**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**206 - 229**

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| **206** | Submitter name | Karen Covell |
| Submitter organisation | Progress to Health |

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| This submission was completed by: *(name)* | Karen Covell |
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| Email: | karen@progresstohealth.org.nz |
| Organisation (if applicable): | Progress to Health |
| Position (if applicable): | Chief Executive |

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)

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Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

## Consultation questions

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

### Challenges and opportunities

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

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

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| Action 1 makes mention of starting with a stocktake of current provision. Would suggest that a stocktake of other strategies and principles are also gathered. We cannot have 'one team' or a 'smart system' without this knowledge. One example would be the Enabling Good Lives principles being driven by the Ministry of Social Development. The principles can quite easily be aligned to those of the Health Strategy and are clearly focussed around being person-centred and the person being in control of the choices they can make around their health and wellbeing. |

### 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 Centre for Inclusion and Citizenship in British Colombia, Canada has developed the 7 keys to citizenship. If these are laid over the above statement, the key areas can easily be identified:  1. Love – having friends and family, loving and being loved.  2. Life – living fully and making a difference  3. Home – having a place where we belong  4. Freedom – taking change of our own life  5. Community – being active and valued in our community  6. Purpose – setting our own direction  7. Money – having enough to live well. |

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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| Refer to the comments made above to question 1. |

### 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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| We must remember that nothing being suggested within the five themes is new, and it’s great to see that things that are already working are being acknowledged with the I. Future Direction document. If we build on what is already successfully working then there is every chance of getting close to the vision of what great might look like in 10 years. |

### 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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| We applaud the action steps stated within the roadmap, but are concerned at the apparent lack of inclusion of NGOs (community and social sectors) within them.  The Ministry is seeking a whole of system response, and whilst the inclusion across the whole strategy of NGOs might be inferred, it is doubtful that it will receive whole scale engagement with only two explicit references in Action 11 and Action 16. |

### 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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| Please don’t lose sight of the experience, knowledge, motivation and energy that can be tapped into within the NGO sector.  There are many conversations and development programmes happening to create outcome focussed frameworks e.g. MoH outcome agreements for health and disability services (results based accountability); the MoH mental health and addictions population-based outcome framework; MSD’s Enabling Good Lives demonstrations; cross-ministry streamlined funding contracts. It would be great to see all the existing/current work being woven together rather than another layer and something ‘new’ being implemented |

### Any other matters

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

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| NGOs are the ones that in the main are working to people-powered principles; we are the ones working with people closer to their homes and in their communities; due to the public funding we receive we are striving to , and indeed are required to, provide value and perform at a high level; we would dearly welcome being part of one system rather than being the afterthought and having things prescribed for us; and likewise being part of a smart system, where we can share our information and our learnings and contribute for the better - to a vision of ‘all New Zealanders living well, staying well and getting well’ |

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| **207** | Submitter name | David Mitchell |
| Submitter organisation | PharmacyPartners Ltd |

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| This submission was completed by: *(name)* | David Mitchell |
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| Organisation (if applicable): | PharmacyPartners Ltd |
| Position (if applicable): | Director |

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on behalf of a group or organisation(s)

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### Challenges and opportunities

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

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

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| We have no additional challenges to contribute. We think the strategy provides a good overview of current and future challenges for the health sector as the sector currently understands them. |

### 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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| It does capture our expectations for both users of the health system and providers of services to the health system. While some people may think the sequencing of the live well, stay well, get well is around the wrong way, we think the sequence is correct as it ensures the system has to take a long-term approach to the health of New Zealanders in addition to restorative care which dominates the thinking of most care providers at present. |

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

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

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| We support the proposed principles. In our role as a sector agent for community pharmacies we believe they provide a suitable and essential framework for the development and refinement of services and service agreements and to guide the thinking of community pharmacists as they develop, deliver and deliver their services to New Zealanders. |

### 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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| The five themes do provide the right focus for action. In passing we note they are already embodied to a greater or lesser extent in the current community pharmacy services agreement and thinking for the next agreement. The headings and descriptions are more helpful than existing material and should better communicate the direction of the strategy.  The “what great might look like in 10 years” sections provide helpful clarity. One always has reservations about trying to paint a clear picture of how the future might look in a time of rapid change as the pictures will inevitably be wrong when one looks back at what is actually achieved or so vague as to be of limited use. It is likely as time goes on that individual practitioners will want more detail as it applies to their specialty to help them focus their thoughts. That said we think the descriptions and objectives in them form a useful starting point for thinking. |

### Roadmap of Actions

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

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

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| On balance we believe the theme areas have identified the most important action areas. As they are relatively broad, it is likely that people at the practitioner level will want more information which is specific to their circumstances as the strategy is developed. We think that material should be managed through specific sector plans (like the Pharmacy Action Plan) or sector grouping plans (eg a combined primary care plan) rather than in the overarching strategy document. This perhaps might better expressed as providing a series of views of the overall action plan which allow individual practitioners to filter the action plan according to their interests and needs to make the project more transparent and accessible.  Over time we think it is likely some of the action areas will turn out to be either more or less important than originally thought and the will be new, currently unenvisaged actions, added. In consequence, the strategy and resulting action plans need to be flexible enough to admit new actions and modify priorities without being so flexible as to drift off course because the original objectives are lost sight off. |

### 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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| Clearly, implementing the strategy will be a very significant project management exercise. While it will be tempting to manage the project from the viewpoint of the various professional sectors affected by it, we think this would be a mistake as it is likely to retain the existing barriers to care integration rather than break them down.  That said it will be very important for members of each sector group to be able to keep track of progress on the actions affecting it and any new actions being added to the plan. We think it will be very important for complete transparency so individual practitioners can maintain their own watch and assessment of progress rather than having to rely on intermediaries to keep them informed. |

### Any other matters

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

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| We have no other matters to raise. |

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| **208** | Submitter name | Brian Vickers | | |
| Submitter organisation | Northland District Health Board Consumer Council | | |
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| *(town/city)* | | | | Whangarei 0145 |
| Email: | | | | kevin.salmon@alzheimers.org.nz |
| Organisation (if applicable): | | | | Northland District Health Board Consumer Council |
| Position (if applicable): | | | | Consumer Council |

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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

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

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| Appreciate that this is an aspirational global goal document, but would recommend that equity of outcomes for Maori and an intensified effort for Maori to achieve equity in relation to their present poor outcome status be emphasised. Hand in hand with this in the north is the paucity of opportunities for economic advancement of large portions of the population – particularly Maori. Economic opportunity needs recognition as an integral part of a person’s ability to achieve good health. Part of the plan should address steps to achieve 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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| Yes this is good. |

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

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

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| Yes, with the addition of equal economic opportunity to one of the principles. This in relation to the large numbers of people in Northland who are caught in a poverty trap, for whom it is not possible to better their situation, but through their children, who may escape – but given their poor health status and the consequent poor educational development let alone difficulty in accessing their own cultural supports which have diminished, have extreme difficulty even in giving their children a fair start in life.  Further, recreational (drugs/alcohol substituted by sport/outdoor activities) and dietary choices and availability might be targeted to promote healthy wellbeing. |

### Five strategic themes

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

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

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| Yes, this is good - provided it is recognised at a strategic level that in some areas, providing appropriate services closer to the people results in unintentional fragmentation, lowering of quality of services provided – thus in some areas providing localised, culturally appropriate teams will result in more access, but inadvertently drive poorer service, quality wise, without proportional extra expenditure to ensure the quality to achieve the Health for All aim.  One team (whole of government) may need to be implemented further down to local areas better in the future – on the ground the “Better/One Government” approach is still apparently very silo-ed with individuals needing multiple appointments to achieve simple tasks with government agencies. When mobility is an issue, this results in poor service for the un-empowered. |

### Roadmap of Actions

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| Achieving economic sufficiency outcomes could usefully be one of the milestones in the table of actions – or movements toward achieving this. Perhaps savings to drive this might be achieved by amalgamating the WINZ Agent/Health navigator roles into a health and welfare agency set-up within the most needy populations to drive the realisation of health and economic wellbeing. Of course education will need to be a key part of this. Health literacy in terms of healthy choices could usefully be a part of enhancing actions to achieve wellness for all – along with legislating against unhealthy food stuffs in the same manner tobacco is targeted (taxation/advertising limitation/limited area for consumption)  Mental Health Goals seem light in the whole document – good physical wellbeing, hand in hand with mental well being should be aspirations. Milestones targeting good mental health precursors in the community should be prominent> |

### 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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| Public education, Further development within our health systems DHB PHO and NGO. If targets are well publicised subsequent measurement and development of standards of performance etc.  Clear statements of what each milestone will look lie in practical terms for consumers and surveying consumers as to how close they are experiencing this (Modified – Consumer user Experience Survey) – better measurement of on the ground penetration of targets and reception of same.  Houshold surveys reviewing the deprivation index with a view to measuring the lowering of incidence of deprivation. |

### Any other matters

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

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| **209** | Submitter name | Queenie Rikihana Hyland |
| Submitter organisation |  |

Update of the New Zealand Health Strategy

All New Zealanders live well, stay well, get well

Consultation draft

Submission form: Hora te Pai ki Kapiti – Maori Health

**December 4, 2015**

Tena koutou katoa,

I am writing in support of the submissions made by many Maori Health submitters concerned at the dropping of Te Tiriti from Health documents.

May I ask that you commit to the meaning and intent of the Treaty. Can I also remind all that since the Wi Parata te Kakakura v Prendergast case of 1877 – where the treaty was declared a ‘nullity…’ that it took 100 years for the intent and direction of the Treaty entered into by Maori was completely ignored… We have lost decades in the interim and Maori health and wellbeing of many of our mokopuna looks to be in peril.

I am a long time supporter of Hora te Pai – Kapiti and we recently celebrated 25 years of exisitence. Our survival deserves consideration..

My mother Ra Awatea Eruini/Parata Rikihana was a stalwart supporter of Horo te Pai… she walked beside all of her relations we the Maori health organisation set up clinics at Whakarongotai marae, Waikanae.

I have been a member of the Maori Health Committee of Compass - rohe of Wgtn, Wairarapa, Porirua and Kapiti – for the past five years. I am also a kuia of Whakarongotai marae – nga hapu Otaraua/Kaitangata. My ancestory is – Eruini te Marau and Wi Parara te Kakakura.

Heoi ano

Queenie Rikihana Hyland

[redacted]

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| **210** | Submitter name | Leanne Samuel |
| Submitter organisation | Nursing and Midwifery, Southern District Health Board |

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| Southern-60 |  |

3 December 2015

New Zealand Health Strategy Consultation

Ministry of Health

P O Box 5013

**WELLINGTON**

**New Zealand Health Strategy: Submission from Nursing within the Southern DHB**

Thank you for the opportunity to provide feedback and also the presentations provided in the south of the South Island. These were certainly appreciated and have helped to inform our submission.

Overall the draft strategy was well organised and clearly articulated. In terms of the content, we support the courageous focus within the strategy and that it is based on determinants of health.  We offer the following feedback:

1. All policy development that then drives funding decisions needs to be sustainable and longer term ie. over 3 years for true outcome benefits to be felt.
2. Moving away from a medical or sickness model needs to be overt to a wellness or health model.
3. The phrase “all New Zealanders live well, stay well, get well” is limited as the reality is people die while in contact with health services so needs to include end of life decision making as well eg. live well, stay well, get well and end life well.
4. New services that are community based need to be made attractive for nurses and other health professionals to move from the very secure hospital based services.
5. Education needs compelled to move rapidly to multi-disciplinary teaching models to teams become the norm.
6. Models such as Whānau Ora that focus on community or family groupings may in the longer term be very appropriate for some but not all communities.
7. Nurses are the largest group of health professionals in the community …. models that involve nurses working in greater numbers in community settings within wider community teams, so duplication and silos are minimised will be a step forward.
8. Perhaps there are some new roles around health navigation that nurses are ideally suited for.  These roles have the potential to save money by ensuring that it is spent appropriately ie. the person gets the best service for them in the best place by the best practitioner for their individual need. Funding around the consumer rather than sitting with providers would ensure access to services that best suit them, with the help of the navigator. Navigator roles spanning more than existing healthcare services are the direction for the future.
9. Top of scope is a given – for all practitioners. For example GPs don’t provide a service that could be provided for by an alternate practitioner.  Advanced practice is a given as frameworks are well established within nursing.
10. Health literacy and drivers to establish say a national health information portal for all to access for general and specific information could be possible for a small country.
11. A single health IT system that means access across the full system, with patient portals would be great so they too can access their own information.
12. Silos between health and social services need to be eliminated as the inputs and outcomes of both are so inter-related so the work planned to reorientate health and social services is essential moving forward.

**Leanne Samuel**

Executive Director of Nursing and Midwifery

Southern District Health Board

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| **211** | Submitter name | Carol George |
| Submitter organisation |  |

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| This submission was completed by: *(name)* | Carol George |
| Address: *(street/box number)* | Community Health Services District Nurses Kenepuru Hospital Ambulance Drive |
| *(town/city)* | Kenepuru. |
| Email: | Carol.George@CCDHB.org.nz |
| Organisation (if applicable): | C&CDHB |
| Position (if applicable): | CHS Respiratory Clinical Nurse Specialist |

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Academic/research  Other *(please specify)*: Community Health Respiratory CCDHB

### 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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| Long Term Conditions are addresses and feature on the strategy nearer towards 201021. There is a need to target Long Term Conditions immediately including Respiratory Long term conditions such as Chronic Obstructive Pulmonary Disease and bronchiectasis which represent a high heath burden for people in New Zealand. |

### The future we want

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

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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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| --- |
| I agree with the principles. In addition,  Paul Mc Donald writes “reduce poverty and increase social connectivity and inclusion – because it is good for health and the economy”.  Reducing poverty is an essential principle in improving health outcomes for New Zealanders. |

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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| My main concern for the Health strategy is that the “closer to home” is a healthy home. The need for warm dry housing is imperative as based on the research by Professor Howden Chapman:  http://www.healthyhousing.org.nz/  We can achieve health that meets all the guidelines, closer to home. And if that home is unhealthy we will have on-going increased burden of health particularly for respiratory conditions. |

### Five strategic themes

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

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

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| People Powered is a great strategic theme. However people need to be resource to be empowered.  The Health Determinants need to be a social and policy priority in order to ensure people are educated have finances, employment and housing in order to achieve people power. |

### 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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| Long Term conditions need to be moved forward in the actions. In addition respiratory conditions need to be prioritised.  Milne & Beasley 2015 note the prevalence of COPD and Bronchiectasis in NZ. We have significant burden of disease and this is too high particularly amongst Maori and pacific people.    Prioritise partnerships for managing Long Term Conditions and extend the partnerships intersectorial and include respiratory conditions. |

### Turning strategy into action

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

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| The formal target for all NZ to achieve health determinants:  Housing- warm and dry, education, employment and no poverty.  The targets for housing need to be extended beyond private land Lords tfor NZ Housing to be leading in healthy homes.  NZ Housing can lead thw way and provide a road map for NZ to follow to acieve healthy housing in NZ. |

### Any other matters

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

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| We have been discussing health determinants for 30 years. To ensure all New Zealanders live well, stay well and get well the Health Strategy needs to reflect that all NZers have the right to be poverty free, be educated and live in affordable health homes. |

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| **212** | Submitter name | Dr Jeff Brown |
| Submitter organisation |  |

Start well, live well, go well.

The end of life (going or ending well) is critical in managing complexity and frailty, without wasting resource. Reference the work of Atul Gawande in highlighting alternative approaches that care more, make each day the best day, and do not chase expensive futile interventions.

Living well encompasses all the preventive, public health, personal health, and interventions to make things better in acute and long term care. The amount and intensity of this part of health care is dependent on policies of the day, on political whims, and on the country’s finances as to what it can afford.

Starting well is the “first 1000 days” from conception. Every child should be born to a healthy mother and grow up in a healthy home. As per Prof Gluckman, ensuring that women are healthy when they conceive, have a healthy pregnancy, a safe birth, and their child has investment in the first few years, will establish the trajectory of health (or illness) for the rest of their life. Investment in these first 1000 days has a return of many dollars (see Rand etc) and should be bipartisan, apolitical, and enshrined in the Strategy to survive political and economic cycles.

