**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**173 - 205**

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| **173** | Submitter name | Koral Fitzgerald and Jill Nuthall |
| Submitter organisation |  |
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| Name | | Koral Fitzgerald & Jill Nuthall |
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| Please indicate what sector(s) your submission represents. | | Other professional association |
| Release of personal details? | | I do give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | There is room to consider ways in which Pharmacy can support better access for Maori, Pacific Island and CALD communities. IT platform for Pharmacy that provide efficient use of existing health information on a patient using a safe shared platform (e.g. HCS) to increase efficiency of the workforce. Increased health literacy options through community pharmacy. |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Yes! Collaboration is growing: many areas have some adopters, but there is a trend towards 'sit back, watch and wait' - therefore many late and non-adopters. How do we manage those who steer away from change? |
| 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? | | #6 - and trusting professional relationships. there is still an essence of ground protection as opposed to patient-centric holistic care. #8 is key for pharmacy to improve primary care outcomes. IT focus is critical Increased transparency regarding decision making. |
| 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? | | Links to health literacy is important in pharmacy. A suitable IT platform 'understand the needs' by appropriate, trusting access to shared patient health info Community pharmacy is an ideal place to provide 'closer to home management of LTC' Preventative care is lacking mention here - pharmacy can assist in this area. |
| 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? | | Balance skill / workforce expertise with resource availability. Support a culture that allows trusting and transparent primary health teams to work as a collective, supported by the right tools, skills and resourcing. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Collate quarterly update reports form key groups / providers on specific statistics - quantitative with some qualitative data. |
| Are there any other comments you wish to make as part of your submission? | | Action 5 d &h - effective prevention engages sectors other than the treatment of illness services with many leadership roles played by health professionals. Actions proposed to address obesity must address the environment where people live and what support there is for healthier choices. Add to these actions support for public transport as this is more reliable and well proven method to reduce obesity. Action 7 - As the majority of health services are used by older people, expand these online initiatives to other modes that are easier to access for this group, e.g. email, person-to-person Action 11b - Longer term contracting is essential for NGOs to plan and provide top quality services. the one year contract has seen hundreds of skilled people leave the organisation / sector. |

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| **174** | Submitter name | Iris Pahau |
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| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | Māori |
| Release of personal details? | | I do give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | There is no correlation or connection to He Korowai Oranga - the Maori Health Strategy. It is the whole of the Health Sector's responsibility to meet the needs of Maori under Te Tiriti o Waitangi. The Maori health outcomes should be woven into the National Health Strategy - not separated. |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Maori paradigms need to be incorporated into the future direction. Utilising 'kupu maori' (Maori words) into the text would enable Maori to see themselves as part of the strategy and also acknowledge that te reo is acknowledged as an official language in this country. |
| Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy? | | The principles should engender some positive activities towards improved health of our people and communities. The statement acknowledging Maori is insufficient. The principle should more reflect the need to lift the health status of Maori. The 'special relationship' Maori have with the crown via the Treaty has not improved Maori health in the past and unlikely to do so in the future. There needs to be a statement about cultural appropriateness to reflect the multiple cultures (including Maori culture) who reside in this country. New Zealanders is not appropriate because so many of our cultures/people do not consider themselves New Zealanders. There needs to be a Maori Culture ethos incorporated into the Health Strategy - that will respond to the special relationship the crown has with Maori |
| 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? | | The most significant focus for Maori is 'close to home' particularly relating to the care of our kaumatua and kuia.. The current health model doesn't compensate Maori for caring for the elderly at the home even though it saves the health sector millions of dollars per annum. Non-Maori choose to house their elderly in resthomes costing the tax payer milliions of dollars each year. Maoridom are not compensated equally for caring for their elderly. |
| 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? | | Maori or Maori models of practice are not reflected in these actions |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | The funding does not reflect the lack of improvement in Maori health outcomes. Service Providers, including General Practitioners should be penalised for failing to meet Maori needs and improving Maori health outcomes. |
| Are there any other comments you wish to make as part of your submission? | | There are many great Maori health outcomes that have been achieved by Maori Service Provides (MSP) and whanau for which they have not been funded. There needs to be a better funding model that rewards improvement in Maori health outcomes and penalizes those health providers who fail to do so. |

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| **175** | Submitter name | [redacted] |
| Submitter organisation | Belmont Medical Centre |
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| You are submitting this: | | on behalf of a group or organisation, or in your professional capacity |
| Please indicate what sector(s) your submission represents. | | Education/training |
|  | | Service provider |
|  | | Consumer |
| Release of personal details? | |  |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | Yes, I belive you have paid insufficient attention to our demographics and you should note how many New Zealanders are going to die in the next 30 years- so you should add " die well" to your live well, stay well and get well |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Add "die well" as above and strategies for how to do that |
| Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy? | | Yes, they are incomplete however as described above. We are going to have so many people in their 80s and 90s and even 100s and you have taken insufficient account of this. |
| 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? | | The themes are all right. Need something about not over-investigating. The issue with portals is that on-line appointments( which I have in my general practice already) may mean that patients get to make appointments with Drs for minor conditions which do not need a Dr. This does not then make efficient use of the Dr's time. |
| 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? | | These are OK, but I have discussed competing issues with portals above. I regard strategies for dying well as entirely left out. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Use the District Alliances of DHBs/PHOs to track/report |
| Are there any other comments you wish to make as part of your submission? | | I am very serious about adding " die well" |

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| **176** | Submitter name | [redacted] |
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| Please indicate what sector(s) your submission represents. | | Māori |
|  | | Service provider |
|  | | Non-governmental organisation |
| Release of personal details? | |  |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | No |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | The statement is adequate however it is your interpretation of the statement which concerns me. When the statement says 'ALL New Zealanders' it concerns me that this means that particularly vulnerable or high need groups - for example youth, the elderly and Maori and Pacific peoples - will be treated like they have EXACTLY the same opportunities and abilities as other sectors of our population which is patently untrue. The statement 'ALL New Zealanders' makes me concerned responsiveness to these population groups will be sacrificed in order to meet the needs of the (reasonably well) majority thus producing nothing new and indeed perpetuating existing gaps between high need groups and the rest of our society. What measures are in place within this draft plan to ensure this does not occur? |
| 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? | | These principles are adequate however it is your interpretation of and meaningful commitment to the principles which concerns me. For example 'Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing' is a commendable principle however in my experience we have yet to see Integrated Contracts and Compliance processes (now referred to as Streamlined contracting and compliance) work. Our organisation has been a part of endeavouring (for the past 4 years) to get integrated or streamlined contracting and auditing working which in our case has involved the MOH, MSD and Waikato DHB. After 4 years we have progressed not one bit and it is hold ups on the part of MOH, MSD and Waikato DHB which have made this so. The principle of 'Acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi' is also an adequate principle however what the MOH might see this principle as meaning in application concerns me. The Werry Centre for example conducts a region by region annual stocktake of the ICAMHS workforce and found in the 2014 stocktake that the 5 DHBs in the Midlands Region - which serves the largest Maori population of any of the regions - has an ICAMHS workforce of 318.35 FTE. When the nature of these FTEs was examined only 2% (6.5 FTEs) were culturally assigned roles. This means that the Maori workforce development and cultural leadership in this sector is provided by other organisations (e.g. groups like Te Rau Matatini and Matua Raki), or by providers (DHB and NGOs) seeking to wring more out of their Maori staff assigned to other roles (e.g. clinical or non-clinical), or by the sector relying upon the non-funded cultural support and good will of kaupapa Maori service providers and NOT by a conscious intent on the part of the MOH to purchase and provide culturally assigned roles within the sector. 2% of the ICAMHS workforce does not indicate a meaningful commitment to the TOW in my opinion and in fact demonstrates how much Maori staff and organisations are taken for granted when it comes to the provision of health services. |
| 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? | | These themes are adequate however it is your interpretation of them which concerns me. For example 'People-powered' is not my experience of how services are designed and delivered with regards to the MOH. A very recent example is how funding for young people using methamphetamine to access residential care was 1) cut in half by the MOH, and 2) then redirected (the funds cut) to purchasing residential care for adult methamphetamine users. As opposed to focusing on how youth using substances could be better served (and redirecting the funds to other youth substance use initiatives) the MOH, with no public consultation on the matter, made a unilateral decision based on the disorder (i.e. methamphetamine use) as opposed to the people (i.e. substance use disordered adolescents). Another example is with the theme of 'One Team' which claims to focus on a number of areas including 'strengthening the roles of people, families, whānau and communities as carers'. In our recent experience the Waikato DHB has taken an example of building the capacity of families, whanau and carers to contribute to the health of their own people and turned it into a simple manufacturing exercise. For the past 3 years our Iwi Health (public health promotion) service had run workshops (wananga) teaching Maori parents, grandparents and whanau to weave wahakura (or baby pods using traditional Maori skills) in order to reduce the likelihood of SUDI (sudden unexplained death of an infant) in their whanau. This financial year the contract changed from teaching whanau the skills to make these resources (thus enabling them to take control of this health resource for themselves and their whanau) to a simple manufacturing contract. No education, workshops, skills transference is to occur now people simply get a wahakura delivered which may assist them immediately but which contributes nothing to their taking greater control of their health. What measures are in place within this draft plan to ensure this does not continue to occur? |
| 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? | | You need to establish an advisory body EXTERNAL to the MOH, DHBs and/or other government bodies as a matter of priority. This body will be there to provide objective criticism of your progress, stated intentions and chosen actions, and approach to realigning 'the system' of health for all New Zealanders. This body must be particularly inclusive of those groups with high priority needs and who have established issues with accessing the public health system. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | You need to have an advisory body EXTERNAL to the MOH, DHBs and/or other government bodies to provide objective criticism of your progress, stated intentions and chosen actions, and approach to realigning 'the system' of health for all New Zealanders which is particularly inclusive of those groups with high priority needs. It is unreasonable and unrealistic to expect those who work within the system to be able to provide real criticism when it comes to the crunch. |
| Are there any other comments you wish to make as part of your submission? | | I think the principles and themes of this strategy are good but I have real concern about how you will interpret them in application based on very real and some very recent history. The most significant thing you can do to make this vision reality is bring in external monitoring from a body imbued with meaningful powers. |

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| Please indicate what sector(s) your submission represents. | | Māori |
|  | | Pacific |
|  | | Asian |
|  | | Education/training |
|  | | Non-governmental organisation |
| Release of personal details? | |  |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | No. |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Yes. |
| Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy? | | Yes, well done. |
| Do these five themes provide the right focus for action? Do the sections "What great might look like in 10 years" provide enough clarity and stretch to guide us? | | Yes. |
| 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? | | Yes. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | |  |
| Are there any other comments you wish to make as part of your submission? | |  |

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| Please indicate what sector(s) your submission represents. | | Non-governmental organisation |
|  | | Consumer |
|  | | Disabled Persons Organisation |
| Release of personal details? | |  |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | There are many challenges that disabled people face when accessing the health system that are not covered sufficiently in the draft strategy. These include: • Accessible information – for many people this is a massive barrier as there is very little information that is accessible. Information such as discharge summaries, prescription fact sheets and appointment letters should all be in easy read, New Zealand Sign Language and Braille. Forms that are required to be filled at the GP clinic or hospital are not accessible. • Health professionals have very little disability awareness training, and none that is provided by disabled people. This impacts the level of care that is provided to disabled people when they access health services. Disabled people are reporting that when they access health services regardless of the reason for accessing those services their disability is brought up, even when it is not relevant to the issue being discussed. Often symptoms are not investigated due to them having a disability. • Communication – many disabled people do not feel that they are recognised as individuals, with majority of Doctors talking to their support person instead of them. • Appointment Times – There is no effort from the health system to collaborate appointments. This impacts negatively on the health of disabled people as the cost to attending appointments can be a barrier which prevents them from attending all appointments. • GP Cost – Many disabled people struggle to afford the cost of a GP visit, this means that often they will not seek medical attention until it is critical. This then can result in hospitalisation. We would recommend a free annual check up to help prevent the deteriorating health of disabled people. |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | The statement does not adequately cover the needs of indigenous people. A member provided the following feedback “indigenous peoples with disabilities will have the authority and rights according to the Treaty of Waitangi to determine their own path of well being and not be subjected to western health models but their own consistent with tino rangatiratanga” People with disabilities have evolved cultural norms which describe the tikanga of their collective with some going so far as to have their own language recognised as an official language (Deaf). If the Health system is to be “people powered”, which we assume to mean driven by recipients of the systems services, then the system has to be responsive enough recognise that there are significant cultural drivers which shape the manner in which disabled people interface with it, and be able to accommodate those differences in the manner in engages to respect disabled peoples tino rangatiratanga and mana. There are a number of things that will need to be achieved to create a health system that follows this direction. With being a people powered system it is important that disabled people are listened to and their needs and wants are acknowledged through the health system. It is also important to note that the one team must also be the right team. The accessibility of the system needs to be a priority to ensure that all New Zealanders are able to access the level of care required. |
| 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? | | Principle 2 – would be more effective if it read “an improvement in health status and services of those currently disadvantaged” The 4th principle about relationship between Maori and Crown needs to be focused more towards giving disabled Maori the authority to determine their own health priorities and well-being needs. Principle number 6 would be more effective and apply to more people of it read “a high-performing accessible system in which people have confidence” |
| 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 – information not only needs to be relevant it also needs to be in the users preferred format. Further there needs to be full disclosure of information relating to the individual and not be censored by the professionals based on an assumption that “they will not understand it” as this is both patronising and often inaccurate. Closer to home – if the option of mobile vans/clinics is further investigated it needs to be done in a partnership with disabled people to ensure that they have equal access to these services. In order for disabled people to be safe well and healthy in their communities the health professionals need to have a knowledge of disability and be trained in disability awareness. The cost of attending appointments can be barrier to disabled people so bringing services closer to home will help better the health of disabled people. It also needs to be acknowledged that significant number of disabled people and in particular disabled Maori live outside of main centres which increases their costs of seeking medical assistance. Value and high performance – need to be particularly careful that this does override the persons choice in services. The main outcome should be the end result for the person, not the value for money of providing that service. Quite simply providing a service to a non-disabled person living in a main centre with public transport networks is likely to be notably less that providing that same service to a disabled person living in a rural area with no public transport. One team – disability and cultural (in the broadest sense of the word) awareness training included in the “leadership, talent and workforce development throughout the system” Smart System – with any online system it needs to be accessible to people using screen readers. It also needs to be really clearly set out who can access this information and what users can do to stop people accessing it. While the use of telehealth could be good for some, for others it will be seen as very impersonal and will affect the level of communication. This should be an option but there should be no pressure on any users to go down this path. Health must be about people not systems. |
| 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? | | Action 4 – poses a real risk of over prescribing the wrong drug, particularly with people with a disability as there may be many factors that a nurse or pharmacist would not know about that person. Anyone prescribing medication needs to have a knowledge of disability and medication interactions Action 5 – the person needs to be at the centre of a service, not the outcome. By putting the outcome first it may affect a person’s eligibility to use that service. This is particularly relevant for disabled people. Action 7 – ensure the online patient experience survey is available in all accessible formats Action 11 – having funding awarded on the basis of the strongest investment cases for a three to five year period is making people and their health a commodity. People need to be at the centre of all approaches, not funding or outcomes Action 20 – “continue to improve and simplify processes and systems for prioritisation and procurement of technologies.” – This also needs to be done for disabled people accessing equipment through enable. There is currently a large level of variance in accessing equipment around the Country. This service needs to be streamlined. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Approaches to support the development of the roadmap actions needs to be transparent and have people at the centre of it. It needs to be “people driven” and for that to happen disabled people need to be involved in the development of the roadmap. Any reporting on progress needs to be done in a way that includes disabled people. Current methods of collecting information such as the health survey are not accessible and do not adequately portray the needs of disabled people. This creates a false view of the health of New Zealanders. |
| Are there any other comments you wish to make as part of your submission? | | Disabled people often struggle to interact with their health service because of access issues and cost. It is important that disabled people are able to access all services they need to live a fulfilled life. Mid Central Health Board have implemented a disability nurse which has helped disabled people access the hospital. It would be great to see more DHB’s take up this position. There needs to be more accessible information on managing one’s own health. It can be hard for disabled people to get this information in a way that they can use. |

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| You are submitting this: | |  |
| Please indicate what sector(s) your submission represents. | |  |
| Release of personal details? | |  |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | a continuing service for day activity centres is a must for mental health consumers even if they are senior members |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | |  |
| 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? | |  |
| 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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| **180** | Submitter name | 4361080512 |
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| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | |  |
| Are there any other comments you wish to make as part of your submission? | | health profesionals sould be trained about ME/CFS we get treated very poorly becouse they do not understand the this disibility |

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| **181** | Submitter name | 4360011401 |
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| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | Māori |
| Release of personal details? | | I do not give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | I am an obese Maori female and I'm sick of being offered opportunities to learn about "healthy eating options". FYI I am reasonably intelligent and did not manage to miss the thousand or so messages over the last couple of decades. Your food pryamid message is annoying, is technically and ethically questionable, and spending millions more to tell me this is the panacea to most/all of my issues is a waste of government money. |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | I want to see alternative therapies intergrated into the system. "People powered" sounds like slaves in the basement. |
| Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy? | | Yes. |
| 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? | |  |
| 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? | |  |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | |  |
| Are there any other comments you wish to make as part of your submission? | | I'd like to see doctors treating beneficiaries costs seriously rather than making patients political battering rams. |

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| **182** | Submitter name | 4358156702 |
| Submitter organisation |  |
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| Respondent ID | | 4358156702 |
| Name | |  |
| Position (if applicable) | |  |
| Organisation (if applicable) | |  |
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| Country | |  |
| Email Address | |  |
| Phone Number | |  |
| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | consumer and provider |
| Release of personal details? | |  |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | No visibility of laboratory services strategy within this framework |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | I suppose |
| 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? | | Who would really disagree with those principles? They should, if really used as a guide, help implementation. |
| 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? | | Probably |
| 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? | | They are pitched at a too non-specific level for me. I realise this is high level, but there is no need to be vague |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Reporting what is used to intervene and improve is important - not reporting for the sake of reporting is equally vital |
| Are there any other comments you wish to make as part of your submission? | | Again, include laboratory services and be deliberate about high quality implementation rather than looking at it as a purchasable service commodity only |

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| **183** | Submitter name | 4355716800 |
| Submitter organisation |  |
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| Respondent ID | | 4355716800 |
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| Position (if applicable) | |  |
| Organisation (if applicable) | |  |
| Address | |  |
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| Town/City | |  |
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| Country | |  |
| Email Address | |  |
| Phone Number | |  |
| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | Education/training |
|  | | Academic/research |
|  | | Regulatory authority |
|  | | Consumer |
|  | | Someone who fits under the older people strategy. |
| Release of personal details? | | I do not give permission for my details to be released. |
| Are there any additional or different challenges or opportunities? | |  |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Please include 'die well' unless the strategy is really an immortality strategy. |
| 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? | | For principle number eight would rather have 'Working for an economy and market place that supports the health and well being of the community'. |
| 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? | | These strategic themes are fine. In ten years' time what would also look great to me is an economic policy that is working with the health service towards better health for everyone., e.g.,illegal to advertise sugary foods. |
| 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? | | These actions can only be achieved if other sectors get behind the aim of better health for all New Zealanders, e.g., private landlords of poor quality housing. Other actions include working more effectively with the social policy and business communities to ensure an adequate income and safe housing. |
| What approaches might best support ongoing updates to the Roadmap of Actions? | | Much more could be done to convince business people that it is in their interests to support health improvement in the community. |
| Are there any other comments you wish to make as part of your submission? | | The term 'health literacy' is jargon - a term known only to the elite. The push for consumers to achieve health literacy is an example of long term attempts to push responsibility for understanding their health and the health service on to 'consumers' when the elite make a living from constantly inventing new terms and ever more complex systems. It is the responsibility of health funders and providers to understand the consumer's perspective when they are faced with a health issue and to make things plain to them. |

