**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**346 – 360**

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| **346** | Submitter name | [redacted] |
| Submitter organisation | Tala Pasifika |



**Submission on**

**Update of the New Zealand Health Strategy: All New Zealanders Live Well, Stay Well, Get Well**

**Submission on behalf of:**

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| Contact name: [redacted] | Title/position: Programme Manager |
| Organisation: Tala Pasifika - National Tobacco Control Service | Email: [redacted] |
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**To: New Zealand Health Strategy Consultation**

**Ministry of Health**

**PO Box 5013, Wellington 6145**

Date: 4 December 2015

Tala Pasifika would like to thank the Ministry of Health for the ongoing good work it does to improve the health of all New Zealanders, as well as for giving us the opportunity to respond to the draft New Zealand Health Strategy at this time. We acknowledge the extent of the work that has taken place to date on the proposed update of the New Zealand Health Strategy.

Tala Pasifika represents a collective call for action for Pacific peoples here in New Zealand on tobacco issues. Ensuring that the Pacific voice is heard and the diverse Pacific perspectives are represented as part of the discussions for Smokefree Aotearoa and tobacco elimination.

We recommend the following to strengthen the proposed New Zealand Health Strategy:

* A stronger focus and specific targeting of Pacific and Māori priority populations including pregnant women and youth through prevention and/or early detection interventions.
* Include the reduction of tobacco use to be central to the new strategy.
* Incorporate the government agreed goal of a Smokefree Aotearoa 2025.
* Include the plan of action currently being prepared by the government to reach the Smokefree Aotearoa 2025.
* Highlight key and urgent smokefree interventions such as the: a) Standardised packaging; b) Regular and large tax increases; c) Targeted media campaigns; d) Licensing system for retailers and; e) Smokefree cars to name a few.
* Include the words ‘die well’ in the statement on page 8 of I.

**Recommendation 1:** A stronger focus and specific targeting of Pacific and Māori priority populations including pregnant women and youth through prevention and/or early detection interventions.

Pacific and Māori people experience poorer health outcomes as a result of their lower socio-economic status (1). This is evidenced by the high rates of obesity, diabetes and smoking rates amongst both Pacific and Māori communities (2):

Pacific:

* 25% of Pacific children are obese
* 67% of Pacific adults are obese
* 9% of Pacific adults were diagnosed with diabetes
* 23% of Pacific adults smoke

Māori:

* 16% of Māori children are obese
* 46% of Māori adults are obese
* 7% of Māori adults were diagnosed with diabetes
* 37% of Māori adults smoke

**Recommendation 2:** Include the reduction of tobacco use to be central to the new strategy.

The use of tobacco is the most important preventable cause of death, disability and health inequalities in New Zealand. Pacific peoples suffer from an unequal burden from the effects of smoking. Over 20% of Pacific adults in New Zealand reported being smokers in the 2013 Census. For Pacific people, smoking is an important contributor to inequalities in life expectancy between Pacific and Non Pacific/Non Māori groups. Compared to the reference group of decile 1 Europeans with the greatest life expectancy, the total years of life lost were 9.5 years for Pacific men and 7.1 years for Pacific women. Smoking accounted for 37% of this loss for men and 13% of the loss for women (3).

**Recommendation 3:** Incorporate the government agreed goal of a Smokefree Aotearoa 2025.

The proposed Strategy has a strong primary care focus with no inclusion of any population health goals such as the national Smokefree Aotearoa 2025 goal. The spend on immediate need is good but it will displace our opportunities to save more premature deaths via public health initiatives. On the other hand, the 2000 Health Strategy listed 13 priority population health objectives with corresponding rationales as to the reasons for their selections (4).

It is very important to continue with the national commitment and momentum to achieving the Smokefree Aotearoa 2025. Current smoking rates are declining but they are not decreasing at a fast enough rate to reach the less than 5% for all New Zealanders (5). Its exclusion from the proposed Strategy could well slow down or increase the smoking rates in New Zealand. An outcome that would be devastating with worsened health outcomes for New Zealanders.

**Recommendation 4:** Include the plan of action currently being prepared by the government to reach the Smokefree Aotearoa 2025.

We understand the government is currently preparing a tobacco control plan of action. We applaud the government for taking leadership to develop New Zealand’s first government-led Tobacco Control Action Plan. This is a very important step to reach the goals of Smokefree Aotearoa 2025. It will provide a clear directive and a focus for all of government, across sectors and communities at all levels to collectively implement and monitor the action plan.

**Recommendation 5:** Highlight key and urgent smokefree interventions such as:

a) Standardised packaging; b) Regular and large tax increases; c) Targeted media campaigns; d) Licensing system for retailers and; e) Smokefree cars; to name a few.

Tala Pasifika, along with other national tobacco control services, prioritised the above initiatives based on international best practice and evidence to increase the rate of decline for smoking rates in New Zealand (6). This is of particular importance for priority populations who have higher rates of tobacco use i.e. – Pacific and Māori. These initiatives provide value for money and could be implemented without too much effort.

**Recommendation 6:** Include the words ‘die well’ in the statement on page 8 of I.

‘So that **all** New Zealanders **live well, stay well, get well and die 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.**’

Both life and death are highly regarded to be of cultural significance within Pacific communities. Whilst the inclusion of the words relating to living well, staying well and getting well are included in the above statement, it is equally important from a Pacific cultural perspective to acknowledge the opportunity to ‘die well.’ Love and respect are core values for not only Pacific peoples but for all New Zealanders and should be applied for all end of life experiences. This is important for not only the dying person, but also for their families, friends, carers and the whole of society at large.

**Conclusion**

Tala Pasifika is pleased for the opportunity to have contributed to this consultation. Like you, we aim to achieve best possible health outcomes for all New Zealanders, our collective approach will avoid further unnecessary premature deaths.

We trust you will consider our proposed recommendations to improve the draft New Zealand Health Strategy which in-turn will allow all New Zealanders to live well, stay well, get well and die well.

Signed:

[redacted]

This submission was completed by:

[redacted]

Programme Manager

E: [redacted]

On behalf of:

Tala Pasifika

PO Box 17160, Greenlane, Auckland 1546

*Faafetai tele lava, Malo aupito, Meitaki maata, Vinaka vaka levu, Fakafetai lasi, Fakafeta’i*

*Fakaue lahi mahaki*

**References:**

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| **347** | Submitter name | [redacted] |
| Submitter organisation | Thrive Teen Parent Support Trust |

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4 December 2015

Tena koe

**Submission on New Zealand Health Strategy**

1. Thank you for the opportunity to make a submission on this key document.

**Who are we?**

2. Thrive Teen Parent Support Trust (‘Thrive’) is a non-profit organisation which supports young people to thrive and be confident as parents. The Trust was set up in 2010 in response to an 18 month-long collaborative community research project which called for a dedicated young parent service in Auckland. Thrive has as its vision that young parents are able to reach their full potential by being connected and secure within their families and communities.

3. Thrive works to improve equity of service uptake and to reduce inequalities of teen parents and their babies, children and whanau through engagement, advocacy, assistance and professional support.

**Challenges or Opportunities**

4. The challenges or opportunities that form part of the background of the Strategy must clearly present the cost that is currently being directed into the health sector and to address that burden with de-constructing the system by placing greater emphasis on early intervention, prevention, health promotion and the maintenance of health and wellness.

5. The Ottawa Charter and the Treaty of Waitangi as frameworks vis a vi covenant, must imbue our social consciousness if real change is sought.

**The Future we want?**

6. Population health targets that are responsive and reflective of the health burden faced from conception to 3 years, pre-school to adolescence, adolescence to youth should be prioritised over the treatment and medicalisation of the aging population.

7. Social bonds should be developed as a preferred option for the aging population to access service provision.

8. Maori population health targets should be developed with Iwi and Maori communities and afforded its own funding formula and appropriated to Vote Maori appropriations. Iwi and Urban Maori, must take a leadership, governance and business role in establishing a commissioning agency that has Iwi as the main shareholders with the Crown and other invited/selected Commercial interests.

9. The Mental Health pathway needs to be better evidenced, led and supported across all segments of the community. Mental health services must go beyond the acute illness stage with more emphasis directed to prevention (e.g. Alcohol and Drug treatment, activities to foster social inclusion, neighbourhood social supports), early intervention and the maintenance of wellness whilst in recovery.

10. Mental health funding needs to be spent on mental health and not siphoned off to other cost centres in DHBs.

11. It is well known that DHBs wield un-elected power and control over millions of dollars without the same accountability as Central Government. Local Government must play a stronger role in the composition of DHB Governance Boards and should be more transparent with its pricing, funding formulas and procurements.

12. View on the statement:

“A**ll** 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**”

12.1. The statement should read *“that every citizen is afforded the opportunity to start well, to stay well, to live well and to die well”.*  The removal of the terms “get well” removes the onus of treatment, of the medicalisation or clinical paradigm upon the lifespan of a contributing and connected citizen.

12.2. The five strategic themes: People Powered

A key driver for this theme must be the enabling of a strong, rigorous coordinated body of knowledge that is specific to the populations groups; Maori as tangata whenua, Pacific, young people, tangata whaiora and others that can be incorporated into the planning and funding cycles.

12.3 A strong emphasis should be placed on health and wellbeing of the most vulnerable population groups currently in Aotearoa New Zealand. The starting point must be at conception through to older adult and be inclusive of whanau and social support systems including friends, community agents and leaders.

12.4. The five strategic themes: Closer to Home

Thrive strongly supports this theme of ‘services closer to home’ as this will have a direct impact upon the mental and social factors of citizens. Furthermore, this has wider implications as financial costs (infrastructure) can be saved by having more mobile or portal services prioritised.

12.4.1 A more realistic and affordable approach should focus on health and wellbeing strategies that are embedded in public health: prevention and health promotion with all facets being interconnected (safe and sustainable environments, warm housing, clean air, pollutant free, local green zones, accessible primary care services) and more.

12.5. The five strategic themes: Value and high performance

Thrive strongly supports this theme of value and high performance with the new direction being placed on the value of community involvement, participation and ownership. Less emphasis and power should lay with the medicalisation of people’s health and wellbeing. High performance should be measurable with distinct health and wellbeing indicators that impact upon Maori and Pacific and lower socio-economic groups. Measureable performance population outcomes must be the baseline and improvements in outcomes must be rewarded.

13. Thrive is not able to provide further written comments at this time, but would welcome an opportunity to present or discuss further thinking on the Strategy.

Nga mihi

[redacted]

CEO

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| **348** | | Submitter name | Michael Howard | | |
| Submitter organisation | General Practice New Zealand | | |
| This submission was completed by: *(name)* | | | Michael Howard |
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| 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)*: National primary care membership organisation

### Challenges and opportunities

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

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

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### The future we want

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

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

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

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| This sentence has a lot of words and is full of slogans, but it is very generic. It could equally apply to any health system in the world. Can we have something aspirational, easily remembered, meaningful, clear and engaging for New Zealand? Healthy New Zealanders for example. |

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 document is light on how these will be measured. They may be guiding principles, but it is unclear how the rest of the document and the actions link into these. |

### 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, but the action items are light. How will the ‘what great look like be measured’? What are the baselines? The ‘what great might look like’ is in some instances very generic. Health is becoming increasingly driven by people’s expectations. The need to invest in technology solutions to support new and emerging models of care is under stated. This is much more than patient portals, which is the main point made regarding technology.  We would suggest a set of statements that make it a NZ document. The current statements are mostly generic, broad and open to interpretation. For example we could have: “a smokefree New Zealand by 2025”, “eliminate childhood obesity by 2025” etc. The statements should be inspirational, engaging, clear and precise. This is a “New Zealand” Health Strategy, and those who read it should be saying – “yes I want to be part of making that happen”. It reads far too bureaucratic.  The whole philosophy on how care is delivered will need to change to support these goals and combat the stated challenges. Otherwise we will just be supporting an outdated transactional model of care that will not deliver what is needed for the future. This seems to only lightly be touched on in Closer to Home (eg minor surgery in the community) and only on an individual service basis rather than how the system is strategically configured. |

### 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?

*Specific Suggestions:*

Action 1: Inform and Involve People

It is suggested that a stocktake be undertaken as the first step. Stocktakes often take a while to develop and are only current to a point in time. It will quickly go out of date unless it is maintained, which we doubt will happen for the long term. We recommend this action be deleted.

Instead of the Ministry having a specific social media action on diabetes, we recommend that the Ministry enable greater use of mobile technologies, eg through the Health App Formulary proposed in Action 19 (d).

Action 2: Know and Design

Dissemination of information is important (eg through conferences), but it does not lead to consistent service implementation. The proposed action is just to ‘showcase’ three examples, rather than do anything with them. It is recommended that a second part of this action could be to consider these for a funded national rollout.

Action b. discusses ‘support clinician-led collaborations’, however, it is unclear what ‘support’ means. Is the Ministry considering funding these collaborations with service planning, implementation and service delivery to their high need patients?