Dr Jeff Brown  
Paediatrician  
Clinical Director Child Health  
Chair NZ Paediatrics and Child Health Division Committee of Royal Australasian College of Physicians  
Member of ex National Health Board  
National Secretary and past President of Association of Salaried Medical Specialists  
Member Sector Reference Group NZ Health Strategy 2000

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| **213** | Submitter name | Leigh Murray | | |
| Submitter organisation | DHB Family Whānau Advisors | | |
| This submission was completed by: *(name)* | | | | Leigh Murray |
| Address: *(street/box number)* | | | |  |
| *(town/city)* | | | |  |
| Email: | | | | lmurray@adhb.govt.nz |
| Organisation (if applicable): | | | | DHB Family Whānau Advisors |
| Position (if applicable): | | | | Co-Chair |

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

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

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

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 x Other *(please specify)*: Family, Whānau

### 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?

|  |
| --- |
| This is a comprehensive summary of challenges & opportunities. |

### 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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| --- |
| Inspirational vision statement |

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

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

|  |
| --- |
| Yes |

### 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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| **Under Closer to home – What great might look like in 10 years**  Under bullet point 7 we think there might need to be a statement relating to ‘addressing stigma and discrimination’ which relates to inequity in health outcomes. Currently those with mental health problems in particular are hugely disadvantaged in terms of physical health outcomes . Some of this is related to stigma and discrimination by physical health services.  **Under Value & High performance-What great might look like in 10 years**  On page 18 under point 4 we would recommend adding in bold “…Maori, Pacific peoples and people with **mental health problems and** disabilities.  Under One team – on page 21 Point 6 – As a family, whanau group in mental health and addictions we do not support use of word ‘carer’ which is is not endorsed by our sector. Service users have stated they do not want their family to be their ‘carer’ which implies a fixed role with a top down approach that can hinder recovery & personal responsibility. We do acknowledge that at times as whanau we are asked to take on a caring role so would prefer “Strengthening the **caring role** of people, families, whanau and communities” or perhaps ‘Strengthening the **caring capacity** of people, families, whānau and communities. |

### 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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| ***People Powered***  On page 33 Under people –powered/What do we want in 5 years? “ …& how they can take greater responsibility for their own health. **( & support healthy choices in their whanau)** Suggested addition in bold  Concern that an individualistic self-management approach is being promoted that does not serve children, young people , the elderly or those who are vulnerable through mental distress or disability & those who identify with a collectivist culture (probably majority of population).  On page 34 under Action 1 – d – Create partnerships for better health services by giving everyone on the health team, including the person **and their natural supports,** access to the same information. (suggested addition in bold)  ***Closer to home***  Under Action 5 on page 37 there does not seem to be a specific prevention or early intervention action that relates to long-term mental health conditions.  There is evidence to suggest that tackling mental health stigma and discrimination in the community will enable people to access help earlier for mental distress and prevent a long term condition from developing. Mental distress is very common. However there are a significant number of people who live with their family hidden and protected from life responsibilities (ie on welfare) due to stigma who could have received help in their early teens and have gone on to lead fulfilling lives. **Suggestion that there is an action related to tackling stigma and discrimination across the whole sector.** This is still present today.  Under Action 6 on page 38 – Relating to point a. and h. We would like to see the MoH actively lobbying the government to restrict and regulate access to alcohol so that preventable life long conditions like fetal alcohol syndrome are stopped at the source. We would like to see MoH regularly publish figures on the social and health harm caused by alcohol including the how many children are born every year with fetal alcohol syndrome.  ***Value & High performance***  – As we are bringing a family, whānau perspective we are hoping that under Action 7 – “service user experience measures” this also includes whānau. HQSC’s online patient experience survey is currently only for the identified patient. However Realtime feedback survey in mental health and addiction services incorporates services user and whanau views.  ***One Team***  Under action 16 – e could the word carer please be taken out ie “..accelerate workforce devt actions for the support workforce.”  As whānau we see our role as valuable - being there to support our whānau when it is needed. We see ourselves as more than a workforce though at times we need support, information and education to develop relevant skills so we can provide the right kind of support to those we love and are close to. If the capacity of natural supports is built up there will be less reliance on the public health system. Whānau ora approach is needed across the sector.  We would like to see a separate bullet point created to reflect this.  ***Smart system***  We agree in principle with this. However we would just like to make a point that face to face support is still required. Phone lines and websites can be helpful sources of support but talking to someone in front of you who is understanding and compassionate can help us get through a difficult situation. |

### 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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| We would like to see the roadmap of actions reported against annually for every area of health which could available to view online. To make it accessible it would be great to see it written in language that is understandable to the general population and not more than a few pages. To reflect our growing ethnic diversity it would be great to see it translated into 5-6 languages online. |

### Any other matters

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

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| **214** | Submitter name | Georgia Wakefield |
| Submitter organisation |  |

186A Rintoul St

Berhampore

Wellington, 6023

3rd December 2015

New Zealand Health Strategy Update Consultation

New Zealand Health Strategy Team

Ministry of Health

PO Box 5013

Wellington 6145

To whom it may concern,

**Re: New Zealand Health Strategy Consultation**

Thank you for the opportunity to provide feedback on the proposed New Zealand Health Strategy Update (Future Directions and Roadmap of Actions). I acknowledge what has been a considerable amount of work to prepare these for consultation.

I have opted not to answer your specific questions but provide you with over-arching feedback and specific feedback relating to the dietetic workforce. I trust the comments made in my submission will be given due consideration.

**Introduction**

Dietitians are registered health professionals who meet standards required by the NZ Dietitians Board under the Health Practitioners Competency Assurance Act (HPCA) 2003. In New Zealand, by law, dietitians must be registered with the Dietitians Board and hold a current practising certificate, work within a specified scope of practice, participate in a continuing competency programme and adhere to a Code of Ethics.

Additionally, registered dietitians can undergo further training to be legally qualified to prescribe nutrition supplements. Dietitians are the only registered and suitably qualified profession in New Zealand able to prescribe and manage therapeutic diets for patients and provide the nutrition supplement that will have the best outcome for the patients. **Closer to Home**

I am concerned that there is a fundamental lack of reference to nutrition professionals in the Roadmap of Actions document, who I believe are pivotal to the Ministry of Health (MOH) fulfilling the principle of services being delivered ‘Closer to Home’. The Roadmap of Actions talks about health professionals [namely nurses] being trained in tasks that they have not traditionally performed and altering their scope of work. Whilst this may be necessary in some areas, particularly in rural areas where there is a definite need; there is currently already a near 600 strong dietetic workforce who are skilled and qualified to carry out many of these tasks but to date have not been harnessed even close to their full potential.

Further, I am concerned that to ‘continually invest in training’ when there are a lack of jobs for new graduates, is not an incentivizing career pathway. This is worsened if overseas trained or other health professionals [namely nurses] are trained to fill a nutrition role when a capable dietetic workforce exists. I see an investment in dietetic roles, particularly in primary care, as a more currently pertinent priority than an investment in training.

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

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

**Tackle Long Term Conditions and Obesity**

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

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

I believe that in order to ‘make primary care more accessible and affordable’, to provide ‘more and better access to community services’ and for people to ‘access practical evidence-based health advice that makes it easier for them to make healthy choices and stay well’, significant integration of allied health services at a primary care level is required. With only 20 FTE dietitians employed in primary care nationally we consider this an area of untapped opportunity.

**One Team**

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

Further, I am concerned that the Future Directions document focuses too heavily on the traditional doctor nurse model of care and that there is a lack of recognition of other health professionals who may be the more appropriate service provider or lead care provider. Nor has there been sufficient attention to the need for central health coordinator to assist patients in navigating the health system.

**Value and High Performance**

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

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

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

**Improve Performance and Outcomes**

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

**Some Overarching Concerns**

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

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

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

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

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

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

**Summary of Interventions**

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

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

Yours Sincerely,

Georgia Wakefield

New Zealand Registered Dietitian

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| **215** | Submitter name | Helen Sawyer |
| Submitter organisation |  |

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| --- | --- |
| This submission was completed by: *(name)* | Helen Sawyer |
| Address: *(street/box number)* | [redacted] |
| *(town/city)* | [redacted] |
| Email: | [redacted] |
| Organisation (if applicable): |  |
| Position (if applicable): |  |

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

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

on behalf of a group or organisation(s)

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√ Māori  Regulatory authority

Pacific √ Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research √ Other *(please specify)*: Nursing

### 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 can keep expanding our thinking about who contributes to health by tapping into the skills of individuals, families, communities and businesses through stronger and earlier partnerships.” Add to this:  ***We can integrate, into our communities, discussions which lead to the development culturally acceptable Advance Care Plans which reflect values and beliefs regarding New Zealanders’ future health care*** |

### 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?

|  |
| --- |
| So that **all** New Zealanders **live well, stay well, get well, and die well,** etc…. |

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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| --- |
| Broadly yes |

### 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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| The themes appear the right focus.  They could be strengthened thus:  **Page 13: people-powered** health in 10 years  Add bullet point   * Having frequent conversations with family/whanau and health care providers about what is important (values and beliefs) becomes naturally integrated into all aspects of New Zealanders’ lives   **Page 17: closer to home** in 10 years  Our health system contributes to lifelong health, (and through bereavement), through its support for parents, children, families and whānau.  Add bullet point   * We provide optimal for people living with life limiting conditions, wherever they may be   **Page 20: value and high performance** in 10 years   * The health system provides high-quality, accessible, health services that best help people live well, stay well, get well, and die well, at the lowest cost it can and within the income it has.   Add bullet point   * The health system provides the opportunity for all New Zealanders to develop and express their preferences for end-of-life care based on their personal views and values. |

### 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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### Turning strategy into action

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

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### Any other matters

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

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| Whilst I have a clear comment from a personal professional perspective that a public health approach should be applied to integrate acknowledging and talking about the fact that all people will die. This should be across all aspects of any health strategy, with my view reinforced by reading of the WHO Global Atlas of Palliative Care at the end of life which includes:  “Ensure that palliative care is integrated into appropriate national health and disease-specific policies.”  **Source**: WHO-WPCA (2014) Global Atlas of Palliative Care at the End of Life |

Thank you for taking the time to provide feedback.

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| **216** | Submitter name | Joe Asghar |
| Submitter organisation | Physiotherapy New Zealand |

4 December 2015

New Zealand Health Strategy Consultation

Ministry of Health

Po Box 5013

Wellington

Dear Sir/Madam

**New Zealand Health Strategy: Physiotherapy New Zealand (PNZ) Response**

Thank you for providing us with the opportunity to provide feedback on the proposed NZ Health Strategy and Roadmap of Actions. PNZ would like to acknowledge the considerable thought and work done to get it to this stage.

PNZ is the professional association for physiotherapists that represents the majority of 4300 physiotherapists practicing in a variety of settings across New Zealand. As a member of Allied Health Aotearoa New Zealand (AHANZ) we represent a significant number of the 30,000 allied health professionals nationwide. The commentary provided here reflects the collected views from across the profession.

We are encouraged to see that the MoH is considering making better use of available resource in innovative and dynamic ways. We feel the vision presents a sound platform that reflects the needs of a modern and contemporary health system.

Nationally and internationally, we acknowledge that the future of healthcare lies in developing a cohesive, integrated multi-professional approach to patient care to help the individual to live as independently as possible, and able to manage their own health condition(s) as appropriate. Physiotherapists, as an untapped resource can assist in this space. Early intervention and collaborative care plans with in conjunction with secondary care and key primary care based professions will enable innovative and sustainable community centred models of care to be developed and delivered. The true benefits of physiotherapists as an untapped resource needs to be realised in a time where service demand is likely to increase in a continuing resource-constrained environment. There is an urgent need for physiotherapists (and other allied health professionals) to participate in designing new models of care alongside patients.

Improving outcomes in the sector care will require a more integrated policy approach encompassing not only health but also social care, education and justice. We view physiotherapists and others as pivotal to delivering many of the actions outlined in the strategy and would urge real consideration as to how these professionals can be better used in our new health service.

In addition to comment on the overarching document and the Roadmap, included are thoughts on the opportunities that the profession could bring to the strategy.

M N (Joe) Asghar

Chief Executive

**I. New Zealand Health Strategy**

**General comments**

As the sector works towards new integrated models of care, the scope and range of skills that physiotherapists (and other professions) can offer provides an opportunity for the health system to capitalise and build on these professionals.

There needs to be increased willingness to engage from government, health leaders, DHBs, PHOs and NGO leaders on the potential contribution from physiotherapy and Allied Health generally. The multi-professional and inter-sectorial approach that is regularly demonstrated by physiotherapists means that they are well placed to contribute and lead new ways of integrated working focused around the patient and their whanau.

For example, the role of Physiotherapy in maintaining older person's health is not well recognised. Concern is often expressed about the lack of community supports, intermediate and transitional care that is available for the elderly when they are discharged from hospital early which can result in readmission. Physiotherapy has a key role in preventing admissions/re-admission (e.g. Community Response Teams, Falls Prevention Clinics) and in supporting and educating around long term conditions e.g. pulmonary rehabilitation, cardiac rehabilitation, diabetes management/education. Physiotherapists should be involved with many of the national care pathways that have been developed.

What is described is ambitious and will need a change in behaviours and attitudes to collaborative working and professional respect at all levels. Fundamentally there has to be a change in the relationship between practitioners, where value is being added and outcomes monitored. The value/contribution from other professions to population health needs to be recognised. In annual planning terms, clear accountabilities for DHBs around primary care and funding shifts focusing on integrated working delivering outcomes through a team approach should be key. PNZ feels IT systems integration provides an opportunity (but not the answer alone) to change the culture in respect of patient power, accountability and one team.

The lack of visibility of primary care and allied health in the strategy suggests that any reference is cursory and could be considered an afterthought. This is a significant missed opportunity in a service that is looking to deliver services ‘closer to home’.

The pharmacy agreement is a significant milestone. The principles set by this agreement has general applicability to other professions, including physiotherapists, that requires focussed discussion to build on this opportunity and if we are to meet the pressures the system will face shortly.

More explicit integration across the five strategic themes to define the team outcome metrics is needed – and must involve other professions. These metrics cannot and should not be developed in isolation or from a medical model alone (or indeed by primary or secondary care alone). Expanding the base of alliance contracting to bring other professionals and the social care and NGO sectors into the frame offers an opportunity.

Throughout the strategy there is a lack of detail around how the strategy is going to be resourced and implemented. It is clear that significant changes will be needed to the way in which services across primary and secondary care are commissioned, purchased and funded, where services are delivered and the accountability and success measures expected. If we keep doing what we do we will get what we have always got.

**Why a Health Strategy?**

Now, and in the future, we consider that Physiotherapists have a central role to play in wellness and injury prevention as well as in treatment post injury. However, physiotherapists could also make a broader contribution keeping our population well – physios routinely work alongside other services such as gyms, sports clubs, schools and NGO providers, nursing and residential homes. If supported physios could add to the ‘healthy conversations’ that need to take place to change population health e.g. last year there were 3 million consultations with approximately 500,000 patients through ACC alone – a missed opportunity. The emphasis on musculoskeletal injuries has led to the profession being viewed in a rather myopic way and means that these autonomous professionals are not able to contribute fully to the team around prevention and wellness. Currently there is no incentive to support team based behaviour. Despite these challenges many physios do try and ‘get included’ as part of the team. These highly skilled professionals are ready, able and looking to step up to the challenges faced by our health and social care systems identified and agree that we need a multifaceted approach to prevention, treatment and rehabilitation.

**Health in the wider context**

As stated, physiotherapists are not working to their full potential as autonomous practitioners. The training and preparation develops a practitioner that is able to provide a holistic view of the patient and who can be found across a variety of professional settings including occupational health, private nursing homes, social care etc.

We are pleased to see the partnership intent across agencies and providers reflecting where our population and people go to get well. Given the opportunity to contribute we believe our members can contribute effectively to many of the wider government goals including better social outcomes.

A recent Physiotherapy NZ organisational survey has identified that physios are one of the most IT connected professions providing the opportunity to collect outcomes data, connect with patients and other professionals and of course other systems such as the EHR and the patient portal.

We agree with the logic of an investment approach to health. Dollars invested in the system need to provide a return based on robust outcome measures. As a profession physiotherapists are goal orientated. This language is common and understood affording an opportunity to work in a constructive way.

Considering the broader social determinants of health and chronic/long term conditions is something that the system needs to address urgently. Integration and closer working with other including physiotherapist practitioners to help lift the burden on already over stretched GP/nurses. Managing upstream demand will become an issue in the near future with the changing demographic of the GP workforce.

