**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**230 - 253**

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| **230** | Submitter name | Papaarangi Reid |
| Submitter organisation |  |

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Please indicate which sector(s) your submission represents  
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X Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

**The Treaty of Waitangi is Our Founding Document.**

Don’t ignore it, don’t pretend it doesn’t exist – be proud of it. It provides exceptional leadership. Lead with it. Real inclusion of the Treaty will provide a safe space for everyone, but especially Māori.

**Equity is the New Zealand Way.**

While the strategy states ‘all’ NZers, that is the only word that captures the concept of equity. As such the strategy statement fails to make it clear that New Zealand has an ethos of equity, fairness and social justice. Despite classic right-wing ideology and discourse of ‘individual responsibility’, New Zealanders understand “a fair go”. We celebrate the ANZAC spirit of leaving no-one behind. Without a specific statement on equity, we will continue to focus on singular strategies and inequities will grow.

**“And-And” as a policy norm.**

For example, while I welcomed the extension of the free primary health care from under 6 years to under 13 years, it is easy to predict that any singular strategy will increase inequities. It will do some good for all but more good for those with the most resources to access and utilise the health system as it is currently organised, therefore existing disparities in child health outcomes will be increased. Our outcomes will become more unfair. Privilege will be re-inforced and those whose health is most marginalised will be blamed for not making the most of this initiative. Singular strategies must be recognised as problematic when operationalised uncritically. There needs to be a critical understanding of the complex and multi-layered barriers to access to and through the health system. A strategy to improve the health of New Zealand children is a fantastic goal. It cannot be a single strategy unless the intention is to deliberately increase inequities. Fantastic strategic health goals must not be dammed by naïve strategies. This will mean that we will need a comprehensive set of strategic actions for every goal that will include both universal strategies as well as ones that provide specifically to eliminate inequities.

**Can we please get real about Climate Change**

Health must play an increased role putting this global emergency much higher on our agenda. We have inherited a vulnerable planet, mother earth. We do not have the luxury to repeat mistakes from the past, in the way we produce goods, consider the environment as a source of goods, and fail to utilise available alternatives. We must act like good ancestors for future generations.

**Who is Running the Health System.**

As health workers, we are worried. It is nice to have a strategy and consultation is good etc etc. But what we are really worried about are the following:

1. Is health funded at an appropriate level for our population and if not, what are NZers willing to give up, - shouldn’t we be consulting on – whether NZ should means test superannuation and fund new cancer drugs with the savings, or subsidise housing or environmental management with savings.
2. The power relationships between the MoH and the DHBs – until we have agreement on funding noted above and make DHBs (and PHOs) accountable for their performance, people like me are getting mixed messages about the leadership of the Health Sector – is it the Minister, the Ministry or DHBs. It makes the sector hard to read.
3. The conflict of primary health care being a for-profit business in most cases.
4. There are still huge silos. Intersectorial collaboration has been talked about for years but there has been very little real movement. It has to happen urgently for environmental issues, for social issues and for structural issues.

**Can we get with the evidence please.**

For example, the way we are talking about Health Literacy is 30 years behind the evidence. We are using the term to mean very old fashioned and ineffective health education rather than using it in the modern sense as a system quality issue. A similar example is Childhood Obesity – hello – please do not make yourself or the Minister look ridiculous by saying ‘personal responsibility’. We have to own the consumerist culture we have fostered and structural impediments to a healthy lifestyle. Come on guys – get with the evidence please.

Mauri Ora

Papaarangi Reid

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| **231** | Submitter name | Canterbury Clinical Network |
| Submitter organisation | [redacted] |

**New Zealand Health Strategy Feedback Submission**

**Name: Canterbury Clinical Network (CCN) Programme Office**

**Authors:** [redacted]

Top of Form

**Challenges and opportunities**

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

RESPONSE:

The CCN Programme Office is in agreement with the challenges and opportunities identified. We suggest four additional challenges:

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

**The future we want**   
The statement on page 8 of *I. Future Direction* seeks to capture the future we want for our health system:  
  
So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as one team in a **smart system**.

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

RESPONSE:

CCN Programme Office supports the statement of “live well, stay well, and get well”, however suggest the use of “all” is a little unrealistic and that the use of “New Zealanders” would be sufficient.

“People powered” is also not supported as it does not feel inclusive of those vulnerable populations that can’t for whatever reason “power” themselves to access services or take a more proactive role in their health. Suggest “people centered” or “focusing on people, their families and communities” would be more inclusive.

Dying well is also important. We encourage the Strategy writers to work in something that is about ‘end of life’ planning.

In terms of workforce, we support the principle of alliancing and clinician led stakeholders working collaboratively and so in this context “people powered” is appropriate.

For us the sentence is missing some important elements. We suggest the following would be better…

That New Zealanders **live well, stay well, get well and die well**, through the provision of services that are **focused on people, their families and communities** and are delivered **closer to home**, by providers working as **one team** in a **smart system** designed for **value and high performance.**

**Eight principles**  
A set of eight principles is proposed to guide the New Zealand health system. These principles are:  
  
• The best health and wellbeing possible for all New Zealanders throughout their lives  
• An improvement in health status of those currently disadvantaged  
• Collaborative health promotion and disease and injury prevention by all sectors  
• Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi  
• Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay  
• A high-performing system in which people have confidence  
• Active partnership with people and communities at all levels  
• Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing*.*

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

RESPONSE:

CCN Programme Office supports these eight principles and agrees that they will help guide us to the implementation of the Strategy.

Further we suggest Alliancing enables patient-focused services that are clinically led and integrated in the way service responses are designed. In Canterbury we have demonstrated transformational health services delivered to our population through an alliance approach and would be eager to see the country achieve the same benefits for the people on New Zealand through alliancing.

**Five strategic themes**  
The Strategy proposes five strategic themes to focus action – people-powered, care 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?**

RESPONSE:

Again CCN Programme Office suggests “People powered becomes “**People centered”.** As stated above, to empower people to take responsibility for their own health and to be partners in their own health is one aspect, but in addition to this the whole system needs to buy into the concept of being ‘people centered’ from facility design to service design to process design. From this people are empowered to be involved in their own health. For this reason CCN suggests that “people powered” is limiting in its scope.

CCN Programme Office supports the “Closer to Home” theme. This has been a major focus for CCN’s alliancing activity through local initiatives such as Falls Prevention Services, Medicines Management Services and CREST to name just a few.

CCN Programme Office supports the “Value and High Performance” theme where smart investment ensures best value for the dollar spent. We also support the sharing of successful innovations across the whole health system and collaborative approaches that enable standardised approaches to common challenges or needs.

We suggest the “One Team” theme could be strengthened to empower the whole system toward alliancing and cross sector responses. While this is mentioned in the People Powered theme, the One Team theme is where it is best demonstrated. Alliancing principles enable cross sector engagement and locally driven responses to locally identified challenges. Health alliancing or inter-sectorial alliancing where health takes a lead needs to be included in the One Team theme.

CCN Programme Office supports the “Smart System” theme. Collaborative care through shared care planning and telehealth enable the delivery of “patient centered” health services. Technology such as patient portals provides the tools to empower people to be partners and be self managing their own health and that of their families.

**Roadmap of actions***II. The 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?**

**RESPONSE:**

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

**Turning strategy into action**

**\* 6. What approaches might best support ongoing updates to the *Roadmap of Actions*? Do you have ideas to track and/or report on progress?**

**RESPONSE:**

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

**Any other matters**

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

**RESPONSE:**

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

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| **232** | Submitter name | Terry Quilty |
| Submitter organisation | Whanau Ora Community Clinic |

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| Organisation (if applicable): | Whanau Ora Community Clinic, (Manukau) |
| Position (if applicable): | Independent Academic/Research |

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Education/training  Local government

X Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

1. **Perspective**

This submission is from the perspective of designing and implementing integration of Clinics operating General Practice, Social Services, Domestic Violence Counselling and Justice Restorative Justice Contracts. The clinics are of varying size, services provided, training, capability and capacity. There is a need to develop both capability and capacity to allow scaling. To scale the systems core elements must be replicable and able to operate on a uniform platform.

1. **Funding and Whanau Ora relationship.**
   1. The clinic(s) are taking a Whanau Ora delivery model approach. They are not funded from the ‘Whanau Ora’ funding. The funding is general health capitation and consulting, and, other services contracts.
   2. This submission is not related to the specific funding mechanisms of Whanau Ora.
2. **The Whanau Ora relevance.**

This is a Whanau centric focus for the delivery of services. Key issues in building a group are;

* 1. Barriers and resources for the integration of the services within a clinic, across a group, and with external agencies
  2. A consistent delivery model and platform across the group, which integrates with external current and future obligations, and, supporting growth.
  3. A sharing and EBP knowledge management to build capability and capacity across the group to target Whanau in multiple locations.

Achieving these aims is based on building a uniform platform.

1. **Application of the Health Strategy.**

The strategy and Roadmap are entirely consistent with the group aims. Health Strategy statements are fully supported.

This submission is aimed at the implementation mechanisms. The roadmap contains statements of intent and action statements.

The main theme of this submission is for a more granular approach to building the implementation processes.

1. **Integration**

Integration is clearly key. This is linked to networks. In this section the term group is used as it is the perspective of this submission. A group denotes integration of resources, merging and fusion of functionality. A network is relationship based and may vary from a group as described to a formal or informal sharing of single or multiple resources.

There is clearly a difference between integrating organisations and integrating services.

Integrating services is not a uniform process and multiple structures can be used. There are various mechanisms for service integration with Whanau. Three are noted

* *Brokering of services by intermediaries – the Whanau Ora navigator model. This is a top down/bottom up meshing which is appropriate for large number of providers in small business units and creation of collectives for scale and delivery.*
* *Colocation of services such as with medical and social hubs*
* *Integrated networks or groups of geographically separated providers operating on a common platform.*

The last is an organisational integration in the sense of a merging of functions, resources, capability and capacity. From an external perspective this integrated group is one provider. It is not necessarily a single legal entity.

This grouping gives a critical mass which allows for

* Resource sharing
* Staff development
* Capacity and capability development
* Scaling.
* Experience sharing and dissemination of EBP more effectively
* Engagement and tracking of population health initiatives.

Building such a group is within the Strategy statements. There is nothing to stop this occurring. However to enhance the ability to build such groupings that integrate the services the ability to engage with multiple agencies is essential, as is an understanding of the priorities across the agencies.

In most practices each provider is a separate entity and joining a group involves loss of autonomy and control. The cultures, capacity, capability, financial position, and demographic will vary. The result is that creating groups or networks operating uniformly is not easy. There is an inherent inertia.

To establish a group should be driven up not down. From above comes the environment and support.

A single large network of diverse providers is a long term goal. An interim step is the creation of networks and sets of networks that grow the consolidation and standardisation of systems. The role of groups is in the creation of uniform highly integrated networks. This allows a more progressive growth of networks, sharing of resources and growth of capability and capacity in smaller and rural centres. This is an incremental process.

**Submission**: *The Roadmap recognise a range of desirable structures. This includes the brokering (with navigators), the top down collectivising of providers, the single network or group, and, an amalgamation of networks or groups. Recognised structures would have access to the agency engagement mechanism. (Below) A recognition process by agencies may be needed for resource reasons.*

1. **Engagement with Government agencies:**

Engaging with government is not easy. The creation of effective networks is a pragmatic process. Access to technical and the interpretation of policy is important. This will identify where this is a pragmatic, or policy, roadblock.

However, it is not efficient or effective to engage with multiple agencies for the group and it is not efficient for agencies to engage with all groups coming forth.

The agencies have an imperative to cooperate and collaborate. However, their objectives relate to their ministry. This may be a barrier to growth of networks where agencies have different interpretations and priorities. Prioritisation is key. If for example Child health is the objective, housing is relevant. This overlap has many practical and legal issues. If this also involves domestic violence the issues magnify with court, probation and corrections issues. In this situation it is also recognised that any innovation will have risks. The integration of the three is conceptually quite simple. However, how that processes, forms and client point of engagement, ongoing monitoring, referral and management, and not simple. The organisation of the forms will cause a behavioural prioritisation as will point of engagement. There may also be conflicts in the process when interpreting the directives of the multiple agencies reporting requirements.

A mechanism is needed to allow for innovations to be properly developed. From a design perspective a proposal will need to be mapped, risk assessed, capability and capacity assessed and an implementation plan. This will identify the agency issues. At this point an engagement mechanism is needed.

***Submission: A specific mechanism with the following aspects/process***

* Provide a single entry point to engage across agencies.
* The proposal by the provider, identifying services, linkages, the issues, and the engagement needed.
* Acceptance of proposal in principle measured against priorities in the Health Strategy and other relevant Ministry Strategy.
* Identification of the appropriate level of engagement. This may be technical, legal, or policy.
* A response process identifying issues, protocols, regulatory impact or requirements.
* A statement of priorities and conflicts to understand the design intent of the agency or agencies.
* Referral to a facilitation workgroup agreed which comprises personnel with the appropriate capabilities.

1. **Technology**

At many points in the Strategy and Roadmap reference is made to integration utilising technology, for clinical, for patients and dissemination for community.

This relates to the interconnectivity and transferability of information for better care outcomes needed, particularly with an increasingly mobile population.

Integration can be considered at the macro (cross- govt), meso, and micro levels. These are of course inter related. For current purposes micro relates to health integration and health care mapping. Meso is related to inter clinic or network alignment in populations and specific groups. This is about the meso. The health mapping and integration sits on that platform. If this level is not efficient the health integration will be adversely affected.

The main issue for a clinic group in aligning and supporting the health strategy is in that platform. The platform is both the business model and the IT model.

We would suggest that there will never be one system, or one architecture, or one language that will meet all requirements. Single common platforms are the ideal and there are developers working on these, but, interconnectivity of multiple platforms is the probable medium term outcome. The participants will simply be connected.

Understanding the requirements of the wider system, minimum requirements, and performance criteria would be ideal in design and resource planning. An acceptable specification/solution would be useful.

**The submission**: A system design statement that includes:

* *Minimum published data sets in regard to integration (i.e. across agencies), this will also assist with internal integrated pathway matching.*
* *platform and device independent (operating system agnostic)*
* *TCP IP based.*
* *Open source ideally (we realize this may not be possible) but the systems should not be proprietary and mandatory. This will stifle innovation. ( A developer user interface language at the least to build features)*
* *A standardized hardware/software minimum specification for integration for providers of services. (so providers can include performance outcomes in purchasing based on existing and future integration needs) – This correlates with the ‘standardized technology’ statement in the strategy.*
* *Clear policy on security, data integrity and encryption as consequences of a practice ‘cloud’ model*
* *Include clear statements of intent in design (to avoid different aim conflicts across the agencies or prioritise them). This will assist in designing submissions or suggestions for new delivery options that are cross agency. This may be essential for providers to instigate new ideas. This couples with the engagement submission above.*

1. **The ONE Team Theme: Evidence based decisions and access to research and current practice.**

Knowledge management is key to consistent, professional and current best practice delivery. Clinics are busy places, clinicians are not always full time, social workers often work out of the clinic and across clinics, and the clinics are geographically and demographically separated.

It is also central in community health literature issues. Knowledge of current practice, research, pilot programs, results and recommendations are readily available now with access to health databases, professional memberships, and, the ability to use the search engines.

Linking clinics as intended in a group with a common knowledge management system will increase the capability of smaller locations. Capability is the first requirement for capacity and scaling.

In a 2015 scoping review[[1]](#footnote-1) of the barriers to the application of EBP (Evidence based practice), it was noted that filtering down to the clinician could take 10 years to occur. One of the barriers identified was fast easy access to information. The conclusion supported by a number of other studies[[2]](#footnote-2) that “*Empirical literature needs to be available, if not at the point of care, then at the very least in an easily accessible designated area within each department*”, begs the question of how the clinics, with varying levels of resources can have access to such data, or other data.

The technology exists to deliver the information. The question is access to the information. Databases need to be accessible on a low cost to providers. The existing databases can be accessed with customised search capability and coupled to educational material. This would integrate with professional development. Forum exchanges could run alongside the database. The search engine needs to be specific and easily learnt.

**Submission**: *Establishment of a Community health practice specific search engine coupled to existing journal databases and research facilities. Accessible at low cost to health care workers.*

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| **233** | Submitter name | [redacted] |
| Submitter organisation | Tāmaki Treaty Workers |



**Tamaki Treaty Workers**

**To Ministry of Health**

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

**4th December, 2015**

Thank you for the opportunity to contribute to this Health Strategy.

Tāmaki Treaty Workers is a network of groups and individuals in Tāmaki-makau-rau/Auckland who affirm Te Tiriti o Waitangi as the basis for the future of Aotearoa.

Our meetings provide a forum for Pākehā and Tauiwi (non-Māori) to discuss and organise anti-racism and Treaty work.

We work to provide information about Te Tiriti, anti-racism and related issues such as institutional and structural racism, in co-operation with tangata whenua groups.

We are part of Treaty People, a national network for Treaty workers.

We have been very concerned over the years about the negative impact of all government institutions, including health on hapu and iwi in Aotearoa. The statistics on Maori health over many years has not been good, with lack of access to health care, much higher rates of untreated childhood illnesses, higher rates of diabetes and kidney disease and lower life expectancy. Some of this is due to poor living conditions and poverty which is higher in the indigenous population in New Zealand, as it is many other indigenous populations around the world.

We believe that the causes of this are never adequately taken into account in the organisation and running of our institutions, including health. We are aware that there has been a commitment made to the Treaty of Waitangi and that considerable effort has been put into educating staff about the effects of colonization on hapu and iwi and on ways of putting into effect implementation of a more equal system that acknowledges their rights. But the gap between Maori health and the rest of the community, although improving, still persists.

Unfortunately the effects of institutional racism, which is a pattern of differential access to material resources and power by race, which advantages and privileges one sector of the population, which has more power and is endemic in our community, persists. Tamaki Treaty Workers are of the opinion that this will not change substantially until there is a better balance in the decision making level between Maori and other members of the community. This does not only apply in the health service but across all sectors of our community.

It would be great if the health service could take the lead and show the way in overcoming this health inequity by appointing enough Maori to senior decision-making positions who were able to provide the advice needed and given the resources to overcome this problem. We hope you will take this opportunity to make these much needed changes.