Action 3: Shift Services

“The Ministry of Health, with input from the system, will ensure the right…” Although it is laudable and high level, we are not sure this is achievable. We recommend more emphasis be placed on addressing the known barriers for shifting services. This is particularly regarding DHBs’ sunk costs in their hospital assets, change costs for DHBs (particularly those with deficits that are reluctant to invest in spending more in the short term), Union issues, etc. It is relatively easy to develop the service pathways, but nothing will change unless the DHBs are able to address these issues. We strongly recommend this action be reframed to addressing these barriers.

Action 4: Shift Services

Although part of the care team, pharmacists do not provide continuity of medical care to patients. We recommend caution in extending pharmacists’ prescribing rights, and acknowledge that this is a controversial issue.

Action 5: Tackle Long-Term Conditions and Obesity

This action only discusses the role of “the Ministry of Health and DHBs”. It is recommended that the Ministry acknowledge the role of service providers. The Ministry and DHBs cannot implement the NZHS by themselves.

Although we acknowledge the risk obesity poses, there are no actions on reducing the prevalence on smoking. Although obesity is the new government target, we do not consider the Ministry loosing sight of the risk that smoking poses to be appropriate within the NZHS. It is unclear if it is still the government’s intention to aim for a smokefree New Zealand?

We recommend the NZHS more strongly indicate the need for an increased focus on preventative health to address avoidable long-term conditions. The statistics regarding childhood obesity and obesity in general for example reflect a disappointing failure as a system.

Consistency in some of the goals across elections (or individual Ministers) would help provide stability and clarity for the system.

Sub-action d. Successful partnerships cannot be “required” as stated. Partnerships are built on a foundation of trust and respect. We recommend this be re-worded to state “the Ministry will help foster successful partnerships to develop between organisations”.

Action 6: A Great Start for Children, Families and Whanau

This action places a focus on “at risk” children, however the document does not state what the children at risk of. This could be interpreted as poor oral health, poor hearing, poor educational achievement, witnessing family violence, poverty, depression, obesity, abuse etc, etc. This could be defined to include a very large part of the New Zealand population with its wider definition. We recommend this be defined to provide clarity (for example with a footnote or a reference to another document that has an appropriate definition).

Sub-action b. It is unclear whether ‘promoting healthy nutrition’ will be enough to change deep lifestyle habits and therefore lead to reduced prevalence of obesity. The Ministry could work with the Ministry of Education on policy requirements regarding sugar and fat content in food for schools and tertiary institutions. The Ministry could also work with District Health Boards, local Councils and other government-owned entities to do similar.

Sub-action f. There is an opportunity for the Ministry to work with the Department of Corrections in ensuring that prisoners are enrolled with a general practice as part of their release plan.

Action 8: Improve Performance and Outcomes

Although the loss of traction on the Integrated performance Incentive Framework (IPIF) is very disappointing, it is positive that a health outcome-focused framework is still a goal. We strongly recommend that this includes a co-designed and co-governed approach with the sector (rather than “with involvement from the health and disability system”. The idea behind IPIF was generated from the primary care sector and passed to the Ministry. May be as an alternative, the approach could be turned around and the Ministry could contract with the primary care sector to deliver a working model?

Action 10: Align Funding

Sub-action d. “Agree on IT project funding priorities” reads as an after thought. It may be better to integrate IT solutions to support new service pathways and models of care throughout the document. We would suggest that “agreeing priorities” does not go far enough. We recommend that this be re-written to have IT systems implemented as the goal. The current goal would not result in any IT system being implemented, which would be inappropriate.

Action 11: Target Investments

We recommend this action could include developing and using a health and social investment approach.

Action 13: Clarify Roles, Responsibilities and Accountabilities

It appears this action relates to the Ministry of Health, DHBs and any Ministerial Advisory Committees. We recommend that the leading sentence be re-worded from improving decision-making “across the system”, to be “within the Ministry of Health and DHBs”. If it is intended that the governance arrangements and decision-making processes of providers is included, then we recommend this is explicitly stated.

Action 14: Clarify Roles, Responsibilities and Accountabilities

Sub-action a: Recommend this action be re-worded to be review “and implement changes as necessary”.

Action 15: Integrate Health Advice

It is unclear what “incorporates or takes into account relevant existing national committees” means. Does this mean those committees will be absorbed into the new Integrated Health Advisory Structure? If it is, then that would be very helpful. However we would question the need for this new structure to have its own governance board. This could be with the Ministry of Health’s internal staffing structure. We question what return on investment the creation of these types of structures (NHB Board for example) has provided to the system.

Action 18: Strengthen National Analytical Capability

Recommend a new action be included on working with other Government departments to electronically determine eligibility to health and disability services. This would particularly include the Departments of Corrections and Internal Affairs. This could then be integrated into the National Enrolment Service (and potentially the NHI for hospital and other services).

### Turning strategy into action

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

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| As stated above many of the actions and “what great would look like” don’t appear to be very measurable. They are not SMART actions. There are no baselines provided. Some of the language is “improve” – but by how much should the target be stretched?  Full public reporting should be completed annually. Data should be made available so true progress can be measured. Too much reporting is redacted by the Ministry, so the true picture remains unknown. “You can’t manage what you don’t know”, and the system needs full disclosure to support healthy New Zealanders. |

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| **349** | Submitter name | [redacted] |
| Submitter organisation | Midcentral District Health Board |



4 December 2015

New Zealand Health Strategy Update Consultation New Zealand Health Strategy Team

Ministry of Health PO Box 5013

WELLINGTON 6145

Dear New Zealand Health Strategy Team

**Ref: New Zealand Health Strategy Update Consultation**

Thank you for the opportunity to provide feedback on the update to the New Zealand Health Strategy.

Firstly, we acknowledge the work that has gone in to review, assess and update the New Zealand Health Strategy in order to “outline for all New Zealanders the intended direction and focus for the public health sector over the next ten years”. We congratulate the team on successfully meeting the high expectations associated with this exercise and the very tight timeframes under which it has been achieved.

The general direction, Vision, Principles and Strategic Themes are sound. There is a good balance between continuity with the previous strategy and the introduction of new elements in response to contemporary developments.

The Strategic Themes cover the main issues of today; MidCentral DHB has heard similar messages emerging from our community and stakeholders while engaging in a refresh of its own strategic direction.

The areas where we consider the Health Strategy needs to be developed further are in the Roadmap and in the technical aspects of how the Strategy is expressed. We would like to see stronger links between the Directions section and the Road Map. In particular we would like to see intervention logic more clearly expressed throughout the document.

This will then result in a Strategy that will serve the health system well over its expected five to ten year timeframe. We appreciate that this is a consultation document and the next phase will involve more detailed planning which will address these issues.

Please find below more detailed feedback, organised under the headings Future Directions and Roadmap of Actions.

MidCentral DHB looks forward to the further development of the Strategy and would be delighted to support the process in any way possible.

Yours sincerely

[redacted]**General Manager**

**Strategy, Planning and Performance**

**Strategy, Planning and Performance**

Board Office, Heretaunga Street PO Box 2056, Palmerston North, 4440

Phone (06) 350 8626

# Appendix 1

1. **Future Direction**
   1. General direction

Overall, we support the general direction the Strategy proposes for our health system and the guiding principles underpinning the Strategy, including the additional principle pertaining to crossing the traditional boundaries of “health”.

We note that the principles are sitting under the title of “culture and values”. In our view this is not the right heading. A culture and values section would be a good addition, in which case it should include details of the desired culture and values that a public health (disability and social) system should be demonstrate.

We note that principles 1, 2 and 4 are not followed through in the strategic themes or action plans.

* 1. Vision, outcomes and strategy

The five strategic themes are very good. We have been undertaking a refresh of MidCentral DHB’s strategic framework and we have identified similar themes from our community and stakeholders.

We note the deliberate focus on a “high level direction for the health and disability system”, rather than a health strategy with goals and objectives to achieve the first part of the vision statement “all New Zealanders live well, stay well and get well”… To turn that around, if we had a health (disability and social) system that was people- powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system, would that mean that “all New Zealanders live well, stay well and get well”? It is imperative that specific population and other health strategies are indeed updated, as suggested on page 4, to address the desired future state (“…highlights wellness as a goal”), in terms of population (and sub-populations) health outcomes, goals and objectives.

The Strategy would do well to have the health system outcomes “New Zealanders live longer, healthier and independent lives” and “the health system is cost effective and supports a productive economy” statements up front (assuming they remain existent), coupled with explicit links to The NZ Triple Aim (goals) of improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources.

It is difficult to assess the desired change when it is not clear how we will know we’ve got there and/or what will be different.

It has been suggested that the wording “value and high performance” in the Strategic Themes be reworded as “high performing and delivering value”.

There are several position statements to describe the vision of “what great might look like in 10 years” for each of the strategic themes.

The outcomes to be derived from implementing the Strategy are not clear. It is almost as though the strategic themes are being treated as the goals rather than the approach to all that we (the health, disability and social) do; the enabling mechanisms (or tactics used to achieve something). An example is the vision for people-powered health in 10 years’ time includes “health and injury services provide a more consistent experience for people”. What change will enable that to occur and by when is not evident.

* 1. Challenges and opportunities

Some of the challenges and opportunities are not carried through in the description of the 10-year vision described under the strategic themes or in the subsequent action plans. For example, addressing the roles, functions, capability and capacity, investment in training, of a broad range of regulated and unregulated workforce contributing to the health and disability (and social) system is not strong.

“Improving our health system and wider social services…. a key factor will be our ability to work together”. There is very little carry through in objectives and actions that might enable that. For example, enabling policy and legislation and operating models that do not retain the split and separateness of Disability Support Services, Accident Compensation Commission and Public Health Services. Further, what actions could/will be taken to ensure the Ministries of Education, Social Development, Maori Development, Justice and departments, as well as the economic policy promulgated by Treasury are aligned to the Health (disability and social) system? And, what partnerships could/will be established for what purpose?

It is suggested that the role of the Ministry of Health be strengthened in leading/engaging with cross-sector central government departments/ministries/agencies to ensure shared goals on the “health system agenda” are reflected in the plans and actions of those ministries/departments/agencies, and, that enabling legislation and policy is consistent across government.

There needs to be further work on the health and social connection. Also with the current barriers identified on page 7, how do we ensure these are linked with the focused actions? We need to address prevention and access earlier and that means at times a culture change is needed. There is also absence of the equity lens across all areas.

Results of an impact assessment (of opportunities, challenges, risks, strengths and weaknesses) are under developed. Surely this forms the basis for change – the links are not apparent in the proposed Roadmap. We note with interest Treasury’s view about the issue of unaffordability. The question might also be around the coherence and connections to economic policies that shape the lives of all New Zealanders….

Treasury has a key role in enabling the health and wellbeing of New Zealanders

What is important is that there is clear connection between the Background, Guiding Principles, Strategic Themes, Roadmap and Action Areas and that certain aspects labelled as important in the pretext (page 7) of the document don’t get lost in the Action Areas.

# Roadmap of Actions

Critical to the Roadmap of Actions is *Improving where it matters most* and *Driving change.* As the foreword suggests, the purpose of the Roadmap is *to bring the strategic themes to life, proposing an evolution of change to realign our operating model, encourage innovation and ensure sustainability”.* As currently

drafted, the Roadmap seems very Ministry-focused rather than health (disability and social) system focused. Perhaps that was the intent given one of the purposes of the Strategy is apparently to realign the operating model (for the Ministry of Health).

Turning strategy into action (the Roadmap) then disaggregates the 10 year vision into “what do we want in 5 years?” with twenty actions proposed. Some of the position statements for 5 years’ time are status quo, what currently occurs – it is difficult to ascertain what will actually be different. It is at this point that execution seems to be disconnected from the Strategy. The intervention logic seems somewhat blurred.

We encourage a reconsideration of the linkages between the “what great might look like in 10 years” in each strategic theme and the “what do we want in 5 years” under the Roadmap of Actions for each theme. This would help strengthen the intervention logic, and perhaps more clearly identify what the objectives are – what’s required to change. This will be critical to ensure we can track and report progress. We do not want input based reporting, nor solely outputs – outcomes/impacts/results based must be a leading priority.

There seems to be a disconnect between the objectives, their identified actions for each and the “what do we want in 5 years” under each strategic theme.

There are a number actions proposed that appear to have been “retrofitted” so it is difficult to understand how these will make a difference/achieve the desired change.

The Roadmap should be more about summarising the What We Want in 5 Years rather than prejudging the means of getting there. Throughout the following sections the focus seems to be on what it appears the Ministry of Health can/will do rather than the broader health community and gives impressions that many actions have been decided in anticipation of the Strategy rather than flowing from it. This gives a feeling of disconnect between the Strategy and Turning it into Action. A stronger attention to the objectives for the four to five years rather than the actions (actions are best placed in annual planning). (Four years is suggested to align with the requirements for 4 year plans). Further it may be that Government priorities at the time supersede or conflict with the actions outlined in the Strategy.

There is a need to ensure coherence between the actions identified for the “objective” under each and between each strategic theme. Cognisance of dependencies and predecessors, and or the intervention logic in and between the actions is not particularly evident.

As currently written the “One team” and to a lesser extent the “Smart system” strategic themes are fairly well focused on the Ministry of Health and national bodies. There is an opportunity to consider “One team” much more broadly, for example with actions that draw in the cross-sector / social services intention much more (the eighth principle).

