**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**361 – 378**

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| **361** | Submitter name | [redacted] |
| Submitter organisation | Health Promoting Schools |



Health Promoting Schools

Child health, Ministry of Health

<http://www.health.govt.nz/our-work/life-stages/child-health/health-promoting-schools>

# Submission: Draft Health Strategy

# New Zealand Health Strategy Consultation, [nzhs\_strategy@moh.govt.nz](mailto:nzhs_strategy@moh.govt.nz)

# December 2015

## Introduction

Health promoting Schools (HPS) welcomes the opportunity to submit on the *Draft New Zealand Health Strategy* (the strategy). This is an important strategy, and will affect the quality of life for thousands of New Zealanders in the future.

HPS uses a community development approach to improving the health and wellbeing of school communities. It aims to enhance whānau wellbeing through evidence informed practice, focusing on reducing inequities in health, social and educational outcomes.[[1]](#footnote-1) HPS is delivered through District Health Boards (53 FTE) and prioritises decile 1-4 schools, and schools with a high proportion of Māori, Pacific and disadvantaged students and whānau. HPS makes explicit the link between wellbeing and education (Figure 1), and is underpinned by New Zealand research showing education is a health intervention. A strong sense of belonging and success in school significantly contributes to student and whānau wellbeing.[[2]](#footnote-2)

Figure 1: The link between health and education



* Attendance
* Retention
* Engagement
* Achievement
* Improved access to income/resources
* Health and Social/psychological benefits
* Healthy neighbourhoods

HPS is predicated on the understanding that community-led collaboration between agencies and communities improves outcomes for disadvantaged children. There is evidence from HPS and elsewhere[[3]](#footnote-3) that a community-led strengths-based approach has a positive and sustainable impact on children’s outcomes.

## Summary

HPS supports the principles (p. 9) outlined in the strategy and themes (p. 10) outlined in the strategy. Given the inequities in health outcomes for low-income families, and Māori and Pacific people; we support the prioritisation of disadvantaged groups (principle 2). We also support active partnerships with communities, and collaboration to achieve better wellbeing in the broader sense than just physical health. In practice these principles must mean actively supporting communities to improve their own health, and greater coordination and information sharing within the health system, and across sectors and programmes. Evidence from New Zealand shows that better engagement with families and whanau improves outcomes for them and their children.[[4]](#footnote-4)

We do, however, have a number of areas of concern. While these are implicit in the successful implementation of the strategy, we consider that they need to be explicitly outlined in order to ensure they are not overlooked during the planning and implementation of the strategy. They are:

* the lack of an evidence-based quality assurance framework for the health system;
* the lack of any measures or contractual obligations to implement greater coordination and cooperation within health disciplines or across sectors;
* the lack of quality assurance and effectiveness measures for the plethora of programmes funded directly/indirectly by District Health Boards;
* lack of measures to address the environmental factors that make unhealthy choices the easy option for many people;
* lack of substantive actions and a funding commitment to reduce health inequities experienced by disadvantaged groups.

We outline our concerns more fully below.

## Submissions

* *HPS submits that services funded by DHBs should be incentivised to ensure they collaborate for the best outcomes and impact for their target communities, with adequate funding and appropriately drafted contracts to achieve this.*
* *HPS submits that programmes and projects funded directly and indirectly through District Health Boards be audited to identify duplication, and ensure they are monitoring and reporting on their impact and following best practice.*
* *HPS submits that prevention and healthy choices must be supported by a commitment to addressing the environmental factors that make unhealthy choices the easy option. This includes: a commitment to a smokefree New Zealand by 2025; commitment to creating a physical environment where it is safe for people to walk/bike to school or work; substantive actions to address alcohol outlets and fast food outlets in communities; and revisiting a tax on high-salt foods and sugary drinks.*
* *HPS submits that the strategy needs to outline substantive actions and a committed funding stream to reduce health inequities and improve the health of disadvantaged groups.*

### Evidence-based quality assurance

The strategy refers to evidence-based best practice (p. 5), and notes that improved data systems will improve evidence-based decisions (p. 24). We strongly support the requirement that policies and programmes be evidence-based, but suggest that this alone is not sufficient to ensure best practice is maintained and that programmes are cost-effective and efficient.

Policies and services not only need an evidential base, they need to be clearly and transparently monitored and evaluated, with learnings applied to future programmes and services. Where policies and programmes are failing to meet their stated outcomes, they should be revised or, if appropriate, abandoned in favour of policies and services that are known to be more effective.

We also note that evidence must be independently collected and collated (e.g. through anonymous surveys) in order to preclude bias and the exclusion of evidence that contradicts expected results. Data must also be relevant to the outcome sought: for example, while there is a correlation between school attendance and student attainment, the first does not necessarily lead to the other. Therefore attendance data cannot be assumed to be a proxy for achievement data.

*HPS submits that a quality assurance framework that includes ongoing evaluation and review of all aspects of service delivery for programmes funded directly and indirectly by District Health Boards, and is consistent across DHBs, is a necessary component of ensuring services are appropriately targeted and delivered.*

### Coordination across sectors and programmes

The strategy has an explicit theme of collaboration and cooperation between service delivery agents (‘one team’). HPS welcomes this focus while noting that although this has been a government priority for many years, it has proved difficult to achieve in practice. This is likely to remain the case as the strategy does not outline any measures to implement greater coordination and cooperation within health disciplines or across sectors.

Collaboration across agencies and sectors has proved difficult to implement, especially in health where funding tends to be short-term and fragmented across multiple programmes and providers. Collaboration is also difficult where agencies have different aims and expected outcomes, or their aims may even be at cross purposes (e.g. cheap housing vs access to employment). Greater collaboration needs to be supported by improved information systems and incentives for agencies to cooperate. In New Zealand there is little evidence that cross-agency or cross-sectoral collaboration is effectively implemented, or that it is improving outcomes for their target groups.

Targeted community-based initiatives have an important role in preventing and addressing poor physical and mental health. However, to be successful, they require good systems and support. Service delivery agencies should be incentivised to collaborate with target communities to achieve the best outcomes, with funding contracts made sufficiently flexible to ensure that indicators and outcomes can are coherent and aligned.

*HPS submits that services funded by DHBs should be incentivised to ensure they collaborate for the best outcomes for their target communities, with adequate funding and appropriately drafted contracts to achieve this.*

### Audit of existing programmes

There is currently a plethora of programmes funded directly/indirectly through the Ministries of Health, Education and Social Development, many hoping to improve outcomes for Māori and Pacific children and children from low-decile households and schools. For example, there are approximately 1,000 social and other programmes being delivered in South Auckland alone. In Glen Innes there are 21 financial literacy providers offering their service. Yet the evidence shows that educational, health and social outcomes for many South Auckland children have barely improved,[[5]](#footnote-5) with the equity gap remaining largely unchanged.

Many of these programmes duplicate the work of each other (e.g. financial literacy programmes), and do not integrate with other programmes. It is also unclear if they are monitoring and reviewing their programmes and following best practice.

*HPS submits that that programmes and projects funded directly and indirectly through District Health Boards be audited to identify duplication, and ensure they are monitoring their impact and following best practice.*

### Choice and environmental factors

The strategy aims to make “healthy choices easy” for individuals. There is, however, very little on improving the environment that makes unhealthy choices the easy option for many people, particularly low-income children and households. In particular, we note there is no commitment to making New Zealand smoke-free; no commitment to creating a physical environment where it is safe for people to walk/bike to school or work; nothing on reducing alcohol harm (except in the context of alcohol and drug dependency); and nothing to deal with sugary drinks or the prevalence of fast food outlets in low-income neighbourhoods. The strategy’s emphasis on prevention before treatment is welcome, however it is non-communicable diseases that have the greatest potential for prevention. Environmental factors are a major influence on the lifestyle choices that promote non-communicable diseases, yet these have mostly been ignored. This omission is puzzling given that the savings that would accrue from a preventive approach to addressing non-communicable diseases.[[6]](#footnote-6)

*HPS submits that prevention and healthy choices must be supported by a commitment to addressing the environmental factors that make unhealthy choices the easy option. This includes: a commitment to a smokefree New Zealand by 2025; commitment to creating a physical environment where it is safe for people to walk/bike to school or work; substantive actions to address alcohol outlets and fast food outlets in communities; and revisiting a tax on high-salt foods and sugary drinks.*[[7]](#footnote-7)

### Addressing inequities

The second principle of the strategy refers to an improvement in the health and wellbeing of those currently disadvantaged. In practice, this means dealing with the inequities that result in poorer outcomes for Māori and Pacific people in particular (although this also applies to other vulnerable groups such as refugees and migrants). Improved health and wellbeing for Māori and Pacific people has not significantly improved relative to European and Asian health outcomes for some time now. HPS therefore supports the focus on the inequities experienced by these groups.

Addressing inequities (see p. 18 of the strategy) requires coordinated action across sectors, and must be adequately resourced to achieve long-term sustained improvements in wellbeing. As with addressing environmental factors, confronting and dealing with health inequalities, especially those experienced by children, is a key preventive measure that would mitigate later treatment costs and mean people lived healthier lives.

*HPS submits that the strategy needs to outline substantive actions and a committed funding stream to reduce health inequities and improve the health of disadvantaged groups.*

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| **362** | Submitter name | Alexa Joyce Masina |
| Submitter organisation | Hutt City Pacific Voices |

***To: Ministry of Health New Zealand***

***Submission for: the New Zealand Health Strategy Draft.***

***From: Alexa Joyce Masina on behalf of - Hutt City Pacific Voices***

Kia ora, Talofa lava, Kia orana, Malo e lelei, Fakaalofa lahi atu, Bula vinaka, Namaste, Malo ni, Halo ola keta, Mauri, Fakatalofa atu

We wish to acknowledge the work and effort of the Ministry of Health in the development of the New Zealand Health Strategy and for the opportunity afforded to contribute to the process of this consultation.

We commend the overall vision of “All New Zealanders Live Well, Stay Well and Get Well”.

The spirit we present this submission is one of partnership and inclusiveness. We recognise the importance of ensuring a health care system that serves all New Zealanders to which is not a new approach or aim for the Ministry of Health.

Our challenge and request is for the Ministry to be more courageous, explicit and deliberate in identifying greater accountability of the system (this including community) to those who experience poorer health outcomes and who continue to be underserved by the system. All New Zealanders do not live well, nor do they stay well or get well. To ensure this vision is meet specific focus and priority of the strategy needs to reflect this.

Our overall comments hope to see the strategy reflect greater accountability and response to those who experience poorer health comes: Māori and Pacific adults and children, and in those living in the most deprived areas.

It is with respect that we participate in this process with a focus on Pacific. Not excluding our support of “All New Zealanders Live Well, Stay Well and Get Well”.

Fa’afetai tele lava

Alexa Masina on behalf of: Hutt City Pacific Voices

41 Wainui Road Waiwhetu

0211276376

alexa\_masina@yahoo.co.nz

1. **People-Powered**

Commends:

* The focus of people contributing to the design of services.
* The focus of encouraging and empowering people to be more involved in their health
* The focus of communication and navigation of the system

Recommends:

* That the narrative reflects the “systems “response to enabling the encouragement and empowerment of people to be more involved in their health and wellbeing. Not just a focus of people or users of the system.
* That the strategy recognise effective Pacific forms of engagement and communication, this including proven forms of Pacific health literacy engagement.
* A review of how effective forms of communication and engagement such as mobile phones and internet are for Pacific people and ensure these are not additional barriers for Pacific to access information and services.
* Recommends that the “design of health and disability systems” reflect and are accountable to deliver and meet Pacific outcomes/targets.
* That the strategy visibly notes Ala Moui: Pathways to Pacific Health 2014 – 2017 as a supporting driver in the systems response to Pacific health.
* Recommends evidence of better health outcomes using Pacific models and approaches of care are recognised and supported.
* Recommends Pacific service users are afforded opportunities to inform design and delivery of services that impact on their health and wellbeing.
* Recommends that Pacific Health Providers access health funding to deliver and expand their services to improve access for Pacific peoples. This including investment in Pacific health workforce, Pacific communications, Pacific health literacy and Pacific provider capability to deliver excellent, fresh and state-of-the-art services to Pacific communities, Pacific capability across the “sector” to ensure a better responsive “system”.
* Recommends that the “design of health and disability systems” reflect and are accountable to deliver and meet Pacific outcomes/targets.

Action 1:

* Recommends that “access to same information” recognises that effective and appropriate engagement of “information” is crucial to ensuring Pacific people are informed and involved in their health and wellbeing. Eg: Language, cultural intelligence, knowledge of users use, access and challenges to information and services and ensuring a Pacific responsive and capable workforce and “system”.
* Often negative attitudes and cultures to Pacific professional, cultural development and responsiveness can impede on ensuring quality services, approaches and information are suitable and effective for Pacific users. The “system” must value, resource and ensure a culture that recognises the benefits of developing and delivering services and information that are culturally and worldview responsive; especially to those who have poorer access to services and information.

Action 2:

* Coordinated voice of Pacific users, providers and Pacific health workforce are included to support “decision making and design of engagement with high-need priority populations on key health issues” that impact their health and wellbeing.

2. **Closer to home**

We commend the closer to home approach addressing a focus on “prevention, early intervention, rehabilitation and well-being for long term conditions”.

* Recommends that the narrative explicitly identifies who those “designed for people at higher risk” and “particularly those of poor health or social outcomes” are, to ensure accountability alignment is explicit; ensuring alignment of planning, resource allocation, activity and deliverables to these populations.

What do we want in 5 years?

* Agrees and commends the focus of services, information and support be as closer to home, especially in those areas who experience poorer health outcomes and access to health services.
* Recommends Pacific users of the health system, Pacific health providers and Pacific health workers participate in early stages of strategic planning for regional planning.
* Recommends that Pacific providers and services already serving in high need areas have equitable access expenditure to grow and develop services for Pacific communities. These services are already are strategically placed in high deprivation areas and have a proven track record of effective programmes that meet the needs of Pacific people.

Action 6:

* Agrees and supports that there is a need for government agencies to work more collaboratively to improve and make more equitable health and social outcomes for all children, families and whanau.
* Recommends the narrative “particularly those at risk” identifies who this is to ensure the plan is clear who “those at risk” are.
* Agrees with promotion of healthy nutrition and activity for pregnant women and recommends this action recognises the aiga/whanau approach model, successful existing programmes such as the Pacific Heartbeat Community Nutrition Course and various Healthy lifestyle initiatives delivered by Pacific providers.
* Agrees with (c) but greater course of action across government to ensure the intent is resourced.
* Agrees with (d)
* Agrees with (e)
* Agree with (f)
* Recommends that the narrative for (g) recognises Pacific and Pacific young people as partners to design and develop programmes that reduce incidence of sexual and family violence.
* Recommends (h) the Ministry recognise Pacific users (including mothers) and health professionals have a voice in improving systems that response to children and families who are living with fetal alcohol spectrum disorders.

**3. Value and high performance**

We have no feedback on this priority area but support it.

**4. One team**

The ‘One team’ approach should include a focus on the social determinants of health. The biggest determinants of health are income, education and housing so the Strategy needs to address how the MoH might work with other sectors to improve health outcomes in those areas.

**5. Smart system**

* We recommend a smart system is more responsive system that meets the diverse needs of Pacific people. The majority of Pacific peoples use mainstream (non-Pacific) services, so cultural competence, capability and intelligence of mainstream services and their workforce is critical.
* Health Literacy – Pacific peoples have poorer health literacy than other groups and this can impact on how they navigate the health system, consume medicines etc.

***We would like to thank the Ministry of Health for the opportunity to provide feedback for the New Zealand Health Strategy Draft.***

***If there is an opportunity to present or discuss some of the key points of our submission we would like an opportunity to present these in a oral submission.***

***Ia manuia – best regards***

***Alexa Masina on behalf of: Hutt City Pacific Voices***

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| **363** | | Submitter name | Dr David Crum | | |
| Submitter organisation | New Zealand Dental Association | | |
| This submission was completed by: *(name)* | | | Dr David Crum |
| Address: *(street/box number)* | | | Building 1, 195 Main Highway |
| *(town/city)* | | | Ellerslie, Auckland |
| Email: | | | david@nzda.org.nz |
| Organisation (if applicable): | | | New Zealand Dental Association |
| 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)*:

### 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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| Our health system has many strengths including publicly funded, universal health system, availability of ACC and PHARMAC. Apart from those described in the drat Strategy additional challenges that should be part of the background Strategy are;   * Emergence of an ageing dentate population. Like all New Zealanders, older people must have an acceptable level of oral health to socialize, eat, speak and be free of pain. * Since most oral diseases are progressive and accumulative over time the risk of developing oral diseases increases with age. The 2009 New Zealand Oral Health Survey reported high levels of untreated decay and missing teeth among older adults. In addition, older adults aged 75 years and over have highest burden of untreated root decay. * When it comes to oral health older people living in rest homes are known to be one of the most disadvantaged and vulnerable population groups. The unpublished results of the Survey of Older People living in rest homes is expected to demonstrate and highlight the need for immediate actions to tackle poor oral health among this vulnerable groups. * Oral healthcare for adults receives virtually no public funding in New Zealand, and without any immediate actions to address this issue, the increasing dental treatment needs compounded by co-morbidities experienced by older people is only expected to increase the burden on New Zealand’s public health system and health expenditure. * Through lack of consultation with the oral health sector during its development, the draft Strategy document presents no recognition of the interrelationship between oral and general health therefore lack of emphasis on oral health within the draft Strategy. As per the 2009 Oral health Survey oral diseases are among the most prevalent chronic diseases in New Zealand. * Maori and Pacific people and people of low socio-economic status from all age groups (children, teenagers and adults) experience worse oral health and have greater unmet need. Unacceptable levels of existing oral health disparities is seen among these groups.   Opportunities:   * Inclusion of oral health care as part of prevention and management of chronic conditions such as obesity, diabetes and cardiovascular diseases. * Integration of oral health within general health system where possible. Promotion of appropriate oral health behaviours throughout life by everyone who delivers and supports services in the health and disability system. * Improving oral care access through coordinated, community-based services and increasing the capability of clinical providers at the primary healthcare level would benefit the dependent elderly (and their families) as well as reducing pressure on secondary services. * Water fluoridation benefits people of all ages with teeth. Introduction of community water fluoridation to ensure all New Zealander’s have access to optimally fluoridated water. |

### 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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| While we agree with this statement, the roadmap of actions does **not** reflect this vision with respect to oral health diseases and the huge burden they place on New Zealanders and healthcare provision with New Zealand. The Strategy doesn’t address the emerging burden of oral diseases among older people. How will oral health particularly for adults and older people be integrated in the smart system to work as one team? Oral health has been separated out from the general health for too long. |

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

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

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| Yes, agree with the proposed principles. Once again, roadmap of actions doesn’t reflect this for oral health. For example the draft doesn’t address how oral health status of those currently disadvantaged will be improved. Without addressing oral health issues how will we improve the outcomes for people suffering from chronic conditions such as diabetes and cardiovascular disease? |

### 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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| Good themes to focus action. It is important to track progress and share outcomes. |

### 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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| Oral health is closely related with general health and people’s quality of life. We cannot improve a person’s health without improving their oral health. A decline in oral function can affect a person’s health and social status, and can place considerable pressure on public resources. Since the areas set out in this Roadmap is critical we recommend integration of oral health under the following action areas.  Action 1:   * To include oral health in the development of digital technology to facilitate interdisciplinary collaboration among health professionals. * Inclusion of key oral health messages to support self-management of chronic diseases – better management of diabetes, to improve quality of life of these patients   Action 2:   * Inclusion of dentists in the clinician-led collaborations to engage with high-need populations. Recognising the link between good oral health and good general health.   Action 3:   * Consider access to assisted dental care for vulnerable groups such as pregnant women, low income adults and older people.   Action 4:   * Utilisation of nurses and pharmacists in the delivery of key messages towards promoting self-care practices for patients suffering from chronic conditions   Action 5:   * Recognition of dental caries and periodontal disease as one of the most prevalent chronic conditions in New Zealand. Oral health should be part of common risk factors approach. * Inclusion of dentists as part of patients care plan team. Oral care can help reduce the risk of complications for some chronic conditions such as diabetes.   Action 6:   * Consider access to assisted dental care for pregnant women. * Ensure community dental services are part of integrated approach to improve health and social outcomes for children. Improved collaboration between social and health services with community dental services.   Action 8:   * Inclusion of community oral health services under the health outcome-focused framework   Action 9:   * Inclusion of oral health specific target outcomes for publicly funded oral health services such as children and adolescents services.   Action 10:   * For low-income adults, there is a need to address the financial barriers to accessing oral health care services through public funding which would allow affordable access to oral health care; there is a need for creation of new minimum levels of service for publicly-funded oral health programmes and ensure that the resources to meet these standards are made available; the patient must pay for part of the cost of care (i.e. some form of co-payment); adult oral health services are best provided by an oral health team led by dentists; given that the vast majority of oral health care for adults is delivered within the private sector and the public DHB services are focused primarily on meeting the needs of their high needs and vulnerable patients, it is necessary to work with the private sector and the public DHB services are focused primarily on meeting the needs of their high needs and vulnerable patients, it is necessary to work with the private dental sector to devise a system to address financial barriers experienced by low-income adults   Action 19:   * Inclusion of oral health status under national electronic health record through collaboration with private dental providers * Inclusion of dental provider and dental visit status as part of patient portals * Development and inclusion of oral health app in the list of ‘Health App Formulary’ |

### 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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| * Engagement with oral health sector. Given that this sector was not engaged during the initial consultation period by the Strategy development team priority should be given to consult the oral health sector to discuss ways to implement the action areas suggested above. |

### Any other matters

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

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| The NZ Dental Association has a membership rate of 98% of NZ’s dentists and welcomes further consultation.  Attached are summary policy statements on;   * Adolescent and young adult oral health * Child oral health * Oral health services for dependent older people * Access to oral health services for low income adults |

Summary of NZDA position statement on young adult and adolescent oral health: 

Summary of NZDA position statement on access to oral health services for low income adults:

Summary of NZDA position statement on child oral health

Summary of NZDA position statement on OHSDOP 

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| **364** | Submitter name | [redacted] |
| Submitter organisation | PHARMAC |

4 December 2015

Dear Chai,

**PHARMAC feedback: Update of the New Zealand Health Strategy**

Thank you for the opportunity to be involved in the development of the New Zealand Health Strategy. We acknowledge and appreciate the comprehensive sector engagement that has been undertaken in the development of this plan.

In general, PHARMAC is supportive of the draft Strategy as a framework that sets the direction for the next 5-10 years. We feel the broader strategy is generally consistent with PHARMAC’s own strategic direction.

Our feedback below is grouped into the general themes, to align with the consultation questions in the consultation document.

*General comments*

The case for change throughout the Strategy is quite centred on the fiscal unsustainability of health care expenditure and the growing burden of chronic disease. The Strategy quotes the Treasury’s long-term fiscal statement as evidence for this. However, in that fiscal statement, the Treasury also noted that demographic pressure is not the main driver of health care expenditure, rather that the main drivers are income (people expecting more from their health care system as incomes rise), declining productivity and technology adoption (i.e. the system adopting new expensive technologies at significant cost). The strategy does not explicitly address these drivers, and in fact, encourages technology adoption throughout (statements like “the health sector can take advantage of advances in technology”). We recommend that the distinction is made between cost-effective technology that improves the efficiency of the system, and technology that creates additional costs with small gains in health or effectiveness.

Relatedly, prevention and care closer to home are also emphasised as ways to reduce health care expenditure. We would caution emphasising this as a rationale for focusing on prevention and shifting services to primary care, as PHARMAC suspects that these activities are rarely directly cost-saving. However, PHARMAC supports both being key themes throughout the Strategy, because of the potential health benefits and improvements in access to care.

The ‘Future Direction’ document acknowledges some of the big problems facing the health system; however, we feel that not all of these are carried through into the roadmap of actions. PHARMAC suggests there should be greater emphasis on acknowledging the barriers that exist, and the actions should be more explicit in addressing how those barriers will be broken down. This includes more explicit acknowledgement of the broader determinants of health.

*Vision Statement*

At the Strategy Workshop held in Wellington on 28 November, there was discussion about the inclusion of ‘start well’ and ‘end well’ to this vision statement. PHARMAC supports the inclusion of reference to the importance of health at the beginning of life and on quality at the end of life – whether that is through the vision statement or through further emphasis throughout the strategy.

*Challenges and opportunities*

Advances in technology have been acknowledged in the Strategy as an opportunity to make improvements to the health system. However, this in itself is also a challenge for the system as there is already such incompatibility between systems across New Zealand. Actions must address the need for consistency across the system in order for everyone to see the benefits of technology advancements.

An opportunity that is reflected throughout the Strategy is the ability to share the huge amount of data that is available across the system. We support the emphasis on the sharing of data, and believe this is something that to date the health system has not actively enabled. However, we also think the other important point to emphasise is that it is the *analysis* of the data that results in benefits (ie. the data needs to be disseminated in a useable and meaningful form in the first instance).

A challenge that we feel should be made explicit alongside long term conditions and obesity, is the growing burden of mental health. In addition, we would like explicit mention of the increasing emergence of antimicrobial resistance, which is a concern both internationally and for New Zealand.

*Principles*

PHARMAC staff largely support the principles that have been refreshed to underpin the strategy. Although a key principle that we believe is not reflected is the concept of operating within our means, or the financial/economic constraints of the system. For example, principle 6 is “a high performing system in which people have confidence;” a high performing system must be achieved within the budgetary constraints of the day.

*Five strategic themes*

*People-powered*

We are supportive of the five strategic themes. However, we question the framing of ‘people-powered’. We are supportive of a person-centred framework; however there is a risk that this rhetoric could focus too much on the responsibility of the person and less on the responsibility of the system to enable the person to be empowered. Personal empowerment stems from both a person’s improvement in their own health literacy, and the system being enabling through appropriate communication, ease of access, cultural responsiveness etc. Additionally the focus on ‘people-powered’ potentially loses the importance of family/whānau and other support mechanisms that are also important contributors to a person’s empowerment.

PHARMAC recommends the issue of direct promotion of pharmaceuticals to both consumers and prescribers is something that the Ministry should consider addressing under the proposed theme of ‘power-powered.’ We note that the Ministry has indicated that under the vision (what great looks like in 10 years – p.13) that people are able to make informed choices and to access practical evidence-based advice that makes it easier for them to make healthy choices. Although enablers such as technology may go some way toward achieving this, there is a need to also ensure the environment and health system is conducive to allowing a person to make informed and evidence-based healthy choices.

PHARMAC considers direct to consumer promotion of pharmaceuticals is one barrier to achieving a person-centred environment. We are concerned about a lack of clarity in advertising and potential inability of consumers to distinguish between non-biased health information, and promotion / advertising. Similarly with direct to prescriber promotion of pharmaceuticals, people need to know the extent that their prescriber has been influenced by advertising, which can be selective or inaccurate and thus risk suboptimal health outcomes or loss of opportunities[[8]](#footnote-8).

Additionally, direct to consumer or prescriber promotion may place a fiscal strain on the pharmaceutical budget (for example by increasing demand for advertised pharmaceuticals) impacting on PHARMAC’s ability to achieve our statutory functions of managing the Pharmaceutical Schedule and promoting the responsible use of medicines.