Email: [tamakitreatyworkers@gmail.com](mailto:tamakitreatyworkers@gmail.com)

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Ponsonby

Auckland. 1144

Ph: 09 3608001

[redacted]For Tamaki Treaty Workers

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| **234** | Submitter name | [redacted] |
| Submitter organisation | Taranaki District Health Board and Te Whare Punango Korero |

*E-Mail* [redacted]

Good Afternoon – At a recent combined meeting of  the Taranaki District Health Board and Te Whare Punanga Korero the NZ Health Strategy was discussed.

Te Whare Punanga Korero is the Maori Health Governance Group which works strategically with the Taranaki District Health Board to improve Maori health and reduce and eliminate Maori health inequalities.

The Boards agreed that:

**That the joint boards make a submission to the NZ Health Strategy consultation that there be explicit linkage to Pae Ora as described in He Korowai Oranga, embedded into the strategy.**

On behalf of the two Boards thank you for giving us the opportunity to comment.

[redacted]*Acting Chief Executive*

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| **235** | Submitter name | Jim Green | | |
| Submitter organisation | Hauora Tairāwhiti DHB | | |
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| Position (if applicable): | | | |  |

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Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

|  |
| --- |
| * The potential that post Treaty settlement iwi provide in enhanced economic and hence health outcomes for Māori. * The high rates of inequity in outcomes – how you take everyone forward but ensure Māori and Pacific make the greatest advances. * The siloed and blinkered approach of most providers and agencies when we need a joined up system approach. The experience with Children Teams emphasises 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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| * Not keen on the people-powered wording. Sounds very last century and twee. Really means understanding, responsiveness and people centredness. * Services closer to home. Note wording that is later in the strategy this actually means you might have to travel further for some services – when we develop a long term plan for services in NZ, something we have not succeeded in doing to date. * Value – need to define what that means – whose perspective? People, clinicians, DHBs, MoH or government? * Overall the statement is too long and too complicated. * Shorter statement concentrating on health for all through an enabling system that allows people to develop and strengthen their potential across the whole lifespan. * Lack of clarity as to the detail “the team” actually means |

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?

|  |
| --- |
| 1. Yes. And system works internally and across government, iwi and community to ensure this happens. 2. Yes but not say currently disadvantaged, more in terms of people who have inequitable outcomes. 3. Yes. 4. No. Sounds mysterious – special relationship. Spell it out. We are going to advance health outcomes for Maori to remove health inequalities/increase equity while advancing outcomes for all New Zealanders. 5. Yes. Extend this. 6. Yes. 7. Yes. 8. Yes. Totally agree but people might find this one hard to understand. Spell it out. Working across government, with communities, iwi and people themselves to achieve wider gains in health and wellbeing.   Yes. They narrow the field. Give us the chance to focus in on areas where we can actually effect change. |

### Five strategic themes

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

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

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| 1. People power. Don’t like the term. Really is about the system revolving around individuals and families. Understanding the needs of people and how that can be coordinated from the perspective of the person. So much of the system at present is a serial collection of individual clinician inputs. Rarely is this put together from a person perspective.  Understanding the needs and goals of people is one thing; more important is how this fits together for that person. Asking how it is working and responding. The health system is uncoordinated at present in many respects.  High quality services need to be defined by the service users.  No mention of the ‘responsibility' of people for their own health in the language of health strategy. Slightly different political message.  Need to train health practitioners in a different way to work in partnership rather than the hierarchical model.  2. Closer to home. Sounds good but does it really mean it when services are being withdrawn from communities and there is talk in the plan of a Long Term Plan that sounds like making decisions to group services together. Need to be transparent. This will be good in some respects. Don’t shy away from it.  Early intervention – really mean this. Absolutely target conception to 5 years period in a coordinated and whatever it takes fashion. Include total health of pregnant women. Really put our efforts here as this will give the greatest long term benefit.  Journeys in health currently start in people’s homes and often, but not always, end there now. That is not defining anything new.  Leveraging scale. Is that code for centralising services?  Move to a model of prevention. Allied are skilled in prevention.  Consultation document very light on prevention and heavy on hospital/clinical treatment. Need to stop people needing the treatment in the first place.  Equity issues related to access. Because care is free in hospitals/secondary care, poor people will access care here.  Needs a stronger focus on equitable services throughout the document.  Allied Health services are perceived to be hospital based which is a barrier.  Correlation between day readmission, length of stay and amount of allied health input. Latest Health Round Table Report shows this.  General Practice model: access to allied health providing rehabilitation and recovery is via GPs. This is a barrier for people.  The exception is pharmacists where people can walk in to community pharmacy. Example given of teenagers seeking health care at pharmacy as they can ‘walk in’. It would be useful if allied could work more like this. For example osteoarthritis treatment by physiotherapists is via referral from GP. Instead they could be focussing on prevention and health promotion good balance, gait etc more upstream. |
| 3. Value and performance. Clinicians need to understand this will be defined by people using the services. What does it mean to them? What really is performance?  Strive to always do things differently. Currently the system is predisposed to the status quo and we keep saying that is not going to do it. This plan doesn’t really propose much different.  Not just a lift in health outcomes for people disadvantaged, health outcome equity on a base of all health outcomes substantially improved. We are not tinkering and need to back ourselves.  Funding approaches – do not break down the holistic approach in funding. Multiples bottom lines sounds complicated and fragmented, less effective.  Needs to look at funding streams, introduce flexible funding so that this isn’t a barrier to integration.  Health literacy is a big problem. Stanford programmes.  Access to smart technology – what is peoples ‘role’ in this?  Health information – three aspects: health information that health practitioners hold, health information that patients hold about their own health and health information across agencies/government.  What are people-powered performance measures?  Different patient and health professionals may have different goals – are practitioners willing to go with patients goals?  Needs more focus on how we are going to support the workforce to develop into new and diverse roles.  4. One Team. Team is not well defined. Needs to be brought down to the base levels of the team with the family/whanau that is supported to achieve Hauora. Then the team with community health providers. These are the teams to emphasise the most. Certainly agree the health system is more than the sum of the parts. People interacting with it are the glue, but often not recognised in this way.  Investing in workforce. Laudable and we do it now but this implies more. Will we be able to deliver on this?  Hierarchical rather than networked.  People perceive the team to be doctors and nurses. They forget allied health or don’t understand what allied health do.  Need to work together across professions inter-professional learning especially postgraduate level.  Learning to ‘walk in others shoes’.  The role of peer support, health navigators, nurse practitioners and nurse prescribers needs more emphasis.  5. Smart System. Issue here is the penetration of technology in the community and who can afford to access it. Increasing the use often technology is a good strategy but it will tend to increase inequity because Maori and Pacific have lower access. Hand in hand need wider sector action to enable technology in all homes in NZ. Never can take away quality interaction on a human to human level. Plan should be clear about this.  People at risk of conditions need to get high and free access to accessible health services. Staring with targeting to pregnant women and through to 5 years of age.  Understanding the needs and goals of people is one thing, more important is how this fits together for that person. Asking how it is working and responding. The health system is uncoordinated at present in many respects.  High quality services need to be defined by the service users. |

### 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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| * These seem underwhelming and many are rather process orientated rather than targeted actions for defined health outcome improvement. * There are few actions to reduce the reliance on secondary health services. * Focus should be on actions to address inequities in resource allocation. * Total focus on pregnant women to five year olds. * Not likely we will develop the plan in 3. We `have not been able to do this in many attempts. * Aligning funding – allow shifting to get greater access to reduce ill-health and impact downstream. * Health investment – good idea but additional funding, not top slicing, have a commitment to the investment approach. Invest additional resources only in actions that will improve outcomes and reduce inequalities in outcomes. * One team. No actions at the grass roots level where the largest gains are possible. * No mention of getting alcohol under control in society. Huge impact on health and social issues but no mention of reducing access, restricting advertising, lowering limits, increasing cost etc. * Great start – let’s put more actions in here. Our biggest opportunity. Let’s get all NZ children to five fit healthy and happy. * No talk of attachment and then later on mental health outcomes. * Quality and safety. Incorporate Quality Accounts into Annual Reports. * Older persons need and mental health areas need to be strengthened given the ageing population – strategy is a bit light on this. * Needs more focus on the social determinants of health. * Need a national IT strategy that supports a platform across the continuum of health. |

### 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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| * Think it needs more work on actions that are targeted and will show results. Only these actions should be listed in a document of this type. It should be totally outcome orientated not system or process orientated. * Set targets to achieve with graded steps. Really show progress. Highlight where the most change is occurring and tell the story of that so that is can be replicated, tenfold. |

### Any other matters

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

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| Overall the strategy seems to cover most things, but when you drill down it’s a bit fluffy and doesn’t provide the grunt that is needed to challenge and change the status quo. |

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| **236** | Submitter name | J Millar | | |
| Submitter organisation | Grey Power Otago Inc | | |
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| Position (if applicable): | | | | President |

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

x on behalf of a group or organisation(s)

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Māori  Regulatory authority

Pacific

X Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| Like to see District Health Boards have a consumer advisory group which can explain how the interpretation of policies affect the consumer in their everyday life 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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| Yes |

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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| Yes as long it is people focused and tailored to individual needs |

### Roadmap of Actions

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

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

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### 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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| This could be one of the benefits for the consumer advisory group to ensure everyone understands the processes |

### Any other matters

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

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| On the whole it is a very comprehensive document. The most important thing is to remember that it may well be 10 years before everyone is media savvy. There must be protocols to ensure those non computer people have a method of personal service. |

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| **237** | Submitter name | Johanna Wilson | | |
| Submitter organisation |  | | |
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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

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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| Thank you for the opportunity to provide feedback on the new strategy.   * Tobacco use is the most important preventable cause of death, disability and health inequalities in Aotearoa. * Children are our most valuable asset and are particularly vulnerable to second-hand smoke due to their smaller lungs and lower body weight.  Children need to be protected from second-hand smoke as much as possible. * Exposure to second-hand smoke during pregnancy can reduce foetal growth and other complications. * Reducing exposure to second-hand smoke in cars and homes are two areas where we can really make a difference to prevent smoking-related illnesses. * Reducing tobacco use should be central to the new strategy as the Government has agreed to the Smokefree 2025 goal and yet I don’t see it mentioned in the strategy. |

### The future we want

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

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

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

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| I believe it starts with the baby. If **ALL** children are born smokefree and live smokefree lives then it would be easier for **ALL** New Zealanders to live well, stay well, get well.  This is a big ask and to date suggests we haven’t been working together. Sometimes it is better to keep it simple and mean it rather than say a whole lot of words e.g. ‘value and high performance’, ‘one team in a smart system’. Sounds pretentious and unrealistic.  It would be better to say ‘working together in a cost effective way’. |

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?

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| Please include specific objectives to reduce tobacco related harm for individuals, families 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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| I can only see one reference to Smokefree homes promotion on point C of Action 6. There needs to be an all-inclusive tobacco control response to private, public and online environments of children and ways that tobacco is still being normalised within them. |

### 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 government could do more to help the Smokefree 2025 NZ like: standardised packaging, regular and large tax increases, a licensing system for retailers, smokefree cars and targeted media campaigns. |

### Any other matters

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

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| A health strategy that doesn’t seriously address tobacco use, is not a health strategy. |

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| **238** | Submitter name | Junior Kiki Maepu |
| Submitter organisation | NET Pacific |

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| --- | --- |
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| Position (if applicable): | Group Manager |

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on behalf of a group or organisation(s)

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Primary health organisation  Other professional association

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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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| With regard to integrated approaches to health, this reduces costs to providers and its ability to recruit a mobile global workforce.  Hutt Valley region only has 4 Pacific providers but the definition of what a provider is outdated and needs to be redefined.  Pacific people need to be explicitly mentioned in the Strategy as a high needs/priority group. In the 2000 strategy, not set targets, just token mention of Pacific but NO real actions behind it. |

### 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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| **To be honest, the language about all NZ is a fallacy because the rest of the NZ does NOT suffer from poorer health outcomes when compared to Pacific and Maori population.**  Change the language to target most deprived areas and population which are primarily occupied by Maori and Pacific...to be equitable; the focus of population health needs to clearly state ...**Pacific and Maori statistics have not significantly improved since 2000. Do we have to suffer again for another 15years?Better Public Service target? Get real and show it with actions** |

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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| Child Health should be main priority, Access to services, Pacific workforce and Health Literacy needs to be long term strategies.  The impact of strengthening workforce and how our people navigate the health system, consume medicines etc is the focus on PHO and DHB and this feeds into the NZ strategy. |

### Five strategic themes

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

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

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| In 10years, Pacific health outcomes look similar to the current statistics.(little improvement in some areas) The notion that our people are living longer isn’t true because the frontline work that we do contradicts this fallacy.  If our Pacific peoples are living longer – one has to really examine the quality of their lives. The majority are home bound, isolated because our children have lost their culture and eventually it is costing more to the health system. |

### 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 2000 strategy, there were only 13 principles and in 15years...not much has changed...20 areas in 5years is simply not feasible. Focus more on tangible and can be measured with RBA framework. In some cases, such as with rheumatic fever and child obesity, Pacific  people experience worse outcomes than Maori. A specific mention of Pacific peoples will ensure that DHBs and health providers prioritise and meet the health needs of Pacific people in their regions. |

### 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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| Focus more on results based accountability as this tells a better picture instead of the depressing statistics that we have been hearing since the 1980’s-90s.  If we are to combine health and social approaches; health leadership needs to be singing from same sheet as social service funding bodies.  Nurses cannot carry out the same tasks as Social workers. And having more than one public official visiting vulnerable families can be overwhelming and they will lose trust and disengage |

### Any other matters

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

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| In order for any of the Pacific outcomes to improve. The health workforce still lacks diversity and considering that Superdiversity is about to have a major impact in NZ population. The emphasis should be educating the workforce so they are mobile and clinicians can go to the people.  Costs have been one of the main factors in DNA and ASH rates for years. Build the Pacific workforce as this will have contributing economic and social factors and reduce inequality. More qualified workforce will have lasting effects on all of NZ (not just Pacific peoples) |

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| **239** | Submitter name | Karen Magrath and Marianne Grant |
| Submitter organisation | Royal New Zealand Plunket Society |

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| Email: | Karen.magrath@plunket.org.nz |
| Organisation (if applicable): | Royal New Zealand Plunket Society |
| Position (if applicable): | National Clinical Advisors |

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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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| **Challenges:**   * The first point is that throughout the document there is reference to technology and an assumption that everyone (including patients, clients consumers and practitioners) has access to technology – the strategy needs to ensure that this is not creating barriers which could restrict services to people who either cannot afford technology or for some reason don’t access technology. |
| * Another point to consider is that even in circumstances where people have access to technology they still exercise choice and should be supported in these choices regarding the modes of engagement and access they use |
| * It needs to be acknowledged that many New Zealanders on low incomes struggle to access health services due to cost. This is not going to be addressed purely by bringing services “closer to home”. A barrier for many people accessing primary care in a timely way is the cost associated with GP services (in particular after hours). If families and whanau have unpaid bills with a GP practice, this can prevent them from accessing free services for their children. |
| * The Wicked problem of obesity - including continued influence of food marketing to consumers and its influence on health in NZ e.g. ‘Big Alcohol’, ‘Big Coke’, foods that are known as ‘empty calories ‘ |
| * Continued disparity between population groups in NZ over a wide range of health conditions especially between non-Maori population and Maori , non- Pacific and Pacific populations |
| * Continued inequity in access to health care for Maori and Pacific populations |
| * Continued disparities in access and health care for vulnerable populations - children, people with disabilities, LGBQTI peoples , refugees and migrants |
| **Opportunities:**   * Progress towards national health record and bringing all records into that needs to be sustained. This needs to be across all streams of the health system that people access |
| * This strategy provides opportunities for us to do things differently. Philosophically a good fit for us as nurses and all who work in health. Nurses as a group are an underutilised resource – they are agile, highly trained and relevantly prepared to work differently, very aware that opportunities now for active participation at all levels and across the continuum of health |
| * Empowering health: paper is still quicker than some systems. Healthcare 5-10 yrs behind other technology. Healthcare that works, is safe and leaves no one behind. Disruption of care, change systems i.e. triage of care innovators challenging us, Uber and taxi industry. Monitor and manage care without walls, between visit care remote monitoring (wearable technology) . |
| * Virtual healthcare needs to be defined and consideration given to structures and policies to support working in this way. |
| * Improve technology user experience and clinical productivity |
| * War on paper, make paper based processes better |
| * Workforce issues also provide opportunity-Slightly less nurses are training now. Contextual issues need to be addressed such as Aged Care and entry to NETP programme. Five years nursing shortage again like in 1980’s. There are good examples like the central model, partnership with aged care and others, student go to DHB for study days. There are opportunities also to partner with business owners |
| * Preparing the workforce of the future requires funding. Investing in prevention is a key theme and an action plan for this needs to be clearly outlined. |
| * Conversations with consumers about this massive change are critical consequently a major socialization of the strategy will be required: investing in children and young people. We all have work to do to help consumers and colleagues to understand the triple aim and population health outside of our caseload, unit, and specialty. |
| * Opportunity to consider wicked solutions to wicked problems |
| * Increasing Workforce capacity and capability to engage in partnership with the diversity of populations to increase better health outcomes |
| * Opportunity to consider proportionate use of resource to make a difference for vulnerable populations and begin to reduce inequity. |
| * Match resource to need ( by Needs Assessment ) not perceived and normative need |
| * Opportunity to describe wellness and support wellness via strengthened understanding of health promotion and attention to health literacy |
| * Could there be a national communication system e.g.: between DHB dental services. Each DHB dental service work in isolation which is not effective with ensuring high needs transient families receive ongoing care. |
| * Co Design and the importance of consumer voice |
| * Critical nature of evaluation of outcomes |
| * Partnership with consumers and their families should be an underpinning foundation for the development and design of any programme. |
| * Downstream historically focused on unwell – redesign community wellness equity and access. NGOs, Plunket & WCTO Providers , LMCs often not invited but they are the ones engaging with families, social services in their own homes and communities. |
| * Nursing upstream intervention 0-24yrs outside of the boundaries of the general practice model. Funding short term contracts. Well Child and others examine how to fund these services to support improved health literacy and improved health outcomes. |