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| **184** | Submitter name | Dr Frances Pitsilis |
| Submitter organisation |  |
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| Respondent ID | | 4353186851 |
| Name | | Dr Frances Pitsilis |
| Position (if applicable) | | General Practitioner |
| Organisation (if applicable) | |  |
| Address | | P.O. Box 31572 |
| Address 2 | | Milford |
| Town/City | | Auckland |
| Postal Code | |  |
| Country | |  |
| Email Address | |  |
| Phone Number | |  |
| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | Education/training |
|  | | Primary health organisation |
| Release of personal details? | | I do give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | Yes. Chronic illnesses are allowed to develop, not actually cured or well managed clinically in Western Medical systems although we are great at emergencies and surgery. WHO states that at any one time, 66% of people have Asthma, pain, etc. WHO states that chronic illness is the major cause of premature death. Chronic illness has been defined as " long lasting progressive condition ......needing long term support and rehabilitation" It also causes poor quality of life, dependence on the state, inability to work, participate in life and social isolation etc. It is a very important area to get under control in terms of the costs to us across the board. What generally happens now is that anyone with a chronic illness like metabolic syndrome is observed as they worsen then get given more drugs etc. then they worsen further. They are not cured, which can be done if caught early. There are increasing autoimmune disease necessitating the use of expensive biologic drugs. You have already identified Obesity, dementia and diabetes. Elderly frail will increase too. Population distortion in the future will find us with an overburden of aged people. Keeping them well and active and even working and paying more taxes is what we need! You should also account for the increasing rate of Autistic spectrum disorders which is currently approx 1/60 children. Improving the organization of chronic illness has been focused on by the health system in primary care - good so far. However, instead of focusing only on drugs as treatments, please also focus on evidence based natural therapies like fish oil , vitamin D and zinc etc Diet is incredibly important too - much evidence there. As a GP with an interest in chronic illness who sees patients from all over NZ and overseas, I regularly reverse diabetes, obesity. I actually cure Anxiety, Depression, PMS, Asthma. Irritable bowel syndrome. I significantly improve inflammatory bowel diseases and reduce their need for expensive drugs. I cure Fibromyalgia and Chronic fatigue syndromes. I am able to help patients return to work and come off benefits. All of the women with severe menorrhagia who have seen me have been spared a hysterectomy. All this is via correction of diet and correction of nutritional and hormonal deficiency. THESE RESULTS NOT EXAGGERATION. I suggest Pharmac could additionally examine these therapies and formulate new treatment protocols to save drug money. Or can consult with me and my colleagues. I practice Integrated Medicine which is the study of all evidence based therapies. This includes conventional medicine as well as any other research based therapies. I suggest placing more of these evidence based natural therapies on prescription subsidy so that doctors will use them - e.g. Omega 3 fish oil, Magnesium Citrate, larger doses of Vitamin C that currently subsidised, etc. Currently some vitamins are actually subsidised ( zinc, Vitamin D, Vitamin C, Vitamin B6) but we need more. We could also do with a subsidy on Melatonin and Micronised Progesterone. Then later, a subsidy on other, safe evidence based hormone therapies like DHEA. This means that teaching Integrated Medicine in Medical schools must happen. Or at least post graduate. More doctors practising as I do are needed to save chronic illness grief and excessive health spend. My Integrated Medical GP Peer group is currently forming a society - the NZSIM ( NZ Society of Integrated Medicine) which will invite only members who follow our evidence based standards and protocols. This Society will be under the umbrella of the Royal NZ College of GP's. By next year, we will have the beginnings of a website with numerous resources. We will not be a training organization, as this is well done by several entities on the east coast of Australia. Our senior members will be available to consult to bodies such as Pharmac, the NZ medical Council and the ministry of health etc. The Primary care model is moving towards keeping patients well - good. The problem with 'one problem per visit' in general practice is that there is no recognition of several problems being connected, thus needing more time to get on top of them all. An example of this is a typical female patient who may have all of these problems - PMS, unable to sleep, irritable bowel syndrome and migraines. So the patient must keep attending the GP and not really get anywhere as the visit is only 10-15 minutes long. This situation needs to be examined and changed. Perhaps each practice of doctors is encouraged to have a chronic illness specialist who does take the time ...? The above would however need knowledge of Integrated medicine and funding. However, it would save all those other doctors visits that done' get anywhere, but still cost. I favour saving money on expensive drugs and applaud Pharmac. We need to save even more money by using Integrated Medicine and some natural therapies along with diet. I would like Medical schools to understand this form of scientifically based medicine so that the general principles can be embed from the earlier years of medical school. Dozens of Universities In the USA are teaching Integrated Medicine. Australia is about to add an Integrated Medicine post graduate GP pathway with its own college - don't know the name yet. Integrated medicine is an important scientifically based GP discipline that should participate in the new system. |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Yes. I agree with keeping people well and not letting them deteriorate. This means education within their own communities about healthy diet and living. |
| 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? | | Generally. I think keeping open and collaborating is important. Obviously I would like the people at the top to acknowledge the sort of medicine that my colleagues and I do, so that somehow it can be used for greater benefit and health of all New Zealanders. |
| Do these five themes provide the right focus for action? Do the sections "What great might look like in 10 years" provide enough clarity and stretch to guide us? | | Yes. People should be able to go to who they think is giving them the best care. The best care within a smart system must take account of all scientific knowledge which means my sort of medicine being part of it somehow. It would reduce drug consumption, create a healthier population and give doctors more professional satisfaction than they now have. I see patients who have seen many doctors, specialists and hospital clinics. More doctors like me would save on all these visits. |
| 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? | | Yes, as already mentioned, a very strong focus on individuals and communities taking responsibility for their own health. Too often people just want a prescription from the doctor - this must change. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Its a huge job, I can see. Its great that its being done, as we cannot keep going like this. Health seems to be a big hold that money is thrown down. It needs to be smart, evidence based and innovative. It must start with the people at the top being open to a change in concepts. One of them is that its not all drug driven. That diet, lifestyle, a look at environmental health etc, can create a new foundation for health in NZ |
| Are there any other comments you wish to make as part of your submission? | | In summary... 1. Look after environmental chemical exposure, especially in your and pregnant. 2. Diet and lifestyle 3. Use Integrated Medicine which has married Western medicine with other scientifically validated treatments - this will give the advantage. 4. Create an environment where our medical schools can start teaching some Integrated medicine concepts and allow the already established schools in Australasia to complete the training in the post graduate phase. This medicine is well suited to GP's because of their general nature. 5. Pharmac ( or another entity) could save us more by investigating/ collaborating with NZSIM to create evidence based protocols that will work. It is important to keep people well and to not allow the slide into poor health that occurs because of ignorance, modern foods and ignorant doctors. Please contact me or any of my colleagues at NZSIM. I WOULD ALSO LIKE TO COMMENT ON THE DOCTOR SHORTAGE I believe that GP's are highly trained and do not need to spend their days looking in children ears, taking smears,seeing colds, taking blood pressures and doing generally easy things in the clinic. These can easily be given to properly trained nurses so that GP's can focus more on the more complicated patients that need more help. I favour a larger role in the health team for nurses as well as Pharmacists. the bottom line in my view is that primary doctors' training and expertise is wasted in a system that doesn't delegate minor problems. I know this is now happening. We need more. Then these doctors, if interested, an learn Integrated Medicine and actually do more for their chronic illness patients. |

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| **185** | Submitter name | 4352461915 |
| Submitter organisation |  |
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| Respondent ID | | 4352461915 |
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| Position (if applicable) | |  |
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| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | Consumer |
| Release of personal details? | | I do not give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | No |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Yes, it is excellent |
| 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? | | Acknowledging the special relationship between Maori and the Crown etc should be removed. We are all New Zealanders with equal rights and responsibilities. |
| Do these five themes provide the right focus for action? Do the sections "What great might look like in 10 years" provide enough clarity and stretch to guide us? | | Yes |
| 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? | | Yes they are very good |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Strong leadership at all levels is essential. We are fortunate in New Zealand that it is relatively easy to keep in touch with activities nationwide. It is vital for those at the top be kept regularly informed. The standard reporting and monitoring system would be strengthened if Health Liaison Officers were introduced in all DHB areas whose sole task is to observe what's really going on at ground level reporting daily to the top people at the Ministry of Health This would provide a picture of the operating of the health system throughout New Zealand on a daily basis. |
| Are there any other comments you wish to make as part of your submission? | | It needs to be emphasised that New Zealand is a multi-cultural society and that all cultures are equally important. All reference to the Treaty of Waitangi should be removed from the Strategy. |

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| **186** | Submitter name | 4352461366 |
| Submitter organisation |  |
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| Respondent ID | | 4352461366 |
| Name | |  |
| Position (if applicable) | |  |
| Organisation (if applicable) | |  |
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| You are submitting this: | |  |
| Please indicate what sector(s) your submission represents. | | Government |
| Release of personal details? | | I do not give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | |  |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | I do not think the location of services (closer to home) is relevant enough to be mentioned in the mission statement. Services should be appropriately located that may be locally or further afield. If services are not local then I understand that there will be assistance to travel. |
| 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? | | I appreciate that principles are high level guidelines how-ever I am not sure that they are directive enough.. I have limited involvement in my local community however I would expect government to mandate that the public health system was required to partner with local school age delivers of education. I would expect to see District Health Boards via for instance public health professionals and GPs / Nurse practitioners in schools - does this happen? |
| 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, goodness what's that! Sounds like we have doctors and nurses on treadmills or is it about people / communities taking responsibility / ownership of there own health care. Care closer home, goodness what's that about - care in the right place I trust. Value and high performance, trust that's done well and safe One team, is that the right term -> do you mean working together. Smart system, sounds expensive, looks like it needs to be limited, will we gat a health return for the spend? |
| 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? | | .. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | .... |
| Are there any other comments you wish to make as part of your submission? | | ... |

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| **187** | Submitter name | 4352258007 |
| Submitter organisation |  |
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| Respondent ID | | 4352258007 |
| Name | |  |
| Position (if applicable) | |  |
| Organisation (if applicable) | |  |
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| Town/City | |  |
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| Email Address | |  |
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| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | Service provider |
|  | | Non-governmental organisation |
|  | | Primary health organisation |
|  | | parent |
| Release of personal details? | | I do not give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | No mention of palliative and end of life care? Think it would be good to eventually get dying back into the normal setting of hospitals/home (District Nurses & GPs) using all the fantastic expertise and skill Hospices have but no longer having dying separated and institutionalised (thereby marginalising the dying)...part of "One Team" and "Closer to Home" |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Again-nothing on dying? Can that be fitted in-Advanced Care Planning? |
| Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy? | | yes-very good. |
| Do these five themes provide the right focus for action? Do the sections "What great might look like in 10 years" provide enough clarity and stretch to guide us? | | Yes-need to add in dying as above. |
| 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? | | Yes-covered apart from Palliative and EOL. Guess the Disabled fit in but what about clarity around collaboration with Social, Medical & Education services for the Disabled. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Ongoing evaluation with consumers. I have come across this at work in a health service but have a disabled son and do know that other parents would have no idea that this is in existence-need to put it on FaceBook etc and let Support Groups know plus DPA etc etc. |
| Are there any other comments you wish to make as part of your submission? | | Nil |

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| **188** | Submitter name | [redacted] |
| Submitter organisation |  |
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| Respondent ID | | 4350090490 |
| Name | | [redacted] |
| Position (if applicable) | | [redacted] |
| Organisation (if applicable) | | [redacted] |
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| Postal Code | |  |
| Country | |  |
| Email Address | |  |
| Phone Number | |  |
| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | | District health board |
| Release of personal details? | | I do not give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | |  |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | I like it. |
| 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? | |  |
| 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? | | I like the themes. I did not find the "what great might look like" sections added enough. |
| 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? | | Too long and complex. |
| What approaches might best support ongoing updates to the Roadmap of Actions? Do you have ideas to track and/or report on progress? | | Need a simple 1-3 page document that can easily and frequently refer back to. Keep the main things in everyone's minds. Other idea is to focus on different areas at different times. Cannot focus on 20 actions (each with sub-actions) at the same time. |
| Are there any other comments you wish to make as part of your submission? | | See #6 for key points I wanted to make. This has really good potential, but we need to keep it quite simple as a framework. Different providers can then bring it to life in various ways in their own unique settings. |

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| **189** | Submitter name | Sara Morton |
| Submitter organisation |  |
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| Respondent ID | | 4341959108 |
| Name | | Sara Morton |
| Position (if applicable) | | Cancer Nurse Coordinator |
| Organisation (if applicable) | | Southern District Health Board |
| Address | | PO Box 5488, Moray Place |
| Address 2 | |  |
| Town/City | | Dunedin |
| Postal Code | |  |
| Country | |  |
| Email Address | |  |
| Phone Number | |  |
| You are submitting this: | | as an individual or individuals (not on behalf of an organisation) |
| Please indicate what sector(s) your submission represents. | |  |
| Release of personal details? | | I do give permission for my details to be released. |
| Are there any additional or different challenges or opportunities that should be part of the background for the Strategy? | | - Recognition was given to the challenges of our aging health work force on page 7 (Future Strategy) and the need to invest in training. However, no mention was made of exploring opportunities to enable staff retention in the health force past the age of 65. I would suggest many health care professionals intend to remain in the health workforce past retirement age. In the strategy we need to both recognise this in the strategy, and acknowledge that we must be proactive in enabling them to achieve it. - Also I acknowledge that the government and the Ministry have done some excellent work around cancer with its faster cancer treatment focus. I accept that there may be new areas to focus on. However, cancer is still our biggest killer and should be acknowledged more frequently within this document. For example as a long term condition it should be included in the second paragraph on page 30. The cancer programmes developed over the last few years are still being refined and as such will continue to be a work in progress for the next five years. - For telehealth to work to its full potential it requires more than a videolink between the patient and the consultant. Opportunities for further staff training need to be explored. For safe practice during a consultation a physical assessment is often required. Therefore programmes to train rural nurses to undertake these physical assessments will be essential. The nurses can then sit with the patient during the link and provide an invaluable support for the hospital based clinician. This will broaden the scope of patients able to be cared for and reduce the hours of travel and overnight stays often required currently. For example frail cancer patients on palliative treatment in Central Otago would be seen when needed, rather than when the next visiting clinic is held or after traveling for hours on the Red Cross transport to Dunedin. |
| Does the above statement capture what you want from New Zealand's health system? What would you change or suggest instead? | | Yes this captures what I want from the health system. Particularly the emphasis on working as one team in a smart system. |

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| **190** | Submitter name | [redacted] |
| Submitter organisation | National Nursing Organisation |

The NNO group is made up of New Zealand’s key nursing stakeholder organisations comprising representatives from employers, educators, and professional bodies. The Regulator and the Office of the Chief Nurse are part of this group but operate within the boundaries of their particular roles and responsibilities.

**NNO position**

The NNO group believes further investment in school nursing services would have a positive impact on the health and wellbeing of secondary school students in New Zealand. The Ministry of Health and the Ministry of Education need to work together towards a policy of having on-site nurses in all schools funded by health.

**Rationale**

Poor youth health statistics showing young people’s needs were not being met by existing primary care services lead to the development of nursing services in schools. In a few schools nursing services are funded by education out of operational grants. Some of these nurses are employed as support workers with pay and conditions commensurate with that status and without professional leadership, supervision and development. In most schools nursing services are funded by health. From 2008 health funding has been provided for school nurses in decile 1 and 2 secondary schools, teen parent units and alternative education facilities. From 2013 this was extended to decile 3 schools, under the Prime Minister’s youth mental health initiative but does not include young people in decile 4-10 schools who also have unmet health needs.

The most common model of health service provision in schools is a visiting public health nurse. Other schools have an on-site nurse and some have a multidisciplinary team on site for most of the week. Some secondary schools have no health services beyond the minimum requirement of first aid provision.

New Zealand research suggests high quality school health services, with sufficient registered nurses on-site, trained in youth health, with adequate time to work with students and perform routine health assessments, impact positively on student health outcomes such as depression, suicide risk, sexual health, alcohol misuse and school engagement. These services also lessen the use of hospital Accident and Emergency departments by students.

Schools with higher levels of health service (an on-site school nurse or multidisciplinary health team) are more likely to have more facilities, to be better integrated with the school, the community and local Primary Health Organisations, and to provide routine comprehensive health services.

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| **191** | Submitter name | [redacted] |
| Submitter organisation |  |

Kia ora koutou

Tahatū Rangi: Reimagining the Mental Health and Addiction Landscape Symposium targeted non-government organisations to focus on future 'Change and Action - what to leave behind, to take with you, do differently, build on and start doing'' as a follow up to 'On Track' report. Some key outcomes noted from the two day symposium;

* Commitment to continuous transformative actions, working in a consistent direction to achieve collective impact in addressing the wide range of challenges facing the Mental Health and Addiction system
* Implementation of individual actions towards effecting organisational and system level changes
* Strengthening connectedness throughout and beyond the NGO sector
* Continued commitment and courage to think, act and do things differently for the collective good

Key messages identified in the feedback session on day 2 regarding the New Zealand Health Strategy (NZHS) included:

* One Team: The New Zealand Productivity Commissions recommendations on commissioning are fully implemented
* Value and High Performance: Strong emphasis on Equity focus needed
* Close to Home: Housing issues are significant (Housing is an anchor service - You can't live well if you don't have a home)
* Co-design is made a core skill for any one who works in health
* Ministry to show stronger stewardship/leadership as described in the New Zealand Productivity Commissions and be clear on what is led from central and from locality
* The attached document is all feedback on the NZHS received at the symposium.

New Zealand Health Strategy Feedback

Tahatū Rangi: Reimagining the Mental Health and Addiction Landscape Symposium 1 & 2 December 2015

The following information was provided on day 2 at the above symposium through hosting an open space opportunity to attendees for their feedback (comments, views, statements) on the NZHS.

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| Close to Home | Value & High Performance | One Team | Smart Systems | People Powered |
| Housing is an anchor service | |  | | --- | | Despite best intentions for PHO’s to move/shift/innovate – The Funding Model still stifles change and has done since the last NZHS – what will change? |   More focus on equity, currently not very visible change the title of this to “Value, High Performance and Equity focus” | Using system Stewardship and enabling environment as described in the productivity report | Conditions of success | How can you live well if don’t have a home to live in? |
| All New Zealanders are well housed | Co-production and co-commissioning  (collaboration and capability) | Ensure there are skilled and talented commissioners | Consider funding power constructs that continue to separate Primary (GP) mental health care provision across the continuum. Shifting funding does not equal capability and capacity – A new model is needed. | Get well  Stay well  Live well  Get well is visible in the strategy but there is less about the ‘stay well and live well’ statement. In addition, these 2 latter statements are too hospital centric |
| GP funding – Impact of co-payments on accessing GP services | Need a shared understanding and definition of what *‘Value’* means e.g from a Ministry lens and an NGO lens | The Productivity commission’s recommendations on commissioning are fully implemented | Courageous behaviour across the roadmap |  |
| Mental illness as a Long term condition should be targeted not generalised | Central contracting;  (Tight loose Tight)  Ministry to NGO  DHB to NGO | Co-design is a core skill and expectation of anyone who works in health |  |  |
| You cannot live well if you do not have a home to live in? i.e get well, live well, stay well | Should have explicit mention of the rates of premature mortality for people with mental health illness and addiction | Identify discrete complementary skill sets that work to strengths |  |  |
| Get well message is ok, but the live well and stay well seems too hospital centred |  | Recognition of multi-morbidities, eg schizophrenia, diabetes, heart disease, depression etc and how the treatment of one, affects the other |  |  |

|  |  |  |
| --- | --- | --- |
| **192** | Submitter name | [redacted] |
| Submitter organisation | Federation of Women’s Health Councils |

Co-convenors

[redacted]

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4th December 2015

New Zealand Health Strategy Consultation

Email: nzhs\_strategy@moh.govt.nz

**Submission – Draft New Zealand Health Strategy**

# Organisation background*:*

# *The Federation of Women’s Health Councils Aotearoa – New Zealand (FWHC) is a national umbrella organisation of women’s health councils, women’s health groups, and individual women throughout New Zealand. The Federation has a commitment to providing a powerful voice for women consumers of health and disability services, and to act as a public good advocate in matters that affect their well-being interests and those of their family/whanau.*

**Preliminary general remarks**

Revisiting the 2000 NZ Health Strategy (NZHS) is not only a required obligation under the New Zealand Public Health and Disability Act 2000, we agree it is useful to review whether we had the right priorities and to challenge us about what we will need to do differently to achieve significant health gains in particular areas. Most of the action areas remain priority concerns today.

