate beer, its contribution to the economy, and to social wellbeing through responsible consumption. Our members (Lion Ltd, DB Breweries, Carlton United Breweries and Cooper’s Brewery) produce approximately 95% of the beer brewed in the trans-Tasman market.

The brewing industry is a major contributor to the ongoing success of the New Zealand economy – the grain to glass value chain is worth over NZ$2.2 billion. The brewing industry contributes over NZ$720 million to GDP. There are at least 90 commercial brewing operations throughout New Zealand employing over 1,800 people. The brewing sector contributes NZ$330million in excise tax plus Health Promotion Agency levy, and a further NZ$283million GST paid on domestic beer sales.

The Brewers Association encourages the responsible consumption of beer by informed adults. Many people enjoy drinking beer which can be part of a healthy lifestyle when consumed in moderation. The Association believes that to reduce instances of harmful drinking behaviour, targeted interventions and education, together with effective enforcement of proportionate regulation, and available appropriate treatment options, are best placed to successfully reduce harm for specific at-risk groups.

We welcome the review of the New Zealand Health Strategy to provide a framework for the Government’s overall direction for the health sector.

***Support for working together to achieve health goals***  
The Brewers Association supports in principle the framework for achieving the goal of all New Zealanders being able to “live well, stay well and get well”.

The Brewers Association believes that a health strategy that covers alcohol should be based on establishing a positive drinking culture that maximises the enjoyment and benefits of moderate consumption while tackling the harm caused by alcohol misuse. It should recognise that the policy focus for alcohol is moderation, and the vast majority of adult New Zealanders consume alcohol responsibly most of the time. As noted in the National Drug Policy 2015-2020 “*in most cases Alcohol and Other Drug [AOD] is not problematic. For example, many people enjoy moderate consumption of alcohol in social settings with few ill effects. However, harm can result when people misuse AOD, particularly when social patterns of misuse and intoxication become entrenched”[[108]](#footnote-108).*

We support an investment approach that targets resources and priorities of the health sector, and takes a proportionate view of the risk and harm. We agree that the whole community can contribute to health and wellbeing, and that community includes business, and look for opportunities to partner across government to achieve the health outcomes. We hope that these sentiments can be more clearly articulated in the future direction action plan as it is developed.

***Commitment to the promotion of wellbeing***

The Brewers Association is committed to the promotion of responsible consumption of alcohol. Sociability and wellbeing is a key focus for breweries, and fits with consumer trends in that direction. Lion and DB Breweries are leading the development of non-alcohol, low, light and mid-strength beers (ie. under 2.5% alcohol by volume).

The alcohol sector recognises that it also must play a part to help reduce alcohol misuse and harm. As such, the Brewers Association, together with New Zealand Winegrowers and the Spirits New Zealand, formed in 2012 ‘The Tomorrow Project’ with the goal of helping New Zealanders understand how best to consume alcohol, to strengthen social norms in favour of responsible consumption, and encourage safe and sociable drinking behaviour.

*Cheers!* is the consumer facing brand for the initiative which provides tools and information to help people make smarter choices ([www.cheers.org.nz](http://www.cheers.org.nz)). All *Cheers!* initiatives are firmly grounded in evidence, and are targeted and measurable. Over the past 3 years the website has had over 90,000 unique visits with an average visit time of 2 minutes –unprecedented in the world of public message sites. The key point of difference for *Cheers!* is that the alcohol brands themselves also promote the responsible drinking message through their own campaigns, such as Steinlager’s “Be the artist, not the canvas”, and Heineken’s “Sunrise is for moderate drinkers” successful activations.

DB also recently supported the Health Promotion Agency’s ’Not Beersies’ moderation campaign in key bars in Auckland, Hawke’s Bay and Wellington. The activation saw the installation of ‘Not Beersies’ - or water ’brewed by clouds’ - taps in selected bars, alongside normal beer taps so consumers have the option to order a ‘Not Beersie’ at the point of purchase.