**Challenges and opportunities**

We agree our health system is strong – it can be strengthened further by truly supporting integration and a culture of respect and cooperation a change that accords with good leadership. Our recent strategy consultation with the profession recognises the same global challenges identified and importantly the move from: institution to networks, fixed to distributed and mass produced to bespoke. To meet these challenges head on, we must use the complementary skills across professions in solid networks that support individuals, whanau and communities. The concept of a *Health Care Home* proposed by GPNZ could and should actively involve physiotherapists.

Our professional strapline of *Movement for life* describes the importance of mobility. The profession recognises the importance that this makes to self-perception, confidence health and wellbeing. Keeping people moving is what the profession does! When we consider the long term health impact of obesity (diabetes, CVD, arthritis, immobility etc.) a role for the physiotherapist is evident. In addition, the profession routinely works alongside NGO partners such as Parkinson’s, arthritis, stroke etc. to support and train carers to deliver care/self-manage their conditions. Our practitioners recognise the inequalities that exist but are not empowered to act because of the lack of connectivity – new co-designed models of care would address this.

At a national level, we are developing our ideas around practice based research to gather data and information to show outcomes in a private practice/primary care setting. This could be more effective if we were working in a joined up sector. Physiotherapists are looking for change and desire a close working relationship with the wider care team to be able to fulfil their obligations to clients. Finally, we are looking to use new technology more effectively in rural/semi-rural areas, supporting standards of practice and developing our professional career pathways.

**The future we want**

In considering culture and values: as stated earlier trust and respect will be essential to support true integration and ultimately to change patient/population behaviour. It is important we agree shared team goals and find ways to resource these. Prevention activities will require a change in focus, recognising that impact timeframes will be longer and clear outcomes to measure success will be required – having the political will to *stay the course* will be central to success on health prevention strategies.

Refreshed guiding principles: we absolutely need to respect the Treaty and our obligations but also need to consider our bicultural heritage in the context of a modern multicultural society. High performance requires a clear structure of accountability and participation in clinical governance activities across all professions looking critically at how clinical or social care interventions increase benefit or risk to patients. Finally, in thinking about sectors we should consider the ‘private’ health sector contribution to health alongside PHO/DHBs.

**Strategic Themes**

1. **People Power**

In thinking about the person at the centre of the system, feedback has suggested that there needs to be consistency in messaging given by different providers and reducing the repetitiveness of questioning around medical histories. Generally the public are not interested in differences across or between professionals, they want to know care as good as it can be, information is shared to avoid retelling stories - people today are time hungry.

Physiotherapists can empower people to manage their chronic conditions however services are not always timely secondary to lack of resources.

Historically, and going forward, physiotherapy services have been reshaped to meet patient/client needs e.g. after normal hours appointments. In this context, physios have and continue to grow a customer centred approach and have significant experience to draw on. To step this up, additional partnerships/relationships are central if we are to focus on the client/patient across their life. Lifelong learning for the patient and the profession is central to our direction and is supported by PNZ and its members. At the same time we recognise the importance of bespoke and distributed care within a systems approach that will be important for a modern and contemporary health service

Putting the patient first demands an effective shared care record – physios require access sooner rather than later in order to safeguard continuity of patient care. It is clear that integration conversations can be started through shared learning and professional development opportunities are a vehicle to consider here.

In the future virtual support through technology can help patients recover, rehabilitate or prevent injury. Today many physios are using App based technology to support patients and help them self-manage their rehabilitation. Encouraging self-management will require breaking down barriers to collaboration, openness to alternative and complementary viewpoints.

Internationally NZ physiotherapy practice is recognised as world leading, innovative and dynamic – but as is often the case, perhaps not in NZ. Indeed, a recent article from Australia has suggested that patients are driving demand for physio input. Of the five jobs about to boom in Australia, IBISWorld is forecasting the physiotherapy services industry to grow by 2.3 per cent in 2015-16, and continue to grow at an annualised rate of 2.5 per cent over the five years. This will largely be driven by demand growth. More patients are able to access physiotherapy services through their private health insurance, and as the population ages, older Australians are more likely to require physiotherapy services. NZ is not different in this respect.

1. **Closer to Home**

Physiotherapists have great diagnostic skills that are underutilised to keep people at home. They regularly work as gatekeepers, but have to weigh up (in relative isolation) the impact of LTCs, social circumstances and medication on a person’s ability to move and rehabilitate. They routinely consider the wellness and prevention aspects of a person’s care. Concern has been expressed about the lack of community resources for physiotherapy and community based rehabilitation. The access to community MDT DHB teams - to enable rapid and safe discharge/ rehabilitation in the home environment needs collaboration with GP and DHB at the community level especially for patients who have high health care needs or frequent admissions to ED.

In local communities physiotherapists are evident and provide support in non-clinical environments e.g. gyms, exercise/Pilates classes, sports side lines etc. all of which keep people in communities heathy and mobile - and they are ready to take on more. While physiotherapists are trained in paediatrics and have a special interest in a hospital environment, most involvement with children comes through the side lines (over 700 physios describe themselves as having an interest in sports injuries/prevention) and education (special needs). This routine connection gives an opportunity for ‘healthy conversations’ in teams to influence the wider family. As a young and dynamic profession they *want* to make a difference. Importantly, as an evidence based profession this fits with the need and desire for interventions to be robust and to deliver an outcome.

Often physios are working in rural/remote locations and we are looking to work with technology e.g. telemedicine to support rural practice and connectivity across teams. Mobile physiotherapists may be another opportunity alongside integrated practice settings. To develop these and other ideas again relies on technology and different ways of thinking about reaching *hard to reach* communities. Falls prevention, balance and core strength to keep people well and independent has been the mantra for physiotherapists for many years, working with our Maori and pacific communities to ensure that our most disadvantaged communities are served.

Managing acute demand has pushed work additional onto general practice and they are already overloaded. With an estimated 20% of all consultations MSK related, it makes sense to capitalise on a workforce ready and able to work as part of the team. If this expertise works alongside the NGO sector we can look to keep our ageing population as mobile as possible..

While MAPs are an excellent opportunity to test concepts and involve physiotherapists into the care team, it is focused only on one part of the repertoire that physios can offer. Many are already work with businesses to get employees back to work and prevent injury recurrence – expanding wellness clinics closer to home with a team approach to eating, exercise, sleeping and mental health offers opportunities thus far untapped. But cross agency working will require cross agency learning and being prepared to take a risk and test new models of care.

1. **Value and High Performance**

Physios already focus on outcomes. The challenge identified is moving to a *team based focus* for outcomes. This will require robust, clear, long-term outcomes not influenced by party politics. The triple aim framework gives a solid foundation as a start point, but clarity around accountability and deliverables in a *team setting* will help establish a culture (fair blame?) where learning can be shared openly cheaply and quickly.

Concern has been expressed about the lack of transparency of information particularly to clinical staff about what opportunities and changes that are occurring. Lack of consultation to what might change the role of physiotherapy or demands of the physiotherapy service.

An investment approach to health will help our population and providers understand what is needed for a sustainable health service for the foreseeable future. But, it requires sustained investment and should not be a vehicle for cuts by stealth. It requires solid robust leadership, commitment from all and agreed outcomes at the beginning. In addition, it requires excellent structures and processes and outcomes models based on effective co-design practice. The future demands engaging the public in self-care/management, the ability to question, novel service commissioning tailored and bespoke to the client, in a distributed way.

Environmental scanning of best evidence will assist in shaping behaviours but will require effective vehicles to distribute the learning and facilitate uptake that is then measured through reporting systems that are transparent reducing poor or inconsistent practice.

1. **One Team**

As indicated already, the language and perception is that primary care is entirely GPs/nurses and the ‘others’ including physiotherapists are not routinely considered to be part of the ‘core team’. Yet as one of the larger professions, using physios to their fullest ability will improve outcomes and allow more routine care to be delivered by less qualified staff e.g. assistants/carers.

PNZ’s strategic direction recognises the need for strong clinical leadership to support change and allow flexible and innovative responses. Again, integration relies on good communication, trust, agreed accountabilities, shared information, system transparency and the ability to troubleshoot. All of this comes from strong clinical leadership. We need solid succession plans for the future and the desired culture needs to be actively nurtured and grown from the top by leaders who want to see change.

Concern has been expressed about the lack of support for the development of physiotherapy specialist roles – given that a degree of specialty can enhance physiotherapy services that can be offered to help achieve wider health goals.

1. **Smart System**

We need robust and rapid systems to deploy technologies – irrespective if they are IT, software, medicines, APPs, exoskeletons, scanning or sensor-based technology, while ensuring patient and operator safety. New developments need to be risk assessed, tested and researched at implementation. Smart system implementation relies on no boundaries – public, private, secondary, tertiary, NGO etc. Any system should be seamless across agencies and support the client journey, data collected should be used to support future decisions and fed back as information to providers and patients routinely echoing transparency. Of the course the challenge is resourcing and implementation.

Information should be available and accurate. Technology across all sites should be standardised which can make communication and transferring information and patient care easy

**II. Roadmap of actions:**

**General comments:**

Generally there is limited/little reference to physiotherapists/allied health professionals in the Roadmap – a significant workforce that could be mobilised to support delivery of the goals. There are examples where the Roadmap refers to solutions being delivered ‘over time.’ This is not a measurable outcome and does not provide a clear description and requires being tighter. Also, a clear plan on how the patient portal will be rolled out is essential in the context of a smart system. This should include how users (public and providers) will be supported in implementing and using the system.

1. **People Powered**

A1:

* It is important to identify the gaps from a service/service provider perspective as we need to use as many as possible vehicles to get information to end-users.
* The roadmap suggests that diabetes is the test platform. There are other LTC’s that would lend themselves to good social media interaction e.g. OA, Asthma, CVD etc. The question is what percentage of the target population have access to and can use the digital technologies today and will this impact the short/medium term outcome?
* Telehealth needs to be available across primary, secondary, private and public health providers – this needs to be more than GP practice centric

A2:

* People led service design – health professionals have a role here in supporting and responding to high need priority populations and should be part of any co-design.

1. **Closer to Home**

A3:

* Engaging with DHBs and PHOs is not an easy task to allow best health outcomes to be delivered. The MoH could facilitate interaction by requiring DHBs to involve allied health professionals in service configuration design and developing planning guidance.
* The term ‘primary care’ needs to be broadened to ensure that the wider team perspective is brought to bear. Without this thinking, it is likely that GP practices will be overwhelmed by demand where much upstream demand could be managed by providers working in the community if good team work and communication existed.

A4:

* As before, physios are an underutilised profession, restricted by historical funding and working practices. However, 3,000,000 consultations through ACC alone represent a significant stream of work that could be used to add value in other ways e.g. healthy conversations.
* Rural physios frequently operate as autonomous practitioners in partnership with their GP, nursing and other colleagues. This rural network is something that could be purposefully supported to better integrate services for patients (that often have greater health need) using smart technology and mobile services.

A5:

* In each of the conditions mentioned, healthy conversations could be applied and wherever/whenever a patient comes in contact with a professional an opportunity to reinforce wellness messages presents – but vehicles/mechanisms and communication needs to be in place to facilitate and support this.
* Physiotherapists are about movement – this adds significant potential to the broader LTC space
* Sharing health outcome data at PHO/DHB level with practitioners across the spectrum (using a co-design approach) will strengthen outcomes for patients and interaction between professionals. Participation in service design of *local* services to support clients will add value but this needs to be forced. The current system does not seek this input.
* Physios are actively involved in the vocational rehabilitation/return to work space but operate in relative isolation. Cross flow of information between professionals and the patient will support them and their employer in earlier return to work.

A6:

* There is reference here to a variety of programmes and initiatives but no indication of the scale of implementation or how the programmes (e.g. obesity) will be resourced.
* Physios can again support work with children through their involvement with sports clubs, schools and special education teams – this is an opportunity and connection that could be capitalised on to change engagement around activity and impact behaviours of parents. This opportunity needs formal development with an outcomes focus.
* As a central service provider to ACC, physiotherapists work with family members across a variety of social settings and as stated previously could contribute further for example on the injury prevention space.

1. **Value and High Performance**

A7:

* Improving performance will require a culture of openness etc. Other professions could/should be part of the HQSC service user views. This could be expanded into the primary care/NGO sector.

A8:

* A health outcome-focused framework relies on good flow of information, clarity of outcomes (evidence based) and measurement tools in place from individual and team perspectives. The development of these is not described.

A9:

* Any system needs to offer *real-time* reporting. Performance management through indicator sets such as IPIF cannot be driven by the medical profession alone in the future. A team approach will be required. In fact channelling resources through the traditional general practice model will also need reviewed as it will no longer be the sole repository of information given the distributed model the EHR affords.

A10:

* For improved commissioning to work, barriers (actual and perceived) will need to be taken down between private and public care settings and recognise that just as general practice is a business it is legitimate for other professionals to be in business too. Making best use of all available practitioners (as has been done with GPs and Pharmacists) in an effective way will increase health outcomes.
* Aligning funding across the system is welcomed – there is limited reference to primary care where most of the ‘action’ will occur when it comes to LTC’s.

A11:

* Targeted investment approaches while sensible in the current climate does require an integrated approach to service delivery across primary and secondary care to be successful. Expansion of Alliance Contracting Teams to involve other professions, NGOs and community stakeholders will be essential if we are to think about health *and* social care.

A12:

* Improving system quality and safety: in this space physios are working to improve outcomes from treatment, and to reduce re-injury. There is significant risk to client outcomes if information is not shared or indeed is shared in an insecure way because systems do not allow safe or convenient communication vehicles or are prohibitively expensive.
* It is pleasing that there is acceptance of the need to ensure funding and information systems support providers improve their services. Ensuring *‘across the system’* input will be crucial from a credibility perspective for the principles of the strategy.

1. **One Team**

A13:

* Agreed: this requires bringing clinical leaders in from professions other than medicine and nursing

A14:

* It is unclear who the current ‘leaders in the system’ are – if these are the same leaders you have had there is a risk you will always get what you have always got!

A15:

* There is a need to develop an advisory framework that supports the shared future direction. PNZ would be delighted to participate and contribute to address the issues presented in this response.

A16:

* This needs to be broader than just the public sector – if clinical and general leadership is not built across all facets of health (including NGOs) there is a risk of continued fragmentation and siloed thinking.

A17:

* Multidisciplinary input into DHB (and of course PHO planning) is essential to grow leadership, understanding, service co- and re-design and of course delivery of services locally tailored yet cognisant of national priorities. Physiotherapists have the potential to be a group of leaders in the new service through their clinical insight, patient focus and system understanding
* Whole of system fora may add value but this requires careful planning and support to help the wider health system participants to understand the machinations of the ‘system’ and its requirements
* Delivering this action (and others e.g. 3,4,5,7,8,10,12,14,16)  will require input from allied health professionals. This requires a seat at the table though either the MoH appointing an Allied Health Advisor or alternatively ensuring robust mechanisms allowing professions access to policy teams to contribute to the debate.

1. **Smart System**

A18:

* Many physio practices have Practice Management Systems that imply the profession could be IT ready and capable to participate in the EHR and Patient Portal

A19:

* We expect that physiotherapists would be considered ‘certified providers’ and would be a priority group for linking to the EHR.
* The use of Apps is a space well-trodden when it comes to physiotherapy practice. In establishing a ‘list’ we would look to have input to support best decisions.

A20:

* Other technologies to assist living and movement are routinely being used and will form part of future care packages including exoskeletons, real time monitoring of vital signs and movement etc. PNZ would be happy to assist in the development of the regulatory scheme as appropriate.

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2nd December 2015

New Zealand Health Strategy Update Consultation New Zealand Health Strategy Team

Ministry of Health PO Box 5013

Wellington 6145

To whom it may concern,

Re: New Zealand Health Strategy Consultation

Thank you for providing us with the opportunity to provide feedback on the proposed New Zealand Health Strategy Update (Future Directions and Roadmap of Actions). We acknowledge what has been a considerable amount of work to prepare these for consultation.

We have opted not to answer your specific questions but provide you with over-arching feedback and specific feedback relating to the dietetic workforce. We trust the comments made in our submission will be given due consideration.

**Introduction**

Dietitians are registered health professionals who meet standards required by the NZ Dietitians Board under the Health Practitioners Competency Assurance Act (HPCA) 2003. In New Zealand, by law, dietitians must be registered with the Dietitians Board and hold a current practising certificate, work within a specified scope of practice, participate in a continuing competency programme and adhere to a Code of Ethics.