Indeed, FWHC is dismayed to note that many of the targeted goals of the previous NZHS have shown little improvement and some areas have become significantly worse. While we agree that more elective surgery overall is being provided, for example, we also note, anecdotally, that many more people are being referred back to their GPs because their respective DHB doesn’t have the capacity to see or treat them within the Government’s four month waiting time target. We also note that we continue to have postcode provision of elective services with variable thresholds for patients to go on their DHB waiting list which exacerbates inequitable access to services for a nationally funded public health system.

Of course we are pleased to note the progress made across the population in reduction of tobacco smoking and related harms and observe that regulatory controls and incremental increases in the tax on tobacco have played a significant role in this trend. We submit that the government-endorsed nation-wide goal of Smokefree 2025 should explicitly be part of the background for the New Zealand Health Strategy, given that (a) smoking is still one of the most significant modifiable causes of disease and premature death, particularly among Maori and Pacific population groups; and (b) the current programme for achieving Smokefree 2025 will need sustained political and health system support if it is to be realised. The need for a strategic response to the health challenges from smoking should be made explicit in the section on ‘challenges’ in the “Future Directions” document (p.6), and in the next section, on ‘opportunities’ (p.7).

We would also support much stronger interventions, including regulatory changes, to lead other much needed health gains in the arena of reducing obesity and diabetes issues.

FWHC also has concerns about the current dominant focus on collection, storage and re-use of health data. While this undoubtedly is leading to many gains for people, patients and clinicians, if not carefully prioritised and managed, it has the potential to become an all-consuming activity on its own, diverting significant resources from investment in health care services. We need to be very confident that any investment in IT and any increase in the sharing of health information will indeed make a positive difference to people’s health and wellbeing and patient care.

FWHC continues to support evidence-based decision making of clinical decisions, but when the evidence no longer supports particular directions, whether it relates to pharmaceutical regimes or screening programmes, for instance, we need to be much bolder about disinvestment. It is patient outcomes that matter most, not political support.

We also wish to express our deepening cynicism about the common misuse of particular terms such as ‘patient centred services and care’. The present ‘industrialisation’ of care/care options for the elderly, for example, in many cases isn’t person-centred, and often fails to provide care and/or services that matter most to the person.

Finally, in relation to the continued need for ongoing review of policy directions FWHC has concerns about the propensity for the MoH to undertake targeted consultations as opposed to wide consultations where consultation documents are published/widely available via the website. The latter process needs to happen more often, given some of the very significant actions being proposed in this new Strategy.

Specific remarks on the two documents that comprise the update of the NZHS follow.

1. **Future Direction**

**Challenges and opportunities**

Challenges

* Older people living longer being more vulnerable to disability and having more than one long term condition – there needs to be more emphasis on reducing polypharmacy and a refocusing of home-based support services so that assessed needs are met by [a mix of] service provision that ‘matters most’ to the person.
* Obesity – our rates have increased significantly since 2000, to the point where NZ, when compared with other OECD countries, has the 3rd highest obesity rate among adults and the 4th highest rate for overweight and obese children. Our approach to tackling this burgeoning problem to date has been timid, especially when compared with the approach taken to smoking.
* Maori and Pacific peoples – while some progress has been made, disparities still exist. The workforce in mainstream health services must be culturally competent and mainstream services culturally responsive.

Other concerns that need more emphasis and actions within the Strategy and Roadmap

* People with disabilities – they continue to be marginalised and more effort is needed to provide disability supports that will enable more independent living and participation in society, including more employment opportunities. This involves better cross-sectoral collaboration. People with disabilities may also struggle to have their health needs met.
* People with mental illness - as a country we still seem to have made minimal progress with the provision of mental health services, especially for those with serious mental illness [who may have co-morbidities]. While most people don’t want to go back to the days of institutional care, community care must be strengthened. There is concern about NZ’s suicide rate, lack of mental health workforce, the over-use of drugs when other therapies may be more effective, poor communication with service users and families, lack of social housing and the level of homelessness, percentage of the prison population with identified mental illness. As a women’s health organisation we have shared the Perinatal and Maternal Mortality Review Committee’s repeated concerns about maternal mental health. While we note some progress has been made on developing services there is more to do.
* Impacts of poverty, low incomes, homelessness and the widening gap in unmet needs – no further explanation required
* Entrenched drinking culture – needs no further elaboration
* Use of other drugs – as above
* Family violence - as above
* Oral health, particularly adult oral health – while progress has been made on child and adolescent oral health, there has been no meaningful attention paid to addressing the glaringly obvious unmet oral health needs in our adult population.
* Establishing a robust regulatory framework for medical devices – this has been an area of shameful neglect of adequate risk protection for NZ patients for far too long
* Involving and valuing consumer and community voices at every level of the health sector – Over time we have observed opportunities for meaningful consumer involvement by way of engagement and consultation diminish.

While DHBs heralded ‘Community’ voice’ on their governance boards and a requirement to consult with their communities when developing their District Strategic Plans (DSP), the requirement for DSPs and the related consultation opportunity was removed when the NZ Public Health and Disability Act was amended in 2010. Subsequent health planning regulations saw the need for consultation determined by the Minister.

Following the Ministerial Review Group Report (2009) many, but not all, of the Ministry’s advisory committees were disestablished and opportunities for consumer input were diminished. This has been exacerbated by the Ministry’s propensity to conduct ‘targeted’ consultations whereby consultation documents are not published on the website, with selected organisations and individuals ‘targeted’ to attend meetings and/or submit written comment.

Appointments to the layperson positions on the governing bodies of the respective health practitioner Responsible Authorities have tended to be people with professional qualifications but no specific expertise in providing consumer perspectives.

No consumer has been appointed to the Board of HQSC. While HQSC has stepped up its programme of work around consumer involvement, for the most part it seems to be focused on service co-design with priority on DHBs to strengthen their processes for consumer engagement as well as involving consumers in service co-design (Partners in Care). While this is hugely important it is not the only part of the health sector where consumers need to be involved.

Notably the National Health IT Board has a consumer attending its Board meetings, albeit in an ex-officio capacity; and it has established a Consumer Panel to provide advice but the Panel has limited capacity and limited visibility in the public arena.

In the last 2-3 years a number of DHBs, either separately or regionally, have appointed Consumer Councils, involved consumers in clinical networks and the development of clinical pathways, shared electronic health records etc. With regard to the latter, Canterbury DHB positively stands out.

The Regional Cancer Networks have been sufficiently resourced to have cancer consumer advisory committees.

Opportunities

* Tapping into the skills of individuals, families, communities i.e. involving and valuing consumer and community voices at every level of the health sector

This will be critical if we are serious about:

* people-centred services and being more responsive to meeting the needs of Maori and Pacific peoples, people with disabilities, people with serious mental illness etc;
* more integrated care closer to home that requires health practitioners to be working at the top of their respective scope of practice or upskilled to practice competently and safely in an expanded scope of practice;
* optimising consumer input at every level of the health sector i.e. governance, strategy, policy, planning, service design, monitoring and evaluation
* progressing to more cross-sectoral collaboration and the proposed investment and commissioning approaches. There are many issues to be considered not only in service design and provision, but in collecting, storing and sharing information.
* Tapping into the skills and resources of businesses – yes, there are likely to be opportunities but we caution against conflicts of interest, particularly the grocery industry, alcohol industry, pharmaceutical companies.

**The future we want**

The Statement (pg 8)

This does not encompass ‘dying well’. Death is inevitable and it is important we get end of life care right i.e. recognise when someone has reached the end of life stage; don’t continue to offer/provide treatment that will have no therapeutic benefit/is futile; enable the person to access quality end of life care/palliative care that ensures that what matters most to them is prioritised and put in place.

Principles, culture and values (pg 9)

The seven principles from the 2000 Strategy are sound and have stood the test of time.

Proposed new principle 8 – Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing. While this is reflected in the narrative of the 2000 Strategy, establishing it as a specific principle strengthens the approach for more collaboration within the health sector and cross-sectorally.

Although we acknowledge the impact social determinants have on health and wellbeing, we are concerned that cross-sectoral, multi-agency initiatives may take a top down approach rather than a bottom up/community development/collective impact approach, where consumers/communities are involved in a meaningful way from the outset, and continue to be involved in the monitoring, evaluation and reporting of outcomes.

As previously noted these initiatives will rely on increased collection and sharing of data. FWHC has taken an interest in the Children’s Action Plan, Children’s Teams, the establishment of the ViKI database and the Approved Information Sharing Agreement (AISA) that permits information from the participating government agencies to be shared without consent. There has been limited consultation on the information sharing; limited information available on the information that will be collected either with or without consent; information governance processes and/or specific business rules for the operation of the ViKI database don’t appear to have been developed yet.

If the public is to have confidence in these integrated social responses there must be greater transparency around all aspects, including the collection, storage and use of data.

**Five strategic themes**

People-powered

We support this theme in principle but make the following points:

* Improving health literacy is important, especially with enabling people to better manage their own health, however ready access to health advice via a Patient Portal does not replace the conversations/explanations/exchange of information that should take place between patient and clinician during a consultation.
* People-powered is not determined by counting interventions that are ‘done to people’ and are easy to count such as immunisation, cardiovascular risk assessments, participation in screening etc.
* While better use of data is an important component to better understanding people and populations, and knowing what works and why, it would be most unwise to rely solely on the data. Data do not tell the full story. Qualitative analysis and narrative, and possibly patient stories, are just as important in ‘telling the story’.
* While people may have the evidence around healthy choices, some do not have the financial means to afford them.

Closer to home

We support this in principle but make the following points:

* The section on “Long-term conditions, including obesity” (p16) should be extended to include “and smoking” in the title, and reference to smoking cessation interventions and prevention strategies in the subsequent text.
* While new skills and technologies are allowing us to shift some services closer to home, the public needs to be confident that the relevant health practitioners are appropriately upskilled to provide these services competently and safely. Are the Responsible Authorities ensuring the requisite training is in place and that practitioners are competent to practice at the completion of said training?
* Well-designed and integrated clinical pathways must still allow for clinical override in the event of unusual and/or complex presentations that don’t fit neatly into a ‘box’. Care must not become a ‘tick box’ exercise.
* Not all people living in remote rural areas have access to, or can afford, reliable ultra-fast broadband so telehealth may not be a straight forward option for them to access.
* Funding models are likely to have to change to accommodate new roles in the health sector.
* Funding models will have to change across Government agencies to facilitate cross-government initiatives.
* We need to start seeing some progress reports from the Children’s Teams already in place. Even if it’s too early to report outcomes, we need to get some insights into the wrap around services that are being put in place, what is working well, what needs to improve, and what obstacles are being encountered. We need to hear about their use of information/data.
* It would also be useful to hear more about the work of Maori and Pacific organisations, their models of care, and the differences they are making. The trial in Porirua is showing some promising outcomes.
* We need to be sure there is a balance between the zeal for investment in data and the better use of that data, and the investment in services. It would be counter-productive and extremely worrying if data are amassed as a default surveillance tool, because services are starved of the necessary investment to increase their capacity and capability to meet needs.

Value and high performance

We support this theme in principle but make the following points:

* We agree the approach to results needs to take account of the full range of factors as outlined. Are we correct in assuming ‘financial factors’ refer to low income and/or poverty?
* Any model of integrated care must describe the role and purpose of all the players involved at an operational level including access to personal health information being defined, based on their respective roles.
* A robust regulatory framework needs to be established for medical devices. Meantime, Medsafe needs to be more responsive and take meaningful action when harm caused by devices is identified e.g. surgical mesh.
* We need to be confident that all results from research undertaken in NZ are reported.
* If value for money is an imperative, then we need to disinvest in services/interventions where evidence demonstrates there is no benefit or harms outweigh the benefits.

One team

We support this theme in principle but make the following points:

* Note earlier comments under ‘Closer to home’ regarding adequate upskilling of health professionals expanding their scopes of practice.
* We note there have been legislative barriers to change in the past. While change has to be made with care, the delay in making the legislative change and subsequent processes to allow nurse prescribing was drawn out and unnecessary.
* The structure within the Ministry of Health must be a lot easier to understand than what it has been.
* The ‘culture of enquiry’ must be open to and accepting of enquiry from all stakeholders, including consumers and the public.

Smart system

Undoubtedly technology can be a game changer, and undoubtedly it brings about efficiencies, but it is not the be all and end all of health care. The relationship between clinician and patient, [or health care team and patient] established through face to face consultations, remains, and is likely to remain, hugely important.

* As already noted, data alone, are not the full story.
* With the increase in data collection and data sharing that is proposed within the health system and cross-sectorally, privacy and security are all important as is ongoing and robust information governance. We don’t have sufficient visibility of that yet.
* In 10 years time it is anticipated that when people first attend a health service, the provider already knows their details. We ask: Is it that simple? Does this mean the provider will have had access to demographic details? Demographic details and a summary of key health information? The entire health record?
* We note the IT initiatives announced recently as part of the Health Strategy are:
* a single national electronic health record for all New Zealanders;
* a digital hospital blueprint;
* a preventative health IT platform; and
* a health and wellness dataset to support health and social investments.

Consumers need to have meaningful input into all these initiatives as they are developed.

We a note that younger clinicians and consumers are invited to the first discovery workshop to bring fresh perspectives to the table. We hope the fresh perspective doesn’t include the assumption that young people don’t care about the privacy and security of their data.

What ‘great’ might look like in 10 years across the five strategic themes

There is insufficient clarity in these sections to judge whether they are good guides or not. There are a lot of unknowns around ‘investment approaches’ and ‘commissioning’. Much will depend the suite of measures and outcome reporting that are developed overall.

Other comments relating to pg 1

**Affordability of primary care** – progress is noted but it is still an issue for many on low incomes.

**Electives volumes and waiting times** -undoubtedly there have been increased volumes of elective surgery since the waiting times target was introduced, and the waiting time target has reduced from 6 to 4 months. However, in moving the waiting times for FSAs and elective surgery to 4 months, and with DHBs keen to avoid financial penalties if they don’t meet the target, anecdotal evidence suggests an outcome is that more people are being declined FSAs and surgery, and returned to their GP. If this is confirmed, it cannot be ignored.

As already noted no progress has been made on ‘national equity of access to elective services and patients have similar access regardless of where they live’.

**II. Roadmap of Actions**

1. **People-powered**

Action 1 Inform and involve people

1. This appears to be about the way existing health promotion and health education information is delivered with no review of content.
2. Use of social media is well and good, but we have no insight as to what the information on early stage diabetes covers/will cover. What is it intended to achieve? What about prevention of diabetes?
3. No comment
4. Is someone in the person’s health team designated as the coordinator? This would seem to be an important step.

Note the Maternity Portal has no visibility

Expanding the number of DHBs implementing the Maternity Clinical Information System from 5 to 10 in the next 5 years seems like glacial progress and is a far cry from what was anticipated.

Action 2 Know and design

1. Support clinician-led collaborations to work in partnership with high need priority populations on key health issues

**2.Closer to home**

Shift services

Action 3 -support

Action 4 – support, but noting our thoughts on training and upskilling for changing roles

Tackle long-term conditions and obesity

Action 5

**Comment:** this action seems very conservative given the concerns expressed about long term conditions and obesity. Adult oral health has links with diabetes and mental illness.

FWHC has some reservations around g). We aren’t certain what it is that is being proposed and assume it is targeted for an investment approach.

A great start for children, families, whanau

Action 6

**Comment**: While we may support the general intent of the actions, we remain extremely cautious around social investment and lifecourse approaches. These need to be developed from the bottom up with involvement from consumers and communities.

We understand the focus on children at risk, but we must not forget the special place of the pregnant woman/mother. She is not a commodity and her needs are as important as those of the healthy fetus/baby/child.

We also note poor oral health is a concern in pregnancy.

When discussing early childhood [education] services, the focus needs to be on quality services. The evidence suggests poor quality services add no benefit.

We are pleased to see fetal alcohol spectrum disorders included in the list of actions but where’s the action within a wider public health context around availability and use of alcohol, warning labels for pregnant mothers on bottles of alcohol, marketing and advertising of alcohol especially during TV coverage of sports fixtures when children are watching?

**Include** “and smoking” in the title, and reference to smoking cessation interventions and prevention strategies in the subsequent text. Key interventions worth noting include standardised plain packaging, further tax increases on tobacco, targeted media campaigns, a licensing system for retailers, legislation to ban smoking in cars with child passengers, and the extension of the current ABC intervention in hospitals and primary care to include key government agencies and NGOs in the wider health and social services sector.

**3. Value and high performance**

Improve performance and outcomes

Actions 8 and 9

**Comment**: both need consumer involvement. The Integrated Performance and Incentive Framework should look somewhat different from previous frameworks if it is to be more focused on outcomes.

Align funding

Action 10

**Comment:** we need more understanding of ‘commissioning’ and its implications.

We agree that IT project funding needs to be prioritised so that investment is made in those projects that will deliver the most benefit. We have noted that many IT projects cost more than was budgeted, are complex, and don’t necessarily deliver the anticipated benefits.

Target investments

Action 11

**Comment:** We don’t have enough information to really understand how this approach is likely to work and how it will be funded. More information needs to be made publicly available about this approach as per a).

Improve quality and safety

Action 12 – support

**Comment**: noting that Medsafe should be involved if treatment injury is related to problems with medicine safety or safety of medical devices.

**4. One team**

Actions 13 – 17

**Comment:** generally supportive. Governance must include information governance

**5. Smart system**

Please clarify on pg 45, ‘social services information’ within this context ... have online access to their health and social services information’.

Strengthen analytical capability

Action 18

**Comment**: while it is stated that ‘privacy is assured’ we are concerned about the risks of re-identification of individuals when multiple datasets of de-identified data are analysed. We are also concerned that some de-identification mechanisms may not be as robust as is claimed, given advances in technology.

The Ministry of Health and other Government agencies would be unwise to take a cavalier attitude towards this. A significant breach of privacy would be very damaging to public confidence and trust in this major push to share more data.

The public must be informed about what information sharing is being proposed and have an opportunity to have a say.

Use electronic records and patient portals

Action 19

**Comment:** we expect more engagement with the public, in addition to the group of young service users and clinicians already involved, on the design of the national electronic health record.

We need clarification on the status of the implementation of the Maternity Portal/Women’s Maternity View.

Strengthen impact of health research and technology

Action 20

**Comment:** while this action suggests it seeks to improve engagement with people who access health services, promote healthy behaviours and self-management, and aid people-led design it’s difficult to see these in a,b, and c.

However, it is good to see the regulation of medical devices in this action.

Gaps?

The Strategy and Roadmap need to include an explicit focus on health promotion activities to ensure these aren’t lost in their entirety or diminished within the busy-ness of relevant actions within the Roadmap.

Where do elective services and related Government targets fit within the Strategy? They don’t seem to have any real visibility in the draft. What about the Faster Cancer Treatment programme of work and related targets?

What will continue as Business as Usual in the meantime?