### The future we want

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

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

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

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| --- |
| We would suggest a modification such as:  Think about “every”…. |
| The statement would be strengthened by depicting a future health service in which “all New Zealanders can **access and engage** with services they need for health and wellbeing”. Otherwise it appears that we are “doing to” people instead of “with them”. Services need to strive to ensure they are accessible and promote engagement and responsiveness with individuals, families and communities. The health workforce in particular nursing with its ageing population needs to be flexible across all primary healthcare nursing services in order to meet changes in demand for services. Overall the statement supports primary health care, services closer to home. We need to ensure the quality of those services. There needs to be increased investment in technology that supports a collaborative approach in health service delivery. The Privacy Act 1993 needs to be better understood in a health context to support the statement above. |
| Who are all New Zealanders? Can all people in NZ access free health care? |
| Who cares for Pacific children, what about health care for non-residents with severe dental caries, high health needs, obesity, rheumatic fever etc.? |
| The overarching theme of **’closer to home’** - may mean different things to different people and set up expectations that cannot be met, e.g. some services will not be able to be provided ‘ closer to home’ – specialist services - child cancer, radiotherapy, specialist cancer services, specialist surgery  This term appears to encompass a range of services that would/could and are delivered in the Primary health care sector -   * suggested instead of close to home - community delivered or Primary health care located * the link to Healthy Housing concepts is a strength |
| In the closer to home section there is mention of the social determinants, but the question raised at one of the forums is does the structure and systems allow a cross government approach with the client in the centre – at the moment there are so many loopholes and barriers that for clients/patients it is very difficult.  To be health we need to ensure all social determinants as well as health determinants are considered.  Poverty is an example and agencies such as the MOH need to take leadership on this as it is not just a social issue but affects the health as 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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| These 8 principles reflect a broad range of action oriented goals for the NZ Health system, however there could be more specific emphasis on a focussed action towards decreasing inequities for Maori as this was not achieved over the last 15 years since the previous health strategy was actioned. This is implied in the Treaty of Waitangi principle but acknowledgement needs to equate to action and initiatives that respond to the diverse and intergenerational needs of Māori. There needs to be increased emphasis and investment in primary health care services for the elderly as this is a growing vulnerable population that is often ignored. It is the actions that sit underneath these principles and the link between the two which will result in health outcomes. |
| While the 8 guiding principles appear to encompass a holistic view of health, looking at health equity, health promotion and continued connection and collaboration with communities, there is an absence of acknowledgement and the significance of the social determinants of health and their impact on health trajectories for our people. This is particularly salient with regard to vulnerable populations such as infants, children and their families, the aging population, people with disabilities, people with mental illness, chronic conditions, youth, COPMIA, Children in Care etc.… homeless people, and migrants and refugees. |
| There also needs to be increased recognition of the importance of community development and ownership of health, this will involve a joined up approach towards increasing baseline levels of health literacy, by providing education in partnership with people in their communities. This will also facilitate people and communities supporting and looking after each other.  A broader definition of Literacy with regard to such factors as finance, food, housing education, it is very important to consider the approaches that are taken with regard to the continuum of cultures, age groups, circumstance, and opportunity. |
| These principles reflect a broad range of action oriented goals for the NZ Health system, however there needs to be inclusion of a clear plan for training and development of the health workforce across the sectors, to work in this way, with a particular view to governance and leadership.  With regard to the section “Aligning behaviours” the bullet points clearly and relevantly outline a vision for the shifts that are required to achieve progress and “the future we want”. |

### 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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| There are meta -themes across the themes including:   * Integrated services. Clarity will need to be provided about what level of integration is optimal across service areas / sectors to guide integration and collaboration. |
| * Management, analysis and exploitation of data, information and knowledge will need to be considered. The notion of “big data” is also relevant as this has implications for consumer trust, funding allocation and future planning for services. Whilst there is a focus on this in the smart system theme, all other themes are dependent on this. |
| * Providers who build a trusted information culture and an ability to make data-based operational and investment decisions earlier in the curve will be able to make use of this volume and variety of information; others will not. |
| * It would be great to have some focus on ensuring quality and effectiveness of community and primary health initiatives. |
| * It would also be a strength to have some clarity around Referral pathways and increased collaboration between services. |
| **The five themes:**  **1 People powered** –   * the focus on enabling & harnessing technology is admirable |
| * it is critical to consider the segment of the population for whom access is a barrier for a number of reasons including but not restricted to: * Confidence with the health system * Levels of health literacy * Levels of technology literacy * Cultural considerations * Resources e.g. hardware, connectivity, knowledge, experience |
| * This is particularly salient with regard to vulnerable populations such as infants, children and their families, the aging population, people with disabilities, people with mental illness, chronic conditions, youth, COPMIA, Children in Care, homeless people, LGBQTI peoples , migrants and refugees |
| * A great service in 10 years would be engaging and responsive, able to invest where there is the greatest need and identify what makes an approach “customer focused”. People should not have to tell their story over and over to health professionals – particularly when the issue(s) have remained the same. There needs to be increased investment in collaborative inter and intra-sectorial initiatives and ways to easily identify packages of services and support available for individuals and families as part of a plan of care. Children’s’ Teams need to be established and functioning at a high level with high quality services and systems that work across sectors. |
| **2 Closer to home**   * The overarching theme of ’closer to home’ - may mean different things to different people and set up expectations that cannot be met. |
| * It must also be made clear that in order to work within resource and maintain quality some services will not be able to be provided ‘ closer to home ‘ specialist services - child cancer, radiotherapy, specialist cancer services, specialist surgery |
| * This term appears to encompass a range of services that would/ could and is delivered in the Primary health care sector. |
| * suggested instead of close to home - community delivered or Primary health care located |
| * The link to Healthy Housing concepts is a very strong and positive link |
| * Primary health care workforce is predominantly invisible and these resources are already working close to home |
| * Nurse practitioners are also an unseen and under-valued resource |
| * In the closer to home section there is mention of the social determinants, but the question raised at the forum is does the structure and systems allow a cross government approach with the client in the centre – at the moment there are so many loopholes and barriers that for clients/patients it is very difficult.  To be health we need to ensure all social determinants as well as health determinants are considered.  Poverty is an example and agencies such as the MOH need to take leadership on this as it is not just a social issue but affects the health as well |
| * While the strategy is broad - the emphasis on current wicked problems is invisible in the strategy, e.g. smoking and alcohol use of illicit substances with regard to comment on obesity taking over from smoking |
| * The importance of the preconception and ante natal period particularly with regard to high quality consistent care for all- but especially with a vision of reducing inequity for young, disadvantage, Maori and pacific women and their families. For example; the examples of smoking, non-communicable (including CVD, diabetes, cancers, CORD). Attention to reducing the burden of poverty would positively impact on the incidence of these conditions. |
| * What great looks like: there needs to be a greater emphasis in this section looking ahead ten years on health promotion health education, targeted prevention strategies and upstream thinking to cater for the bulk of the population that will be increasingly using the health system. |
| * Action 6 would benefit from a specific reference to focused programmes such as injury prevention to reduce the prevalence of childhood unintentional injury. |
| **3 Value and high performance**   * An oversight in this section is an emphasis on health economics, cost benefit analysis and cost effective analysis alongside outcomes driven allocation of funding, with a view to both short and long term outcomes. In order to take this approach the following factors would need to be taken into account: |
| * Accountability and responsibility |
| * Encouragement of innovation |
| * A culture of Continuous Quality Improvement |
| * Implementation of Quality measures to support quality outcomes. |
| * Relevant and measureable performance indicators |
| * Robust and consistent Clinical governance |
| * The use of the Triple aim framework is strategically sound- its adaptation for WCTO has been supportive to addressing consistency and CQI. |
| * Outcomes and investment based on this and not investing in services that do not show outcomes. Social sector investment and getting best value education, housing or health. Investment into the sector. There are many examples of projects that illustrate how we can save $1 mil spent later by spending $300k up front. For e.g.: A project focused on housing may have a more immediate outcome but one focused on non-communicable diseases may not show outcomes in the short term , but track towards true improvements in health outcomes in the longer term. |
| * Careful attention must be paid to Inter-operability of systems as they are developed to facilitate the sharing of success stories and strategies to support cross sector improvement and innovation. |
| **4 One team**   * The issue of adequate resource and infrastructure will need to be addressed in order to support an integrated and collaborative way of working to facilitate an episodic but continuous consumer pathway. To achieve an interdisciplinary system requires agile and responsive guidance and governance. |
| * Primary health care workforce is less visible than it should be in the strategy - this group are flexible and agile - and have the ability to increase and improve outcomes by achieving more traction in delivery of health promotion and health education. |
| * The key factor to consider when approaching the use of technology is that of choice. Careful consultation and effort to engage people relevant to the target group is critical. Face to face (in person) – Kanohi ki te Kanohi is a very valuable tool which should always be a choice where possible- it is critical that the importance of this is not undervalued in the underpinning drive towards increased use and importance of technology. The nuances of body language, voice and engagement can be lost in technology - segments of our population should not be disadvantaged by re -orientating of health sector/ system as this would risk further increasing inequity. |
| * There is always a risk that fragmentation will arise out of specific contracting environments so these must also be developed to support collaboration and integration. |
| * There is a clear evidence base to support that across sector team approaches and working together more collaboratively, does take considerable resource to start with – and this always needs to be balanced with delivering on contractual or fiscal obligations. |
| * There will be a need to increase workforce capacity and capability to integrate knowledge and skills to work across other disciplines and interdisciplinary - alongside core skills for engaging and supporting effectively people/ customers from different cultures/ethnic groups / age groups / vulnerable peoples etc. |
| **5 Smart system** –   * There needs to be further expansion on the inequity theme (Maori and Pacific), the need for a common language across sectors including PHOs and DHBs needing to talk as collaborative members of a team. |
| * Important to have consistent attention to the lens on patient journeys: how we plan collectively to improve efficiency and outcomes. |
| * Becoming more predictive, we are incredibly data rich … how is it used to inform decision making. |
| * Human 70% accuracy can increase to 95% accuracy with the use of smart systems. |
| * Co design including all key stakeholders and particularly the consumer is a valuable resource that must be increasingly considered as a foundation for smart systems. |
| * Patient demand systems says we have some of this yet we cannot get the funding for these systems. Examples include e-prescribing, then add in human system and increase error rates!! |
| * “Great” in the “smart system” theme is painted very cautiously. Within 10 years it is likely that consumer-grade and prescribed home-monitoring devices become pervasive. This will be positive for patients/people, and also challenge to manage with regard to volumes of information, and the drive for integration. |
| * National Health Information record referred to in the document, is it a record or is it a system that can link via NHI. It is unclear what is expected here, some investment in this space. |
| * Interconnectivity between providers presently is an obstacle to providers across sectors and within sectors working seamlessly together and with increased flexibility is inability for IT systems to connect with one another safely. |
| * SMART system requires cognizance to Privacy standards for peoples personal ( & health) information - this is missing in the strategy |
| * Clinically lead projects are imperative. To improve efficiency and consumer experience these need to be designed to support responsive care and nursing workflow. However your 10 year old clinical process may not be the right one in a technology world. Don’t transport current clinical processes into IT processes need to work together. |
| * This is a rapidly changing landscape examples such as Suri on iPhone, and technologies that can talk think and interpret. Reinvent business processes and systems. Building the intelligent cloud, making it easy to buy applications, and limited limitations within IT departments. |
| * It is important to build on where we are seeing progress and success such as: mobility experiences, enhanced productivity and collaboration, health analytics, cloud platform and innovation. |
| * With the smart system one thing to highlight is that technology is just a tool and this must be seen as a choice and a tool to support communication and not a replacement for it. |
| * Attention will also need to be paid to legislation and systems to support this collaborative way of working, cognisant of consumers’ needs.  Using technology such as telehealth has great potential as it does support the notion of access and keeping the services closer to home when approached mindful of legislation and systems to support it. |
| * It must be noted that when talking technology and avoid making the assumption that all people have access to technology – we must avoid potential barriers which will restrict rather than provide access to services to people who either cannot afford technology or for any other reason don’t access technology. |

### Roadmap of Actions

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

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

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| * Progress towards national health record and bringing all records into that needs to be sustained. This needs to be across all streams of the health system that people access. |
| * People must be supported to be involved in decisions regarding their health. We need to really examine what we are measuring to know if a difference has been made – there are many examples of where this opportunity has been missed, around how to put the person in the middle for all services not just health, How do we integrate to maintain wellness. We do need to strengthen the work cross-sectorialy with the person is the centre. The consumer and the workers also have to be involved in the design. |
| * There needs to be regular monitoring of all programmes/services to ensure delivery design and output is reflective of what has been purchased by the Ministry. This appears to be inconsistent throughout the country and across services. There is a need to strengthen feedback mechanisms at individual, local, organisational and Ministry levels in order to ensure health services and the system are appropriate and responsive to the needs of New Zealanders. This is not only about identifying and creating opportunities for consumers to provide feedback about individual experiences, but also determining the way the feedback is managed and considered at every level of service delivery as part of quality improvement. |
| * No 5. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions and for obesity is very relevant and needs a lot of work to improve referral pathways and guidance for staff working in the community. |
| * No 6. Work with the system to develop a performance management approach with reporting that enhances public transparency, is important to ensure Community agencies and Primary health care are accountable and ensuring continuity of client care, response to referrals and more collaboration. |
| * With regard to action5 & 6 - there is no mention of supporting Breast feeding as the Gold standard for infant feeding which reduces the risk of obesity in later life ( along with a range of other health benefits that are well documented ) |
| * The universal services are not visible in this document. |

### Turning strategy into action

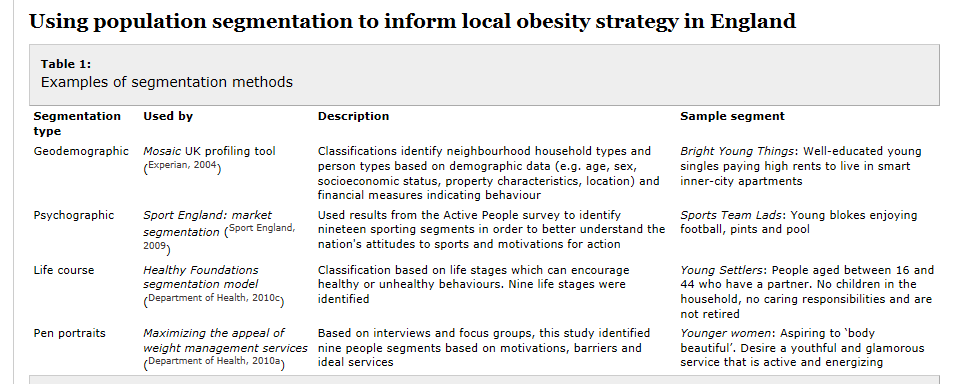
6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| **General Comment:**   * Identifying who is required to do what and in what timeframe and how it will be measured. Ensuring the workforce is adequately trained. Consumer input and feedback mechanisms are established. Workforce flexibility across primary healthcare. Open and transparent communication to support trust across services. Cross-service monitoring and measurement of outcomes. |
| * We would applaud the practical approaches to facilitating ‘people powered’, ‘closer to home’ and ‘One Team’, we would suggest that there needs to be more collaboration between all services from DHB, Dental services nationally, PHOs, NGO’s i.e.: Well Child Tamariki Ora Providers on a community with a partnership, needs based and socio ecological approach. |
| **Tracking and reporting of progress**   * Evaluation should be built into programmes, not an afterthought - with well thought out measures at the onset. |
| * Recognition that some outcomes will take longer to realise |
| * There are current measures that should continue and not be discarded - consider strengthening of others - e.g. smoking cessation, alcohol brief interventions |
| * Care with reliance on technology in face of natural disasters and conflict e.g.: experience of Christchurch earthquake - important to learn from both success stories and challenges. |
| * Emphasis on technology as a tool and a conduit without losing sight of the person and their experience. |
| * Use of tried and true systems and measurements with reliable denominators - we currently have some data sets that don’t contain all the data and / or have missing data |
| * It is important to improve the accuracy of data collection with regard to consistent definitions and criteria, e.g. ethnicity data collected in the manner that was intended with ethnicity protocols (and increase use of associated evaluation tool). |
| * Progress towards a national health record with NHI – this could then be considered the basis for evaluation as well as an electronic health record. |

### Any other matters

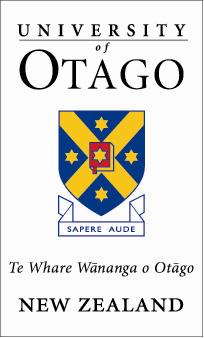
7 Are there any other comments you want to make as part of your submission?