Equally applicable, if not more so, is the partnership between the Ministry and DHBs and contracted providers (the principal delivery vehicles to achieve the “vision”).

Holding an annual forum will not “create a one team approach for health in New Zealand…..”. Thinking about the role and responsibilities that contribute to the One Team needs to be much broader than restructuring and reorganising the operating model within the Ministry of Health.

The actions under “Smart system” generally suggest maintenance of the status quo in terms of national bodies (HWNZ, HQSC, NHC, HRC, National Health IT Board) – albeit focused on information systems and technology, yet the “One team” theme considers an action to integrate the health advisory structure to oversee health system changes etc…. There seems to be mixed messaging about functions, roles, responsibilities and accountabilities (for which there is another action proposed but in order to fulfil the Ministry’s stewardship function).

One Team and Smart System would also benefit from a whole of system thinking to a health care continuum approach. That is, from prevention right through to rehabilitation and support. Our “system” does not enable or support this continuum easily. For example the Public Health Services still being “accountable” to the Ministry of Health rather than to the population they serve through DHBs (similarly the National Screening programmes although to a lesser extent), and, having a separate Disability Support Service system and a separate ACC system. Thus navigating the systems is problematic for service users (and arguably for those leading, administering and delivering it).

The step towards online or digital information systems and electronic patient records is an excellent, beneficial focus area that warrants particular attention sooner rather than later. It is currently a rate limiting step. It will, however, involve considerable capital investment within both hospital and community settings. There are issues of cost, commitment, asset ownership, attribution, feasibility and affordability that need to be tested – ideally before being committed to in the Strategy.

Having more information available online will be important, although it’s important to note that we should not place all the emphasis on digital solutions as people do not always read information just because it is available. Education and face to face are still relevant and important mechanisms of communication.

Having stated that there are challenges around the health workforce, the proposed priorities/objectives/actions are relatively silent in addressing this challenge. There are opportunities to think more broadly around workforce development, building capability, functions and utilisation of professional roles and unregulated workforce (there is reference to volunteers too in earlier section, but we suggest this is a diminishing pool) across all of the Strategic themes.

# Summary

In summary, we are encouraged by the intent of the draft update to the New Zealand Health Strategy. In our view there is considerable work still to be undertaken to clarify and link the purpose of the Strategy and the Roadmap of Actions that signifies a pathway to achieve explicit change that benefits the health of all New Zealanders.

We look forward to receiving the next iteration following the consultation process. We anticipate further clarity will then inform the shape of potential actions that we, as a key player in delivering the intent of the Strategy, to which we can then contribute both in the short and longer term.

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| **350** | Submitter name | Jane Cumming |
| Submitter organisation | NZ Committee of RANZCOG |

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| This submission was completed by: *(name)* | Jane Cumming for the NZ Committee of RANZCOG |
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| Organisation (if applicable): | NZ Committee of RANZCOG |
| Position (if applicable): | Executive Officer |

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

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

X 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

X 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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| RANZCOG NZ agrees with the global challenges as detailed in Part I: Future Direction. Emphasis should also be on the following:  Challenge: tackling obesity, smoking and drug dependence, mental health. Strategies may in some cases need to be underpinned with legislation.  Challenge: equitable access to reproductive and sexual health education and family planning services. Education and family planning services, particularly long acting reversible contraception, should be a priority.  Challenge: improving immunisation rates. A benefit of a focussed health strategy should ensure better uptake of immunisation services. There is currently a low uptake of the Gardasil vaccine in NZ.  Challenge: education and health literacy, early intervention. |

### The future we want

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

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

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

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| The statement does capture a positive future for the health system. Written at the highest level, it is good to see that the refreshed guiding principles cover access issues, the special relationship afforded between Maori and the Crown under the Treaty of Waitangi and the benefits of collaboration |

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 the principles do capture most of the important considerations.  To support the commitment to the Treaty, we urge that emphasis be put on the need for cultural competency within the health workforce.  Also, in service terms, to acknowledge the cultural needs of Maori, Pacific and other ethnicities within the health sector environment and to make a commitment to responding and adapting to those needs.  At number 6 we suggest that the reference to a “high performing system” be expanded to note the vital contribution that strong clinical leadership brings to such a system.  Further, when “thinking beyond narrow definitions of health…” that the health effects of climate change be included at number 8. |

### Five strategic themes

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

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

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| --- |
| 1. People-powered theme. We agree with the concepts covered in this section. We particularly note the importance of resourcing DHBs to safely implement digital developments. The introduction of the Maternity Clinical Information System has recently faltered due to inadequate resourcing and testing however RANZCOG NZ believes that ultimately this, and other technical developments, will be empowering to the public and to health professionals.  2. Closer to Home theme. In order to bring care closer to where people live there needs to be some lateral thinking. The suggestion that community settings be utilised is a practical one. RANZCOG NZ has a particular interest in broadening public access to high quality, affordable Family Planning services, allowing individuals / families to plan pregnancies at optimum time.  In order to rely more solidly on primary care for women’s health, GPs need to be more thoroughly trained in women’s health at medical school and then supported.  At some specialised levels there are enormous challenges in bringing care closer to home. In our field, Maternal Fetal Medicine and Gynae-oncology services are particularly vulnerable.  A supported health workforce is fundamental to ensure retention. Thoughtful approaches to training schemes and to the development of workable systems and models of care will assist in the recruitment and retention of NZ-trained medical graduates. In order to provide high-quality care as close to home as possible NZ trained doctors could be incentivised to work in disadvantaged and rural communities.  One of our objectives is to encourage all pregnant women to book early with maternity providers. Accessible services (i.e. close to home) are an important consideration for many women, particularly those in disadvantaged circumstances.  3. Value and high performance theme.  RANZCOG NZ strongly supports the theme. The Triple Aim framework is a useful one.  In the maternity sector, we have made significant progress in recent years through the Maternity Quality and Safety Programme and the National Maternity Monitoring Group.  It is vital to invest in research – funding, disseminating information and implementation. We agree that we need to get better and faster at sharing the best new ideas and that more funding is required for translation of international research.  4. One team theme – again, RANZCOG NZ supports the thinking behind the theme. Certainly the encouragement of collaborative models and the development of genuine clinical leadership are fundamental.  NZ needs a sustainable workforce whose size and skills match New Zealand’s needs and geography and we support any developments in this area that will provide a more cohesive plan.  In order for the Ministry of Health to provide the type of leadership required in the women’s health area, there needs to be some dedicated resource within the Ministry.  We see great potential in an integrated approach to health services that combine different services under one roof; for example, provision of Well Child / Tamariki Ora checks at the same location as ultrasound scans and family planning services.  Health Auckland Together project and future projects need evaluation to determine efficacy.  5. Smart System – RANZCOG NZ note the importance of including consideration for pregnant women who have multiple health needs.  We note the importance of equitable access and consistency when updating technology to ensure there is no disadvantage to some areas. |

### 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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| RANZCOG NZ agrees with all of the proposed actions but we do particularly and strongly support the following:  Action 1: RANZCOG NZ supports the use of digital technology to support self- management of health – in our case, we need to address the issues with the Maternity Information System and introduce appropriate digital resources to further the aim of an integrated health record for pregnant women and children (d. ii.).  Action 4: a. One of our priorities is to widen access to contraception. We supported the recent proposal to reclassify certain Combined Oral Contraceptives (COCs) to allow appropriately trained pharmacists working in suitable premises to make repeat prescriptions.  b. Although it is not desirable to rely totally on telehealth for servicing rural/remote communities, we support the development of telehealth approaches as part of a comprehensive health plan that takes into account cultural needs and different population needs.  Action 5 :  a. RANZCOG NZ endorses increased support to pregnant and postnatal women experiencing mental health and alcohol and other drug conditions. An integrated, multidisciplinary approach is important.  b. RANZCOG NZ strongly endorses promotion of healthy nutrition and activity for pregnant women and children to reduce the prevalence of childhood and adult obesity.  Implementation of the Gestational Diabetes Mellitus (GDM) guidelines will not be successful if left to chance. Direction needs to be provided to allow DHBs to address the issue of obesity in pregnancy and GDM in order to achieve national consistency and improved outcomes for mothers and babies.  Action 6: “A great start for children, families & whānau”.  Having the view that all women should have control over their fertility i.e. equitable access to contraception, RANZCOG NZ is fully supportive of the proposed actions with a particular interest in the first three.  With regard to maternity we reiterate the need for women to have  • access to information  • equitable and timely access to maternity providers  • support for early bookings  • informed consent about their antenatal, intrapartum and postnatal options  • equitable access to the seamless, collaborative care provided by NZ maternity providers. This seamless, collaborative care is underpinned by such things as the MQSP and NMMG.  To further improve outcomes for mothers and babies, national support is required to fund programmes such as GROW which reduce potentially avoidable stillbirth.  With regard to children, RANZCOG NZ supports the reinstatement of healthy food choices in schools accompanied by targeted education programmes for families.  Action 6.e.ii. Consider introducing a year 12 health check for children with screening for general health, mental health and sexual 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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| For MoH to have ongoing engagement with all its stakeholders to ensure the best outcome for communities.  For there to be an assessment of what drives inequities. A logical, structured approach that takes into account education, transport, health workforce capability and availability and capacity.  For there to be evaluation of existing projects e.g. Health Auckland Together and future projects to determine efficacy. |

### Any other matters

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

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| RANZCOG NZ strongly recommends that a dedicated Women’s Health resource be set up in the Ministry of Health.  RANZCOG NZ supports the operation of a national model for the delivery of specialised services such as gynae-oncology and Maternal Fetal Medicine (MFM)  RANZCOG NZ agrees that, in order to provide equitable access to high-quality, affordable healthcare, strong support must be provided to primary healthcare workers and imagination applied to the service models they work to.  To give equal importance to the protection of the people in communities and the health workers who service them, the Roadmap of Actions needs to be fully supported by a sustainable health workforce.  We recommend that the Family Planning clinic model be resourced to allow for broader geographical coverage. |

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| **351** | Submitter name | [redacted] |
| Submitter organisation | The Royal Australian and New Zealand College of Radiologists |



## 4 December 2015

## New Zealand Health Strategy Update Consultation New Zealand Health Strategy Team Ministry of Health PO Box 5013 Wellington 6145 [nzhs\_strategy@moh.govt.nz](mailto:nzhs_strategy@moh.govt.nz)

**New Zealand Health Strategy Consultation Submission**

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

The Royal Australian and New Zealand College of Radiologists (RANZCR) is the peak body advancing patient care and quality standards in the clinical radiology and radiation oncology sectors. It represents over 3,500 members in Australia and New Zealand.

RANZCR’s role is to drive the appropriate, proper and safe use of radiological and radiation oncological medical services. This includes supporting the training, assessment and accreditation of trainees; the maintenance of quality and standards in both specialties, and workforce mapping to ensure we have the staff to support the sectors in the future.

**Structure of RANZCR**

RANZCR consists of two faculties, each representing a different speciality.

The Faculty of Clinical Radiology is the bi-national body for setting, promoting and continuously improving the standards of training and practice in diagnostic and interventional radiology for the betterment of the people of Australia and New Zealand.

Clinical radiology relates to the diagnosis or treatment of a patient through the use of medical imaging. Diagnostic imaging uses plain X-ray radiology, computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound and nuclear medicine imaging techniques to obtain images that are interpreted to aid in the diagnosis of disease. In addition to their diagnostic role, clinical radiologists also provide treatments and use imaging equipment in an interventional capacity.

The Faculty of Radiation Oncology is the peak bi-national body advancing patient care and the specialty of radiation oncology through setting of quality standards, producing excellent radiation oncology specialists, and driving research, innovation and collaboration in the treatment of cancer.

Radiation oncology is a medical specialty that involves the controlled use of radiation to treat cancer either for cure, or to reduce pain and other symptoms caused by cancer. Radiation therapy can be used to treat almost all cancers, anywhere in the body.

RANZCR has responded to the questions asked and included some general comments under question seven.

### *Challenges and Opportunities*

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

RANZCR agrees with the strengths in the New Zealand system that have been outlined in Future Direction.

RANZCR also agrees with the challenges outlined including the ageing population, increasing prevalence and complexity of chronic disease, unequal outcomes for Maori and Pacific peoples, ensuring children can access the care they need and financial sustainability of the system.

***Tackling Chronic Disease***

Regarding chronic disease and clinical radiology, better and more consistent electronic connectivity between primary care, radiology practices and secondary care would:

* allow electronic DI referral leading to timely, consistent and accurate information flows;
* provide more information to clinical radiologists to determine the most appropriate DI modality and protocolling of the examination; and
* facilitate linkages that allow primary care clinicians and others to view diagnostic images in the picture archive computer systems (PACS) of radiology practices.

These advances would in turn improve management and treatment options for people with complex and chronic conditions.

***Cancer and underutilisation of radiation therapy***

Cancer is the single biggest cause of death in New Zealand[[1]](#footnote-1). The overall optimal radiation therapy utilisation rate for all cancer patients, based upon the best available evidence is 48.3%[[2]](#footnote-2). This means that one in two people diagnosed with cancer would benefit from radiation therapy at some point in their cancer journey. Those patients who miss out on clinically appropriate radiation therapy treatment can be adversely affected. The consequences can include compromised health outcomes, inadequate symptom control, reduced quality of life, increased suffering and premature death. Current utilisation of radiation therapy in New Zealand is at a national intervention rate of 37.4% (with a range by District Health Board of 27–45%).