Additionally, registered dietitians can undergo further training to be legally qualified to prescribe nutrition supplements. Dietitians are the only registered and suitably qualified profession in New Zealand able to prescribe and manage therapeutic diets for patients and provide the nutrition supplement that will have the best outcome for the patients.

Dietitians New Zealand Incorporated (Dietitians NZ) is the professional association of registered dietitians and associated nutritional professionals. With a membership of approximately 590, we represent the largest group of fully trained food and nutrition professionals in New Zealand. This submission has been developed by National Office and reflects the comments and opinions of our overall membership.

**Closer to Home**

Dietitians NZ is concerned that there is a fundamental lack of reference to nutrition professionals in the Roadmap of Actions document, who we believe are pivotal to the Ministry of Health (MOH) fulfilling the principle of services being delivered ‘Closer to Home’. The Roadmap of Actions talks about health professionals [namely nurses] being trained in tasks that they have not traditionally performed and altering their scope of work. Whilst this may be necessary in some areas, particularly in rural areas where there is a definite need; there is currently already a near 600 strong dietetic workforce who are skilled and qualified to carry out many of these tasks but to date have not been harnessed even close to their full potential.

Further, Dietitians NZ is concerned that to ‘continually invest in training’ when there are a lack of jobs for new graduates, is not an incentivizing career pathway. This is worsened if overseas trained or other health professionals [namely nurses] are trained to fill a nutrition role when a capable dietetic workforce exists. Dietitians NZ see an investment in dietetic roles, particularly in primary care, as a more currently pertinent priority than an investment in training.

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

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

**Tackle Long Term Conditions and Obesity**

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

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

Dietitians NZ believes that in order to ‘make primary care more accessible and affordable’, to provide ‘more and better access to community services’ and for people to ‘access practical evidence-based health advice that makes it easier for them to make healthy choices and stay well’, significant integration of allied health services at a primary care level is required. With only 20 FTE dietitians employed in primary care nationally we consider this an area of untapped opportunity.

**One Team**

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

Further, Dietitians NZ is concerned that the Future Directions document focuses too heavily on the traditional doctor nurse model of care and that there is a lack of recognition of other health professionals who may be the more appropriate service provider or lead care provider. Nor has there been sufficient attention to the need for central health coordinator to assist patients in navigating the health system.

**Value and High Performance**

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

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

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

**Improve Performance and Outcomes**

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

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

**Some Overarching Concerns**

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

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

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

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

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

Dietitians NZ supports self-management of healthcare through the use of digital technologies and the use of social media particularly in the area of Type 2 Diabetes Mellitus (T2DM).

However, it has been raised with the MOH before that many of the high needs populations that are most at risk of chronic long term diseases, such as T2DM do not have access to smartphones or know how to use social media apps.

**Summary of Interventions**

Dietitians are pivotal to the delivery of a number of the actions outlined in the Roadmap of Actions Document. We urge the MOH to consider how dietetic services may bebetter utilised in the development of future primary care models and future funding arrangements.

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

Yours Sincerely,

Georgia Wakefield

New Zealand Registered Dietitian Dietitians NZ

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| **218** | Submitter name | Johan Morreau | | |
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| Organisation (if applicable): | | | | Lakes DHB |
| Position (if applicable): | | | | Paediatrician – previously CMO |

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

x 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 x 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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| --- |
| Documents overall are very good  There is however a lack of acknowledgement of the importance of public health – national policies re pricing of eg alcohol, cigarettes , sugar , the impact of growing inequality of income , inequity as determinants of health |

### 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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| Need to focus on trust in the workforce to “do a good job” – then support workforce with nurture , training, not being over managed and scrutinized in a “blame culture”.This will generate more “can do”, more flexibility, less risk averse behaviour (which itself generates costs)  Also need – more flexible contracting , less tick box , less “risk averse”(all of the above drives costs and reduces output )– this all needs to be better balanced  Current approaches have over time increased needs for for more health management, more reporting, bureaucracy and reduced real health delivery |

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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| All good |

### 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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| Insufficient emphasis on First 1000 days of life (includes pregnancy), ithe importance of attachment and real investment in parenting, early intervention – this determines “the rest of a life” and has huge cost benefits for a country ,both individual wise and cost wise  Insufficient emphasisis on ensuring youth are in education and / or work  Smart system needs to include a national approach to procurement which could in time reduce locum costs, reduce purchasing costs at the same time as improving quality of care through standardisation |

### 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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| Re above |

### Turning strategy into action

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

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### Any other matters

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

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| --- |
| Needs strong focus on provision of excellent palliative care  Needs a strong focus on improving continuity of primary health care to elderly in the community – this will reduce unnecessary hospital admissions , reduce hospital costs and improve quality of care – a critical initiative  Need to improve the culture of services to ensure responsibility is taken for $ being spent wisely – need a Clinical Governance approach nationally, within the MOH , especially in hospital based services, but also in primary health – key to antibiotic resistance development avoidance also  Suggest many eg CYFS social services come “under the umbrella of health” – essential for them to develop a nurturing rather than the current punitive risk averse culture.Without this current Children’s Team approach will be relatively ineffective and not go close to achieving it’s potential.  Well done - apologies that my submission doesn’t clearly align with all of the strategy segments – am sure those closer to it’s development can easily find the right places for my suggestions  Good to see document taking shape – would be grateful for inclusion for some of the above thinking |

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| **219** | Submitter name | Penny Jorgensen |
| Submitter organisation | Allergy New Zealand Inc |

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| --- | --- |
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| Position (if applicable): | Allergy Advisor |

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✓on behalf of a group or organisation(s)

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Service provider  Government

✓Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

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| Additional challenges:  i) Risk factors contributing to the increase and therefore the burden of chronic illnesses - one identified is climate change - but there are also factors relating to adaption to a westernised lifestyle in general, some of which are intergenerational (e.g. epigenetic change).  The opportunity is to better understand (through research) and address these factors (through applied learning) as they impact the NZ population, particularly Maori, Pacific and Asian people.  ii) There is also an opportunity to move from the concept of ‘early intervention’ to ‘early investment’ in the health of children, so that this is seen as a benefit to the population and society as a whole, not just as a way to reduce or contain health spending in the future. Additionally, we should expand our thinking about what – as well as who – contributes to health.  As an example, allergic diseases have been increasing in prevalence, complexity and severity for the last 3 decades. One in ten infants is now likely to have a food allergy by 12 months of age; it is estimated at least 30% of the population overall have an allergy of some form. Global research into causes of the epidemic point to a complex interaction between our genetics and the changing environment and lifestyle associated with urbanisation and westernisation. Studies also increasingly point to desensitisation (immunotherapy) in children as the most successful approach to minimising the atopic march including the development and life-time burden of conditions such as asthma and allergic rhinitis.  iii) The health strategy has identified as a challenge that some of NZs population receive unequal benefits from the health and disability system. Those most affected are identified as Maori and Pacific people, on the basis of life expectancy; and children. In our experience, there are also significant inequalities in benefits based on:   * geographic location – with DHBs serving larger populations able to provide more diversity in specialist services * medical specialisations – with traditional, well-established specialisations more accessible than those for non-communicable and chronic health conditions even though there has been a significant increase in prevalence in these in recent decades e.g. immune-related, metabolic, skin conditions and so on.   Opportunities in relation to this challenge already identified include taking advantage of technologies and sharing information to ‘let us know who is missing out and what isn’t working so we can change it’; and in working together. However there is also an opportunity to expand this to a cross-portfolio approach not only within the health sector but across government, using the social determinants of health as the basis. |

### 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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| ‘All New Zealanders living well’ should be an all of government goal, not just that of the health sector. There are many determinants of health and well being that cannot be controlled by the health sector alone. In addition, there are chronic health and disability conditions that mean people may not be able to ‘get well, stay well’ but their quality of life can be significantly increased with appropriate support, provided it is well-coordinated and resourced. |

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

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

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| Yes in general, although we would like to see an additional principle: “Acknowledging the good health of our children is an investment in the future for all New Zealanders” (it is noted this is referred to in the strategies e.g. ‘closer to home’ but we feel it needs to be elevated to the list of principles and be addressed in all strategies). |

### Five strategic themes

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

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

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| In general the 5 themes provide the right focus for action. However while the ‘People-powered’ theme states it is about ‘understanding people’s needs and wants and partnering with them to design services to meet these’ this is not necessarily reflected in the ‘One Team’ theme. It could be useful to incorporate the mantra of the disability sector – ‘nothing about us without us’. This could be reflected in, as a principle, involving relevant patient/consumer organisations and networks in developments of models of care, clinical pathways, decisions on research projects etc; and ensuring there are pro-active, ‘no-fault’ feedback loops for people (the current complaints process is too confronting for most people, e.g. they may be afraid of losing access to a service if they complain) designed to improve services as well as to identify what works well. |

### 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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| In general agree with the actions, although there are steps or ‘stakeholder groups’ we recommend be added, as follows:  Action 6: Agree particularly with d) to improve collaboration with early childhood services and health services; there should be an additional action reflecting the just published Ministry of Education’s ‘Special Education Update’, which also identifies the need for better interagency coordination particularly with paediatricians and nurses, as well as NGOs. It is noted that in many schools in NZ, public health nurse support has been reduced in order to implement the rheumatic fever prevention programme (e.g. in the Auckland region) in low decile schools. This reduction in health support is occurring at a time when chronic health conditions in children are increasing.  There also needs to be a greater understanding of how health conditions can impact social and psychological development and therefore learning in children. For example, food allergy is a complex and stressful condition, with the risk of life-threatening reactions from food common in every-day diets. Food-allergic children can become anxious in any situation where food is involved, with the potential for long-term mental illness. This may be preventable with appropriate health and social support in early childhood and schools.  Action 17: Lead whole of system forums: Pharmac is noticeable by its absence in this (further comment below). |

### 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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| Evaluation of Actions:  It is important to know if policies actually work before implementing on a large scale. Consideration should be given to pilot programmes, with research evaluating outcomes before widespread roll-out. This should also include a realistic assessment of the resources and time-frames needed to achieve the desired outcomes. Communities including NGOs should be engaged in the determination of needs and best health outcomes, the design of services, and the evaluation and reporting of these. |

### Any other matters

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

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| i) While the Health Strategy has a focus on improving health & well-being for NZers based on what we know now, there should also be a strategy to identify emerging trends, and ensure the health system has the ability to adapt or take action as appropriate, and to lead an all-of-government approach if required. For example, food safety and suitability is an emerging issue internationally, yet is currently the responsibility of the Ministry of Primary Industries. Much of their action is re-active.  ii) While it is pleasing that PHARMAC is implementing new Factors for Consideration from the middle of next year, there does not appear to a clear link to the proposed Health Strategy. Pharmac’s operations are not consistent with most of the guiding principles for the health system (as defined on p.9 in ‘Future Directions’); or with most of the strategic themes proposed in the Health Strategy. One issue in particular is that of prevention of long term health conditions, and how these should be prioritised (or not) compared to acute care, through use of medicines. |

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| **220** | Submitter name | Sandy Hall |
| Submitter organisation | Women’s Health Action Trust |

Submission on the:

*Update of the New Zealand Health Strategy*

*All New Zealanders live well, stay well, get well*

*Consultation draft*

On behalf of Women’s Health Action Trust

Compiled by: Dr Sandy Hall

Policy Analyst.

Due: 5 pm on Friday 4 December 2015.

New Zealand Health Strategy Consultation, Ministry of Health

PO Box 5013, Wellington. Email to: nzhs\_strategy@moh.govt.nz

Women’s Health Action is a women’s health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policy makers and other not for profit organisations to inform government policy and service delivery for women. Women’s Health Action is in its 31st year of operation and remains on the forefront of women’s health in Aotearoa New Zealand.

We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women’s health (including screening), public health and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, women’s sexual and reproductive health and rights and body image.

In 2014 we published a case for creating a Women’s health Strategy[[1]](#footnote-1) and in 2014-2015 we undertook a stock take and review of recent literature in regards to the health of women over the age of 65 in Aotearoa New Zealand[[2]](#footnote-2). We also made a submission on the Older Person’s Health Strategy in 2015[[3]](#footnote-3). Based on this evidence we have identified some of the key strategic policy issues relating to the health of women and girls in Aotearoa New Zealand including the effects of gender and age discrimination.

We therefore welcome the opportunity to give feedback on the *Update of the New Zealand Health Strategy*. Because our area of expertise is the health of women and girls we have focused our comments on strategies for improving the health of women and girls in Aotearoa New Zealand.

**General Comments:**

*“To achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities”* (World Health Organisation, 2002).

The New Zealand Public Health and Disability Act 2000[[4]](#footnote-4) both sets out the purpose of the New Zealand health system, and mandates the development of health strategies (section 8). Section 3 of the Bill refers to the objectives the Government is required to achieve for all New Zealanders including the improvement, promotion, and protection of their health, the promotion of the inclusion and participation in society and independence of people with disabilities, the best care or support for those in need of services, a reduction of health disparities by improving the health outcomes of Māori and other population groups and the provision of a community voice in matters relating to personal health services, public health services, and disability support services. It also includes reference to mechanisms to enable Māori to contribute to decision-making and service delivery with a view to improving their health outcomes. We therefore believe that the consultation draft requires additions and changes in order to meet these objectives, which we have commented on below followed by our comments on the specific consultation questions.

* **Further development of the guiding principles:**

We believe the guiding principles should contain specific reference to the Ottawa Charter[[5]](#footnote-5)as well as Te Tiriti o Waitangi, as crucial underpinning frameworks for development and implementation of any health strategy in New Zealand. This would also reinforce the principle of broadening the view of health and addressing wider determinants of health.

* **Inclusion of a gender lens:**

Planning and delivery of health services and health research must include all New Zealanders and prioritise the needs of those with the highest risk of poor health. The World Health Organization’s definition of health includes *“complete physical, mental and social wellbeing and not merely the absence of disease and infirmity. Women’s Health involves their emotional, social and physical wellbeing and is determined by the social, political and economic context of their lives, as well as biology”[[6]](#footnote-6).* We are disappointed that specific mention of including a gender lens is lacking from the draft strategy as sex and gender are basic determinants of health, which give rise to different health outcomes and different health care needs for women and men[[7]](#footnote-7).

There are health issues that are unique to women including chronic illness and injury; violence against women; mental health; and sexual and reproductive health are particular health issues for women and girls. Aotearoa New Zealand has high levels of violence against women and children, there is a significant income gap between men and women, and women are often held responsible for the health of their families. Women can also expect to live 14 percentof their lives in poor health or with a disability[[8]](#footnote-8). Improving women’s health requires recognition and respect for women’s unique natural life courses including, menstruation, fertility, pregnancy, childbirth, breastfeeding and menopause. In fact, similar jurisdictions to Aotearoa New Zealand such as Australia, Canada and the USA have specific women’s health policies or strategies which address sex and gender differences in health, emphasise prevention and health promotion, and take into account the social determinants of health and the diversity of their female populations[[9]](#footnote-9).

The 2004 Action Plan for New Zealand Women noted that inequalities exist between men and women across a wide range of indicators including health[[10]](#footnote-10). Women are the majority of health consumers, the majority of health service providers and the majority of carers in our society. Increasing participation and decision making at community, government and service level and involving women in both the development and delivery of services improves service provision for everyone[[11]](#footnote-11).

We therefore believe that any successful health strategy must be responsive to the needs of women and actively promote participation of women in health care. This requires a gender analysis in health care strategies, policies and research and greater understanding of gender as a key determinant of health.

The strategy should also be consistent with the principals of the Treaty of Waitangi and other relevant Aotearoa New Zealand legislation such as the Human Rights Act and the international human rights conventions to which we are signatories[[12]](#footnote-12).

* **Clear commitment to address health inequalities and a human rights approach:**

Health inequities are *“the avoidable inequalities in health between groups of people within countries and between countries”[[13]](#footnote-13).* These include the effects of colonisation, culture, affluence and deprivation, political and economic systems, and socioeconomic characteristics, such as education, employment and income as key determinants of health. Addressing health inequalities requires a targeted approach and a health system that is responsive to the specific needs of all. This is not reflected in the draft strategy.

There is ample research that suggests positive changes in the adverse conditions of people’s lives reduce avoidable health inequalities[[14]](#footnote-14). For example, women are over represented amongst lower income New Zealanders, and are more likely to be receiving a benefit, providing unpaid care, sole parenting and receive lower incomes than men. It is the adverse social and economic circumstances of people’s lives that lead to high levels of stress and unhealthy behaviors that then lead to high rates of disease and injury. Issues such as poverty, homelessness, transportation and accessibility impact on women’s health service use. Women on a low income are less likely to prioritise their own health and dental care, and have a poorer nutritional intake[[15]](#footnote-15).