ENDS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **193** | Submitter name | Dr Beverley Burrell | | |
| Submitter organisation | Centre for Postgraduate Nursing Studies, Uni of Otago | | |
| This submission was completed by: *(name)* | | | Dr Beverley Burrell |
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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)*:

√ Academic/research

## Consultation questions

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

### Challenges and opportunities

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

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

|  |
| --- |
| The contribution of NGOs, PHOs, not for profit organisations, and businesses that deliver health services funded by the MOH needs to be supported by organisational quality improvement, leadership development, including education of staff to fit the new environment of collaboration, co-operation and consumer partnerships. The 7th guiding principle cannot be fulfilled without enhancement across all sectors. |

### The future we want

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

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

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

|  |
| --- |
| It is adequate.  The emphasis on achieving a ‘people powered’ service is an important cornerstone.  Regarding health professionals, efforts to foster inter-professional and collaborative ways of working is vital. |

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

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

|  |
| --- |
| Yes, they build upon the direction commenced in 2000 with the initial Health Strategy and the policies that have ensued. The principles guide and facilitate progress towards more equitable outcomes/services, population and community involvement, the drive for high quality/effective services and a system utilising the capabilities of diverse professionals in a co-operative mode, and optimising technological advances. |

### Five strategic themes

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

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

|  |
| --- |
| Yes |

### Roadmap of Actions

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

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

|  |
| --- |
| We believe an overt commitment to research and evaluation of effectiveness of strategies is needed. And acknowledgment that a high performing system is dependent on research to demonstrate improvements.  University of Otago has three initiatives to build inter-professional co-operation in practice, particularly in rural areas, such models if replicated would enhance understanding and co-operation between professional groups. |

### 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?

|  |
| --- |
| Significant initiatives have evolved and changes are showing success, facilitated discussion/decision making forums to get effective cross-sector communication and referrals, alliance approaches, and planned strategic change processes for introducing innovations. Leadership development is most important aspect for embedding change and supporting adoption of innovation in the long term.  At a practical level increased utilisation of Nurse Practitioners would enhance accessibility in communities. Optimising the capacity of our health professional workforce is vital. |

### Any other matters

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

|  |
| --- |
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|  |  |  |
| --- | --- | --- |
| **194** | Submitter name | Brad Olsen |
| Submitter organisation | National Youth Advisory Group |

You do not have to answer all the questions or provide personal information if you do not want to.

|  |  |
| --- | --- |
| This submission was completed by: *(name)* | Brad Olsen |
| Address: *(street/box number)* | [redacted] |
| *(town/city)* | [redacted] |
| Email: | [redacted] |
| Organisation (if applicable): | National Youth Advisory Group |
| Position (if applicable): | N/A |

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

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

on behalf of a group or organisation(s)

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

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

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)*: Young people (12-24)

### 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?

|  |
| --- |
| A small focus group of young people from the National Youth Advisory Group responded to a survey in October 2015 to inform this submission. This submission is based off these responses.  Mental health, especially amongst young people, should be included as a significant challenge as part of the background of this strategy, due to its importance to young people and the increase this year to the highest since records began[[1]](#footnote-1).  Additionally, accessibility to healthcare should be further highlighted, as there is often a disconnect between available health services and those that require them. Young people, even more mobile than the general population, often find it hard to both physically access healthcare and find the means to financially access this. |

### 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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| Young people rated the need for ‘services closer to home’ highly, but felt that it be recognised that these must be ‘closer to home’ but also open and welcoming, not judgemental and presumptive as is often the case. Healthcare and advice should be fostered in a non-judgemental way without prejudiced views — especially in areas such as mental and sexual health. Young people often feel stigmatised and belittled for what they are seeking advice and treatment on, leading to less young people willing to access healthcare for fear of judgement.  Further, ‘value and high performance’ must be geared to increasing confidence in the health system for young people to start and then remain engaged in healthcare — where superior outcomes are championed for young people. This ties into the need for ‘people powered’ healthcare, recognising that young people need tailored healthcare that seeks to help them in a specialised way without compromising on quality. Healthcare should be constructed with youth in mind, and specific youth healthcare strategies should be constructed only after meaningful consultation with young people to ensure their views are heard. |

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 principles work well towards improving healthcare for New Zealanders. Of particular importance is Principle 2 around the improvement of status for those currently disadvantaged. This in part includes young people, as there are a number of young people who cannot access adequate healthcare or are unwilling to do so because of previously mentioned issues around judgement, location and cost. Looking to ensure all New Zealanders are on an equal health footing is commended.  Principle 5 is also important as timely access to healthcare is crucial to ensuring young people can retain their health without the need for prolonged interactions with professionals – moreover, the second part of this Principle is of great importance in that it recognises the inability for some to fund healthcare, including young people, and this Principle establishes that this should not be a barrier to care.  As previously mentioned, confidence in the system and youth-tailored solutions through working with youth inside communities are also important to overall wellbeing, and are recognised in Principles 6 and 7. |

### Five strategic themes

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

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

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| These themes target healthcare that can be easily utilised by individuals in a timely manner with a focus on ensuing that the outcomes not only benefit people, but are constructed with the end-user in mind.  In particular, the emphasis in Principle 2 “Closer to home’ around targeted initiatives and integrated services are important, as it will allow young people to access healthcare that meets their needs, at a location that works for them, and at a broader level of caring to ensure that different areas of their wellbeing can be looked after in a swifter process.  Looking at broadening integrated services is a key step in addressing youth health concerns, as young people will begin to be able to access various services (medical doctor, social worker, psychiatrist etc) all under one umbrella rather than as distinct and disjointed services. |

### Roadmap of Actions

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

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

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| Action 2: Clinician-led collaborations can have major impacts on youth health and provide ways for comprehensive support to be given to young people – examples of this include a number of youth health ‘drop-ins’ that have proved effective in engaging young people such as Hawkes Bay’s Directions Youth Health Centre[[2]](#footnote-2), Whangarei’s Octane Youth Health[[3]](#footnote-3), Taupo’s Anamata CAFE[[4]](#footnote-4) and Rotorua’s Rotovegas Youth Health Centre[[5]](#footnote-5). We strongly encourage that these projects are championed, retained and further development/expansion is encouraged.  Action 4: Training also needs to be included for health sector workers to ensure no judgment and stigma is attached to prescribing drugs, especially to young people (notable examples include anecdotes of young women feeling uncomfortable accessing the emergency contraceptive pill and other contraception because of fear of judgment).  Action 5: It is encouraging to see Mental Health be recognised here, and agree that this should be addressed in various ways (as laid out in this Action paragraph) from prevention to intervention to rehabilitation. It is also encouraging to see obesity in youth being addressed here.  Action 6: The actions mentioned here are incredibly encouraging but more emphasis is needed on youth mental health here, in its own right, in recognition of not only its impact on youth but also its ability to be addressed by this Strategy.  Action 1o: Young people often identify cost as being a barrier to accessing healthcare[[6]](#footnote-6) and we encourage young people to be taken into account for low cost access under Section ‘A’.  Action 15: The National Youth Advisory Group strongly recommends that the Ministry of Health included young people in health advisory structures, as they will ensure proposals will provide the intended outcomes for young people. Youth participation has been previously utilised on targeted messaging around rheumatic fever projects[[7]](#footnote-7).  Action 19: This also provides the ability for young people to access their own healthcare records and take further responsibility for their healthcare. However, young people find the confidentiality of their health data to be of the utmost importance and so any accessible database would need high levels of security. |

### 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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| Further to the discussion on Action 10 (above) heavily subsidised or free healthcare for young people has been recommended to remove the previously mentioned barriers for young people to access healthcare. Similarly this should extend to subsidised and accessible follow-up treatment for youth health issues, otherwise young people will not follow through with healthcare plans and lead to further issues if the original issue is not resolved.  Again, greater training, awareness and emphasis should be put into youth Mental Health, both for treatment and prevention of this aspect of health that has enormous impacts on young people across New Zealand, in an attempt to reduce the rates of young people requiring assistance with these issues and in turn reduce the flow on effects this has on young people. |

### Any other matters

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

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| --- |
| N/A |

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| --- | --- | --- |
| **195** | Submitter name | Teresa Chalecki |
| Submitter organisation | Smokefree Canterbury |



Smokefree Canterbury submission in response to the Update of the New Zealand Health Strategy Consultation draft

All New Zealanders live well,   
stay well, get well

Submission on behalf of: Smokefree Canterbury

Contact name: Teresa Chalecki

Role: Chair, Smokefree Canterbury

Contact Details: Teresa Chalecki RN

Nurse Manager

Canbreathe

Unit 1, 6 Raycroft Street

P O Box 13 091

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| --- | --- |
| This submission was completed by: *(name)* | Amanda Dodd |
| Address: *(street/box number)* | Cancer Society of New Zealand |
| *(town/city)* |  |
| Email: | amanda.dodd@cancercwc.org.nz |
| Organisation (if applicable): | Smokefree Canterbury |
| Position (if applicable): | Executive group member |

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)*: A regional Smokefree coalition consisting of a diverse range of organisations supporting tobacco control work across Canterbury.

Smokefree Canterbury is a network of agencies committed to reduce the impact and harm that tobacco has on our communities. Smokefree Canterbury has been in existence for over twenty years and represents many key organisations and individuals who support Smokefree initiatives throughout Canterbury.

Smokefree Canterbury is a strong advocate for the Government’s goal to achieve a Smokefree New Zealand by 2025 and works with partner agencies across New Zealand to support a coordinated approach to Smokefree advocacy as outlined in the national Smokefree 2025 Roadmap.   
Smokefree Canterbury welcomes the opportunity to contribute to the *Update of the New Zealand Health Strategy Consultation Draft* (Draft strategy

### Challenges and opportunities

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

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

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| Smokefree Canterbury strongly believes that the opportunities section should clearly reference the government goal of a Smokefree Aotearoa by 2025. The goal has been accepted as a Government goal and as such should be included as a key opportunity to reduce tobacco related harm and disease across our communities.  The challenges presented within the consultation document inform us that “*Some of New Zealand’s population groups receive unequal benefits from the health and disability system. This can be seen in life expectancy statistics; while New Zealanders overall are living longer, Māori and Pacific peoples still have a lower life expectancy*”. In terms of Tobacco, this inequity for *Māori and Pacific communities* could be addressed with continued and sustained support for targeted smoking cessation work.  The ‘Inquiry into the Determinants of Wellbeing for Tamariki Māori’ Recommendation 18, highlights the need for increasing support for the promotion of Smokefree environments as the norm for healthy growing children.[[8]](#footnote-8) This indeed should be the norm for all children aiming for a future where New Zealand children and young people are a tobacco free generation.  Given that tobacco control programmes are widely regarded as pro equity and the **Smokefree 2025** goal has been commended as a strategy for ‘ill-health prevention that addresses risk factors contributing to health inequities’,[[9]](#footnote-9) the lack of reference to tobacco control measures is inconsistent with a pro equity health strategy. A recent NZ modelling study concluded that a suite of tobacco control measures is necessary to continue to reduce smoking in N.Z. Whilst ‘*ongoing tobacco tax increases deliver sizeable health gains and health sector cost savings and are likely to reduce health inequalities*’…the authors warned that *‘ if policy makers are to achieve more rapid reductions in the NCD burden and health inequalities, they will also need to complement tobacco tax increases with additional tobacco control interventions focused on cessation’* [[10]](#footnote-10).It is for these reasons that Smokefree Canterbury would urge the inclusion of the Smokefree 2025 goal as a key opportunity for the NZ Health Strategy. |

### The future we want

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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| Whilst the language used is commendable the terms themselves could be widely open to interpretation. The aspirational statement needs to sit within an action based framework identifying clear health outcomes with prevention at its heart.  We acknowledge clear reference to the determinants of health, but would support the practical application of these within action plan areas. |

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

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

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| The principles outlined are aspirational and require clear outcomes to identify meaningful change that can be achieved and sustained.   * The best **health and wellbeing** possible for all New Zealanders **throughout their lives.** Response:This principle needs to include a commitment to person centred planning and the promotion of health literacy with individuals, families, communities and professional networks. * Thinking beyond narrow definitions of health and **collaborating with others** to achieve wellbeing. Response: Would be good to set out a multi-agency commitment here recognising the importance of the NGO sector, professional networks and forums (especially Smokefree Coalitions operating throughout New Zealand) and Territorial Local Authorities as key service providers seeking to gain community health outcomes (alignment with health and wellbeing). In this way the strategy could have a Health in All Policies HiAP) commitment at its core. * Active **partnership** with **people and communities** at all levels. Response:There should be a commitment to appropriate forms of capacity building opportunities to encourage participation in decision making. * A **high-performing system** in which people have **confidence.** Response:   Incorporate user feedback to assess service performance and user satisfaction. |

### 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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| Tobacco use is the leading cause of preventable death in New Zealand, accounting for around 4300 to 4600 deaths per year.[[11]](#footnote-11) As a result, the overarching principle of all New Zealanders to live well, stay well and get well should include specific objectives to reduce tobacco related harm for individuals, families and communities.  In addition where the document highlights The NZ Health Strategy in its government context (1. Future Direction P4 fig 1.3) clear reference should be made to the Smokefree 2025 goal and the Smokefree 2025 Roadmap [[12]](#footnote-12)  As **Ill-health prevention** is one of the Ten next most important actions to reduce health inequities in Aotearoa New Zealand [[13]](#footnote-13) we would suggest an additional prevention focussed theme is included in the strategy. |

### Roadmap of Actions

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

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

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| |  |  | | --- | --- | | Action 6 | The Ministry of Health will continue to **collaborate across government agencies, using social investment and lifecourse approaches**, to improve and make more  equitable the health and social outcomes for all children, families and  whānau, particularly those at risk. |   Response: Vulnerability of children to ill health due to tobacco harm is not reflected here i.e. exposure to Second Hand Smoke (SHS), smoking in cars, those living in homes where at least one parent /carer is a smoker. The 2013 NZ census informed us that 600,000 children in NZ are exposed to smoking in their homes.[[14]](#footnote-14). There is one reference to Smokefree homes on point c but this needs to be developed to reflect a comprehensive tobacco control response.   |  |  | | --- | --- | | Action 8  **Develop and implement a health outcome focused framework** |  | | Response: Recognition of tobacco related harm and an effective and appropriate  response needs to be addressed in the development of the health outcomes  framework. Tobacco control measures to reduce tobacco supply and  demand of tobacco (continued tax increases), legislation (in particular the  introduction of plain packaging in NZ for tobacco products and Smokefree cars)  and sustained funding to target at risk populations to never take up smoking,  stop smoking and remain Smokefree need to have clearly identified and  measurable health targets within the framework. |  | |

### 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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| Wide consultation process with generous time scale to encourage response across sectors. Collaborating across sectors particularly with established health networks such as the National Smokefree Coalition and Regional Smokefree Coalitions. |

### Any other matters

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

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| Development of a N.Z tobacco control action plan (or a MOH Road Map) within or aligned to this Strategy must be a priority. |

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| **196** | Submitter name |  |
| Submitter organisation | The New Zealand Telehealth Forum |

# Submission on the Draft National Health Strategy

## Introduction

The New Zealand Telehealth Forum (NZTF or “the Forum”), welcomes the opportunity to make this submission to the consultation on the National Health Strategy. The Forum is sponsored by the National Health IT Board to promote the use of telehealth in healthcare delivery and to address the barriers that stand in the way of its wider adoption. It further aims to maximise the benefits of the Government’s broadband programme, and recognises that telehealth can – and should – be a significant contributor to the shifts that are taking place, in New Zealand and globally, in the delivery of healthcare. The Forum is clinically led; its national Telehealth Leadership Group includes clinicians who are experienced in the practice of telehealth as well as clinicians and others in various health management and health informatics and technology roles.

“Telehealth” in its broadest sense is the term for the use of information and communication technologies (ICT) to deliver healthcare when patients and care providers are not in the same physical location. The various types of telehealth describe the ways of delivering services, rather than services in themselves. The Forum’s focus is primarily on three types of telehealth: a) telemedicine, includes interactive sessions using videoconferencing e.g. for consultations with patients, multi-disciplinary meetings, and education or store and forward for applications like transmission of radiology images; b) telemonitoring, i.e. remotely collecting and sending patient data so that it can be interpreted and then contribute to the patient's ongoing management and c) mHealth, i.e. the use of mobile communications technologies in medical and public health practice, including the delivery of health information, health services and healthy lifestyle support programmes. The use of telephone and call centre-based facilities such as the National Telehealth Service, can also be included under the overall “telehealth” umbrella.[[15]](#footnote-15)

## Comment on the Draft National Health Strategy

The Forum welcomes the recognition of the importance of ICT technologies in the draft strategy, and in particular the mention of telehealth in the Smart System theme[[16]](#footnote-16) along with the Central Otago example.

However, telehealth technologies can enable almost all of the themes in the Strategy. For example in **People Powered**, mobile and home-based technologies and devices can enable people to be more involved in their health. In **Closer to Home**, telehealth technologies can provide better, sooner, more convenient access for patients and caregivers alike. In **Value and High Performance**, telehealth technologies – *if effectively and sustainably deployed, along with appropriate funding and re-imbursement policies* – can improve efficiency and productivity for service providers and patients. In **One Team**, the use of telehealth technologies can greatly improve collaboration amongst clinicians, support a more cohesive team approach in shared care, and enable upskilling of the workforce.

## Comment on the Roadmap of Actions

While there is no explicit mention of telehealth in the Roadmap actions, it appears to be implicit. We recommend the following amendments be made in **Roadmaps** **Section 5 Smart System**:

1. that the section “What do we want in 5 years” be amended by adding the following bullet point:

*“Regulations, professional bodies and policies relating to infrastructure investment, funding and re-imbursement support and encourage both innovation and the sustainable uptake of ICT technologies, including telehealth, with a strong evidence base for the benefits.“*

1. that the wording of Smart System Action 20 be amended to include a reference to telehealth. The following is suggested, (amendment underscored):

“This action area seeks to improve the health system’s service effectiveness, reduce cost, improve engagement with people who access health services, promote healthy behaviours and self-management and aid people-led design. It includes use of new technologies (medicines, medical devices from dressings to robotics, cell and tissue therapies), service design/models of care, and information and communications technologies (e.g. eHealth and telehealth).

Note – the interpretation of this statement from a telehealth perspective would be that telehealth technologies should be considered in the design and delivery of hospital, primary and community services, and it would support the Forum’s work in addressing the barriers to uptake. Telehealth can then be a viable enabler for improving the effectiveness of the health system.

1. that the second bullet point under Action 20 be amended as follows (amendment underscored):

“Continue to develop and implement the regulatory scheme to support the assessment and uptake of medical devices, therapeutic products and telehealth technologies.”

Note – an example of the need for this amendment is the current regulation regarding prescribing, which can be an inhibitor to the uptake of telehealth for patient consultations.

1. that a fourth bullet point be added under Action 20 that signals national leadership in support of technology uptake:

*“Support the implementation of tools and the operational environment necessary to ensure effective and increased uptake of new technologies.”*

Note – telehealth examples in the above bullet point include the need for a Health Videoconferencing Directory, and a seamless environment for videoconferencing interoperability and interconnectivity.

## Conclusion

Telehealth technologies provide the opportunity at a very basic level to reconstruct the way healthcare is delivered. There is some progress being made in New Zealand, but much more needs to be done to deliver significant benefits. We look forward to further developing and carrying out the Forum’s Work Programme in conjunction with the Ministry and other government agencies and in support of the National Health Strategy.

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| **197** | Submitter name | [redacted] |
| Submitter organisation | New Zealand Council of Christian Social Services |

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

**All New Zealanders Live Well, Stay Well, Get Well**

**Consultation Draft**

**NZCCSS Submission to the Ministry of Health**

**Executive Summary**

The New Zealand Council of Christian Social Services (NZCCSS) welcomes the review of the New Zealand Health Strategy and supports its overall goal for New Zealanders to live well, stay well, get well.

NZCCSS commends the Ministry for its thorough review of the health system (strategic direction, funding, capability and capacity review), and consultation process. NZCCSS sees the draft strategy as an opportunity to strengthen already existing work to integrate a broader range of health services into communities, develop an early investment approach across the age spectrum, build on the strength of inter-agency collaboration to improve the lives of vulnerable people, and engage technological advancements to empower people to be actively involved in their health.

The NZCCSS notes that the general *direction of travel* reflects some elements of the Community Investment Strategy (CIS) currently applied by the Ministry of Social Development to the social services sector, particularly those parts of the health strategy that support an increased focus on vulnerable children, young people and families/whanau.

Overall, the NZCCSS supports an investment approach to health but advises that this investment needs to be more than a re-prioritisation exercise; it requires new funds from which the specific health needs of ‘high’ risk groups are met. Over-targeting and prioritising has the potential to reduce access to services to those not in priority groups, and this may, as an unintended consequence, result in the overall decline in the health of the general population. NZCCSS would be concerned to see a reduction in the availability of early intervention services to people who are outside of the ‘high risk’ category set out in the strategy.