We acknowledge the complexity of the issue, but also consider with the regulatory review currently underway, it is timely to consider mechanisms to address these issues, whether that is in the short term, or by enabling it to be addressed in the long term. As noted, this action would align with the current proposed theme of ‘people-powered.’

*Value and high performance*

PHARMAC believes that what is missing from this theme is a shared definition of ‘value’ across the health system. We suggest initial actions may be required to work across the system to define ‘value’ in relation to this theme.

*Roadmap of actions*

The roadmap of actions are quite specific and we think there would be value in providing more context around the actions to describe what the current situation is, and what the proposed action is intending to fix/improve/change.

PHARMAC staff felt there was a gap in trying to reach those people and whānau who are not currently engaged with the system. The actions are primarily focused on improving the services for those already engaged with the system. We think some additional actions under the first action area (people-powered) would be beneficial.

Relatedly, we are not convinced that there are actions that are specifically addressing the significant health disparities that exist, and that are acknowledged in the introductory section of the strategy consultation document. 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 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. Relatedly, we note the absence of reference to populations with disability as a disadvantaged population group throughout the strategy, and recommend more explicit inclusion in both the strategy and in the roadmap of actions.

The importance of collaboration with family and whānau should be emphasised further, for example in action 2.

Thank you again for the opportunity to comment on this draft strategy. We would be happy to discuss any of this feedback with you in more detail if required.

Yours Sincerely,

[redacted]

Policy Manager   
PHARMAC

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| **365** | | Submitter name | Victoria Hinson | | |
| Submitter organisation | National Ethics Advisory Committee | | |
| This submission was completed by: *(name)* | | | Victoria Hinson |
| Address: *(street/box number)* | | | P O Box 5013 |
| *(town/city)* | | | Wellington |
| Email: | | | neac@moh.govt.nz |
| Organisation (if applicable): | | | National Ethics Advisory Committee |
| Position (if applicable): | | | Chair |

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)

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Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research √ Other *(please specify)*: Ministerial advisory committee

### Challenges and opportunities

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

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

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### The future we want

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

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

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

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| NEAC supports the statement and notes that ‘living well’ captures much more than just physical health. For example, for people with dementia, living well is also about social inclusion and maintaining independence as much as possible. |

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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| NEAC supports the eight principles. It is good to see a focus on partnerships with people and communities (principle 7), and thinking beyond the narrow definitions of health and collaborating with others to achieve wellbeing (principle 8). |

### 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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| In general, NEAC supports the five themes for action but we consider they could be strengthened through a greater focus on how principles 7 and 8 will be given effect. NEAC also considers that people living with disabilities are not adequately represented across the five strategic themes.  Again, NEAC’s recent work on dementia has highlighted the role of families, whānau and friends in providing support and care to people with dementia. We are pleased to see that support for families is discussed under the ‘One Team’ theme but we are disappointed that the role of families is not captured in ‘what great might look like’.  NEAC suggests that the use of technology by people with disabilities to support independence also be included under the ‘Smart System’ theme. |

### 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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| NEAC members note that many of the actions are Ministry-led, health system focused. We recommend the inclusion of actions that reflect principles 7 and 8. This could include for example, the role of the wider community in promoting health and enabling social inclusion, person-centred approaches such as individualised funding models, and integrating health and social support services.  NEAC notes that the Roadmap of Actions mentions the importance of privacy in relation to increasing access to data (under 5 Smart System). NEAC’s work on new ethical guidelines for researchers has identified other issues associated with increased accessibility and linking of health data with other government data. NEAC supports the work of the New Zealand Data Futures Partnership in developing guidance for trusted and ethical data use in New Zealand. We recommend that this work is captured in the Roadmap of Actions. The indicative action plan for the Data Futures Partnership includes: providing guidance and information for trusted and ethical data sharing and use to different sectors and New Zealanders; and a deep-dive on effective ethics arrangements for data use. |

### Turning strategy into action

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

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| The specific example on page 31 regarding the principle that acknowledges the Treaty of Waitangi resonates with NEAC and will apply to the Committee’s revised ethical guidelines for researchers. |

### Any other matters

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

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| NEAC notes that two actions (13 and 15) refer to the roles of ministerial advisory committees. We would be interested to know whether this work is intended to include NEAC and suggest that, for the sake of clarity, the ministerial advisory committees covered by this work is made explicit. |

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| **366** | Submitter name | Grant Aldridge |
| Submitter organisation | NGO Council of the NGO Health and Disability Network |

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| --- | --- |
| This submission was completed by: *(name)* | Grant Aldridge (Secretariat) |
| Address: *(street/box number)* | c/o 16 Gosling Cres, Halswell |
| *(town/city)* | Christchurch 8025 |
| Email: | secretariatngo@gmail.com |
| Organisation (if applicable): | NGO Council of the  NGO Health & Disability Network |
| Position (if applicable): | Secretariat to NGO Council |

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

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on behalf of a group or organisation(s)

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Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| The front of the document should state clearly that the NZ Health Strategy should be read alongside:   * The NZ Disability Strategy * He Korowai Oranga - NZ’s Māori Health Strategy * The Primary Health Care Strategy |

### The future we want

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

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

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

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| * We support inclusion of the suggested ‘die well’ addition to the tagline ‘Live well, stay well, get well’. Perhaps it could be re-ordered to ‘Live well, get well, stay well, die well’. * More needs to be included about the impact and importance of climate, ecology and environmental factors. * Scope for effective use of legislation, taxation and government incentives/ disincentives to influence corporate behaviour is missing from the document – government already uses taxes and duties on tobacco and alcohol to limit use of these harmful substances and collects funds through ACC levies and road user/vehicle registrations to help cover costs related to injuries/harm caused by various items/activities. The Strategy needs to include scope for similar approaches to minimise harm caused by other potentially harmful substances such as sugar, salt and pollution as evidence of their harm grows. * Equity (of access and outcomes) for different groups based on ethnicity, location, economic status etc needs to be strengthened in the document. * Despite the inclusion of ‘live well’ and ‘stay well’, the Strategy still has a very clinical focus to it and there is not sufficient focus on population-level prevention activities that will have the biggest health impact, reduce inequalities and deliver value for money. |

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

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

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| * We are comfortable with the eight proposed principles and particularly support thinking beyond the narrow definitions of health, as this will help to address determinants such as poverty, housing, environmental factors, etc. * Many of those currently disadvantaged in their health outcomes are not able to live well due to environmental factors such as poor housing, limited employment opportunities, social exclusion, or community and whanau dislocation and isolation – working intersectorally across traditional boundaries is the only way to address these. As many of these determinants are outside the direct influence of health organisations, greater cross-agency partnering (particularly between health, housing, the justice system, education, child protection and whanau support services) will lead to better health outcomes and to more people living well. |

### 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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| * A **smart system** is about more than just technology – there also needs to be a focus on making aggregated anonymised information widely available to all those working to improve health outcomes as this will help provide an evidence base for initiatives. (The Statistics NZ model is an example of how this can be done effectively.) * All providers also need opportunities to up-skill to make use of new IT and keep pace with fast-changing technology, as currently few outside the medical professions have access to continuing education. * For the system to be truly **people-powered**, resources need to follow the individual so they can access the services they choose. Existing capitation and population-based models do not currently support people power effectively and changes will be needed to ensure this theme is a reality. Current under-valuing of the under-trained and underpaid unregulated workforce was a theme that was strongly made in the Ministry’s engagement workshops – there is a need to address this through the Strategy’s themes and actions. * Openness and trust and a move away from competitive funding models will be needed to ensure a **one team** approach. * **Closer to home** sounds great, but the reality for many (especially rural-based consumers) is that expectations of what they can access locally is diminishing. * To ensure sufficient ongoing focus on preventing illness and disease, consider adding a sixth theme around **prevention** or **investment in health.** |

### Roadmap of Actions

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

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

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| * The importance of environment and prevention are not sufficiently covered in the roadmap of actions. There need to be more actions at a population health level as these have the potential to have the greatest impact due to their preventative approach. * Action 4 recognises the value added by **all people working in the health system**, but there is scope for other actions to also maximise the contributions of all health providers (not just clinicians) – especially those actions with a community or prevention focus. |

### Turning strategy into action

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

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| * More resourcing directed to prevention and public health services will be needed to make the investment approach a reality. (Again, effective use of data and rich information will be vital to support the investment logic.) * Investment into health literacy will be needed – not just to support individuals, but to ensure clinicians use language that people understand. Opportunities to improve health literacy through the education system should be explored. * Explore overseas concepts such as Choosing Wisely (<http://www.choosingwisely.org/>) to improve patient-provider interactions and enhance health literacy and targeting of services. There needs to be a national approach to considering the evidence for effective treatments and services. Such services require high levels of technical expertise and these should not be fragmented across DHBs. Evidence resources need to be provided to policy makers, consumers and providers and should support health literacy initiatives, as well as purchasing decisions. * Reviewing ineffective services will encourage re-consideration of investment options and consideration of ways to improve value and performance throughout the health system. It is not always possible to continue to try and deliver the same services for lower costs - so we need to look at whether we are purchasing services that are the most effective. * Long term conditions such as diabetes and obesity cannot be addressed solely through initiatives designed to influence personal choice – we must consider controls on potentially harmful products such as sugary foods/drinks and salt. * Some targeting and additional resourcing for those with the worst health outcomes is needed. Look for opportunities to expand the types of services provided through individuals’ existing interactions with health providers (e.g. some people with mental health issues have regular blood tests due to the psychotropic medication they are on, but currently they are not routinely offered blood pressure or diabetes checks etc at these regular appointments, so early opportunities to address potential health issues are lost.) More comprehensive regular physical health checks and/or development of individual care plans would improve health outcomes for groups such as those with serious mental health and addiction issues, whose overall health outcomes are currently worse than any other group. * Traditional ways of purchasing services will need to change to support innovation, flexibility and collaboration. A greater degree of flexibility will be needed to support better outcomes for highly vulnerable, hard to reach people with various co-morbidities. |
| * To support the **one team** approach, greater opportunities for workforce development must be accessible to community and non-profit providers as they are not currently resourced at the same levels as DHBs, PHOS etc. Funding models must also be equitable across the sector so community providers can offer salaries, conditions and career opportunities to attract and retain workers. * While being responsive to local needs is good, there is also a need for national approaches for services for specific small groups that are not sufficiently numerous to warrant local strategies (eg: Deaf mentally ill people, people with eating disorders, Hep C, refugee trauma etc). * Targeted resourcing will be needed to get all providers to the same baseline with technology to support the **one team, smart system** approaches – some government resourcing may be needed for community providers, but government should not necessarily lead development of ICT tools as it is not nimble enough – instead it should look for opportunities to harness local innovation that is responsive to user requirements and make this more widely accessible (eg: purchasing new Apps created by individuals/ innovators, etc). All users will need training and education in technology so they use it as intended. * Government also needs to have the ability to mandate that providers receiving public funds must be required to share health information with other providers. It is not sufficient to encourage shared information. * The impact on health needs to be considered in the development of ALL policies across government. * In the current health system, DHBs wield significant power and influence over the services delivered to their communities (eg: approx 48% of the Vote Health funding non-profit NGOs receive comes via DHB contracts for service), so we would like to see accountability where DHBs fail to address challenges and actions identified in the Strategy or do not engage in the direction of the Strategy. |

### Any other matters

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

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| * We commend the Ministry on its consultation process so far, with realistic timeframes and various opportunities for people to contribute face-to-face, in writing and online. The genuine attempts to engage and incorporate feedback received so far are reflected in the draft document’s content and we hope submissions received during this second phase of consultation will also be evident in the final Strategy. * We endorse the inclusive and easy to understand language used throughout the document. * We recommend that those finalising the Strategy re-read the NZ Productivity Commissions report on the *More Effective Social Services* review to ensure key insights and ideas (such as strengthening the commissioning and national outcomes frameworks) are reflected in the Strategy.  <http://www.productivity.govt.nz/inquiry-content/2032?stage=4> |

**About the NGO Health & Disability Network**

**Origins**

The NGO Health & Disability Network (formerly the Health and Disability NGO Working Group) has partnered with the Ministry of Health since 2002 to implement the [*Framework for Relations between the Ministry and Health and Disability NGOs*.](http://ngo.health.govt.nz/resources/ministry-health-publications/framework-relations)

The Framework identifies key areas (communication, consultation and capacity/capability building) where working together can strengthen the sector and achieve better health outcomes. It complements the [*Kia Tutahi Standing Together Relationship Accord between the Communities of Aotearoa NZ and the Government of NZ,*](http://www.dia.govt.nz/KiaTutahi)which was signed by the Prime Minister and many others in 2011.

**Network membership**We had 508 NGO members and 114 affiliate members on 1 December 2015. (These NGOs range from small providers with one FTE employee, to large multi-million dollar agencies with more than 2,400 paid staff.)

98% of Network members are registered charities. Based on data from the Charities Register[[9]](#footnote-9), we know the following about these members:

* Member NGOs received $1.54 billion in combined annual government funding.
* Member NGOs paid more than $1.3 billion in annual salaries and wages to 18,830 full-time staff and 15,695 part-time staff.
* In an average week, a total of 1.25 million hours were worked by paid staff and 124,196 hours provided by over 28,426 unpaid volunteers.
* 36% of member NGOs had a net annual operating deficit in their last reported financial year, so had to draw on reserves to continue delivering services.

The Network’s membership represents about half of those not-for-profit NGOs that receive Vote Health funding to provide services in New Zealand communities.

The activities of the NGO Network extend far beyond the voting membership as many non-members attend Forums and workshops and provide feedback via Network projects and surveys.

**About the NGO Council**

The elected NGO Council connects with health and disability organisations to hear views and convey issues and ideas to the Ministry. The Council is made up of three Māori Health representatives, and two representatives from: Pacific Health, Mental Health and Addictions, Personal Health, Public Health, and Disability Support Services.

NGOs that receive Vote Health funding (i.e. have contracts with the Ministry of Health and/or DHBs) can register in a maximum of two categories, and are registered to vote as follows:

* 224 in Disability Support Services
* 112 in Māori Health
* 142 in Mental Health and Addictions
* 102 in Personal Health
* 114 in Public Health
* 25 in Pacific Health

The current elected members of the NGO Council are:

**Disability Support** Victoria Manning Deaf Aotearoa Wellington

Mark Brown LIFE Unlimited Hamilton

**Māori Health** Karaitiana Tickell Purapura Whetu Trust Christchurch

Josie Smith Te Kotuku Ki Te Rangi Trust Auckland

Donna Matahaere-Atariki

*(Chair)* Arai Te Uru Whare Hauora Ltd Dunedin

**Mental Health** Marion Blake Platform Charitable Trust Wellington

**& Addiction** Barbara Disley Emerge Aotearoa Auckland

**Pacific Health** Pesio Ah-Honi Siitia Problem Gambling Foundation Wellington

Robert Muller Village Collective/Family Life Auckland

Education Pasefika Services Trust

**Personal Health** Kathryn Jones Laura Fergusson Trust (Canterbury) Christchurch

Catherine Marshall Takapau Community Health Hawkes Bay

**Public Health** Jackie Edmond Family Planning NZ Wellington

*(Vice-Chair)*

Warren Lindberg Public Health Assn of NZ Auckland

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| **367** | Submitter name | Dr Ramon Pink and Ramai Lord |
| Submitter organisation |  |

|  |  |
| --- | --- |
| This submission was completed by: *(name)* | Dr Ramon Pink and Ramai Lord on behalf of  Te Kāhui o Papaki Kā Tai |
| Address: *(street/box number)* | c/- 160 Bealey Ave |
| *(town/city)* | Christchurch |
| Email: | Ramon.pink@cdhb.health.nz  ramai.lord@pegasus.org.nz |
| Organisation (if applicable): |  |
| Position (if applicable): | Ramon Pink: Medical Officer of Health, Canterbury Community and Public Health, Division of the Canterbury District Health Board and Chair, Te Kāhui o Papaki Kā Tai  Ramai Lord: Māori Health Manager for Pegasus Health and Project Support for Te Kāhui o Papaki Kā Tai |

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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

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| Nei rā te mihi kau atu ki a koutou katoa, mai ngā pae maunga o Te Waipounamu, ngā Tiritiri o te Moana ki te Tai o Mahaanui, ā, ki Te Tai o Marokura hoki, arā, ngā Pākihi Whakatekateka o Waitaha  Tēnā koutou, tēnā koutou, tēnā rā tātou katoa  This submission is made on behalf of the members of Te Kāhui o Papaki Kā Tai (Te Kāhui) by:   * Dr Ramon Pink, Medical Physician Community and Public Health and Chair for Te Kāhui * Ramai Lord, Māori Health Manager Pegasus Health and Project support for Te Kāhui   Te Kāhui is a Canterbury-wide combined group of clinicians, community organisations, Manawhenua ki Waitaha, Māori health providers, the three Canterbury Primary Health Organisations, and the Canterbury DHB who provide leadership and advice within the Canterbury health system on Māori health improvement. Our main purpose is to lead the system toward achieving health equity for Māori through:   * Ngā Manukura – We provide community leadership, health leadership, tribal leadership, and alliances between leaders and groups in Canterbury * Mana Whakahaere – We provide the capacity for self-governance that gives effect to Māori aspirations, relevant processes and the adoption of sensible measures and indicators * Whakawhānaungatanga – We respect, foster and maintain important relationships within the Canterbury health system * Manaakitanga – We pay respect to each other, Ngāi Tahu, Manawhenua ki Waitaha and ngā mātāwaka * Tohungatanga – We pursue knowledge and expertise based on information and evidence that leads our work and guides us toward achieving our purpose * Kaitiakitanga – We recognise that health is a taonga and work actively to protect the health of all Māori living in Canterbury * Tikanga – We strive to ensure that tikanga Māori is actioned and acknowledged in all of our outcomes * Rangatiratanga – We strive to maintain a high degree of personal integrity and ethical behaviour in all actions and decisions we make   Te Kāhui welcomes the review of the New Zealand Health Strategy (NZHS) and the opportunity to feedback into improving our health system for all Māori |

### Challenges and opportunities

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

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

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| Te Kāhui agrees that the key challenges include:   1. Improving health outcomes for Māori, which remain inequitable    1. Assertive mention of equity in the NZHS confirms commitment to it. Ensuring fairness and justice for Māori is about embedding equity as a core principle within our health system 2. Inequitable access to health services for Māori    1. Equitable access needs to address the bias within our system. This will require a redirection of some existing health resources and a prioritised allocation of new health resources   Te Kāhui agrees that opportunities include:   1. Explicit promotion and utilisation of the “Equity of health care for Māori: A Framework” (MoH, 2014) 2. Explicit linkage of the NZHS to “He Korowai Oranga: Māori Health Strategy” and Pae Ora, especially explicit linkage to all domains in Pae Ora; Mauri Ora, Whānau Ora and Wai Ora 3. That Wai Ora explicitly be utilised to identify how environmental factors including social (housing), built (urban design) and natural (Air quality, water quality) impact on health 4. Overall improvement of the quality of ethnicity data through the use of the Ethnicity Data Audit Tool across all of primary and secondary care    1. There is an undercount between Primary Health Organisations and census data. Ensuring improved accuracy, consistency and completeness of ethnicity data collection and recording will ensure Māori are being counted properly 5. Take action on reducing the steepness of the social gradient for Māori and other disadvantaged groups through “Proportionate Universalism”    1. The Marmot review stresses that universal actions must be with ‘a scale and intensity that is proportionate to the level of disadvantage’ |

### The future we want

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

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

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

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| --- |
| Te Kāhui:   1. Supports the statement of “live well, stay well, and get well” but not “…all New Zealanders live well, stay well and get well” as it excludes the socially disadvantaged 2. Strongly recommend that the statement utilises the word equity to articulate equity of health for all New Zealanders as a priority 3. Does not support the statement of “People powered” as it excludes vulnerable populations who, for a variety of reasons, have poor health literacy and do not have the “power” to overcome barriers to access services 4. Suggest “people centred” or “focused on people, whānau and communities” would be more inclusive   We suggest the following would be better…  “That New Zealanders live well, stay well, get well, through the provision of services that are focused on people, whānau and communities and are delivered closer to where people live, by providers working as one team in a smart system designed for value and high performance” |

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

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

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| Te Kāhui supports the retention of the seven principles from the NZHS 2000 and the inclusion of an eighth principle for the new NZHS. However, Te Kāhui suggests that the principles be reordered and reworded as follows:   1. Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi 2. Achieve health equity and the best health and wellbeing possible for all New Zealanders throughout their lives 3. A focus on improving health for those currently disadvantaged 4. Collaborative health promotion and disease and injury prevention by all sectors 5. Timely and equitable access and quality of care for all groups of New Zealanders to a comprehensive range of health and disability services regardless of ability to pay 6. A high-performing system in which people have confidence 7. Active partnership with people and communities at all levels 8. Strongly supporting an improved health outcomes and health equity focus through collaboration with other partners who have influence over the determinants of health including integrating Government funding streams |

### Five strategic themes

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

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

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| Te Kāhui suggests:   1. “People powered” becomes “people centred”. To empower people to take responsibility for their own health and to be partners in their own health is one aspect, but in addition to this the whole system needs to buy into the concept of being ‘people centred’ from facility design to service design to process design then to delivery 2. “Closer to home” becomes “Closer to where people live” as this is more inclusive and captures the disadvantaged who have transient lifestyles because of seasonal work and social circumstances 3. “High quality and value” includes the key aspects of the Triple Aim which also includes equity 4. “One Team” implies collaboration is happening vertically and horizontally within the system and is implies improved intersectoral collaboration, particularly with Social Services and the Education sector 5. “Smart System” is supported. Implicit in this statement is shared care planning, whānau planning, a focus on health literacy, all encouraging families/whānau to better self-manage their health |

### Roadmap of Actions

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

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

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| Te Kāhui strongly recommends that:   * There needs to be an explicit action that targets Māori health improvement. As partners with the Crown through the Treaty of Waitangi, inequitable health outcomes for Māori are avoidable, unfair and not acceptable * One action that explicitly targets Māori health improvement is explicit links to all parameters of He Korowai Oranga i.e. Pae Ora – healthy futures: Mauri Ora – healthy individuals, Whānau Ora – healthy families, Wai Ora – healthy environments but also explicit links to all parameters of Te Pae Mahutonga especially, Toiora – Healthy lifestyles, Te Oranga – Participation in society, Te Mana Whakahaere – Autonomy and Ngā Manukura - Leadership |

### Turning strategy into action

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

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| Te Kāhui agrees that:   * An annual forum would be a good way for the Ministry to engage with local health providers. For it to work well it does need to foster a two-way exchange and real partnership |

### Any other matters

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

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| Te Kāhui wishes to thank the Ministry of Health for the opportunity to make this submission.  We compliment Te Kete Hauora on the Māori specific hui held in Christchurch. The open space methodology was refreshing and engendered strong participation. Participants appreciated the way Te Kete Hauora staff sat in and participated in the discussion stations.  Nō reira, ka nui te mihi ki a koutou katoa,  Tēnā koutou, tēnā koutou, tēnā rā tātou katoa. |

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| **368** | Submitter name | [redacted] |
| Submitter organisation | Spirits New Zealand |



**Spirits New Zealand**

Submission to Inform the Review of the New Zealand Health Strategy

Prepared for the Ministry of Health

December 2015



**Introduction**

Spirits New Zealand (formerly the Distilled Spirits Association of New Zealand) is the national trade organisation representing New Zealand’s leading producers, distributors, brand owners, importers and exporters of premium spirits and spirit-based drinks.

Spirits NZ members are Bacardi, Beam Suntory, Brown-Forman, Diageo, Hancocks, Independent Liquor, Lion, Moet-Hennessy and Pernod Ricard. In addition we have three associate members who are Anchor Ethanol, EuroVintage and Federal Merchants.

Spirits NZ represents over 96% of spirit industry interests in New Zealand.

We have a direct interest in the review of the New Zealand Health Strategy as it touches on areas we believe are important to changing our drinking culture and reducing the harm caused by excessive consumption. We believe that lasting culture change will only be achieved through the government-wide integration and development of:

* well-evidenced and coordinated policy interventions;
* targeted education programmes;
* appropriate regulation; and
* industry partnerships.

We are therefore heartened by some of the discussion in the Health Strategy documentation as there are direct and indirect references to the need for government to become better coordinated, targeted, more inclusive and to develop and implement sound regulation to give effect to its health outcomes. Lastly we believe that industry has much to offer in this area and challenge government to work with us to harness the considerable resolve and expertise we have to create a moderate, sociable drinking culture.

Please do not hesitate to contact me to discuss anything in this document in more detail.

[redacted]

**Chief Executive**

**Spirits New Zealand Inc**

**Email** [redacted]

**Submission**

1. Spirits NZ supports in principle the review of a New Zealand Health Strategy that seeks to better understand and refine New Zealand’s health outcomes and then create a functioning, cost effective, cross-government platform of activity to give effect to these outcomes.
2. We acknowledge the difficulties government faces maintaining a first world healthcare system with an increasingly older population, population growth per se, rising costs of healthcare and an ever increasing focus on the delivery of health services with, in relative terms, a static or decreasing funding base.
3. We also understand that the health strategy has been developed from an ‘inside to out’ perspective in that it captures how government can better achieve its defined outcomes by working from within (with a detailed understanding of health priorities of course). Although this is perhaps a simplistic description we were therefore pleased to see mention of better and more effective partnering with business –

*“We can keep expanding our thinking about who contributes to health by tapping into the skills of individuals, families, communities and businesses through stronger and earlier partnerships.” (page 7, Future Direction – Why a Health Strategy)*

***A Partnership Approach***

1. Partnering with government to more effectively change our drinking culture and reduce the harm caused by excessive consumption is a key outcome of ours. We believe that through a government and industry collaborative approach we will be able to more quickly and lastingly reduce harmful drinking.
2. We therefore support the eight guiding principles detailed on page 9 of the Future Direction documentation. We are particularly drawn to guiding principles 3, 7 and 8 –

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

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

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

1. These three guiding principles support our own efforts to change NZ’s drinking culture. We draw your attention to the *Cheers!* programme of activity (www.cheers.org.nz).
2. *Cheers!* aims to understand the drivers that lead to excessive drinking and its associated negative outcomes and then address these through a range of activities, education programmes and tactical interventions. *Cheers!* is jointly funded by Spirits NZ, the Brewers Association of Australia and New Zealand and New Zealand Winegrowers.
3. Established in 2012 the sector has invested over $2 million dollars in the programme – this is in addition to the almost $36 million the sector has been levied for use by the Health Promotion Agency over the same period. A summary of the first three years of *Cheers!* activity can be found in our recently released triennial report at -<http://cheers.org.nz/r/content/CHE0001_Annual_Report_V12_FA_Emailable_medium.pdf>.
4. *Cheers!* adopts many of the approaches outlined in the New Zealand Health Strategy in that it is a cooperative venture coordinated by the three associations across all major alcohol brands. It is evidenced-based, targeted and results driven. It is also agile and able to respond to identified needs – as evidenced by *Cheers!* messaging to support activity focused on drinking and pregnancy.
5. We believe that *Cheers!* provides a cooperative vehicle through which industry and government can promote a moderate drinking culture. A more explicit statement from government as to the advantage of this approach would be beneficial and we ask that this is considered as an addition to the narrative within the New Zealand Health Strategy.