Research also describes persisting health inequities for Māori in New Zealand. Māori women experience poorer health across almost all health areas and age groups compared to other women[[16]](#footnote-16). In general social exclusion and the effects of stigma and discrimination have also been found to have negative impacts on health. A further example is the studies that have found that LBTI women experience higher rates of physical and mental illness and have reduced levels health service access. Being part of any socially or economically disadvantaged group may mean there are barriers to healthcare access including a lack of affordable health care services or female doctors, or a lack of Māori and Pacific service providers. Discrimination and prejudice such as the racism, homophobia or transphobia of health care service staff may also prevent certain groups accessing health services[[17]](#footnote-17).

The draft strategy describes ‘the health and disability system’ but barely mentions people with disabilities many of whom struggle not only to access essential disability support services to allow them to participate in society, but to get equitable health care[[18]](#footnote-18). Similarly, lack of public transportation, language barriers and poor disabled access to buildings may affect access to healthcare of migrant, rural, or older women. Health policy must therefore be designed to meet the needs of women of all ages and backgrounds, take account of the diversity of cultural and ethnic backgrounds and be culturally and linguistically appropriate.

The International Covenant on Economic, Social and Cultural Rights includes as a central provision *“the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”* as part of international human rights law[[19]](#footnote-19). Any health strategy must be informed by human rights obligations which should be explicitly stated as goals.[[20]](#footnote-20)

* **The problematising of age:**

Concepts of aging and attitudes towards older people and being older are variable and culture based. By the twentieth century western popular culture began to present an increasingly negative view of older people and for the first time in history, long life had become a problem[[21]](#footnote-21). By 2051 older New Zealanders will make up 26 out of every 100 people, and the majority of those older New Zealanders will be women. This pattern of increasing longevity of people throughout the industrialised world has generated a substantial body of new policy and theory and this growing group are often discussed with by problematising aging and focusing on perceived economic and other burdens and gender and age discrimination.

Similarly, in cultures where both sexism and ageism are present older women face the “*double jeopardy of exclusion related to both*[[22]](#footnote-22) ”. The problematising of age creates another challenge in constructing successful health strategies and the older adult population can become the target for cost control or feel blamed for increases in healthcare costs. The increasing focus on the health care ‘burden’ of the aging populations means a reduction in state funded benefits can become a real risk. What is often ignored is the contribution ageing women make to the social and economic well-being of their families, communities and nations[[23]](#footnote-23). We would therefore like to and less problematising of certain groups such as older or bigger New Zealanders and more focus on environmental and economic challenges to health.

It is important that access to health care as a basic human right be reflected across age groups and genders. The ageing of our population also has implications for how we protect the human rights implications particularly for the frail, disabled or ill elderly. Older women who are poor or disabled or belong to minorities often experience multi‐sectored discrimination. Similarly, older women in prison, older sex workers and older disabled women can face neglect and abuse or financial insecurity. Prohibitive costs, lack of transport or the absence of geriatric medicine, primary health or mental health services often prevent older women from enjoying their human right of access to health care.

New Zealand’s Age Concern’s Elder Abuse and Neglect Prevention (EANP) notes that older people who are dependent on others are particularly vulnerable to abuse and that for many their health was significantly affected by the abuse they experienced[[24]](#footnote-24). In addition, the health care reforms of the last decade have also had a negative effect on poorer people, including the closing of acute-care beds, and early release from hospital without a corresponding increase in support in the community which has left ageing women with an increased and unrecognized burden of caring for partners and other family members who are ill or frail[[25]](#footnote-25). We would also like to see mention made in the strategy to the role and support of caregivers many of whom are women[[26]](#footnote-26).

Health strategies must take a human rights approach to health care and address issues such as income support and access to appropriate housing and transport. The United Nation’s “Between gender and aging” report recommends certain strategies for addressing older women’s health including a life course approach, providing supportive policies and activities at key transition points in a one’s life, addressing gender and age discrimination and addressing the underlying determinants of health[[27]](#footnote-27). Our Health Strategy should also include reference to intersectoral objectives that enable full and equal participation in society and encouraging intergenerational solidarity and respect.

* **Including data collection, privacy and informed consent strategies and research**

Government statistical data and the data of organisations such as ACC and HDC must be disaggregated by sex and age to provide gender specific information about health. Gender sensitive research is also required into cost-effective ways to help older and disabled people remain in their homes in the community and address the health issues faced by specific groups and the impact of health care reform on gender equity.

Specific reference needs to be made to consumer involvement and informed consent including as a target on the ‘roadmap’. Along with this specific strategies need to be added to embed privacy and consumer rights into the strategy.

**Consultation questions**

**Future directions-Health in its wider context**

Health is treated throughout this section as an input, with little recognition that is also a significant outcome, to which income, social support, inclusion and exclusion, housing, power and participation all contribute. For this reason, we believe the strategy should be assessed for impact on health outcomes and on equity and from a human rights perspective.

The draft strategy starts with a positive view of New Zealand’s health system, reflecting apparently high levels of New Zealanders self-reported sense of good health, access to services and satisfaction with care. We believe this is not entirely accurate and that New Zealand’s performance is mixed and we perform poorly in many areas including avoidable hospital admissions, re-admissions to hospital for mental health disorders and survival rates for some cancers. The OECD notes that NZ’s health spending has slowed significantly since 2009.

The health strategy and intersecting strategies need to address high risk illnesses and chronic disabilities experienced by women as well as men by developing gender sensitive health interventions and include measures that enhance quality of life and support independence.

Local government has an important and often inadequately recognised role in the health of New Zealanders – creating and maintaining healthy environments that are unpolluted, safe and which encourage physical and social activity. Therefore the strategy explicitly includes local government in the whole of government goals. We also believe that local government, NGOs and Consumer support organisations are inadequately recognised in the draft strategy and the role of the private sector is not clearly described.

### 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?**

We agree that New Zealand’s health system continues to be relatively strong but in fact, most of the challenges identified in the 2000 strategy are still with us, and some have worsened. In addition there is concern about the costs of health but other than containment no initiatives to ensure all New Zealanders are provided with accessible health care. There is no cost assessment of the various targets or initiatives.

We also believe that the role of the Ministry and the whole health system structure must be made clearer in the strategy. We would support the inclusion of specific targets for the MOH and its obligations. We would prefer a diagrammatic representation of the system that is a matric with consumers/ patients who are also the funders (taxpayers) of this system at its core. The relationship expected between DHBs and NGOs and the roles of Consumer groups, unpaid health carers and the private sector should also be represented.

The draft acknowledges certain ‘global’ challenges in particular the ‘burden’ of providing health and social services to increasing numbers of older people who are living longer and specific local challenges, including ‘obesity, especially among children. We believe the targeting of certain groups-including older people and bigger people and the ‘disadvantaged’ is contrary to the promotion of good health, inclusiveness and promotes a health culture that wrongly places the blame for illness on the individual. For example, individualising the causes of obesity and blaming bigger people has already given rise to discrimination and stigma here and there is now evidence of ‘hate crimes’ targeting bigger people[[28]](#footnote-28).

We believe the health strategy should include addressing some of the significant global and local factors contributing the marketing of food and alcohol in ways that promote obesity and poor nutrition. Other significant global challenges to health such as climate change and terrorism are absent. In addition, if any section of our society is seen a burden or disposable their rights may be eroded. In addition, we believe the strategy should also include intersectoral targets that enable full and equal participation in society and encouraging intergenerational solidarity and respect. This includes dispelling misconceptions, negative attitudes and stereotypes about aging and addressing sexism and violence against women.

The use of such language as ‘some of New Zealand’s population groups receive unequal benefits’ (p6) implies among other things that the health and disability system is the primary reason for disparities in life expectancy or that access to the system is not a right. The strategy should indicate that all New Zealanders must be able to access decent income and housing which support healthier lives, as well as making services accessible, safe, relevant and appropriate. For this reason, one of our major recommendations is that the strategy explicitly commits the New Zealand health and disability sector, including the Ministry of Health, to reducing inequalities in health and taking an intersectoral approach to addressing wider determinants of health.

### 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?**

The draft starts with a discussion of its overall goal: “All New Zealanders live well, stay well, get well” is a laudable aim but we would like to see the inclusion of an explicit commitment to reducing inequalities.

*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?**

We support many of the existing strategy’s principles, in particular the proposed shifts from the current mode of competition to trust, cohesion and collaboration, and from ‘fragmented health sector silos to integrated social responses’. However, we suggest the current wording ‘from treatment to prevention and support for independence’ should be changed to include such values as interdependence and mutual support, which are central to Māori as well as to other New Zealand populations.

At present, the draft strategy is heavily weighted towards treatment and the sector consultations strongest themes centred around a shift to primary prevention, which has not been well reflected in the strategy. The challenges of improving performance in the treatment area (‘get well’) do not override and overwhelm the challenges of living and staying well and health prevention and we believe promotion strategies and intersectoral collaborations are currently not given enough weight.

### 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).*

* **People power**

Despite its focus on "people power" the strategy fails to comment on where people will get reliable sources of evidence-based information to inform their decision making. We do not think positioning the patient/consumer as a ‘customer’ necessarily improves their “people power” particularly when no mention is made of consumer advocates or representatives or processes for complaints or auditing of performance of both the MOH and health services.

Page 12 mentions an award winning evidence-based app but gives no real detail about cost or how it would work and page 13 notes " *People access practical evidence-based health advice that makes it easier for them to make healthy choices and stay well. Technology tools such as mobile devices, smartphones and wearable devices are options for everyone".* However, the app/s seem to be designed to make appointments or get prescriptions and test results, while they may save money and time, do not to improve understanding. There is also no comment about how privacy would be protected.

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

There is also no clarity about how health literacy will be improved and how independent evidence will be compiled and used and who by. As health care has become more complex, health literacy and obtaining independent, evidenced based information can be difficult. Lack of informed consent procedures, media based misinformation, medication or treatment-induced illness, unsubstantiated statistics (for example mortality rates following hip fracture) along with patient disempowerment, all add to health challenges. People’s power to maintain health is often limited by the power of big business, the media, the pharmaceutical and food industries and alcohol companies. We would like to see more commitment to promoting health literacy - both for consumers and in teaching health practitioners how to support consumers to make evidence-informed decisions. We would also like to see a commitment to transparency around what ‘best practice’ evidence is and how the outcomes of overarching strategies such as the early stage diabetes strategies and the obesity reduction initiative.

In general, this section seems to be less about people power or “the process of enabling people to increase control over, and to improve, their health” (Ottawa Charter, WHO 1996) than about health professionals leading the system, and treating people as ‘customers’ (p11). We believe ‘people-power’ should focus on healthy public policy, supportive physical and social environments, as well community action, personal skills and re-orienting health services. This section should include targets to reduce health issues such as heart disease or infection with a focus on the external environment and regulation not the individual. For example, regulations to ensure rental accommodation is secure and comfortable or to prevent the marketing of unhealthy processed foods to children or controlling sexist or exploitative advertising.

* **Closer to Home**

We strongly support the concept of bringing services closer to communities and believe we should also include providing services to specific disadvantaged communities. We support the focus on wellness and prevention of long-term conditions. However, nurses and doctors at consultation meetings on the strategy identified one of the ‘demotivators’ constantly having to send people back to damp, cold, or unsafe housing in the knowledge that the person will be returning to the health service again soon. While we support such local initiatives as DHBs and local authorities working together on home insulation programmes, more is needed to make sure that people with health problems can heat their homes, and that houses are accessible.

This section should describe partnerships with other sectors to support a healthy start, like housing, local government, early childhood education, primary prevention of violence (including sexual violence), access to safe housing, older persons and disability support services, employment, and income support.

We note that many small rural areas will also have considerable difficulties delivering primary care nursing services in a sustainable way partly because of the capitation funding arrangements which are not always shared by GPs. Service integration will require specific strategies and changes to funding arrangements. There are also major workforce issues around the perception of nurse practitioners amongst other providers. There needs to be more encouragement to use these skilled practitioners in all areas particularly rural and remote areas and the use of new technologies such as telemedicine.

* **High Value and Performance**

Value for money is vitally important. However cost/benefit analysis of investing in activities such as prevention have been included. Similarly there is no discussion of how we fund our health care system. PHARMAC is, quite rightly in our opinion, applauded for the savings in health care dollars but no attention is given to our increasing use of medical devices and implants and how both their safety and cost effectiveness will be guaranteed.

We believe an active review of over-servicing/ over-diagnosis and inappropriate care is called for. For example, the US, Canada and Australia have embarked on programmes called "Choosing Wisely" where ineffective care/ practices are identified by professional colleges and form a part of campaigns to improve practice.

Better information, clear accountability, better research and evaluation will all help measure high performance but won’t actually produce equitable outcomes. We believe the strategy must contain clear and measurable targets and to report on them. It would have been helpful to include information about how we have met the targets set in the 2000 strategy. Priority setting in health care services must be based on evidence that is free from systematic gender- bias.

We believe not enough attention has been given to workforce issues in the draft. There is no strategy or goal related to the training of additional nurses and doctors despite reference to the aging workforce. We would like to see some strategy for investment to be made in this area before the expertise of this groups is lost. Nor should the sector continue to rely on the work of unpaid carers particularly in areas such as the care of frail elderly or disabled people. Simply transferring formal care to the unremunerated care which is often provided by ageing women without providing compensation for lost wages and community support services is discriminatory. People, whānau/ families and communities are often more than carers. They are also the volunteer NGO governors, volunteer drivers and emergency staff. We need to ensure the system does not compromise their wellness by failing to recognise and support them.

The strategy should also recognise the need to invest in people’s health. Intersectoral strategies such as creating housing designs that enable multigenerational living and assistance with home modifications and repairs, accessible housing; hazard-free streets and buildings; safe, accessible public transportation; creating public spaces that encourage active leisure and socialization along with all age-friendly cities and communities and education about new technologies can address many of the factors in the physical environment that help determine the state of people’s health.

* **One Team**

We support the concept of ‘one team’, although we think the present definition must include the patient/consumer. If you can put the consumer at the centre of all activities then it is more likely that one team could emerge with the consumer as the leader. As we noted above we need to train practitioners into helping consumers understand their health care options, their bodies and the health care system.

We also need to review the funding models to ensure that they support integrated care and service delivery and to ensure all parts of the system are adequately and fairly funded. We suggest that the roadmap set and targets for identifying and urgently addressing what is stopping that goal being achieved. We need to remove barriers to collaboration such as contracting regimes that promote competition between service providers. We would like to see clearer strategies for DHBs, local government and NGOs to engage as well as for intersectoral collaboration. We would like to see consumer groups and others as well researchers identified as part of sector collaboration.

* **Smart Systems**

The key to the smart systems will be the evidence-based information used by the different devices. Along with our comments above we would like to strategy to have ensuring privacy and confidentiality as well as an opt-in informed consent process.

There also needs to be some description of the systemic changes required to ensure practitioners share information with the service providers chosen by consumers. Anecdotally information sharing by GPs and inter-hospital information sharing has been fraught with problems. In addition there have been several well publicised cases of government departments not keeping information secure. The strategy must have privacy and informed consent as a key priority.

We believe this aspect of the strategy in particular will require investment in workforce capability and health literacy. We also think the strategy should clearly indicate that technology is never a substitute for hands on professional care. We would like to have seen greater emphasis in using allied health professionals and nurses both to contain costs and to ensure service delivery can be local and tailored to a patient’s needs.

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?**

We do not believe this section is extensive enough. Please see our general comments for what we believe is missing.

### Roadmap of Actions

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

The Roadmap appears disconnected from, and in some respects contradictory to, the principles of the Strategy and the possible results do not seem to reflect the approach set out in the strategy. It also contains untested initiatives without any reference to establishing they are successful for example “obesity reduction initiative in place”. Simply putting an initiative in place is not an outcome. Similarly the “One Team” theme actions are inadequate and there is no clarity about who is in the team or the roles of the MOH or DHBs are. We note that at the Wellington consultation meeting on the strategy, there was strong support from people right across the health and disability sector, as well as health service users and others, for adopting a Health in all Policies (HIAP) model in the strategy and would support this.