Continued investment in the radiation oncology sector is essential to meet increasing demand, ensure patient access regardless of geographical location or financial means, and work towards the optimal utilisation rate of radiation therapy (approximately one in two cancer patients).

Given the ageing population in New Zealand, it is disappointing that cancer and palliative care do not feature more prominently in the draft Health Strategy.

RANZCR supports the use of clinical pathways and guidelines to guide the management of complex and chronic diseases, including cancer.

***Workforce***

RANZCR monitors closely trends in the clinical radiology and radiation oncology workforce through periodic censuses. They have revealed some interesting trends that could impact on the New Zealand workforce.

***Radiation Oncology***

According to the Association of Salaried Medical Specialists in New Zealand International Medical Graduates (IMGs) comprises a high proportion of the New Zealand workforce. In year 2012/2013 IMGs made up of 49% of all specialist registrations and 56% of new specialist registrations. This was evidenced in the RANZCR radiation oncology workforce census 2014, as 16%. Furthermore, the 2014 census reveals, one half of the radiation oncologist are in their retirement age within next 15 years and further analysis indicate that there is a gradual decrease in their practising hours in next three years. This could create a potential shortage of radiation oncologists in New Zealand in near future.

***Clinical Radiology***

The New Zealand clinical radiologist workforce has seen growth of 11% from 2000 to 2014 (221 to 376), accumulating 84 radiologists per million population. However, this is still less than the average for OECD countries of 100 radiologists per million[[3]](#footnote-3).

The clinical radiology workforce is also reliant on IMGs, who constitute 30–40% of the workforce and the larger proportion of IMG’s are in their mid-career and approaching retirement in next 15 years. Furthermore, the average age of an active radiologist is around 50 years, slightly older than reported by the Medical Council New Zealand in 2011 (47.0). 30.4% of active radiologists are aged over 55 years. There is likely to be a considerable ageing of the New Zealand workforce over the next 10 – 15 years.

Female radiologists comprise one third of the workforce, and this figure is projected to increase since 46.8% of current New Zealand radiology trainees are female. Furthermore, there is a significant difference in ages between genders, with male radiologists older than their female colleagues. The reported average age of males and females were around 51 and 48 respectively[[4]](#footnote-4).

In summary, clinical radiology and radiation oncology share several of the workforce challenges outlined in Future Directions and would wish to be involved in strategies to address these concerns.

Both disciplines have a lot to offer in terms of addressing them and improving outcomes across the healthcare system, something which not be overlooked when determining the final composition of the NZ Health Strategy and how it will be implemented.

### *The Future We Want*

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

***Response***

Yes. RANZCR feels that it does. The statement above encompasses equity; the importance of socio-economic and lifestyle factors in determining health outcomes; choice and accessible community services; value for money, safety underpinned by high professional and practice standards; and collaboration supported by regular and structured communications.

RANZCR believes that clinical radiology services already encompass much of this vision with: very good and generally equitable access to hospital and community-based medicine; a team environment involving clinical radiologists, allied health professionals and nurses; information sharing across clinical boundaries; innovative, high technology and valuable services which support clinical decision-making across the healthcare system.

However, there is still room for improvement in cancer care in New Zealand – given the inequalities in cancer survival between ethnic and socioeconomic groups, and the unacceptably large survival gaps between Māori and non-Māori for some cancers[[5]](#footnote-5). Also, despite similar health care systems and health professional training programs in New Zealand and Australia, research has shown that New Zealanders with cancer die from the disease sooner than cancer patients in Australia, particularly in cases of liver, lung and ovarian cancer[[6]](#footnote-6).

RANZCR would also like to see more consistency in funding between District Health Boards, especially for radiation oncology – so as to not exacerbate the problem of underutilisation.

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***

RANZCR agrees that there are many advantages in the New Zealand health system, and much to be proud of, evidenced by international comparisons. RANZCR welcomes the perspective and foresight to review specific challenges, opportunities and to plan ahead to ensure that the New Zealand health system continues to function effectively and support the health and wellness of New Zealanders.

RANZCR agrees with the principles which have been listed on page 9 of ‘Future Direction’. Although by definition these principles are high level, we would like to see an explicit commitment to:

* supporting the ageing population and especially individuals with chronic illnesses, and
* using technology wherever possible to improve and foster communications and information sharing between clinicians and patients to assist in coordinating and managing health care.

Whilst these could be argued to be implicit or covered in the details contained within the five strategic themes, RANZCR sees value in bringing these points out more clearly in the guiding principles.

### *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?*

***Response***

Yes. RANZCR is pleased with the approach of five inter-related strategic themes which reflects the complexity of delivery of health care services and demonstrates the need for balance both at individual and population levels.

RANZCR agrees that the vision for ten years’ time provides enough clarity and an ambitious plan to work towards.

Clinical radiology already encompasses many of these themes in that patients have significant input into the decision to have diagnostic imaging, they have a choice of where to attend for services in most areas across the country, services are provided both in hospitals and at accessible locations in the community,

RANZCR strongly agrees that patients would benefit from more information about clinical radiology and their care. RANZCR has a range of resources designed for this purpose, including Inside Radiology and Choosing Wisely recommendations and we would be pleased to discuss greater dissemination and awareness of them in New Zealand. RANZCR is already involved as a founding partner of Choosing Wisely New Zealand.

Similarly, referring clinicians would benefit from the Choosing Wisely recommendations, RANZCR Education Modules and guidelines about appropriate use of diagnostic imaging. RANZCR sees a central role for imaging guidelines to support referring clinicians and consumers in determining when diagnostic imaging is indicated and appropriate. RANZCR has embarked on a plan to adopt imaging guidelines for use in Australia and New Zealand and looks forward to discussing this with key decision makers in New Zealand.

In terms of value and high performance, we wish to reiterate the importance of reaching the optimal utilisation rate[[7]](#footnote-7) (i.e. approximately one in two cancer patients) for radiation therapy. Radiation therapy's contribution to the fight against cancer is significant – it has been estimated to be involved in 40% of all cancer cures, compared to 49% of patients being cured by surgery and 11% through systemic treatments[[8]](#footnote-8).

Despite the fact that radiation therapy represents high value patient care, it remains underutilised in New Zealand. The reasons for this underutilisation are a complex mix of lack of awareness, physical access to a treatment centre, and patients not being provided with comprehensive information about all possible treatment options.

In an effort to raise awareness and demystify radiation oncology (amongst referrers and consumers alike), as well as inform consumers about their treatment options, the RANZCR Faculty of Radiation Oncology established the Radiation Oncology: Targeting Cancer campaign in 2013 – which includes a website (<http://www.targetingcancer.co.nz/>) containing general and tumour-site specific information on cancer, and radiation therapy as a treatment option.

Patients, carers and families need to be empowered through the provision of current, relevant and evidence-based information about all potential cancer treatment options – developed in collaboration with all cancer professional groups. For example, a patient diagnosed with prostate cancer should have a discussion with an urologist about surgical treatment options, as well as a discussion with a radiation oncologist about radiation therapy, prior to deciding which treatment pathway to follow. All too often though, the option of radiation therapy is not mentioned at all, or not explored in sufficient detail. In the case of prostate cancer, this has been shown to lead to decisional regret in some cases[[9]](#footnote-9).

All of these themes require the support of clear and structured communication channels to share information across the healthcare system. As noted above in response to Question 1, there is a range of benefits from better and more consistent sharing of information between primary care, clinical radiology and secondary care. RANZCR supports use of eReferral, electronic health records and systemised access to diagnostic imaging results. Due to the advanced IT structures already in place, we feel that clinical radiology is very well placed to participate in pilots on how a smart system might support the New Zealand health system. A smart system will require targeted investment strategies from the Government to make it a reality.

Also noted in Question 1, RANZCR supports the use of clinical pathways and guidelines to guide the management of complex and chronic diseases, including cancer.

### *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?*

***Response***

RANZCR agrees that the chosen action areas looks considered and appropriate to their specific strategic themes.

We do not have any suggestions for additional actions, however we would wish to meet with the Ministry of Health to discuss in more detail how clinical radiology and radiation oncology can be involved in the implementation of the Roadmap.

### *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?*

***Response***

RANZCR agrees with the proposed actions and the commitment to annual review. This is an ambitious plan and will need to be appropriately resourced.

As a general comment, RANZCR would like to see clearer commitments to co-producing (‘co-creating’) the implementation plan with patients and health care practitioners and targeted stakeholder engagement. We would wish to see this commitment more clearly outlined in the actions noted which would greatly complement the engagements between agencies outlined in the implementation plan.

### *Any other matters*

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

In summary, clinical radiology provides essential medical services that support decision making across the healthcare system when diagnosing a patient or monitoring their condition and provide treatments via a range of image-guided interventions. The practice of modern medicine is heavily reliant on clinical radiology to improve patient outcomes.

About one in two cancer patients would benefit from radiation therapy, yet the actual utilisation rate in New Zealand is closer to one in three – which means that thousands of cancer patients are currently missing out on potentially beneficial treatment. Given cancer is the single biggest cause of death in New Zealand, ongoing investment in radiation therapy facilities, equipment and the multidisciplinary workforce must remain a national health priority.

**RANZCR would wish to be involved in any discussions about changes to the healthcare system in order to input from the perspectives of clinical radiology and radiation oncology. We would be pleased to meet with you to discuss any of the points raised above in more detail. We look forward to supporting the new strategy.**

Yours sincerely

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| [redacted] | [redacted] |
| Chairperson New Zealand Branch | Chair Radiation Oncology Executive |

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| **352** | Submitter name | [redacted] |
| Submitter organisation | The Royal Australasian College of Physicians |

11 December 2015

Mr Chai Chuah

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

WELLINGTON

Dear Chai

**RACP’s Submission on the proposed New Zealand Health Strategy; *All New Zealanders live well, stay well, get well***

Thank you for the opportunity to contribute to the refresh of the New Zealand Health Strategy; *All New Zealanders live well, stay well, get well*. The Royal Australasian College of Physicians (RACP) congratulates the Ministry of Health (the Ministry) on the draft update of the Strategy and believes the refresh is timely in view of potential issues and opportunities facing the health system.

The RACP trains, educates and advocates on behalf of more than 15,000 physicians – often referred to as medical specialists – and 7,500 trainees across Australia and New Zealand. It represents more than 32 medical specialties including paediatrics and child health, cardiology, respiratory medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of New Zealanders.

**RACP contribution to the New Zealand Health Sector**

The RACP acknowledges progress against the current health strategy during the last 15 years, and notes advances in information technology and clinical approaches to care are significantly improving delivery and quality of clinical practice. Access to better clinical data provided quality information to understand health issues and experiences faced by patients and populations. This information base supports physicians to work in teams that span non-traditional boundaries covering the breadth of the health system, particularly in integrated care initiatives where they are working across primary, secondary and community jurisdictions.

RACP physicians are at the front-line of health services and in a position to comment on increasing pressures within the health system. They are in a position to directly observe the health outcomes of the impact and consequences of societal factors and environmental issues faced by growing urban populations, isolated communities and diverse ethnicities.

Physicians advise that the impacts of complex, long term conditions such as diabetes, currently largely among older people, will be compounded due to increasing numbers of children and young people presenting with obesity. They warn that this situation poses a significant immediate and long term risk to the ability of the health workforce to respond to these emerging health needs, and that it will ultimately impact on the sustainability of health services, and ability to access care needed.

The focus of the RACP submission is on what it can contribute to the New Zealand Health Strategy, *All New Zealanders live well, stay well, get well*, into actions. This submission was developed with input from RACP Divisions, Faculties and Chapters.

Yours sincerely

[redacted]

New Zealand President

**The Royal Australasian College of Physicians**

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

Physicians have an important role in keeping people out of hospitals and providing care closer to home, and the RACP welcomes the opportunity to continue working with the Ministry to help it achieve the goals of the NZ Health Strategy.

The RACP notes increasing healthcare costs are a feature of the current health landscape, adding pressure across primary and secondary care systems, and resulting in unmet need in some patients and populations.

The RACP supports approaches that improve cultural competence, develop workforce specialisation, and increase value through waste reduction and efficiency. It is committed to working with others to produce health gains, and reduce inequalities, particularly for children, Māori and Pacific people, while also maintaining health of the population. The RACP’s own investment strategy provides an indication of the contribution that it is already providing value.

The RACP’s work programme has six key priorities for action that can contribute to the Ministry’s proposed Strategy (These priorities align with the Ministry’s Roadmap of Actions):

1. I**nvesting in children’s health**

E.g. a *College-wide initiative to reduce the impact of obesity, with a particular focus on children*.

The RACP is making a significant investment in children’s health due to concerns raised by RACP New Zealand committees about the growing incidence and impact of obesity in New Zealand. This has led to an agreement to participate in a College-wide collaboration with each committee identifying how they will influence and act on causes to reduce the impact of obesity.