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| * There needs to be clarification of the definition of health that underpins this strategy-What is the desired outcome – would it be good to return to the WHO definition of health which could underpin this approach. Live well, stay well, get well puts added responsibility on the consumer for their health. |
| * Where is the role of health economics in the strategy - this appears to be absent - many ideas but we do require robust measures - utilizing health economic principles - cost benefit analysis , cost utilization analysis etc. |
| * We need to be mindful not to base action on the assumption that a level of health literacy exists which in fact does not exist across all populations. |
| * There will be need to be careful consideration of sensitive information with regard to ‘patient portals’ and their use for documentation of care planning and analysis, especially such issues as family Violence screening and mental health. |
| * a more obvious link to He Korowai Oranga with emphasis on reducing disparities and inequity of access |
| * A link to the underpinning Child health Strategy and The Disability Strategy with a particular emphasis on Partnership. |
| * An increased & strengthened emphasis on mental wellness |
| * While the strategy is broad - the emphasis on current “wicked” problems are invisible in the strategy e.g. smoking and alcohol use of illicit substances |
| * There needs to be more emphasis on Universal Service/s. |
| * Consider using more terms that people ( health care users/ customers ) understand e.g. Primary health care |
| * With regard to a specific target such as long term conditions and Childhood obesity – a number of pathways will need to be mapped to outline what services will be available to support families for example: are referral pathways available and obvious and what additional training are health practitioners expected to do. It will also be important to be clear about the health practitioner who is responsible for case management long term. |
| * There are a number of countries ( Denmark , Norway )  that have Big Data  to provide a basis for planning and  evaluation etc   which link up , including prescribing, immunisation, cancer registry. A strong recommendation to investigate this approach into NZ. This would provide a strengthened  and linked data repository .   cid:image001.png@01D12E95.936B90C0 |
| * With regard to Population segmentation - Is this the best definition to use and we would suggest this needs more explanation - * The model discussed in this article divides the population into eight groups: people in good health, in maternal/infant situations, with an acute illness, with stable chronic conditions, with a serious but stable disability, with failing health near death, with advanced organ system failure, and with long-term frailty. Each group has its own definitions of optimal health and its own priorities among services. Interpreting these population-focused priorities in the context of the Institute of Medicine's six goals for quality yields a framework that could shape planning for resources, care arrangements, and service delivery, thus ensuring that each person's health needs can be met effectively and efficiently. Since this framework would guide each population segment across the institute's "Quality Chasm," it is called the "Bridges to Health" model.   Reference : Using population segmentation to provide better health care for all: the "Bridges to Health" model. [Lynn J](http://www.ncbi.nlm.nih.gov/pubmed/?term=Lynn%20J%5BAuthor%5D&cauthor=true&cauthor_uid=17517112)1, [Straube BM](http://www.ncbi.nlm.nih.gov/pubmed/?term=Straube%20BM%5BAuthor%5D&cauthor=true&cauthor_uid=17517112), [Bell KM](http://www.ncbi.nlm.nih.gov/pubmed/?term=Bell%20KM%5BAuthor%5D&cauthor=true&cauthor_uid=17517112), [Jencks SF](http://www.ncbi.nlm.nih.gov/pubmed/?term=Jencks%20SF%5BAuthor%5D&cauthor=true&cauthor_uid=17517112), [Kambic RT](http://www.ncbi.nlm.nih.gov/pubmed/?term=Kambic%20RT%5BAuthor%5D&cauthor=true&cauthor_uid=17517112) |



<http://radar.oreilly.com/2013/08/the-next-top-5-identifying-patients-for-additional-care-through-micro-segmentation-2.html>

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| **240** | Submitter name | Dr Louise Marsh |
| Submitter organisation | The Cancer Society Social & Behavioural Research Unit, University of Otago |

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Submission in response to the Update of the New Zealand Health Strategy Consultation draft

Submission prepared by:

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Tobacco Control

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04 December, 2015

Thank you for this opportunity to make a submission on the New Zealand Health Strategy. The Cancer Society Social & Behavioural Research Unit undertakes research for the primary prevention of cancer in New Zealand, including research on tobacco control, mainly around young people. Our work focuses on preventing smoking uptake and exposure to second-hand smoke, reducing access to tobacco, examining the retail of tobacco and changes in the patterns of smoking among young people. We have a strong record in tobacco control research since 1990. We have published more than 37 peer-reviewed journal articles on tobacco control, and presented at a number of national, Australasian and international conferences.

**Introduction:**

We would like to take this opportunity to acknowledge the many strengths of the proposed update of the New Zealand Health Strategy. The focus on strengthening the health care system, the need to improve the health status of Māori, whānau ora, reducing harm to young people, housing, climate change and the role that changing technologies will have in the future health of New Zealanders is commendable. However, from the perspective of population health, prevention, and cost effectiveness, the draft Strategy could be strengthened.

Tobacco smoking remains the number one preventable risk factor for health loss in New Zealand. It is also a major contributor to health disparities between Māori and non-Māori. Yet, the draft Health Strategy fails to adequately address New Zealand’s biggest killer, tobacco, which is scarcely mentioned in the draft.

In 2011, the New Zealand government committed to the Smokefree 2025 Goal. In working towards this goal New Zealand has received global recognition for its innovative approach and leadership in tobacco control, and there has been significant progress made:

* The introduction of targets throughout primary and secondary care
* New funding for piloting and evaluating innovative cessation programmes
* New funding for building evidence toward further tobacco control interventions
* Legislation to ban tobacco retail displays
* Legislation to reduce duty-free quotas for entry of tobacco into the country
* Annual tobacco excise tax increases
* Standardised packaging of tobacco products

However, robust modelling of prevalence rates to 2025, indicate that all of the above efforts are still not enough to achieve the Smokefree 2025 goal. The New Zealand tobacco control sector have developed a “roadmap of actions”, which sets out a detailed plan for reaching the 2025. Furthermore, the Government recently committed to developing a comprehensive strategy for achieving the 2025 Smokefree Goal. Neither of these, nor the world-leading Smokefree 2025 goal, are addressed in the draft.

### Challenges and opportunities

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

There is no reference within the discussion to the government’s goal of a Smokefree Aotearoa by 2025, even as an aspiration. Such a commitment should be included as a key opportunity for our sector to strategize measures to

* reduce tobacco related harm and disease across our communities,
* adequately fund cessation services and treatments, and
* prevent uptake of smoking among children.

Priority should be given to the third of these points, with emphasis upon the children of current New Zealanders who smoke. For example, an action in the Health Strategy could be to increase support for the promotion of smokefree environments where children are.

Prevalence and consumption of tobacco tells an adult story about smoking. But the impact of smoking prevalence and consumption is largely upon unequally exposed children, who not only suffer and die (sometimes before they are born) from the effects of second-hand smoke, but grow up in an environment where tobacco is normalised by their caregivers. Nothing in the draft Health Strategy addresses this story of exposed children and the huge health risk to their long-term wellbeing.

### The future we want

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

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

The term “all” is not reflected adequately in the discussion nor the roadmap. “All” indicates that these actions are universally applied, and yet the strategy makes clear it intends to emphasise services to people most in need with this strategy. While we agree with the intent of this word, it is not consistent with the content of the strategy.

We suggest: So that **all** New Zealanders **are born well, are served well through life, then die well…**

This statement of intent would more adequately encompass the great challenges we have in insuring our services can create for future generations the best possible start to life, beginning with targeted cessation services and adequately funded health promotion to support smokefree pregnancy, cars and homes. This new statement gives emphasis to staying well through life and the quality of life that living healthy affords New Zealanders. It also acknowledges New Zealand’s aging population and their needs, despite the suggested refocus on the start to life.

We do not support this value statement’s prioritisation of “home” when there is such a housing crisis in New Zealand, and for many more New Zealanders, their home is not a safe environment, and/or not a healthy one.

We do however fully support the prioritisation of “working as one team within a smart system” and encourages all sectors to look closely at the success of our tobacco control sector in this regard. There is strong collaborative leadership through a National Smokefree Working Group, and alliances across all DHBs with the NGO sector via regional coalitions, as well as ourselves as researchers.

The only reason why this Health Strategy would need to reinvent the wheel on value and high performance is because it risks ignoring the great value for money and high performing network in tobacco control, developed largely outside of government and despite the lack of a tobacco control action plan.

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

The principles outlined are aspirational (like the commitment to a Smokefree Aotearoa by 2025) and require clearer measurable outcomes to identify meaningful change that can be achieved and sustained.

* The best **health and wellbeing** possible for all New Zealanders **throughout their lives.** This principle needs to include a commitment to the promotion of health literacy with individuals, families, communities and professional networks.
* Thinking beyond narrow definitions of health and **collaborating with others** to achieve wellbeing. This needs a multi-agency commitment, recognising the importance of the NGO sector, professional networks and forums (especially Smokefree Coalitions operating throughout New Zealand) and Territorial Local Authorities as key service providers seeking to gain community outcomes (alignment with health and wellbeing). Also relevant for Active **partnership** with **people and communities** at all levels. Appropriate forms of capacity building opportunities to encourage participation in decision making.

### Five strategic themes

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

There should be included specific objectives to reduce tobacco related harm for individuals, families and communities.

### 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 environment is not adequately addressed as a determinant of health outcome in this strategy. Health promotion and advocacy needs adequate funding to:

* expose the rogue industries within New Zealand that promote dangerous / addictive products to children
* build public support for a comprehensive government programme of regulatory interventions

There is but one reference to Smokefree homes promotion on point c of Action 6: this is inadequate and we recommend a comprehensive tobacco control response to both the private, public and online environments of children and ways that tobacco is still being normalised within them.

We support action 8, to develop and implement a health outcome focused framework, so long as it emphasises measures to reduce supply and demand for tobacco through adequately funded health promotion and tobacco control advocacy.

### 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?

Tracking and reporting progress needs independent research, which needs adequate funding. There should be an alliance between government, the NGO sector, and research units across New Zealand, to develop an outcomes evaluation plan that allocates funding of research in specific health outcomes to their relative NGO, while in health service outcomes to each DHB. For example, the Asthma Foundation has recently launched its Respiratory Health Strategy: ongoing research on respiratory health in New Zealand must be resourced adequately and independently through this Foundation’s funding, to track progress against this collaborative approach to improving health literacy and services to sufferers of respiratory disease in New Zealand.

**Summary**

A stronger focus on preventative measures is needed, especially initiatives to address tobacco smoking, New Zealand’s major cause of preventable illness and death. Stronger preventative measure in this area have been shown to be cost effective in that they lead to reduced health care costs over time and deliver the best health outcomes in the long term.

There is also a need for a stronger focus on priority populations like Māori and Pacific, and reducing health disparities. Initiatives that address the wider negative determinants of health (poverty, education, employment) and improve access and “user experiences” in the primary care and cessation/treatment setting have been seen as key factors to addressing the high smoking rates amongst Māori.

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| **241** | Submitter name | [redacted] |
| Submitter organisation | Ministry of Pacific Island Affairs |

**MEMO**

**To:** Ministry of Health – NZ Health Strategy consultation team

**From:** [redacted], Deputy Chief Executive

**Copy:** [redacted], Chief Policy Advisor

**Subject:** Ministry submission on New Zealand Health Strategy

**Date:** 8 December 2015

**Purpose**

1. This memo present’s feedback from the Ministry of Pacific Island Affairs (the Ministry) on the draft New Zealand Health Strategy (NZHS).

**Background**

1. The Ministry has been involved in the development of the draft NZHS in several ways, namely through the Cabinet paper process, and supporting regional community consultation fono on the NZHS.
2. Whilst health is not an organisational priority for the Ministry, having input into the Strategy is important for the following reasons:

* Pacific peoples continue to experience poorer health disparities when compared to their non-Pacific, non-Maori counterparts.
* Health is interconnected to many other social and economic outcomes, including education and employment (which the Ministry focuses on).
* The NZHS is the key strategic health document that will set the direction for the health system for the next five years. It has not been updated since 2000.

**Approach**

1. Our submission covers strategic Pacific health issues as well as key themes that have been raised at Pacific community consultation fono on the draft Strategy. Our submission is also aligned with *Ala Moui: Pathways to Pacific Health 2014 – 2017* which outlines the strategic direction in Pacific health.

**Submission**

1. The following section provides the Ministry’s feedback according to the five strategic themes and action areas of the strategy.

***Overall comments***

1. Pacific people need to be explicitly mentioned in the Strategy as a high needs/priority group.

Life expectancy for Pacific peoples is at least six years lower than that of the New Zealand population[[3]](#footnote-3),[[4]](#footnote-4). Pacific peoples carry a significant burden of disease, with high rates of rheumatic fever, communicable (tuberculosis, respiratory and skin infections) and non-communicable diseases (cardiovascular, diabetes, stroke, cancer, asthma, mental health-suicide, injuries) and risk factors (smoking, alcohol use, obesity, gout, and poor nutrition)[[5]](#footnote-5). A specific mention of Pacific peoples in the NZHS will ensure that DHBs and the health providers allocate resource appropriately to meet the health needs of Pacific people in their regions.

***People-Powered***

1. There needs to be continued investment in the Pacific health workforce. The Pacific health workforce makes up a very small percentage of the total health workforce but evidence suggest that a workforce that reflects the diverse population has clear benefits, particularly in terms of cultural connections and comfort of patients[[6]](#footnote-6). Our specific recommendations are:

* Recommends that the narrative which refers to the diverse range of cultures and ethnicities also recognise those who have greater needs.
* Recommends that Pacific Health Providers access health equitable expenditure to deliver and expand their services to improve access for Pacific peoples.  This including investment in Pacific health workforce, Pacific provider capability to deliver modern, fresh and innovative services to Pacific communities, Pacific capability across the sector to ensure a better responsive “system”.
* Recommends that the “design of health and disability systems” reflect and are accountable to deliver and meet Pacific outcomes/targets.
* Recommends evidence of better health outcomes using Pacific models, frameworks and approaches of care are recognised and supported.
* Recommends Pacific service users have better access to influence the design and delivery of services that impact on their health and wellbeing.

Action 1:

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

Action 2:

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

***Closer to home***

1. The narrative for closer to home sets a good tone specifically addressing a focus on “prevention, early intervention, rehabilitation and well-being for long term conditions”.   Our specific recommendations are:

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

*What do we want in 5 years?*•    Agrees and commends the focus of services, information and support be as closer to home, especially in those areas who experience poorer health outcomes and access to health services.  
  
•    Recommends Pacific users of the health system, Pacific health providers and Pacific health workers participate in early stages of strategic planning for regional planning.     
  
•    That Pacific providers and services already serving in high needs areas have equitable access expenditure to grow and develop services for Pacific communities.  These services are already are strategically placed in high deprivation areas and have a proven track record of effective programmes that meet the needs of Pacific people.   
  
*Action 6:*•    Agrees that there is a greater need for government agencies to work more collaboratively to improve and make more equitable health and social outcomes for all children, families and whanau.  
  
•    Recommends “particularly those at risk” are explicitly noted to ensure the plan is clear who “those at risk” are.  
  
•    Agrees with promotion of healthy nutrition and activity for pregnant women and recommends this action recognises the aiga/whanau approach model, successful existing programmes such as the Pacific Heartbeat Community Nutrition Course and various Healthy lifestyle initiatives delivered by Pacific providers.    
  
•    Agrees with (c) but greater course of action across government to ensure the intent is resourced.  
  
•    Agrees with (d)   
  
•    Agrees with (e)  
  
•    Agree with (f)  
  
•    Recommends that the narrative for (g) recognises Pacific and Pacific young people as partners to design and develop programmes that reduce incidence of sexual and family violence.    
•    Recommends (h) the Ministry recognise Pacific users (including mothers) and health professionals have a voice in improving systems that response to children and families who are living with fetal alcohol spectrum disorders.

***Value and high performance***

1. The Ministry has no feedback on this priority area but supports it.

***One team***

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

***Smart system***

1. A smart system is more responsive system that meets the diverse needs of Pacific people. The majority of Pacific peoples use mainstream (non-Pacific) services so cultural competence of mainstream services and their workforce is critical.
2. Health Literacy – Pacific peoples have poorer health literacy than other groups and this can impact on how they navigate the health system, consume medicines etc. A smart system needs to be cognisant of this and those who are digitally disadvantaged.

Ministry contact:

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| [redacted] | [redacted] | [redacted] | [redacted] |

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| **242** | Submitter name | Lisa Campbell |
| Submitter organisation | The Salvation Army Addiction Service |

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| --- | --- |
| This submission was completed by: *(name)* | Lisa Campbell |
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| Organisation (if applicable): | The Salvation Army Addiction Service |
| Position (if applicable): | National Operations Manager |

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

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

√ on behalf of a group or organisation(s)

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

√ Service provider  Government

√ Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### 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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| **Challenges:**  Aging population and challenge of funding – needs whole of government approach & alignment, as Health sector cannot do this alone.  The government refers to ‘investment in the health sector … has a positive long-term financial impact for the social sector’. Given that investment in health contributes to outcomes across government - how do Social Development, Justice & Corrections, contribute to these “shared outcomes”?  Needs to be a whole of government strategy rather than just a health strategy if based on a social determinants framework e.g. more holistic outcomes like housing, employment etc.  Future of Pharmac with TPPA – where will the funding come from to support Pharmac?  IT required to enhance system – where will the funding come from to develop this?  Additional long term conditions should include cancer, mental health & addictions in an aging population.  With a smaller proportion of population in younger age groups – will taxes be sufficient to fund this strategy?  Require funding and capacity for workforce development to ensure the strategy is implemented.  Incentives for NGO sector and local government (district councils) who are called on to provide more services in the community to meet need.  Need equity across Government & NGO sector – in compliance costs, training opportunities.  There is a large number of DHB’s for our small country and population – economies of scale may be achieved by a more collective approach.  Ensure we do not lose the voice of the local community.  Find ways to fund and undertake evaluation of approaches by NGOs and government.  The Strategy states the health system is functioning well and is strong, however, we question this in reality. Does the data reflect real improvements or changes in criteria?  The role of private provision of health care alongside the public system is not addressed.  A universal system, whilst attractive, is unaffordable, and may not address inequities within the system.  Opportunities:  Regional growth of services – especially regions closer to Auckland which will be impacted by population spill from Auckland and put demand on health services. Burden of demand will move out of Auckland, however, smaller regions will lose economy of scale and skilled workforce and facilities. So need alternative ways t provide access – and infrastructure to support new methods of delivery eg access to high speed internet  Alignment with Local plans – including support to provide housing, access to services, and how this aligns with national strategy.  Population based funding may not be appropriate for every DHB, community ownership of solutions, and selection of priorities through co-design with communities with local communities and services eg NGO’s  Cultural flexibility as NZ becomes more multi-cultural |

### The future we want

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

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

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

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| The statement projects an ideal, but likely does not embrace people on the margins who will continue to experience inequities. The words are not clearly defined and do not set a clear measurable outcome which will evidence that the future has been achieved.  People-powered is an ambiguous term?  The statement should talk about quality services ahead of value for money & high performance. |

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

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

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| The language being used currently does not have a shared understanding of what each principle means, eg who is disadvantaged, and by what criteria?  We agree that the system should be high performing, but do not see how it will be independently monitored for quality.   1. How are we defining disadvantage? 2. This statement is ambiguous 3. Health promotion is linked with disease and injury promotion. These should be separated out so health promotion, which is broader, can be given full attention. 4. Treaty should be elevated as a greater priority – should be No. 2. 5. Agree with this. 6. Want to see quality included in this 7. Agree with this. 8. Focus on the system ignores the needs of the individuals navigating across multiple agencies.   These principles seem too high level to assist with specific implementation of the strategy. |

### Five strategic themes

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

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

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| We remain concerned about the lack of reference to quality, as it appears quality is secondary to value for money. There is a lack of an independent measures of review in relation to quality, outcomes, etc  How will achievement of this health strategy be measured?  Triple A framework is not described adequately by ‘value and high performance.’  The description seems very simplistic. Sharing of information needs to be considered in light of people’s rights. Risk management of this needs to be part of this system – protocols need to be established.  Better systems will assist delivery of a quality system.  There is not enough clarity – the high level principles appear to be ambiguous, and understanding of language is not a shared understanding. |

### 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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| Implementation is about systems without concrete pathways of action in specific health areas.  No guidance as to how specific health areas will be prioritised to ensure inequity is addressed. To address inequity will need clear guidance as to what this looks like. Local communities will need to establish priorities, but how is leadership is being provided as to how this prioritisation will happen?  How does this align with established government priorities, and projected health care needs moving forward? How is this aligned with priorities such as Hard to reach families, reducing wait list times, access to surgery – alongside the most marginalised groups such as mental health and addictions? |

### 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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| Co-design, community consultation.  There should be shared outcome measures across whole of government, which include NGO participants in the system. Equity between NGO and non-NGO providers; one system across all sectors; to address inequalities will need to be redistribution of resources rather than a universal system.  Unless there is recognition of inequity within service groupings e.g. mental health and addiction, then access to services that sit within one area of a service grouping will continue to create barriers to access to specialist services that are not offered in another area service grouping. |

### Any other matters

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

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| Overall the strategy seems good but the issues will be in the implementation and evaluation.  Thanks for the opportunity to provide a brief submission |

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| **243** | Submitter name | [redacted] |
| Submitter organisation | Compass Health |

**NZ Health Strategy refresh**

Compass Health submission

4 December 2015

Compass Health supports the five strategic themes outlined in the draft refresh of the NZ Health Strategy:

* People powered
* Closer to home
* Value and high performance
* One team
* Smart system

Overall the themes provide a good reflection of the critical success factors needed to usher the NZ Health system into the information age. However, while we consider the overall themes to be useful, we found the draft action areas less compelling. In particular, we need greater focus on investing in general practice capacity, capability and models of care to manage the future challenges to the NZ Health Sector.