### 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?**

We would like to see the action areas strengthened to include the role of local government and NGOs in particular in supporting healthy cohesive communities, promoting acceptance of diversity, safety including from violence, all of which have major effects on health. There also needs to be more clarity about how to achieve intersectoral action at national, regional and local levels. In addition, there is an absence of input from consumer organisations. In addition in the first sector consultation in Wellington there was considerable discussion about the inequitable funding of NGO’s compared to the rest of the sector.

The influence of academic work and of the pharmaceutical and medical device manufacturers on the sector and on sector strategies and policies needs to be made clearer and ethical and independence issues identified.

We note that that the roadmap is intended to be a living document co-created via an annual forum. It is not clear who is to be included in this forum, nor what information they are to base this ‘co-creation’ on.

### Any other matters

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

We have covered this question in our general comments above. We would like to stress we believe the strategy must contain specific targets in relation to informed consent and privacy. We think informed consent needs to be a part of health literacy at least and to be added to the roadmap as a goal in the sort and long-term. We also believe another roadmap goal must be the protection of the privacy of all patient data and that reducing inequalities in health must be explicitly committed in our health strategy.

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

Please contact us if you require any further information

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| **221** | Submitter name | Chris Perkins |
| Submitter organisation | NZ Dementia Cooperative |

Feedback on NZ Health Strategy, Dec 4th 2015 [nzhs\_strategy@moh.govt.nz(link sends e-mail)](mailto:nzhs_strategy@moh.govt.nz)

New Zealand Dementia Cooperative

In our professional experience of working with people who live with dementia, we are very aware that the current methods of care do not meet the needs of consumers. Therefore, it is with a sense of hope that we take this opportunity to contribute to the Strategy, proposed principles for service delivery in dementia care. The adoption of an integrated approach to dementia care emphasising high quality and recognising that caring for people with dementia requires specialised training and knowledge is welcome.

The NZ Dementia Cooperative will support the Ministry of Health in its leadership role by making the significant expertise of providers, researchers, managers, educators, and others who make up the Cooperative available. To ensure the principles outlined in this document are upheld we submit the following comments.

**Health in the Wider Context (p.3)**

We applaud the emphasis on coordination of government agencies. It is commonly known that health is defined by many variables so to live well with dementia, other important factors must be taken into consideration. These include: housing, the environment, education at many levels, social welfare, justice, transport and immigration policies. The social determinants of health also need to be an integral component of health care for people with dementia (Ministry of Health, 2014)**.**

**The Investment Approach (p.4)**

An investment approach to health from the time of birth could potentially reduce the risk of people developing dementia in later life. All the factors important for heart health (e.g. exercise, smoking cessation, maintaining normal weight, treatment of diabetes and hyperlipidaemia) also apply to brain health. Other factors that are thought to reduce risk include: a high level of education, avoidance of head injury, ongoing learning and socialisation (Alzheimers Australia, 2015). Obviously these are important issues for people at all ages and stages of life. Implementation would require a cross-agency approach

Figure 1:3 (p.4) indicates that population ageing is not high on government’s priority list and there is no mention of this in “Government Priorities” or “Cross Government Strategies”- yet in the next 10 years as the “baby-boomers” age, this may become a more pressing issue not only for the health sector, but also many other government agencies.

Baby boomers who choose to retire over the next 10 years will certainly affect the workforce, but equally they may use their skills in a voluntary capacity (Cornwall & Davey, 2004). Already, many retirees are caring for people with dementia and this involvement is likely to continue. Investment in the health of older volunteers and family carers (by supporting them to remain well) will pay dividends in maintaining people living with dementia in the community.

**Challenges and Opportunities (p.5)**

The New Zealand Health System has many strengths. We should strive to retain equitable and functional services despite concerns about the cost. It is important that the greater numbers of older people, along with the increasing challenge of long-term conditions such as dementia, are incorporated into future planning.

There is an urgent need to address workforce issues affecting those who work with older people. The high staff turnover in the support worker/healthcare assistant role in both home based and residential care affects providers’ ability to deliver a quality service (Ravenswood, Douglas & Teo, 2014). The issues driving this turnover are extensive and relate to remuneration, working conditions, workforce management, immigration issues, training and qualifications, and a general undervaluing of the support role. Essentially, there is a significant need for workforce development and cross agency discussion to avoid the ongoing turnover of staff and to reduce the risk of significant shortages and poor quality service delivery (Naden, 2014).

With regards to Treasury’s prediction that we will be paying 11% of GDP on Health in 2060, if preventative strategies are put in place *now* (as per “The Investment Approach”- e.g. tackling obesity- p.4) this figure may be reduced. Furthermore, the last of the baby-boomers (born in 1964) will be 96 in 2060. Population ageing will have slowed down and will continue to decrease thereafter, potentially reducing the amount of funding required for older people’s health (Dale, 2015).

**Opportunities**

Prevention, using everyone’s (including older people’s) skills, taking advantage of technology, and sharing information will improve the health system’s capacity to function well for people living with dementia. The NZ Dementia Cooperative strongly advocates that we all work together.

**The Future We Want (p.8)**

The Cultures and Values and Aligning behaviours sections are all relevant to people with dementia and their family/ whanau.

1. **People- powered (p.11-13)**

Listening to people with dementia and their support people is essential to inform service provision. What people want will not necessarily increase the costs of care, rather, costs may be reduced by enabling people to live at home for longer (Cantley, Woodhouse and Smith, 2005). People want more flexible care packages and respite options. The current system is too rigid, providing only standard options rather than person / whanau-centred care. This is particularly important as it has a significant social impact. Other people living with a chronic condition have access to individualised funding for care (Office of Ministry for Disability Services, 2007). This should be an option for people with dementia and those who support them.

Access to different forms of information e.g. recently updated brochures from Alzheimer’s NZ, electronic information and patient portals would be very helpful e.g. *About Dementia* (Alzheimers NZ, 2015)

1. **Closer to home (p.14-17)**

Transport can be a problem, especially when driving is no longer possible. Therefore, care closer to home is important, especially as the ‘Ageing in Place’ policy (MSD, 2015) encourages older people to live at home as long as possible.

Poor access to GPs, particularly after-hours, contributes to unnecessary general hospital admissions (Mays, 2013). Emergency department visits and hospital admissions often impact negatively on people with dementia as any change in their environment is disorientating and distressing, especially when cognitive impairment is aggravated by physical illness (Hirschman et al 2011).

Encouraging GPs to improve their care of people with dementia in aged residential care while addressing workforce and funding issues for after-hours care may result in fewer hospital admissions and greater patient / family wellbeing thus offsetting avoidable costs.

Specialist clinics (such as geriatric or psychogeriatric clinics) in a general practitioner’s (GP) surgery would be a cost-effective way of providing ongoing care for people with dementia and supporting primary care to do so. For example, see Waitemata DHB Cognitive Impairment Clinical Pathway (Holland, 2013).

1. **Value and high performance**

The aim for health equity for all populations includes older people, including those who are cognitively-impaired and their carers (who are at risk of deteriorating health). For example, people with dementia have a right to receive excellent general hospital and palliative care yet this is not always provided (Souza et al.2014). The targeting of Maori, Pacific and Asian older adults and their families whom have dementia would further help address disparity. (Dyall, 2014). There is a paucity of New Zealand research addressing care provision and measuring outcomes to enable continuous quality improvement.

**One team (p. 21-23)**

People living with dementia benefit from vertical and horizontal collaboration with all sectors involved. They and their support people must be at the heart of the team and should be listened to.

Good examples of initiatives in the community include: local police holding a database of people with dementia who might get lost, DHB dementia care pathways involving primary and secondary care and NGOs. International initiatives include: dementia-friendly cities.

1. **Smart System (p. 24-26**

While easy access to information and ready communication is vital for health care, technology has enormous potential for helping people with dementia to remain independent e.g. tracking devices, fall detectors, various alarm systems, medication monitoring. Here again research is needed to evaluate the utility, acceptability and ethical aspects of such devices in New Zealand.

Turning Strategy into Action

On the example road map given on page 29 we do not see reference to older people (including those with dementia). This is unusual since older people are the focus as noted on page six. (p.6)

Keeping an older person healthy and independent usually takes more health and social services than are needed for younger people. Older people are also more vulnerable to disability and to having more than one health condition.

Long-term conditions are a particular challenge with an ageing population. Dementia is one example and we expect the number of New Zealanders with dementia to rise from about 48,000 in 2011 to about 78,000 in 2026.

Maintaining and maximising an older person’s health and independence usually takes more health and social services than younger people require. Older people are more vulnerable to disability due to multiple health conditions. Chronic conditions are a particular challenge for the ageing population; dementia is but one example. It is important to keep in mind that the number of New Zealanders with dementia is expected to rise from about 48,000 in 2011 to around 78,000 in 2026 (p.6).

Possible results for the road map might include:

**People-powered:** Each person with dementia and their support person is able to access an individualised care package. Services provided are those requested by the people involved rather than a standardised package or whatever happens to be available.

**Closer to home:**

1. Secondary-care - highly trained dementia workers are established in GP practices, 2. Aged residential care is supported to become an attractive option to GPs.

3. 100% of aged care facilities have effective after-hours cover.

**Value and high performance:** People living with dementia and their carers are consulted about the quality of care provision in primary and secondary services and from contracted NGOs.

**One team:** No change

**Smart System**: People with dementia and their support people can access technological support to enable the person with dementia to remain living at home safely, for as long as possible.

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**Feed Back on NZ Health Strategy 2015**

Thank-you for the opportunity to give feedback on the Draft NZ Health Strategy.

**Health in its wider context:** (pp 3 &4)

It is important to see health and health services within the wider social context. Health impacts on all aspects of life, just as society affects health via many routes such as education, home and work environments, transport and recreation.

In recognition of this interconnection, it is good to note government’s intention to coordinate agencies to deal with social and health issues, especially for disadvantaged New Zealanders.

The “investment approach” thus should not just focus on health per se, but consider important social issues such as poverty, inequality of income and opportunity, housing (avoiding overcrowding and cold), nutrition, education, spirituality and agency (truly allowing life choices), avoidance of social isolation and loneliness, and reduction of domestic violence and drug and alcohol abuse. All these issues impact significantly on long-term health, and probably have more effect on wellbeing than does the health sector per se.

I commend the health sector for working with other agencies to provide healthier homes, attention to families (hopefully including elders) via whanau ora and reducing assaults on children. I would like to see policies that produce age- and disability-friendly homes and communities. As well as reducing assaults on children, attention should be given to reducing elder abuse.

I note that despite the ageing of the population, the cross government strategies mentioned are mainly focussed on youth. For example, most disability occurs in older people but this is not acknowledged in the NZ Disability Strategy and there is no specific mention of older people here, as there is with children and youth. I am pleased to note, however, that most aspects of the NZ Health Strategy DO apply to older people. The ageing of the population must be addressed by the government as a priority because of the important effects on social welfare, employment and the economy as well as health.

**Challenges and Opportunities** (pp 5-7)

It is accepted that by international benchmarks health care provided in New Zealand is generally good. However I disagree with bullet point 6 in the list of

“strengths …a growing best-practice evidenced-base developed through research” (p. 5).

In fact health research is poorly funded and lacking in many areas. Funding for research, in New Zealand is less than 1/3 of Australia, 1/5 of UK and 1/10 of USA per head of population (Reid et al, 2014). In the specific area of dementia, New Zealand research is meagre and of patchy quality, and there are huge unexplored areas e.g. dementia in Pacific people, best ways to care for people at home, entering residential care and much more. We rely on *estimates* for numbers of people with dementia and have done no research into prevalence or incidence. And this is in an area (p. 6) that will significantly challenge health resources! Much more funding should go to local research, particularly into important local issues of care (rather than, for example, trying to find the cure for dementia).

Although providing services to frail old people may be seen as a *challenge*, our ageing population is a positive thing – we have survived. Many older people care for frail elders and many others in a variety of voluntary roles. Harnessing the energy and skills of healthy retired people is a great *opportunity* that should not be missed.

Most advances in life expectancy have resulted from social change e.g. sanitation, improved housing, mandatory seat belts in cars, social stigmatisation and increasing cost of tobacco smoking, rather than the provision of health services. Wealth and educational level are currently the best predictors of longevity. Maori and Pacific people have lower life expectancy, but this is as much to do with poverty, life-style and cultural alienation as to access to health care.

If Treasury thinks too much is spent on health, it might be worth looking seriously at preventive or risk-reduction approaches. Wilkinson and Pickett (2009) demonstrate that many health outcomes improve when economic disparities are minimised. Mandating a “living wage” might be a first step.

**The future we want** (pp. 8-9)

While the health system by itself can do very much to reduce disparities in health outcomes or ensure “wellness”, promoting ease of access to and responsiveness by health services is a worthy goal.

With the proviso that the way to improve health status in those currently disadvantaged is to reduce disadvantage, the refreshed guiding principles are good. The aligning behaviours are fine, though how will these be measured?

**Five Strategic Themes** (pp. 10-13)

It is recognised that there will be times when these interconnected themes must be balanced against one another.

1. **People-powered** (pp.11-13)

* *Understanding people’s needs and wants:* e.g. understanding older people’s desire to stay at home, despite health problems and to partner with them and their informal carers to design services to meet the need. Currently we have very inflexible services with poorly-paid workers who have little time to supply older people with what they really need (often company). We need to recognise the substantial cost of family caring for those with disabilities or health care needs. It is interesting that Hillary Clinton is calling for tax credits to compensate relatives who need to take time out from the workforce to support their elders. It is also suggested that leave from work for elder care should be viewed in the same way as parental leave for childcare. (Khimm, 2015)
* *Empowering people:* Making healthy choices easier for people includes not only the health sector but also, for example, the food and beverage industry, local government (transport and safe walking) and various NGOs, easing loneliness and social isolation.
* *Communicating well*: Communication of health information is important but motivation for healthy living is vital. This comes only when people see a positive future for themselves; this is not always the case for disadvantaged individuals and families.

People with *age-related* disabilities (in line with other disabled people) should also have ‘individualised funding’ in the form of a personal budget to get the services that best suit their needs. (This would be in line with not discriminating against disadvantaged groups such as older people).

1. **Closer to Home** (pp. 14-17)

We should try to shift resources out of the hospital and into the community. One way to do this might be to increase funding to Aged Residential Care (ARC) so that residents can be treated without transfer to hospital. Advance directives and adequate availability and effectiveness of GPs in ARC would also help this.

In Australia, telehealth is routine, even for across town meetings of health teams as well as for clinical assessment. This works well, especially since the equipment is easy to use and reliable once set up. It would be great to see this used for cross-sector meetings as well.

Inaccessibility of GP because of cost: perhaps people should be paid a living wage, benefit levels increased and/or greater subsidies provided so that cost is not a disincentive to receiving appropriate care. Integrated Family Centres and tips for warmer drier homes are interesting examples of different sectors working together, but I wonder how families crowded into damp Auckland houses are able to afford “space between sleeping children” (p. 25)

*Long-term conditions, including obesity*

As noted, it is children living in deprived areas who have the greatest risk of obesity. Is it possible to address the causes of deprivation that make obesity more likely? This would take a cross-sector approach and may require tough decisions from government and a softening of the neoliberal philosophy of non-state interference.

*What the health service might look like in 10 years*

This is a great vision. I wonder if you might specifically mention adequate community care for older people since this group will be very prominent in 10 years.

1. **Value and high Performance**

A focus on results is ideal though having players in systems other than health may cause difficulty in determining which contributions are the most important. How do we decide what “results matter most” in order to focus on them? I agree that sharing evidence and ideas and implementing them nationally is much better than each region developing its own approach to common problems. Certainly a holistic perspective will help decision-making. Spirituality, an important aspect of holistic health that contributes to wellbeing, should not be neglected.

The 10-year vision looks great, bearing in mind that the Health sector will play only a part in lifting health outcomes for Maori, Pacific and disabled groups and that social and economic changes are also necessary for this to happen.

1. **One Team**

I agree with the team approach, particularly including patient, family / whanau and volunteers as team members and other non-clinicians. I have noticed over years of working in the NZ Health system that there is often a gulf between managers and clinicians. It would be very useful for grassroots workers to have more say in the way the health dollar is spent. We are often aware of duplication, expensive, defensive practices and unnecessary, unhelpful bureaucracy that waste our time and ultimately money.

In 10 years I would hope there is enough investment in community and ARC services to have significantly reduced the 20-30% annual staff turnover that makes it difficult to increase the capability and capacity of the aged care workforce.