***The Five Strategic Themes and Roadmap of Actions***

1. We support the five strategic themes as described on page 10 of the Future Direction document and again on page 31 in the Roadmap of Actions document. However we feel that references to a broader cooperative approach carried earlier in the Health Strategy narrative has not translated well into the themes - nor into the Roadmap of Actions.
2. Once again we believe that developing lasting linkages with the private sector for the actionable development of interventions that support agreed health outcomes should be explicitly considered within the strategy and the planned out years of actions. This is particularly relevant to the alcohol sector which is motivated to reduce the harm caused by excessive consumption both nationally and globally.[[10]](#footnote-10)
3. Again we challenge the Ministry and government to actively consider how these cooperative linkages are formed.

***Research***

1. 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.
2. 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.
3. 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.

1. 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.*

1. 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.

**In Summary**

1. Spirits NZ is supportive of the direction of the review of the New Zealand Health Strategy but is seeking a more active approach to partnering with industry for the long term benefit of health outcomes.
2. We have some specific concerns with regards how alcohol research is funded from the industry levy and would welcome a closer discussion about this.

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| **369** | Submitter name | [redacted] |
| Submitter organisation | PHO Alliance |

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 comment on the consultation draft of the Update of the New Zealand Health Strategy. Please find below our overarching feedback together with specific comments where we wish to respond to selected individual consultation questions you posed.

**General comments**

We believe the Future Direction paints a clear, high level vision which builds on the 2000 Health Strategy and is based on well rehearsed and well documented evidence regarding New Zealand’s demographic and sustainability challenges.

However, we believe history tells us that unless the Strategy is underpinned by a robust and resourced change management framework, we will not deliver the outcomes expected or the level of change required. In this regard, we feel the Strategy and Roadmap are noticeably light on detail regarding the required changes to the current policy and financial framework setting which will be needed to deliver change ‘at the front-line’. In this regard, we are pleased to offer our proposals which we reference as appropriate throughout this submission and its attachments.

**Q5. 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?**

There are a number of action areas within the Roadmap which are consistent with recommendations we made in our February 2015 publication *A time to act: 7 actions which will help sustain the New Zealand health service for future generations* (copy attached). We specifically welcome the Roadmap’s focus on:

* Prioritising more services and funding to those most in need
* Re-focusing priorities and health targets towards patient level, evidenced based outcomes
* Strengthening IT leadership and consistent infrastructure standards

We also welcome the following action areas which are essential to provide strong foundations for the change management required:

* The re-emphasis of the Treaty obligations upon all partners
* The strengthening and consolidation of national system leadership and a review of the myriad national boards and committees
* The focus on a financially sustainable ‘social investment’ approach. We believe this is particularly important to ensure we target more services and resources to those most in need and reduce New Zealand’s unacceptable inequalities
* The focus on strengthening quality and safety across the system. In this regard we welcome the intention to clarify individual roles and responsibilities which we believe often become confused in an ‘Alliancing’ environment and during the development of ‘integrated’ services

Conversely, we believe that there are some significant gaps in the action areas and we would specifically point to the need to:

* Directly target New Zealand’s unacceptable health inequalities experienced by our Maori, Pacific and high needs communities, and particularly with respect to children and the vital first 4 years of life
* Address the out-dated funding frameworks which do not support the required transition towards a ‘one-team’, patient-centred and integrated primary care based service.
* Address demand-led barriers to access such as making all primary care consultations affordable and removing the perverse ‘patient cost’ differences between various sectors of the system
* Remove the organisational and system barriers which prevent early intervention by those clinicians best placed to do so (e.g. removing barriers to diagnostic services)
* Address the long-standing inertia preventing the required shift of services and investment from high cost secondary care settings into the domain and direct management of primary care. In this regard, we believe that Action 3 relating to shifting services simply repeats the approach which has consistently failed to deliver the required level of change over the past 15 years.

**Q6. 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?**

Following our publication of *A time to act* in February 2015, we were challenged by the Ministry of Health to develop practical solutions to support implementation of the actions we proposed. In May 2015, in direct response to that challenge, we published *A time to act: Implementation solutions*, which set out 31 recommended solutions to support the direct implementation of the system change required. We attach a copy of that publication which remains relevant and forms part of our direct response to this consultation question.

In addition, to directly address the inherent barriers within the existing funding framework, we are pleased to enclose *Targeting Resources: Strengthening New Zealand’s primary care capitation funding formula* which we are publishing alongside this submission.

**Q7. Are there any other comments you want to make as part of your submission?**

We would like to thank you again for the opportunity to comment. This submission and the attached publications have been developed by our member organisations in consultation with a broad range of sector wide partners and stakeholders.

We would repeat our previous offers to make ourselves and our members directly available to help continue the development of the required policy and financial framework settings that will be needed to ensure the Strategy is delivered and we continue to provide a safe, high quality, sustainable and patient focused health service for future generations of New Zealanders.

Yours sincerely

[redacted]

**Chairman**



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| **370** | Submitter name | [redacted] |
| Submitter organisation | Takapau Health Centre |

**TAKAPAU HEALTH CENTRE**

***Te Whare Hau Ora O Takapau***

*Administered By*

*The Takapau Community Health Charitable Trust*

TAKAPAU HEALTH CENTRE

60 CHARLOTTE STREET Phone: [redacted]

TAKAPAU

CENTRAL HAWKES BAY E-mail : [redacted]

10 December 2015

**Keriana Brooking**

NZ Health Strategy Consultation

Ministry of Health

P O Box 5013

Wellington

Tena koe Keriana

**COMMENTS ON THE FUTURE DIRECTION - DRAFT NZ HEALTH STRATEGY**

Thank you for coming to the NGO Council meeting last week and for giving us an extension for making submissions on the strategy documents.

The Takapau Community Health Charitable Trust is pleased to have the opportunity to be involved in steering the future health services in Aotearoa. We have read the Future Directions document and support many of the higher level approaches - such as having a people-powered system that delivers care closer to home by one smart team.

As a small primary care nursing service delivering care to a high health need, decile 9, rural community, we experience  difficulties  everyday of  the current fragmented, doctor-dominated funding model delivers:

* Our clients are marginalised and often unable to enrol with local GPs because their books are oversubscribed with many GPs receiving capitation for around 2,500 people.
* There are long waiting times for GP appointments and so we end up providing care for those people without a local GP as well as people who cannot/ will wait to see a GP. Despite the important role we have in catching people who fall between the cracks of the current system, our nurse practitioner is not able to enrol patients.
* The local PHO and DHB are either unable or unwilling to monitor the performance and delivery of local GP services to ensure that their enrolled patients receive all the care they are entitled to.
* The Ministry of Health will not change its policy on capitation to allow nurse practitioners to receive capitation and as a result we are significantly under resourced.
* When we provide care and advice to local people who need to see a GP, we send full medical records and information to the GPs to ensure that the clinical information does not need to be repeated and can improve co-ordination of care. Despite ongoing requests, most local GPs refuse to send copies of the medical records  of their consults to us. This makes a mockery of the whole care co-ordination paradigm and does nothing to encourage linked up care and our services operating as a united team delivering person-oriented care.

We have made the following comments on the five strategic themes identified in the draft strategy**:**

**1          People Powered**

We completely support the need for a people-powered health service with the clients/ consumers/ health users at the centre. Services must be designed to meet the individual needs of all the people in our country . We do not agree that we should "*move towards a stronger customer focussed approach"*. This is not sufficient. We must operate and provide a customer focussed approach in all aspects of care. This can be done by introducing "co-design" approaches to all services and by actively engaging consumers in all planning and policy activities.

We are also pleased to see mention of empowerment and health literacy. However we do not see a sufficiently strong commitment to promoting health literacy in the document or the Road Map - either promoting health literacy for consumers or for teaching health practitioners how to support consumers to make evidence-informed decisions coming through in the Road Map document.

* There should be stronger roles for consumers in all aspects of health care - from front line through to high level policy input. At present there is no national consumer agency that can link up health consumer groups such as the Health Consumers Forum in Australia.
* Programmes such as the UK's People in Control of their own Health and Care[[1]](https://mail.google.com/mail/u/0/" \l "151842991d804bcf__ftn1" \o ") should be initiated in New Zealand. This report shows that "Patients want it, and the evidence shows that when they are involved, decisions are better, health and health outcomes improve, and resources are allocated more efficiently".
* There should be mention of programmes in school and in communities to teach people about health literacy
* There should be programmes in health professional education courses in how to work in an environment where there is shared decision making .

"Effective health care requires physicians tailor care to patients' individual life contexts, including their financial situation, social support, competing responsibilities, and cognitive abilities. Physicians, however, are poorly prepared to consider patients' lives when planning their care. The result is measurably harmful to individuals and costly to society[[2]](https://mail.google.com/mail/u/0/" \l "151842991d804bcf__ftn2" \o "). There are now many studies and programmes (For example, Weiner and Schwartz) that show how health system errors can be minimized through changes in how doctors are trained, changes in how medicine is practiced and paid for, and ways for patients to assert their individual circumstances during visits."

 We note that on page 12 there is mention an award winning evidence-based app - and further on (pg 13) the strategy states that

" *People access practical evidence-based health advice that makes it easier for them to make healthy choices and stay well. Technology tools such as mobile devices, smartphones and wearable devices are options for everyone*"

and then...

"*But in general we need to get better and faster at sharing the best new ideas and evidence and putting them to work throughout the system. This will help us avoid unwarranted variations in the quality, safety and sustainability of services, and will also mean that effort is not wasted when regions or organisations independently develop solutions to common problems. This can be achieved if we take the learnings from successful implementations and apply them systematically to areas in need of improvement*." Pg 19

We support these approaches however, it isn't clear whether there is going to be a NZ based evidence translation process as part of the big picture.

In our view, there should be trusted sources of evidence-based health information and decision aids that are identified and suitable for the NZ context of care. Resources that used to be developed by the New Zealand Guidelines Group are now out of date and not routinely collected in one location. There is no replacement national agency with the integrity and independence to provide national advice. We are concerned that by separating activities across different regions there is a strong risk of fragmentation and duplication of this activity. We therefore recommend that an agency with a national capacity and expertise in the assessment and application of evidence-based health care (not solely guidelines) be identified.

**Closer to Home**

As a rural service provider we completely support the approach of offering a wide range of client focussed services closer to home.

Here in the Hawke’s Bay in small rural areas we have considerable difficulties delivering primary care nursing services in a sustainable way - this is largely because of the capitation funding arrangements which are paid to GPs and not shared. We do not currently see service integration occurring.  This means that for the strategy to be enabled, there needs to be a complete review of the way primary care services are funded. We would support an approach where the funding follows the patient/client and can be used to provide the care they choose - rather than have the funding captured by medical practitioners as it is at present.

In order to deliver services closer to home, skilled nurse prescribers will be invaluable. As an employer of a nurse practitioner we know and treasure the skills and services they can provide. However we also know that there are also major workforce issues around the perception of nurse practitioners amongst other providers.

The Ministry and DHBs  need to actively encourage the whole sector to train and use these skilled practitioners to their full scope of practice in rural and remote areas - and to allow them to provide care via telemedicine. Currently the Nursing Council will not allow Nurse Practitioners to prescribe without physically having contact with their clients. We also think there is opportunity for telemedicine to be used as an approach for involving GPs and specialist in nurse-led care in rural areas. The strategy needs to ensure that the regulatory framework empowers this kind of flexibility and innovation is not hampered by professional boundaries and commercial interests.

We also believe there is a potentially strong role for nurse practitioners in the delivery of after hours and emergency care in rural areas and areas where there are few GPs and large enrolled populations. In Central Hawke's Bay, local GPs are not prepared to have Nurse Practitioners on the after-hours roster as they wanted a ‘real doctor’. This is extraordinary as the local afterhours triage service provided by the DHB is run by nurses. However it demonstrates that many of the barriers to creative and innovative service delivery closer to the homes of rural people are blocked by medical practitioners seeking to maintain their strangle hold on capitation funds even when it means that the services offered to the community are put under pressure.

We also think there needs to be a review of the number of DHBs and the arbitrary nature of the boundaries that exist. As an organisation sitting on the border of two DHBs we are very aware of the differences in ways DHBs fund services and we are also hampered in our working relationships with providers in our district because we are obliged to focus only on working with one PHO.

We also believe the strategy/ road map needs to include a review of the funding models to ensure that they support integrated care and service delivery. Any new primary care funding models need to have inbuilt flexibility to allow for local circumstances and conditions. For example, within Takapau - a high health needs rural community - we have one side of a street designated as decile 5 and the other side of the street is designated decile 8 which is nonsensical. This means that we are reimbursed at different rates depending on which side of the street - not on the basis of health need or ability of an individual to pay. We have been advised that these designations cannot be reviewed as they are predetermined by Statistics NZ. We find this ridiculous and believe that there should be some capacity to consider local circumstances.

**High Value and Performance**

Value for money is vitally important. However, it is important not to squeeze NGOs to the point of extinction.

As an NGO we are perpetually told to deliver more and to live within existing or lower resources. However small NGOs don’t have the scale and scope to absorb the kinds of cost containment that large DHBs require.  This causes even greater stress on the already over worked voluntary sector and makes it difficult to retain high quality staff. Does this result in value?

The other thing to consider as part of the value for money review would be to promote the active review of over-servicing/ over-diagnosis and inappropriate care. For example, the US, Canada and Australia have embarked on programmes called "Choosing Wisely" where ineffective care/ practices are identified by professional colleges and form a part of campaigns to improve practice (<http://www.choosingwisely.org.au/>).  Cancer screening should also be part of this review.

**One Team**

- see our earlier comments about the need to train practitioners into helping consumers understand their health care options, their bodies and the health care system. If you can put the consumer at the centre of all activities then it is more likely that one team could emerge with the consumer as the leader.

**Smart Systems**

The key to the smart systems will be the evidence-based information used by the different devices (see earlier comments).

We are pleased to see that the strategy promotes open access to health information. However, currently our service experiences blocks by local GPs to sharing information. While our nurses supply full notes to people referred to local GPs, local GPs refuse to notify us of their treatment and advice.

To change this outdated and obstructionist behaviour, there needs to be systemic changes to require practitioners who receive public funds to be obliged to share information with the service providers chosen by consumers. This should be enforced by DHBs and PHOs. Currently they are powerless to mandate this information sharing.  This approach to free-flowing information should go hand-in-hand with providing consumers with a greater understanding of the importance of their health records (through health literacy training) as well as opening up access information portals consumers can use free of charge.

**General comments**

We also noted that health inequities and outcomes are missing from the Strategy.  There is mention of disadvantage and access but not inequitable health outcomes.

The strategy refers to "all New Zealanders".  However it is important that this strategy should also recognise the importance / need for making significant improvements in the health of tangata whenua and in particular looking at ways of making the system more approachable and easier to use and tailoring services to the needs of different groups.

Thank you for considering our comments. If you would like to make contact with me, my phone number is 021 907770 or I can be emailed at bluekakariki@gmail.com

Nga mihi

* [redacted]
* Independent Guideline Adviser
* Member of the NGO Council
* Deputy Chair, The Takapau Community Health Charitable Trust

submitted on behalf of the Takapau Health Centre - Te Whare Hau Ora Takapau

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| **371** | Submitter name | [redacted] |
| Submitter organisation |  |

To: Ministry of Health

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

Kia ora,

I am a Pakeha New Zealander, and have relatively recently and in a growing sense come to understand that our public institutions (education, media, justice, as well as health) systemically discriminate against Maori, let alone proactively fulfil on the promises of te Tiriti o Waitangi.

My submission focuses on how effectively the approach taken by the update to the Health Strategy addresses this or not. My intention is to be in support of a meaningful update of the NZ Health Strategy in this area. It does not mean that the other areas are not important, but it is the focus of my submission.

**Giving effect to and having a plan for the principles**

There is acknowledgement of those currently disadvantaged, and recognition of the treaty relationship within the principles of the Health Strategy. I came across a page on the update on the NZ Health Strategy, including the invitation to send in questions/comments[[11]](#footnote-11) that stated:

*“The 2000 New Zealand Health Strategy includes seven principles that reflect the values of the health system and the expectations of New Zealanders. The seven principles are enduring approaches for our system and are included in the current update of the Health Strategy”.*

The two principles were named as:

* 'Acknowledge the special relationship between Maori and the Crown under the Treaty of Waitangi', and
* 'An improvement in the health status of those currently disadvantaged'

*Feedback:*

* Whilst these are named as principles, there is no evidence that there has been any meaningful consideration of the update of the strategy. Doing a word search on ‘Maor’i and ‘treaty’ highlight the principles, reference to Maōri health strategy, some disparity, and that Maori health providers as connected to their communities, and that training should occur for health care workers and board members. This is not the same as developing a plan. A clear coherence from these principles through to action areas needs to be explicitly made.

This kind of feedback is not new. I had a read through the summary of submissions on the 2000 Health Strategy to see what had been said on these issues in the past. It appears the feedback provided has not yet been taken on:

* “NZHS is weak in framing systems and processes to demonstrate how the sector will be held to account under the Treaty of Waitangi” (p63)
* “Some believed that the document lacked sufficient detail or specificity on how the goals and objectives for improving Mäori health would be delivered, and how the system would be held to account for its performance on this matter. This paucity of information concerning the next steps, timeframes and responsibilities was a cause of concern for many: ‘The NZHS is promoted as a living document but doesn’t provide any clarity around the practical application or implementation of high level objectives.” (p63)
* “The establishment of principles is supported. However, the implementation of policies to fulfil those principles is crucial’ (p64)

*Feedback:*

* Acknowledge and itemise responses to each of the feedback items for this strategy update and the 2000 Strategy feedback and incorporate into revised update.

**Addressing Disparity – this is also not new. Name and address Institutional Racism**

The Hunn Report in 1961 was the first place that pulled together and highlighted significant disparity between Māori and the wider population- this was done over 50 years ago and the health related excerpts are available online[[12]](#footnote-12). One of the key issues with the framing of the original Hunn Report was that it was framed as a problem with Māori, rather than a problem with Pākehā or Pākeha institutions.

A key area to name and address is institutional racism – not isolated to within health. A recent paper[[13]](#footnote-13) defines institutional racism as

*‘an entrenched pattern of differential access to material resources and state power determined by ethnicity and culture, which advantages one population while disadvantaging another’.*

The paper also notes:

*[Hayward and Lukes 2008] three-dimensional analysis of power is another tool for examining the cultural and institutional roots of policies. The first dimension is the processes and outcomes of overt decision-making. The second dimension is the process of shaping or framing an issue so that certain ideas are considered, discussed, and esteemed while others are not. Finally, the third dimension is characterised by the ability to define or determine what is considered to be a relevant issue for discussion through setting agendas and determining priorities.*

Further:

*‘Power can be exercised through policy frameworks, overt decision-making, agenda setting, shaping meaning, withholding information, prioritisation, and imposing worldviews, all of which are social practices. Far from being fixed, such features of institutional racism are amenable to change through policy development and restructuring, which are commonplace in contemporary society. Rather than focusing on the intentions and motivations of individuals as the defining characteristic of institutional racism, the target is to eliminate racial disparities and the structures that generate it.*

The paper highlights four key ways to address this, one of which is transforming public institutions – a clear one is Health.

I note from article[[14]](#footnote-14) on Mason Durie’s commentary, there have been some improvements but disparities remain:

*Over the past 30 years Maori life expectancies have increased by 8 years for both men (65 to 73) and women (69 to 77), but significant disparities remain in areas such as diabetes, most cancers, mental health issues and rheumatic fever.*

And also from a recent article[[15]](#footnote-15):

*Acting Deputy Director-General Maori Health Paula Searle said while the health system works for most people, most of the time, there are persistent health inequalities that need to be addressed.*

*Lead researcher Bridget Robson said it would be harder for people to ignore that institutional racism was part of the health sector, given the major disparities.*

*"It's so terrible that these are the [statistics] but it isn't surprising given the socio-economic factors," she said.*

*"The profiles remind us that stark inequalities in health continue. They provide a useful base for identifying key issues and planning actions to improve Maori health."*

Unless Institutional racism is practively addressed, disparities will continue, and the vision of value and high performance in 10 years’ time that ‘there has been a clear lift in health outcomes experienced by population groups previously disadvantaged...’ cannot be achieved.

*Feedback:*

* Name and include institutional racism in the update.
* In the action plan, under ‘Performance and Outcomes’, there should be a specific action area about reporting on and ensuring equity for Māori and other specific measures in place, developed from an evidence base, that are supportive of countering institutional racism.
* Given the importance of the role of decision making ensure there better balance in the decision making level between Maori and other members of the community, and recognition and advocacy by non-Māori of the role of discrimination.
* Map out and demonstrate how advocacy from health ministry into other areas that are the determinants of health: e.g. housing, poverty.

Kind Regards,

[redacted]

Citizen

Auckland, New Zealand

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| --- | --- | --- | --- | --- | --- |
| **372** | | Submitter name | Marion Blake | | |
| Submitter organisation | Platform Trust | | |
| This submission was completed by: *(name)* | | | Marion Blake |
| Address: *(street/box number)* | | |  |
| *(town/city)* | | |  |
| Email: | | | Ceo@platform.org.nz |
| Organisation (if applicable): | | | Platform Trust |
| Position (if applicable): | | | CEO |

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

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)*: Platform is a network of NGOs many of who contract with Crown agencies to provide community services in mental health and addictions. [www.platform.org.nz](http://www.platform.org.nz)

### Challenges and opportunities

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

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

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| The strategy need strengthening around the connected wider global challenges and commitments. As a member of the UN NZ will be expected to frame agendas and political policies over the next 15 years to achieve the sustainable development goals (SDGs). It also connects to other obligations and conventions UNCRDP UNCRC etc. |

### 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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| Language of the direction is right living well and staying well etc. There is something about people who won’t get well living well as well. Interested in who are the ‘we ‘, is it the Ministry, the people who work in health, the Government, citizens ?? |

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

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

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| These are right and appropriate if a bit jumbled. Given the poor state of Maori Health perhaps the special commitments of Treaty relationship should come higher up the list. Eight is a tricky number and some of the principles belong with the system and some are behaviours. This could probably be worked up (edited) more succinctly. |

### Five strategic themes

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| 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?  **People Powered**  Pacific people having services through churches is not a stretch its common now. The stretch might be developing and resourcing multi service, cross agency community health and social service hubs run by Pacific people working alongside health staff and others. The focus needs to address the issues that trouble and concern the community such as disconnected youth and suicide, this work could also developing community resilience and preparation for the impact the arrival of climate change refugees will effect this community.  People powered means people designed – co designed. You don’t need to train staff to know more about lifestyle or experiences just get them to listen to what people are asking for.  Feedback systems are only as good as system re- correction or improvement so this needs to have some qualification about efficacy.  There is some confusion in this theme about whether the focus is individuals or groups of people, both matter but it implies that I’m not a service user until I meet whatever threshold my disability/ illness/disease/ distress generates. However as a citizen I have a view about how health should be providing people centred approaches. This will require bolder engagement strategies that redefines ‘service users”.  **Closer to Home**  Understand that this is a statement is a proxy for the idea of having the support needed provided locally however the literal interpretation is confusing and conflicting for rural communities. Many are currently experiencing removal and closure of local services so statements like ‘services when they want them’ is frustrating. Regional planning may address this however the usual dichotomy is rural/urban, so perhaps more development of the emerging rural alliancing and rural collaborative of health and social supports provided in a way that a rural community requires is the stretch. This may be irrespective of prescribed DHB boundaries and more attuned to naturally occurring communities /networks.  Absolutely agree that the workforce needs to change and this will challenge and be challenged by the professional bodies, academic institutions, trade unions, some employers and many others who have a vested interest in the status quo. It will not happen without a rigorous implementation strategy.  **Value and high performance**  This is a critical theme, funding and investment are the levers to change behaviour. The case for more services are to be delivered in communities has been made and this is the theme that will activate that. We think the underlying element of this theme is that the capacity of the NGO sector needs to be mobilised and that investment and value for money approach applies to all.  The area of investment in prevention is not strong and all the evidence suggests this is probably the area where most health gains can be made.  **One team**  System ownership/ leadership needs to be developed in the context of a changing community, economics, business practices and relationship of citizens to service provision. The need for new allies and new governance frameworks are overdue. Integration and cohesion in the health system can learn lots from the new thinking that is emerging in business and enterprise, this is reflected particularly in the start-up nimble space. However the key activity of MoH in the strategy needs to maintain and own the overview of the whole of system. This is way beyond the current micro management and surveillance functions, and it will require skill in social design processes that contribute to improving wellbeing, community development, engagement and resilience. Clinical practice and managerialism need to be subsumed into overall systems thinking.  **Smart system**  Good quality information is only as good as its collection and utilisation and we need to drive changes that improve the relationship of all these factors. The NGO mental health and addiction sector is very keen to see better use of information and data that is useful and takes us forward not just measures what has been. Knowledge and meaning-making about the data must be developed in partnership as the isolation that has thrived in this area has meant that much data production is difficult, delayed and without context. It is questionable whether the cumbersome machine of Health can ever adjust to the speed that information needs to move at, particularly in the growing area of social analytics. This means the Ministry must be open to having a different set of relationships with providers and facilitating collaboration over analytics and analysis. Health needs to look to other Govt agency such as Statistics who have grappled with and succeeded in the production of accessible and useable social data. |