Lion has developed an education tool called *Alcohol&Me* which provides relevant and meaningful education via a highly interactive programme. It is available free of charge to all New Zealanders online and is already seeing great interest from businesses and individuals alike.

***Commitment to a great start for children, families and whanau***  
The Brewers Association supports the focus of Action 6, to deliver a great start for children, families and whanau. We are working with government to monitor the prevalence of a pregnancy advisory message across beer products, and to play our part in the broader strategy to ensure all women receive the appropriate message.

The members of the Brewers Association have been proactive in placing pregnancy health advisory messages on the labels of beer sold in New Zealand and Australia. This takes the form of either a written message that the safest option for pregnant women is not to drink alcohol, or a pictogram to that effect, or both. The *Cheers!* website also includes information and resources for women who want to know about alcohol in pregnancy (<http://www.cheers.org.nz/to-good-health/mummy-matters.html>).

***Sustainability and Health***The Brewers Association members in New Zealand have a strong sustainability focus with specific goals set for water, energy and waste reduction. This not only keeps the focus on continuous improvement, but it also means the focus is owned by everyone working at the facility. Showing sustainability leadership in the industry is one way that Lion and DB can contribute to encouraging a focus on positive environmental outcomes across the food and beverage manufacturing industry.

But sustainability for a business is not refined to solely environmental incentives. A sustainable business is one that looks after its customers as well as the environment, and one that takes a broad view of health. To positively shape New Zealand’s drinking culture and contribute requires addressing the poor knowledge and poor choices that underpin unhealthy drinking and anti-social behaviours. But ultimately poor knowledge and poor choices are only part of the problem. The underlying causes of alcohol misuse often derive from socio-cultural or psychological issues or a cycle of poor role modelling.

Lion and DB Breweries also focus on supporting positive relationships and building strong families and communities. Lion works with the Foundation for Youth Development which focuses on building emotional wellbeing and resilience in young people through evidence-based programmes. DB Breweries has partnered with the New Zealand Leadership Institute to provide “Leading Light” scholarships to build leadership and business capability in the South Auckland community where their largest brewery and head office is located.

***Research***

We were pleased to note that Action 20 on page 46 of the Roadmap of Actions document specifically addresses the strengthening of research capability and activity. We too have been interested in the relationship between funding, research topics and outputs and the impact of alcohol research on related health policy.

Earlier this year the sector commissioned an independent piece of work from NZIER looking at this area. The final report – *Alcohol Research Funding in New Zealand – Funding Landscape and Research Networks 2004 – 2014* finds, among other things, that there is room for improvement in the way alcohol research is organised and funded.

The report points out that alcohol research funding is unique in New Zealand in terms of including:

* an industry levy partially used to fund research
* a research agenda set in a highly centralised fashion
* little industry and consumer consultation on research questions
* limited transparency about what has been funded to what end.

The report’s authors go on to say –

*Alcohol research tends to be investigator-initiated and is not very strategic. This may be because none of the key players in research (funders and researchers) face the costs of alcohol levies. Consultation with industry or consumers who fund research through alcohol levies would bring greater scrutiny of the effectiveness of research.*

And

*Dedicated levy funding is contrary to sound public finance practice. Greater scrutiny is thus important to help offset the problem that levy funding reduces incentives to control spending – relative to spending programmes funded out of general taxation.*

There are other comments about duplication of research effort and a lack of scrutiny on research approaches after funding is provided but needless to say we would be happy to meet to discuss the NZIER report in more detail as it would effectively inform your deliberations as described in Action 20.

**Conclusion**

Beer and the brewing industry make significant positive contributions to local cultures and economies, and brewers want to protect these communities by making sure our products are always consumed as part of a safe and sociable occasion in a way that helps New Zealanders to live well, stay well and get well.

The Brewers Association would welcome involvement in any further discussion the Ministry of Health might have about the development and implementation of the New Zealand Health Strategy.