We offer the following suggestions to strengthen the actions. These should be read in conjunction with the NZ Health Strategy roadmap action areas document.

**Inform and Involve People**

*Action area 1*

1. Social media is an important tool for supporting self management and behaviour change. Funding should be considered to support Primary Health Organisations to use this tool not only for early stage diabetes, but also for other behaviour and lifestyle change initiatives for people with long term conditions, and currently healthy, but at risk groups such as pregnant women, or obese individuals.
2. Patient portals are likely to require funding in the medium term to boost their uptake while GP business models are refreshed. There is a risk that we will get a proliferation of patient portals (eg for maternity, hospital, GP, physio, etc) – it would be much better for patients if we recognise the central place of primary care, and the need for a GP patient portal, that other providers can integrate with.
3. We support strengthening the national telehealth service offerings. This could include GP afterhours telephone triage, and the provision of symptom checker apps integrated with patient portals.

**Shift Services**

*Action area 3*

1. Successive Governments have struggled to find the levers to get DHBs to shift services to Primary Health Organisations over the past decade. We believe that most community services and some outpatient services need to be centrally funded to achieve the closer to home objective. This would remove the DHB road blocks to achieving local service shifts. For instance, district nursing and community allied health could be funded according to national population or output based funding schedule, with providers selected on merit.
2. Another option is to institute a cap on DHB provider arm expenditure – restricting spend on provider arm services so that it rises at a rate less than the annual price and demographic funding adjustor.

Action area 4

1. We support removing the legislative barriers to allowing broader health practitioners to prescribe in limited circumstances, provided these health practitioners are part of the Health Care Home – the broader general practice team.

**Tackling Long Term Conditions and Obesity**

*Action area 5*

1. Primary care is in a great position to take a larger role in prevention, early intervention, and management of long term conditions. However, it would be useful to have joined up funding (e.g. access to some DHB service funding, such as diabetes services) to support this role.
2. The Porirua Social Sector Trial indicates that PHOs are in a good position to work inter-sectorally on obesity prevention, provided they are given the mandate and the funding required.

**A great start**

*Action area 6*

1. Funding divisions sometimes create service fragmentation. Having the funding for maternity services outside the PHO agreement is not conducive to integrated service delivery for pregnant women. PHOs are in a good position to facilitate joined up models of maternity care – if they are given a mandate by including the LMC funding in the PHO agreement.
2. Well child services are currently provided in parallel to general practice rather than through integrated service models. This could be rectified by moving well child providers to an enrolled population funding approach, and allowing general practice to offer alternative delivery models. This would enable general practice to offer more of a one stop shop set of services.

**Improve performance and Outcomes**

*Action area 8 & 9*

1. The primary care sector is ready to engage jointly with the Ministry in setting a health outcomes focused framework. We expect that such a framework would be developed collaboratively, rather than unilaterally.

**Align Funding / Target Investments**

*Action area 10 & 11*

1. We consider that DHBs are too small, and are too conflicted by the need to run their hospital services, to have effective commissioning teams. The commissioning role needs to be shifted to regional or national bodies.
2. We support using an investment approach to target funding to high need populations based on known risk profiles and funding for outcomes.

**Strengthen national analytical capacity**

1. PHOs have good access to patient level data, and could make a strong contribution to mitigating the impact of social distress (poor housing, benefit dependency, etc). One of the barriers to this is the ability to obtain patient level identifiable data for our population from MSD and the MOH. National data sharing agreements would be helpful to overcome this.

**Electronic Health records**

1. The national electronic health record policy will be most effective if it takes account of the role of general practice to provide continuity of care over time and to coordinate access to other services. The GP PMS could form the basis of a national EHR if it were centrally funded.

Thank you for considering this submission

[redacted]

**CEO, Compass Health**

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| **244** | Submitter name |  |
| Submitter organisation | Canterbury District Health Board |

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| --- | --- |
| This submission was completed by: *(name)* |  |
| Address: *(street/box number)* |  |
| *(town/city)* |  |
| Email: |  |
| Organisation (if applicable): | Canterbury DHB |
| Position (if applicable): |  |

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on behalf of a group or organisation(s)

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Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| The strategy identifies several strengths which we agree with, including the value of the workforce, strong primary care, the focus on serving the whole population throughout their lives, the promotion of integration, the ideal placement of DHBs to respond to local needs, and strong Māori and Pacific providers. We note within the challenges and opportunities:   * quality and continuity of leadership is a challenge to progressing the Strategy. * the mention of long-term conditions in the population however, the Strategy does not address population level strategies to address primary prevention of these conditions. We support a focus on ensuring children get a healthy start in life, but this needs to be more than a focus solely on services. * the Strategy mentions lack of visibility of results and the consequent lack of ability to realise long term cross sectoral benefits of investment, but the Strategy focuses on the use of data for clinical care rather than potential for data to inform the allocation of resources, to drive service improvement, to feed into research, the sharing of data within and across sectors to support advanced planning. * the Strategy mentions the lack of ability to change service design to respond to demand, but misses the potential of the agility created by alliance ways of working, which allow intra and cross-sectoral collaboration that allow effective responses to emerging needs in the population.   Challenges will change over time so the strategy should be adaptive. |

### The future we want

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

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

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

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| --- |
| We see that in general, the Strategy is strongly focused on the health system, rather than on the health and well-being of New Zealanders. The Strategy mentions health in its wider context, but focuses on the ‘get well’ part of the statement, and is weak in the parts embodied by ‘live well’ and ‘stay well’. It concentrates on the health of the population through actions to improve the ability of the system to promote the health of individuals. But it does so without approaching measures that focus on the wider determinants of health and the distribution of health outcomes across the population, other than in the principles (which themselves seem to sit in isolation without strong connection to the rest of the document).  Managing population health needs to focus on assisting individuals and whānau to ‘get well’, but must be strongly underpinned by interventions aimed at the underlying social, economic and environmental determinants of health that enable people to ‘live well’ and ‘stay well’. There needs to integration within the health system, and between health and other sectors, and well-coordinated care particularly for older people and those with long-term conditions. The Strategy contains little mention of the primary prevention of those conditions from which people have to get well. For example, there is discussion of the challenges posed by obesity, but no reference to the obesogenic environment that creates the conditions in which the prevalence of obesity is rising. There is very little mention of tobacco or the vision of a Smokefree Aotearoa by 2025.  In general the Strategy does not link with, and refers only in passing to, other important strategies that guide action to improve the health and lives of New Zealanders: the Primary Health Care Strategy, He Korowai Oranga, Ala Mo’ui, the strategy for achieving Smokefree 2025, the Disability Strategy, the Health of Older People Strategy, Cancer Control Strategy, Palliative Care Strategy and others.  The Strategy needs to better clarify where accountability lies in the health system, and the role of the Ministry of Health – in control of the health system or with a stewardship and leadership role to improve the lives of New Zealanders?  There should be greater emphasis in the Strategy on informed and shared decision-making that recognises patient’s choice.  We think that end of life is not covered in the live well, stay well, get well statement. |

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

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

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| While we strongly support the principle of “Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay”, we would like further clarification added around the concept of access.  Access (an opportunity to have health care needs fulfilled) is important for maintaining and promoting the health of our populations. Quality primary health care is able to reduce the adverse effect that income and socio-economic inequality has on general health. Poor access to primary health care services can exacerbate inequities in health outcomes.  We propose that the strategy reflect the five dimensions of accessibility as outlined by Levesque et al. (Levesque, J.F., M.F. Harris, and G. Russell, *Patient-centred access to health care: conceptualising access at the interface of health systems and populations.* Int J Equity Health, 2013. **12**: p. 18.) – Approachability, Acceptability, Availability and accommodation, Affordability and Appropriateness.  Approachability – services identifiable and people know about them; Acceptability – services are acceptable to people from all backgrounds, age groups, cultures and belief systems; Availability and accommodation – services can be reached and have capacity, dependent on distribution of services, transportation systems etc; Affordability – not only charges, but acknowledges cost of lost income while attending services; and Appropriateness – the fit between the client and need and the level of integration and continuity of care.  We also recommend that the strategy shift the focus from hard to reach patients to concentrating on improving on hard to access services, reframing the way we approach this population to remove the blame on the patient. The focus is then on making services accessible for those who need them most. |

### 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**  The title people-powered misses something that is captured in people- or person-centred.  When we talk about people-powered services, and partnering with people we suggest that marae is specified additionally to schools and churches.  We should take care not to reduce access if Māori, rural and most deprived populations don’t have access to the internet.  Social isolation is an important issue, particularly for older people, and the vision statement needs to include connecting people to whānau and to their community.  **Closer to Home**  This section talks about housing without including Housing NZ.  We propose that this section include an acknowledgement of the role of providers which have a reach into the community that is unique in the health system. Contract providers exist in all DHBs and reach individuals and whānau in the homes, streets and neighbourhoods. We must ensure that they are providing what people and the health system need from them, with strengthened leadership and capacity. The strategy should include community-based health hubs that improve access for people who may have poorer health outcomes, with services from providers who are effective for these populations.  The Strategy mentions population-based strategies under the Closer to home theme – they don’t fit well there.  In discussing children, the focus is on health services. These are vital and must be effective and well-coordinated. However, good health, starting in childhood and continuing throughout the life course, requires investment in prevention and interventions that make the environment in which children grow, learn and play a healthy one.  The Strategy talks about managing long-term conditions in primary and community settings, but lacks a strong focus on prevention, in particular it talks about obesity without proposing any real strategy to deal with it. In general the strategy is light when discussing effective prevention of long-term conditions, and does not propose any action to tackle the main risk factors for ill health.  The focus in 10 years’ time: well-designed and integrated pathways also need to be easily accessible.  **Value and High Performance**  We suggest that the barriers to remove to do better for populations that do not enjoy the same health as others needs to include poor health literacy, underdeveloped cultural competence, and the lack of training for providers. Without addressing these as foci, we will continue to have too much wasted time and effort in the health system, for example in people not attending health appointments (DNAs).  **One Team**  We propose that strengthening the capability of providers should include training and contract review. The focus in 10 years’ time should have a balance between the system’s goals and health system users’/patients’ goals.  **Smart System**  We emphasise the need to ensure that the smart system vision for ten years’ time includes highly accurate, comprehensive collection of ethnicity data across the health system. We caution that people’s increasing interaction with the health system online must not exclude those with poorer access to the internet, and people’s access to the health system should not be dependent on being able to interact online.  The smart system can use data to drive integration. Integration is enabled and empowered by sharing data within the local ecosystem of health and social services, so that data and observation can be aligned:   * Sharing data in this way requires a clear purpose-based matrix that is agreed by the participants and consulted with the community so that information sharing is supported at its multiple levels and community understands the purpose. * Data can be used for providing care – needs to be identified. * Sharing data assists for planning systems allocation of resources, driving service improvement, research – needs to be unitary but anonymised. * Shared data should be available to all on the basis of the purpose matrix to enable improved outcomes across the system. * Outcomes in a complex system are not derived in a linear way the contribution and attribution is complex and inter dependant. So we need to work together using data and analysis to define problem and identify solutions. * Need to use routine data to drive change captured as part of the process of care/service delivery. * Record data once use it many times for many purposes in many settings. * The value of the data is obtained when it is combined with real world observation. Data without observation is misleading, observation without data is anecdote. |

### 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 recommend:   * a greater emphasis on population health strategies. * promotion of a range of actions that will improve health literacy. * workforce development should include improving cultural competence and explicit include NGO/providers in that development. * tying into the government’s priority of Better Public Services, we support the acknowledgement of health in its wider context supporting shared public service responses. Housing, employment and education all play a role in supporting and developing the population’s health and wellbeing. Nationally, health is the largest workforce and has the potential to play a lead role in developing shared policies that work toward improved outcomes for the whole population. We also suggest stronger acknowledgement of the role of primary care as a key intervention point for all services as many people’s first point of call. * a broadened scope of existing programmes, such as that interventions to locate more care in the community (e.g. the Acute Demand Management Service in Canterbury) could be include more preventative actions, such as getting insulation installed in home * broadening approaches to prevention, early intervention, rehabilitation and well-being for long-tern conditions and obesity to address determinants of health, such as the obesogenic environment.   In turning strategy into action, we support an adaptive leadership approach where the role of management is to clarify the problem and then help empower and support staff to develop and implement the solution. In order to achieve this we need our current sector leaders to commit to a total system vision and lead a cultural change, empowering staff to take action in their own area.  We note that improvements in performance of the health system, particularly locally, can rely on simple factors such as how well the sector is organised, collaboration and technology that promote rapid diffusion of innovation, and funding arrangements that allow for the flexibility to transform practices. Replication of innovative high performance in DHBs should be promoted. |

### 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 suggest better linkage to other strategic documents, and clearly establishing strategic direction for Māori and Pacific health.  We suggest a robust approach to ensure the health system does not perpetuate or increase existing inequity, for example:   * by excluding people’s access to health through their lack of access to technology. * in making care closer to home, by relying on unpaid care by whānau members, for whom giving up work to care for elderly relatives is culturally a natural choice.   We encourage working with DHBs, but recommend engagement also with alliances and regional responses. We note the issue of closer to home needs careful consideration on where it applies – with regionalisation and shifting services, doing more to use capacity in other DHBs is potentially at odds with actions to promote care closer to home.  We suggest a stronger role for national health technology assessment in integration of health advice. |

### Any other matters

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

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| Are families and whānau different? They are used next to each other throughout the document - they may describe different phenomena, but their continued use in this way could also suggest a segregationist approach in the Strategy. |

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| **245** | Submitter name | Kate Reid |
| Submitter organisation | Orion Health |

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

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

√ on behalf of a group or organisation(s)

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

√ Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| * Yes a useful outline of the big issues facing our health system (and every other health system Globally) * Ideally we need to understand what the causal drivers of these are in order to address these in our NZ Health Strategy and achieve the impact we need to shift the needle. * What are the underlying lifestyle, cultural and wider societal influencers that inhibit some people from making healthy choices * How do we achieve an interoperable health system that is cross sectorial and interconnected and allows us to profile individuals, assess their risk and intervene? How do we find people early on this journey through ‘SMART SYSTEMS’ and then use that data to act early and prevent cost/poor health downstream. A whole of system approach needs to be adopted that supports the person and does not silo Health from Social/Housing/Education etc. – they are and drivers of outcomes. We need to adopt a holistic approach to assisting people to be healthy, well and productive (both in a spiritual and physical sense). The use of effective IT systems will be a key determinant of the success of this strategy and a long-term (20 years) view must be taken rather than the current 3-5 year cycle. * We feel that a focus on the modern health consumer is missing – there will be an ever greater demand for consumers to own their data, to be in charge of where their data sits, who sees it and what they want to receive in terms of care * There will be a greater reliance on analytical engines to inform clinical care and patient self-care – many of these will be automated and seamless * Personalisation of the healthcare experience is crucial to achieve long term sustainable behavioural change * With a diminishing workforce at the front end and increasing demand on services, we need to focus more on the automation of healthcare services that are resource-intensive to free up our workforce to spend more time directly in care. IT/technologies become key enablers to achieve this * Mobility needs to be a near-term goal for healthcare services * There is much to be learned from the disciplines of Health Psychology – how people’s beliefs drive health related behaviours and Behavioural Economics – designing systems and services that make the right choice the easy choice for the consumer. * We unfortunately intervene too late when beliefs and habits have become the persons new normal. We also make it very hard for people to choose the healthy option and interact with the services on offer. A good example of this is the poor uptake to Cardiac Rehabilitation and Diabetes Self-Management Programmes. We need to more deeply understand the drivers for this poor uptake and redesign our systems and services to increase adoption and engagement. What is in it for me (the consumer of health) needs to be much more clearly articulated * We need to be more future focussed and determine what the “health system and its models of care” will look like in 20 years’ time then establish the way in which IT will support and enable this. For example, providing care closer to the home will mean a significant shift in the way technology is used and will need to become embedded into the daily lives of every citizen based on a generation ‘cradle to cradle’ model embracing all of whanau in the change and using the power of the family social construct as a networking or enlisting effect. Once this long-term view is established then we can work back to the present time with the knowledge there is a vision for the future. We should be making more opportunity from the systems that we have already developed to support this – before school health checks, immunisation registry, government targets e.g. heart and diabetes checks – if one person in the family has been identified to be at risk, how do we create a system that supports the entire family and friends circle. * We are experiencing the consumerisation of healthcare: consumer demand for personalised information is leading technological advances. We need to embrace this and think about how to manage healthcare data and ensure privacy, now and into the future – when there is now so much personal healthcare data out there, and providers are becoming more digital. * Current models of care delivery focus on applying treatments for conditions, not for individuals. The consequence of that "one size fits all" approach is that individuals do not receive treatments that take into account the factors that make people unique  - their family and clinical history, environmental and social factors, and importantly their genome, which when combined with other information can reveal which treatment and prevention strategies are ideal. With the complete picture of an individual's genetic makeup and clinical history, combined with family history and social factors, clinicians can truly tailor care. Through a platform that applies machine learning techniques to patient and population records as well as research and reference material to distil data into diagnostic and treatment recommendations that can be applied at the point of care.  This capability will truly enable the best possible personalised treatments to be delivered each and every time – It is a totally new world and this health strategy needs to be ready and embrace this change to be able to enable a Personalised/Precision Medicine Health 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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| * This statement captures the end game of where we want to be however the fundamental building blocks that will enable us to get there need to be articulated in here as one – One Team talks to this around the behaviours we need to adopt. All in it for the same reason – to benefit the health of NZers. * More emphasis needs to speak to these One Team behaviours such as “enablement, empowerment and partnerships” that places the emphasis on working together with open and transparent systems, sharing of best practice across regions, not reinventing the wheel when something is working well in a different region, gaining a much greater pace of change and innovation by working together. * We are supportive of ‘people powered or people centred’ the key point being that individuals, families/whanau and communities doing “for themselves rather than having it done to them”. They are involved in co-design throughout the system and we are not making assumptions about how people want to be involved in their own health and how much support they want, when they want it and how they want it. We need to ask and have systems that it easy for people to navigate and have choice. * This statement will only be achieved with strong leadership that holds organisations and individuals to account if they are not demonstrating the key components. It describes a “brave new world” where people will be trusted to do the right things and supports will be in place to enable risk taking whilst recognising that the biggest gains will come from innovation that can no longer happen as an isolated event. * One Team and a Smart System are very large statements – currently the building blocks and behaviours are not in place to enable the vendor or payor communities to realise this. This needs to be a key focus of the strategy – what fundamentals have to be in place, mandates to interoperability standards and a philosophy of sharing and openness to ensure open flow of data between sectors, systems etc. Otherwise we will continue to be many teams all being purchased separately with no mandate, funding or scope to connect. This will require a new style of leadership - keeping people safe from harm whilst enabling a system that can innovate and deliver a new model health and social services to New Zealanders. One driven by the users and how they want to consume and interact with health – not top down. |