1. **Smart system**

New technology would be great to ensure rapid communication and access to clinical and other data. There needs to be investment in suitable hardware for community workers visiting people at home and for staff in ARC

The 10 year vision is good. It is important not to get clinicians collecting data that is of no use to them clinically. Collecting information on the duration of an appointment for example, is of no interest, but whether the treatment works and long-term follow up over the years does matter. Having someone to collate and feed back data would be very helpful for clinicians who often lack the time or expertise to do this.

**Turning Strategy into Action**

I agree on need for all services to be integrated. *Implementation* is the difficult part. What measures can be used to track progress? Will DHBs make their progress known, accessible and easy for public to understand?

The “possible results from implementing the roadmap of actions” (p. 29) are very vague and mostly relevant to younger people. Would it be better to put numbers and dates on outcomes, so there is a target to aim for?

**Summary**  
The Ministry of Health only has control mainly over medical / illness services. An approach designed to reduce disparities in health must address disparities in socioeconomic, educational and cultural status. This is a much more powerful approach to wellness and one which necessitates working with other sectors as emphasised in this strategy.

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**Submission on draft NZ health strategy**

December 2015

**Summary**

HFANZ appreciates the opportunity to submit on the draft NZ health strategy.

HFANZ is the industry association representing health insurers and the 1.3 million people with health insurance in New Zealand. We have a keen interest in the broader health system and a desire to contribute positively to the debate over how to ensure our health system is sustainable into the future.

HFANZ is supportive of the strategic goals and outcomes proposed, although is concerned that the ability to achieve them will be unnecessarily constrained by the omission of a fundamental strategic goal relating to system financing. To this end, HFANZ seeks the addition of a sixth strategic goal to broaden health funding sources, so as to achieve better health outcomes.

**Focus on health financing**

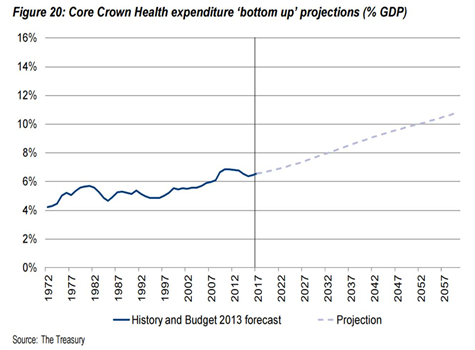
HFANZ is supportive of the need for a health strategy and supports the key themes and content. We are concerned that the ability to deliver on the outcomes may be compromised as a result of future public funding constraints. Such constraints, coupled with the failure to broaden health financing sources, are likely to significantly impede progress on the strategic goals.

HFANZ believes this danger can be mitigated by a more strategic focus on health system financing, and this is the primary focus of this submission.

The draft strategy acknowledges the projected rising costs and unsustainability of present system. However there is no acknowledgement of private funding sources, nor discussion of measures which might broaden funding streams to relieve public funding pressures over the longer term.

While the draft strategy contains some useful goals relating to value and high performance, it is unlikely that the measures in the draft (including those in the proposed roadmap of actions) will in themselves be sufficient to address the unsustainability of the present system. Nor is it likely that they will have much impact on the projected increase in public costs from 7% of gdp to 11% of gdp over coming decades.

**Projected Government Health Spending as % of GDP**



In recent reviews of its long term fiscal statement, the Treasury canvassed some broad options for curtailing the unsustainable growth in public funding, including increased use of rationing devices, such as waiting lists, moves to withdraw completely from public provision of certain services, and moves to broaden revenue from user charges (which would also have a demand mitigation effect).

It is understandable that there is generally a lack of political will to implement such measures to any significant level until funding problems move beyond acute into crisis territory.

**The tax-funded share of health spending will inevitably decline**

Whichever option or package of options the government of the day eventually takes, the inevitable result will be a lowering of the percentage funding for health which comes from taxation revenues (currently an unsustainable 83%).

By 2050, the public share of total health spending will likely fall to below 75% and could even fall below 70%. Over the past four decades, the taxation-funded share of health spending has varied significantly – from a low of 74% to a high of 95%. More problematic is the fact that over the past two decades, New Zealand has become more dependent on taxation funding rather than less.

This contrasts with the average OECD average public and private shares of health spending, which have remained remarkably stable over the period. The current OECD average private share of health funding is around 28%, compared with New Zealand’s 17%. Since 2001, the gap between New Zealand and the OECD has worsened from just 5% to 11%.

**Private share of total health financing: OECD vs NZ 2001-2011**

**Why is this a key strategic issue?**

This is a key strategic issue for the Ministry of Health for two reasons:

1. Achieving the best possible health outcomes for New Zealanders within the constraints of a limited public budget requires consideration of how the best use might be made of alternative funding streams.
2. The public health sector does not exist in a vacuum. There is also a private health sector and the two have complex interrelations. Consideration of both is required for development of an overall health strategy.

HFANZ submits that failure to adequately acknowledge these factors means there is a heightened risk of failure to achieve the outcomes contained in the document.

The draft document fails to adequately acknowledge the existence and contribution of the private sector in health. Throughout the draft strategy, the terms ‘whole of sector’ and ‘public sector’ appear to be used almost interchangeably.

On the funding side, the draft appears to draw heavily on the recent 2015 funding review. Unfortunately, the value of this has been limited by the fact that the review’s terms of reference openly prohibited any discussion of the mix of public and private funding.

It is not clear why the terms of reference for that review were so self-limiting in terms of planning for what Treasury have effectively labelled the single biggest fiscal problem facing the Government.

**Fail to plan = plan to fail**

If the resulting health strategy fails to explore options for developing alternative funding streams for healthcare, then it is effectively selling New Zealanders short by imposing an unnecessary cap on the level of future health outcomes.

Failure to develop and implement strategies for growing alternative funding sources will also likely expose New Zealand to worsening health inequalities.

As already noted, the share of public spending will fall, irrespective of which package of options the Government of the day implements over coming decades. However, failure to adequately plan and provide people with both clear messages about what the future public system will deliver will effectively rob people of the opportunity to plan adequately for their own healthcare over time.

Such a haphazard and ad hoc transition will mean those with higher incomes and wealth will be better able to deal with minimal notice of changes. Those on lower incomes, or without any accumulated savings, will be less able to cope effectively with sudden changes.

**Optimising future health outcomes**

HFANZ submits that the overall future health outcomes can best be optimised by making the best use of both taxation funding and private funding streams. The increasing resource constraints facing the public sector will likely lead to growing acceptability of targeted universality – effectively another way of saying those who can afford to pay more will do so.

A similar principle should be applied to effectively plan for a rising private share of health funding. The strategy should aim to research and set achievable targets for the growth of the private share of health funding. It should also explore policy options for moving in the right direction – beyond the Treasury suggestions which appear solely focused on cuts to public spending.

* ***Recent research by NZIER suggests that health insurance could feasibly be funding up to three times its current level of healthcare if New Zealand could match what the best performing countries with similar health and taxation systems were achieving. In simple terms, this would equate to an additional $2 billion in today’s dollars – significant enough to warrant further investigation.***

**Possible fiscal effects**

For any future given level of tax-funded spending on healthcare, raising the level of private spending will permit higher overall outcomes. Notwithstanding this, a planned transition which leads to a significantly higher level of private funding may also permit some reduction in fiscal cost while still achieving higher overall health outcomes than possible without a planned approach.

This effect is illustrated in the chart below, which compares the impact of a planned transition resulting in a third of health spending being private, with an unplanned one which sees a lower increase in private spending to just a quarter.

**Simulated future health funding scenarios**

There are four key benefits from a planned transition:

* Greater ability to deliver on strategic health outcomes
* higher overall level of health outcomes attained than from unplanned transition;
* lower levels of health inequalities than for unplanned transition;
* some fiscal savings possible without compromising the above outcomes.

**The sixth strategic goal**

HFANZ submits that the potential costs and benefits are so significant that the draft strategy must include a goal to increase the share of private funding, along the lines of the following:

***“To plan for a sustainable and equitable increase in non-taxation funding for healthcare, so as to increase overall health funding and improve overall health outcomes.”***

As an association, HFANZ has a strong commitment to ensuring New Zealand has a sustainable health system which meets the needs of all New Zealanders into the future. We have particular strengths and capabilities which may be of use in helping model impacts of various options for improvements in the private financing of healthcare. To this end, HFANZ is willing to engage and assist collaboratively in the identification of possible options which might help form part of the road map of actions.

Roger Styles

Chief Executive

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| --- | --- | --- | --- | --- |
| **224** | Submitter name | Helen Gillespie | | |
| Submitter organisation | Department of Conservation | | |
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| *(town/city)* | | | | Hokitika |
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| Organisation (if applicable): | | | | Department of Conservation |
| Position (if applicable): | | | | Project Coordinator - Healthy Nature Healthy People |

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

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Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*: Department of Conservation

1. **Future Direction**

This submission is presented in the context of Healthy Nature Healthy People (HNHP). This movement, recently adopted in New Zealand by the Department of Conservation (DOC), is based on Healthy Parks Healthy People, which was first launched in Victoria, Australia in 2000 and is now spreading globally.

The key principles of HNHP are:

1. The wellbeing of all societies depends on healthy ecosystems.
2. Parks nurture healthy ecosystems.
3. Contact with nature is essential for improving emotional, physical and spiritual health and wellbeing.
4. Parks are fundamental to economic growth and to vibrant and healthy communities.

In essence, the movement acknowledges the inextricable link between natural environments and people, and that the health of each is dependent on the other. Nature has no boundaries and HNHP extends from everyone’s backyard and beyond, into natural environments variously administered. It means working with others to improve the health of people and the health of nature.

In this context, DOC supports:

* The Health Strategy focus on health set within a wider context, including the environment. Individual and community health are reliant on healthy natural environments, which are integrally linked to the value placed on them by communities.
* Working across agencies in innovative ways to collectively address health issues in the wider context.
* The proposed investment funding approach. Beyond investing in the traditional social sector, the natural environment sector provides a valuable setting for improving individual and community health. The more people place importance on the environment for their health and wellbeing, the more they value and seek to protect it.
* A prevention focus and making healthy choices easy through approaches at both population and individual levels. DOC, alongside others, currently provides the setting, infrastructure, and resources for young and old alike to participate in the natural environment. Examples of this in the DOC setting include:
  + Kiwi Ranger - guides families to make the most of their visit to key conservation places, by taking it beyond a mere walk in the park, to an experience worth remembering and treasuring. The programme is geared especially for 6-12 year olds and, in most cases, is free to participate.
  + Recreation facilities to cater for all abilities from buggy friendly walking tracks and camping grounds to back country huts and wilderness areas.
  + Walking tracks close to where people live; in many cases up to five tracks within   
    45 minutes of where people live.
  + Children under 17 stay free in all our huts including those on our Great Walks.
  + Opportunities to volunteer all over New Zealand in natural environments.

The global challenges are also the local challenges – an aging population, the increase in lifestyle diseases, and increasing urban populations. The refreshed guiding principles for the health system places value on engaging with others. DOC actively supports HNHP and working across multiple sectors to improve the health of both nature and people. DOC through its stretch goals seeks to enrich 90% of New Zealanders lives through their connection to nature.

**II. Roadmap of Actions**

DOC, in the context of HNHP, supports the key themes of the strategy.

*People powered*

* People at the centre of their own health. HNHP draws together the integral links between the health of the environment and the health of people. When people understand the part that healthy environments play in their own health, they will place more importance on it.

*Closer to home*

* Wellness and prevention of long term conditions, population based and targeted initiatives.
* Supporting our next generation so that they can thrive and contribute positively to their communities.
* Supporting population based strategies that encompass natural environments, for example Smokefree.

*Value and high performance*

* Developing relationships with non traditional partners may support efforts at the point of care and in the longer term.
* There is a range of factors that affect health outcomes including physical environment and social factors.
* Equity for populations, removing barriers to participation for those with disabilities, and providing enabling opportunities for social connection and meaningful contribution.

*One team*

* Working towards shared goals and being able to work beyond organisational boundaries, proactively assisting people and populations in need.
* Integration – coordination with initiatives in other sectors.
* Share best practice and examples of innovation.

In direct response to the specific questions posed in the strategy feedback submission form:

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

The global challenges referred to on page 5 are generally adopted through the revised strategy for New Zealand’s health system, with the exception of the *‘health and social consequences of climate change’.* HNHP draws the environment and people into one conversation and invites relationships with non traditional partners.

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

The guiding principles are broad and invite non traditional partners to the table. The subsequent proposed actions align with the principles.

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| **225** | Submitter name | Dr Lloyd McCann |
| Submitter organisation | New Zealand Private Surgical Hospitals Association Inc |

3 December 2015

**NZPSHA Response to Draft refresh of the New Zealand Health Strategy**

The New Zealand Private Surgical Hospitals Association represents:

* 25 Member Organisations
* 38 Surgical Facilities
* 1821 Surgical beds (including ICU, recovery, day-stay chairs and resourced beds)
* 3122 FTE in Staff (combined payroll exceeding $120 million)

NZPSHA members provide procedures for approximately 164,000 patients every year, representing approximately 50% of all elective surgery performed in New Zealand. Principal funders include private insurers, ACC, District Health Boards and paying patients. The large majority of member hospitals provide overnight care. ACC and DHB contracts account for over 40% of revenue for some of our members.

NZPSHA thanks the Ministry of Health for leading this important piece of work. We appreciate the opportunity to contribute to the development of this strategy.

**General Comments**

* NZPSHA supports the over-arching vision and purpose statements outlined in the strategy. NZPSHA commends the Ministry for outlining the broader factors impacting on health and the view that ‘health’ should be seen as an ‘investment’.
* Our association also supports the ‘one team’ and ‘smart system’ approach. The language used about a ‘whole of sector’ approach resonates very strongly with the NZPSHA.
* NZPSHA strongly agrees that there is a need for behaviour change within our health system and our sector more broadly; and that intra- as well as inter-sectoral collaboration will be necessary to meet some of the challenges outlined in the strategy.
* The role of other entities (e.g. ACC) is noted. The NZPSHA works closely with ACC to ensure that elective services offer value.
* As the document progresses, we believe that the narrative and actions outlined become dislocated from the broader principles and over-arching approach initially outlined. We will identify specific examples through each of the strategic themes and the roadmap of actions.
* There is minimal reference to, or acknowledgement of, the role the private or NGO components of the sector currently plays in service delivery or the role these significant components of the sector could or should play in a strategic sense Whilst there is acknowledgement that the financial challenge is significant, there is no consideration given to the impact more appropriate use of the breadth of resources available outside of the DHB environment would have on health outcomes, financial sustainability and health equity.
* The NZPSHA believes that if a true ‘whole of sector’ approach needs to be taken, then the strategy needs to acknowledge and reflect the contribution all components of the sector should make. This in our view would be the first action required to invoke real behaviour change.
* The NZPSHA has recently undertaken work which shows that there is significant capacity (non-allocated capacity of 35% based on normal shift hours) within the private component of the sector to enhance service delivery which would have an impact on outcomes, equity and sustainability.

**People-powered**

* The NZPHA supports the overarching concepts outlined in this theme.
* A key component the strategy outlines is ‘understanding people’s needs and wants and partnering with them to design services to meet these’. This speaks to the broader notion of choice within our system and sector. The private and NGO component of the sector plays an important role in offering true choice to individuals.
* A true ‘whole of sector’ approach in this strategic theme would see capacity in the system maximised to enable healthy choices.
* Our member organisations place a huge emphasis on customer experience and user-centred-design. This approach could inform the broader sector to increase our capability to be people-powered.
* In order to support the objective to receive timely, high-quality and appropriate services in the most convenient way, broader sector capacity must be utilised. As the strategy outlines, people should be treated in the most convenient way – this may be in a non-DHB setting.
* This strategic theme should reflect the role the NGO and private component of the sector must play to deliver on the vision of what ‘great’ could look like in 10 years.

**Closer to home**

* Here again the role the private and NGO component of the sector needs to be acknowledged and considered.
* There is currently significant use of non-DHB resource to support care in the community and care at home.
* Whilst earlier parts of the strategy acknowledge the challenges associated with an ageing population, subsequent themes lose track of this critical challenge. There is a clear need and good evidence to support shifting care closer to home. The role of specialist services will still be important and these should be provided in the right setting. Our suggestion here is to utilise the capacity that exists in the broader sector instead of investing in duplication of services through additional capital projects as one example.