The New Zealand Policy and Advocacy Committee agreed to extend the obesity initiative to its Australian colleagues, and consequently will lead trans-Tasman collaboration with RACP Adult Medicine and Paediatrician physicians working across Australasia to reduce the impact of obesity. Each Committee has agreed to identify their own contribution and take into account current evidence, best practice and engaging in integrated initiatives, such as *Healthy Auckland Together*.

In early 2016 the College will develop a strategy to ensure actions by committees are captured to identify the value and impact of their contributions and interventions.

The RACP notes the Government’s review of long term causes, consequences, and interventions that impact on obesity and supports moves to community-based initiatives focusing on “healthy lifestyles”, and activities such exercise and “healthy decision-making”[[10]](#footnote-10).

Why RACP is concerned about obesity:

* Childhood obesity in New Zealand has increased by almost 30% in 6 years, from 8% in 2006/07 to 11% in 2012/13. The long term view for future populations is not promising and physicians are concerned about the impact of high body mass index (BMI), including obesity, projected to overtake smoking as the leading risk to health of New Zealanders by 2016[[11]](#footnote-11).
* New Zealand has the third highest rate of adult obesity in the OECD[[12]](#footnote-12), with Pacific peoples[[13]](#footnote-13), Māori, and people living in deprived areas showing a higher prevalence of obesity-related diseases. The RACP believes that organised and systematic collective efforts involving contributions from all relevant sectors, families, communities and health professional and research organisations is the only way forward, and that progress is measured against relevant measures that reflect best practice.
* Paediatricians are frustrated with lost opportunities to influence children, mothers, parents and families, and increasingly they are dealing with cases where children are admitted to secondary care with serious health issues related to poor nutrition. They believe more could be done to connect with children between the ages of 2 – 14 to reduce long term effects of overweight and obesity[[14]](#footnote-14).
* Paediatricians identify an additional lost opportunity to educate parents about nutrition and physical exercise in the years between two and five. There is no formal contact after the Wellchild Check until the B4 School Check, which only provides an assessment of school readiness against targets[[15]](#footnote-15). RACP paediatricians believe that every health visit provides an opportunity to, “weigh every child, every time”. This would provide essential base-line data which would be used to predict obesity and connect to support or early interventions.
* Adult medicine physicians also report significant morbidities and increasingly complex co-morbidity associated with consequences of obesity, and note the increasing costs of care for the health system. The increasing burden of ill health for patients with obesity-related illness is worse for Māori and Pacific populations, and there are additional pressures due to greater demand on specialist services, which is reducing access to services and technologies.
* The RACP notes that the impact of obesity will have a direct impact on the ability to provide health services and medical care. In 2006 additional health care costs attributable to overweight and obesity were estimated at NZ$686m or 4.5% of New Zealand's total health care expenditure. Ten years later it is estimated that the combined costs of health care and lost productivity is closer to $1bn[[16]](#footnote-16).
* Obesity is the main preventable cause of type 2 diabetes, and linked to other co-morbidities such as cardiovascular disease and hypertension.
* The RACP believes that more attention could be given to cultural competency, health literacy and connecting mothers, children, young people and adults to services that provide them with opportunities to learn about the benefits of good nutrition and physical activity.
* The World Health Organization (WHO)’s – *Interim Report of the Commission on Ending Childhood Obesity[[17]](#footnote-17)*, identified the lack of a comprehensive national action plan, and funding to address unhealthy food as a major policy gap in New Zealand. The report has 34 recommendations, and seven of these are identified as a high priority. Relevant targets are for: reducing childhood obesity, reducing salt, sugar and fat intake, and reviewing food consumption.
* The RACP is working to raise awareness of common goals and believes agreed targets will further influence action to reduce obesity, and measure, the impact of obesity initiatives throughout New Zealand.

During 2015, the Minister of Health, Hon Dr Jonathan Coleman, invited RACP to discuss its obesity initiative and delegated you to continue to engage with RACP on this issue. Subsequently, Dr Pat Tuohy has met with RACP’s Paediatric and Child Health Division Committee to discuss how to work together most effectively, and how it can add value to the MOH workplan. The RACP will continue to inform the Minister and MOH about progress with the initiative.

1. **Reducing inequalities in health**

E.g. *A Call for a New Zealand Rehabilitation Strategy[[18]](#footnote-18).*

The RACP supports the *Call for a New Zealand Rehabilitation Strategy* jointly issued by its Australasian Faculty of Rehabilitation Medicine (AFRM), and the New Zealand Rehabilitation Association (NZRA).

The *Call for a New Zealand Rehabilitation Strategy* was informed by international evidence, best practice and collaboration within the rehabilitation sector. It contains guidance for a nationally consistent strategy to improve equity and patient outcomes.

A national rehabilitation strategy will provide the framework for a collaborative and integrated approach by health and rehabilitation sectors to improve access to rehabilitation services, in order to function at optimum ability. Integrated care and health teams are at the centre of this approach.

RACP is supporting the development of a national Rehabilitation Strategy for the following reasons:

* RACP supports care that is closer to home and returns people to their own home, rather than an institutional care facility. Investment in a nationally coordinated approach to New Zealand’s rehabilitation infrastructure and workforce could significantly improve access to rehabilitation services, ensure efficiency of limited resources, and be beneficial for patients, their whānau and New Zealand.
* There have been significant advances in physical and medical rehabilitation treatments and in evidence-based, best practice models of care which increase opportunities to restore independence and/or improve function for those who have acute and chronic disabilities due to aging, illness or injury.
* Growing evidence supports the cost benefits of early access to rehabilitation and supported discharge to home with reduced lengths of stay, fewer re-admissions to hospital and successful return to work and life roles. Rehabilitation through community based rehabilitation teams (home-based interdisciplinary rehabilitation services), hospital rehabilitation services, any early discharge programmes have shown strong societal and financial benefits.

A New Zealand Rehabilitation Strategy would guide policy and service development, to enhance the health and wellbeing of New Zealanders who experience disability from aging, illness or injury.

*Next steps*

* Convene cross government collaboration, including the Ministry of Health, Ministry of Social Development, Ministry of Education, Accident Compensation Corporation, and The Treasury to progress a national rehabilitation strategy. This will ensure a comprehensive and equitable approach to provision of skilled rehabilitation and rehabilitation services for all New Zealanders with disability regardless of their age or the cause of their disability.
* Involve key stakeholders in the provision of health and social services, leaders in Māori health affairs, people who use health and disability services, rehabilitation medicine specialists and providers of rehabilitation services, in the development of a national rehabilitation strategy. This will result in a patient centred and all-inclusive rehabilitation strategy which will ensure the best rehabilitation opportunities for New Zealanders with disability and one which will meet the WHO expectations for member states.
* Operationalise policies within national and local action that is audited and evaluated for patient and societal outcomes, government impact and cost benefits will ensure resources are well managed and patient outcomes optimised.

Development of the *‘Call’* was a collaborative effort involving the rehabilitation sector in New Zealand. Following the launch of the document in October 2015 there has been a positive response by those stakeholders to continue their involvement toward building a national strategy.

In support of efforts to provide skilled rehabilitation care that is closer to home, the RACP is keen to meet with the Ministry to discuss the work by its Faculty of Rehabilitation Medicine (AFRM) and to assist with the development of a *New Zealand Rehabilitation Strategy*.

The RACP is would like to meet with the MOH during the next phase of development with a preliminary meeting between the Chair of RACP AFRM and the Director General Health.

1. **Preventing illness through clinical integration**

E.g. *An investigation into successful approaches to integrating care and enablers to support physicians withe effective clinical integration*.

New Zealand is recognised as being at the forefront of integrated care, and early successes have provided important lessons. The RACP’s Integrated Care Working Party is undertaking its own investigation to understand more about barriers and enablers so it can provide guidance to physicians about how to work effectively in integrated care settings. Case studies will be undertaken to review success factors in specialty areas, e.g. diabetes care.

The RACP’s Integrated Care Working Party is working to understand the elements of integrated care needed to support clinical integration and teamwork. Outcomes of the work will inform collaborative approaches to person centred care, and where appropriate, recommend improvements to teaching, training, and continuing professional development, and equip physicians to integrate care. The investigation will identify any documents, models, and materials needed to support physicians, in particular:

* Develop a policy and position statement on Integrated Care and its key drivers, enablers and Barriers
* Develop case studies, detailing how Integrated Care might work in the context of aged care and/or a chronic disease issue such as diabetes, and highlighting the potential benefits to clients, clinicians, and the overall health system.
* Investigate and recommend new models of care and funding options which would promote and support the delivery of Integrated Care.
* Identify models that would enable the provision of specialist services in primary and community based settings, and mechanisms which would appropriately reward the time and work required to deliver and support Integrated Care.
* Identify where improved electronic health records could provide better information flows across the health system.
* Identify where the increased use of telehealth and other technologies could support Integrated Care.
* Investigate potential modifications to the training curricula which would better equip physicians to engage with and provide Integrated Care.
* How to foster and lead cross-professional collaboration to model effective multidisciplinary relationships in the health sector.

The RACP would be keen to connect with the Ministry about outcomes of its investigation into integrated care.

1. **Improving Māori and Pacific health through cultural competence**

e.g. *Improving the health of indigenous populations through cultural competence*

The RACP’s Māori Health Committee is leading work within the RACP, and working with the RACP’s Aboriginal and Torres Strait Islander Health Committee and RACP Pacific Working Group, to improve understanding and approaches to Cultural Competence, and how that might address health issues faced by indigenous populations.

The Māori Health Committee is advocating for:

***A high quality Cultural Competency Resource Site for New Zealand Healthcare Professionals***

The RACP Māori Health Committee is of the view that for New Zealand’s health system to be people-powered healthcare professionals must be able to recognise and respond to the role that culture plays in interactions with patients. They believe that there is significant potential for New Zealand healthcare professionals to improve cultural competency skills and thereby improve clinical outcomes.

The RACP is one of many medical and surgical colleges in Australasia seeking to improve cultural competency among its members and its trainees. The RACP’s Māori Health Committee would like to see the Ministry take the lead in the development of New Zealand resources for healthcare professionals in this area.

RACP supports its Māori Health Committee in advocating for a:

* A *single high quality resource site*, with contributions from Colleges, institutions and professional bodies, is preferable to many health organisations attempting to develop resources individually. New resources could be added to the site at regular intervals so that any healthcare professional can use it to continually improve cultural competency throughout his or her career.

The RACP’s Māori Health Committee has experience and expertise and wishes to contribute lessons and ideas about how a cultural competency site could be a successful addition to healthcare resources in New Zealand. It would be happy to discuss these ideas with the Ministry of Health.

1. **Building a sustainable specialist workforce** - e.g. *Physicians and Paediatricians Practising in Isolation – A discussion paper[[19]](#footnote-19)*.

The specialist workforce in New Zealand is not large and many specialties have small numbers of actively practising physicians and paediatricians. The challenges many NZ specialists have relating to their professional or geographical isolation is the subject of the recently launched discussion paper, *Physicians and Paediatricians Practising in Isolation – A discussion paper.*

For a variety of reasons physicians working in isolation find it difficult to maintain their skills and engage in relevant continuing professional development (CPD) activities. Physicians and paediatricians working alone in a specific speciality or in a rural setting may also find it difficult to engage in CPD activities.

* At the heart of the Health Practitioners Competence Assurance Act 2003 is the view that a competent practitioner is one who engages in CPD. The link between CPD and competence is also reinforced by the Medical Council of New Zealand’s requirement that all registered health practitioners participate in a recognised recertification programme. The RACP notes that is the joint responsibility of employers and the physicians to ensure that work commitments and environmental factors do not constrain the practitioner’s ability to engage in appropriate CPD and peer review activities.
* Obstacles may include limited availability of appropriate staff to back-fill positions whilst attending workshops or courses, and significant travel requirements to attend speciality-relevant CPD activities in major centres. Some regional or tertiary services do not provide or group structured CPD activities into half or full day sessions that rural physicians could attend.
* The RACP believes more could be done to support local CPD activities, such as generic hospital-based activities, relevant CME (Continuing Medical Education) focusing on professional qualities, access to online learning and teleconferencing facilities to support CPD and peer review needs of isolated physicians, and reduce the need for travel or leave, the implementation of multidisciplinary case teleconferences such as those via the regional cancer networks.

The RACP considers that it is essential to continue to work with health sector organisations to find ways to meet the needs of Physicians and Paediatricians practising in isolation to ensure continuation of a high quality physician workforce.

1. **Enhancing value and reducing waste and inefficiency in healthcare** - e.g. *EVOLVE[[20]](#footnote-20)*

RACP EVOLVE reflects a commitment to a high quality, safe and sustainable health care system. It is an initiative by RACP to work collaboratively with its Specialist Medical Societies, and each identifying their top five low value interventions. This initiative aligns with the international *Choosing Wisely Campaign*, but the RACP’s focus is on a professionally-led approach to identifying evidence based practice improvements to produce greater effectiveness and efficient use of resources.