***Key points:***

1. The underlying motivation for improving the health and social outcomes of vulnerable communities should be driven by human compassion and not reducing ‘liabilities’and savings to the public purse.
2. Given that New Zealand’s aging population is set to increase, it is critical that the health system includes in its planning specific actions to manage this demographic change. NZCCSS refers the Ministry to its recent comments on the *Review of the* *Health of Older People Strategy* [copy attached].
3. NZCCSS supports a focus on ‘*building the capability and diversity of the workforce to meet the demands for more integrated health care’*. This focus raises a number of health workforce issues particularly for the older people (and disability) sector. Finding solutions to ensure the fair funding of the workforce is intrinsic to ensuring good health outcomes for older people.
4. NZCCSS acknowledges the benefits of digital technology but cautions that face-to-face access to medical services/information should remain available to those who are more effectively supported in this way.
5. The digital divide is narrowing but there remains some population groups, especially low income households, elderly people, Māori, Pacific people, and those living in small towns, who have limited access to digital technology. Given the focus of the strategy on digital access to health information, the issue of digital divide will need to be addressed.
6. The effectiveness of the health strategy to reduce inequities would be greatly improved if family/household income is raised. There is an abundance of evidence that supports the relatonship between low income and poor health outcomes [Marmot 2010].
7. NZCCSS supports the consideration of a more refined mechanism for procurement of health and investing in services that achieve the ‘best’ outcomes. The mechanism for procurement, however should ensure that the broader ‘community outcomes’ achieved by local/community-based health services are included in funding decisions. NZCCSS refers the Ministry to [Outcomes Plus – the added value from community social services](file:///C:\Users\oem\AppData\Local\Temp\Health%20Strategy%20Submission.docx%20%20Monday%2030%20November%202015.docx), Nielson with Sedgewick and Grey, 2015).
8. The status of the document [From Cost to Sustainable Value: An Independent Review of Health Funding in New Zealand, 30 June 2015](file:///C:\Users\oem\AppData\Local\Temp\Health%20Strategy%20Submission.docx%20%20Monday%2030%20November%202015.docx)] and its relationship to the implementatiuon of the health strategy is unclear. More information is needed on any changes to the way DHB funding decisions are made.
9. NZCCSS agrees that good health begins at home and supports an approach that increases the availability of services, information and support as close as possible to home. This approach will be particularly beneficial to children and families/whanau with limited transport, along with older people who live in the community and are reliant on public transport, and those who live in provincial centres where public transport options are very limited or non-existent.
10. NZCCSS supports the application of technological advance to the health sector and agrees this change is likely to empower people to be more involved in their health, particularly young people. The collection, storing and sharing of personal information is a complex area however and raises important issues around privacy and confidentiality that will need to be fully addressed. There are likely to be some increased costs associated with implementing new IT and reporting systems. NZCCSS would like to see some recognition of the cost of introducing new IT and reporting systems in contracts to ensure the quality of service delivery is not compromised.
11. All government ministries are currently grappling with the same need to provide more robust data to meet population health, social and welfare targets set by government. It is critical that the Ministry of Health works in partnership with other ministries to develop common reporting mechanisms (reporting measures and portals) whenever possible to reduce the administration burden for community organisations and practitioners.

**Introduction and Approach**

The New Zealand Council of Christian Social Services (NZCCSS) is a national umbrella group representing the social services agencies of the Anglican Care Network, Baptist Union of New Zealand, Catholic Social Services, Methodist Church of New Zealand, Presbyterian Support New Zealand Inc. and the Salvation Army. The agencies we represent provide social and health services throughout New Zealand for people of all ages and particularly for people who are vulnerable and disadvantaged.

NZCCSS works for a just and compassionate society in Aotearoa New Zealand. Our role is to represent the common interests of Christian social service agencies and their clients, provide information to members, analyses, and advocacy for policies which will assist poor, vulnerable and disadvantaged members of society.

*Mission and values*

The guiding principles for NZCCSS’ comments on the update of the New Zealand Health Strategy are our mission statement.

Mission: *The New Zealand Council of Christian Social Services works for a just and compassionate society in Aotearoa New Zealand. We see this as a continuation of the mission of Jesus Christ.*

*Values: In seeking to fulfil this mission we are committed to giving priority to the poor and vulnerable New Zealanders and Te Tiriti o Waitangi.*

*Human value and dignity*

NZCCSS’ comments reflect our deeply held belief in the inherent value and dignity of all human beings. Integral to this is the belief that there is no requirement to achieve, earn or purchase this value and dignity; it is simply accorded by the grace of God at birth to all. We are created in the image of God and therefore we are identically valuable.

*Underlying motivation of health investment approach*

NZCCSS Supports the inclusion of an investment approach to the New Zealand Health Strategy, with a focus on those most at risk of poor health and well-being outcomes. It note this approach contains many of the elements (and language) of the Community Investment Strategy currently being applied by the Ministry of Social Development to the social services sector.

Member agencies have long expressed concern about the health and well-being of vulnerable individuals and families/whanau across the age spectrum. Financial barriers to primary health services and dental treatment, including debt incurred to a GP/medical centres, along with transport barriers, are consistently reported by our social service agencies. [NZCCSS Vulnerability Report series].

The general view of NZCCSS is that greater public investment is needed to improve the health and well-being of our most disadvantaged children, young people, adults and older people, and that a whole of government approach is also needed to support those with highly complex needs that go beyond health (education, employment, housing, social services).

NZCCSS expressed some caution, however, when the New Zealand Health Strategy was considered against background paper [From Cost to Sustainable Value: An Independent Review of Health Funding in New Zealand, 30 June 2015](file:///C:\Users\oem\AppData\Local\Temp\Health%20Strategy%20Submission.docx%20%20Monday%2030%20November%202015.docx)]. Here, the investment approach is associated with fiscal/actuarial liability and return on investment. More information on the relevance of the above report on the updated strategy would be useful.

NZCCSS’ concern lies in the underlying motivation of an investment/liability approach. Social justice is considered the primary motivation behind an increase in public investment to our most disadvantaged citizens, rather than reducing financial liability to the state. Human distress and frailty, often the result of persistent material deprivation and limited ‘choices’ due to inadequate family/household income, is not a financial liability; it is a moral failure.

1. **Eight guiding principles for the health system**

NZCCSS supports the proposed high level principles underpinning the updated health strategy. It is noted that Principles 2, 4, 5, 7, 8 are critical if New Zealand is to significantly address inequalities in health outcomes. As the Ministry is fully aware, there is substantive health evidence that people across the age span living in Māori communities, Pacific communities, and economically disadvantaged communities, have poorer health outcomes and die younger than other groups of New Zealanders. [[The 2013/2014 New Zealand Health Survey](http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey), [Reducing Inequalities in Health 2002](http://www.health.govt.nz/publication/reducing-inequalities-health), [Independent Life Expectancy in New Zealand](http://www.health.govt.nz/publication/independent-life-expectancy-new-zealand-2013-0). [NZDep 2013. Index of deprivation](http://www.health.govt.nz/publication/nzdep2013-index-deprivation)]. This gap in health equity is long-standing and must be addressed.

1. **Strategic Themes**
2. **People Powered**

*Face-to-face access more effective for some groups*

NZCCSS supports all initiatives to ‘empower’ people to be involved in the management of their health, along with the expansion of digital technology to support self-management of health. NZCCSS is aware of some evidence that supports the use of apps to support some groups of people. The use of digital technologuy also offers the opportunitiy to engage and empower younger people to take a more active part in their health care. Reports from our network advise, however, that in cases where people are particularly at risk of poor health outcomes (often with mental health needs), the most effective approach is face-to-face contact. Opportunities for face-to-face interaction with health professionals and services should therefore remain available to those who are more effectively supported in this way.

*Cultural dimension*

Face-to-face interactions also enable culturally appropriate ways of communicating to be conveyed to those who are from other cultures. Western medical and health messaging needs to be conveyed in a way that links with the values of the recipients. For example, a whānau may need to understand that the western ways of health do not need to conflict with traditional values. This work has to be done face-to-face.

*Digital divide*

Given the emphasis placed in access to digital technology, NZCCSS wishes to raise the issue of the ‘digital divide’, which remains a concern, particularly for low income households. Information from the [2013 Census](http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-transport-comms.aspx) shows that while [internet access](file:///C:\Users\oem\AppData\Local\Temp\Health%20Strategy%20Submission.docx%20%20Monday%2030%20November%202015.docx) is increasing for all New Zealanders, more than [half of households with the lowest incomes](http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/qstats-infographic-transport-comms.aspx) (under $20,000) have no internet access. Nearly all of households with incomes over $70,000 (over 90%) have internet. In addition, a recent report on internet use in New Zealand, identified the poor, elderly people, Māori, Pacific people and those in small towns have less access to internet, and make less use of core services provided [[World Internet Project New Zealand](file:///C:\Users\oem\AppData\Local\Temp\Health%20Strategy%20Submission.docx%20%20Monday%2030%20November%202015.docx)]. The 2015 update of this survey is currently in progress and NZCCSS recommends health officials refer to this document for the latest trend in digital access, when available.

*Know and design*

Action 2, proposes collection and sharing of good examples of people-led service design, particularly for effective reach and understanding of high-need priority population (p34). NZCCSS strongly supports this action and recommends the extension to non-government organisations; there are many examples of good practice in people-led service design among NGOs and these learnings also need to be captured.

*A focus on household income*

Individual health and well-being cannot be separated out from family/household income. The socioeconomic, living and working realities for the people our member agencies walk alongside provide an environment for what Karlo Mila called ‘constrained’ choices. [Inequality: A New Zealand Crisis, BWB, 2013. These constrained choices impact not only on an individual’s needs but also the needs of their wider family/whanau (children, youth, elderly).

Over the years the [Vulnerability Report](http://nzccss.org.nz/publications/vulnerability-report/) series has captured the reality of low wages on the health and well-being of families, along with the impact of poor quality (and sometimes high cost) rental accommodation on families’ ability to meet basic necessities, including health. While the proposed Actions (1 and 2) may well lead to positive health and well-being outcomes for some people, without increasing family/household income to a level that enable families to afford basic (health) life necessities, these achievements are unlikely to have a sustained positive impact on health inequities.

*“People pay their doctor and don’t buy food, or won’t go to the doctor because they owe money from previous visits. We do have some schemes for supporting people in accessing medical care and prescriptions but these are in specific areas only. One centre reported a doctor’s fee being $67 for clients – just not affordable and when they have to visit to get clearance for W&I this is too much for them. Some clients choose not to seek medical treatment for themselves because of cost but ensure their children receive medical help.”*

***Salvation Army***

“*People are not going to doctors as this is not seen as a priority when they have to pay for rent and food*.” **City Mission**

“*Even though these people look very unwell, Work and Income require a medical certificate to prove this but they don’t have money to go to the GP and/or need support to make an appointment to go*.”

**Kokiri Marae Health and Social Services**

“*There is instability at present with private rental housing. Home owners / landlords are riding the real-estate wave; selling the homes leaving tenants homeless. In one case I have had a single working mum with 3 dependants who had 3 moves last year due to the rentals been sold from underneath her. This meant each time she had an increase in bonds & letting fee that put her into additional debt including moving costs incurred. My client become quite sick with the stress and the strain*.”

**VisionWest**

“*If whanau have GP bills they cannot attend the GP. We know of people who are unable to go to the GP and go to the hospital when their children are sick. Public health nurses are a wonderful resource in the community and support families as best they can*.”

**Hawkes Bay Presbyterian Support**

“*Cost of Doctor visits means adults especially mothers are often ignoring chronic conditions. Early signs of mental health issues are not picked up*”.

**Christchurch City Mission**

“*Dental care is a high need for the homeless population who don’t have the type of money required to access the service. Costs are incredibly high and their dental needs are usually complex. One-off free dental days can be helpful but many require ongoing treatment to maintain good health (as do all people) and this is not financially viable for beneficiaries*”.

**Wellington City Mission**

**ii. Closer to home**

NZCCSS agrees that good health begins at home and supports an approach that increases the availability of services, information and support as close as possible to home. For the vulnerable families our members walk alongside, travelling to different service for treatment can presents a significant barrier to accessing health (and social) service. The provision of health services ‘closer to home’ is also essential for the elderly who live in the community and are reliant on public transport. This is especially true for those living in provincial centres where public transport options are very limited or non-existent.

“*Living close to medical care is essential for people accessing those services. Transport costs are okay, but benefits don’t allow for much of this each week*”.

**Wellington City Mission**

“*In Rural Otago transport costs to these services are an issue and there are only a few public transport services available*”.

**Otago Family Works**

*Children, Families/Whānau*

NZCCSS commends the lifecourse approach and specific targets for vulnerable children in Action point 6. It clearly identifies the interagency partnership required and the targeted population. We are able to recognise how this action point relates to strategies of other ministries while maintaining the focus on health.

*Inclusion of older people*

NZCCSS wishes to express some concern that:

**Action 5** (p38) does not include any specific mention of health conditions associated with older people. Given New Zealand’s aging population is set to increase, it is critical that the health system includes in its planning specific actions to manage this demographic change. NZCCSS would like to see added to Action 6 the inclusion of long-term conditions that are specific to older New Zealanders.

**Action 6** (p38) the health of older people appears to be excluded as a key health targets. In the development of the new Health Strategy, NZCCSS would like to see similar action points developed for older peoples health that targets the most vulnerable older people as has been identified for vulnerable children, young people, high needs populations.

An increased focus on our most vulnerable children is understandable given growing concern about children missing out on health care, and that health outcomes of this group of children is poorer in comparison to older people overall.

At the same time, however, NZCCSS sees no justification for losing focus on maintaining and building achievements for older people. Rather the focus on children’s health should be seen as complementary and an area for additional investment and not a reason to reallocate scarce resources away from older people’s health into child-focused health areas. If a whānau/family focused approach is taken to health, then the place of kaumatua and older people within whāuau/family needs to be recognised and understood and a holistic approach taken to children’s and older people’s health.

NZCCSS refers the Ministry of Health to NZCCSS comments on the Review of Health and Older People Strategy (HOP) provided on 30th October 2015 [see attached copy] for its full position on older people strategy.

1. **Value and high performance**

*Collaboration across agencies*

NZCCSS agrees that there is a need to understand how health and social service organisations are supported by a mix of funds (government agencies, philanthropic, and own funds) to promote health and wellbeing. It is hoped that a focus on targets does not destabilize the ability of community-based services to continue to provide services to people in their communities.

*Broader definition of effective outcomes*

NZCCSS supports consideration of a more refined mechanism for procurement of health (and social) services and investing in services that achieve the ‘best’ outcomes for consumers. The mechanism for procurement, however should ensure that the broader ‘community outcomes’ achieved by local/community-based health services is included in funding decisions.

NZCCSS refers Ministry officials to research [Outcomes Plus – the added value from community social services](file:///C:\Users\oem\AppData\Local\Temp\Health%20Strategy%20Submission.docx%20%20Monday%2030%20November%202015.docx), Nielson with Sedgewick and Grey, 2015), This study identified three components of ‘community value’ that provided the environment for sustained positive outcomes for individuals and families/whanau: 1. **Community cohesion** - the ability for whanau and families to identify with, be involved in and be mutually supported by their communities; 2. **Community development** - communities are engaged with and own their developmental projects and processes; 3. **Community empowerment** - the ability for communities to identify and achieve their own outcomes and results.

In order to gain full value for every dollar of public expenditure government agencies must ask, “What is the whole contribution of the organisation to ‘community value’ and through strong communities to sustained, positive outcomes for whānau and family”?

*Targeted investment*

An effective investment approach requires more than a re-prioritisation exercise; it requires new funds from which the specific health needs of ‘high’ risk groups are met. Over targeting and prioritising has the potential to reduce access to service to those not in priority groups, and this may as an unintended consequence result in the overall decline in the health of the general population.

The availability of universal, lower-threshold services has been a critical component of New Zealand’s health gains at key life stages for the vast majority of New Zealanders. If the funding of lower threshold services are reduced in favour of targeted health services, there is a real risk that we will lose the health gains we have achieved over decades. Proportionate universalism recognises this need for the funding of both universal services and additional targeted measures(Marmot, 2010).

NZCCSS supports proportionate universalism on the basis that lower threshold universal services are not traded-off to fund targeted services. NZCCSS believes there are sufficient public resources to support an effective health system and that funding issues are largely a reflection of what as a nation we value.

*Impact on smaller organisations*

It is noted that the strategy has some potential for an inbuilt bias towards larger organisations that have financial resources to adapt their services to meet new expectations to deliver ’multi-disciplinary service’. This purchasing bias could have a significant impact on smaller, specialised services that serve a distinct population group and focus on a single health/social issue.

**Iv. One Team**

*Lead whole of system format*

NZCCSS agrees that the health system requires a more integrated system that supports the change of focus set out in the strategy. A whole-of-system forum (undertaken in advance of DHB planning) is set out under Action 17 however does not constitute a one team approach but rather this is a single event approach. More opportunities across the year for the different components of the health system to come together at the regional and national level is needed to make a sustained cultural change, promote a learning culture and provide opportunities for review of implementation across the sector.

*Build system leadership, talent and workforce*

NZCCSS agrees that workforce development, system leadership is integral to the effectiveness of the New Zealand Health System, and supports the inclusion of NGO in initiatives to strengthen skills and capability, and expand the support for the NGO/primary and voluntary sector [Action 16 (b)].

NZCCSS is aware of many examples of good collaboration between the Ministry of health and the NGO sector that should also be recognised. For example, in the mental health sector the Ministry offiicals and stakeholders have co-produced “On Track” Co-Creating a Mental Health and Addiction System New Zealanders Want and Need (Te Pou and Platform Trust).

**V. Smart System**

NZCCSS agrees that technological advance is changing the way people interact with government agencies, including health. It also agrees that sharing of (anonymised) data and introducing reporting systems could provide insights into the health system and contribute to service planning.

The collection, storing and sharing of personal information is a complex area, and raises important issues around privacy and confidentiality that need to be fully addressed. NZCCSS has been part of considerations around the development of an Approved Information Sharing Agreement (AISA) to support the sharing of information from NGO social service agencies. NZCCSS noted this was a complex process that required a national consensus about how organisations work, collect and store personal information and share this information to other agencies. The same thorough consultation process is required to engage NGO health services.

*InterRAI*

The implementation of the InterRAI needs assessment tool into the home based support and aged residential care sector has also shown the many challenges of moving to shared data collection and information technology platforms. It is important that the learnings from this experience is taken into wider health strategy work, especially when such change is part of a regulated and enforced transition process.

*Cost of new IT and reporting systems*

The cost of implementing new IT systems and reporting systems is likely to present a financial burden to some community-based providers, particularly smaller ones. NZCCSS would like to see some recognition of the cost of introducing new IT and reporting systems in contracts to ensure the quality of service delivery is not compromised.

Consideration impact of multiple databases/recording and reporting systems community-based providers are already required to use across government contracts (up to 5 or 6 in many cases currently) is also needed. All government Ministries are currently grappling with the same need to provide more robust data to meet population health, social and welfare targets set by government. It is critical that the Ministry of health works in partnership with other Ministries to develop common reporting mechanisms (reporting measures ans portals) whenever possible to reduce the administration burden for community organisations and practitioners.

**Contact details for this submission** are [redacted].

**Review of the Health of Older People Strategy**

**NZCCSS comments**

**30th October 2015**

***About NZCCSS***

The New Zealand Council of Christian Social Services (NZCCSS) has six foundation members: the Anglican Care Network, Baptist Union of New Zealand, Catholic Social Services, Methodist Church of New Zealand, Presbyterian Support New Zealand Inc. and the Salvation Army. NZCCSS works for a just and compassionate society in Aotearoa New Zealand. We see this as a continuation of the mission of Jesus Christ. In seeking to fulfil this mission, we are committed to giving priority to poor and vulnerable members of our society and to Te Tiriti O Waitangi.

Nationally, NZCCSS membership consists of multiple social service groups working from almost 640 separate organisational sites, which collectively provide over 1,200 social service programmes throughout New Zealand. Our members deliver a wide range of services that cover such areas as child and family services, services for older people, food-bank and emergency services, housing, budgeting, disability, addiction support, community development and employment services. Our networks have a long history of working with older people including social work and community programmes, day programmes, home support, aged residential care and retirement living.