### Roadmap of Actions

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

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

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| The actions described are quite clinical and medical in focus.  **People Powered**  In the mental health and addiction sector there are a range of self-management approaches that are already used that could easily be scaled and others that could be applied. There is huge scope for better use of smart phone technology, SMS for feedback, reminding, checking in with help, and stress indicators even wider use of ignition or breath alcohol interlock devices. Simple fitness levels could be addressed by simple devices e.g. Fitbit. This will require a bridge between clinical/diagnostic based psychiatry and wellbeing management as well as an overhaul of how money gets closer to people.  Coordination across digital solutions in Action 1 is critical and can’t be diagnosis lead without consideration of co-existing issues and relationship with other health issues e.g. diabetes/mental health /pregnancy often happen at the same time.  Action 2 begins to get exciting with the ideas of design labs, sharing examples of effectiveness but the detail quickly reverts to clinician led collaborations and an annual forum. If we are to be creative across the whole system we need to be inclusive of all the elements of the workforce, the analysists, the financial teams, the support workforce, the outreach and community people. There is no point in a cutting edge interventions that get crushed by the financial planning because that department doesn’t get the relevance of the work or solutions that only work on a ward when people live at home.  The social science skill of collaborative people led design is often not in the skill set of many clinicians who describe these as “soft skills” and not real science.  Annual forums are OK but there are also more efficient and effective ways of engaging, transmitting and collectively evolving ideas and this will only increase over the next 5 years.  **Closer to Home**  **Shift Services** These actions are limiting and we would like to suggest a bolder approach that assumes the community is the first response. We need to ensure that clinical staff are doing what they are trained to do and that other tasks and duties are undertaken by other staff. There are new and emerging roles that need to be better understood and the workforce skills improved. This would also apply to service activities of DHBs that could be more than adequately undertaken by NGOs. There are a wide range of services in the mental health and addiction area that could very easily be shifted to NGOs. This could include; residential bed based services, day care, respite care, slow stream rehabilitation. This could be expanded to include social detox, behavioural support for people with mental health and learning disabilities who are still living in DHB long term services - these are all examples of current DHB provision and population groups already served by NGOs.  Increasing the access to specialist clinical support to people by basing clinicians with community NGOs rather than at hospitals, or at least having clinics in NGO settings.  PHOs are part of but not a default for community.  **Children/families and whanau** This is a key area of interface for social health. Frameworks and strategies for activity across Government agencies will help but there also needs to a reason for collaboration across NGO agencies; mental health and addiction issues in families, whanau and communities, creates a common agenda. The varying roles of community support work /social work/specialist worker/therapist need to be better understood across the health and welfare continuum. We suggest running a NGO lead prototype collaborative for shared outcomes across Ministry of Social Development (MSD) and DHB funded NGOs, working with populations that are at risk of poor health and social outcomes.  Getting mental health support needs to get closer to schools. Education providers at all ages are often at a loss about how to support the children they know are having difficulties at school. Mental health and addiction issues in families still carries a certain degree of stigma and so people may not know what to do and/or they may be reluctant to seek help. We suggest that NGOs be charged with scaling up the virtual school wellness support team. This would create a number of soft entry points for families/whānau where mental health and/or addiction issues are a problem. The model enables families to receive the right level of support and/or treatment interventions at an early stage when problems are first identified, thereby reducing the likelihood that these problems will escalate into a crisis.  **Value and high performance**  Commissioning and contracting are the critical drivers of change the urgency to do implement these changes cannot be stressed enough. As chapters 6 & 12 of the Productivity Commission report emphasises there are many elements of system adaptations, workforce considerations, guidance development, data collection and analytics that need to be addressed as well.  Investment approaches that create generational change are important in the mental health and addiction area if we are going to transform our system. An example of this is a serious intentional and focussed evidence based employment support for newly diagnosed and at risk young people to support them to continue their education or move into employment. In undertaking this work NGOs are able to recognise and address overlapping social problems that often occur, such as lack of secure housing, illiteracy and poor self-management of health issues.  **One team**  There is a body of literature in the area of innovation that discusses how people who do decision making and governance are not the same people who take risks and support innovation, these are very different skills. Therefore it is unlikely that innovation will come from existing DHB governance arrangements – even with training. This contradiction would need to be addressed in the action roadmap  DHB performance review is important and consistent performance measures need to be evolved. So let’s include the range of expectations across population health not just hospital or clinical measures this might be a task of our evolving cross sector talent team.  We cannot stress enough how important it is to develop the capability of all of the NZ health workforce irrespective of their employer. The focus of the actions still seems to be the clinical workforce and the practice of the Ministry via Health Workforce NZ to exclude development and investment into the community support workforce across all sectors cannot continue if we are to achieve services closer to home and within the current funding context.  Utility of new language such as stewardship requires a shared understanding of what is being demanded. The responsibly of health and wellbeing needs to be understood and more than a fiscal outcome. For example: We would imagine a future where the governance of the health and social system is horrified and shocked into actions by information that tells them that more New Zealanders killed themselves than died in traffic accidents. The numbers of young people who suicide is a powerful indicator of our failure, changing this is what we need to see in 5 years.  **Smart system**  Where there is shared interest such as the health and wellbeing of citizens Government departments must collaborate around the reporting of social outcomes. BPS has provided the framework for collaboration however each agency is still operating its own version of contracting, outcome measures and now investment strategies which is wasteful for a country the size of NZ.  We agree with the action to work with Stats and Superu to provide high level data stories.  Data duplication is rife and the requirement at a local DHB level for contracted NGOs who are still required to provide trivial information which adds no value to the system. These low level irritants impede the general acceptance of the strategy.  It is clear that good health and wellbeing is a key direction for the health system and there is already significant evidence of the role that wellbeing has, in maintaining good mental health.  Building a knowledge base that enables the system to have confidence in health investment, the return on that investment and measurement of outcomes is critical. NGOs are a key service provider across all aspects of health yet there is no attempt to develop collaborative practice in this activity. We propose either the Ministry of Health or Treasury, partner with the sector to build all of our capabilities in this emerging key activity  . |

### 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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| Open data, smart data, relevant facts, transparency and data visualisation will engage citizens.  The current dense data dumps are not useful. Mental health is data rich and knowledge poor. An example of engaging accessible public information about progress is Vital Signs - started in Canada and now rolled out to many areas of USA and UK. This data comes from multiple sources and tells a story that makes sense to citizens and is engaging.  <http://cfgp.ca/downloads/VitalSigns2014ProcessDocument.pdf>  <http://www.vancouverfoundationvitalsigns.ca/society/health-and-wellness/>  <http://www.communityfoundation.org.uk/vitalsigns> |

### Any other matters

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

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| **373** | Submitter name | [redacted] |
| Submitter organisation | The Royal Australian and New Zealand College of Psychiatrists |

**New Zealand Ministry of Health Draft Health Strategy consultation**

**December 2015**

**RANZCP New Zealand National Committee submission to the Ministry of Health on the Draft Health Strategy**

**About the Royal Australian and New Zealand College of Psychiatrists**

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP has more than 5,000 members, including around 3,700 fully qualified psychiatrists and almost 1,200 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support people in recovery, including pharmacotherapy and psychotherapy.

**Introduction**

This submission has been developed in consultation with the RANZCP’s New Zealand National Committee/Tu Te Akaaka Roa.

Overall, the RANZCP supports the key tenets of the Health Strategy (the Strategy).

We commend your approach in establishing links between the Ministry of Health and other social sector agencies. There is a significant body of literature linking social determinants such as low social economic status, poor housing, and low educational achievement, to poor health outcomes (Office of the Children’s Commission, 2012; Marmot Review, 2010). Cross-government agencies working in concert with a shared philosophy will be able to address complex, long-term problems that currently exist in New Zealand. With the further development of the Department of Statistics’ Integrated Data Infrastructure (IDI), the Government will have the ability to identify those populations who most need assistance and develop coordinated initiatives to reduce health inequities that currently exist in New Zealand. The RANZCP has commissioned research demonstrating that people with mental illness experience significantly higher rates of premature mortality and morbidity due to reduced access to health care relating to stigmatisation and discrimination, and poor management of their physical co-morbidities (RANZCP, 2015a). We recommend that the Strategy explicitly articulates the current inequities that exist in the health sector so there is the capacity to measure progress in reducing the gaps in health care access and delivery.

We also support the Strategy’s life-course approach to health recognising that early investment and developing resilience in children will support well-being into adulthood. The Strategy does stress the importance of improving the health status of children in New Zealand but there is limited acknowledgement that young children are experiencing poor mental health and behavioural difficulties (Superu, 2015). Other than the Prime Minister’s Youth Mental Health Project there is generally little in the Strategy that promotes the importance of mental health. The British government has prepared a paper that contends there can be no health without mental health (Department of Health, 2011) and we urge the Ministry of Health to examine the Strategy from this perspective thus giving greater prominence to mental wellbeing.

We are pleased to note that the key theme throughout the Strategy is to deliver health services that are patient-focused rather than provider-focused. Such an approach will require reconfiguring current services towards prevention and early intervention and implementing new models of care such as developing polyclinics delivering integrated care “under one roof” (King’s Fund, 2008) and care pathways where medical specialists practise outside the hospital delivering services in the community (King’s Fund 2014). Strong clinical leadership will be critical to bring about this transformation. As noted in the Strategy patients will increasingly play a role in refocusing health care services. However the RANZCP recommends that the Ministry of Health supports the Strategy with initiatives to lift the population’s health literacy enabling them to partner with health providers, underpinning this drive to provide a patient-centred health service is the implementation of the integrated electronic patient record allowing the patient to access their health data and ensuring the multidisciplinary team has accurate and shared information regarding the patient.

We note that Whanau Ora and the Pacific Fonofale are included in the future health care models. We support health care models whereby Maori/Pacific people develop, deliver and have access to health programmes that best address their own particular needs in a culturally responsive way. Whanau Ora aims to integrate many social services together based on whanau-centred principles. There is promising data indicating the Whanau Ora general practice collectives are performing well (Ministry of Health, 2015 b) and that some initiatives e.g. the navigator role are successful (Superu, 2015b). Maori and Pacific People experience higher rates of mental illness compared with the general New Zealand population therefore it is critical new models of health care are adopted that can contribute to better health outcomes for these populations.

The RANZCP understands that the Strategy is a high level document seeking support from the sector regarding how future health services will be delivered in New Zealand. With this in mind the RANZCP has provided general comments in response to the key themes detailed in the Strategy.

**General feedback**

1. People with mental health issues – linked to all themes

Early investment in the health of children and their families/ whanau is specifically identified in the Strategy as a key area of focus. The evidence is unequivocal that childhood experiences impact greatly on adult health outcomes including mental health and well-being (Office of Children’s Commission, 2012; Pickett & Williamson, 2009). The RANZCP agrees that more needs to be done to improve the uptake of the services currently available such as Well/Child Tamariki, B4 School Check to ensure that children get the best start in life. The pace of implementation needs to be stepped-up to quicken changes within the system as a number of children still have significant unmet health needs (Ministry of Health, 2012).

It concerns the RANZCP that there is no explicit mention of improving mental health services for children. The Children’s Action Plan’s “aim is to help children thrive, achieve and belong” but this objective will remain aspirational unless children with mental disorders or developmental disorders are well supported to achieve their full potential. Currently the prevalence of these disorders is low, but evidence indicates that the number of children diagnosed with emotional and behavioural issues are increasing (Ministry of Health, 2012). Furthermore, research indicates that the onset of mental illness occurs early in the life-course (Mental Health Commission, 2012), therefore it is critical that the Government addresses the consequences of mental illness in the early years of a child’s development. We are also concerned about those risk factors that impact on the child’s life-chances and in particular those children who live with parents and caregivers who are experiencing mental health and/ or addiction issues. Children of parents with mental illness have an increased risk of adverse developmental outcomes and mental health problems (RANZCP, 2015b). The Strategy should acknowledge the importance of investing in children’s mental health –by early access, interventions and responses -to improve “educational participation and a reduced risk of later mental health and addiction and anti-social behaviour or offending” (Mental Health Commission, 2012).

The Strategy does not explicitly prioritise mental health. On page 12 the Prime Minister’s Youth Mental Health project is mentioned but poor mental health permeates all segments of New Zealand’s population. There is scant reference to mental health elsewhere in the document. In our view this is a serious omission in the Strategy. A comprehensive survey of New Zealand’s mental health, (Ministry of Health, 2006) noted that the prevalence of mental disorders was common within the New Zealand population, furthermore 37% of those diagnosed with a mental disorder presented with other mental or physical co-morbidities. The burden of mental illness within the health sector is significant with mental illness and addiction (in Disability Adjusted life Years) now exceeding cardiovascular disease and cancer (HDC, Mental Health Services Productivity Improvement). Furthermore mental health is inextricably linked to long-term physical conditions e.g. patients who experience a cardiovascular incident may also develop depression and people who have mental illness may develop metabolic disease due to anti-psychotic medication (RANZCP, 2015c).The Strategy does not acknowledge the interplay between mental health and physical conditions and how these complex issues will be addressed in future service models.

Given the prevalence, complexity and economic cost of mental illness, in New Zealand, the Strategy should give some consideration as to how people with serious mental illness will be accommodated within the proposed health care model. Theme 1 describes how in the future patients will use mobile Apps, electronic patient portals, smart phones and wearable devices to engage with their health providers. We require further information as to how these new proposals will support people with serious mental illness as people with mental illness currently have a low rate of engagement with the health sector (Ministry of Health, 2006) offering electronic communications is unlikely to increase this interaction. Evidence suggests that people with serious mental illness have difficultly comprehending health-care advice and/or carrying out the required changes in lifestyle due to their psychiatric symptoms and other adverse consequences of their mental illness (RANZCP, 2015). These challenges presented by their illness suggest proposed methods of health-care delivery may not best meet this population’s health needs.

The RANZCP argues that tackling suicide is a complex social problem that requires particular attention within the Strategy. New Zealand has one of the highest suicide rates in OECD and while suicide is particularly high for youth (people aged 15–24) it is not entirely confined to this age group, with high rates also recorded within the young adult population (people aged 25–44) (Ministry of Health, 2006). We know in particular that Māori youth have the highest rate of suicide which is 2.4 times greater than the general population and requires urgent attention and intervention (wakahourua.co.nz/suicide-facts). In addition data indicates that the number of elderly committing suicide is increasing (Ministry of Justice, 2014). The Strategy should including building awareness of mental health services and developing health promotion around providing more effective care and assistance to suicidal people.

Poor mental health is often associated with a range of co-morbidities such as tobacco use and alcohol misuse (Department of Health, 2011).The Strategy should put more emphasis upon initiatives to reduce tobacco consumption and to address the harmful use of alcohol. Recent data demonstrates that poor drinking behaviours have declined but 16% of all adults report engaging in hazardous drinking (Ministry of Health, 2015a). One in six women continued to drink during their pregnancy (Ministry of health, 2015a). Maori women of child-bearing years are continuing to smoke tobacco (38% of Maori women between the age of 15 and 38 smoke daily, Ministry of Health, 2015). These behaviours have the potential to impact on the population’s health outcomes including children’s health and therefore the Strategy needs to build on the previous health promotion activities undertaken in this area.

**2. Health literacy - linked to themes 1, 2 and 5**

The vision for the future will only succeed if New Zealanders improve their health literacy. We understand that both the Ministry of Health and the Health Quality and Safety Commission have initiatives underway to build the public’s capacity in this area. A recent report noted that half the New Zealand population has poor literacy skills (Ministry of Health, 2015a). Implementation of the Strategy is contingent upon people understanding their own health data, increasing their capacity to make decisions about their own health and using the appropriate technology to interact with multiple health providers. We recommend that a well-developed and targeted public health strategy is implemented to educate the public about understanding and using health information enabling them to effectively manage their own health care.

Recent evidence indicates that while some patients are embracing the patient portal concept and there is concern that those who could benefit from the portal, namely the elderly are not comfortable using technology (New Zealand Doctor, 2015).

We note that the sector, led by the National Health IT Board, has made significant gains by implementing the National Health Index (NHI) and Health Provider Index (HPI) that will provide a strong foundation to further develop the technological infrastructure. In our view the Ministry must not delay investing in the development of an Electronic Health Record (EHR) that can be accessed by the patient, community, primary and secondary providers. A recent review of New Zealand’s electronic health records found “overall system landscape is still quite complex, diverse and difficult to manage. We lack ‘universality’ in terms of common systems and processes that are nation-wide. We also struggle to scale innovations nationally and often IT is viewed as a cost burden” (Deloitte, 2015).

The Strategy should be wary of not over emphasising the benefits of technology, such as rolling out patient portals and developing the single electronic record, as the “silver bullet” that may solve many of the sector’s current challenges.

**3. Workforce Issues - linked to themes 2 and 4**

The RANZCP agrees that it is critical that the health workforce is a cohesive team working towards delivering a seamless health service across a range of settings. Some of the issues we have identified relate to managing the unregulated workforce, ensuring there are clear scopes of practice, reducing duplication and addressing workforce shortages.

Workforce shortages within a range of medical specialities including psychiatry coupled with a health workforce that is mal-distributed remain persistent problems in regards to optimal service delivery in New Zealand. Health Workforce New Zealand has several programmes underway such as the Voluntary Bonding Scheme but more needs to be done to develop initiatives to address these ongoing challenges.

It is clear that future health services will be delivered closer to home by primary care providers. We would see the general practitioner playing a critical role in developing patient care plans and having general oversight of the patient’s journey. The Strategy needs to be explicit about the recruitment and retention of general practitioners and also examining how the role of the nurse practitioner can be better promoted.

The Strategy also mentions that health services may be delivered by volunteers and other unregulated health workers. We recognise the need for a more flexible workforce that can be redeployed to meet changing health needs. A balance must be found between the increasing burden of regulation and ensuring patient safety is not compromised. In the United Kingdom, it was proposed that a voluntary registration was established for health care workers to “drive up the quality of the workforce” and reduce the costs associated with regulation (Secretary of State for Health, 2011).

**4. Leadership – linked to themes 3 and 4**

In order to deliver a health service that meets the New Zealand public’s expectations, clinicians must be empowered to lead innovation and transformation within the health sector. This can only occur when clinicians have adequate protected time to develop solutions to improve efficiencies and to address quality of care (ASMS, 2009). Clinical leadership is central to re-engineering the health system as proposed by the Strategy. Whilst the Strategy acknowledges the importance of building leadership capabilities and we also understand that the Health Quality and Safety Commission is developing a framework to develop skills in this area, we would be keen to learn how these initiatives would be implemented in practice.

**5. Public Investment in health systems – linked to theme 3**

The OECD reports that achieving value for money in health care is a chief concern for OECD nations (OECD, 2010). It is a difficult balancing act to provide a health service that is cost-effective whilst meeting the public’s expectations. The Strategy suggests that the health sector can take advantage of cross governmental partnerships as well as public and private partnerships. The RANZCP seeks further information regarding the involvement of private partnerships in health services. Inviting private agencies to be participants in the health sector leads to fragmentation of care and inconsistency of service. We recommend that the Ministry of Health seeks further evidence regarding private investment in the health sector and how such investment has contributed to measurable improvements in health outcomes.

**Conclusion**

We appreciate the work that has gone into producing the Strategy. Considering the diverse needs of the New Zealand’s population is a challenging task.

The RANZCP supports the over-arching themes of the Strategy. We make the following recommendations:

• That the Strategy explicitly articulates the current inequities that exist in the health sector so there is the capacity to measure progress in reducing the gaps in health care delivery.

• We urge the Ministry of Health to examine the Strategy from the perspective that without good mental health people may struggle to experience overall good health. We argue greater prominence is given to mental health and wellbeing in the Strategy. We have presented evidence in our submission that New Zealanders experience a high prevalence of mental disorders; that children exposed to risk factors at any early age have a high change of developing mental disorders; and that New Zealand has one of highest rates of suicide in the OECD. We have also demonstrated that those experiencing mental disorders are likely to have poor physical health. The Strategy identifies that with an ageing population, individuals will present multiple chronic diseases but it does not seem to address how poor mental and physical health are inter-twined. The Strategy should include new service models to meet the growing complexity of an ageing population who will be presenting with both physical and mental health issues requiring, in our view, a sustainable specialist workforce to meet these demands.

• We agree with the Strategy’s proposed philosophy that health care delivery should be patient or consumer focused. The RANZCP contends that patient empowerment is only possible by developing initiatives that support health literacy.

• It is clear that future health services will be delivered closer to home by primary care providers. We would see the general practitioner playing a critical role in developing patient care plans and having general oversight of the patient’s journey. The Strategy needs to be explicit about the recruitment and retention of general practitioners and also examining how the role of the nurse practitioner can be better promoted. Related to future workforce development we seek further information regarding the regulation of the non-medical workforce. Workforce shortages within a range of medical specialities including psychiatry coupled with a health workforce that is mal-distributed remain persistent problems in regards to optimal service delivery in New Zealand. Health Workforce New Zealand has several programmes underway such as the Voluntary Bonding Scheme but more needs to be done to develop initiatives to address these ongoing challenges.

• Transforming the health sector will require strong clinical leadership and the Strategy while acknowledging the importance of building leadership capabilities, it remains unclear how this will be implemented in practice.

• We recommend that the Ministry of Health seeks further evidence regarding private investment in the health sector and how such investment has contributed to measurable improvements in health outcomes.

**References**

ASMS - Association of Salaried Medical Specialists (2009) In Good Hands.

Deloitte (2015) Independent Review of New Zealand’s Electronic Health Record Strategy.

Department of Health, (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, United Kingdom.

Department of Statistics, New Zealand, accessed on 11 November 2015 at http://www.stats.govt.nz/browse\_for\_stats/snapshots-of-nz/integrated-data-infrastructure.aspx

Mental Health Commission (2012) Blueprint 2 Improving mental health and wellbeing for all New Zealanders.

Ministry of Health (2015a) Health and Independence Report 2015, New Zealand.

Ministry of Health (2015b) Report on the performance of general practices in Whanau Ora collectives.

Ministry of Health (2006) Te Rau Hinengaro: The New Zealand Mental Health Survey, New Zealand.

Ministry of Health (2012) The Health of New Zealand Children 2011/12: Key findings of the New Zealand Health Survey.

The Ministry of Justice (2014) Press release Chief Coroner releases provisional annual suicide figures, 20 August 2014 http://www.justice.govt.nz/courts/coroners-court/suicide-in-new-zealand/provisional-suicide-statistics.

New Zealand Doctor (2015) Not a matter of “if” but when to adopt patient portals, 11 November 2015.

OECD (2010) Health care systems: Getting more value for money, OECD Economics Department Policy Notes, No. 2.

Office of Children’s Commission (2012) Working Paper no.2: Lifecourse effects on childhood poverty, Expert Advisory Group on Solutions to Child Poverty.

Pickett, K & Williamson, R (2009). The Spirit Level: Why More Equal Societies Almost Always Do Better. London: Allen Lane.

Secretary of State for Health (2011) Enabling Excellence: autonomy and Accountability for healthcare workers, social workers and social care workers, United Kingdom.

The Health Quality and Safety Commission, Partners in Care Programme. Accessed on 4 December 205 at http://www.hqsc.govt.nz/our-programmes/partners-in-care/work-streams/health-literacy/

Superu (2015a) Vulnerability in early life: how are New Zealand children faring? September 2015.

Superu 2015b) Integrated social services for vulnerable people, November 2015.

The King’s Fund (2008) Under one roof- will polyclinics deliver integrated care?

The King’s Fund (2014) Specialists in out of hospital settings.

The Marmot Review (2010) Fair society, Healthy Lives.

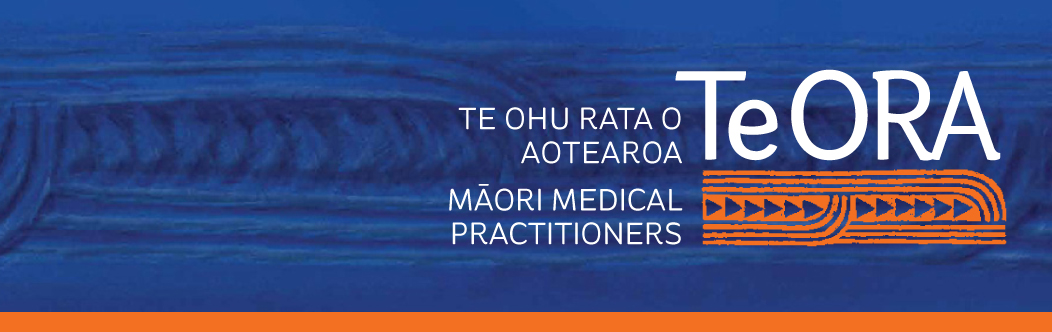
The Royal Australian and New Zealand College of Psychiatrists (2015a) Minding the Gaps.

The Royal Australian and New Zealand College of Psychiatrists (2015b) Position Statement 56 – Children of parents with a mental illness.

The Royal Australian and New Zealand College of Psychiatrists (2015c) Keeping body and mind together.

wakahourua.co.nz/suicide-facts accessed 4 December 2015.

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| **374** | Submitter name | [redacted] |
| Submitter organisation | Te Ora Maori Medical Practitioners |



**Ministry of Health - New Zealand Health Strategy – Consultation**

**Te Ohu Rata o Aotearoa, Māori Medical Practitioners Association (Te ORA) – Draft Submission**

**NOVEMBER 2015**

**Te Ohu Rata o Aotearoa, Māori Medical Practitioners Association (Te ORA)**

Te ORA is a professional body representing Māori medical students and doctors working as clinicians, researchers and teachers. We have approximately 340 active members; therefore Te ORA represents the majority of the Māori medical workforce in New Zealand.

Te ORA does not deliver health services but seeks to provide support services to its membership such as: annual Hui-ā-Tau and Reo Wānanga (Te ORA and Te Oranga). We also try to find specialist training opportunities for our membership and advocate strongly in all areas of Māori health.

Te ORA has international networks which include formal collaborations agreements with the Medical Deans of Australia and New Zealand (including the Leaders in Indigenous Medical Education network), and Health Workforce NZ. Te ORA also works closely with the Australian Indigenous Doctors’ Association (AIDA) and more recently with the National Aboriginal Community Controlled Health Organisation (NACCHO).

Thank you for the opportunity to provide feedback on the draft update of the NZ Health Strategy. We commend the Minister on the decision to update the existing Strategy. We have used the consultation submission form to frame our feedback as follows.