* The intent is that each medical specialty identifies the clinical circumstances in which some of their practices, whether they are medical tests, procedures and interventions, should have their indications or value questioned and discussed by physicians. These practices may be overused, inappropriate or of limited effectiveness in a given clinical context.
* Working in partnership with Specialty Societies, the initiative aims to create a list of the top 5 ‘low value' practices used in commonly encountered clinical scenarios which are within the area of expertise of each of the RACP's specialties (The lists will be published on the RACP’s website). Across all its specialties this will produce benefits to patients, services and the health system.
* International experience stresses the importance of this work being led by the medical profession1. International evidence such as JAMA Internal Medicine highlight that transparent methods are fundamental when looking to identify interventions, procedures, tests and treatments "*that cause potential harm or provide little benefit to patients, are frequently misused in clinical practice, are measurable, and are under the control of the providers"*2.

Based on the final lists, the RACP will work with the medical profession, health sector, and community, to develop and promote recommended changes in clinical practices. The RACP would be interested in engaging in a discussion with the Ministry about the EVOLVE initiative, and is supporting the NZ Council of Medical Colleges’ initiative to identify how New Zealand Colleges can support the National Health Committee *Choosing Wisely* initiative.

**The future we want**

**Five strategic themes**

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

* The RACP supports ‘people-centred’ as a philosophy. People-powered indicates an inequity, power imbalance or unequal relationship between those providing services and those using services. This goes against the concept of people/patients being part of the health team, and therefore, part of the solution. This approach may result in unintended power relationships. For example, health system and services engagement in community-based interventions to work with at-risk populations, won’t work unless people are fully engaged. Having a people-powered workforce approaching at risk communities is a frightening concept; however, approaching it from a ‘people-centred’ method and working with communities to learn about the strengths and resources that exist within families and communities, might provide better results for all.

1. **Closer to home**

* To change the way the health system provide services and engages people who use services, the RACP believes radical and systematic investment and changes are needed to support the *Closer to Home* strategy. The RACP acknowledges the collaborative work in District Health Boards (DHBs) to establish integrated care initiatives, and believes that they are leading the way to develop new approaches, with reports of good relationships and processes forming as people learn to work across a system. Continued success will be dependent on those who work in the health system being supported to foster new working relationships and resources to enable joined up solutions. A review of DHB funding, policy and planning systems to identify and reduce barriers, and understand enablers is essential. Physicians report more investment is needed in IT platforms, to support integrated patient management, new technologies, and communication tools, and improved clinical learning opportunities to enable teams to learn about tools for quality improvement, safety, and management of care together.
* Care that is provided closer to home will require health teams to coordinate care across non-traditional boundaries such as primary, secondary, tertiary, community and private providers. Physicians are concerned about lack of clarity by the Ministry and DHBs about scopes of practice to ensure the skills of each professional group are recognized and supported in contracting and professional development processes. The RACP’s view is that it is better to build and strengthen the base rather than create new professional groups, as it causes additional pressures within the system, particularly for those expected to provide mentoring and supervision outside scope. RACP notes that Health Workforce NZ is working closely with the Council of Medical Colleges, but this is an area for development and will require significant modelling and support by government to connect funding through integrated contracting processes. RACP physicians also report that there is an issue for some DHBs who don’t have the resources to develop capacity and capability to support health professionals to work across systems.
* The RACP notes that in some DHBs integrated care initiatives, such as Healthy Auckland Together, have enabled adult medicine physicians and paediatricians to work across systems including within the primary care space. This approach is a more efficient use of their expertise and enables specialist care to be provided closer to home. The outcomes of the RACP Integrated Care Working Party will help the College to understand how to maximize contributions and identify barriers, opportunities and resources needed to support this approach.
* Working more closely with patients, families and communities within their own communities will require greater understanding of the barriers for them in the health system, and their connection with services and professionals. The RACP supports the work by the NZ Health Quality and Safety Commission’s Partners in Care Programme, and recommends that it explores consumer perspectives on care closer to home and provides advice to the sector.
* The RACP has invested in work with the Consumer Issues Forum to understand how to integrate thinking about consumer perspectives and voices. It is keen to work more closely with organisations that are close to consumers so that they can advise RACP policy, education, training, and CPD programmes.

1. **Value and high performance**

* RACP members raised concerns about the language and tone of messages in the strategy which relates to the banking and finance industry valuing efficiency rather than a strategy to meet the health needs of New Zealanders.
* DHB autonomy has created both risks and benefits for people and professionals. Information technology is an area where competition has disadvantaged clinicians and patients. Variations in access to technology or systems capability have let down high performing teams when they were not supported with robust information. This has let down initiatives where there has been good participation and engagement, because the results and interventions were not measured or reported well.
* Individual autonomy has undermined important national strategies such as the NZ Triple Aim initiative. The lens has not been applied in all DHBs and results in an imbalance in equity of care when the focus is on efficiency and services at the expense of effectiveness of care for patients and populations. The sector could invest in helping DHBs understand the NZ Triple Aim and develop implementation tools to assist DHB Boards, management and clinicians. Value and high performance needs to be organised and systematic to achieve the stated values in this section.
* The NZ health system needs to understand the failures in the system and it currently has limited capacity to draw information to make conclusions. Recent sector discussions on *Better Data* highlighted the inadequacy of data presentation and interpretation for learning. The ability to be a high performing system is limited by its capability. The Better Data workshops also highlighted the importance of appropriate interpretation of data and the need to involve consumers in the process.
* An area of success for some DHBs is in regional thinking and actions, through initiatives like Healthy Auckland, and Healthy Families which has resulted in regional planning and servicing, collaborative engagement, improvements in integration and information being shared for the benefit of patients.

1. **One team**

The RACP notes that physicians have a crucial part to play in health. They work across the spectrum of contact with individual patients and are active at all levels of leadership, clinical leadership, research, policy, planning, management, and implementation within the health system. Physicians have embraced the concept of interdisciplinary and multidisciplinary teams and believe that collaborative approaches are invaluable to the work they do. The Ministry could make better use of physicians’ expertise in planning health services.

* RACP notes that clinical networks and engagement in integrated care networks is core to professional practice, with physicians actively engaged in these activities in DHBs throughout New Zealand. Physicians also operate in local, national, and international context through their professional networks, and this is an underutilised resource. Many of our physicians advise international health systems and in turn learn from them.
* Physicians’ skills and their contribution to the team must be valued. Proposing new professional groups instead of building on our current professional base devalues the contribution and expertise of those working and practicing in New Zealand. Upskilling and developing knowledge, or increasing numbers where applicable would be more beneficial, and this makes good sense in a financially constrained environment as it builds and strengthens the sector.
* Physicians want to engage in new ways of working and have the knowledge and skills to do things differently. Their unique specialist and clinical skills contribute to multidisciplinary teams and in some instances, already work across health and community systems, enabling them to contribute to culture and system changes needed to change practice. Their individual skills and knowledge base contributes to supporting a range of professional disciplines, including allied health and other community based professionals.
* A ‘one team’ approach needs greater clarity about the ability to provide services to meet patients’ needs across jurisdictions, such as public/private/primary, and the impact this will have on professional practice. The main concerns are the expectations of working across interfaces, and being clear about the parameters, such as who has ultimate responsibility and the expected outcomes or repercussions: measures of accountability, clinical outcome targets, quality, safety, contracts, funding, IT systems, information sharing, models of care and what it means to professional boundaries and clinical decision making or supervision. In relation to this the RACP notes the importance of the work by the College Integrated Care Working Party.
* The RACP notes the move to increase public/private initiatives. It believes these areas need greater clarity in relation to ‘one team – one system’, and confidence about the level of equipment, support, patient information, or the ability to request tests, have implications for quality and safety. The RACP notes that health professionals will be expected to do more with less and collaborate with others in a ‘one team’ environment. There are risks for physicians in this environment as solutions for addressing workforce pressures are currently focused on devolving work and training others to do the work of doctors, or developing new professional groups as an alternative.
* The Ministry noted that trade-offs and choices will be a feature in an economically challenged environment. RACP is concerned that physicians’ ability to provide the level of care that patients need may be compromised in these situations.
* Physicians believe that teams are invaluable, particularly for learning, discussions, and debates but there is a need to acknowledge the complementary nature of different skills sets contributing to clinical decisions and practising in scope. Some physicians have experienced strongly opinionated members of a team reversing a decision based on the strength of their personality rather than the strength of evidence.

1. **Smart system**

Smart technology may have potential but equally could create inequity and amplify the problem for others if not properly established. Personally-driven health services and smart technology, such as patient portals poses a risk due to a small percentage of the population being signed up. At this time the majority of DHBs have not yet committed resources so patients around New Zealand do not have equal access to this resource. Total reliance on patient portals as a future management tool poses a risk to patients when availability or equity of access is an issue, e.g. older, disabled, rural, low income and marginalised populations. IT tools should be seen in the context of a suite of tools and from RACP’s perspective there should be ‘one true source of evidence’ that is held within the public health system to enable robust data collections that can be used to determine the quality, safety and clinical outcomes of care provided.

**Roadmap of actions**

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

* The rapidly changing IT environment creates challenges for planning and funding predictions. It’s impossible to know what information technology would look like in the future, and difficult to cost. For health professionals to support the Health Strategy it would need to include an investment stream to respond to technological improvements, so that continual upgrades or technologies would be available and allow physician care to keep pace with international best practice and use ‘fit for purpose’ tools. Advances in technology are moving rapidly and keeping pace with evidence based, best practice technologies are essential as they continually increase the ability to provide effective and efficient care that benefits patients and the health system. Physicians operate in a global learning system and their input and advice into health IT improvements have improvements to support integrated care approaches that are closer to home.
* To reduce the burden of increasing financial pressure the Ministry could rethink its funding philosophy and mechanisms to accommodate rapid changes in technology, practice and evidence. The Ministry noted that its focus will be on outcomes and transparency but there was little indication of opportunities at front end opportunities. Early indications seem focused on funding linked to specific outcomes. The RACP believes that focusing on ‘efficiency as a key value’ will miss opportunities for actual interventions and improvements that will influence outcomes. Our interpretation is that the focus in the contracting environment will be on obtaining value for public funds spent, at the expense of improvements in quality of services that achieve gains for patients.
* The RACP notes that a strategy to reduce the burden of increasing financial pressures will create more opportunities for public, private, community or allied health partnerships. RACP is concerned about the impact that this would have on physicians and their access to equipment, resources, patient information and how information would be shared across the system.
* RACP notes the Capacity and Capability Review and the Productivity Commission Report are likely to have a significant impact on DHB funding models. The RACP agrees that the Ministry’s review of District Health Boards, including governance, terms of reference, and structure is important to inform a new ‘fit for purpose’ strategy.
* To reduce confusion and waste in the health sector, RACP members believe the Minstry should consider valuing and creating the ability to build on previous work. New innovations arising from funding innovations often detract and undermine early initiatives that worked well, as funding at the end of a ‘new innovation’ ceases due to its status as a discrete project and usually funded for a defined period. Some new initiatives eventually fail and do not always add value to a programme of work, however funding removed from a successful programme results in a double failure, and doubles the cost. By design, innovations are a ‘new’ idea or one off project.

**Turning strategy into action**

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

**Implementing the strategy**

RACP believes enabling the NZ Health Strategy will require significant work to develop an integrated care framework with national strategies. For people to *live well, get well, stay well*, it will require a whole of government and community approach to development of strategies, which includes the spectrum of local government, government departments, public health, DHBs, allied health organisations, community based organisations, people, families, communities, research and evaluation, universities, medical schools, professional organisations, regulators etc. Over 24% of people in New Zealand identify themselves as having one or more disabilities. Disability can occur at any time in life, from birth, after birth through injury or illness and from natural aging. A national Health Strategy must include as part of its strategy approaches for optimising health and well-being in those with disability.

The RACP has significant experience and expertise within its membership to assist with informing national strategies, and its work programme aligns closely with the intent of the health strategy.

**Measuring progress to identify unmet needs and health gains**

The RACP acknowledges the work by the Ministry to collect health outcomes for people who use health and disability services, and believes it is essential to measure and understand where needs are not being met need to understand the extent of health needs or where the system is not achieving health gain. Shared measures are important for local and national learning and gain. A there needs to be a greater focus on how to disseminate learning from success and provide access to learning within clinical environments to provide greater gains for patients and the health system. The RACP supports leadership by the NZ Health Quality and Safety Commission to develop a quality training programme that links into clinical and health settings. This would extend knowledge and skills within clinical settings and provide health teams with better access to understanding how to focus activity on health need for health gain. Health sector training in quality is unaffordable for most health practitioners and requires significant time away – more could be done to support clinical learning approaches on site, and across primary and community care settings.

The RACP notes the impact of growing complexity in the health system on services, and the ability of physicians to provide levels of care needed due to the increasing number of patients who require coordination of their complex medical needs and the growing complexity of funding disability support packages. Children’s disability is an area where there is a rising burden for unmet need; other areas are chronic disease, societal pressures such as a growing younger population with high needs, increasing population diversity, an ageing population, and lifestyle illness or injury. In some areas there are significant disparities in the ability to provide full services to meet need. RACP notes significant disparities in the provision of rehabilitation services in New Zealand are due to different government areas of responsibility and funding.

The RACP believes there is an urgent need for cross sector integrated contracting mechanisms to address responsibility for funding and reduce disparities in access to care.