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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| * As guiding principles these are excellent as long as they become embedded right across the health sector and beyond into other government departments. * We do need to embrace however, these principles will need to be considered beyond the usual 3-yearly cycle, and new models of funding that support a longer term view on wellness. * This fundamentally changes the way services are currently structured and funded. Intervening with people with they are already on multiple medicines, with multi-comorbidities is unacceptable when we have systems that can identify people many years before this. We need to build a Health and Wellness System (not continue to deliver a sickness system) * The best health and wellbeing possible needs a focus on prevention, keeping people well. We need to move away from taking care of sick if we ever have a hope of reducing the cost in the system & improving outcomes) & person centred approach (rather than people centred).  We need to go further than this right down to a person/individual centred and personalised health system. A system which recognises that there are differences in how people approach health and how successful outcomes are driven.   + “I can access care in a place where I feel more comfortable & where I can be supported by people who are important to me"   + "I can access health education & am nudged towards healthier behaviours across communication channels that I use and identify with”   + “When I am diagnosed with a condition I can see the pathway that is set out for me, and provided with access to information that I can trust which is relevant to me, and does not include information which is not relevant, which shows me how to manage my condition, options that are relevant to me in terms of where I can go to for support – how I can take control of my health” - I’m not filtering information etc, its done for me. * We need a health system that pulls in social data as one of the key determinants of health outcomes, one that again looks at the person & is personalised to take steps to recognise and address barriers to care.  The strategy touches on this, with more community focused & accessible health care centres, and in the past with insulation for homes funding etc but more could be done with regards to addressing these on a more personal level – perhaps an extension of the concept of individualised funding concept. Or giving care coordinators access to organise services for families or patients – e.g. Access to better quality food, or insulation or providing transport to appointments etc. * We need a system that uses its resources as effectively and efficiently as possible. We are a country the size of a small city, we don’t need all the cost, politics and inefficiencies of so many procuring entities and no formalised way to share best practice. * NZ needs to be prepared to fail fast – any good innovation is driven through being open to piloting, experimenting, learning & collaborating to get the right outcome.  Partnering with key NZ industry on that journey to get the right outcomes for NZers.  To get a truly patient centred approach we also need to be prepared to work closely with the patients as a means to test new ideas, and modes of delivering healthcare. Co-Design is paramount to our success. |

### 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**  Completely the right intent – People in charge of their own health. Communicating well and supporting people navigation of the system, by building health literacy, as well as using technology such as mobile phones and internet.  The way the strategy is worded however, might need a little work. It implies that it is all back on the patient to be able to navigate and coordinate care when really there needs to be a recognition the system itself needs to undergo significant change to ensure navigation and coordination is incredibly easy for patients and their family. Having care navigators, care coordinators and apps to support this points to a system problem that needs to be solved.  Patient portal example as part of GP systems. While a GP represents a person’s first point of contact with the health system and provides continuity of care the delivery of care, especially for those with long term conditions involves lifelong interactions with many different providers across the health and social sector. For this reason surfacing information via an individual GP system may not be the only model that should be explored. A patient should be able to access a care record that spans GP practice, allied health professionals, hospitals, pharmacists and social care providers. Multiple portals with different sign ons across different organisations is not a patient centric approach to delivering a consumers health information. We need to make is much easier for people to participate.  Encouraging self-management by shifting power back to the people? This is an overly simplistic view on health, broken down to it’s most basic premise if we provide access (patient portal) then people will become engaged. The issue here is people don’t see themselves as patients and often engaging with the health system is the last thing they want to do. Understanding beliefs, drivers, social and cultural context and tailoring approaches and message to get people in the right head space to even start engaging. Shifting power back to the people almost falls into the trap of building a system for the worried well and already motivated when our real focus, reducing health inequalities has to be focused on the disengaged, vulnerable and marginalised populations.  **Care closer to home;**  Integration of health services and to wider public services has to be on all of our roadmaps - building toward a model where “patient/health consumer centred” must include broader social services that are important to the individual and address specific social determinants of health. Investment on early life and a focus on precision medicine, including data capture and analytics based on wider social determinants and genetic risk factors to help inform an entire life path approach to wellness.  Focus on wellness and prevention of long term conditions will require cost effective digital approaches to expand support to a much larger cohort of patients. In order to make sure spending is targeted at the right individuals a broad data set including health, social, genomics, family and community data. This data set should not only be used for targeting funding but personalising the interventions to ensure the best chance achieving the right outcomes.  Shifting care closer to home and community is a great goal but needs to be underpinned by a shared medical record, seamless care coordination and interoperability (both technical, clinical and organisational) between a myriad of private providers, NGO, alternative health and wellbeing providers, wellness, community and social services. To really achieve this goal there needs to be the systems in place to create seamless health consumer engagement and care.  Tackling LTC burden. While prevention and management of the risk factors of Long Term conditions is absolutely the correct approach there again needs to be a unified platform in place to target resources (population health and precision health), coordinate care across health and social services, and collect outcomes data to ensure continuous evaluation and measurement of interventions. The Ministry needs to place a similar level of assessment on community interventions as PHARMAC does to medicines. While lack of evidence should not prevent new pilots or proof of concepts being developed there must be a far more wide spread and rigorous approach to assessing value for money. The other challenge associated with prevention is budget constraints. Given tight fiscal constraints within the health sector DHB and other funders are naturally attracted to interventions with short payback periods and significant ROI. This results in investment that targets high risk patients at the top of the cost pyramid and managing those already ill in a more cost effective way. Initiatives such as the lets beat diabetes face the challenge of having payback periods in the magnitude of decades rather than months, making an investment decision in community and wellness interventions a difficult one for DHBs  Care closer to home will also require systems that can incorporate user generated data (via devices, apps, wearables and feedback) and interpret and make the information consumable and usable by the patients care team. This will require an open platform approach with advanced analytics and sharing functions.  **Value and high performance**  Use of investment approaches across both social and health will require a platform that can connect, consume and generate predictive, precision metrics for investment planning at the community, family and individual level.  If we go down the measurement and accountability route we need the courage and mandate to remove services and interventions where they are not delivering value, shift funding to areas that are delivering value.  There are many examples across health of wasteful recreation of what is already working well elsewhere. Sharing of best practice needs to be the default position for all DHBs, PHOs, Vendors – each delivery of any funded project must be a new innovation that takes the NZ Health system to a better place and advances health outcomes. There is so much duplication and bespoke systems which is costly and limiting the pace of change. No public tender should be allowed to proceed if other regions have already delivered the service/products/systems change – existing work should be leveraged and advanced and this needs to be called out through the leadership. We are a small Nation of $4.2 m people and we should be capable of greatness that is exportable and leading the world stage.  **One team**  One Team must be expanded beyond the concept of just health. We need to include other stakeholders in ensuring the government is delivering true patient centred care which includes a broad range of service providers across departments  Shared platforms and access will play a big support role in the reduction of fragmentation in the health system.  **Smart System**  This is key - an open interoperable platform to consume data from sector wide sources enabling a personalised and precise medicine approach.  Care coordination and health navigation will be important roles/functionality and will be necessary because we at present can’t move beyond the current silos and the level of ensuing complexity to support people through the system. Putting these roles in place is a band-aid or should be viewed as a first step and we must aim to address the overarching systemic problem that these systems need to speak to each other. We need systems that can realise precision medicine, personalised interactions, behavioural psychology approaches, incentives and gamification etc. |

### 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 achieve the strategy, there needs to be a clear set of priorities and timeframes by which these must be achieved and a clear line of responsibility that pushes the priority areas where the biggest gains can be made * The primary and community care sectors must be enabled to take a lead role in the health and wellbeing of New Zealanders. With this comes a reconfiguration of the funding models based on a “risk and rewards” model that recognises efforts to keep people out of hospitals and as well as they can be in their homes and communities. Both secondary and primary sectors have to work more positively toward achieving a “connected system” that is interdependent rather than isolated in terms of outcomes for the population. * In 5 years’ time we definitely must have a sustainable solution in place based on “a system that measures what matters to people, and people’s involvement improves quality, safety, experience and health and equity of outcomes”. This factor is now well understood across most health services and outcomes are becoming clearly defined. Exactly **how** this will be achieved is less defined in this strategy particularly in a way that better manages ever constrained resources such as funding, human resources and infrastructural requirements. |

### Turning strategy into action

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

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| * IT/technology-based solutions are available now and will increasingly become embedded throughout the health and social systems to enable tracking, monitoring and reporting on virtually all areas required. This will require high levels of integration and interoperability supported by funding and resources to create, implement and sustain the system. * Transparency & publication of best practice and success stories in all areas is going to be paramount. * Leadership of this is essential so that people are aligned to the outcomes and working on doing the right things to achieve them. * If people are fearful of their job security or working in a constrained, difficult working environment then the desired outcomes will not be achieved. * We must have a cost-effective health system that utilises its resources as effectively and efficiently as possible and does not reinvent the wheel over and over. The repetitive nature of the health system needs to be replaced with a “centres of excellence” approach that would see certain DHBs/PHOs (for instance) establish themselves as experts in specific areas of the health system. These DHBs/PHOs then lead the implementation of their programmes on a national basis.   **Technology and change management needs to be viewed as an investment not a cost. On this basis we strongly believe that more resources have to be put into these with a very clear understanding of the return on investment this will generate. IT solutions may not just be an enabler any more, they may in fact be the leader of this change in health strategy. We may not achieve this desired step change in health delivery unless we do things differently.** |

### Any other matters

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

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| **246** | Submitter name | [redacted] |
| Submitter organisation | The Asthma and Respiratory Foundation of New Zealand |

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**Submission on “Update of the New Zealand Health Strategy Consultation Draft”**

The feedback below is presented on behalf of The Asthma and Respiratory Foundation of New Zealand by members of the Foundation’s Expert Advisory Group:

* Dr Tristram Ingham, Senior Research Fellow, Department of Medicine, Otago University of Wellington
* Dr Kyle Perrin, Clinical Director of General Medicine, Capital & Coast DHB
* Prof Innes Asher, Starship Respiratory Paediatrician and Head of Paediatrics, Auckland University
* Prof Richard Edwards, Co-Head Department of Public Health, Otago University of Wellington
* Dr Api Talemaitoga, General Practitioner and Chair of the Pasifika GP Network.

Our submission includes recommendations from two significant publications that were recently developed with extensive health sector input. Both present the latest epidemiology, evidence and advice to help the health sector address the significant and worsening burden of respiratory disease and other long term conditions with common determinants:

* Te Hā Ora: The Breath of Life - National Respiratory Strategy <http://asthmafoundation.org.nz/wp-content/uploads/2012/03/Asthma-National-Respiratory-Strategy-online-version-80ppi-with-line.pdf>
* He Māramatanga Huango: Asthma Health Literacy for Māori Children in New Zealand – A report to the Ministry of Health <http://asthmafoundation.org.nz/maori-health/he-maramatanga-huango-report/>

**General comments**

In general the Draft New Zealand Health Strategy contains a number of sound principles, goals, themes and actions but does not link them together clearly in a cohesive approach, making the document difficult to follow. The intervention logic behind the chosen actions has not been made obvious for the reader, nor has the meaning of many actions. These aspects will need to be strengthened in order to encourage buy-in and uptake from the wider sector.

We note that a particular strength of the draft strategy is its call for a “one team” approach. To improve the health system the strategy rightly identifies the need for:

* more and better quality collaboration across health and social services such as housing, education, social development and justice
* greater acknowledgement and support for the role of the NGO and voluntary sector.

Having said this, there are significant and obvious gaps in the Strategy document. The complete lack of population health goals other than unmeasurable slogans like “get well, stay well…” is very disappointing. It is also disappointing to see important issues identified in “Future Direction” that are not followed through in the actions. These include health literacy and issues for people with disabilities, among others. Presented below are five aspects we consider are in most urgent need of strengthening.

**1: Inclusion of respiratory disease as a priority long term condition** (Closer to Home)

Respiratory disease is currently mentioned in the Strategy within a list of conditions. It should be made an explicit priority given the following:

* Of the four most significant non-communicable diseases worldwide according to WHO (cardiovascular diseases, cancers, chronic respiratory disease and diabetes), New Zealand has dedicated national programmes and targets for all except one: respiratory health.
* Respiratory disease is our third most common cause of death (after cancer and cardiovascular disease - WHO) and applying a body system classification accounts for our third highest cause of health loss (ref: Ministry of Health 2013 Health Loss in New Zealand).
* More than 700,000 New Zealanders (one in six) live with a respiratory condition costing the country over $5.5 billion each year.

**2: A stronger and more explicit equity focus** (People-powered, Closer to home, Value and high performance)

Among the most significant challenges facing the New Zealand health system are the extreme inequalities experienced by certain population groups – in particular Māori, Pacific peoples, adults and children in low income families and people with disabilities. For example, respiratory disease has pervasive and worsening inequalities similar to other long term conditions:

* More than half of the people admitted to hospital with a poverty-related condition are there because of a respiratory problem
* People living in the most deprived households are admitted to hospital for respiratory illness over three times more often than people from the wealthiest areas
* Across all age groups hospitalisation rates are much higher for Pacific peoples (2.6 times higher) and Māori (2.1 times higher) than for other ethnic groups. For some respiratory diseases these disparities are even worse, in some cases more than six times higher.

Based on the evidence, the statement “New Zealand’s health system performs well” (Future Direction p.2) would more accurately read “…performs well for some groups but not others.” We note there are no equity statistics presented with this statement. A system that fails to deliver equitable outcomes to the extent found in New Zealand is clearly not performing well.

The health system should be measuring itself and other health agencies (such as ACC, Health Safety and Quality Commission, Health Workforce NZ) in how it is doing in improving the health and wellbeing of ALL New Zealanders equitably.  This can only be done if data is collected by ethnicity and by regions for all the agencies concerned.

The equity focus needs to be strengthened and made more explicit in all areas of the Health Strategy. To this end we recommend the inclusion of an ambitious and dedicated goal such as “***Zero inequalities by 2025***” and actions such as:

* Make health care accessible and affordable for all, in particular for Māori, Pacific peoples, and people on low incomes
* Make it a priority to build the capacity and capability of the Māori and Pacific health workforces
* Increase the number of health workers providing services in low-income areas
* Introduce zero-fees doctors’ visits and medicines to people and families in need
* Extend services beyond clinic settings into homes, schools, marae, churches, kōhanga reo, and other settings where people gather
* Provide free transport to health services for those in most need
* Provide appointment systems that are flexible to meet the needs of families, such as outside of work hours and walk-in appointments
* Collect and analyse all data by ethnicity and region to more effectively monitor progress and target services and investment.

The Strategy also needs an explicit focus on the two population groups who comprise a significant proportion of the New Zealand population, but are largely absent or not visible in the Roadmap of Actions: **People with disabilities** and **low income families.**

**3. A much stronger focus on prevention** (Closer to home)

While the Draft Health Strategy document quite rightly includes a commitment to increasing effort on the prevention of long term conditions, the actions listed are not comprehensive and unlikely to make any substantial difference to population health.

The Draft Strategy espouses a value for money and investment approach. Yet, major population based preventative interventions which will have the largest population health impact, and are the most cost-effective, are absent. These include interventions to achieve Smokefree Aotearoa 2025 (which is not even mentioned as a goal) and to tackle the obesogenic environment.

Personal responsibility for prevention, while important, needs to be de-emphasised as the primary mechanism to address long term conditions. To this end actions to improve access to services, models of care, healthy environments and other determinants such as adequate income, housing, education, affordable nutrition, will make the most difference.

To strengthen and make a real difference to prevention the Strategy needs to:

* Add prevention as a sixth theme (given it is almost absent in the other areas, besides a brief mention within closer to home, which is not an obvious fit)
* Include comprehensive action such as:
  + Develop and implement a comprehensive national plan detailing the pathway towards achieving a smoke free Aotearoa New Zealand by 2025, with substantial engagement from Māori and Pacific communities
  + Introduce a warrant of fitness for rental housing to ensure all rental houses are dry, insulated and heated
  + Implement the final recommendations of the Commission on Ending Childhood Obesity.