### Challenges and opportunities

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

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

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| **Health Inequities**  While addressing inequalities in the health system is broadly captured within the draft Strategy we suggest that addressing inequalities is such a fundamental issue (both in terms of health outcomes and delivering on the Treaty relationship) that it needs to be more specifically referenced in the background as a particular challenge.  Health inequities are a challenge which many have called a ‘wicked problem’. Although health inequities have multiple causes, solving them, or achieving equity does not require overly complex solutions. The good news (and thus the opportunity) is that we know much about how to achieve equity in outcomes. Several key principles should guide efforts to remove inequities.  First, the Ministry should look to reveal inequities by reporting all performance data stratified according to parameters of equity e.g. ethnicity, socioeconomic status. Change cannot occur if the health system believes that health care is optimal and that inequities are society’s problem.  Second, the Ministry must track outcomes that matter to patients, such as quality of life and the ability to function. To reach adequate outcomes, we must talk to patients and their whānau in order to meet their needs and aspirations. Evidence supports the fact that successful health services tailor care to patients, their whānau and communities. Patient centered care, as defined in the IOM’s seminal ***Crossing the Quality Chasm*** report is a widely accepted dimension of quality, and one that is explicitly recognised in our NZ Triple Aim in *‘Experience of Care’*. (1,2) Patient centered care is described as “providing care that is respectful of and responsive to the individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. This must specifically be a goal for Māori and other population groups for whom the health system presently does very poorly in this dimension.  Third, we encourage the Ministry to align incentives to remove inequities and address social factors. A business case to achieve equity motivates and sustains improvement. Health organisations are more likely to implement interventions to improve equity if those efforts are paid for. The health system has largely been silent with regard to creating incentives explicitly to remove inequities. We should pilot interventions that specifically provide incentives for achieving equity and reward both high levels of quality and achieving steps towards equity.  Finally, payment systems should support approaches to public health that create healthy communities, provide equitable population health and primary care, and prevent costly hospitalisations.  Examples of where inequities have been eliminated exist across all sectors. The consistent application of learnings from equity success stories will require government leadership and the setting of clear expectations. Those expectations must be made explicit in our national health strategy. |

### The future we want

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

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

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

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| The statement does not fully capture what we want from NZ’s health system. There are inconsistencies within this document and between this draft strategy and other Ministry publications such as *He Korowai Oranga: Māori Health Strategy 2014* and *Equity of Health Care for Māori: A Framework* both of which were published only last year. The draft strategy is persistently tolerant of inequity, and remains virtually silent on actions and behaviours to address equity as a crosscutting dimension of quality.  Despite labouring the point that the health system performs well for most people, the draft strategy then largely ignores the issue of those that the health system performs most poorly for. This makes the term ‘all New Zealanders’ problematic for Māori as Treaty partners with the Crown because ‘all’ in this context actually means ‘most’ and Māori are over-represented in the group for whom the health system does not consistently perform well. Māori are largely an afterthought of this Strategy.  Initiatives that are underpinned by equity invariably lead to improved health for all. But initiatives that are designed without an adequate equity focus frequently create, maintain or reinforce inequities.  The Treaty relationships laid out in the draft Strategy comment on the need to ‘reduce’ rather than ‘eliminate’ the inequity in health outcomes appears to accept some remaining level of inequity. Such an approach is inconsistent with setting an expectation of equity and is not in keeping with the Ministry publications noted above.  This focus on ‘reducing’ inequities rather than ‘removing’ inequities highlights inconsistencies with the overall aims of the draft Strategy. On one hand it is a strategy for ‘all New Zealanders’ equally, yet it is acceptable for the health system to continue to operate unevenly at the expense of ‘some New Zealanders’. Inequities are not acceptable and the strategy must be clear that inequity cannot be tolerated.  Our vision is for a health strategy that encourages and requires providers to focus on equity as well as improving the health of the total population. This will only become a reality if there is a mind-set change across the entire system so that a focus on equity becomes the norm rather than the exception or a footnote.  For example, it is well established that despite higher levels of need, Māori are less likely to access health services than non-Māori. Analysis of prescription data shows that, even when need is accounted for, Māori are less likely to be prescribed many medications including those to treat and prevent cardiovascular disease, diabetes and other conditions. This phenomenon is recognised worldwide and has been named ‘the inverse care law’, where those who have the greatest need for health services have the lowest access to those services. (3)  Some would argue that ‘all New Zealanders’ has an implicit focus on equity. However, any such implicit focus has only worked for the unfairly advantaged population groups, not Māori or other groups that experience disadvantage, and there is no reason to believe that it will work to deliver health equity in the future.  There must be an explicit and crosscutting focus on equity in order to change the status quo. |

**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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| **Tiriti o Waitangi**  Recognition of ‘the special relationship between Māori and the Crown under the Treaty of Waitangi’ is proposed as one of the refreshed principles upon which the Strategy is built.  However this is the only reference to the Treaty in the draft Strategy. This gives the impression that the statement is ‘lip service’ and that there a lack of intention to practically reflect this relationship or a lack of understanding about how this might be achieved.  This is disappointing, particularly as much of the Strategy, and particularly the strategic themes that underlie it, are entirely consistent with the Treaty relationship or have the potential to greatly enhance that relationship.  Reference to the Treaty relationship should be made in relation to each of the strategic themes, noting how various aspects of each theme build that relationship.  Identifying the Treaty relationship in each of the strategic themes would also help to identify where the strategy is likely to fall short in meeting the Crown’s treaty obligations.  For example, although we shouldn’t only be striving for equity but rather working towards achieving it, the goal under ‘Value and High Performance’ of ‘striving for equity of health outcomes for all New Zealand populations’ is a goal that is consistent with the Treaty relationship. This is because the Treaty relationship is founded on the basis of equity between Māori and other New Zealand citizens. It should therefore be acknowledged that such a theme is entirely consistent with the Treaty relationship if achieving equity is our major goal.  The aspiration of what the health system will look like in 10 years’ time as a result of this strategic theme is ‘that there has been a clear lift in health outcomes’ for Māori and other disadvantaged groups. A similar approach is repeated throughout the draft strategy – i.e. what is being aimed for is a ‘reduction’ in or an ‘improvement’ in the health status of disadvantaged groups (without an explicit expectation of equity). These goals assume that some level of inequity for Māori (and other groups) will persist and that this is acceptable.  This is not consistent with the principles of the Treaty, in particular the Treaty principle of equality.  To comply with the Treaty of Waitangi the New Zealand Health Strategy must consistently expect equity of health outcomes between Māori and other New Zealanders – not simply that the current inequity is ‘less bad’.  The Crown’s obligation is to actively protect Māori interests rather than to accept a lesser standard simply because equity is seen as difficult to achieve. What the health system should aspire look like in 10 years’ time is one with equitable health outcomes and care for all population groups.  There is also a distinct lack of reference to the Treaty relationship in the Roadmap section of the draft Strategy. This is despite the Roadmap noting that the principles should guide decision-making around the redesign of services and outcomes to be expected. The example of how the design of training for health workers and board members should reflect the Treaty relationship principle once more gives the impression of tokenism as none of the five year goals or specific actions set out in the Roadmap, nor the actions listed, are guided by the Treaty relationship or make any mention of this.  It is difficult to expect decision makers within the health system to appreciate how the guiding principle of the Treaty relationship should influence decisions and service redesign if the Strategy and Roadmap themselves do not lead by example. |

### 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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| In keeping with previous, health equity should be explicitly woven throughout any strategic themes of the NZ Health Survey.  The five themes above should support the creation of healthy communities, provision of equitable population health and primary care, and prevention of costly potentially avoidable hospitalisations. However, the focus appears to be on primary, secondary and tertiary health care services. The lack of planning for the key population health challenges New Zealand will face (such as climate change, increasing cost and complexity of medical care etc.) is concerning. (4,5)  Notable for its absence is a strategic theme on ‘prevention’. |

### 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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| **Road Map**  The Roadmap is a critical part of the draft Strategy as it provides the focus on the tasks that need to be undertaken to meet the goals of the draft Strategy. The Roadmap notes that the actions listed within it ‘signal their importance for the future of New Zealand’s health system’.  As it is currently drafted, it is difficult to trace the linkages between the actions listed in the Roadmap, the 5 year vision of the Roadmap, the 10 year vision of the draft Strategy, and the principles that underlie the Strategy.  For example, the draft Strategy states that ‘Māori and Pacific health models, such as Whānau Ora and the Pacific Fonofale model, are used to provide effective and accessible care responsive to their communities’ is a vision for health services in 10 years’ time. However the 5 year outcomes listed in the Roadmap make no mention of using these models, and nor do the immediate actions listed in the Roadmap.  There will not be optimal development of Māori and Pacific health models as a way to provide effective and accessible health care in the next 10 years if steps leading towards this are not identified as a priority in the short to medium term.  Similarly the vision for value and high performance in 10 years’ time notes ‘a clear lift in health outcomes experienced by population groups previously disadvantaged’. Exactly what would constitute an acceptable ‘lift’ in health outcomes is not clear; the expectation ought to be one of equitable outcomes in keeping with an expectation of equity. Furthermore, it is impossible to identify the elements of the Roadmap that will lead to realising this vision. The earlier steps are phrased in such a way that there is no clear connection to the 10 year vision of the health system.  **Health Equity**  The Roadmap must paint a picture of health equity for Māori and other groups that experience inequality by including the discussion of the health needs and aspirations of Māori for each section. In doing so the Roadmaps should also meaningfully reference The Treaty of Waitangi as our founding document.  A commitment to health equity must be explicit across all action areas within each strategic theme. Actions explicitly focussed on Māori health must be comprehensively developed and all other actions require a strengthened focus on Māori health to align with *He Korowai Oranga: Māori Health Strategy 2014* and the Ministry publication*, Equity of Health Care for Māori: A Framework*.  **Specific Comments**  **The entirety of the Roadmap requires a comprehensive review from a Māori health and health equity perspective. These specific comments do not address all of the actions but highlight some of the shortcomings of the actions listed, which are for the most part too high level, and fail to adequately consider the needs of Māori and other population groups that experience inequity in the present health system.**  **Action 6: A great start for children, families and whānau.**  This action should be expanded to explictly include the youth population. More support is required for pregnant women who smoke to have a smokefree pregnancy and motherhood. Smoking during pregnancy is one of the most important causes of avoidable illness and death for unborn children, infants and their mothers in New Zealand. It is clear that pregnant women are not currently getting the services and help they need to be smokefree.  **Recommendations:**   1. Including the following action; ‘Ensure pregnant and postnatal women who smoke are supported to be smokefree by providing ready and free access to nicotine replacement therapy and support to quit services.’ 2. Developing a Health Target measuring the percentage of hospitalised pregnant women who smoke who are provided with cessation support.   Data for the smokefree pregnancy hospital target could be readily accessible with the new Maternity Information System and this must be mandated.  **Action 13 revised as follows:**  **Action 13:**  Improve governance and decision-making processes across the system, through a focus on ***equity****,* capability, innovation and best practice, in order to ***achieve equity and*** improve overall outcomes.   1. \* Review governance arrangements across the system, including those of the Ministry of Health and ministerial advisory committees. 2. Develop and implement a regular review of DHB governance performance. 3. ***Require DHBs and governance bodies to self-audit against the Ministry of Health tool, Equity of Health Care for Māori: A Framework***   **Action 14 revised as follows:**  **Action 14:**  The Ministry of Health will work with leaders in the system to improve the cohesion of the health system, including by clarifying roles and responsibilities/accountabilities, ***including for achieving health equity*** across the system as part of the planning and implementation of the Strategy.   1. \* The Ministry will review its structures, processes and culture to ensure it is well positioned for its stewardship role in the system and its leadership role in implementing the Strategy, including ensuring good-quality policy, ***a strong equity focus*** and legislative/regulatory advice, and monitoring of performance ***by equity parameters e.g. ethnicity.*** 2. DHBs will carry out their roles and responsibilities at national, regional and local levels, including any changes to these as a result of implementation of the Strategy. |

### Turning strategy into action

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

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| There should be mandated equity focussed reporting, ensuring that targets can only be counted as being met if it is met for Māori and other demographic groups that experience health inequities. There is a growing call for equity focussed health reporting. An approach that mandates equity focussed reporting will best support an ongoing focus on achieving health equity.  Currently, service providers can reach health targets for ‘all New Zealanders’ while failing to reach the same target for Māori. For example, a provider may ensure that 80.9% of New Zealand Europeans access a service, but only 61.5% of Māori, resulting in a total population result that nearly reaches an 80% target.  Thus data can be reported either in an equity focussed or total population manner. Both methods send very different messages to the reader; for one, equity is the focus, the other; equity is not the focus.  There is anecdotal evidence that providers are cherry picking the easiest to recruit (NZ European women) for cervical screening, and actively stopping trying to recruit Māori women (because it takes more effort), in order to ensure to reach the total population target of 80%. |

### Any other matters

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

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| We would like to see the Ministry demonstrate leadership regarding a stronger accountability focus on health services to achieve health equity. Currently, it seems that many organisations view health equity goals as optional extras despite statutory obligations under the NZ Health and Disability Act 2000. The currently proposed focus serves to absolve the health and disability sector from its responsibilities toward improving health for ‘all New Zealanders’.  Additionally we would like to see acknowledgement of the ***‘special role’*** of the Māori health workforce as detailed below:   * The role of the Māori health workforce is much more than just an advocacy role, and certainly more than a symbolic role as a “visible reminder that Māori are represented as health practitioners”. There is limited explanation of the additional responsibilities that our health system places on Māori health practitioners. For example, Māori health improvement is the responsibility of the health system, not just that of Māori health practitioners. However, Māori health practitioners are expected (both by their own communities as well as by non-Māori) to work over and above their professional obligations in order to mitigate the negative impacts of the inequities that Māori patients experience with respect to health determinants and the access to resources needed to improve their health outcomes. * Additionally, despite Ministry of Health documented discourse around obligations to the principles of the Treaty of Waitangi, Māori health practitioners have held disproportionately less power and influence at governance and policy level within the health sector. This current situation has not redressed the historical imbalance (which precluded a genuine Treaty partnership), and instead has privileged those belonging to the dominant culture at the expense of Māori and other minority groups. * The Strategy must acknowledge and respond to the additional expectations placed on Māori health practitioners by ensuring that the health system supports and maintains their additional training and ongoing cultural and other professional development needs. * In addition, it is imperative that the Strategy focuses on the non-Māori health workforce and the role of the heath system in ensuring that the health workforce is high quality, culturally competent, health literate and therefore fit-for-purpose to meet the needs of the Māori population and all population groups within New Zealand. |

**References:**

1. Institute of Medicine. Crossing the quality chasm: a new health system for the 21th century. IOM. 2001;(March):1–8.

2. Health Quality and Safety Commission New Zealand. No Title [Internet]. [cited 2015 Aug 31]. Available from: http://www.hqsc.govt.nz/news-and-events/news/126/

3. Tudor Hart J. THE INVERSE CARE LAW. Lancet [Internet]. 1971;297(7696):405–12. Available from: http://www.sciencedirect.com/science/article/pii/S014067367192410X

4. Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R, et al. Managing the health effects of climate change. Lancet [Internet]. 2009;373(9676):1693–733. Available from: http://linkinghub.elsevier.com/retrieve/pii/S0140673609609351

5. Bipartisan Policy Center. What Is Driving U . S . Health Care Spending ? 2012;(September). Available from: http://bipartisanpolicy.org/library/what-driving-us-health-care-spending-americas-unsustainable-health-care-cost-growth/

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| **375** | Submitter name | [redacted] |
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**Update of the New Zealand Health Strategy**

The question posed at the consultation meeting I attended in Dunedin on 1 December 2015 was “What action has the greatest potential to improved health or the health system?” The meeting focussed on each person considering their most important action and this submission will focus on one main action but I will comment on one or two additional points.

My initial thought after reading the document and the two supporting documents, hearing the presentation and taking part in the discussion process, was that the language used to convey health information should be understandable by most people in New Zealand. Simplicity of language should start with the Strategy Document and be reflected in all decisions made to implement the Health Strategy. The language used in the draft document seems directed more towards academic economists, university students and politicians rather than to a person with a reading age of about 15 years (Year 11) – which is the recommended level to be used in many countries for “simple language” insurance policies.

**Use of Language**

Language is the way we communicate ideas and the use of language that everybody can understand is not always easy. Ideas and proposals should be explained in clear language. I found the use of bold text to highlight certain words in the consultation document was distracting. It uses a visual emphasis to highlight words that the author wants to be seen. It distracts readers from understanding and interpreting the whole document. Highlighted words visually detract from smaller size text type which was not in bold. For example the box on page 1

**A strategy is a guide** for achieving the sort of **future** that you want. It can help people, organisations or whole systems to **work together** more effectively on the most **important things**. Without a strategy, things that are small problems today can become big problems over time.

The phrase “… help people, organisations or whole systems…” is an important qualifier of the phrase “A strategy is a guide” in the previous sentence. Similarly the word “effectively” qualifies “work together” and should be emphasised. Words not set in bold type at a smaller size are less obvious when first reading the book and consequently may not be given sufficient attention by the reader. The authors / designers of the book have already made decisions on what points to highlight for the “consultation”. The editorial direction points to the need to accept change. If it is a true consultation, the facts and proposals should have been presented in a non-emotive way so that the reader (community) could decide on priorities and not simply comment on the most obvious (in bold type) points that the Ministry of Health wishes to highlight.

Recently I was an examiner for the fellowship of the Faculty of Public Health Medicine of the Royal Australasian College of Physicians. One question required the candidates use plain language to explain a medical concept. This was the most difficult question in the examination. The ability to use plain language that can be understood by technical and non-technical people is one of the most important and critical skills of anybody who is working in the community. In the introduction the Director-General of health states *A draft Roadmap of Actions brings these strategic themes to life, proposing an evolution of change to realign our operating model, encourage innovation and ensure sustainability.* *I recognise the way forward will require us all to think and act differently.*

The best way to do this is by not using complex jargon for simple themes.

The box in page 4 is referred to of page 3 of the text for its definition of “investment approaches”.

An **investment approach** takes into account the **long-term** impact of current spending on people’s lives. Investment in the **health** sector, which results in people having a greater ability to **participate** in **education** and **employment** and be free of, for instance, alcohol and drug dependency, family violence or mental health conditions, has a positive long-term financial impact for the **social sector.** It also has non-financial benefits as people experience **longer lives**, lived in **better health** and **independence**, and with **dignity**. As a specific funding mechanism, ‘investment funding’ gives providers an incentive to focus on these long-term impacts and **value them** alongside immediate, short-term gains.

At first glance, **investment approach, long-term, health, participate, education, employment, social sector, longer lives, better health, better health, independence**, **dignity, value them** are highlighted as the important words in the paragraph.

The emphasis can be changed by highlighting other words.

*An investment approach* ***takes into account*** *the long-term* ***impact of current spending******on people’s lives****. Investment in the health sector, which results in* ***people*** *having a* ***greater ability*** *to participate in education and employment and* ***be free******of****, for instance,* ***alcohol and drug dependency, family violence or mental health conditions****, has a* ***positive long-term financial impact*** *for the social sector. It also has* ***non-financial benefits*** *as people experience longer lives, lived in better health and independence, and with dignity. As a specific funding mechanism,* ***‘investment funding****’ gives* ***providers an incentive*** *to focus on these long-term impacts and value them alongside immediate, short-term gains.*

These high-lighted words ***takes into account, impact of current spending******on people’s lives, people, greater ability, be free******of, alcohol and drug dependency, family violence or mental health conditions****,* ***positive long-term financial impact, non-financial benefits,*** *,* ***‘investment funding****’,* ***providers an incentive*** suggest a more human-centred approach.

When all text is set in the same size and weight it becomes more difficult to get an immediate response from the paragraph.

*An investment approach takes into account the long-term impact of current spending on people’s lives. Investment in the health sector, which results in people having a greater ability to participate in education and employment and be free of, for instance, alcohol and drug dependency, family violence or mental health conditions, has a positive long-term financial impact for the social sector. It also has non-financial benefits as people experience longer lives, lived in better health and independence, and with dignity. As a specific funding mechanism, ‘investment funding’ gives providers an incentive to focus on these long-term impacts and value them alongside immediate, short-term gains.*

The Flesch Reading Ease is an index of readability. Most 13 to 15 year olds easily understand levels of 60 to 70 while levels under 30 are best understood by university graduates. The 2013 New Zealand Census of Population showed about 18% of the population had attained a bachelor’s degree or higher qualification. The Flesch Reading Ease of the example is 24.6 hence many in the community may find it difficulty to understand. The language needs to be adapted so that more than 20% of the population can understand the proposed Health Strategy.

My interpretation of the paragraph in plain language is that putting money into early development will, in the long-term, result in a reduction of overall health costs.

**Closer to home**

The practice of working with the community to prevent disease is an essential feature of public health medicine. Health protection and health promotion have been basic principles of public health practice for over 160 years. John Snow removed the pump handle in Broad Street, London to control an outbreak of cholera by stopping access to polluted water. Historically public health actions have been responsible for significant advances in the health and wellbeing of the world. For example, the introduction of clean water and sanitation has seen a reduction in the incidence of water-borne diseases in the developed world and continues to demonstrate its effectiveness in those places with poorly developed health facilities or in times of civil unrest. The incidence, morbidity and mortality of many infectious diseases has been reduced through immunisation and the use of antimicrobial agents. These actions required coordinated intervention by several groups working alongside health practitioners to be successful. On a global scale, poliomyelitis will be eliminated globally within the next decade. This is possible because all countries of the world have used mass poliomyelitis vaccination programmes as well as improved sanitation and water supplies to reduce cases of disease since the first effective vaccine was introduced in the 1950s. These population interventions have taken a long time before their effects become manifest and measurable at the community and global level.

It is much easier to count people who have been taken off a waiting list within a given time period to show the effects of programmes to “reduce the waiting list”, than it is to demonstrate reductions in cases of a vaccine-preventable disease. The recent outbreaks of measles demonstrate that even with 90% of the population vaccinated, outbreaks can occur in the 10% who are unimmunised but cases will also occur in a proportion of the immunised because no vaccine is 100% effective.

The long time effects of too frequent use of antibiotics are now becoming apparent with the rise of antibiotic resistance. During my time as a general practitioner, I remember patients who requested and expected the prescription of antibiotics for uncomplicated viral infections. People considered their immediate “wants” as being more important than the intangible long-term effects of inappropriate use of antibiotics. There were doctors who would give antibiotics “just in case” and patients who only took part of a course and kept the left-overs for use should the symptoms recur. Over time and across the world misuse of antibiotics has resulted in the emergence of antibiotic resistant organisms. It is difficult to see how it would have been reasonable for a general practitioner it consider such a long-term effect of a prescription but many individual actions have lead to a global problem.

The statement in the Box on page 4 states *…‘investment funding’ gives providers an incentive to focus on these long-term impacts and value them alongside immediate, short-term gains.* This appears to be a different interpretation from that given in the Independent Review of Health Funding in New Zealand *From Cost to Sustainable Value* whichstates:

**4.1.2 An investment approach that supports earlier intervention**

Funding can also be better matched to return: i.e., proportionately more funding on those population segments where early intervention will have the greatest positive impact over the lifetimes of people in those segments. Here an investment approach is required: i.e., one that estimates the actuarial cost of a lifetime of publicly funded remedial interventions .

Flesch Reading ease = 19.6

The Funding review suggests the establishment of four funding streams – Existing foundation services, Government priorities, Health Investments and Social Investments. Health investments would benefit individuals and enhance the financial sustainability of health services. Social investments would be for activities where the benefits are largely produced and or captures by / or within the social sector. This pool would take funding from other Votes besides health because the benefits are gained in sectors other than Vote:Health. Only the latter two funding streams would be subject to the investment approach. The mention of “health investment” is confusing and some of the thinking is confused. A plain language explanation of “investment funding” would avoid confusion around what appears to be an important principle for the future funding of health services in New Zealand.

Renaming the process of allocation of resources as an “investment approach” implies that previous generations acted without the benefit of “the market place” and economists as drivers of social policy. It is important to remember that many government policies are dependant of the three-year electoral cycle and so planning tends to have a short-term horizon. The emphasis on giving providers an incentive to focus on long-term impacts as well as immediate short-term gains calls for a major rethinking of the philosophy of many people working in health and social services. I learned as a general practitioner that I had to work with the person in front of me now. Focus on long-term solutions may alleviate future problems but for the patient the important thing was their present symptoms of illness. The doctor has to deal with the here and now. Their acute bronchitis is treated and if time allowed it was suggested giving up smoking would be a good idea.

After 10 years in general practice, I moved in population health and found it possible to focus on shaping societal change through community action. We did not talk about “investment approach” but we redirected resources into areas where many in the community would benefit. Family health centres and community based counselling were developments of the 1970s and 1980s which depended on close collaboration with other services providers and government departments such as Social Welfare and Education. These developments were very early casualties of the reforms the early 1990s when the funder/provider split introduced competition in place of co-operation. The present document restates the importance of the community in deciding the mix of service provision and being empowered to be involved. It is pleasing to see the expected move “from competition to trust, cohesion and collaboration”. This move will need to be clearly stated to those providers who are only slowly learning the language of the funder / provider split.

**Principles**

An Eight Guiding Principle has been added to those put forward in the Health Strategy 2000 namely:

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

I suggest that a New Zealand definition of “health” should be included in the document. It should recognise Māori concept of Te whare tapa whā - four cornerstones of Taha Tinana, Taha Wairua, Taha Whānau and Taha Hinengaro. Some recognition could be given to Katherine Mansfield’s idea, written in her diary on 10 October 1922 three months before she died.

*By health I mean the power to live a full, adult, living, breathing life in close contact with what I love — the earth and the wonders thereof — the sea — the sun. All that we mean when we speak of the external world. I want to enter into it, to be part of it, to live in it, to learn from it, to lose all that is superficial and acquired in me and to become a conscious direct human being. I want, by understanding myself, to understand others. I want to be all that I am capable of becoming so that I may be (and here I have stopped and waited and waited and it’s no good — there’s only one phrase that will do) a child of the sun.*

Flesch Reading ease = 73.1

**Evaluation of proposed changes**

The document talks about the need for change and makes many proposals. However it does not subject the proposed changes to any evaluation. In the United Kingdom HM Treasury has stated as “All policies, programmes and projects should be subject to comprehensive but proportionate evaluation, where practicable to do so.” (Magenta Book 2011). In the United States, the Centers for Disease Control and Prevention issued a series of documents detailing the process of evaluation. <http://www.cdc.gov/injury/about/policy/evaluation.html>

The following CDC definition highlights the need to evaluate the effectiveness of policy interventions in a systematic manner.

“Policy evaluation uses a range of research methods to systematically investigate the effectiveness of policy interventions, implementation and processes, and to determine their merit, worth, or value in terms of improving the social and economic conditions of different stakeholders.”

They CDC draws heavily on two documents from the UK Treasury (the Green Book and the Magenta Book) in stressing the need for planned evaluation of policy interventions. When any new strategies are put in place there is a need to evaluate their effects. The words “evaluate” and “evaluation” each appear once in the document (on page 45 in relation to new technologies) so there is room to consider how society is to be reassured that the changes to the direction of our health system will be evaluated over the next ten years.

The *Update of the New Zealand Health Strategy* should have a formal evaluation written into it (and funded) so that when it is due for review in 10 years time, the effects (and effectiveness) of the interventions can be presented and society can judge the need for further change.