**Any other matters**

1. **Additional comments**

*Missing themes and opportunities*

**The Health Benefits of Good Work**

* The RACP notes that there is no mention of the role of work as an independent social determinant of health, and highlights the workplace as an ideal venue for influencing health – *the place where most people spend a considerable proportion of their waking hours*. In addition, the NZ Health and Disability Strategy stresses the link between the poor health outcomes of people with disability, with one of the initiatives to address this being to increase the proportion of disabled people in employment. This is an ideal opportunity for cross government working, particularly linking health and social factors in outcomes falling under the remit of the Ministry of Health and Ministry of Social Development. There are specific areas where this link and cross-overs are of key relevance, particular mental ill health.
* The burden of occupational disease for people, their families, and the impact on the New Zealand health system is under recognised. It is not well addressed because people are often not able to access health services easily and present late. This aspect is underreported. Chronic care is a particular area of concern as these people are more likely to have poorer health outcomes. Those with impairment or a disability are also affected, for example acute injuries caused outside work and needing ongoing primary care services. Recognition by the Ministry of this as an area for development would provide significant early gains in reducing the impact on the health system. It is an opportunity to consider how to utilise workplaces to deliver healthcare near to patients more often and more conveniently. RACP occupational and environmental medicine physicians have specific expertise in all these areas, and are in a position to provide expertise and support to the Ministry, health professionals and employers.

In recognition of occupational barriers to accessing health the RACP is the custodian of the New Zealand Consensus Statement on the Health Benefits of Work, led by the Australasian Faculty of Occupational and Environmental Medicine. The project has recently been renamed the Health Benefits of Good Work in recognition that bad work can be as harmful to health as no work.

Increasingly employers are now more aware of the value of promoting the health of workers, particularly in view of the challenges presented by the aging workforce. Wellness initiatives are being offered within the workplace, and there is the opportunity to tie these in with an increased emphasis on annual health monitoring and occupational health which will be required under the new Health and Safety at Work Act 2016. This presents an opportunity for public health initiatives to be partnered with services offered by employers, to mutual benefit and potentially shared costs. Occupational and environmental medicine physicians have specific expertise in all these areas, and in a position to provide expertise and support to both employers and health professionals in order to maximise the potential and facilitate such potential initiatives.

* The RACP in New Zealand is in the process of establishing a NZ Signatory Steering Group comprising key stakeholders, including other medical colleges, service providers and key peak industries. Mr Paul Mackay, Business NZ, has agreed to chair group for the first year, which will commence early in 2016. Initial discussions indicate that a useful goal might be providing 100% access to occupational health for NZ workers could be a goal, with a key focus on how to link people to primary care, particularly those that might not access care and pose the greatest risk.

The RACP looks forward to continuing to engage with the Ministry to inform solutions during the next phase.

* **Antimicrobial resistance**

Antimicrobial resistance is a global public health issue, and RACP believes New Zealand must contribute to international management AMR approaches, such as implementing the WHO’s 6-Point Strategy:

1. Adhere to a comprehensive, financed national plan with accountability and civil society engagement
2. Strengthen surveillance and laboratory capacity
3. Ensure uninterrupted access to medicines of assured quality
4. Regulate and promote the rational use of medicines and ensure proper patient care
5. Enhance infection control
6. Foster innovation, research and new tools

The RACP will contribute to New Zealand’s application of the Strategy by:

1. Offering clinical expertise to inform New Zealand’s response to antimicrobial resistance
2. Contributing to reviews of laboratory services in New Zealand
3. Participating in PHARMAC consultations and reviews of decision-making criteria
4. Maintaining involvement in quality improvement programs and advocate for best practice based on available evidence
5. Contributing clinician expertise to infection control teams and antimicrobial stewardship programs in DHBs
6. Incorporating research and developments in antimicrobial resistance into its online resources, and highlight it at scientific conferences

Antimicrobial resistance is a complex public health concern in New Zealand. The RACP believes the Ministry can be proactive in combating resistance by introducing measures to reduce the potential threat posed by pathogens resistant to existing antimicrobial treatments. The RACP has encouraged physicians to remain informed and up to date on the profile of resistance for various pathogens in New Zealand and globally, and supports a centrally coordinated, national initiative to respond to increasing antimicrobial resistance in New Zealand.

The RACP recommends that the Ministry develops and coordinates a national AMR governance programme to manage increases in antimicrobial resistance. A national programme would encompass evidence-based policy and guidance for practitioners and awareness campaigns for the public.

A nationally coordinated antimicrobial resistance strategy would incorporate antimicrobial stewardship programs operating at the local level, in hospital and community settings.

**Climate Change and health**

The RACP is of the view that it should understand more about health in the 21st century. It has worked with other peak medical organisations around the world to raise awareness of the damaging health impacts of climate change and developed a consensus statement to raise awareness of the need for action.

**CONSENSUS STATEMENT**

***Act now to reduce the damaging health impacts of climate change***

Peak medical organisations from around the world have come together to call on States at the 2015 UN Climate Change Conference (COP21) to commit to meaningful and urgent action to combat the adverse health impacts of climate change.

The recently released Second Report of the Lancet Commission on Climate Change and Health: policy responses to protect public health released in June 20151 and the wealth of available evidence demonstrates unequivocally that climate change is a global health issue.

The devastating impacts of climate change on human health across the globe can no longer be ignored. Extreme weather events, disruptions to food and water supply, loss of livelihoods, threats to human security and alterations in climate-sensitive disease distribution and frequency will all be exacerbated by unchecked climate change.1 These have serious consequences for physical and mental health and well-being.

Furthermore, the evidence suggests that countries that contribute the least to climate change are most likely to be severely affected. Many have limited resources to allow them to adapt to climate change and their health services already struggle to cope with the burden of climate-sensitive disease.2

COP21 offers the opportunity to limit the degree of warming to levels where adaptation is still possible. States must commit to meaningful measures to circumvent the adverse health effects of climate change that threaten us all. It is imperative that States commit to investing in climate change mitigation measures and in assisting lower income countries to do so.

Alongside these commitments from States at COP21, as a global health and medical community, we will also commit to promoting measures which will have positive co-benefits for our patients. There are significant immediate health benefits that flow from taking action on climate change at the individual and local level that will result in reduced rates of obesity, diabetes, cardiovascular and respiratory disease, improved life expectancy and reduced pressure on health systems.3

1 The 2015 Lancet Commission on Health and Climate Change: Policy responses to protect public health

2 Kjellstrom, T & McMichael, AJ. Climate change threats to population health and wellbeing: the imperative of protective solutions that will last. Glob Health Action 2013 Apr 3;6:20816.

3 Australian Academy of Science. Climate change challenges to health: risks and opportunities. Canberra: Australian Academy of Science; 2015. Available from <https://www.science.org.au/supporting-science/science-sector-analysis/reports-and-publications/climate-change-challenges-health>

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

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

on behalf of a group or organisation(s)

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*: Technology provider

### 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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| There is no mention of the opportunity to use analytics to inform decisions, empower consumers, to provide insights and prescriptions for better healthcare spending. For example population health analytics can help identify and treat people in the community and alleviate some of the pressures on the hospital systems. Likewise analytics at the point of care across a number of data sources can provide a more complete picture for treating the patient.  It is also noted that sharing of information across organisations can let us know who is missing out and what isn’t working. We would recommend that the integration of social data be a priority as it is a well-established fact that social factors play a large part in determining the ongoing health of an individual.  May we also offer an expansion of one particular Challenge noted in the strategy document , in quotation marks below. We believe the promise of mobile, digital and cognitive technologies to assist in the large scale and rapid training of healthcare professionals to be an enormous opportunity. New technologies such as IBM’s Watson can now learn at an exponential rate, interact with clinicians in human/natural language, and be an instant source of advice to healthcare professionals. The promise of these new cognitive technologies in producing on-demand learning opportunities for clinicians already overburdened with information, is significant.  “New Zealand’s health workforce also faces challenges. It is ageing– 39 percent of doctors and 46 percent of nurses are aged over 50.9 It also has a large number (about 63,000) of care and support workers, or kaiāwhina, who often have limited access to training. Many of our workforce have trained overseas – 43 percent of our doctors, 34 percent of our midwives and 26 percent of our nurses – and are not permanent residents.10 This means we need to continually invest in training to ensure that the skills of our health workforce can meet the health needs and expectations of care of New Zealanders.” |

### 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 shows great intent and aspiration and we certainly believe there needs to be a real emphasis on “one team” approach, breaking down silos.  We would also add the critical importance of access to information and data insights for all players and stakeholders across the health system. Information is the life blood of health care operations, patient experience, system performance and overall population health; having better and more joined-up access to information will be imperative to health care transformation for New Zealanders and for health care providers. |

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, we would note that the principles seem well aligned to help implement the strategy.  Considering the relatively low maturity, compared to other industries such as banking and entertainment, of the New Zealand health system in the area of utilising technology to engage with people, we would recommend adding a key principle in this area. Mobile and digital technologies will have an enormous impact on health care, as health care learns to incorporate these new capabilities into day-to-day operations. |

### Five strategic themes

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

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

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| These five themes provide the right focus. The areas to watch are:  How do we measure as we go and fine tune (i.e. keep the approach agile) which is discussed as a goal, but difficult to implement.  We need to ensure we can measure this and that the fifth theme (Smart System) is openly discussed and planned. The ‘single source of truth’ in terms of making data accurate and available should have top priority and be supported by a set of regional or a single national information repository.  Another point in regards to the Smart System is that by joining up information about the individual, and their family or whanau, from across the government services sector, it will be possible to enable more New Zealanders to live *well*, not just more healthily. |

### 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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| Yes, we would note that the actions seem well aligned to help implement the strategy.  Some comments on specific actions are:  **Action 18. Increase New Zealand’s national data quality and analytical capability to improve transparency across the health system.**  There is an element of the national data agenda for New Zealand that should be looking at how the deep insights gleaned through big data and analytics are key to a smarter healthcare system. By leveraging new and existing data sources and analytic innovations, healthcare professionals not only can deepen their understanding of individuals’ needs, but also facilitate cross-agency collaboration, case management, and program access and delivery. In addition, they can uncover valuable insights into lifestyle choices, social determinants and clinical factors. Context-based insights from social and clinical analysis allow care professionals to segment populations by risk profiles, inform care approaches for individuals, and proactively manage finite care resources faster and more efficiently, leading to improved outcomes. Hence the Data agenda should extend to driving a more effective and efficient system which would include transparency across not only the healthcare system, but also the wider public services sector.  There are existing frameworks for healthcare globally that could be shared with the Ministry and adapted for NZ (Action 8) rather than reinvent.  The Ministry should also consider building an analytics community of practice across the health sector, and focus should be on appointing DHB CDOs (chief data officers) to help implement the above vision.  **Action 19 - The Ministry of Health will establish a national electronic health record that is accessed through certified systems including: patient portals, health provider portals, and mobile applications.**  The establishment of Electronic Health record for New Zealand is important to assist in aggregating information at a single point for access for all members of the health team including citizens. The Electronic Health Record will need to be virtual and should include information governance as part of its oversight to ensure its data is ‘trusted’.  The area that has not been mentioned is the systems that will support the EHR –especially information from the DHB’s. Today very few DHBs have invested in Electronic Medical Records (EMR) which would be one of the key sources of information for the EHR.  Consideration for the long term of this strategy should also be given to enhancing the Electronic Health Record with relevant information from other public services, as the exogenous social factors of an individual’s life have a significant impact on their health.  Patient Portal uptake may also be limited because traditional portal approaches are no longer relevant to patients in a mobile-first world. This needs to focus on patient-centric delivery of services via mobile channels.  The above could also apply to the public hospital systems where information could be delivered via mobile channels (with appropriate privacy safeguards) rather than a single portal and may potential stifle innovation in the sector.  With regards to publishing a list of certified mobile ‘health apps’ this action may be too prescriptive and doesn't leave room for innovation. In the case where there is common, standardised and curated information it should be made available for consumption by different end user devices and apps, rather than being forced through portals only.  Also to enable the better measurement of performance there needs to be more electronic capture of data from the New Zealand Health, Social Services and community based services to make the analysis more effective in measuring performance of the system. The ability to capture, integrate and analyse data across different stakeholders, care settings and geographies is essential.  Lastly in conjunction with the above systems there is no action item for using analytics in health system planning. This would involve 'closing the loop' in using financial information, care outcomes, physician/system performance, and population health to plan investments. |

### 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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| Each action will require precise measures of success that are assessed against outcomes (not self-assessed). Baselines and targets will both need to be developed. Reporting of progress should be an automated process (created dynamically) and able to be viewed at any point in time. There should then be a dashboard developed that enables ‘drill down’ against agreed measures and outcomes for each initiative so we know if we are succeeding or need to adapt the approach. |

### Any other matters

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

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| One further comment regarding access and equity.  It is often misunderstood that lower socioeconomic areas have less access to digital and mobile technology. In fact, access to digital and mobile technology in poorer areas is expanding exponentially, precisely because this is a relatively cheap and quick way to access different services in society – from banking, to travel, to consumer goods. Healthcare is next in line – an economically sustainable health system of the future must fully capitalise on this societal shift towards digital access.  There are no further comments but we would like to note that you have produced a well written, easily read document and kudos to the staff who wrote this. |

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| **354** | Submitter name | [redacted] |
| Submitter organisation | New Zealand Nurses Organisation |