These comments are general comments aimed at informing the strategy development process for the new Health of Older People Strategy. Contact person for these comments is Paul Barber, Policy Advisor, PO Box 12-090, Thorndon, Wellington, Phone 04 473 2627, [paul.barber@nzccss.org.nz](mailto:paul.barber@nzccss.org.nz).

**Guiding Principles in our comments**

The guiding principle for our comments is driven by the mission of our organisation and the agencies with who we work.

*What would a Health of Older People Strategy look like that is genuinely focused on responding to the situation of older people with a particular concern for those who are poorer & more vulnerable?*

Allied to this is the commitment to honouring Te Tiriti o Waitangi in the relationships and work that we all do. In the context of the HOP Strategy we would ask:

*How are the commitments of the Treaty relationship being reflected in all levels of this strategy?*

**Summary of Key Messages**

**Include Health of Older People in the key health targets.** The HOP Strategy is being developed in a policy context that does not appear to prioritise the health of older people. It does not feature as one of the top health targets and this is a significant omission.

**Wellness and wellbeing is the positive frame to approach overcoming vulnerabilities**.

Some of the key areas of vulnerability this HOP Strategy must address include:

* **Housing vulnerability** is increasing as fewer older people reach retirement age owning their home mortgage-free and more of them are renting. Good housing is foundational to good health and social outcomes.
* **Dementia and other long-term conditions**: The impact of long term conditions such as dementia is already being felt in communities. Living well with such conditions must be a focus for the HOP Strategy
* **Social isolation and loneliness**: Participation in meaningful community and social relationships is foundational to health and wellbeing.

**Definitions of vulnerability: who is on the margins?**

Questions have been asked in our networks about the definitions of vulnerability for older people that are around and how this might be framed in a more positive and constructive fashion. We welcome the focus in the draft Health Strategy on wellness and maintaining wellness and the initial messages from the HOP Strategy team that “improved health and equity for all” is a driving outcome focus for the health and disability system.

Who are on the margins of our health system and how can it be designed to overcome this marginalisation and achieve greater equity and better outcomes for the most vulnerable? It is important within the HOP Strategy to use inclusive framing for overcoming the marginalisaton of vulnerable older people in society and increasing participation. Listed below are some aspects of this that we have identified that need to be clearly addressed.

* **Housing vulnerability**: Fewer older people are reaching the age of eligibility for NZ Superannuation owing their own home mortgage-free and more are living in rental properties. Good housing is foundational to good health and social outcomes. An understanding of secure and good quality housing to support wellbeing needs to be part of the HOP Strategy.
* **Dementia and other Long Term Conditions:** The impact of the long term conditions that are closely associated with ageing is already being felt within the services and communities in our networks. A clear focus on how to achieve good outcomes in living with these health conditions need to be a priority in the strategy.
* **Social isolation and loneliness**: Participation in meaningful community and social relationships is foundational to health and measures of good social interaction. A clear focus on how the health system can contribute to reducing social isolation is important. We know that psycho-social wellness and social cohesion promotes wellbeing in older people, for instance in the way health services such as day programmes also offer social interaction and relationship building.
* **Socio-economic vulnerability**: This needs to be acknowledged in the frame of achieving meaningful level of wellbeing without significant disadvantage. Measures such as income adequacy and housing quality need to sit beside measures of desirable “good health”.
* **Abuse and violence**: The anecdotal and research evidence suggests a relatively small but significant group of older people are experiencing abuse, neglect and violence. Dysfunctional relationships within families (including often difficult relationships with step-children) impact significantly on older people and are over-represented in those who access the services of our member agencies.
* **Rural & small town communities**: Developing or maintaining viable services that are accessible to all older people in smaller centres and rural areas is a challenge and creates existing vulnerability as well as growing risks for the future. Specific strategies and policies are needed to address this.
* **Workforce:** the biggest workforce supporting older people is the unpaid one – family/whānau carers and friends. In addition, the paid workforce supporting older people is a large workforce facing many challenges. Framing the network of carers that support wellbeing in a positive light and planning to resource the workforce fairly is important in promoting good outcomes for the health of older people.

**Health Targets: what priority does Health of Older People have for government?**

NZCCSS recommends including Health of Older People among the key health targets. The HOP Strategy is being developed in a policy context that does not appear to prioritise the health of older people. It does not feature as one of the top health targets and this is a significant omission. In the development of the new Health Strategy there has been a stronger focus on children from many of those involved. This is based rightly on concern that many children are missing out and their health outcomes are worse in comparison to older people overall.

This is however, no justification for losing focus on maintaining and building achievements for older people. Rather the focus on children’s health should be seen as complementary and an area for additional investment and not a reason to reallocate scarce resources away from older people’s health into child-focused health areas. If a whānau/family focused approach is taken to health, then the place of kaumatua and older people within whāuau/family needs to be recognised and understood and a holistic approach taken to children’s and older people’s health.

**Housing and older people**

There is a lack of focus on housing for older people in the strategy and in wider Government policy such as the Social Housing Reform programme. The strategy needs to recognise the vital role of social housing, including local authority and community housing in supporting older people to live well and independently. Strategies to support good housing for older people, such as universal design, must be included.

Obstacles to developing different models of living for older people are numerous. Existing models such as Abbeyfield, struggle to meet criteria for funding support despite a proven niche role. New models beyond the property development-based model of retirement villages are few and far between. The Social Housing Reform process has not made it easy for existing housing providers for older people to access government funding nor has it provide stable policy frameworks to encourage new and innovative forms of housing such as intergenerational housing.

**Treaty Relationship**

The reality of the context for this strategy is the continuing social change taking place in New Zealand as the Māori population grows and ages. The Treaty settlement process and developing constitutional and social role of iwi structures as well as ‘by-Māori for Māori’ health, community and social services all mean that the way health and wellbeing is understood is changing. This needs to be reflected throughout the Strategy and not seen as a subset of health “populations” that can be addressed within some aspects of the HOP Strategy.

**Overarching Vision for Health of Older People**

The draft Health Strategy has only become available in the last few days so it is not possible to include fuller analysis in the comments we provide. However, the Ministry of Health Older Persons team in the consultation meetings has made it clear that the Health of Older People (HOP) Strategy will be driven by the overarching vision of the Health Strategy and its outcomes framework. This makes the vision statement and five goal areas of the draft Health Strategy decisive elements in the HOP Strategy.

We ask the question, ‘do the two elements of the vision current HOP Strategy still hold’?

*“OIder people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life.*

*They are supported in this by coordinated and responsive health and disability support programmes.”*

We would argue that this vision remains central to health of older people.

The current HOP Strategy also includes 8 objectives:

1. Well-informed choices
2. Support programmes integrated around needs
3. Funding & service delivery promote timely access to quality services
4. Older Māori needs met by appropriate, integrated services
5. Population-based programmes promote health & wellbeing in old age
6. Timely access to primary & community services proactively maintaining health & functioning
7. Admission to general hospital integrated with community-based care & support
8. High and complex needs access timely & co-ordinated services and living options.

The initial workshops for the revised HOP strategy shared a draft outcomes framework framed under the draft Health Strategy vision and overarching outcomes. This outcomes framework is based on three broad health and disability outcomes: “improved health & equity for all populations; better experience of care; and more sustainable use of resources.” The outcomes proposed for the revised HOP strategy are:

* Healthy ageing and independence
* People living well with simple or stable long-term conditions
* People with complex needs, including co-morbidities, dementia and frailty, are supported to live well
* Rehabilitation and recovery from acute episodes
* Respectful end of life where personal and cultural needs are met

While the vision of the Health Strategy provides the overarching context for the HOP Strategy, it would seem important to develop or revise the vision and objectives of the HOP Strategy distinct from the Health Strategy.

**Participation of older in decisions about their health**: It is very noticeable that the proposed outcomes frameworks do not appear to emphasise the participation of older people in decisions about their health, as set out in the current HOP Strategy. While it is not clear how well the current strategy has met this goal, it needs to be included in the revised HOP Strategy because it is clear that the draft Health Strategy is placing a strong emphasis on such consumer participation and the HOP Strategy would be weaker without this.

**Evaluation integrated into Strategy**

Evaluation processes need to be built into the HOP Strategy that are well-designed and do not add to the already significant compliance and regulatory requirements in the sector. Using reporting systems, data collection and above all effective processes for obtaining feedback from older people themselves are important. The impact for older people and their families is the over-riding outcome measure and success indicator. It is striking how in the current strategy this feedback process is virtually non-existent.

**Understanding the challenge of an ageing society**

It is very important that the social achievement of increased life expectancy for all New Zealanders is celebrated as an achievement and not problematized as a “burden” or a “tsunami” of older people. Both the Health and HOP Strategies must take a constructive approach, learning from what has led to this great social achievement, seeking to build on those achievements and not dismantle elements of the very system that has brought this achievement.

It is clear that the fundamental elements of this increased life expectancy are based on universal access to high quality health care and linking this with other essential socio-economic contributors to wellbeing – housing, income, wealth and poverty levels, quality infrastructure, social cohesion and healthy lifestyles.

**Māori and Pasifika**

The changing demographics for our population mean that future needs for health of older people will not be the same as today. Our assessment would be that not enough has been achieved for Māori and Pacific older people. The main models of support for older people that most of our networks are involved in do not include a significant proportion of Māori or Pacific older people. Experience shows that when services such as day programmes are offered in a way that meets the cultural needs of kaumatua, for example, then they are more likely to participate and benefit from them. This suggests more focus is needed to ensure that they are not missing out on health care and designing responses and services that are more inclusive or specifically targeted to meet these needs.

**Cultural Diversity Increasing**

The Asian ethnic group is the fastest growing population group among those aged 65. While remaining a small overall proportion of the population, in some areas such as Auckland the growth and size of the Asian population is significant. The different ethnic groups and their needs and aspirations for care and support needs greater recognition.

**Integration of services**

Feedback from our networks supports other analysis that progress on the 2002 HOP strategy has been variable. In some areas there is frustration that not enough progress in the integration of services has happened. There is an undervaluing of integration that goes across primary/secondary care and aged care’s role in rehabilitation and regaining function is under-utilised. On the positive side, it is essential to identify the places where the HOP strategy is seen as being most successful and learn from that.

The revised HOP Strategy must clearly engage with the primary health linkage. Have better preventative services become a reality? Have integrated models of care to prevent hospital admissions actually been achieved? What more can be done?

**Building relationships**

One aspect of success that has been identified is the importance of building relationships to underpin strategies. One example of this are the forums in Canterbury such as Elder Care Canterbury Providers’ Forum and the Elder Care Canterbury Consumers’ Forum that bring people together from across the sector to talk and better understand each other. We recommend that such opportunities for communication and relationship building be giving more attention within the HOP Strategy.

**Administrative Barriers**

Administrative barriers to the success of the HOP strategy are regularly pointed to. Blind tenders and competitive contracting work against integrated approaches to care and support. There have been many pilot projects that are set up, run but seldom with effective follow up. It has also been pointed out to us that the sheer volume of documentation being required from services is proving very burdensome and seems to be continuing to increase.

**Relationship to other key Government strategies**

There are a number of existing strategies that interact with the HOP Strategy in addition to the Health Strategy. The Disability Strategy is an overarching strategy alongside Health, as well as the population strategies that include the HOP strategy. The HOP Strategy must specifically address these strategies and identify areas of alignment and areas where changes may be needed.

* The New Zealand Positive Ageing Strategy (NZPAS): <http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/positive-ageing/action-plan-and-annual-report/>. The 2002 HOP Strategy was aimed to address the health aspects of the NZPAS, so this needs to be accounted for. Note that while there is one specific health goal in the 10 NZPAS goals, almost all the others contain health-related components (Hood, 2010).

## **New Zealand’s Māori Health Strategy He Korowai Oranga** <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga>

* Pacific Health Strategy: 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 <http://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018>
* NZ Framework for Dementia Care <http://www.health.govt.nz/publication/new-zealand-framework-dementia-care> and also Alzheimers NZ’s: Dementia: A Strategic Framework <http://www.alzheimers.org.nz/news-and-events/nz-information/our-strategic-framework>
* NZ Disability Strategy: <http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/disability-action-plan/index.html>
* The Primary Healthcare Strategy <http://www.health.govt.nz/publication/primary-health-care-strategy> described on the Ministry website as “somewhat dated” but remains a “useful document”.
* The New Zealand Carers’ Strategy <https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/policy-development/carers-strategy/>. The Strategy includes an Action Plan with clear identification of responsibility for implementation.

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| **198** | Submitter name | Dr Kirk Reed |
| Submitter organisation | National Centre for Interprofessional Education and Collaborative Practice, Auckland University of Technology |

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

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

on behalf of a group or organisation(s)

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

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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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| --- |
| We believe that to address the challenges and the opportunities that are outlined there will need to be a considerable re-shaping of health professional education to ensure that new and emerging health professionals can work in an interprofessional and collaborative way. There is little information in the documentation about how up and coming health professionals could/should be prepared for this new environment or how this preparation could/should be integrated into the strategies and action points. We direct you to the World Health Organization’s 2010 document **Framework for action on interprofessional education and collaborative practice** available at http://www.who.int/hrh/resources/framework\_action/en/ |

### The future we want

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

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

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

|  |
| --- |
| We support this statement as we believe that these principles underlie a future health system focused on the people receiving services. We strongly advocate for the need for the future health system to involve collaborative interprofessional practice both in the design and delivery of services. We advocate for strong interprofessional and interagency working with a sharing of “power” between health professionals that actively encourages client/patient participation in the process of designing packages of care that meet the individuals/family/whanau’s needs. |

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

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

|  |
| --- |
| Yes these principles are right for the New Zealand health system and they will from a sound basis to implement the strategy. We particularly like principle 3 and would even encourage a stronger focus or highlighting of the word “**collaborative**” as we believe along with the World Health Organization and the range of evidence that has been developed that interprofessional collaborative practice will make a difference to health outcomes, health service delivery and the cost of providing health services. We draw your attention to the following examples of evidence  <https://www.unispital-basel.ch/fileadmin/unispitalbaselch/Ressorts/Entw_Gesundheitsberufe/Abteilungen/Publikationen/2010/martin_interprofessional-collaboration-among-n.pdf>  <https://www.rcn.org.uk/__data/assets/pdf_file/0004/78718/003091.pdf> |

### Five strategic themes

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

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

|  |
| --- |
| Yes the themes provide the right focus, however in terms of *“Theme 4 – One team”*, we believe that this could be strengthened drawing on the evidence regarding interprofessional education and collaborative practice. For example there is no mention of interprofessional capability and how and when this interweaves with current health and social care practice or the knowledge, skills, values and attitudes that support interprofessional team approaches to client centred health care. We draw your attention to the following     http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Columns/Legislative/Interprofessional-Collaboration.html |

### 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?

|  |
| --- |
| Action 16 (page 44) refers to building system leadership, talent and workforce. There is no clear action on supporting or maintaining the workforce to function as a “team” or to practice collaboratively. We believe that this section should also include details on how to build an interprofessional collaborative ready workforce. There are a range of interprofessional competencies that are now well documented and these should be considered in relation to this Action point, for example  <http://www.aacn.nche.edu/education-resources/ipecreport.pdf>  http://www.cihc.ca/files/CIHC\_IPCompetencies\_Feb1210.pdf |

### 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?

|  |
| --- |
| Assessing teams against a set of interprofessional competencies.  Comparing and contrasting patient outcomes between interprofessional and non interprofessional teams |

### Any other matters

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

|  |
| --- |
| Regulatory authorities should be encouraged to include a strong statement on working interprofessionally. The principles of interprofessional collaborative practice should be mandatory in the competencies for registration for all health professions regulated under the Health Practitioners Competency Assurance Act.  Professional associations should be encouraged to develop position statements on the value of team work and interprofessional practice. See below for examples  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4446653/  <https://www.physiotherapy.ca/getmedia/7f59bd2f-68aa-45c4-aa67-4ca63ccc58a3/Inter-professional-Collaboration_en.pdf.aspx>  https://docs.google.com/viewer?url=http://www.otnz.co.nz/assets/Uploads/pdfs/Position-statements/PositionStatement-InterprofessionalEducationandCollaborativePractice-2012.pdf  The investment by Health Workforce New Zealand into interprofessional education should be continued and expanded to more centres across New Zealand. The following outlines the current project form HWNZ.  http://www.health.govt.nz/our-work/health-workforce/new-roles-and-initiatives/current-projects/rural-health-interprofessional-immersion-programme  http://www.bopdhb.govt.nz/media-publications/2013-media-release-archive/november-2013/benefits-of-rural-life-revealed-for-future-health-professionals/ |

|  |  |  |
| --- | --- | --- |
| **199** | Submitter name | Jeff Symonds and Sandie Halligan |
| Submitter organisation | Nurse Practitioners of New Zealand |



Nurse Practitioners New Zealand

*A division of the College of Nurses Aotearoa (NZ) Inc*

PO Box 1258

Palmerston North 4440

p: +64 6 358 6000

3 December 2015

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

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

On behalf of Nurse Practitioners New Zealand (NPNZ) we thank you for the opportunity to feedback on New Zealand Health Strategy Update Consultation.

|  |  |
| --- | --- |
| This submission was completed by: | Jeff Symonds and Sandie Halligan NPs |
|  | on behalf of NPNZ  a division of College of Nurses Aotearoa (NZ) Inc. |
| Email: | admin@nurse.org.nz |
| Organisation (if applicable): | Nurse Practitioners New Zealand (NPNZ) |
| Position (if applicable): | Executive Members |

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

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

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

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

**√** Professional association

Academic/research  Other *(please specify)*:

**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?

|  |
| --- |
| Nurse Practitioners (NPs) are a workforce that practice at an advanced level and are well positioned to support the initiatives of this health strategy both in the primary and secondary health environments and importantly in the integration of these health arenas. The areas of national, regional workforce development and DHB business planning must reconfigure to include NPs as part of the solution to these challenges rather than as a marginalised section of the health workforce. |

**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?

|  |
| --- |
| NPNZ agree the statement captures what we want from the New Zealand health system. |

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

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

|  |
| --- |
| NPNZ agree that these are the right principles for the New Zealand health system and will be helpful to guide the implementation of the Strategy. |

**Five strategic themes**

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

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

|  |
| --- |
| NPNZ would like to highlight the omission of nurses in “**best mix of practitioners”.** As a group of regulated health professionals, nurses make up a large majority of the New Zealand health workforce. |

**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?

|  |
| --- |
| Yes.  **Page 21:** **“It is important that we have a workforce whose size and skills match New Zealand’s needs. Going forward, this will mean the development of new or stronger skills for some, especially those supporting integrated care that work in teams with a range of health specialties. There is also a need to enable flexible and full use of skills, and this will mean continuing to reduce the barriers that currently prevent this, including legislative barriers”**  **Feedback:** This is in line with the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Billcurrently under consideration.  NPNZ would also like to strongly support the use of telehealth in increasing access to education and upskilling especially to those in rural areas. This decreases the need for travel for clinicians and/or educators and reinforces the use of this medium as a trusted form of clinical support*.*  **Page 22: This Strategy places particular emphasis on integration, which is critically dependent on a team approach. Particular examples of integration in the health system include:**   * **integrated care for a disease condition or population that improves an individual person’s journey; for example, a diabetes pathway** * **integrated health services that combine different services under one roof; for example, provision of Well Child / Tamariki Ora checks at the same location as ultrasound scans** * **coordination with initiatives in other sectors; for example, the Healthy Homes Initiatives, Healthy Auckland Together and Healthy Christchurch** * **vertical integration and service planning that make the right facilities available in the right coverage areas; for example, access to specialists from remote locations, or sharing equipment across hospitals.**   **Feedback**: NPs work across all sectors of health as described above. NPs work in geographically remote areas improving access to specialist health care assessment and treatment. These services often create an interface between primary, secondary and specialist services. This model of practice provides seamless transition in and out of episodic hospital and specialist care. NPs provide outreach generalist and specialist services.  **eReferrals make the patient journey smoother by making the transfer of information between health care providers smoother. They support faster clinical decision-making and increase safety by making it less likely for referrals to be lost or hard to read. eReferrals allow specialists to communicate with referrers on the best treatment options. This may mean that people can be treated in the community, without needing specialist appointments. Auckland, Waitemata and Counties Manukau DHBs have been using eReferrals between GPs and hospitals since 2012. From April to June 2015, eReferrals made up 64,415 out of 86,077 or 75 percent of total referrals in the Auckland metro DHBs.**  **Feedback:** This isanother good example of where NPs can play a key if not pivotal role in supporting to reduce the demand on specialist appointments by providing their NP skills and treatment practices to appropriate people. |