[redacted]

Honorary Clinical Senior Lecturer

Department of Preventive and Social Medicine

Dunedin School of Medicine

10 December 2015

PO Box 5315

Moray Place

DUNEDIN 9058

[redacted]

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| **376** | Submitter name | [redacted] |
| Submitter organisation | Nursing Executives of New Zealand |



**Update of the New Zealand Health Strategy   
Consultation Feedback**

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| **Submitted By:** | **Nursing Executives of New Zealand** |
|  |  |
| **Date:** | **10 December 2015** |

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| **Theme** | **Detail** | **Suggestion** |
| Recognition of prevention | * Strong emphasis on prevention missing in the strategy. * Although it may be included in closer-to-home it is not identified with the clarity it deserves. * Money spent on preventative activities takes time to show “value for money invested” – potential for investment in prevention to be considered and strategically delivered so patients/family /community and staff are getting the best results. * Stronger emphasis on health literacy directed at school children * Each category within prevention needs to be addressed (e.g. Reducing Harm such as Falls, Pressure Injuries, etc.) with defined efficiencies in a linked up health system. This includes ACC. An investment upfront may have long-term health gains | Addressing preventative health factors and ensuring promotion activities/resources/information around prevention in each area of concern.  More emphasis on health for the whole of life in its widest context, not simply health service provision – from the beginning to the end. The strategy needs to explicitly support Advanced Care Planning, and targeting the younger child in order to improve self-awareness associated with good health  Concentrate health promotion/prevention activities around young people to make a difference early on. Strong focus on mental health and wellbeing. |
| “Closer to home” availability | * For this to be effective we need to be ensuring the best use of each team per region. * Identified that the rural teams are effective * Patients deserve excellence in care however need to be careful of the value, efficiencies and risk associated diluting expertise * There is a great opportunity to consider how we should improve school based health services and occupational health services reaching into employers. * Going to where people are and would probably improve access for those that are unable / unwilling to access services as they are. People lose money if they take time off work to see a General Practitioner –this is especially relevant to many ‘low paid’ people hence they leave it as long as they can before accessing their GP. | The theme closer to home lacks a consumer partnership in care. One of the most important supports of the health system into the future will be the family /whanau or informal carer. Supporting carers to continue to care needs to be on the roadmap.  Easy access to services at a local level. This may be Information technology enabled however key message about access and ‘not just in main centers’. |
| Integration/Branding | * The notion of “one team”/”one system” sits very well with Nursing Execs. * Divisive language needs to be non-existent for us to merge together as a team – “DHB-land” and “PHO-land” are constantly thrown around. The division of DHBs, PHOs and the rest is not conducive to a concept of all of us working together for one goal. * The principle of One Team is good however there is a great deal of work to be undertaken to achieve this. One team needs to be inclusive and members need to be enabled to participate effectively. There is a need for something to belong to – a branding to tie everyone together. * Collaboration and partnership is important to better the health care experience across the spectrum. | Collective participation of a rebranding exercise. To achieve a single brand for the health system would be a good start. The NHS is an example of a brand that supports the concept of One Team.  Better links and partnerships with non-government organisations that provide nursing and health services – be involved with re branding. |
| Equity in New Zealand | * Addressing Maori/Pacific Peoples equity in the strategy need to be more explicit and aspiring. | Reducing inequities across the health system is a priority  Focus on young people. No youth health strategy since 2002. |
| End of life | * Community engagement in recognizing the end of life. * “Live well, die well” – should this be so shocking to hear? Peaceful death should be promoted? * Turning a blind eye to the notion of death when a family member’s health is deteriorating can result in blame and fault being directed towards the hospital – this could be resolved by gently reminding and preparing families and patients of end of life – we need to role model. | Educating community on how to participate in Advanced Care Planning well before end of life becomes eminent. Consideration given to educating and preparing the community and family to recognize the onset of end of life.  The statement should include “end well” or “die well”. Being “born well” would add the dimension of healthy mothers and healthy pregnancy, birth and infancy. |
| Frailty costs | * Data will change practice. An example was that current usage data shows costs and the caliber of the population using Aged Residential Care could be challenge if further wrap around services were available to promote living at home. Emphasis on needing assistance with frailty or support for daily living. It was noted there is an increase in calling out ambulances at times such requirements e.g. a fall where the person cannot get up * Cost of this customized care could be reduced if there was a way of investing specific teams to maintain this type of care. | Investment in special teams for patients’/ people pre-ARC to reduce hospital costs when they call ambulances, etc. |
| **Other Notes** | | |
| Health Literacy of the population should be a key goal.  Workforce capacity and capability needs to remain a central goal. Legislation that constrains the ability of health professionals to provide appropriate care within their scope of practice must be speedily addressed.  Disability support requires more emphasis in the strategy. The strategy needs to cover the range of health challenges experienced by people rather than using the medical model to label the top few conditions which by omission increases disparity in health care.  A smart system will produce outcomes and data that evidences the outcomes must be a requirement. National data standards development needs more emphasis.  Aligning funding better across the system and improving commissioning, (*action 10 and 11*). Ensuring that the wider sector, including NGOs, be included as part of the approach and that there is a level playing field for seeking funding.  One of the guiding principles of the health strategy broadly references health equity as an improvement in health status of those currently disadvantaged. This statement should be strengthened and adequately reflected throughout the Future Directions document and action steps. The Strategy discusses equity in the context of improving health system performance and cost-effectiveness. Addressing health equity requires examining systems, policies and practices through an equity lens to assess impact on health outcomes. It is unclear how the strategy and action plan will challenge the underlying social and economic determinants of health inequity including poverty and violence. | | |

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| **377** | Submitter name | [redacted] |
| Submitter organisation | Regional Public Health |



19 April 2016

New Zealand Health Strategy Update Consultation

New Zealand Health Strategy Team

Ministry of Health

PO Box 5013

Wellington 6145

nzhs\_strategy@moh.govt.nz

Re: Submission on New Zealand Health Strategy

Thank you for the opportunity to provide a written submission on this consultation document.

Regional Public Health serves the greater Wellington region, through its three district health boards (DHBs): Capital and Coast, Hutt Valley and Wairarapa and as a service is part of the Hutt Valley District Health Board.

We work with our community to make it a healthier safer place to live. We promote good health, prevent disease, and improve the quality of life for our population, with a particular focus on children, Māori and working with primary care organisations. Our staff includes a range of occupations such as: medical officers of health, public health advisors, health protection officers, public health nurses, and public health analysts.

Overall we welcome the inclusion of the intent to focus on prevention and the acknowledgment of the role population-based strategies play in improving the health of New Zealanders. We support the addition of the principle for “collaborative health promotion and disease and injury prevention by all sectors”, and see this as a key area of work by public health units. However, we recommend specific actions be linked to the focus on population health and prevention, which include the activities of population health services (including public health units). Our submission includes a number of specific comments around this recommendation.

We are happy to provide further advice or clarification on any of the points raised in our written submission. The contact point for this submission is:

[redacted]

Public Health Physician

[redacted]

Kind regards

[redacted] [redacted]

Medical Officer of Health Service Manager

### 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?**

* 1. We suggest a reflection and analysis on outcomes of the original 2000 strategy and the primary health care strategy would be useful: what lessons have we learnt about the impact of the different components of these strategies: what worked well and what did not, and why? We note that Treasury’s 2014 briefing noted the limited impact of health strategies, reinforcing the need for Health to determine what makes an effective health strategy.
  2. Whilst Te Tiriti o Waitangi and health equity are mentioned, they need more focus. For example, how could the strategy help address institutional racism? We suggest that the strategy could articulate further about how to address the various dimensions of equity as well as Te Tiriti obligations.
  3. In terms of equity, we note some vulnerable populations continue to face challenges in accessing primary care. In addition to the cost barrier, there are also cultural barriers, access out of working hours, and sometimes communication barriers. This is well illustrated by the challenges that refugees face in accessing health care, given their high health needs, communication challenges, and lack of income there is a need to develop actions linked to this issue. An example is learning from the ‘one stop’ shop model of providing youth social and health care to address challenges in primary care.
  4. Primary care for mental health and positive well-being remains an under-resourced area with growing need and is not specifically addressed in the strategy.
  5. The health strategy has identified the role of education and social services in meeting equitable health and social outcomes. But the impact of social determinants of health is only partly addressed. The impacts of intergenerational poverty, poor housing, and unhealthy environments need specific strategic roadmaps in order to address the complex interdependencies created by social determinants of health. The role of the Education sector in developing life skills, such as health literacy, is another omission – especially important given the current review of the Education Act. The Strategy could also be strengthened by incorporating the links with social services such as budgeting advice, food banks and housing services, which directly impact on health and well-being.
  6. The role of the Ministry in policy-making can aim to align incentives for providers to improve the wellbeing of clients and those affected by their decisions. Noting the wider social determinants of health, policy strategies should move towards the maxim of reducing barriers and making healthy choices the easiest for all people. This type of leadership at Ministry level would strengthen the principle of ‘Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing’ and any associated actions.
  7. We suggest the health strategy note our collective responsibilities for the health of our Pacific Island neighbours; and the pragmatic implication for New Zealand’s health system from climate change refugees and the increased risk of infectious disease outbreaks. In order to have a resilient health system we need to ensure that strategic steps are in place to mitigate and adapt to unforeseen emergencies.

### 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**.

1. **Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?**
   1. The statement captures important broad concepts, but it is unclear what direction this gives for the wider health sector. It provides positive goals, but the statement does not help with the inevitable trade-offs. For example, how does the statement support prioritising staying well versus getting well; or living well versus staying well? It is also not explicit what the health system will NOT provide and why it is not provided – for example dental (adults) and optometry are not included.
   2. The universality captured in the ‘All New Zealanders” is to be commended. We acknowledge though that there are certain situations where targeting would be a more prudent approach, for example for at-risk groups with individually modifiable risk factors. We suggest that a strong universal prevention programme (live well) should underpin the targeted strategies for staying well and getting well. This is to ensure that healthy choices are the easiest choices to make.
   3. The second critique of the statement is that it is difficult to measure progress. For example, what indicators will be chosen to measure how we ‘live well’ or even ‘get well’ – many diseases are managed rather than cured; or is the intention to focus just on well-being rather than disease? Whilst not all that is important can be measured, ‘what’s measured gets done.’ We note that wellbeing is not solely dependant on alleviation of illness or disease, but has causal factors in economic, environmental and social factors. There are regional examples of how to measure ‘live well’, such as the Greater Wellington Regional Council’s – Genuine Progress Indicator[[16]](#footnote-16), which the Ministry could explore further. The multi-dimensional framework of the indicator allows a retrospective analysis of economic, environmental, social and cultural outcomes. Such a tool allows for quantitative data to support the subjective self assessed outcome of ‘living well’.
   4. An alternate suggestion for the health strategy would be: “Government commits to maximising the health and well-being of its people by ensuring ‘health in all policies’; resources to support healthy life choices; and only providing cost-effective treatment services.” We support the Ministry aim to be cost-effective. The vision, to take steps towards a smart system that enables multidisciplinary care across primary, secondary and tertiary services; care that is close to home and patient-centred and designed around human needs, are all needed for cost-effectiveness.

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.

1. **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?**
   1. The focus on equity is positive but does not appear adequately articulated in the roadmap actions. Would the roadmap be better organised by the principles rather than the five strategic themes?
   2. The value of having health care that is patient-centred could be strengthened within the principles. Within the current principles this is more a focus on active participation by people and communities, rather than health care being closely aligned with the needs of the community. An example of how this principle might impact on what actions are taken, is noting how traditional opening hours of health services often do not meet the need of the community.
   3. Within the principles there will be situations when it is not possible to apply all of these equally. We are uncertain about the challenges of managing trade-offs between the principles – both for population level decisions and individual care. Ministry guidance within the Strategy on how to manage such trade-offs would be helpful.

### 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).

1. **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**?
   1. Each of the five themes is sound and appropriate. There is capacity to fit most ideas under one or more of the five themes. For clarity we request a logic model be created, linking these to the desired outcome of ‘live well, get well, stay well’?
   2. The 10 year vision describes an average, rather than the results for the most vulnerable and high needs groups; this can lead to worsening of equity.
   3. A possible concern about ‘people-powered’ is the over-reliance on individuals and whanau with limited resources; but it encapsulates well the concepts of ‘by Māori, for Māori’. We note that there is a potential transfer of risk s from the state to the individual by the focus on personal responsibility. This has the potential to create poverty traps or stagnate social mobility, in which individual responsibility is the only incentivised route of alleviation. Moreover, such a focus on personal responsibility might lead to increased expenditure downstream, in the form of state funded targeted alleviation of ill health outcomes.

### Roadmap of Actions

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

1. **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?**
   1. It is not clear that the critical actions to achieve the desired changes have been identified.
   2. Additional actions could include:
      1. Policy and funding changes to incentivise health services to better work with other social services to address the social determinants of health. Tightly prescribed policy and funding instruments constrain active collaboration and project development. Prudent, as they may be in the short term, in the longer term the constrained environment has exacerbated the issue of silos in the health and social sectors. We suggest a common funding pool approach to alleviating complex health issues such as obesity. For example, this could incentivise collaboration between urban planners in local government and advisors in public health units to help design and create built environments conducive to everyday physical activity.
      2. Building on the successful pilots in multisectorial work – many of which are described in the paper – into national programmes. From the perspective of Regional Public Health, this includes the Porirua Social Sector Trial; increasing access to preventing serious skin infections; fruit and vegetable co-operatives; healthy homes coordination service; healthy schools and early childhood centres. Such pilots could be integrated into the core contracts, to support and sustain the initiatives from the pilot health programs.
      3. Having clear policies and procedures that guide both investment and *disinvestment* to make sure the principles of equity and Tiriti obligations are met. This might mean the adjustments of discount rates based on the scope and scale of the health investment programmes and the effects they would have on population health outcomes versus modifying individual health outcomes.
   3. Public health units are not visible in the document, but could have a number of key roles in the strategy, including inter-sectorial work at the local level. Public health units are integral to the monitoring of population health and evidence-based action and responding to emerging challenges and preventing illness (e.g. working closely with other sectors like local authorities to influence the environment and determinants of health). This role of public health units and other organisations involved in population health approaches needs to be expanded on within the Strategy.
   4. We suggest that the growing recognition of sustainability, climate change, and environmental stewardship be better incorporated into the Health Strategy. Actions taken from improving sustainability and environmental stewardship have feedback effects not only on operating costs, but in creating resilient and adaptable systems. Furthermore, such actions are part of the complex network of achieving and maintaining equitable social and health outcomes.

### Turning strategy into action

1. **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?**
   1. Tracking of progress requires first defining measurable indicators, which is included as a sub-activity only in one of the actions. Indicators are needed for the principles as well as the themes.
   2. Tracking of progress on the actions themselves will not indicate how effective they are at achieving the overarching aims.
   3. New Zealand already has an excellent information infrastructure to track progress, including the linkage of datasets between sectors. We support the introduction of the Integrated Data Infrastructure (IDI). This would allow better analysis of investment and their effectiveness across state sectors. We suggest that the IDI could form the backbone of a multi-dimensional outcomes framework, which would better assess success of the multiple actions needed for complex health issues.

### Any other matters

1. **Are there any other comments you want to make as part of your submission?**
   1. The strategy and consultation process reflect well on New Zealand’s high quality health system. It also highlights the constraints regarding the potential to do even better. More work is needed especially on equity and Tiriti obligations.
   2. We recommend a greater emphasis on the prevention aspect of the strategy and actions specifically aligned with work of public health units, NGOs and other agencies delivering population health and prevention services.
   3. We would like to see stronger Ministry of Health leadership (e.g. consistent messaging for health and health promotion, pilots sustained into national projects, leading collaboration between the Ministries etc.), especially to enable and/or facilitate local intersectoral work.
   4. A stronger focus on all aspects of health and wellbeing in government policy making (‘health in all policies’) with more resources in the health sector for the under-funded areas such as mental health and health promotion.

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| **378** | Submitter name | [redacted] |
| Submitter organisation | National Health Committee |

Hon Dr Jonathan Coleman

Minister of Health

C/O New Zealand Health Strategy Update Consultation

New Zealand Health Strategy Team

Ministry of Health

P.O Box 5013

Wellington 6145

Sent via email: nzhs\_strategy@mogh.govt.nz

Dear Minister

**RE: Update New Zealand Health Strategy**

The purpose of this letter is to provide you with the National Health Committee’s (NHC’s) feedback on the Government’s Update of the New Zealand Health Strategy 2000, which currently sits alongside the New Zealand Disability Strategy.

The main themes of the Committee’s feedback can be summarised as follows:

1. The strategy needs to be more future focused if it is to capture and hold the imagination of all New Zealanders over a ten year period.

2. The concepts of consumer sovereignty and health literacy need to be more strongly articulated to enable all New Zealanders to guide the sector to provide appropriate care at an individual, community and population level.

3. The focus on technology needs to be lifted from ICT, devices and pharmaceuticals to systems and models of care in order for the sector to unlock the full potential of technological change.

4. The emphasis on the really difficult population health issues for the next ten years needs to be much greater and should include complex issues such as end of life care as well as the current focus on long term conditions.

The following is a more detailed analysis of what these summary principles mean to the National Health Committee and the context in which they sit.

The Committee wishes to acknowledge the Government for taking the opportunity to update the New Zealand Health Strategy. The Committee believes it is important for all the various components of the whole health sector to come together periodically to debate the strategic, long term issues and to unite our activity under the umbrella of a clearly articulated high level direction for the health system on behalf of all New Zealanders. The Committee is also of the belief that it is the responsibility of the sector to work constructively and openly with each other to give maximum effect to the intent of the strategy. The Committee would welcome the opportunity to discuss its feedback with you or your officials directly.

**Context for the Updated New Zealand Health Strategy:**

The Committee notes that the updated New Zealand Health Strategy, in line with those overseeing the activities of other central agencies, should be reflective of and support the Government’s four priorities of:

* Delivering better public services to New Zealanders
* Build a more competitive and productive economy
* Manage the Government’s finances responsibly
* Rebuild Christchurch

which are designed to improve the lives and wellbeing of all New Zealanders.

The Committee is conscious of and supports the Government’s desire to maximise the impact of its strategy on the health and well being of all New Zealanders by driving an investment approach to prioritising spend across all the social sector agencies. Such an approach encourages guidance and planning across the short, medium and long term. This is useful to health, where many issues and the system changes needed to adapt to them, can be predicted a long way in advance.

The Committee understands the Update of the New Zealand Health Strategy is divided into Part I – Future Direction and Part II – Road Map of Actions. This letter provides comment on both sections. The feedback provided is applicable to the long term aim of the documents, but comes from the particular perspective provided by the Committee’s remit, which is to provide the Minister with evidence based independent advice on:

* which technologies should be publically funded in New Zealand
* to what level and where technology should be provided
* how new technology should be introduced and old technology should be removed.

In order to deliver effectively on its remit, the NHC has developed a strong strategic business approach to the prioritisation and management of health technology. Such an approach forms one of the essential business pillars that support a high performing health and disability system to consistently deliver measurable, quality health, wellness and independence gains for its citizens in a fiscally responsible and sustainable way. In addition this business approach enables the NHC to develop high level ‘road maps’ of the medium and long term needs of the New Zealand health system that can be used to align strategic investment in research and health technology development and enhance health’s contribution to GDP and economic prosperity.

In order to give full effect to this facilitative leadership role the NHC operates in an open and transparent way within an accountability for reasonableness framework its terms of reference can be found at www.nhc.govt.nz

**Commentary on the Updated New Zealand Health Strategy**

**Part 1: Future Direction**

It would help the communication of the strategy to articulate its key points in a one page diagram as can be seen in NHS Scotland’s Health Strategy. This should include a flow through to the road map of actions so that the link between the vision and the measurable steps required to get there are clear to all New Zealanders.

**Why a Health Strategy**

The purpose of a strategy is to provide a means of enabling all those involved in health to engage in a process of informed choice and to coalesce around a small number of clearly articulated common goals. The NHC believes the overall construct of this section is well conceived. However, the Committee understands a common feedback theme on the Updated New Zealand Health Strategy is that not all New Zealanders can see themselves in the document as it has been drafted to date.

The NHC believes that this section could be used to address this concern in part by using a pragmatic real world evidence based approach (i.e. a balanced emphasis on randomised controlled trials, grey literature and registry data) to articulating what current challenges the publically funded health care in New Zealand is facing, how it is responding and what opportunities there are for improving the impact the system has on all New Zealander’s health and well being in the short, medium and long term. Currently this section describes a mixture of inputs, outputs, outcomes and impacts. A stronger and more ambitious document might use a tighter focus on outcomes and impacts, particularly in areas where New Zealand does not perform well internationally in the clinical safety and effectiveness, economic, societal & ethical or implementation domains. This last domain is extremely important for without evidence based implementation of the health strategy we will have had no impact on the health of all New Zealanders. The NHC believes this type of strategic, evidence based approach could improve the coalescence and ‘collective ownership’ we are all seeking from the document.

**Health in the Wider Context**

The NHC has no comment to make on this section beyond the general remarks made in the opening paragraphs of this letter, which acknowledge the Government’s strategic direction and health’s place within the social sector.

**Challenges and Opportunities**

The Committee acknowledges the robust diagnostic of the current health environment contained in this section.

Our reading of the document leads us to believe that, although not explicitly stated, the definition of technology which is being worked to throughout the updated health strategy is too narrowly focused at the ICT, device, pharmaceutical and equipment level. The Committee believes it would serve the system better if the strategy applied the international definition of health technology as articulated by the World Health Organisation (WHO); the definition is as follows:

*“The application of organised knowledge and skills in the form of medicines, medical devices, vaccines, procedures,* [models of care] *and systems developed to solve a health problem and improve quality of life”*

The advantage of working to the WHO definition is that it enables the sector to strategically prioritise and target investment and disinvestment in technologies at a model of care and system level, particularly at the front end of models of care i.e.: prevention, early identification and management. This is where the maximum benefit from a prioritisation system can be captured. The nationally consistent application of the most effective mix of technologies in a model of care for defined populations allows prioritisation agencies to target interventions at the populations for whom there is evidence they are clinical safe & effective, economically viable, ethical and feasible to adopt. This approach also enables strategic procurement strategies by providing a medium to long term road map to assist the decision making of national procurement agencies.

Focusing on technologies in a narrow sense, as the updated strategy does, reflects the current international norm where technologies are adopted at the device, pharmaceutical and procedure level on the basis of their comparative cost effectiveness with little thought as to their appropriate place in the mix of interventions which combine to make a model of care.

Consistent adoption of technologies at the system and model of care level also encourages innovation in the health, education and economic development sectors because it allows the health sector to safely lead the development and adoption of new technologies in a manner which enables health to gain an understanding of how to pull through new disruptive technologies via a commissioning with evidence process into business as usual, or to turn those technologies off if they are unable to prove their primary clinical and business end points. At the same time other sectors can capture the spill over benefits from this approach through the generation of national dossiers of evidence required by international markets for successful adoption into more lucrative overseas markets.

**The Future We Want**

The NHC agrees the New Zealand health system is a strong one and we think the Updated New Zealand Health Strategy provides the sector with an exciting opportunity to build innovatively and wisely on that foundation. The updated strategy must enable all of us to collectively and successfully deliver to the high level impact statement of enabling all New Zealanders to ‘live well, get well and stay well’.

The Committee believes the combination of the vision, guiding principles and underpinning values and behaviours articulated in this section of the Updated New Zealand Health Strategy are robust.

However, it also believes this section is unintentionally paternalistic by perpetuating the impression that living well, getting well and staying well is something that the health system does to all New Zealanders. For instance in principle seven the health system partners with people and communities rather than people and communities partnering with the health system.

The Committee believes the document could be much more future focused by moving more strongly towards the principle of consumer sovereignty, an articulation of which has been published by the Scottish Government in its 20:20 Vision document as follows:

*We need to develop a shared understanding with the people of Scotland, which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled / emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.1*

1 A Route Map to the 20:20 Vision for Health and Social Care NHS Scotland

2 www.who.int/healthpromotion/conferences/7gchp/track2/en/

3 Int J Public Health 54 (2009) 131-132

Strong statements such as these are important inclusions in strategic documents as they send clear messages to all participants that the health system is serious about continuing to redress historical power imbalances and to leverage the power that is generated by increasing levels of health literacy and therefore informed personal responsibility amongst all New Zealanders.

**Five Strategic Themes**

**1. People Powered**

The NHC believes this is also an example of a section, which could be more ambitious and future focused. People powered should be about health literate New Zealanders who are able to constructively engage in debates at the population health level, at the community health level and at their own personal health level. The latter is where this section is currently pitched. People will not be able to engage constructively with their own health, healthcare professionals or the health system, no matter how many electronic tools they have access to, if we have not created an environment, which builds a common understanding of what we do and do not want to invest in at the personal, community and population levels.

Health literacy and informed choice is widely acknowledged as being one of the strongest determinants of health status and outcomes. It has been defined by organisations such as WHO as being:

*The cognitive and social skills, which determine the motivation and ability of individuals, communities and populations to gain access to, understand and use information in ways which promote and maintain good health.2*

*Health literacy has three forms, it is functional, interactive and critical.*

This definition allows people to influence not only individual lifestyle decisions, but also raises awareness of the determinants of health and encourages individual and collective actions, which may lead to a modification of these determinants.

This health literacy concept has been captured by NHS Scotland in the quote provided on the previous page as is evidenced by its strong focus on the:

*Shared responsibility for prevention, anticipation, self management and appropriate use [of healthcare services]*

**2. Closer to Home**

This section could more clearly articulate the individual, community, population and whole of system benefits that result from providing effective and affordable integrated care to all New Zealanders at home or in a homely environment in the community.

Targeted strategic investment in this end of the model of care can help the system to realise significant cost containment over an extended period of time while at the same time enhancing health outcomes for individuals accessing healthcare. The NHC is exploring this concept through its work in Chronic Obstructive Pulmonary Disease where New Zealand currently has the second highest hospitalisation rate in the OECD, without necessarily generating a significantly different impact on patient experience or outcome than other countries who invest their healthcare provision efforts at the front end of the model of care.

For this reason the NHC has embarked on a cluster of health technology assessments designed to shift activity from hospitals to home and homely environments in the community. This includes changing the mix of investments to include more emphasis on finding COPD patients early through targeted screening in a primary care setting, a much greater investment in pulmonary rehabilitation where we are chronically under invested by international standards, identifying and removing the barriers to medicines compliance in the community setting, removing inconsistencies in access to long term oxygen therapy and most importantly investing in advanced care planning for this group of patients so that they are engaged in their healthcare and can choose to receive end of life care at home or in the community rather than in the hospital centric environment currently offered by the health care system.

**3. Value and High Performance**

We agree with the strategic principles outlined by this section including the continued use of the triple aim to assist with the articulation of the importance of these strategic principles. The Committee believes that the health business environment is a dynamic space. Continuous quality improvement of agreed, clearly articulated whole of system business model key performance indicators linked to strategic, measurable health, wellness and independence outcomes will be critical to the system’s ability to deliver against the strategy across its one, five and ten year stated clinical and business objectives.

The length of the horizon through which investment decisions are viewed is critical to clinical and financial outcomes. In particular short term horizons can mask long term costs associated with new technologies. The National Institute for Health and Care Excellence (NICE) in the United Kingdom, following the global financial crisis and reduced investment in the National Health Service, is moving to capture all of the cost of a technology regardless of when and where that occurs across the model of care. Previously significant costs associated with the out years of interventions were not captured by NICE, but nevertheless were needed to be funded by the healthcare system. This can be illustrated by the UK’s investment in ultrasound screening for abdominal aortic aneurysm (AAA), which has not altered all cause mortality in the target population, but has added significant up front cost to the AAA model of care and diverted resources away from other critical health care issues.

**4. One Team**

As has been discussed earlier in this feedback document the key to the concept of a single health team is for the Updated New Zealand Health Strategy to be a sufficiently compelling document for the all New Zealanders to coalesce around it and work cooperatively and transparently to achieve the goals contained within it.

Health is and will remain a complex, adaptive, distributed system. As was noted by the Kings Fund in its document: The Future of Management and Leadership in the NHS, No More Heros4 moving from the heroic leadership model to understand and realise the value of leadership that is shared, distributed and adaptive is critical to the success of modern health systems. The Kings Fund emphasises that in the new model leaders must focus on systems of care, not just on institutions, and on engaging staff in delivering results.

4 www.kingsfund.org.uk/publications/future-leadership- and-management-nhs

The NHC believes that the clinical / management partnership model as described by the Kings Fund is critical for success as is the development of leadership skills at all levels and across the whole system “from the board to the ward”. The one team concept must be broad enough to encourage diverse critical thinking and complex problem solving at a systems and models of care level in order to ensure that the best available thinking can be called on to meet ongoing financial and quality challenges in a manner that protects the Minister and Government of the day from unnecessary exposure to risk. In this regard properly constructed and coordinated contestable advice should be viewed as a system strength and not as a weakness.

The one team construct must be based on the principle that each of the players in the team has a specialised role and set of responsibilities that no other player can do as well. In return each of the players must recognise, that in order for the system to deliver, each role is dependent on all the other players leveraging the skills of each other to the advantage of all New Zealanders. As noted in the Updated New Zealand Health Strategy the health system is therefore more than the sum of its parts.