**Value and high performance**

* There is a disconnect between earlier principles outlined and some of the concepts outlined in this strategic theme.
* Utilising NGO and private capacity will aid performance across the sector and has been shown to provide value. There are significant potential efficiency savings to be gained by utilising existing capacity well now and into the future.

This would further enable the investment approach outlined by releasing significant funding to preventative and well-being initiatives.

* The NZPSHA also acknowledges that there is a gap between what is outlined here in terms of performance and the current approach to regulation across the sector. One example here is the lack of a minimum certification standard for Day-stay and Office/Rooms based facility providers in the sector. There is no current mechanism to evaluate safety for this significant component of the sector.

**One team**

* Whilst the strategy refers to a ‘whole of sector’ approach, here again the contribution of non-DHB entities is not acknowledged or considered in a strategic sense.
* The NZPSHA works closely with organisations such as ACC and HQSC and will continue to do this to ensure our members offer high quality and high value services.
* The strategy correctly identifies that we have a highly skilled and highly mobile workforce. The NZPSHA believes that movement between different components if the sector drives learning and innovation. Our member organisations currently train and up-skill a significant proportion of the workforce. We view this as mutually beneficial as it creates capacity and builds sector capability. There is an opportunity to be more deliberate in our approach to training and the NZPSHA believes that funding should be made available to all components of the sector for training.

**Smart system**

* The NZPSHA supports the adoption of technology and solutions that improves outcomes and potentially lowers cost in terms of service delivery.
* Our member organisations represent some of the most innovative environments for service delivery in health and we are keen to share our learning and expertise with the broader sector.

**Roadmap of actions**

* As the strategy outlines, it is critical to engage in meaningful behaviour change to ensure we meet the challenges of the future and utilise the opportunities to improve health outcomes so that New Zealanders can ‘live well, get well and stay well’.
* Whilst some aspirational actions are defined, the overwhelming sense this section of the strategy provides is one ‘how to prioritise business as usual’.
* The NZPSHA believes that this approach will not lead to behaviour change and will not meet some of the visionary objectives outlined.
* The NZPSHA believes that an important action would be to acknowledge and understand the broader capacity in the sector and utilise this well to meet the current and future health needs of New Zealanders. If our approach remains the same, we will retain the status quo.

The NZPSHA is willing to contribute to the ongoing development of the strategy. We believe that all components of the sector have a role to play in delivering the vision that has been outlined.

Kind Regards



Dr Lloyd McCann

**On behalf of the NZPSHA Executive**

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| --- | --- | --- |
| **226** | Submitter name | Helen Lockett |
| Submitter organisation |  |

|  |  |
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| Address: *(street/box number)* |  |
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| Email: | Helen.lockett@wisegroup.co.nz |
| Organisation (if applicable): |  |
| Position (if applicable): | Strategic lead Equally Well |

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

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

on behalf of a group or organisation(s)

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Service provider  Government

X Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

X Academic/research  Other *(please specify)*:

## Overview of Equally Well feedback

Whilst supporting the overall direction of and the underpinning principles of the NZ Health Strategy I believe it can be strengthened to ensure the future system can meet the needs of ***all*** New Zealanders.

Whilst acknowledging that the New Zealand health system performs well for the majority of people (I. Future Direction, p.2), there are significant groups of the population who continue to experience worse health outcomes. To ensure the gap between these populations and the general population does not widen, the New Zealand Health Strategy needs an even stronger focus on monitoring and addressing disparities in health outcomes. ‘Improvement in health status of those who are currently disadvantaged’ and ‘timely and equitable access’ are two of the guiding principles, however these aren’t reflected well enough in the consultation documents; 1. Future Direction and II. Roadmap of Actions. This consultation response provides a number of examples of how these guiding principles can be further incorporated into the Strategy.

At the same time, it is important that the physical health disparities experienced by people who experience a mental illness and/or addiction are explicitly highlighted in the background to the strategy and that this sub-group of the population are formally acknowledged as a priority population not just for their mental health and/or addiction but also for their physical health. This will ensure that throughout the roadmap actions, which focus on priority populations, it is clear that this population’s physical health is included.

The importance of this explicit acknowledgement is that people who experience a mental illness and/or an addiction are on average twice as likely to die before the age of 65 than the general population and this increases to three times for people with a diagnosis of psychosis (Cunningham et al., 2014). Two-thirds of this premature mortality is due to preventable and treatable physical illnesses, particularly cardiovascular disease and cancer (Cunningham et al., 2014; Cunningham et al., 2015). A stark contrast to the life expectancy of 79.7 years for boys and 83.2 years for girls (I. Future Directions, p.2).

Furthermore Māori who experience mental illness and/or addiction have a higher mortality rate than Māori in the general population (one-third greater).

This group have significantly higher rates of physical illnesses including metabolic syndrome, viral and oral health diseases, respiratory disease, type II diabetes and cardiovascular disease (Te Pou, 2014).

Factors driving this disparity are complex and interrelated and include socioeconomic status, the side-effects of psychotropic medication particularly due to their contribution to obesity, cardiovascular disease and Type II diabetes, systemic issues around the physical separation of physical and mental health and addiction services and the problems this population experience in terms of access to and quality of healthcare (Te Pou, 2014).

This is why addressing this health disparity is a whole of health issue not just an issue for mental health and addiction services.

Consultation questions

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

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| **p.6 of I. Future Direction – challenges, paragraph 5 which covers life expectancy statistics.**  The significant reduced life expectancy of people who experience mental illness and addiction should be explicitly mentioned here. This health disparity forms an important challenge which needs to be addressed in the future NZ Health strategy.  Another challenge which should be explicitly mentioned is that of how the future health system needs to meet the needs of people with multiple morbidities. There is currently no mention of this, particularly how we need a system and a workforce able to recognise and respond to each long term conditions and their treatment and the interaction of each long term condition with other long term conditions and their treatment. For example, the co-morbidity at a much younger age of major mental illnesses and diabetes, the prevalence of depression following a heart attack.  The models of integrated care being implemented in the USA provide good guidance around this, for example: [quality\_standards\_for\_integrated\_care\_Ohio\_centre\_of\_excellence.pdf](https://loomio-attachments.s3.amazonaws.com/uploads/97daf4617b21d5c973f691d627620b54/quality_standards_for_integrated_care_Ohio_centre_of_excellence.pdf).  There are a number of places within the document where mental health is incorrectly documented, for example:  I. Future Direction p.4: The investment approach box has a vision where people will be ‘free of, for example, *family violence or mental health conditions’*. Mental health conditions should be removed from this sentence. People diagnosed with conditions like schizophrenia and bi-polar are likely always to have the condition, in the same way a person always has diabetes or Crohn’s disease.  I. Future Direction p.4, third bullet point – there is implicit stigma in here as mental health and addiction treatment is assumed to be needed if there are assaults on children. This assumption should be removed from this bullet point. |

### 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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| There needs to be explicit reference in the future direction statement that shows the commitment to targeting people who have additional needs and/or who are currently disadvantaged – for example:  We will be **people-powered**, providing services **closer to home**, design for **value, high performance** and **addressing health inequities** and working as **one team** in a **smart system**.  This will align the future direction much more strongly with the guiding principles of the health system (p.9 of I. Future Direction). |

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

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

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| Yes |

### 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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| As outlined in 2) above – Theme 3. Value and high performance should be amended to say ‘value, high performance and **equity focused’**.  What great might look like in 10 years time:   1. People-powered – bullet point 1: *People are able to take greater*…add after patient portals ‘**shared-decision making’**; bullet point 2: *Everyone who delivers and supports*… add after *everything they do* add **‘and actively partners with other agencies to achieve this’**; insert an additional bullet point: ‘**health and injury services recognise and actively focus on people who are disadvantaged and are proactive about strategies to empower them to improve health outcomes’.** 2. Closer to home: 7th bullet point: We are good at identifying key health problems and co-morbidities… We provide well-coordinated and holistic care; 8th bullet point – workplaces should be included in the list *‘strong community links with early childhood centres, schools, marae,* **workplaces**, *churches*… 3. Value and high performance. As outlined above this theme should be renamed ‘value, high performance **and equity focused’**. Under the last bullet point ‘*the health system constantly monitors its performance,* ***regularly measuring outcomes for priority populations*** *and scans the environment*…” 4. One team. Bullet point to, ‘*the system has competent leaders… and a culture of listening carefully,* ***an understanding of holistic care*** *and working together to…’* 5. Smart system. Third bullet point – *‘people at risk of various conditions have easier access to follow up tests… and management plans* ***which actively take into account the interactions of one condition and its treatment on their other condition(s) and their treatment’****.* Bullet point five: *the data we collect is more specific* ***and equity focused*** *so that management can be more proactive…’* |

### 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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| To ensure a greater equity focus on the physical health outcomes of people who experience a mental illness and/or addiction it is critical that we build the capability of the health system to monitor this sub-group in the same way we currently monitor gender, age, and ethnicity. Cunningham et al’s., (2015) paper on cancer survival shows how this is possible from a research perspective, but we need to turn this into routine equity monitoring.  To this end actions 5b and 11b are very important and priority should be given to the development of a performance management system which would enable outcomes for this sub-group to be routinely monitored across DHBs i.e. in performance reporting for access to and outcomes from cancer treatment; treatment following a cardiac event etc.  Action 1d – add a **iii) expand the use of shared-decision making tools.**  Action 2b. ‘*Support clinician-led collaborations to engage with high-need priority populations on key health issues’*, goes against the focus of people-led services. Recommend re-phrase this as ‘**co-designed collaborations between clinicians and service users / patients’**  Action 3a. after ‘*heart transplants, need only be in one location)*’. Add ....‘**taking into account the need to work across specialist areas i.e. across mental health and diabetes specialist services’**  Action 4 –add c. **Develop ‘statements of clinical responsibility’ which clearly outline the roles and responsibilities of specialist and primary care clinicians in relation to people with multi-morbidities.**  Add d**. Increase the proportion of health services delivered by primary care and by community organisations**  **Action 5h. Include ‘***targeted interventions for those who are obese,* **and who’s treatment contributes to obesity e.g. psychotropic medications;** increased support for those at risk of becoming obese, and…’ |

### Any other matters

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

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| --- | --- | --- | --- | --- |
| **227** | Submitter name | Dr Hilary Stace | | |
| Submitter organisation |  | | |
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| Address: *(street/box number)* | | | | [redacted] |
| *(town/city)* | | | | [redacted] |
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| Organisation (if applicable): | | | |  |
| Position (if applicable): | | | |  |

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on behalf of a group or organisation(s)

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Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

x Academic/research  Other *(please specify)*:

## Consultation questions

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

### Challenges and opportunities

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

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

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| The impacts of climate change over the next few years will be severe and far reaching on the health of individuals, communities and the whole country. I would like to see this given a very high priority in the health system.  I would also like to see more emphasis on an inclusive system that values and celebrates diversity, especially as we become a more diverse community. So I would like more opportunities for disabled people, Maori, children and young people, older people, refugees and migrants and other ethnic groups and other marginalised groups to have more say in governance of our health system as their specific needs are often overlooked or seen as a burden. One example would be the extension of current arrangements like DSACS on DHBs to include these groups in governance of the system |

### The future we want

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

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

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

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| Needs more emphasis on the diversity of the population and including everyone including marginalised groups and those who might have the highest health 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?

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### 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?

|  |
| --- |
| Better relationship building in all directions is required. |

### 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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| 1. Everyone needs access to a navigator to guide them through the system.  2. The system needs to work towards being more navigation friendly, holistic and collaborative, less fragmentary and discriminatory  3.Less emphasis on rationing and ring fenced funding, more on meeting health needs of the whole population. |

### 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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| Reporting progress on free to air television, social and print media. Demonstrating inclusion and relationship building for a strong responsive health system which values people |

### Any other matters

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

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| While our health and disability systems and disability services and support generally are so fragmented, have so much regional variation and so many gatekeepers and such rigid eligibility requirements, I think it is only fair that everyone has access to a free and skilled personal navigator to help them find the rare services and supports available. We have a social model disability policy in the NZ Disability Strategy and the UN Convention on the Rights of Persons with Disabilities but medical and individual model operational policy based on rationing and ring fenced funding. So we have a system set up to fail people. At the moment it depends largely on luck to get the health and disability services you need when you need them and the love of family or friends to advocate for you to get anything. These are no bases for a sustainable system to do all the nice words in 8.1. Address the inherent wicked problems implicit in this situation by recognising the expertise of those on the front line who giving and receiving or requiring services and bring all their expertise into the governance of the system. Involve everyone, not just the high up officials in the Ministry. |

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| **228** | Submitter name | Hugh Norriss |
| Submitter organisation | Strategy, Advocacy and Research, Mental Health Foundation of New Zealand |

Thank you for the opportunity to provide a submission.

Our comments are less about the draft actions and more about the overall coherence of the strategy in maximising all the opportunities for better health outcomes.

It is positive to see the health strategy include the wider context of health - how we live, the daily choices we make and the relationship between social circumstance and health outcomes. However it is not always clear in the current draft document what the real focus of the strategy is. Is it to make better use of vote health resources for the treatment and prevention of illness in a service environment, or a broader strategy to improve health outcomes by taking into account all the factors that diminish or sustain our health over the life span? If it is the latter, (and we believe it should be) then the strategy lacks a clear future orientated focus and intervention logic about how we will need to respond to rapidly changing social, environmental and cultural conditions, and the growing burden of non-communicable diseases.

Initiatives to make us healthier can be owned by many organisations and individuals outside of traditional health providers.  For example workplaces have a huge effect on the social and environmental aspects of health and there is growing interest in this area which that be encouraged and supported. Also the education sector, local government, sports organisations, iwi and community groups provide excellent arenas to build the knowledge and behaviours for people to live well and stay well.  With this in mind we are surprised that the Health Promotion Agency doesn’t feature strongly in this strategy, as the key government agency that should be driving preventative and upstream approaches.

 ‘The Health System’, (as implied in the definition on page 1 and throughout the draft strategy) deals largely with the ‘get well’ part of the *Live well, stay well, get well* rallying phrase, with ‘get well’ presumably meaning illness management, treatment, and early identification of problems. This is not to diminish the huge importance of these services, but the ‘live well, stay well’ aspects are not strongly addressed.

Hospitals and primary care services are very good at treating people who are ill and helping them get well again, but they don’t have much impact on people’s health much of the time. Diet, exercise, avoidable accidents, housing, urban design, psychological stressors, social inclusion, smoking cessation, alcohol abuse all have a profound effect on health need to feature more strongly in this strategy. In many cases it will not be health and disability professionals that are needed, but community champions who can reach target audiences and who may need periodic support to promote the right evidence based activities.

What could be useful for the strategy is a clear definition of health. This might seem pedantic, however though out this document the word is ‘health’ used interchangeably to sometimes mean a positive state of well-being and at other times as a euphemistic label for illness treatment and management services. We think this rather slippery use of the word health provides confusion around what the end goal of the strategy is.

The WHO definition of Health would be a useful and authoritative one to use…. ‘*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.*  A local definition that complements this well is the widely regarded *Te Whare Tapa Wha* which emphasises underlying cultural, social and psychological strengths as the bedrock of good health.

Much of what we call the ‘health system; is very good at dealing with ‘*disease and infirmity’* but is not tasked with, or even sufficient trained to, increase our ‘complete physical, mental and social well-being’.

A simple model that we suggest to clarify what health is in a wider context would be three concentric circles. The largest circle would be the general social and physical and environment, to represent the huge and fundamental affect that this has on health and injury over the lifespan. The next biggest circle within this would include primary care and specific preventative strategies from health and social care providers. And the smaller circle in the centre would be secondary and tertiary illness and injury management and treatment services.

As well as clarifying what we mean by a healthy individual and society, it would be useful to quantify the affect, based on current evidence, of what makes the most difference to health across people’s lifespan and how investment could be proportionate to good outcomes. This may require some courageous leadership and challenging current notions of health investment that can favour the few and the most vocal, at the expense of the many.

In summary the strategy has many good ideas to improve the current treatment and prevention services, and although there are few initiatives to improve health upstream of medical services, these are rather ad hoc and based on current activities, with little future focus. A more strategic approach would be to look to the future and project scenarios of our rapidly changing cultural, physical and economic realities, how these will influence our health, and how we can collectively as a nation intervene early and intelligently to reduce risks of new diseases and disability and maximise opportunities to stay as healthy as possible.

Please contact me if you would like any further information.

Regards

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Duplication error – deleted.

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