**4. A stronger and more explicit focus on health literacy** (People-powered, Closer to home, Smart system)

Improving health literacy is acknowledged as an important aim in the document but is not explicitly addressed in the proposed actions. Expanding the quantity and flow of digital information will not address this issue, but actions like the following will start to make a difference:

* Develop information resources for adults, children and families that are:
  + interactive and/or audiovisual, simple and easy to use
  + involve Māori in the design of resources for Māori children and whānau, and reflect Māori concepts and values
  + involve Pacific peoples in the design of resources for Pacific children and their families, and reflect Pacific concepts and values
  + written in different languages for different population groups, including a variety of Pacific languages.
* Train all health professionals in health literacy education and cultural competency
* Teach health literacy and long term conditions management at medical, nursing and pharmacy schools and other health training programmes
* Build on existing health literacy research, including a focus on better supporting Pacific peoples.

**5. A stronger and more explicit focus on improving access to primary care** (Closer to home)

We would have a much better chance of achieving all of the above if the Strategy had a greater emphasis on improving and facilitating access to primary care for all New Zealanders.  Despite our reasonable enrolment rates in primary care, we need to ensure that health care delivery uses the best of health literacy tools and is delivered is the most culturally appropriate way for ALL New Zealanders.  If the Ministry if serious about this strategy then increased investment in primary care is necessary.

**Final points**

In summary, the current consultation draft has a number of significant deficiencies and obvious omissions that must be rectified.

* Respiratory health and the burden of disease it places on the most vulnerable New Zealanders needs to be explicitly acknowledged, and made a health target
* The severe inequalities in health outcomes among Māori, Pacific peoples, low income families and children is a national disgrace must be explicitly addressed.
* A much greater emphasis on preventative measures to address the social determinants of health. This must include, at least, a commitment to Smoke free 2025 and a clear roadmap of how to achieve it, and clear policy around healthy housing.

There also needs to be a serious and explicit commitment to investment demonstrated in the Strategy. This includes funding new initiatives, medicines, training the most appropriate and future-proofed workforce, improving technology and directing resource to where it is most needed (indicated by good use of equity data).

Without these elements there is no way the New Zealand Health Strategy can hope to achieve the desired goal that “all New Zealanders live well, stay well, and get well”.

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| **247** | Submitter name | Julie Haggie |
| Submitter organisation | Home and Community Health Association |

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Pacific  Consumer

Asian  District health board

Education/training  Local government

✓ Service provider  Government

✓ Non-governmental organisation  Pharmacy professional association

Primary health organisation ✓ Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| a. On page 2, the list of things that are working well in the health system is entirely focussed on clinical, hospital and primary outcomes. It ignores the successful contribution of community care, community services, aged and disability residential care, disability support services including innovative and consumer centred models, as well as volunteers and informal carers. This light touch on community is reflected throughout the document.  b. On page 5, there is no mention of any community services which are part of (not just supporting) a strong health system). Despite the government’s intention to move services closer to home, there is nothing about the multiple strong community health services. We just have to find ourselves constantly repeating that **Primary is not the same as community**. How about the fantastic work done by services such as Ambulance, Salvation Army, New Zealand AIDS foundation, Diabetes NZ, Age Concern? Or any of the brilliant community health providers working across mental health, child health, home support, cancer support, meals on wheels delivery, disability services. This raises the question of what the writers of the paper define as the ‘health system’. Again, there is also not any mention of the thousands of volunteers who provide volunteer support in the health and allied sectors. This can be found by checking on the Charities Database.  c. On page 7 – the health workforce, good to see mention of kaiāwhina. However we think it is also worth noting that as the demography of work and family accommodation has changed, there are more women working and less ability for families to directly care for ageing and disabled family members. Also it would be worth understanding something about the volunteer and informal carer workforce. |

### The future we want

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

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

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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| a. As long as NGOs, community health providers and volunteers are included in the ‘one team’. Are they? |

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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| a. We support the principles as they are written |

### 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**  a. We agree but think it is a light touch considering the strength of the initial feedback. The Productivity Commission report on social services discusses the elements of choice that ought to be considered in any service model delivery planning. What services to deliver, who will deliver the services, when the service will be delivered, where it will be delivered and how it will be delivered. In many of the current health services, clients may have relatively little or relatively more control over these core choices. All health services within the broader health system ought to be encouraged to consider how their current services are person centred, and how they can enable those elements of choice to be enabled within the available resources.  **Closer to Home**. There is little acknowledgement of community based services, again a clinical focus. Home support services have proven success in reducing the reliance on residential and hospital services, and enabling people to stay where they choose to be. People recover more quickly at home if they have the right support.  b. There is no mention of extending the scope of nurses and allied health in the community, of integrating more clinical services into community settings (eg district nursing).  c. Suggest a booklet HCHA produced this year in collaboration with Carers Nz and ACC called ‘Supporting people to move at home’. It has tips and techniques about helping a person to move around at home. It aims to promote injury prevention, wellness and a person centred approach. It is now in its second print run and over 35,000 copies have been distributed to families, paid carers and organisations.  d. Children, Families and whanau  There needs to be recognition of the impact of poverty and instability on children’s health. There is nothing about preventing violence against children.  e. In relation to obesity, there is strong evidence that maternal/ parental health is a critical contributor to childhood and lifetime obesity.  Closer to Home: What great might look like**,**  f. This should include a vision of community health. Not just that people are healthy, but communities are healthy. That requires increased community engagement and activities that promote health and wellbeing, reduction in social isolation. We need to move the focus of a health system from a centralised control unit, to linked community supports.  **Value and high performance**  g. The Productivity Commission report on social services has been very critical of commissioning responses and of the relationships that exist between funder and providers. We suggest that this is included in what the ‘theme’ is about, eg ‘improved commissioning capacity that results in fair contracting, and respectful commissioning relationships that assist all parties to focus on outcomes.  h. **feedback bubbles** – just seem inane. What about instead, seeking and reflecting the voices of those receiving health services.  i. **The Health Quality and Safety Commission** should extend its scope to include community health services. It largely ignores those services. |

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| **One Team**  i. it is good to see NGO providers mentioned. However there is an underlying implication here that a core descriptor of NGO providers is that they are weaker, which is not always the case. Innovation is a key feature of NGO and community services, and often they are more integrated than the ‘public health system’. The union and community health services are a prime example of that. We suggest a bold option of enabling NGO providers to lead regional or national health initiatives, and supporting them with structural support.  k. It is important that health leadership is not seen to be and does not sit solely within traditional health structures (MoH, DHB, ACC). That gives the wrong message to all. Health and disability leadership funding should also seek out and support emerging leaders in consumer groups NGOs and iwi, pacific and Asian communities.  One Team – what great might look like.  l. We need to embrace health consumers as part of the team. That isn’t mentioned on this page. Otherwise generally the messages are sound.  Great to see the example from Healthy Auckland together  **Smart System**  m. Information for consumers needs to be accessible. This means accessible for the diverse people in our nation. Accessible includes being able to be understood.  n. We also need to acknowledge that in an age of rapidly developing technology consumers will choose their own technology route and tools. We need to be able to adapt to those choices. We also need to remember that it isn’t just about digital technology. We are also talking about electronic tools, adaptive equipment, robots.  o. the one important thing is shared electronic health record. It is mentioned. Is there still a goal for this?  p. Telehealth also offers opportunities for consumers, and for carers, eg supporting and monitoring their family members. We should foster opportunities to support consumers and family decisionmaking around telehealth.  Smart System What great looks like  q. Assumes that people ‘attend a health service’ A smart system can enable a health service to attend a person.  r. Also need to mention above, ie consumers and their carers can choose, access and use technology that helps improve their connections to all aspects of their health and wellbeing. |

### 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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| a. The Figure 11 is largely hospital, DHB focussed, and has scant reference to community based and driven health initiatives.  b. Action 1  Why self-management just through digital technologies?  c. The actions under Action 1 there sound like ones for the Ministry of Health, not others. Everyone wants to see themselves in these actions.  d. Action 2. Why clinician led collaborations? What does leading by clinicians contribute to or take away from better outcomes?  e. What about some work on good practice guide for people led service design – this project led by consumers.  2. Closer to Home  f. What do we want in 5 years? People can connect with the health services because they feel the people they deal with understand their world view and their particular needs.  Action 3  g. Good leadership response.  h. Action 4- focuses just on health practitioners. What about the kaiawhina workforce – supporting the increase in their skills. Also what about informal carers?  i. Action 5. Guessing that because it mentions MoH and DHBs in Action 5, and in other places that the Health Strategy implementation is down to them only. Our initial impression was that the Health Strategy is for all of government, local government, NGOs, private health providers and citizens to have responsibility in and for. This Action appears to be quite specific in its scope and we query why it is so limited?  j. Action 6: Same comment as per Action 5, now just for Ministry of Health. It is quite puzzling. We are all in the same waka but the only one with a paddle is the MoH?  k. Value and high performance  l. What do we want in five years. There is nothing about community health services in this list of bullet points.  m. What about improved capacity to undertake commissioning, and fair commissioning– noted in the Productivity Commission report and repeated oftentimes at consultation events.  n. Action 7. We suggest that service user experience measure development ought to be led by consumers, not by HQSC.  o. Action 9. Sounds like a whole lot more reporting (note MoH DSS streamlined contracting documentation) and less time spent working at the coalface. You need to develop general principles, but allow reporting and outcomes to be relevant to the service.  p. Action 10. It isn’t just about the quality of commissioning, it is about the fairness of it.  q. Action 12. Why quality and safety initiatives only in primary and rest home care? What about the important issues of safe level of care and supervision in home care settings, any area that has not been addressed at any point in time, and where supervision levels are sitting at 1 registered nurse to between 150 and 300 support workers.  R. |

r. One team. The lasts sentence of the second paragraph on page 42 uses the word ‘could’ The question is why would it not? There is a definite desire to ensure the sustainability of the regulated ‘in house’ workforce, but this sounds very much like more of the same, i.e. take care of the traditional hospital based health workforce first, the others are an afterthought. That is not the direction that is needed, especially over the next five years.

s. Action 14. What about an opportunity for providers to drive feedback on the performance of DHBs and the MoH in terms of commissioning and their role in the overall goals of the health strategy.

t. Action

### In terms of developing the NGO/Primary and volunteer sector workforce, it is important to support the independence of those sectors.

### Any other matters

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

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| **248** | Submitter name | [redacted] |
| 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.

[redacted]

Paediatrician

Clinical Director Child Health – MidCentral DHB

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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| **249** | Submitter name | Carol Wrathall |
| Submitter organisation | Hei Āhuru Mōwai |

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| --- | --- |
| This submission was completed by: *(name)* | Carol Wrathall |
| Address: *(street/box number)* | [redacted] |
| *(town/city)* | [redacted] |
| Email: | Heiahurumowai@midcentraldhb.govt.nz |
| Organisation (if applicable): | Hei Āhuru Mōwai |
| Position (if applicable): | Secretariat |

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

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

✓on behalf of a group or organisation(s)

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

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

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

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

✓ Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| It is stated…..”*A strategy is a guide for achieving the sort of future that you want. It can help people, organisations or whole systems to work together more effectively on the most important things*.”  Therefore **achieving** **equity** needs to be the first goal of the NZ Health Strategy. The fact that inequities exist within our health system is a serious problem, that they persist is totally unacceptable.  We need to actively pursue quality care and health equity for diverse populations as a systemic valve and priority not simply as a separate programme or project. The ability to achieve equity in all health outcomes **AND** to consistently and routinely measure those equity gaps we so evidently report about needs to be the core enabler of improving health outcomes. Organisations need to be audited regularly on their performances in addressing health equities. The MoH as the lead government health agency needs to be responsible for this measurement and influence all other Government agencies contributing to the determinants of health to do the same.  This is a challenge that needs to be introduced and measured in all areas of society that contribute to the determinants of health, ie: all Government departments, Non Government organisations and other providers of health and social services.  We need to create successful health services that tailor care to patients, their whānau and communities and measure the things that whanau determine as positive health outcomes.  Hei Āhuru Mōwai agrees with the **Wero/Challenge** laid down by Māori Public Health Physicians to study the examples of where inequities have been eliminated across all sectors AND that the consistent application of these learning’s will require government leadership and the setting of clear expectations.  Those expectations need to be laid out in our national health strategy, ie: **Equity First**. |

### The future we want

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

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

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

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| The statement fails to capture what we ALL want from the New Zealand’s health system as it is written in the absence of any acknowledgement of Tangata Whenua A primary concern is that the NZ health system to date has been developed predominantly from a western medical model and therefore risks promoting institutional racism and the position of white privilege, or privileging the position of the people who make the decisions on how we strive to achieve health for ALL.  The statement promotes ‘All ism” that we are all the same and this is problematic for Māori as it denys the position of indigenous peoples, of Tangata Whenua and is not founded on the principles of Tiriti o Waitangi. This statement promotes equality and not equity which should be the primary goal of our health strategy.  Pae Ora is the overall aim for He Korowai Oranga and promotes the vision of Māori flourishing.  We prefer a statement that is inclusive of Māori and promotes a Tiriti partner approach.  The 2003 New Zealand Cancer Control Strategy has dual equity and total population health goals. Benefits of the NZ Cancer Control Programmes equity focus are reflected in NZs narrowing cancer survival equity gap - with survival improving for Māori by 13% since 1999 versus 10% for non-Māori  Thinking about a future where ‘all New Zealanders’ are well is quite frankly alarming and distressing. We know that ‘all’ is really only ‘most’ and that we are not counted in the most category. In the past and in the present, Māori have been and continue to be a buffer that ensures the most get the best.  Initiatives that promote equity invariably lead to improved health for all. But initiatives aimed at improving health for all customarily either maintain or increase inequities. For example, it is well established that despite higher levels of need, Māori are less likely to access health services than non-Māori. Analysis of prescription data shows that, even when need is accounted for, Māori are less likely to have prescriptions filled for most medications including those to treat and prevent cardiovascular disease, diabetes and most other conditions.  *Equity gap in dispensed medication between Māori and non-Māori adjusted for age and relative disease burden (DALY loss)*    This phenomenon is recognised worldwide and has been named ‘the inverse care law’, where those who have the greatest need for health services have the lowest lower access to those services.  We recommend that the first part of the statement be changed to;  “So that all New Zealanders **equitably** live well, stay well, get well”,  The term ‘all New Zealanders’ undermines the already weak commitment to equity reflected in the document. |

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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| Consistent with the position of the Māori Public Health Physicians we agree we need to work within the framework of the Treaty of Waitangi to address issues for Māori.  We agree with a greater focus on equity and to acknowledge Tiriti O Waitangi and recommend that the draft principles be rearranged and re-worded as follows; as provided Māori Public Health physicians.   1. Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi 2. Achieve health equity and the best health and wellbeing possible for all New Zealanders throughout their lives 3. A focus on improving health for those currently unfairly disadvantaged 4. Collaborative health promotion and disease and injury prevention by all sectors 5. Timely and equitable access and quality of care for all groups of New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay 6. A high-performing system in which people have confidence 7. Active partnership with people and communities at all levels   Thinking beyond narrow definitions of health and collaborating with others to improve access to the determinants of health for the unfairly disadvantaged and achieve wellbeing for al |

### Five strategic themes

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

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

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| 1. People powered, equity first 2. Closer to home 3. High quality and value 4. Kotahitanga, One equity focussed team 5. Smart system |

### 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 recommend that an action focussed on equity and an action focussed on Māori health be developed and that all actions are reviewed to strengthen their focus on equity and Māori health.  We agree with Māori Public Health and support:   * Māori clinical workforce development * Clinician health literacy and cultural safety, * As a Treaty of Waitangi partner, Māori health needs and data be considered independently. * population based strategies – obesity, tobacco, alcohol harm, family violence, childhood hospitalisations with diseases of poverty (diseases with a social gradient), and housing. * Research – require HRC funded research to consider equity in all research proposals to decrease the potential for increasing inequities and increase potential to achieve equity |

### 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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| Mandatory equity focussed reporting and organisational audit.   * equity focussed health reporting to support an ongoing focus on achieving health equity. * Same health targets for Māori and non-Māori without aggregating the results, report on them individually to expose ACTUAL targets reached. |

### Any other matters

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

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| Equity focus - on all health activities   * Including Governance, Priority Setting, Research, Quality Control and Reporting   Quality ethnicity data collection, analysis and reporting   * Equal explanatory and analytical power   Identification of inequity hotspots along care pathways, development of initiatives to achieve equity and monitoring  Baseline = Achieve Equity, Improve Health For All.  Equitable representation on all decision making boards, committees, advisory groups.  Health Workforce:  Increase the focus on the responsibilities of health services for achieving health equity. Consistent with the Equity of Health Care for Māori : A Framework, focus on system organisational and practitioner responsibility to achieving equity. An unwell population is the responsibility of the health sector and the focus needs to remain on the systems and organisations delivering best care.  Increase the Māori Health Workforce and develop a strategy to develop and support more Māori into health services.  He Korowai Oranga, New Zealand’s Māori Health Strategy needs to be included in the actions for the revised Health Strategy and a commitment made to achieving Pae Ora in all health services. |

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| **250** | Submitter name | Dr Grace Wong |
| Submitter organisation | Smokefree Nurses Aotearoa |

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| --- | --- |
| This submission was completed by: *(name)* | Dr Grace Wong |
| Address: *(street/box number)* | Pvt Bag 92006 |
| *(town/city)* | Auckland 1142 |
| Email: | grace.wong@aut.ac.nz |
| Organisation (if applicable): | 1. Smokefree Nurses Aotearoa/New Zealand, Auckland University of Technology 2. Centre for Migrant and Refugee Research (CMRR), Auckland University of Technology |
| Position (if applicable): | Director: Smokefree Nurses  Associate Director: CMRR |

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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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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| P 3. Figure 1.2 Please could the word “culture” be included in the Figure.  P.4. “Investment approach” – top left shaded box – It is very hard to understand what the “investment” approach is and how it will work from this document by itself.  Please put a clear reference to the document “From cost to sustainable value” so readers can find out more about it. From reading this document, I can see that it refers to a different approach to funding health which will have a major impact on delivering healthcare.  This change in funding approach will drive changes in service delivery more than any rhetoric. I do not think that this it is clear in the document that there will be a change in funding mechanisms to match achieving the strategy.  P 6. Please add the Smokefree Aotearoa 2025 goal and tobacco use here because of the proportion and number of deaths caused by smoking; its impact on non-communicable diseases and health equity; the slow progress towards the goal; the urgent need to speed this up; and the need for the Strategy to explicitly express support for it to encourage New Zealanders, and the health work force, to maintain a focus on enhancing tobacco control and smoking cessation. |

### The future we want

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

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

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

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| **‘live well, stay well, get well’** This phrase is in tune with Asian perceptions of health and well-being. This suggests that it will resonate with these sub-populations. In Chinese culture (and Buddhist approaches), individualism serves collectivism. The onus is on the individual to actively care for and develop personal physical and spiritual health and well-being in order to contribute to the maintenance of the family, extended family and community, and to preserve harmony and balance.  The “Smart System” should include public/population health approaches, as well as technology and innovation. |

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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| The five themes are comprehensive and would be enhanced by including population/public health in “smart system’. I agree that targeting groups with high needs in precise and focused ways will be valuable. However it is important to have a strong public health system underpinning this.  ‘Smart system’ - please allow for those who are not able to use computers or the internet.  The use of the word ‘people’ (‘people-powered’) encompasses individuals, families and communities. Great!  Value and high performance – I agree with expanding health professionals’ roles as part of their everyday education and work, and upskilling community health workers. It will be important to avoid role confusion while preserving the ability of health workers to give patients high levels of competent, comprehensive service. |

### 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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| It is hard to see how the roadmap reflects the principles, especially Principle 4 (the Treaty of Waitangi).  The outcomes are critical. Can there be more examples of outcomes related to population health issues please.  The need to deliver personal health services at the population level needs to be explicit, for example, effective interventions to stop smoking delivered to all smoker, measured by quit rates (not service delivery rates).  Please add the Smokefree 2025 goal and the tobacco action plan the MoH said they are creating. |

### Turning strategy into action

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

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| It is hard to see how the investment approach will actually work.  The most important approach will be the way that the outcome are determined using the principles as living principles, and avoiding having the need for quantifiable outcomes determining their choice ie the tail should not wag the dog. |

### Any other matters

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

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| Thank you for giving us an opportunity to comment.  Please include refugees even as an example of an all of government approach (the Refugee Settlement Strategy).  The acknowledgement of mental health is throughout is great given the growing size of the problem and its impact. |

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| **251** | Submitter name | [redacted] |
| Submitter organisation | West Coast Tobacco Free Coalition |

3 December 2015

West Coast Tobacco Free Coalition

PO Box 544

Greymouth 7840

Submission to the Update of the New Zealand Health Strategy

The West Coast Tobacco Free Coalition is a group of organisations and individuals who share an interest in supporting West Coasters to live healthy lives free from the harms of tobacco smoking.