Yours sincerely

[redacted]

Director, External Relations (New Zealand)

Brewers Association of Australia and New Zealand   
Email: [redacted]

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| **345** | Submitter name | [redacted] |
| Submitter organisation | New Zealand Rural General Practice Network |

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| Submission | **New Zealand Revised Health Strategy** |
| To | **Ministry of Health - New Zealand Health Strategy Team** |
| From | **New Zealand Rural General Practice Network** |
| Contact | [redacted]**Deputy Chief Executive** |
| Date | **4 December 2015** |

Thank you for the opportunity to provide feedback during this consultation on the revised New Zealand Health Strategy.

This submission is made on behalf of the New Zealand Rural General Practice Network (the Network).

The Network is a nationwide membership organisation representing the specific interests of rural health and the rural health workforce. Our membership of 1,750 includes rural GPs, nurses and other members of rural general practice teams.

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| **Executive summary** |

The revised New Zealand Health Strategy invites us to look at our current health service models, workforce skill mix and health outcomes and poses some challenging questions around how we will meet the complex and burgeoning health needs of New Zealanders, now and in the next 10 years.

Rural communities, despite continuing to be challenged by workforce shortages, may need to consider embracing new roles within their teams. This may mean a smaller number of well trained and well-resourced community service providers that have more generalist skills. Rural communities need to be enabled to deliver improvement in high quality and consistent health status.

Rural general practice needs to ensure that issues of access, sustainability and equity of outcomes are consistently addressed through training, support, investment and resourcing.

We support the direction which the government sets out in terms of working more closely across social service sectors to better achieve our goals for a healthier New Zealand that ‘stay well, live well and get well’. We also support the focus on investment to tackle the complex issues associated with age, race, and isolation including obesity, rheumatic fever, drug and alcohol dependency, dementia and mental health issues.

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| **Rural General Practice** |

**The challenge for rural communities**

The challenges of rural health care are twofold. Firstly, to ensure that rural people continue to have local access to sustainable, quality health services and secondly to actually improve the health of rural communities and to reduce the inequities in health outcomes and quality of life experienced by rural people.[[109]](#footnote-109)

The New Zealand economy is highly dependent on rural-based businesses. Industries based on the agriculture and forestry sectors generate about 70 percent of our merchandise exports and rural-based tourism makes a significant contribution to the New Zealand economy. The rural community, tourism and those accessing rural-based recreational activities are particularly dependent on a limited number of health service providers and have reduced access to alternatives.

The Network acknowledges the direction of the government’s health strategy in working towards improvements in these vital areas. We note the emphasis in the Minister’s foreword: ‘Some families find our current services hard to reach, and there are greater demands to address the social needs for the most vulnerable.’

In order for some of New Zealand’s most vulnerable people to ‘stay well, live well and get well’ we need to address issues where rural communities are affected by a range of factors.

Rural communities face well documented, specific challenges around their access to equitable, appropriate and sustainable health care service delivery. These include physical access (limited access to transport; distance and cost of travel), affordability of the service (due to higher levels of deprivation in some rural communities), and sustainability of the available service (due to retention and recruitment issues for rural services and the increased difficulty ensuring quality of care received because of isolation of practices for peer review and educational opportunities).

Several key characteristics of rural New Zealand influence the effectiveness of primary health services:

**Low population density and /or isolation.**

* Rural people can be a long distance from services and communication hubs. This affects access to emergency services for communities and is often aggravated by poor broadband and cell coverage.

**Deprivation, ethnicity and poor socioeconomic status.**

* Socioeconomic deprivation is closely linked with poor health outcomes. A larger proportion of Maori in rural areas are in NZ Dep quintile five than urban Maori. Compounding poor access to services through distance, with deprivation and ethnicity places some rural communities at very high risk.

**Workforce issues**

* The rural primary care workforce is recognized to be experiencing shortages across the range of service providers, both in terms of retention of current providers and the development of future workforce.

Alongside these key characteristics we also acknowledge that a significant number of rural people face health challenges through ageing, poverty, mental illness and lower levels of health literacy. Rural people require advocates to speak up on their behalf and make a difference to the potential health outcomes.