**5. Smart System**

In an earlier section of this feedback the NHC addressed the core need to lift the sights of this section beyond the constraints of the definition of technology which appears to have driven the development of this section to date. If this can be achieved the strategy will become much more future focused and ambitious than it currently is and this will in turn enable the sector to deal with health challenges much more effectively than the current draft of the update will be able to achieve.

It may also be that the components of this section which are focused on data and analytics should be couched more in terms of knowledge generation in an “intelligent system” that has an underpinning of a ‘trusted evidence’ basis where intelligence creates, manages and synthesizes critical clinical and business data to drive systems performance, value for money and realises the vision of all New Zealanders being able to “get well, live well, stay well”. Such an approach would also help with the integration of the research and development function into the health system as a core component of critical thinking and innovative change, in contrast to its current one step removed place in the system, which limits the development and translation of new knowledge to patients, clinicians and managers.

**Part II**

**Roadmap of Actions**

The update of our Health Strategy provides all New Zealanders with a very valuable opportunity – to facilitate improvements in the ‘lives and wellbeing of all New Zealanders’. If the health system is to realise the benefits that arise from this opportunity we must all come together and collectively commit to turning the strategic directions articulated in the Updated Health Strategy into sustainable results.

The NHC concurs that the achievement of this reality requires an agreed, clearly articulated implementation plan – a ‘roadmap for action’.

The Committee is of the belief that the current Roadmap of Actions could be improved to enable them to paint the picture of how the Updated New Zealand Health Strategy will be converted into measurable results. The current Roadmap of Actions could be significantly strengthened by including a clear articulation of the linkages between each proposed action, the relevant Updated Health Strategy objective, the relevant systems level strategic performance KPI and the relevant one, five and ten year health, wellness and independence and financial measurable outcomes as set out in the updated strategy.

There are a number of lenses or constructs which might be used to provide a clearer, more succinct roadmap, which will improve the delivery of measurable results. The most simple of these would be the technique of clearly articulating measurable output/outcome actions across a one year period, a five year period and finally a ten year period. Currently it is notable that Part I of the Strategy articulates what “great might look like in ten years” while the roadmap of actions limits itself to actions which only have a five year horizon, which will generate a results vacuum in the out years.

Another simple technique might be to reduce the number of actions and group them according to the agencies which are responsible for them. This would help to generate clarity of focus for those who will be charged with delivering results and for the Minister to measure performance by.

Other more sophisticated techniques might be to group the actions up into those which enable direct clinical outcomes, those which enable support system outcomes and those which enable critical thinking and long term sector capability and capacity.

Again the NHC believes the results focus should be ‘SMART’ (specific, measurable, achievable, relevant, timely).

The NHC looks forward to the final Updated New Zealand Health Strategy and is available to discuss its feedback with you or your officials.

Yours sincerely,

[redacted]

**National Health Committee**

**Strategic Plan 2016/17-2019/20**

**DRAFT**

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Part 1: Message from the committee

The National Health Committee provides an important function within the New Zealand health sector. The advice provided by the committee makes it possible for decisions regarding the funding, investment and divestment from various services and technologies to be made independently and in a safe, fair, and defensible manner.

Our mission is to develop recommendations which are done the ‘right way’ to the ‘right level’ and at the ‘right time’. To deliver measurable health and independence outcomes for all New Zealanders, measurable value for money, system fiscal sustainability and contribution to gross domestic product (GDP) and therefore prosperity..

Clinical and business evidence forms the basis of what we do. All our work is reviewed through consultation with the sector and citizens. This, along with our consistent and respected standards of assessment, significant emphasis on face-to-face engagement with our key stakeholder groups and our ability to capitalise on scarce assessment skills, has provided a strong foundation for the future.

The NHC’s strategic focus is to ‘*Lead and influence sector change*’. Our role is to act as a sector ‘expert’ to help individual parts of the sector address their medium to long-term challenges, as well as to set the agenda and improve the sector’s overall contribution to population and economic wellbeing. Essential is our ability to influence the behaviour of decision makers, including clinicians and health professionals, across government and within the health and disability sector.

This strategic focus is supported by two key goals:

1. *Finding the balance* – Assist the sector to improve clinical outcomes and meet immediate fiscal challenges while providing the medium to long-term view on improving patient and population outcomes and sector sustainability.

2. *Delivering value* – Strengthening the NHC’s ability to prioritise the most effective health technologies. Constantly pursuing improvements to the NHC’s tools, methodologies and approaches. Generating buy-in from all stakeholders to evidence-based, implementable, and fit-for-purpose recommendations.

We are in a unique position to be able to focus on complex systemic issues that providers are unable to address independently, or on particularly controversial issues so as not to distract the rest of the system. We are also in a position where we have capacity to take calculated risks, push the boundaries of innovation and learn to do things differently and better, as well as learn from mistakes, which is not available to other parts of the sector.

We have developed business tools and methodologies to assist address these issues and are testing these through our work with the sector in frailty and omics-based technologies. Demonstrating change as a result of this process and our resulting advice is essential to delivering value to the sector. In particular, evidence that our advice has had real reach in the health system in terms of patient outcomes and financial sustainability.

In addition to providing the sector ‘thinking space’ to consider longer-term challenges, the sector has indicated they value our whole-of-system business approach which recognises the contribution of new interventions and technology in the system to ensure sustainable investment and re-prioritisation. The position of the NHC in the sector, and the work which crosses from policy through to implementation, therefore becomes an important factor in determining the future emphasis of our work programme to ensure the committee remains relevant to the sector.

The committee’s achievements could not be realised without the support of the health and disability sector and the other agencies we work with. The committee is very grateful and continues to evolve to recognise the sector’s expectations and challenges.

Anne Kolbe Peter Guthrie

Chair General Manager

Part 2: Introduction

# The National Health Committee (NHC)

## Who are we?

The National Health Committee (NHC) is a statutory advisory committee under sections 11 and 13 of the New Zealand Public Health and Disability Act 2000 (NZPHDA 2000) responsible for providing the Minister of Health with recommendations on:

* which technologies should be publicly funded in New Zealand.
* to what level and where technology should be provided.
* how new technology should be introduced and old technology removed.

The NHC is required under section 14 of the NZPHDA 2000 to operate a Public Health Advisory Committee (PHAC); a subcommittee to provide the NHC with advice on the public and population health aspects of its recommendations to the Minister of Health.

This supports the sector to achieve the Government’s health goals for New Zealanders as described by the Ministry of Health’s Statement of Intent and supporting business plans. Also in the update of the New Zealand Health Strategy namely “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.”

## Our purpose

The NHC investigates combinations of interventions that may be used to promote health, to prevent, diagnose or treat disease or for rehabilitation or long-term or end of life care. This work is done at a model of care and organisational systems level so that the road map produced can be used by other agencies such as district health boards (DHBs), New Zealand Health Partnerships and PHARMAC to inform decisions on service delivery and new pharmaceuticals or devices. Specifically, the NHC provides independent advice on the introduction of new technologies, the significant expansion of existing technologies and the reprioritisation of existing and old technologies.

Evidence around technologies and interventions is assessed against four domains and eleven decision-making criteria (Figure 1).

Figure 1: NHC domains and decision-making criteria

|  |  |  |
| --- | --- | --- |
| Four domains | Decision-making criteria | |
| * Clinical safety and effectiveness | * Clinical safety and effectiveness * Health and independence gain * Materiality * Feasibility of adoption * Policy congruence | * Equity * Acceptability * Cost-effectiveness * Affordability * Risk * Other criteria |
| * Societal and ethical |
| * Economic |
| * Feasibility of adoption |

‘Models of care’ is a term used within the sector to describe many approaches to how care is provided to patients and consumers. The NHC use of the term models of care refers to the development of:

* a pathway of care which is optimal for 80% of target patient population.
* a business model that supports and manages the resource critical nodes in the pathway of care.
* a system-wide approach to the model including clinical care, operational, business, systems enablers, policy, and performance.

The NHC’s approach is intentionally high-level and developed to enhance simplification of the model of care and facilitate devolved, evidence-based, joined-up clinical and business decision-making.

The NHC is not required to commercialise its recommendations. Therefore, it operates within an accountability for reasonableness (A4R) framework and publishes its findings. It is careful to do so in a manner which allows other agencies to maximise the financial benefits from those recommendations.

Through working internationally, nationally (ie whole of government) and with the health and disability sector, the NHC expects to make an impact in the following key areas to assist the Sector achieve the aims articulated in the NZ Triple Aim Framework:

Figure 2: NZ Triple Aim Framework

* *Improved health and equity for all populations* through the consistent delivery of clinically effective, cost-effective, ethically sound, socially acceptable and implementable technologies and interventions. The NHC takes a whole of system approach from policy, organisation of resources, through to implementation to improve health outcomes.
* *Best value for public health system resources* by assessing the overall model of care for new interventions to ensure they are affordable and provide the maximum benefit while minimising unintended consequences. This approach provides for a more thorough examination of the clinical and business implications within and external to the public health sector, and therefore increases the potential to assist the DHBs and other healthcare providers meet their objectives. Introduction of new interventions and the repositioning of existing technologies is also an opportunity to free-up other resources and implement sector change. The NHC contributes to economic growth through innovation evaluations in conjunction with our partners Callaghan Innovation (CI) and Health Research Council (HRC) which identify and pull New Zealand-developed technologies into use.
* *Improved quality, safety and experience of care* through advice which is consistent and relevant to the sector based on four domains and 11 decision-making criteria; by providing clear direction for implementation, monitoring, measuring and evaluating which is disseminated to all levels of the sector. This is supported by the NHC’s horizon scanning, utilising the relationships with equivalent international agencies, preparing the sector for change, utilising a systems design approach, assessing new technologies within the model of care, assessing affordability and ensuring unintended and unanticipated impacts are minimised.

## The environment

Finding the balance between health, wellness and independence outcomes and the wise stewardship of resources to deliver value for money is increasingly challenging the sector. There will need to be some transformational change if we are going to maintain or improve health outcomes and reduce the financial gap.

Key drivers of cost pressures are uniformly agreed to be: population growth, the high health and support needs group within the ageing population, and technology-driven demand for care. Technology is seen by Treasury and the sector, including in the updated draft New Zealand Health Strategy, as a key area for attention. While new technology has been shown to reduce cost through increasing productivity, it is also known that new technologies significantly contribute to costs through changing the treatment threshold for access to care – that is, patients with a much lower level of need or marginal ability to benefit can now receive care.

The health and disability sector is large, developed, diverse, and operates in a limited regulatory environment and is vulnerable to having expensive technologies which are not necessarily fit for purpose, ‘pushed’ into it from a variety of sources. Introduction of new technologies also highlights and exacerbates unresolved issues in the system. Just assessing the new intervention in isolation does not address the underlying system-wide concerns.

Some of the significant issues which are challenging the health and disability sector include:

* the impact of the development of genomics.
* the ability for strategic investment at the front end of models of care to realise a population wide return in the longer term.
* the impact of long-term conditions on health and support services.
* the impact of inequities and disparities on health outcomes.
* the changing demographic makeup of the population.
* the changing expectations and requirements for end-of-life care.
* the complex, comorbid and often elderly patient.
* the impact of increasing obesity, particularly in childhood.
* reducing ambulatory sensitive admissions and acute demand for hospital services.
* maximising opportunities for patients to be encouraged and empowered to manage their own health.
* providing services closer to where patients live, learn, work and play.
* refocusing resources in the community.
* the impact of an ageing healthcare workforce.
* developing a workforce responsive to the speed of change.
* maximising the opportunities of cross Government partnering.

There also some challenges the NHC faces in order to deliver including:

* defining and agreeing a way forward on some fundamental long standing issues for health including what should the sector’s position be on the timing of the adoption of new technology, including when we should be early adopters, early followers and followers of new technologies
* the achievability of putting a formal structure around the current informal introduction process for new interventions.
* achievement of the above, while still providing the ability for the New Zealand system to participate and contribute to international knowledge generation and benefit our patients through participation in clinical trials.
* developing and agreeing a meaningful outcomes framework that clearly articulates the outcomes achieved by the NHC and sector outcomes the NHC contributes towards.
* ensuring the business systems developed across the sector support the delivery of the model of care with responsibility shared between the clinicians and the managers across the entire sector.

The NHC, working beside other agencies such as Ministry of Business, Innovation and Employment (MBIE), CI, HRC, PHARMAC, Accident Compensation Corporation (ACC), New Zealand Health Partnerships, DHBs and the Ministry of Health, is uniquely positioned to help build an effective and sustainable health and disability system for New Zealand. The committee has an accepted position and role in the sector and is increasingly seen as the thought leader and change agent to provide advice and direction on complex systemic issues, sustainable investment and re-prioritisation.

The New Zealand Health Strategy is currently being reviewed. Elements of the draft update of the New Zealand Health Strategy have been incorporated in the NHC’s plans. The NHC plans will be revised in due course to ensure consistency and alignment with the final update of the New Zealand Health Strategy.

## Who we work with

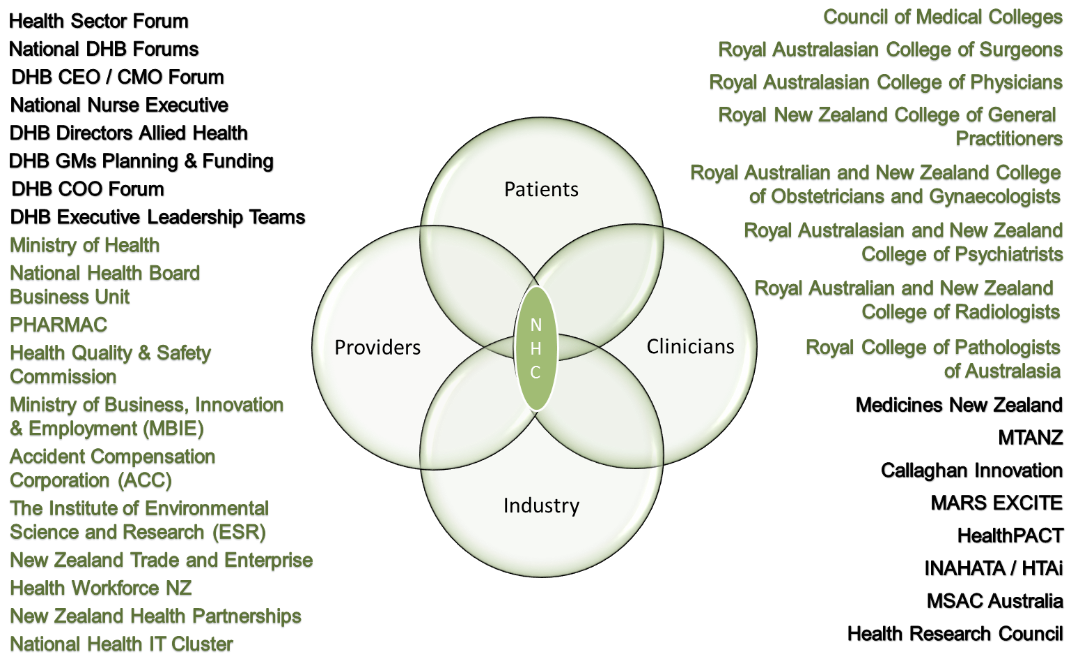
We are responsible to the Minister of Health and work with many stakeholders. Our key stakeholder groups are clinicians, industry, providers and patients and citizens (Figure 3). In particular, we work with DHBs and primary care providers who are the main funders/deliverers of tealth and disability care to their resident populations. They expect the NHC to provide advice to the Minister of Health and ‘negotiate’ with the Minister on their behalf.

We work with clinicians who provide important opinions for the introduction, use and removal of technology across the health and disability sector. Industry representatives engage with us in order to implement the ‘pull model’. Patients and their families are the final recipients of the prioritisation process and are considered an integral part of the assessment process.

We have a responsibility to the citizens of New Zealand to do the best job we can with their input and on their behalf. For the committee, ‘people powered’ is about encouraging the community to choose to work with the sector rather than the sector working with the community. We need to engage and work alongside consumers to develop a shared understanding of expectations of high quality health and disability services as well as consumers’ role in prevention and appropriate use of services to enable them to “live well, stay well, get well”.

Central government agencies work collaboratively with the NHC on ‘whole of government’ opportunities from alignment of strategic business plans through to data sharing and reducing critical gaps and overlaps in the public sector.

Figure 3: NHC stakeholders

Whilst the NHC’s primary focus is the public sector and Vote Health we recognise that technology is often introduced by the private sector. Similarly, we work with private providers as they have a role in the overall NZ health system and this perspective and experience needs to be considered when assessing the overall model of care.

Each group of stakeholders has their own expectation of their role in the prioritisation process and how much influence they should have over the final decisions. However, all stakeholders expect us to undertake our work using evidence, in an open and transparent way, under an accountability for reasonableness (A4R) framework. Engagement with key stakeholders early in the process is essential (refer Figure 4). This provides an opportunity for stakeholders to genuinely participate in the process as well as mitigate implementation risks. Maintaining the NHC profile with the sector’s stakeholders also enables the reinforcement of a consistent prioritisation process across the sector, builds sector capability and capacity and enables distributed adaptive leadership and decision making.

Figure 4: NHC tiered approach for seeking advice and engaging with the health and disability sector

**Source:** NHC Executive

Part 3: The strategy

# Strategic direction

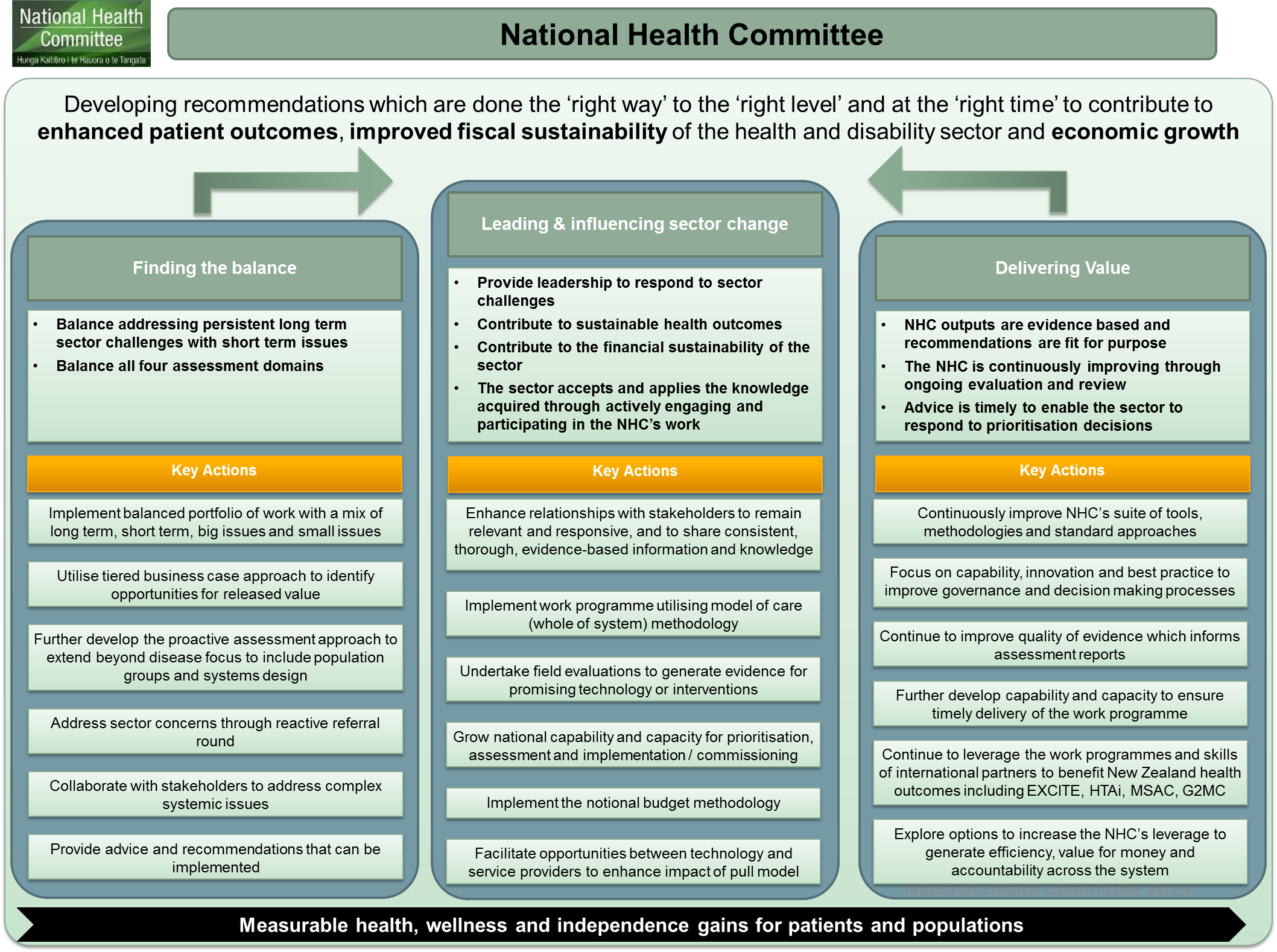
The NHC’s strategic focus is to ‘***Lead and influence sector change***’.

Our role is to act as a sector ‘expert’ to help individual parts of the sector address their medium to long-term challenges, as well as to set the agenda and improve the sector’s overall contribution to population and economic wellbeing. Essential is our ability to influence the behaviour of decision makers, including clinicians and health professionals, across government and within the health and disability sector.

This strategic focus is supported by two key goals:

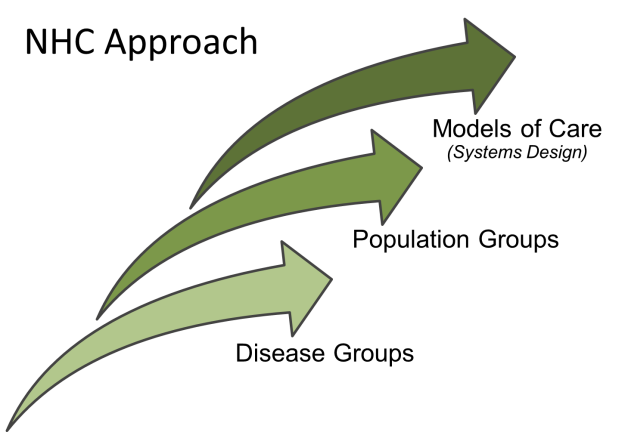
1. ***Finding the balance*** – Assist the sector to improve clinical outcomes and meet immediate fiscal challenges, while providing the medium to long-term view on improving patient and population outcomes and sector sustainability.
2. ***Delivering value*** – Strengthening the NHC’s ability to prioritise the most effective health technologies. Constantly pursuing improvements to the NHC’s tools, methodologies and approaches. Generating buy-in from all stakeholders to evidence-based, implementable, and fit-for-purpose recommendations.

Figure 5: Strategic framework



## Leading and influencing sector change

***Creating and sustaining system change by leading the development of recommendations that are implementable and achieve sustainable health outcomes***

The NHC has a core function of leading the development of recommendations for technology or interventions that are implementable and sustainable. The committee has an accepted position and role in the sector and is increasingly seen as the thought leader and change agent to provide independent advice and direction on sustainable investment and re-prioritisation. There is opportunity to bring together the NHC’s leadership ‘helicopter’ perspective of the sector, evidence based activity and implementation approach to drive change to respond to the wider issues and challenges facing the sector. To maximise the sector’s ability to create sustained change, the NHC is moving beyond the current disease focus to a population and systems focus.

| How are we going to do it? | How will we know we’re successful? |
| --- | --- |
| **Enhance relationships with stakeholders to remain relevant and responsive, and to share consistent, thorough, evidence-based information and knowledge** | |
| * Utilise the interactions the committee and executive have with stakeholders to listen, understand, share new developments, provide updates on the NHC’s work programme and identify mutual opportunities. * Engage and work alongside consumers to develop a shared understanding of expectations of high quality health and disability services as well as consumers role in prevention and appropriate use of services. * Close the ‘learning loop’ for the sector and NHC and demonstrate best practice – consistently and regularly deliver evidence and prioritisation recommendations, utilise international partnerships, provide advice on implementing the recommendations, measure and monitor implementation, and most importantly, provide feedback to the sector to inform their next prioritisation decision-making process or change. * Provide the sector with updates on emergent trends in health, including those from HealthPACT and EuroScan, and through the National Prioritisation Reference Group (NPRG) provide opportunities to discuss future trends and solutions to long-term sector challenges. | * Increased sector awareness of prioritisation and emergent trends measured by the provision of regular reports to the sector (ie horizon scanning, think pieces and reports from international partners eg HealthPACT briefs) * Stakeholders engage and lead consistent, sustainable and measurable implementation for their own organisations due to their participation in NHC work measured by DHBs who implement recommendations as per the NHC advice * Increased community willingness to work with us and have input into our work * NHC continues to add value to the sector measured by DHB satisfaction, and review of NHC terms of reference, prioritisation and assessment processes and strategic sector relationships * Constructive feedback received from the sector on annual plan each year |
| **Implement work programme utilising model of care (whole of system) methodology** | |
| * Implement a broader model of care methodology rather than assessment of single technology or intervention in isolation to achieve sector change and contribute to sector financial sustainability * Extend the model to tackle significant population health, condition prevention, patient outcome and service affordability issues, such as the increasing prevalence of chronic conditions. | * The assessment process extended beyond the assessment of level and mix of current services to include new models of care measured by the number of assessments undertaken each year using the model of care approach |
| **Undertake field evaluations to generate evidence for promising technology or interventions** | |
| * Utilise the innovation fund for: * field evaluations to find out if a promising technology will work in our population (Evidence generation) * understanding the system impact and the affordable management of high cost technology (Commissioning with evidence) * innovation evaluations so we can proactively pull cost-effective technology into the system in an organised way (Pull, plant and embed model). * Enhance and grow our business relationship with the HRC to benefit the sector and the economy | * Field and innovation evaluations generate evidence and support the three strategic outcomes of the fund measured by the fund being fully utilised to support the NHC work programme * Improved strategic alignment between the HRC and NHC with health research embedded into the health and innovation systems measured by successful delivery of field and innovation evaluations |
| **Grow national capability and capacity for prioritisation, assessment and implementation / commissioning** | |
| * Engage the sector’s innovative and strategic thinkers and international partners to strengthen the effectiveness of the NHC’s functions * Ensure the sector has the knowledge and tools available to implement NHC recommendations through stakeholder interactions, assessment reports, presentations and conferences, newsletters, secondments and website updates * Develop executive capability and capacity across core skill sets including research, systematic review, biostatistics, clinical, epidemiology, health economics and implementation | * Sector understands what the NHC does, recognises the committee as a trusted advisor and applies the NHC’s approaches * Stakeholders willing to engage and contribute to NHC assessment processes * NHC becomes an employer of choice |
| **Implement the notional budget methodology** | |
| * Establish a notional budget which captures the benefit of the NHC’s recommendations. Initially, savings in the budget will favour cost avoidance, over time the contribution of productivity and reprioritisation savings will grow until all three measures are contributing effectively to the notional budget target agreed with the sector and recommended to the Minister   • Utilise the model of care approach to identify opportunities for released value and strategic investment, ie the wise use of resources, for all the resources required to support delivery including workforce, facilities, procurement etc | * Notional budget methodology agreed with the sector and subsequently the notional balanced budget target achieved each year * Tier 3 assessments identify the released value or strategic investment opportunities available for resources required to support model of care |
| **Facilitate opportunities between technology and service providers to enhance impact of pull model** | |
| * Actively work with stakeholders to “pull” fit for purpose, affordable technology into a model of care that is primed, ready to adopt and use the technology in a clinical and cost-effective way * Use the evidence to alter the reactive flow of technology to a proactive model | * Innovation evaluations which generate solutions to sector challenges and measureable benefits to the New Zealand economy. * Sector commitment to introducing consistently or not introducing emerging technologies based on the NHC recommendations |

## Finding the balance

***Assist the sector to improve clinical outcomes and meet immediate fiscal challenges while providing the medium to long-term view on improving patient and population outcomes and sector sustainability***

The NHC needs to find the right balance between short-term assistance for the sector to manage current challenges and preparation of the system to deal with emergent need and new interventions over a 5-10 year horizon. The sector needs to be able to manage now to find the space to think about the longer term.