**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?

|  |
| --- |
| **Page 26. New Zealanders make regular and effective use of a patient portal to access their health information and improve their interactions with their doctor and other health care providers**  **Feedback:** NPNZ suggest this is worded “improve their interactions with their health care professional and health care providers”.  **Page 35. “help people in the health workforce undertake tasks they are skilled (or can be trained) to do that have traditionally been outside their roles”.**  **Feedback:** This signals the movement towards doing things differently when delivering health care services, for example NPs working more in traditionally medically dominated fields. Also expanded roles for registered nurses and allied health professionals. |

**Any other matters**

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

**Enable all people working in the health system to add the greatest value by making sure they are providing the right care at the earliest time while fully utilising their health skills and training.**

**a. \* Remove legislative barriers to allow health practitioners, such as pharmacists and nurses, to prescribe under limited circumstances**

**b. \* Increase the use of telehealth approaches, including telemedicine and telemonitoring, to provide services to people closer to their home**

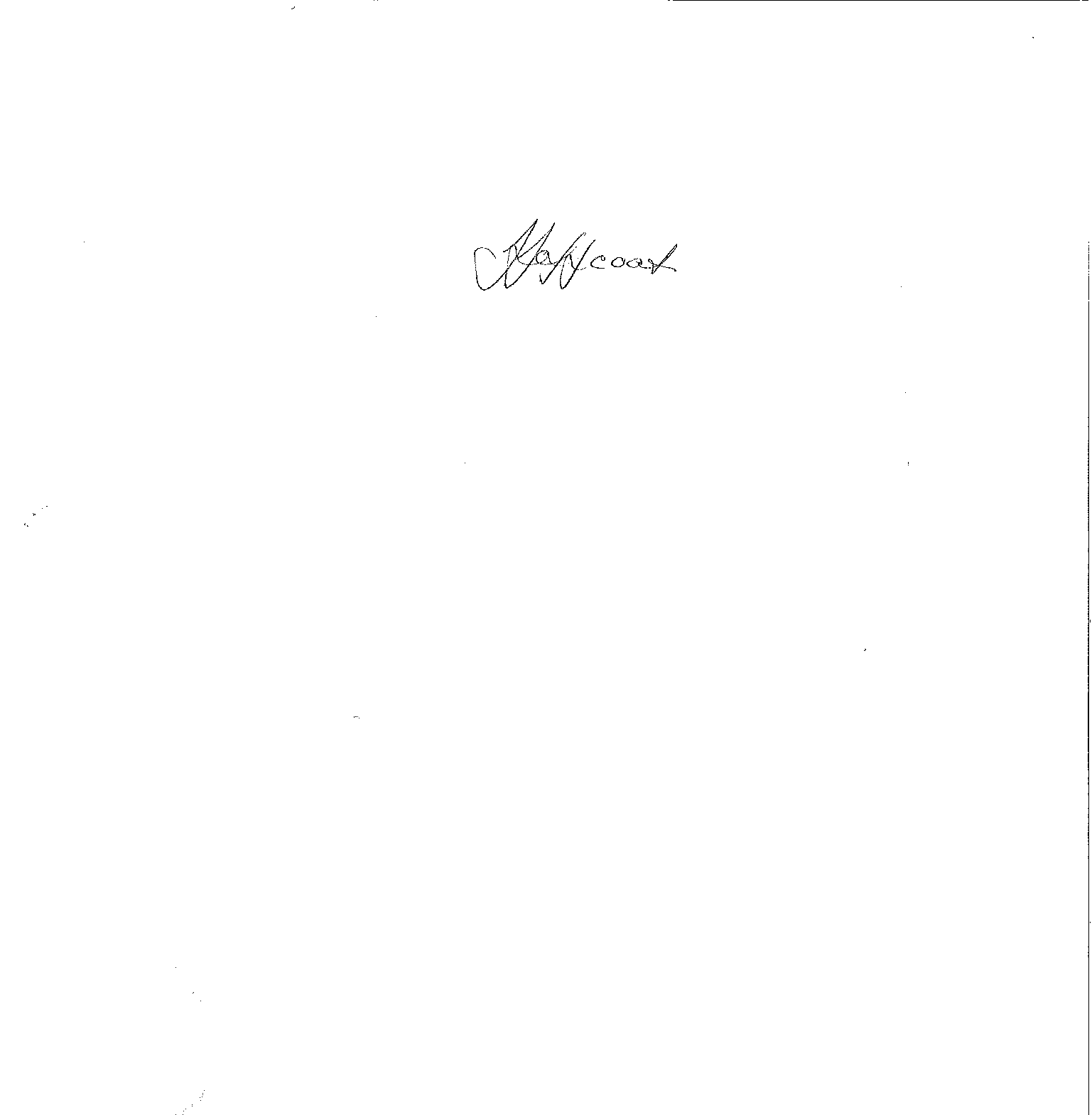
**Feedback: Action 4 a.**

NPNZ agree with the base principle supporting this action appreciating that **4** **a**. relates to registered nurses scope of practice not NPs, therefore we recommend adding in a **4b.** (and 4b to move to 4 c) which reads:

“Nurse Practitioners are authorised prescribers under the Medicines Act 1981 (Reprint July 2104) and accordingly can prescribe medications and treat within their scope of practice allowing them to practice to the full extent of their capabilities.”

**Action 4 c.** NPNZ strongly support the increased use of telehealth services. We have for too long “played” with telemedicine as almost a cottage industry. NPNZ members practice in rural hospitals where they have a telemedicine connection from resuscitation room to the tertiary facility 2 hours away for specialist emergency support. This not only adds to the clinical expertise of the team caring for the critically unwell but also enables clinicians to remain at the bedside while a consultant arranges appropriate and timely transfer to definitive care. In addition telehealth provides a platform by which “face to face” outpatient specialist consultations can happen without the need for the patient or the specialist to travel. This is cost effective on so many levels, decreased risk of DNA due to travel issues such as cost/time off work etc.; clinics running for the duration of session time rather than specialist time taken to travel eating into the session time, limiting the number of scheduled appointments, increasing waiting lists.

Sincerely



Jane Jeffcoat RN, NP, MN (Hons)

Chair,

Nurse Practitioners New Zealand

Nurse Practitioner PHC

Taumarunui Emergency Department

Waikato DHB

Associate Lecturer/Practice Partner

Postgraduate Nursing

Centre for Health and Social Practice

Waikato Institute of Technology

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| --- | --- | --- |
| **200** | Submitter name | Robert Gonzales |
| Submitter organisation | New Zealand Rural Hospital Network |

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**Submission to Ministry of Health**

**From**

**New Zealand Rural Hospital Network**

**(NZRHN)**

**On the**

**Draft New Zealand Health Strategy 2015**

**November 2015**

**Introduction**

The New Zealand Rural Hospital Network (NZRHN) is an Incorporated Society with the following objectives:

* Promote the enhancement of Rural Hospitals
* Promote a coordinated rural health service with high quality, accessible and culturally appropriate approach
* Encourage active involvement of all rural health professionals
* Encourage coordination of training and educational requirements
* Support rural hospital workforce and their families
* Promote equity in health services
* Advocate for rural hospitals
* Form affiliations

There are currently 34 rural hospitals in New Zealand providing acute medical care and / or maternity facilities. Please refer to appendix 1 for a list of these hospitals.

The executive committee of NZRHN consists of representatives of the health disciplines and geographic regions represented by the network.

The executive currently consists of the following members:

Andrea Cairns NZRHN Secretary and Administrative Officer, Oamaru Hospital

Debi Lawry Nursing Services Manager, Dunstan Hospital

Jen Thomas Manager Dargaville and Bay of Islands Hospitals, Northland DHB

John Wigglesworth CEO Hokianga Hospital, Hokianga Health Enterprise Trust

Ray Anton NZRHN Treasurer and CEO Clutha Health First, Balclutha Hospital

Robert Gonzales NZRHN Chairman & CEO Waitaki District Health Services Ltd, Oamaru Hospital

Sharon Wards CEO Tararua Health Group, Dannevirke Community Hospital

Scott Wilson Rural Hospital Medicine Fellow, Ashburton & Dargaville Hospitals

This submission has been made by the executive committee in consultation with the membership of NZRHN.

**Website:**

[www.nzrhn.co.nz](http://www.nzrhn.co.nz)

**Contact Details in relation to this submission:**

John Wigglesworth, Exec Committee Member, [john.wigglesworth@hokiangahealth.org.nz](mailto:john.wigglesworth@hokiangahealth.org.nz)

**Submission:**

NZRHN supports the submission on this strategy from its close working partner Rural General Practice Network (RGPN), and in particular these statements about the challenges facing rural health care in New Zealand:

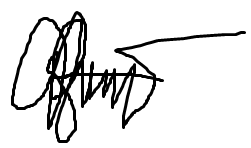
*The challenges of rural health care are twofold. Firstly, to ensure that rural people continue to have local access to sustainable, quality health services and secondly to actually improve the health of rural communities and to reduce the inequities in health outcomes and quality of life experienced by rural people.[[17]](#footnote-17)*

and…

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

1. NZRHN fully supports the general direction of the draft NZ Health Strategy, agrees with the strengths of the sector as a whole, the challenges, and opportunities outlined on pages 6 and 7 of the *Future Direction*.
2. NZRHN is particularly interested in the ‘Closer To Home’ theme of *Future Direction* and the corresponding *Roadmap of Actions.* The network of rural hospitals in New Zealand offers significant opportunities for addressing the health challenges ahead, but we do not think that this potential is sufficiently acknowledged in the draft strategy.
3. Rural Hospitals provide an important bridge connecting locally based primary and community based health care services and the more specialised services offered at base hospitals. Thus they are key to realising the goal of ensuring services are provided closer to home in the rural context.
4. NZRHN strongly supports the statement on page 14 of *Future Direction: ‘Good health begins at home and in communities so it makes sense to support people’s health through services located close to these places where possible’*
5. Emerging skills and technologies, as outlined on page 14, have great potential in further developing the role of rural hospitals in NZ as intermediate stages in care between primary and secondary/tertiary as the complexity of service steps up, during the recovery / rehabilitation phase, and as a step down service, prior to return to community. These skills and technologies include the Rural Hospital Medicine pathway, point of care testing digital imaging diagnostics, video conferencing, telemedicine, and shared medical records and care plans.
6. The language on page 14 falls short of recognising that rural hospitals are part of the community care setting where these new skills and technologies can enhance care. These are alternatives to the ‘specialist hospitals’ instead of hospitals per se. The distinction here is critical from a rural health care perspective.
7. Rural hospitals generally do or have the potential to further integrate services within the rural communities of NZ. Many of NZ’s most comprehensive examples of integrated care are centred around rural hospitals (i.e. Hokianga Health / Rawene Hospital, and Ngati Porou Health/ Te Puia Springs Hospital).
8. Rural hospitals (in whatever shape, size or form) play a vital role in coordinating and sustaining rural health care - in order to group, cluster and support health services in rural communities and provide a critical mass to attract, train and retain health professionals
9. Page 14 does recognise the utilisation of other services for rural communities, it would be important to acknowledge the role of the community / rural hospital in these regards
10. Rural Hospitals also play a role in the other four themes of *Future Direction:*
11. Rural Hospitals are smaller, friendlier, and community based than the larger urban specialist hospital facilities, and thus are able to provide a more person-powered or whanau focused service.
12. Rural Hospitals are a cost effective model for the provision of acute medical hospital care in rural and provisional settings; being well placed to effectively and efficiently manage appropriate medical treatment at a local facility at a significantly cheaper cost to both the health sector and the patient and family, compared to the very expensive costs of service provision at larger specialist hospitals. Provision of inpatient recovery and/or rehabilitation (post acute or elective) is also more cost effective at rural hospitals and relieves pressure on the more complex and expensive inpatient services at the larger urban facilities.
13. Rural hospitals provide a more generalist service often integrating multi-disciplinary teams under the ‘One Team’ concept, providing to the patient and community a one stop shop service. This is particularly the case with rural hospitals that integrate with general practice, primary health care and disability support services. Rural Hospitals offer an ideal environment for developing “shifted services” which is being advocated for by the Ministry of Health. Alternate clinicians will have improved access to the needed support to take on services at the top of their scope. This includes facilities, diagnostics, Allied Health and Community Services.
14. Rural Hospitals represent a smart system as they ensure that the appropriate level of service can be provided close to where people live and work in rural communities. They are also able to be innovative and provide unique, community-focused solutions to the provision of healthcare services in their rural communities. Examples include extended scopes of practice in Balclutha Hospital, robotics and other technological projects in Gore Hospital, generous community goodwill and support towards establishment of CT Scanner services in Dunstan & Oamaru Hospitals, telemedicine at Whakatane Hospital and emergency based point of care testing at Hokianga and Dargaville Hospitals.

On behalf of NZRHN Executive Team



ROBERT GONZALES, NZRHN Chairman

|  |  |  |
| --- | --- | --- |
| **200/a** | Submitter name | [redacted] |
| Submitter organisation |  |

Hi,

Please note:  All details private and confidential thank you.  I do not give permission for any of my details to be made public or released.

This is my feedback relating to the Update of the New Zealand Health Strategy for release 2016.

I have read through the documentation that was kindly provided in written form which included:

National Health IT Plan Update 2013-2014 (two document blue and white paper)

Future Direction

Roadmap of Actions

For me the following proves relevant and timely to consider.

1.    IT is a valuable and important tool in the 21st century.  It is also a tool that excludes people who are not IT literate, do not have money or are unable to access this information due to a number of issues.  Part of this issue is addressed in your documents and I commend you for that.  However, cost factors must be real and fair for those who access versus those who are accountable for the bills and training of and implementing with users, providers, workers and management, CEO realities and outcome requirements.  Levels of access versus ease of use is crucial to get systems to work well for everyone.  Cost must not be an excluding factor for the user of the service.

2.    IT privacy and hack ability must be openly and honestly reported.  If breaches occur there must be real time front up and full disclosure.  Until there is accountability and truth reported and followed up in this area, certain sectors of the community will not engage in providing data.  Again, there must be freedom of choice to provide or withhold any personal details as a basic human right.  By withdrawing or limiting health access to those who not comply – this is unacceptable.  I have a right to know where my information goes and I want to be fully informed before this happens whatever area of place I am connected to.  Equally so, people who are not “legal” or in the system should not be refused treatment.  People should not be billed for treatment with no realistic way of paying for this.  I  know of people who will not seek health care, even emergency health care because they can not afford it.  That is not the sort of system for New Zealand that I want to see.  We need to be inclusive and help those in genuine need.  You can not allow people into a country and then exclude them from the essentials of human care and kindness. Equally, this also relates to residents when costs incurred to attend and take part in active health care are factored in.  This is a reality at present in some sectors of New Zealand that are hidden from the general public. Please do not think that I do not know what is best for me and my family.  I want to know information to make an informed decision, not be told part of a story to produce informed compliance.  I want to be treated with respect and fairly and I want everyone to be treated the same way.  I do not want to be pre-judged.  If I am not paid a living wage or am not in paid employment I am still part of the community.

Finally,

3.   Please continue to work with me, my family, my friends, my community and my world.  Because if we do that, change will happen and All New Zealanders will: live well, stay well and get well.

We also need to accept that sometimes  dealing with an end of life is part of where our story will end at that time and that is important too, for the quality of what happens and how for all concerned.

Thank you for the opportunity to comment.

[redacted]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **201** | Submitter name | Professor Julian Crane | | |
| Submitter organisation |  | | |
| This submission was completed by: *(name)* | | | | Professor Julian Crane |
| Address: *(street/box number)* | | | | Department of Medicine, School of Medicine |
| *(town/city)* | | | | 23 a Mein St, Newtown Wellington |
| Email: | | | | julian.crane@otago.ac.nz |
| Organisation (if applicable): | | | | University of Otago, Wellington |
| Position (if applicable): | | | | Professor |

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?

|  |
| --- |
| Thank you for the opportunity to comment on the health strategy documents  Under the Global Challenges box (page 5) these seem highly appropriate but are predominantly the challenges relating to established ill health or future health problems. They are challenges to “get well”. Is there not a need to have a similar list of challenges for the public’s health about living well and staying well? This list would look at the major challenges to health that lead to many of the problems outlined in the current challenges list. Number 1 would have to be smoking which does not feature at all in this document and yet is the number one global preventable health problem facing countries like NZ. Furthermore a lot of excellent work has already been done in terms of Smokefree 2025 which the government has already signed up to and which would place us in the forefront of smoking reduction globally with all of the enormous health benefits that would flow from that. This would be followed by the other major threats to public health in terms of obesity, diet, alcohol, exercise 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?

|  |
| --- |
| Again the live well, stay well, get well themes are useful but have their own set of challenges that are very different and require different approaches within a joined up system. I am not sure what is really meant by people power and closer to home is not straightforward. For example for many issues closer to home will have great benefits but for others it will be impossible to bring high technology expensive services close to home – the best of these expensive modalities will need to be far from home to be available to the maximum number of people. |

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

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

|  |
| --- |
| Again these are entirely appropriate for any health system with the exception of (4) which of course is important and specific to New Zealand. I would have put it first. It is the only one specific to NZ and is the yawning gap in our one people powered future system of healthcare. It is very clear that in health we are not one people |

### Five strategic themes

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

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

|  |
| --- |
| See above |

### 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?

|  |
| --- |
| Some general comments. I am surprised that digital technologies are the number 1 in the action list. They are important and are already coming in but for many older and disadvantaged communities they are not going to replace current access and service use. What is people-led service design? Action 4 Nurses already prescribe and pharmacists don’t because of a perceived conflict of interest. There seems little innovation here. Why aren’t nurses being trained to undertake many of the more complex screening procedures eg endoscopy or minor surgical procedures in well designed pilot studies?  In Actions 5 and 6 why is there no mention of active or passive smoking – the number 1 modifiable exposure? Why is there no exploration of other levers to modify public health such as sugar, soft drink taxes? They may not be politically expedient but they should be explored as health initiatives. Action 6 c why is this new? How will MoH support families in poverty in low standard rental accommodation? Will it look at legislation to improve standards which are woefully inadequate and favour landlords not tenants. Is that the sort of real support that will be offered/developed? 6(e) Isn’t this being done and if not why not. It was in schools 50 years ago why is it a new strategic direction? What are the priorities in Action 6 a-h which will bring the most benefit and are the most urgent? They seem fragmented and somewhat arbitrary. Is there a detailed cost benefit analysis for each of these? |

### Turning strategy into action

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

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| No specific ideas but it is important that that they are tracked and reported on regularly and publically |

### Any other matters

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

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| On a positive note these documents do provide for greater engagement and involvement of the public in all aspects of healthcare and that is an excellent step and one being taken by healthcare systems around the world. One further addition that I would consider to this is some more detail of the role of research in health care. There is mention of the HRC and their involvement but a greater recognition and public involvement in research as an essential feature of any health system would be valuable. |

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| **202** | Submitter name | Michele Grigg | | |
| Submitter organisation | Hawke’s Bay Smokefree Coalition | | |
| This submission was completed by: *(name)* | | | Michele Grigg |
| Address: *(street/box number)* | | | 76 Wellesley Road |
| *(town/city)* | | | Napier |
| Email: | | | Michele.grigg@hbdhb.govt.nz |
| Organisation (if applicable): | | | Hawke’s Bay Smokefree Coalition |
| Position (if applicable): | | |  |

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

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

on behalf of a group or organisation(s)

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

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(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)*: Local Smokefree Coalition

### 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 needs to include acknowledgement that tobacco use is the most important preventable cause of death, disability and health inequalities in New Zealand. Reducing tobacco use should therefore be a central focus of the new Strategy. The current draft scarcely mentions tobacco/smoking, which is surprising given the focus placed on prevention in the background text of the 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 Strategy has a strong focus on strengthening the health care system. It also, on the face of it, has an emphasis on population health measures, although it is not overly clear how this emphasis will be translated into action. The Strategy’s vision would resonate more clearly with the thousands of Kiwi’s who support a smokefree vision for their whanau and community, if the Smokefree 2025 goal was at least acknowledged. |

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?

|  |
| --- |
| Reducing tobacco use should be highlighted in the Strategy – the number one preventable risk factor for health loss in New Zealand is tobacco smoking. Tobacco smoking is also a major contributor to health inequalities. (ref: https://blogs.otago.ac.nz/pubhealthexpert/2015/12/01/the-draft-nz-health-strategy-will-it-enable-new-zealanders-to-live-well-stay-well-and-get-well/ Accessed 2 December 2015) |

### 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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| Government has agreed to a world-leading Smokefree New Zealand Aotearoa 2025 goal yet this is not mentioned in the Strategy in any form. Projections indicate that the Smokefree 2025 goal will not be met based on current trends, and will be nowhere near met for Māori. This lack of focus on Smokefree 2025 in the Strategy will contribute to a widening, not a lessening, of inequalities. |

### 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 government is preparing a plan of action to reach the Smokefree 2025 goal, yet this is not mentioned at all in the Strategy’s Roadmap of Actions. |

### 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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| Priority interventions for tobacco should be highlighted in the Roadmap of Actions – including but not limited to: standardised packaging, regular and large tax increases, targeted media campaigns, licensing of tobacco retailers, and smokefree cars legislation. |

### Any other matters

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

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| We appreciate the opportunity provided to comment on the draft Strategy, and commend the Ministry for developing a framework for the health system.  However, we are disappointed as a regional Smokefree Coalition that the Strategy as it stands fails to seriously address tobacco use, the leading cause of death and disability in New Zealand communities.  This omission is difficult to understand given the Government’s commitments to Smokefree 2025 and the apparent focus in the Strategy of moving from ‘treatment to prevention’.  There is considerable opportunity for the Strategy to be revised so that it is more informed by the science of health loss. It requires a particular focus on priority population health goals and actions where there is clear evidence of cost-effective interventions. |

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| **203** | Submitter name | [redacted] |
| Submitter organisation |  |



03 December 2015

To the New Zealand Health Strategy Team,

I write regarding your consultation regarding the New Zealand Health Strategy. As a New Zealand citizen, healthcare recipient, and social scientist of medicine, I am pleased to have the opportunity to contribute to the Strategy’s development. I would like to offer my commendations on producing a very thoughtful document, and especially the shift toward a person centred medical model.