We submit that the government-endorsed nationwide goal of Smokefree 2025 should explicitly be part of the background for the New Zealand Health Strategy, given that:

(a) smoking is still one of the most significant modifiable causes of disease and premature death, particularly among Maori and Pacific population groups; and

(b) the current programme for achieving Smokefree 2025 will need sustained political and health system support if it is to be realised.

The “Future Directions” document notes that: “Increasingly, government agencies are working in co-ordinated and effective ways to respond to priority issues.” We suggest that an intergovernmental agency approach to achieving Smokefree 2025 should be an integral part of New Zealand’s future health strategy.

The need for a strategic response to the health challenges from smoking should be made explicit in the section on ‘Challenges’ in the “Future Directions” document (p.6), and in the next section, on ‘opportunities’ (p.7).

The section in the “Future Directions” document on “Children, Families and Whānau” should note the importance of smokefree environments, starting with smokefree homes and cars, for setting “the foundation for lifelong health” (p.16). The section on “Long-term Conditions, including Obesity” should be extended to include “and Smoking” in the title, and make reference to smoking cessation interventions and prevention strategies in the subsequent text.

Equivalent extensions are called for in the “Roadmap of Actions” document, to the sections on “[Tackling] long term conditions and obesity” (p.37) and “A great start for children, families and whanau” (p.38). Key interventions worth noting include standardised plain packaging, further tax increases on tobacco, targeted media campaigns, a licensing system for retailers, legislation to ban smoking in cars with child passengers, and the extension of the current ABC intervention in hospitals and primary care to include key government agencies and NGOs in the wider health and social services sector.

Yours sincerely

[redacted]

Chair – West Coast Tobacco Free Coalition

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New Zealand Health Strategy Team  
Ministry of Health

Thank you for the opportunity to comment on this Update.

I am the paper leader for the undergraduate tobacco control paper at AUT and my PhD programme is in tobacco control with a focus on mental health facilities in New Zealand.

A search of the Zealand Health Strategy Update, reveals that Tobacco is mentioned once at p16. ‘**Obesity rates** have increased. By 2016, obesity is expected to overtake **tobacco as the leading risk to health’**.

It is difficult to fathom the rationale for this when tobacco use is at this time, the important preventable cause of death, disability and health inequalities in NZ. Further, the Government has agreed to the SF2025 goal. The Strategy is silent about this and does not acknowledge current Government work on an action plan.

For people to live well, being smoke-free is essential.

The Strategy needs to include Tobacco Control with an emphasis on a package of measures known to be effective. For example standardised packaging, targeted media campaigns regular and large tax increases, smoke free cars and licensing system for retailers. In addition, there appears to be no evidence that all our District Health Boards are smoke-free all of the time and particularly in the area mental health and addictions. The evidence supports smoke-free mental health and addictions services and this needs to be reflected in the Strategy.

In summary, New Zealand has had a positive reputation for its work in tobacco control.  An updated Zealand Health Strategy is key to continued momentum and tobacco control must have a substantive place.

Nga mihi nui, na

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**SUBMISSION FROM ACADEMIC STAFF, DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF OTAGO, WELLINGTON**

**“UPDATE OF THE NEW ZEALAND HEALTH STRATEGY: ALL NEW ZEALANDERS LIVE WELL, STAY WELL, GET WELL”**

Contact person: [redacted]

**Introduction**

The Department of Public Health University of Otago is pleased to have the opportunity of input into the *Update of the New Zealand Health Strategy Consultation Draft* (Draft strategy)

The Department welcomes the development of a new draft strategy, timely given the fifteen years since the 2000 Strategy. The development of a new strategy provides an opportunity to take stock of how we are doing, identify current challenges, and clarify what is needed for the future.

This submission is based primarily on a public health perspective with two main starting points: the purpose and objectives of the New Zealand Public Health and Disability Act 2000; and an evidence-based analysis of the causes of ill-health in New Zealand.

**General comments**

We consider that the draft strategy provides many opportunities to develop a document which will help set meaningful directions for New Zealand’s health future. The draft strategy includes phrases like a system moving ‘from treatment to prevention’ and ‘a focus on prevention’; and notes that ‘Population-based strategies can also make healthier choices easier for all New Zealanders and help prevent and manage long-term conditions.’ It also espouses as one of its eight principles “collaborative health promotion and disease and injury prevention by all sectors”.

However, despite these worthy phrases, it is very disappointing that the strategy contains few if any meaningful preventive strategies and interventions to improve health at the population level. The five strategic themes (people powered, closer to home, value and high performance, one team and smart system) all focus on the health care system, with the only population-level preventive elements buried within the ‘closer to home’ section. Although the strategy claims to describe ‘the future we want’, unlike the 2000 Health Strategy it includes no population health goals, and even fails to acknowledge such critical goals that the Government has adopted such as Smokefree 2025.

The strategy also acknowledges the Treaty of Waitangi and includes equity focused principles, suchs as “An improvement in health status of those currently disadvantaged’, and “Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay”. However, these principles are not well reflected in the strategic themes and action areas, which rarely provide any specific actions targeted at improving equity in health and health care.

Areas where the Draft Strategy could be strengthened include:

* Greater coherence across the principles, the challenges, the themes and the actions. Currently the logical links between these different elements of the strategies are not readily apparent.
* A more comprehensive and evidence-based outline of the population health challenges faced by the New Zealand health system.
* Inclusion of measurable outcome-based population health targets to give focus to the Strategy.
* A clear commitment to equity in health outcomes and in access to and delivery of high quality health care, and an outline of actions and strategies to achieve these goals .
* Providing commitments to develop and implement evidence-based and cost-effective preventive strategies and interventions to address the population health challenges and achieve the population health goals.

**Guiding principles**

The guiding principles from the 2000 Health Strategy have been augmented with an eighth – ‘Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing’. In our view these principles remain apt and the new principle is a useful addition. However, the principle acknowledging the centrality of the Treaty of Waitangi has been moved from first to fifth in the list. Furthermore, unlike in the 2000 Health Strategy there is no elaboration of these principles or how they are reflected in the new draft Strategy. As a result the strategy lacks coherence across the principles, challenges and actions and strategies.

**Population Health Goals**

The new draft Strategy includes no population health goals. The 2000 Health Strategy listed 13 priority population health objectives with a rationale for why each was chosen. The objectives (e.g. ‘reducing smoking’ and ‘improving oral health’) were limited as they were non-specific and did not include timeframes. However, they did at least set out the overall priorities for population health interventions. The 2015 new draft Strategy fails to do this, and does not even mention existing goals such as the world-leading Smokefree 2025 goal to which the Government is committed. There are also no specific goals for reducing or eliminating inequalities in health, health outcomes and health care access and delivery.

**Challenges and strategies**

The list set out in the box on p 5 of the Strategy includes many major health and sustainability challenges which we agree face New Zealand including those of an ageing population, increases in long-term conditions and the health and social effects of climate change. However, the extent and scope of these challenges is not elaborated and the challenges themselves are not comprehensive. There is also no description or even acknowledgement of the substantial disparities in health that exist by ethnicity, particularly for Māori and Pacific, and by socio-economic status; and there is little in the way of suggested actions to address these disparities. The action areas include little in the way of population-based preventive strategies, and even the prevention action areas that are mentioned are mainly health system led interventions focused on high risk individuals rather than interventions to reduce population levels of key risk factors or address underlying determinants like poverty and por housing.

Most fundamentally, the analysis of challenges is not based on the science around health loss: specifically the 10 top risk factors for health loss in New Zealand (See Table 1). There is scarcely any mention of tobacco in the strategy – the country’s top risk factor for health loss (and also a major contributor to health inequalities). This lack of attention to tobacco is inconsistent with the ‘value for money’ imperative and ‘investment approach’ that are important themes of the new draft Strategy. For example, tobacco smoking results in huge economic costs to society and NZ modelling work suggests that higher tobacco taxes would be highly cost-effective and save substantial health dollars 1.

The word “obesity” gets some mentions, and the degree of the health problems caused by obesity are briefly acknowldeged, and unlike other areas of prevention some attention is given to actions to address this issue. However, the specific actions listed are targeted individual interventions for those who are obese or at risk of becoming obese, and unspecified broad population-based strategies. There are no plans presented to tackle the obesogenic environment (eg, the words “marketing”, “outlets” and “tax” are not mentioned) for example by implementing key recommendations of the WHO report on ending child obesity. 2

Brief mentions are given to the risk factors high blood glucose (in relation to diabetes), physical inactivity (‘exercise’ is mentioned once), and also the word “alcohol”. But there are no substantive primary prevention plans outlined for these risk factors. The lack of focus on alcohol is of note given that this is an area where there is ready scope for large health gains – while also saving health system costs 3.

Top 10 risk factors which are not discussed at all include: “high blood pressure”, “high blood cholesterol”, “high sodium intake”, “high saturated fat” intake”, and “adverse health care events”. From a value for money perspective this also seems unfortunate – given the NZ modelling work that suggests that population-level dietary salt interventions would generally produce large health gains while also saving health dollars 4. Similarly, for NZ work on the benefits of taxing high salt foods 5, and sugary drinks 6.

In addition, neither the summary box nor the text refer at all to structural issues such as poverty, food systems, poor housing, transport issues, built environments, nor issues relevant to income, tax and benefits.

**Next steps**

The new draft Strategy offers scope for development to achieve both “prevention” and “value for money”. Effective population based preventive strategies are highly effective and cost-effective, generally much more so than treatment interventions. For example, among the major interventions modelled by the BODE3 Programme (University of Otago) the health gain from population based preventive interventions such as regulations to reduce food content of foods and tobacco taxes dwarf those of clinical and health systems interventions such as increased use of Herceptin for breast cancer and cancer care coordinators. 7 Effective prevention can make a substantial contribution to reducing health system costs and help address the issue of health care funding sustainability outlined on page 6 and figure 1.5. Prevention is therefore a core component of an ‘investment approach’.

Our ideas for ‘next steps’ would build on the themes in the new draft Strategy, with the addition of a sixth theme to enable implementation of the first concept in the overall vision: to ‘live well’, and some aspects of the ‘stay well’ component. We suggest this would be achieved by adopting a sixth main theme: *‘Prevention focused’, or ‘prevention to live and stay well’*.

The theme of ‘prevention’ would set out measurable population health goals and provide, in brief, details of existing planned interventions and strategies to address these goals and reduce disparities in health, or in their absence, a commitment to develop such strategies. Interventions and strategies would reflect current knowledge on effectiveness and cost-effectiveness, give effect to international mandates and requirements, and impact on the identified current challenges (in particular long term conditions, financial sustainability, and healthy aging). As page 17 notes, ‘population-based strategies can also make healthier choices easier for all NZers and help prevent and manage long-term conditions.

For example, in relation to tobacco, we already have an explicit governmental goal to reduce smoking prevalence and tobacco availability to minimal levels by 2025 in New Zealand. This world-leading goal should be mentioned, along with a commitment to developing a comprehensive evidence-based strategy to achieve the Smokefree 2025 Goal (eg, via higher tobacco taxes 8, restricting outlets 9, revising regulation around alternative sources of nicotine 10 etc). This is particularly important given evidence that current approaches will not be sufficient to achieve the 2025 goal, particularly among Māori 11.

The issue of obesity is mainly discussed in the new draft Strategy under the theme of ‘closer to home’, with the suggestion that primary and community services can work together to prevent obesity in individuals at risk and manage obesity in those already obese. Just released data from the 2015 Health Survey indicates that child obesity rates continue to rise alarmingly 12. This emphasises the need for primary prevention of obesity. We suggest actions to redude obesity should be located in the prevention theme and interventions should include more clearly population-based approaches to prevention. The recent WHO Commission on Ending Childhood Obesity, co-chaired by Sir Peter Gluckman the Prime Minister’s Science Advisor, recommends tackling the obesogenic environment with fiscal measures (such as sugary drinks taxes) reducing children’s exposure to unhealthy food marketing and creating healthy food environments such as schools, sports facilities and urban environments 2 Explicit government commitments and goals are needed in these areas.

Other priority areas should be included, reflecting the major preventable causes of health loss such as excessive alcohol consumption and other nutritional risk factors such as high dietary salt intakes.

In addition to non-communicable diseases and their risk factors, some additional issues that are mentioned but not otherwise discussed should be acknowledged as requiring attention: in particular new infections and antibiotic resistance. We also suggest that actions should relate to *existing* communicable conditions, far from vanquished in New Zealand. Actions here should relate to known preventive strategies, but also protective strategies such as those relevant to resilience of society as a whole, relevant particularly to the possibility of new pandemics and emergencies in general.

Some of the health system organisational ideas included in the new draft Strategy such as stronger primary health care services, better DHB collaboration and integration, greater inter-sectoral coordination, and improved prioritising could also be reflected in the prevention theme, through the complementary actions of the health care and social sector in the provision of preventive services.

Finally, the principle of equity in health and health systems should be much more clearly articulated throughout the document, including through high level goals and through specific actions and strategies to reduce and eliminate inequalites in health, health outcomes and access to and the delivery of health care.

**Conclusions and recommendations**

We acknowledge the extent of work that has gone into developing the new draft Strategy and the many good ideas that are contained in it, particularly for improving the health care system. However, we believe it would benefit from a more coherent and logical approach in which the stated principles are more clearly reflected in the strategy. There should be much stronger focus on prevention with priority population health challenges informed by the burden of disease identified, together with related priority goals and evidence-based strategies to achieve them. Achieving equity should be a key principle reflected throughout the document.

In summary, we recommend that the revised version:

1. Elaborates the principles and ensures they are fully reflected in the health strategy.
2. A more thorough-going analysis of present challenges that are population health priorities and germane to long-term sustainability of the health care system.
3. Adoption of a sixth ‘*prevention*’ theme which includes measurable priority population health goals with explicit timeframes and sets out evidence-based strategies to achieve the goals and reduce health disparities.
4. Achieving equity to be a key key principle and theme throughout the Strategy.

**Table 1: Risk factors for the top 10 causes of health loss in NZ** (from the NZ Burden of Disease Study 13)

| **Risk factor (top 10)** | **DALYs (disability-adjusted life-years) lost in 2006** | | **Mentioned in the draft “Health Strategy” (word search terms used)** |
| --- | --- | --- | --- |
|  | **Number** | **%** (of all health loss) |  |
| 1) Tobacco use | 86,900 | 9.1% | “smokefree” (n=2), “tobacco” (n=1), “smoking” (n=0), ***All nil for:*** “tax”, “outlets”, “2025” (the latter is the year for the Smokefree Nation goal”). |
| 2) High BMI | 75,100 | 7.9% | “obesity (n=13). ***All nil for:*** “overweight”, “BMI”, “diet”, “obesogenic”, “marketing”, “tax”, “outlets”. (See also “physical inactivity” below). |
| 3) High blood pressure | 61,000 | 6.4% | ***All nil for:*** “blood pressure”, “hypertension”, “salt”, “sodium”, “unhealthy” (food) |
| 4) High blood glucose | 43,800 | 4.6% | “glucose” (n=0); “diabetes” (n=12) – but the latter contexts do not seem to address the obesogenic environment (see above under “high BMI”). |
| 5) Physical inactivity | 40,000 | 4.2% | “exercise” (n=1), “inactivity” (n=0). But the obesogenic environment is not considered (see “High BMI” above). |
| 6) Alcohol | 37,000  (net of benefits & harms) | 3.9% | “alcohol” (n=4), “binge” (n=0). ***All nil for:*** with regards to: “marketing”, “tax”, “outlets”. |
| 7) High blood cholesterol | 30,900 | 3.2% | ***All nil for:*** “cholesterol”, “lipid”, “dietary fat”, “fatty acids”, “diet” |
| 8) Adverse health care events | 30,300 | 3.2% | ***All nil for:*** “adverse”, “adverse events”, “hospital acquired”, "health care events". |
| 9) High sodium intake | 16,300 | 1.7% | ***All nil for:*** “sodium”, “salt” |
| 10) High saturated fat intake | 11,400 | 1.2% | ***All nil for:*** “saturated fat”, “cholesterol”, “lipid”, “dietary fat”, “fatty acids”, “diet” |

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