The NHC has a two-fold responsibility:

* Firstly to help the sector address ongoing short-term challenges, as well as identify and assess where the medium and longer-term pressures will arise, in order to provide the advice the sector needs to keep ahead of future cost waves.
* Secondly, the NHC needs to provide advice which balances clinical safety and effectiveness, ethical and societal considerations, economics and feasibility of adoption.

The NHC operates on a finite capacity and needs to focus its efforts on areas of whole of system strategic advantage. So it needs to ensure that the work it does with the sector is positioned to provide wide benefit to all DHBs or is used as a platform to progress whole of system development.

| How are we going to do it? | How will we know we’re successful? |
| --- | --- |
| **Implement balanced portfolio of work with a mix of long-term, short-term, big issues and small issues** | |
| * Include mix of proactive and reactive assessments in work programme each year * Manage phasing of tiered assessments to smooth the peaks and troughs of the work programme | * Recommendations reflect mix of proactive and reactive assessments to achieve the notional budget target across the four-year strategic work programme |
| **Utilise tiered business case approach to identify opportunities for released value** | |
| * Implement tiered business case approach to: * prioritise diseases, population groups or system issues for further assessment * drive stakeholders to engage and lead consistent, sustainable and measurable implementation for their communities and organisations and to ensure released value achieved | * Tier 1, 2 and 3 assessments undertaken as planned * Stakeholders able to prepare for change due to signals communicated through tiered approach |
| **Further develop the proactive assessment approach to extend beyond disease focus to include population groups and systems design** | |
| * Focus proactive assessment process to identify large and growing spends beyond the assessment of the level and mix of current services to assessment and recommendation of new or revised models of care * Continue to prioritise two proactive work streams each year and the thinking for future replacement work streams | * Two Tier 1 proactive assessments completed each year utilising model of care methodology |
| **Address sector concerns through reactive referral round** | |
| * Continue the annual reactive referral round for the health and disability sector to propose areas of concern where they consider the NHC could add value by providing clear direction * Complete assessments from reactive referral round | * Sector’s areas of concern are addressed through reactive referral round measured by completion of the annual referral round each year and DHB satisfaction with process and outcome * Reactive assessments completed as per work programme |
| **Collaborate with stakeholders to address complex systemic issues** | |
| * Focus on one complex system issue each year: * 2016/17 – equitable access * 2017/18 – electives disincentives * 2018/19 – funding disincentives * Continue to work with stakeholders to identify opportunities to disinvest in existing or old technologies and interventions | * Assessment completed for at least one complex system issue each year * Opportunities to add value to other agencies identified and undertaken * Opportunities to disinvest identified and advised to sector |
| **Provide advice and recommendations that can be implemented** | |
| * Develop recommendations that clearly articulate rationale for implementation against the four domains and the A4R framework allowing the sector to understand where and how services and resourcing needs to be prioritised to gain improvements in patient outcomes and return on investment. * Involve the NPRG and other stakeholders in the development of recommendations. | * Assessment process results in implementable recommendations measured by potential unintended consequences minimised, assessment process timeframes reduced and Tier 1, 2 and 3 assessments undertaken as planned. * An increased understanding of the NHC’s role in the implementation of new interventions and technologies measured by DHBs implementing recommendations as per the NHC’s advice |

## Delivering value

***Strengthening the NHC’s ability to prioritise the most effective health technologies. Constantly pursuing improvements to our work. Generating buy-in from all stakeholders to evidence-based, implementable, and fit for purpose recommendations.***

Prioritisation and bending the cost curve is the responsibility of everyone in the sctor. However, the NHC has a specific role to provide leadership, prioritisation expertise, cross health and business sector relationships, and independent advice to the Minister to achieve this goal.

To be successful, the NHC needs to constantly review and improve its approach. This encompasses continuous improvement, as well as incorporating innovative, often disruptive, approaches to its suite of tools.

To derive the maximum advantage, interventions and technologies must be identified early, prioritised, assessed in a timely manner, recommended, and diffused across the health and disability system in a consistent and rapid manner. Therefore, the NHC needs to ensure the sector is fully engaged and genuinely participates throughout this process. The NHC must work collaboratively with the sector to achieve shared outcomes.

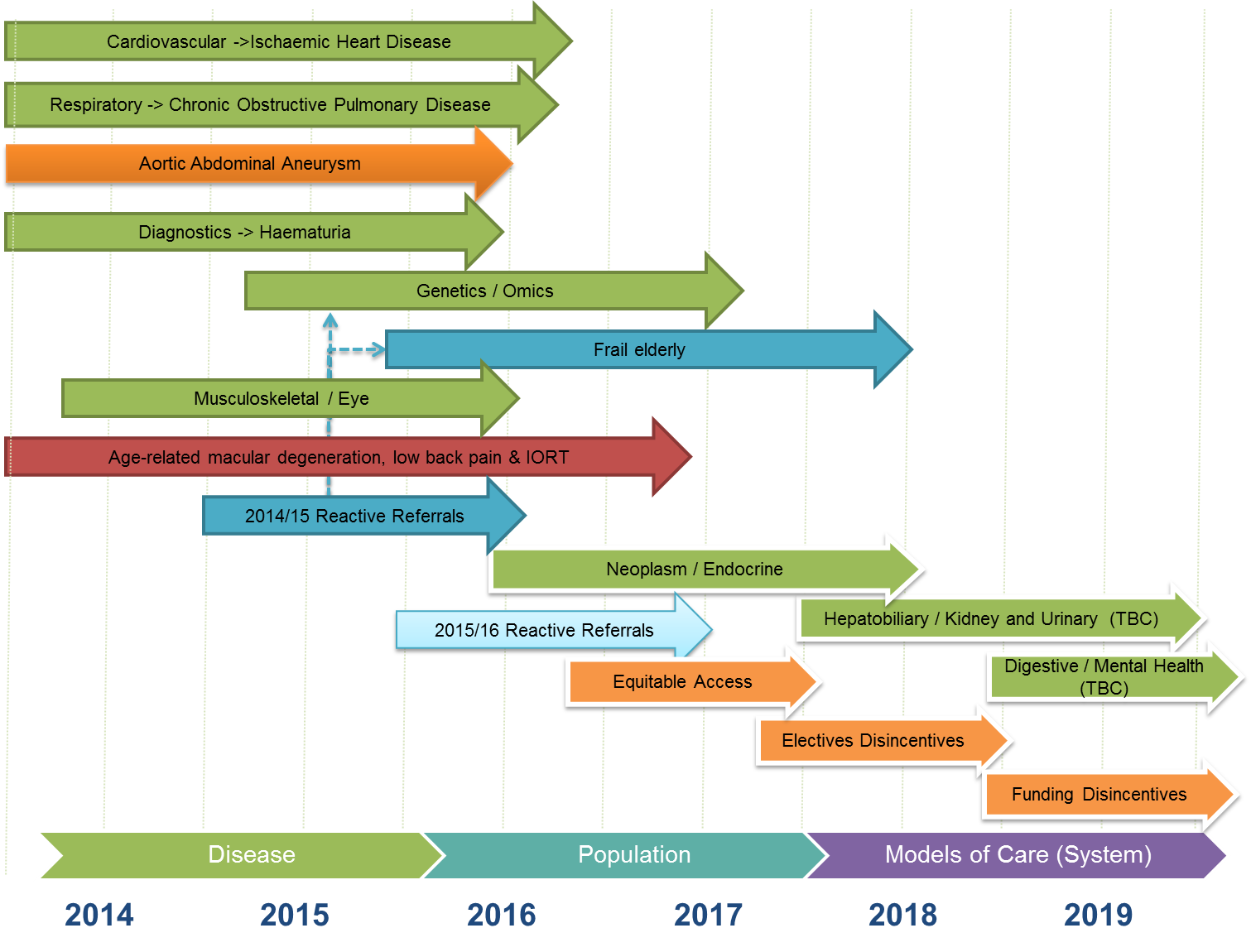
| How are we going to do it? | How will we know we’re successful? |
| --- | --- |
| **Continuously improve NHC’s suite of tools, methodologies and standard approaches** | |
| * Implement a quality framework through all levels of the NHC from governance to process to ensure the NHC continuously improves and utilises best practice evidence and follows robust processes throughout the NHC workflow. * Establish a monitoring and evaluation framework to monitor the NHC’s performance and the implemented recommendations to assess effectiveness and continued relevance | * Evidence of quality framework in all aspects of the NHC workflow * Development of specific performance measures to support implementation and the monitoring and evaluation of recommendations to support continuous improvement measured by results of monitoring activity. * Review programme completed for: * ToR for NHC and PHAC * NHC business model * domains and criteria * identification and prioritisation * HTA process outputs and products * engagement and advice methodology * implementation and monitoring * value for money methodology (ROI, materiality) * local and international partnerships |
| **Focus on capability, innovation and best practice to improve governance and decision making processes** | |
| * Further develop capability for effective identification, prioritisation and uptake of knowledge and new technologies * Utilise specialist expertise and perspectives provided by advisors to support the committee's decision-making | * Opportunities to develop capability undertaken by committee members * Committee decision-making enhanced by access to specialist community, clinical and business advisors |
| **Continue to improve quality of evidence which informs assessment reports** | |
| * Use best published evidence to inform assessments * Work with the sector to improve the quality and usefulness of the data provided to the NHC to inform recommendations | * Improved access to quality data from the sector informs recommendations |
| **Further develop capability and capacity to ensure timely delivery of the work programme** | |
| * Build the capability and capacity of the executive team through growing its permanent team members and contracting a variety of providers to complement the team’s skills * Develop project management skills to ensure timely delivery of the work programme | * Tier 1, 2 and 3 assessments undertaken as planned on time within budget * NHC recognised for delivering quality assessments |
| **Continue to leverage the work programmes and skills of international partners to benefit New Zealand health outcomes including EXCITE, HTAi, MSAC, G2MC** | |
| * Maintain and expand international connections and best practice * Undertake joint initiative with HQO * Undertake joint initiative with MSAC and the Australian Department of Health | * At least one example of where the NHC is able to leverage the work programmes and skills of international partners to benefit New Zealand health outcomes undertaken each year * Work of the NHC internationally recognised |
| **Explore options to increase the NHC’s leverage to generate efficiency, value for money and accountability across the system** | |
| * Identify options for increasing the NHC’s ability to add value to the Sector. Progress the future focussed work, particularly systems design and pull model approach. * Increase alignment with DHB work programmes and utilise the formal mechanisms available through legislation and the DHB accountability framework * Assist other agencies fulfil their responsibilities | * Sector connections deliver efficiencies through collaborative work, entering formal arrangements or clearly identified strategic alignment of work programmes |

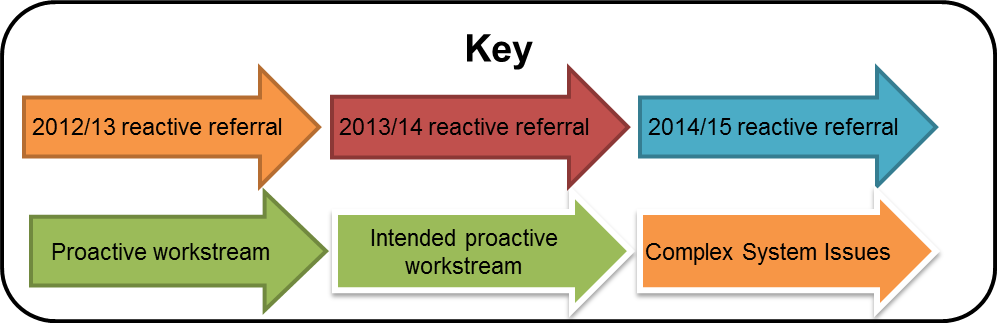
## Work programme

Each year we focus our assessment process into three to four work streams (two or three work streams for proactive assessments and multiple work stream for reactive assessments). The tiered assessment process takes longer than one financial year, and therefore each work stream is at a different phase of the process. Therefore each year some work streams will come to a conclusion with recommendations presented to the Minister of Health for implementation, and new work streams will start with the Tier 1 strategic overview assessment.

Figure 6 describes the planned timing for the reactive and proactive work streams over the next four years. The NHC will review planned work streams annually as part of the planning process.

Figure 6: Proposed timing of work streams





Part 4: Organisation

# Organisation development

This strategic plan identifies that the NHC business model is expected to continue to mature, but not necessarily radically alter, over the plan’s four-year timeframe. The committee will need to maintain a flexible approach to developing capability and capacity. This is likely to include establishing long-term relationships with external providers, particularly in the assessment function.

## Capability and capacity

* ***Governance*** is provided by the committee. The composition of the NHC reflects the skill sets required to make decisions across the four domains. in that there is a mix of age, gender and culture as well as clinicians, business executives and other professionals. The committee is supported by advisors with expertise in primary and integrated care, clinical delivery and innovation, DHB executive management, economics and strategic investment.
* ***Leadership***is provided by a clinical/management partnership between the chair and general manager. Their role is to build credibility in the health and disability sector, to guide the identification of priority areas for reactive and proactive assessment and to refine capacity to generate spill-over benefits for the pull model and health’s contribution to economic growth.
* ***Management*** provides coordination of resources to ensure outputs are delivered that result in recommendations to improve models of care and improve fiscal sustainability.
* ***Executive*** will produce evidence-based outputs by working across a number of core skill sets including research, systematic review, biostatistics, clinical, epidemiology, health economics and implementation.

### Implementation

Year 6 – 2016/2017:

* Enhance skills sets to improve quality and efficiency of outputs.
* Enhance capacity and knowledge by leveraging work programmes between international HTA providers.

Year 7 to Year 9 – 2017/2018 to 2019/20:

* Review team and partnership skill sets to ensure alignment with mature business model.

# Risk

## Risk factors

Technology assessment and prioritisation can be contentious, but it is now recognised internationally as a key element in countries being able to maintain high quality, clinically effective health and disability systems for their populations. The NHC’s greatest ability to ensure success is linked to maintaining a reputation for delivering high quality assessments and recommendations which are implementable. The NHC will also act in an appropriate manner to ensure that New Zealand’s long-term international interests are maintained and enhanced.

## Notional budget

By studying the evidence and taking into account feedback from overseas HTA agencies, the NHC has concluded that the traditional HTA approach to technology prioritisation cannot deliver the released value required by our terms of reference. To ensure the NHC contributes meaningfully to fiscal sustainability, it assists the sector to manage the reactive flow of technology while at the same time moving New Zealand to the more effective business model of proactive assessment and ‘pull’ model prioritisations.

There is a risk that the committee will not:

* choose the right areas of developing technology to investigate.
* gain sector consensus on a reasonable, material notional budget.

The NHC mitigates these risks by:

* using a ‘tiered’ approach to identification and prioritisation of work streams; this ensures an evidence-based approach to deciding what benefits might be gained.
* prioritising the four-year work programme from sector referrals, programme budget analysis, proactive and ‘pull model’ assessments.
* assessing the intervention against the four domains, including the economic domain which considers the cost-effectiveness of an intervention as well as whether the sector can afford to implement the intervention.
* ensuring a balanced mix of investment in and reprioritisation of technologies.
* agreeing with sector leaders what a material notional budget might be defined as.

## Commercial model

The NHC has no actual budget means of control over a largely unregulated technology market. There is a risk the committee will:

* be unable to persuade the sector to implement the recommendations it makes.
* make recommendations out of alignment with provider planning cycles.

The NHC will mitigate this risk by ensuring:

* all recommendations are evidence-based and assessed against the four domains and decision-making criteria.
* that clinical advice is taken and stakeholders are actively engaged at a leadership and operational level throughout the assessment process.
* DHB planning, funding and budget teams, Ministry of Health and National Health Board Business Unit are kept informed of developments as they occur so that implementation can be planned.

# Budget information

The NHC’s budget forms part of the Ministry of Health’s Policy Business Unit budget. The Ministry works in conjunction with the NHC to agree a sustainable level of resourcing, which is then split appropriately to allow for both core and externally contracted resource. The NHC also acknowledges the fiscally constrained whole of sector environment in which it works and actively seeks to expand capability and capacity by leveraging the skill sets and existing outputs of other HTA agencies internationally and other expertise within New Zealand.

## Key assumptions

In preparing this budget, the committee has made estimates and assumptions concerning the future, which may differ from actual results. As the business model continues to mature and deliver results, it may be desirable for the NHC to renegotiate its resourcing to sustain a higher level of outputs that will be necessary in the out years of the four-year work programme.

* ***The budget*** is contingent on appropriate funding and depending on funding decisions, the NHC’s activities and measures for 2016/17 may change.
* ***Expenditure increases generally***– the budget for the next four years assumes that increased activity will be paid for within current funding, by moving to directly employ or efficiently contract low overhead resource. However, this assumes there is the opportunity to renegotiate the budget each year on an ‘as needs’ basis.
* ***Personnel costs***– given the NHC’s people are its key asset, expenditure in human resources is expected to increase to maintain consistency with other public sector organisations.
* ***Future costs***– including inflationary costs, will be managed within a static overall funding level for the next four years as part of the NHC’s commitment to the Ministry and sector generally to provide a high level of service from a basis of strict financial prudence.
* ***Future funding not agreed***– the financial forecasts are dependent on the outcome of future negotiations for out-year funding (yet to be conducted).
* ***Partnership funds***– the innovation fund is $3 million per annum for field evaluations and innovation assessments. The NHC will continue to develop and evolve partnerships with our core partner organisations the HRC and Callaghan Innovation to maximise the utility of the fund.
* ***Legal Risk Fund (LRF)***– there is no separate Legal Risk Fund to that maintained by the Ministry of Health.

## Budget projection 2016/17-2019/20

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **National Health Committee** | **Budget** | | | |
| **2016/17** | **2017/18** | **2018/19** | **2019/20** |
| **Operational** | 3,000,000 | 3,000,000 | 3,000,000 | 3,000,000 |
| **Innovation funding** | 3,000,000 | 3,000,000 | 3,000,000 | 3,000,000 |
| **Total NHC funding** | **6,000,000** | **6,000,000** | **6,000,000** | **6,000,000** |

Note: The NHC expects to negotiate its funding resources on an as needs basis as per the above assumptions. These figures are based on the current year’s budget.

# Glossary and abbreviations

|  |  |
| --- | --- |
| A4R | Accountability for Reasonableness  Accountability for Reasonableness is a framework for making decisions that all parties have a reason to accept as legitimate, even if they disagree with them. It is designed to enable decision-making about contentious issues, there is disagreement about what justice requires. It does this by focusing upon procedural fairness. It has four conditions: Publicity, Relevance, Revision and Appeals and Regulation.  References include:  Daniels, Norman (2008) *Just Health: Meeting Health Needs Fairly* New York, Cambridge University Press, Chapter 4.  Daniels N. Accountability for Reasonableness *British Medical Journal* 2000;321;1300-1301  Daniels N, Sabin J. The ethics of accountability in managed care reform. *Health Affairs* 1998;17:50­64  Daniels N, Sabin J. Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philosophy and Public Affairs* 1997;26:303­50. |
| ACC | Accident Compensation Commission |
| AHMAC | Australian Health Ministers’ Advisory Council |
| CI | Callaghan Innovation |
| COPD | Chronic Obstructive Pulmonary Disorder |
| CMC | Council of Medical Colleges |
| DHB | District Health Board |
| GDP | Gross Domestic Product |
| hA | healthAlliance |
| HealthPACT | Health Policy Advisory Committee on Technology. This committee provides its Australian and New Zealand (NHC and Ministry of Health) members with evidence-based advice on emerging technologies that may impact on the public health system, primarily public hospitals. This information is used to inform financing decisions and to assist in the managed introduction of new technologies. Source http://www.inahta.org/our-members/members/healthpact/ |
| HIP | Health Innovation Partnership |
| HRC | Health Research Council |
| HTA | Health Technology Assessment |
| HTAi | Health Technology Assessment International |
| IHD | Ischaemic Heart Disease |
| INAHTA | International Network of Agencies for Health Technology Assessment |
| MaRS / EXCITE | MaRS Excellence in Technology Evaluation (Canada)  “EXCITE connects health technology innovators with experienced, award-winning researchers to get the right evidence and data they need to show the value of their product and facilitates discussions with relevant health system stakeholders to determine what it takes to get their technology adopted successfully.” Source <http://www.marsdd.com/systems-change/mars-excite/mars-excite/> |
| MoH | Ministry of Health |
| MSAC | Medical Services Advisory Committee (Australia) |
| MTANZ | Medical Technology Association of New Zealand |
| NHB | National Health Board |
| NHC | National Health Committee |
| NPRG | National Prioritisation Reference Group |
| NZ Triple Aim Framework | The improvement framework adapted by the Health and Quality Commission for New Zealand. The three aims are:   * improved quality, safety and experience of care * improved health and equity for all populations * best value from public health system resources. |
| OHTAC | Ontario Health Technology Advisory Committee |
| PHAC | Public Health Advisory Committee |
| Sector | All stakeholders in the health and disability sector including the Ministry of Health, district health boards, non-Government consumer and provider organisations, other central agencies etc |

**National Health Committee (NHC) and Executive**

The National Health Committee (NHC) is an independent statutory body which provides advice to the New Zealand Minister of Health. It was re-formed in 2011 to establish evaluation systems that would provide the New Zealand people and health and disability sector with greater value for the money invested in health. The NHC executive are the secretariat that supports the committee. The NHC executive’s primary objective is to provide the committee with sufficient information for them to make recommendations regarding prioritisation and reprioritisation of interventions. They do this through a range of evidence-based reports tailored to the nature of the decision required and timeframe within which decisions need to be made.

**Disclaimer**

The information provided in this strategic plan is intended to provide general information to clinicians, health and disability service providers and the public, and is not intended to address specific circumstances of any particular individual or entity. All reasonable measures have been taken to ensure the quality and accuracy of the information provided.

If you find any information that you believe may be inaccurate, please email to [NHC\_Info@nhc.govt.nz](mailto:NHC_Info@nhc.govt.nz).

The National Health Committee is an independent committee established by the Minister of Health. The information in this plan is the work of the National Health Committee and does not necessarily represent the views of the Ministry of Health.

The National Health Committee makes no warranty, expressed or implied, nor assumes any legal liability or responsibility for the accuracy, correctness, completeness or use of any information provided. Nothing contained in this plan shall be relied on as a promise or representation by the New Zealand Government or the National Health Committee.

The contents of this plan should not be construed as legal or professional advice and specific advice from qualified professional people should be sought before undertaking any action following information in this report.

Any reference to any specific commercial product, process, or service by trade name, trademark, manufacturer, or otherwise does not constitute an endorsement or recommendation by the New Zealand Government or the National Health Committee.

1. See <http://hps.tki.org.nz/>. [↑](#footnote-ref-1)
2. [http://www.ero.govt.nz/National-Reports/Educationally-powerful-connections-with-parents-and-whanau-November-2015](http://news.nationalgeographic.com/2015/06/150619-data-points-five-ways-to-lie-with-charts/) [↑](#footnote-ref-2)
3. See generally <http://www.who.int/social_determinants/en/>, <http://apps.who.int/iris/bitstream/10665/41987/1/WHO_TRS_870.pdf>; see also <http://www.buildhealthyplaces.org/the-evidence-is-in-5-ways-community-development-and-health-are-linked/>. [↑](#footnote-ref-3)
4. Ibid, fn 2. [↑](#footnote-ref-4)
5. See for example NCEA level 2 pass rates, available <http://www.cometauckland.org.nz/webfiles/CometNZ/files/SNAP_SouthernItitiative.pdf>. [↑](#footnote-ref-5)
6. See: Cobiac L, Vos T, Doran C, Wallace A: Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia. Addiction 2009, 104(10):1646-1655; Nghiem N, Blakely T, Cobiac LJ, Pearson AL, Wilson N: Health and economic impacts of eight different dietary salt reduction interventions. PLoS One 2015, 10(4):e0123915; Ni Mhurchu C, Eyles H, Genc M, Scarborough P, Rayner M, Mizdrak A, Nnoaham K, Blakely T: Effects of health-related food taxes and subsidies on mortality from diet-related disease in New Zealand: An econometric-epidemiologic modelling study. PLoS One 2015, 10(7):e0128477; and Ni Mhurchu C, Eyles H, Genc M, Blakely T: Twenty percent tax on fizzy drinks could save lives and generate millions in revenue for health programmes in New Zealand. N Z Med J 2014, 127(1389):92-95. [↑](#footnote-ref-6)
7. See <http://www.treasury.govt.nz/downloads/pdfs/oia/oia-20150441.pdf>, p. 28. [↑](#footnote-ref-7)
8. Toop L, Mangin D. The art and science of marketing medications. N Z Med J. 2015 Sep 4;128(1421):11–2. <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1421-4-september-2015/6635>; Ma A, Parkin L. Randomised controlled trials cited in pharmaceutical advertisements targeting New Zealand health professionals: do they support the advertising claims and what is the risk of bias? N Z Med J. 2015 Sep 4;128(1421):22–9 [↑](#footnote-ref-8)
9. [Charities register data](https://www.charities.govt.nz/charities-in-new-zealand/the-charities-register/) downloaded 19 July 2015. Data is only as accurate as the information provided by listed charities. [↑](#footnote-ref-9)
10. For more on producers global harm reduction commitments see - <http://www.producerscommitments.org> [↑](#footnote-ref-10)
11. <http://ministryofhealthnewzealand.createsend1.com/t/ViewEmail/i/968E2F301C7EB184/> [↑](#footnote-ref-11)
12. [www.bit.ly/HunnReport](http://www.bit.ly/HunnReport) [↑](#footnote-ref-12)
13. <https://sites.otago.ac.nz/Sites/article/view/290> [↑](#footnote-ref-13)
14. <http://www.waateanews.com/waateanews/x_story_id/MTIyNTY>= [↑](#footnote-ref-14)
15. <http://www.stuff.co.nz/national/health/73949279/report-highlights-new-zealands-health-system-failing-maori> [↑](#footnote-ref-15)
16. http://www.gpiwellingtonregion.govt.nz/ [↑](#footnote-ref-16)