The Network has established the following principles for use by health authorities (DHBs, PHOs and service providers) when planning health services to meet the needs of rural communities. [[110]](#footnote-110)

1. All people, no matter where they live, should have a reasonable ability to live, work, and to contribute to and be part of New Zealand society.
2. Rural people should have the same health outcomes as people living in urban areas.
3. Rural people should have access to services that are equivalent to primary health services in urban centres.
4. Primary care services in rural areas should be comprehensive, sustainable, provide continuity of care by the right person, at the right time, in the right place.
5. Rural communities should be resourced at a level that enables providers to provide the services required.
6. Rural people should have access to primary care services that will be accessible into the future.

These principles can be acknowledged and acted upon through the following suggested process:

* Consider local rural communities when planning every new service.
* Consult appropriately with rural communities.
* Develop solutions that enable equity across rural and urban communities and health providers.
* Ensure implementation plans include a review of how rural communities are impacted by and access the service and make appropriate and necessary adjustments to ensure outcomes are equitable across urban and rural communities.

Rural communities require focused attention to ensure equity of access and outcomes. DHBs, Alliance Teams, and PHOs should ensure their current and future services acknowledge the needs of rural communities and their health service providers.

Providing equitable comprehensive services within rural communities requires a depth and breadth of skills, which may be limited when, across all professions, there is a reduced rural health workforce. This then impacts on sustainability of workforce and services, and on continuity of care.

Appointing “rural champions” within organisations, whose role is to ensure that rural issues are kept on the agenda at every level in the organisation, displays the “organisational will” to take rural issues seriously.

The issues and solutions discussed above are not comprehensive. Rural communities vary from region to region, their needs vary, and the solutions to those issues will often be developed within these communities.

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

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| **General Practice - a key provider in the delivery of rural health services** |

Having reviewed the Ministry of Health’s ‘guiding principles’ we note that the addition of the eighth principle, ‘Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing’ broadens the reach to include collaboration with other services that may positively impact on people’s well-being. This makes sense and is in line with the World Health Organisation (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [[111]](#footnote-111)

The WHO definition sought to include social and economic sectors within the scope of attaining health and reaffirms health as a human right.

The revised health strategy is placing even more demands on rural practices, but is also offering greater opportunities for them to address health issues. Improving links between rural general practices, rural hospitals and other services, including other health providers is a good step. However, this will require more time commitments and will call on the on good relationships between the people leading these services. Retention of key health professionals is therefore key to this working well.

Retaining and recruiting to this workforce requires a context in which health teams feel that their work is meaningful, is professionally supported and is sustainable.

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| **Feedback on the Health Strategy – Five strategic themes** |

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**.

**People Powered**

The Network supports the strategic intention to involve people not only as users of health services but also as partners in health care.

In small communities, rural general practices are normally the focal point for the majority of health care, so this strategy is directly relevant. The concept of the natural healthcare home is already prevalent in rural areas with integrated social services and collaborative working practices being common.

The direction also aligns well with the principles of Mauri Ora (healthy lives), Whanau Ora (healthy families) and Wai Ora (healthy communities) incorporated within Pae Ora which is an approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services to improve outcomes and results for New Zealand families/whānau.[[112]](#footnote-112)

Much illness is caused by poor lifestyle choices. We need to keep looking for new ways to help people exercise more, eat more healthily, and avoid tobacco, drugs and too much alcohol. There are a high proportion of people in rural communities who are more vulnerable to these problems because of their low socio-economic status. Simply providing education is not the answer. Dealing with people’s fears, problems that are overwhelming them, or just plain boredom or lack of purpose in life is hard to do, but we need to look further at how to offer appropriate emotional and spiritual input.

Rural health providers are very well placed to intimately understand the needs of their communities. The way in which services have evolved in rural areas has meant that there is a breadth and depth to the service provision which extends right through to cross sector collaboration and inter agency working. Much can be learnt from the way in which many rural communities work together. However, much more could be done with the appropriate planning and funding of services and initiatives.