In 2013 as part of my Master of Arts degree, I conducted research on Chronic Fatigue Syndrome, or Myalgic Encephalopathy (CFS/ME) as it is otherwise known. This disease affects some 20,000 New Zealand citizens, and is not an easy disease to live with. Patients with CFS/ME suffer considerable pain, debilitating fatigue and physical impairment. Unfortunately medical research on this disease has lagged for decades, and is only recently improving, with suggestions that there are underlying immune, genetic, and neurological pathologies that contribute to the syndromic nature of the disease. Because of this lag, patients often struggle to have their suffering recognised, to receive either diagnosis or adequate treatment. Social awareness of the condition is also lacking, and many find themselves estranged from friends and family. I would like to make (\_) points drawing from my research, regarding the draft Health Strategy and its implications for CFS/ME patients.

First and most importantly, the Health Strategy proposes the development of online portals where patients can self-manage their health, meaning (if I understand correctly) doctors appointments, medication, etc. This will be a very valuable resource for mobility-impaired patients who have internet access. However, it should supplement rather than replace existing systems. One crucial finding from my research was that the shift to self-management (typical of neoliberalising health systems) is devastating for people with CFS/ME. Almost all of these people will, at some point in time, be unable to care for themselves, and will instead by dependent upon family or spouses for basic care such as feeding, or bathing. Self-management is simply not an option in this state of suffering; I suspect the same is true of many others with debilitating diseases that fluctuate over time. It is thus essential that the existing networks of care not only remain in place but are made more robust, with better funding, more staff, and a wider remit of who can receive this care.

Second, the success of the patient portals depends on patients having internet access. Many CFS/ME sufferers do not. This is because they are often ineligible for welfare due to the poor knowledge around CFS/ME as a medical category, and the sheer effort of going through the welfare process with an illness that only permits an hour or two of activity per day. Many of the people I interviewed reported deeply disturbing encounters at Work and Income New Zealand when they sought help in this area. I believe this should be a key area of focus for the Health strategy. Of course preventing long term conditions etc is important, but it is essential that those people who are already suffering from serious illnesses are able to access support in times of need. This will require both working with WINZ staff to ensure an ethos of respect, and ensuring that conditions like CFS/ME have a space in the health system as well as in the doctors office.

Third, the prospect of a ‘smart system’ seems to be a promising area for aiding the cause of CFS/ME sufferers. My project found that many patients had to visit multiple doctors before finding one who recognised their conditions as a physical illness. (It has historically been common for uninformed medical professionals to pass off CFS/ME as a psychological condition; several of the participants in my research had experienced such treatment, and been prescribed psychotherapetuics that caused them significant upset.) A truly smart system for this group of patients would be one that incorporates the most recent information on their disease, and that is updated frequently, to keep pace with the rapid rate of research on this condition. This could be achieved in collaboration with the Associated New Zealand M. E. Society, who do an excellent job of keeping abreast of this literature.

The CFS/ME community New Zealand is highly organised and motivated to improve understanding and treatment of this serious condition. Unfortunately the severity of the disease and the relative lack of awareness about it mean that they are often caught short of energy to further their goals. The New Zealand Health Strategy would be an excellent place to begin accommodating this sadly underserved group of citizens.

My research shows that their suffering is incontestable, and exacerbated by particular features of the New Zealand health and welfare system. Small changes to the latter would make an enormous difference to the 20,000 individuals suffering from this disease. The results of my research are available through the University of Auckland library, and I would be very happy to be consulted further on any matters.

With best regards,

[redacted]

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| **204** | Submitter name | Chris Bullen |
| Submitter organisation | National Institute for Health Innovation, University of Auckland |

|  |  |
| --- | --- |
| This submission was completed by: *(name)* | Chris Bullen |
| Address: *(street/box number)* | Morrin Road |
| *(town/city)* | Auckland |
| Email: | c.bullen@auckland.ac.nz |
| Organisation (if applicable): | National Institute for Health Innovation, University of Auckland |
| Position (if applicable): | Director |

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

X 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

X 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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| New Zealand’s commitment to the WHO of reducing sodium by a relative 30% by 2025.  Will there be an opportunity for healthier diets to be aligned with environmental sustainability?  A greater focus on prevention, especially nutrition as the second leading cause of health loss behind tobacco. Changes in population – not just ageing but also absolute growth and diversity and regional (rural/urban) changes, from economic pressures (macro, such as price of medicines, and local, such as the cost of housing and availability of education and employment), and internal and overseas immigration - will be important drivers of demand and place constraints on services to areas with low populations.  Widening inequality in NZ is not good for health and unless addressed through more fundamental changes that enable wealth redistribution will lead to poorer health for some in particular, but for all ultimately. |

### 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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| --- |
| No change |

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 good principles but our concern is they do not appear sufficiently strongly in the rest of the document when it comes to action  Principle 4 - needs more than mere acknowledgement – it requires that specific actions follow and resources flow accordingly  Principle 6 - a high performing system needs to embrace quality and safety |

### 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?

|  |
| --- |
| Adequate |

### 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 obesity actions are good in themselves but inadequate, so doomed to fail because they do not address the underlying environmental drivers of the obesity epidemic, such as the food system, food composition, availability, pricing and marketing. |

### 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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| Far more collective action is needed with other sectors beyond ‘Health’ whose influence on health exceeds that of the healthcare system - such as Trade and Enterprise, Education, Housing and Local Government.  The Health *System* is far more than just the Healthcare System (which is what this strategy is largely focusing on) and a systems approach to prevention and treatment is needed.  This will require a willingness to break down institutional and departmental silos and sharing budgets and planning processes.  There is some reference to this in the strategy but it does not appear to have translated into the action. |

### Any other matters

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

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| Tobacco smoking scarcely gets a mention yet it is the single most important health issue to tackle to see rapid health improvements, and our national goal of a reducing smoking prevalence to below 5% by 2025 is missing. Surely this should be included as a key outcome/process measure and actions to ensure the target is met considered (note: modelling suggests that with current trends and strategies that target will be missed, and in particular will be missed for Maori and Pacific people by a long way).  There is a similar issue with nutrition which closely follows and is due to overtake tobacco as the leading cause of health loss and early death. A focus on reducing sugar and salt are key, and providing a food system that enables affordable whole food to be purchased by all New Zealanders. |

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| **205** | Submitter name | [redacted] |
| Submitter organisation | Pharmacy Guild of New Zealand (Inc) |



**Pharmacy Guild submission on the draft update of the New Zealand Health Strategy.**

Thank you for the opportunity to provide comment on the draft update of the New Zealand Health Strategy.

The Pharmacy Guild of New Zealand (Inc.) (the Guild) is a national membership organisation representing the majority of community pharmacy owners. We provide leadership on all issues affecting the sector and advocate for the business and professional interests of community pharmacy.

The Guild and its members have taken this document extremely seriously and have taken time to provide a considered response. Our submission is set out below.

### Challenges and opportunities

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

The opportunities and challenges facing the New Zealand Health Sector are well understood and reflected in the draft strategy update. In our view, there are two significant challenges facing the sector that should be further explored – cross agency and multidisciplinary team support, and funding of services.

The challenge of funding enhanced services without increased spending is obliquely referred to as a challenge. A comprehensive approach to funding services should be a core part of the strategy. Taking a coordinated approach to contracting and funding that encourages collaboration will be a critical success factor.

Similarly, “our ability to work together” should be regarded as a challenge rather than an opportunity. While there are some excellent examples of successful cross sector, multidisciplinary approaches to health care, the challenge will be making this the whole of sector norm rather than being limited to local, and project based initiatives.

Local DHB decision makers are well positioned to respond to local community needs and integrate services however our member’s experience has been that this opportunity has not been fully realised. DHBs cite lack of funding as a significant barrier to implementing local initiatives, and the 20 DHB collective appear to have no mechanism to make a collective decision on those things that rightfully need to be decided nationally.

### The future we want

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

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

In general, we support the statement and themes set out in Future Directions, however, we are concerned that “People Powered” is ambiguous and may be subject to misinterpretation. This encompasses three separate and distinct areas – partnership, empowerment, and communication. “Person Centred” would more accurately reflect the intent.

We support the development of integrated health services as a core component of the “closer to home” theme. Community pharmacy is well placed to provide this care in the community, closer to home. This care can be provided from the distributed network of community pharmacies where people can visit a health professional without the need for an appointment.

We agree that health systems should be designed for “value and high performance”. Community Pharmacists are easily accessible by patients, and represent a cost effective healthcare resource committed to making a greater contribution to the multidisciplinary team. In our consultation with the Ministry about the Draft Pharmacy Action plan, we have outlined areas where highly trained and skilled community pharmacist can add value to the health system by providing enhanced services and healthcare closer to home. Of particular note is that the community pharmacy workforce is younger than other health professionals and a higher percentage are New Zealand residents.

We support development of a national electronic health record and believe this should be accorded high priority. With easy access to the patient’s health information, community pharmacists can ensure safer medication use and make medication adjustments or suggestions back to the patient’s prescriber. The shared care record can ensure that all members of the person’s healthcare team are able to work off the same care plan, the same medicines and allergies list and can reinforce the advice and suggestions from the other members of the team. Pharmacists will be better able to work collaboratively with other members of the healthcare team through reading and contributing to the shared record. We support work that will facilitate virtual integration of community pharmacy with other primary health services and health providers, enabling timely information sharing and collaboration of care around the needs of the patient across different sites.

“Smart system” also encompasses funding options. Adequate funding streams must be in place to support new way of working, for example integrated IT systems to provide for sharing of data.

### A set of eight principles is proposed to guide the New Zealand health system.

### *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?*

Principle eight speaks of thinking beyond narrow definitions of health and collaborating with others, however factors that impact on the health and welfare of New Zealanders such as economic, social and environmental conditions are not directly addressed in the document. To be meaningful, the guiding principles should be fully discussed in the strategy.

The principles are visionary and aspirational rather than results focused. Performance management, to measure adherence to the strategy, and progress towards translating visionary principles into achievable outcomes, should be included as an additional guiding principle to ensure vision translates into reality.

### Five strategic themes

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

The strategy is an aspirational document that sets out a vision for the desired future state of the New Zealand Health Sector. Taken in that context, the ‘What great might look like in 10 years’ section is a good statement of intent. However, we would recommend that a bolder series of statements or stretch goals would be more appropriate in a high level strategy document like this. Some general comments are set out below.

**Theme 1 “people powered”**

The outcome statements under this heading are not future focused – they are more in line with initiatives currently underway across the sector. We would suggest statements such as “people make informed decisions on the type and scope of high-quality timely and appropriate services they choose to access”. This statement describes a future state in which health consumers have developed a high level of health literacy.

People often find the health system confusing and daunting. Community pharmacists commonly help people to navigate the health system so that people can make informed choices from what is available.

**Theme 2 “closer to home”**

We believe the “care” component of the closer to home theme is important if we are to improve the health and well being of our communities. The efficient and effective delivery of services cannot be achieved unless care of the individual is a core underlying principle. We ask that this theme be reworded as “care closer to home.”

Community pharmacists are the health professional seen most often in the health system. It is important that community pharmacies continue to be wide spread as an additional point of contact with the health system, to contribute to public health campaigns and minor ailments provision and as an additional point of care in the community. This is especially important for those people who do not consider themselves to be unwell or who when unwell do not necessarily visit a GP.

Statements could be more focussed on outcomes for instance statements such as “Our health system contributes to lifelong health through its support for parents, children, families and whanau” should be avoided. This statement does not describe a desired future state; it describes a general principle which underpins the New Zealand health sector as it functions now.

**Theme 3: “value and high performance”**

We agree that radical integration across the health sector is essential for us to provide the level of care we want for the population within the funding available. We have already mentioned the use of electronic health records as a way for community pharmacists to better contribute to the shared care environment. We also note that clear accountability of who is responsible for what is an essential part of the shared care environment.

We note that medicines are one of the cheapest and most effective interventions in the health system but only if they are taken appropriately. To ensure that the best value is obtained from the medicines purchased we suggest that a system that is redesigned to ensure “value and high performance” would ensure that patients have ready access to pharmacist input. This input will need to cover how to take their medicines and support the patient to understand and want to take their medicines. Pharmacists already provide this advice to people and there is potential to increase the specificity and amount of support that pharmacists provide in this area.

**Theme 4: “one team”**

We support the concept of one-team and effective collaboration for the benefit of the patient. We know that community pharmacists already work closely with the prescribers they share patients with. We believe that greater collaboration can be facilitated with effective IT and better linkages. We believe that community pharmacies remaining at locations separate from GP surgeries have a number of patient and health system benefits;

* the relationship that a person has with their community pharmacist will always be quite different from the relationship the person has with their GP team. This relationship results in an important source of information that can (and often is) shared with the GP;
* people visit their community pharmacy to see if they need to go to their GP or if they can self treat. Community pharmacists triage, treat and refer many times on a daily basis;
* these above interactions could be formalised by having an electronic health record that all members of the person’s health team have read/write access to;
* community pharmacists are better able to reinforce the GP messages by being seen as independent from the GP surgery; and
* people visit a community pharmacy when they are well and when they are unwell. This gives an additional point of access into the health system and an additional point of contact for public health messaging and interventions.

We agree that for change to be affected within the health system it will require strong leadership from the Ministry of Health. The people responsible for achieving the desired outcomes need to be those who have the ability to influence how much money is spent and what on.

**Theme 5: “smart system”**

Smart system should not be limited to describing a health system driven by technology solutions, it should emphasise open and transparent communication and true collaboration underpinned by technology and information sharing. We would recommend adding the following statement; “Communication amongst health professionals and between health professionals and their patients is open, transparent and free from bias” to reflect this.

We would recommend that “what great may look like” should be reviewed on a regular basis – much has changed within New Zealand society and the health sector since the original strategy was published in 2000 and much will change over the next 5 - 10 years.

Regular review of the strategic themes, “what great may look like”, and the strategy as a whole will ensure that the strategy as a whole remains relevant, outcome focused and reflects the current and desired future state of the New Zealand health sector.

### Roadmap of Actions

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

The health strategy is a high level aspirational document that describes a desired future state. As such, detailed action items should not be included as it is not intended to be a project plan, or project initiation document.

In our view, the summary of actions set out in appendix one of the document should form the basis of the Roadmap for Actions. Specific action items should be included with action plans targeted at specific areas of the health sector – for example the draft pharmacy action plan currently in circulation. These would then be allocated responsible persons and timeframes.

As a general comment on the action points:

We see a number of areas mentioned under care closer to home that community pharmacists would be keen to be involved in. They will be particularly useful at contributing to prevention and early interventions.

While we see that pharmacists can certainly contribute their skills as part of the GP practice team for some actions but pharmacists will most effectively contribute to “care closer to home” in prevention and early intervention from their distributed network of community pharmacies.

We refer you to our response to the Draft Pharmacy Action Plan to outline how pharmacy can support implementation through;

* extending the range of national clinically based pharmacy services offered to our communities, and more medicines management input from community pharmacists;
* providing a service network to enable DHBs to deliver on the Ministry’s intent of care closer to home;
* systemised delivery of health promotion and personal health messages. The widely distributed Community pharmacy network is well placed to deliver public health initiatives, not only to the users of health services but also those who are well;
* acute demand management services within community pharmacy. There is value in making this service available with public funding for the most vulnerable in our communities, who may otherwise elect to access free services through the emergency department; and
* providing more services to enable patients to optimise the benefit they receive from their treatments, for example medicine usage reviews provided to appropriate patients by their community pharmacist.

### Turning strategy into action

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

The roadmap provides limited detail on the Ministry’s proposal for setting out roles, responsibilities and accountability for the delivery of the desired outcomes set out in the health strategy. The lack of a central coordinating authority to manage the multiple project streams required to give effect to the vision set out in the strategy may lead to an ad hoc and inconsistent approach that lacks a whole of system perspective.

We would recommend the Ministry establish a Health Strategy project coordination office to monitor activity across the sector on progress towards delivery of the high level outcomes described in Future Direction and the Roadmap for Action. The Office would take the lead in identifying and communicating Government priorities, ensure sufficient resources are in place to deliver on those priorities, provide advice and support to project teams, and hold them accountable for delivery and implementation. Our expectation is that this group would liaise closely with key provider groups across the sector.

### Any other matters

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

The New Zealand Health Strategy was originally published in 2000. While the goals and principles set out in the strategy are still relevant, the challenges facing the health sector have increased in the years since then. It is therefore timely to undertake a comprehensive review of the health strategy to ensure that it remains fit for purpose.

Translating vision into tangible results should be the underlying driver that draws all the elements of the strategy together. Regular review of the strategy including audit of progress assessed against vision and desired outcomes, and incentivising DHBs to focus on MOH goals in negotiating contracts with service providers, will ensure the New Zealand Health Strategy remains relevant and fit for purpose into the future.

It is time for New Zealand as a country to have a challenging conversation about universality. We need to determine the value of private funding of health and incentivising this appropriately to free up services and support for the more vulnerable members of our community. Targeted funding should be reconsidered so the more vulnerable pay less for care, and the less vulnerable pay more, to ensure services remain sustainable.

1. McAllen, J. (2015). *Suicide toll reaches highest rate since records kept.* Accessed on 28 November 2015 from <http://www.stuff.co.nz/national/health/69920289/Suicide-toll-reaches-highest-rate-since-records-kept> [↑](#footnote-ref-1)
2. Directions Youth Health Centre. (2015). *Welcome.* Accessed on 28 November 2015 from <http://www.directions.org.nz> [↑](#footnote-ref-2)
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