We applaud the adoption of the concept of **‘***investment’*(rather than cost) with itslong view on the building ofprimary health services for future needs and we support the focus on such investment to tackle the complex issues associated with age, race, and isolation including obesity, rheumatic fever, drug and alcohol dependency, dementia and mental health issues.

We believe it is important to explore ways to work better across traditional boundaries. We need to look at ways for agencies such as MSD, Work and Income, Corrections, Education and Transport to work more closely with Health. Through closer working and finding common areas of concern we will be better placed to enable people to take responsibility for health and address the inequities that currently exist.

As we begin to consider the potential impact on health through this cross agency approach, we will identify other areas of significant influence on healthy communities such as environmental agencies, Local Government NZ, aged care sector, palliative care services etc.

**Closer to home**

Again, the concept of health service provision being delivered ‘closer to home’ is a model which is already prevalent in rural areas. Indeed there are numerous examples of innovative and effective models around rural New Zealand such as the integrated family health centres in places such as Dannevirke.

The Tararua Health Group was established in 1999 in Mid Central DHB region and has developed a virtual integrated model through bringing together a group of smaller clinics in close geographic proximity. They operate as a team practice providing health care for a practice population of over 16,000 enrolled patients supporting GP and specialist nursing services for Dannevirke, Te Rongopai, Pahiatua and the large rural areas surrounding the towns. They operate from four sites including general practice, community health services and a rural community hospital.  With eight hospital GP beds, three maternity beds as well as x-ray, ultrasound, visiting specialist clinics, community mental health and a lab collection service, the centre operates off a single networked patient management service and employs more than 100 staff.

The practice also works in partnership with the local community pharmacist in Dannevirke. They have established a model of shared clinical records through a direct link between the general practice clinic and the pharmacy via Medtech. This enables the delivery of better community services for the region’s patients. The pharmacist attends the medical centre’s clinical excellence group and is a part of the local peer review group. He is also involved in teaching on the rural medical immersion training programme.

There are many other examples of innovation and new models of care being developed across rural general practice which are achieving results in bringing care closer to home. However, there is much work needed to ensure that these models have the adequate level of investment to ensure equitable and clinically and financially sustainable services.

In more isolated rural areas, the importance of having health professionals who are known and trusted and who have become acquainted with the work required, know their patients and are able to recognise skills and encourage other people in the community who can contribute to the work cannot be overemphasised. Retention and recruitment (with that order of emphasis) therefore continues to be fundamental.

Healthcare in isolated rural communities is usually centred on general practices, with important input from community services. Allied health professionals and secondary or tertiary services are often distant. Services that travel to rural towns face difficulties including the time it takes them to get to the community, the suspicion they are sometimes met with by patients that do not know them if they are not visiting frequently and the waste of resources if patients they have come to see are unavailable during the limited hours that they can be there.

Rural communities may therefore need a smaller number of community service providers that have more generalist skills. They need to be able to see a greater range of patients and spend more time in the community, developing better relationships with both patients and the general practice providers. Time needs to be allowed for general practice and community service workers to meet together and build on what each other is doing.

**Value and high performance**

Improved health outcomes that have meaning and value in improving peoples experience of life instead of ‘counting measures’ is a much better use of our health dollars. Consideration should be given to target funding to the individual ‘health consumer’ rather than the current model which focuses on contracted providers within a region.

Early indications from the feedback received by the general practice sustainability working party, led by GPNZ, point to a desire for a refresh of the current funding models and a move to not only increase funding for general practice but to also ensure it is fairly and equitably distributed on a needs basis.

We agree with the direction of the revised health strategy in looking to ensure that services are configured whereby:

* Population health management is improved through: looking at the population carefully and then focusing on high-risk individuals or other groups; developing multi-sector partnerships, using key stakeholder resources and aligning our policies to provide community-based support for all who wish to make health-related behaviour change; and striving for a fair system.
* Services are configured in a way that is more clinically and financially sustainable and equitable. Services are delivered in community settings where possible.
* Primary care services use teams to deliver core services; develop shared plans of care; better coordinate care with specialists and hospitals; improve people’s access through better scheduling; and work with their communities.

When working towards these aspirational goals, where health service delivery is increasingly provided in the community setting, it will be important to plan for the health dollars to be directed to the appropriate point of care. Particularly in rural primary care, it will be essential to direct the adequate level of funding to enable many small, isolated providers to meet the challenges of increased workloads and extra compliance costs associated with these changes.

Smaller, rural practices do not have the benefits of the economies of scale afforded to larger health providers, therefore it is essential that as a minimum, the existing rural funding adjusters and rural premiums continue to be factored in to health budgets.

**One Team**

‘Primary health care, health promotion, enabling better self-management, preventative care, health literacy, the prevention of avoidable hospital admissions and working strategically to address the social determinants of health is the cornerstone of an optimised and efficient health care system’[[113]](#footnote-113)

We believe it will be important to reshape our workforce to be flexible across primary, secondary and social care. To do this we will need to address workforce supply, distribution, retention and recruitment, and skills mix. This will enable us better to nurture talent; build leadership and capacity for interprofessional practice; and to find ways to integrate care across sectors.

In their study ‘Nursing roles and responsibilities in general practice: Three case studies’ Walker et al describe nurses as a ‘vital resource’. They suggest that enabling nurses to work to the full extent of their scopes, along with adjustments to models of care, and with multidisciplinary cooperation and coordination, could contribute to improving access to health care. [[114]](#footnote-114)

Their study highlights an example of this theory working in a small rural practice. They report that ‘the small size of the practice, commitment to frequent and regular clinical practice team communication and review meetings, and a positive, enabling approach to continuing education and the development of new initiatives in response to community needs has led to the evolution of a model of care. Such models, if scalable, could have an important role in addressing predicted workforce shortages and rising costs of health care – particularly in rural settings.’

We also need to urgently address the issues and challenges around educating, training and developing of a workforce to meet more adequately the needs of our population and health system. We need more focus on attracting ‘courageous doctors’ to study and train to be rural generalists and ‘innovative nurses’ to build on a growing, essential element of our rural health workforce.

New Zealand is currently 1,000 GPs short with rural areas severely affected (as at 30 November 2015, approximately 25% of rural practices have a vacancy for a rural general practitioner.[[115]](#footnote-115)) Currently less than 2% of medical students indicate a desire to work in small communities and only 15% are looking to careers in general practice.

We strongly urge the government to focus on opportunities for health professionals to study, learn and work together in a collaborative style and in well supported contexts, which will ultimately encourage integration across sectors.

**Smart System**

The Network agrees with the principle of working towards ‘unlocking the benefits of information and other technologies’ to improve delivery of health services to communities.

However, we would caution against relying too heavily on this, too soon. There are vulnerable groups of people who will have added challenges engaging with smart systems. For example, in communities with unreliable power source and weather challenges, there can be issues of an over reliance on smart services. Nevertheless, it is essential for appropriate levels of broadband access and speed to be available in rural areas to an equitable level with urban regions.

Also, a proportion of hard to reach patients will not have devices enabling them to connect to digital devices easily. (One rural practice recently conducted a survey of just over 12% of their registered patients and to their surprise found that as many as 62% of those surveyed have a computer or smart phone, and that 45% are interested in using a patient portal).

The aim for all people to be able to access their health information electronically is unrealistic, and not even wanted by some people.

Many of the hard to reach patients may not be motivated to use them. Reaching them through building relationships must not be forgotten when we focus on IT. Research is required to see how beneficial patient portals are for these patients. There is a risk that they will pamper the “worried well” while not helping the patients who most need help.

Areas where we see potential benefit from using IT more smartly are those where shared patient records can be safely and securely made available such as working more collaboratively with colleagues in Pharmacy through shared access to patient records.

**This submission is based on views of the NZRGPN Executive Board but may not reflect the full or particular views of all of its members.**

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