Update of the New Zealand Health Strategy: Consultation Draft

Submission to the Ministry of Health

Date: 4 December 2015

Contact

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NEW ZEALAND NURSES ORGANISATION | po BOX 2128 | WELLINGTON 6140

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| **About the New Zealand Nurses Organisation**  NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.  NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.  NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO’s vision is *Freed to care, Proud to nurse*. |

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the draft Update of the New Zealand Health Strategy (“the Strategy”).
2. NZNO has consulted its members and staff in the preparation of this submission, including members of all Colleges, Sections, regional councils, the Board, Te Rūnanga o Aotearoa, and professional nursing, policy, legal, and research advisers.
3. We have considered the document in the light of earlier sector and individual consultation on the Strategy; the accompanying reviews of *Capability and Capacity* (Suckling Review) and *Funding* (Horn Review); other current strategic updates and documents eg the *Strategic Refresh of the Health Research Council Report*; the update of the *Health of Older Persons Strategy*, the *Disability Action Plan Update*, the *draft Pharmacy Action Plan*, *Implementing Medicines New Zealand*, the Productivity Commission’s report *More Effective Social Services*; and recent regulatory and policy initiatives affecting the health sector eg the *Children’s Action Plan*, social investment pilots, centralisation of DHB services, Health Practitioners (Statutory References to Medical Practitioners Amendment) Bill etc.
4. The comprehensive changes signalled by the above, often without analysis of Aotearoa New Zealand-specific data and within such pressured timeframes as to preclude robust engagement and analysis, are indicative of a politically-infused and ideologically-driven agenda, rather than one that is systematically informed by evidence.
5. This is reflected in the Strategy, where the original focus on improved population health and equity has moved to a purely fiscal and *experimental* approach to ‘investment’ in health based on actuarial risk.
6. The shift from a wellness model of universal public health and primary health care (PHC), to commissioned community-based services, tightly targeted and outcomes-focused, without considering the context of unmet need, or strengthening community capacity and capability to meet it, may improve access (and cost) to healthcare for the ‘worried well’, but is unlikely to improve outcomes for the most vulnerable New Zealanders.
7. We are particularly concerned with the unrealistic framing of inequity which is expressed almost entirely in terms of ethnicity and overlooks poverty, location, access to health care and other factors leading to health disparities.
8. NZNO supports continued development of a coherent health information technology (IT) system, but questions the dominance of IT ‘solutions’ presented in the Strategy.
9. Overreliance on IT risks exacerbating inequity and diminishing the role of health practitioners, unless alternative opportunities for establishing therapeutic relationships are available. These should be articulated in the Strategy.
10. NZNO supports the Strategy’s comprehensive approach to the health workforce, including both regulated and unregulated workers, but notes the requirement for long term planning and coordinated employment, education and immigration policies if Aotearoa New Zealand is to retain and develop a sustainable high quality workforce to meet our population health needs.
11. As indicated in our letter to the Director General (Appendix 1) earlier this year, it is NZNO’s view that the refreshed strategy should encompass global targets underpinning health such as the United Nations Sustainable Development Goals (SDG). We particularly recommend that the roadmap includes specific actions to address the goals outlined in the World Health Organisation’s *Draft Global Strategy for Human Resources in Health: Workforce 2030.*
12. We strongly oppose the experimental social investment model proposed by the Strategy for which there is no supporting evidence and which risks destabilising Aotearoa New Zealand’s universal public health system, and potentially moving it towards an insurance-based health system.
13. The weight of international evidence indicates the effectiveness of universal access to social services that are primarily focused on health and wellbeing, rather than targeted to meet social/health shortfalls.
14. We are disappointed by the somewhat selective use of evidence in the Strategy. For example using international data to indicate where our health system performs well (p2) without also identifying where it performs very poorly eg access and equity; or using data of limited value in specific contexts, eg international comparisons of the percentage of people self-reporting good health are less compelling indicators of health inequity in Aotearoa New Zealand than national comparisons eg between Northland and North Shore – data which are freely available from Statistics New Zealand.
15. The lack of an evidence-based approach is most clearly seen in the failure to consider regulation to address the environmental challenges which impact most heavily on population health: alcohol, tobacco, food, living wage, and the potential impact of climate change.
16. We also record our discomfort with some of the language which is inappropriate in a health context or, more disturbingly, appropriates/distorts widely accepted norms established by eg the Ottawa Charter, Alma Ata etc. eg people-powered rather than people centred, and investment in health being considered in a fiscal rather than primary health care context.
17. A summarised response to the specific consultation questions follows a brief general discussion below.

discussion

**Strategic direction**

1. The 2000 New Zealand Health Strategy articulated a fundamental change to a wellness-focused health system, with the clear aim of improving population health, health equity and efficiency. Its wide acceptance by the health sector, resoundingly reaffirmed at the Strategy meetings, suggested that the refreshed Strategy would focus on removing the barriers to implementing the 2000 Strategy.
2. Clearly there was, and is, a need for the transformation of obsolete, hierarchical and discriminatory decision, funding and workforce structures in health, to modern systems that are responsive, equitable and excellent, that utilise resources efficiently, and empower people to reach their health potential.
3. However, this Strategy signals a complete *change of direction* towards a system focused on managing the actuarial risk of individuals’ *ill-health* within virtually the same service structures. It does not deliver the transformative change needed to embed health in integrated community-based services that support and empower individuals to reach their health potential.
4. Moreover the Strategy outlines a ‘social investment’ approach to commissioning community-based services, which is inimical to a population health approach of strengthening community capacity and capability in order to tackle entrenched disparities and long-term conditions.
5. A bold approach is needed. NZNO advocates the adoption of a comprehensive public health model such as Te Whare Tapa Whā, which encompasses both individual and whānau empowerment and social responsibility for health, rather than retaining siloed health and hospital-focused services, albeit within “ new “ delivery models of integrated family health care, regional hubs etc.
6. Te Whare Tapa Whā’s explicit articulation of the connection of the individual to the wider social, family, community context could also lay the foundation for an integrated approach to health and wellbeing ie the conditions in which people live, grow and thrive, across all government departments and services. There are obvious synergies between eg housing and education which invite unified policy and funding approaches.

**Cost and Investment**

1. As indicated in our submissions to the Productivity Commission (2014, 2015) which we recommend to your attention, we question some of the assumptions underlying their *Effective Social Services* papers, namely:

* that universal public provision of social services is not effective or efficient;
* that the current level of provision of social services is unaffordable;
* that private provision of social services improve efficiency and productivity; and that
* that 'contestability' is synonymous with accountability.

1. The Strategy shows a similar ideological disposition towards devolving State provision of services to community and private providers. NZNO’s experience over many years of change in the health sector is that the devolution of services often leads to the effective devolution of responsibility.
2. While initially there may be some protections in place to assure service quality and continuity, fiscal constraints and the independence of providers outside the State sector, can disrupt and undermine the government infrastructure supporting the delivery of safe, effective services. In particular, the trend to amalgamate services eg fewer, larger PHOs, *without accounting for the loss of community capability* risks a less autonomous (people-powered) and responsive system.
3. We have seen this pattern repeatedly, often to the detriment of rural and Māori populations, and increasingly to the benefit of international corporations which have no public good imperative.
4. Economies of scale *are* relevant and important, though limited by our small and geographically dispersed population. But, as Treasury notes, provision of social services is a public responsibility based on the *social* and fiscal contract between (all) citizens and the elected government[[21]](#footnote-21). Ie social as well as fiscal value must be accounted for in assessing costs and investment returns.
5. While the Strategy articulates the principle of “Active partnership with people and communities” (principle 7), it is not clear how such partnerships will work, nor how strong, capable and empowered families/whānau and communities will be developed. There are no supporting actions to strengthen community capability other than through commissioning “others” (who are not clearly defined).
6. The Strategy needs to clarify how people are connected to the proposed system (as, for instance, PHARMAC does in its Factors for Consideration model), how communities will be strengthened, and ensure that investment models fully account for the value/loss of human capability and capacity where there are changes to services.
7. The way in which social services are commissioned and purchased affects employment, and thus has a significant impact on workforce quality and sustainability. Both workforce and service quality and safety should be underpinned by sound employment and safety standards, to prevent the escalation of prevailing ethnic and gender disparities in wages and conditions in some health services areas, eg Māori and iwi providers, aged care, home based services.

**Health Workforce/IT**

1. NZNO supports the Strategy’s comprehensive approach to the health workforce acknowledging and leveraging the role of volunteers, families, whānau, and unregulated workers (kaiāwhina) as well as regulated health practitioners across all disciplines.
2. Nurses, who work in all health settings throughout the country, understand the importance and value of shared knowledge, coordinated care and utilising skills.
3. However, while NZNO welcomes the strong commitment to a coherent health information technology (IT) system, we are concerned about the Strategy’s focus on digital technologies as the primary means of enabling ‘self-management’, without considering inequitable access and capability (ie the ‘digital divide’), cultural preferences, or the level of health literacy need to make self-management viable.
4. Overreliance on IT risks exacerbating inequity, and adding a further access barrier to the health system to the same vulnerable groups already excluded. IT is a powerful tool which should be used to enhance rather than restrict opportunities to establish therapeutic relationships, or replace them.
5. We draw your attention to the World Health Organisation’s *Draft Global Strategy for Human Resources in Health: Workforce 2030* and strongly recommend the Strategy includes a commitment to the principles and achieving the targets therein eg High & Middle Income countries meet at least 90% of their health personnel needs.
6. This will require long term planning and coordinated employment, education and immigration policies if Aotearoa New Zealand is to retain and develop a sustainable high quality workforce to meet our population health needs.

**Equity**

1. The Strategy discusses inequity almost entirely in terms of ethnicity, ignoring the fundamental factors underlying health disparities: poverty, poor housing, precarious work, location, access to health and education etc.
2. It fails to either identify or prioritise the specific action areas that were central to the 2000 Strategy eg tobacco, alcohol, family violence, healthy eating /healthy action, oral health, mental health, improved access to services for poor, Māori and Pacific peoples.
3. Disappointingly, it also fails to deliver a platform for the delivery of coordinated policy and action on the determinants of health, despite there being successful examples.

CONSULTATION QUESTIONS

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

1. The strengths of Aotearoa New Zealand’s health system are well articulated, but should also include the partnership, participation and protection of tangata whenua afforded by te Tiriti o Waitangi. (p5)
2. There are international obligations which come with being “connected to a changing world” and able to “draw on global ideas and evidence” eg The UN Sustainable Development Goals, WHO Global Human Resources in Health targets, International Labour Organisation conventions etc. set specific agendas and standards for national responses to shared global challenges such as climate change, antimicrobial resistance, global migration, trade etc. These are part of the wider context of health and health policy that should explicitly underpin the New Zealand Health Strategy and its implementation. Eg the target for reducing Aotearoa New Zealand’s high dependence on immigration should be embedded in workforce actions.
3. The (few) identified challenges are selective, oversimplified and almost entirely focused on government’s fiscal costs ie the ‘burden’ of health costs through Vote Health, without acknowledging the fiscal and social benefits of improved population health (or indeed the costs of not funding health care).
4. We are particularly concerned with the unrealistic framing of inequity here and elsewhere in the document, which is expressed almost entirely in terms of ethnicity and overlooks poverty, location, access to health care and other factors leading to health disparities.
5. The Strategy must affirm the intrinsic value of health equity, identify the main drivers of health disparities and have specific actions to alleviate them, based on prevention, early intervention, rehabilitation and treatment. eg improve Māori access to medicines; strengthen community capability.
6. We recommend to your attention the Public Health Association of New Zealand’s *Policy on Reducing Health Inequalities*, (2002) which identifies the following principles for reducing health inequalities, which the Strategy could be measured against.

* Have an explicit commitment to implementing the principles of the Treaty of Waitangi - participation, partnership and active protection
* Acknowledge Māori perspectives of health such as *te whare tapu whā*
* Are systems-level interventions that address multiple risk factors
* Actively involve primary care providers and the district health boards
* Favour the least advantaged
* Ensure the participation of the least advantaged
* Foster social inclusion and minimise stigmatisation
* Take a population approach
* Are focused on early rather than late interventions
* Impact, where possible, on the short, medium and long term
* Are responsive to changes over time in the social and economic circumstances of populations
* Increase people's competence and control over their life circumstances
* Support and build the capacity of local organisations

1. We strongly challenge the disingenuous use of selective statistics and Treasury’s considerations about health spending. Contrary to the statement that Aotearoa New Zealand is not “*unusual in the amount of health expenditure funded by taxpayers*” – the United Kingdom, Norway, Sweden, Denmark, Japan and Mexico, Poland and Turkey all have a similar or greater proportion of public health expenditure, for example, while Treasury’s projections in their document *Health Projections and Policy Options for the 2013 Long Term Fiscal Statement* (New Zealand Treasury, 2013, p6) were based on specific assumptions amenable to change (which was part of the thrust of the document) and a very explicit conclusion that:

We do not currently see a clear case for moving away from a predominantly single-payer, tax-financed health system. Systems like ours are typically better at containing health spending and there is no one system that presents a clearly more efficient alternative.” (New Zealand Treasury, 2013, p40)

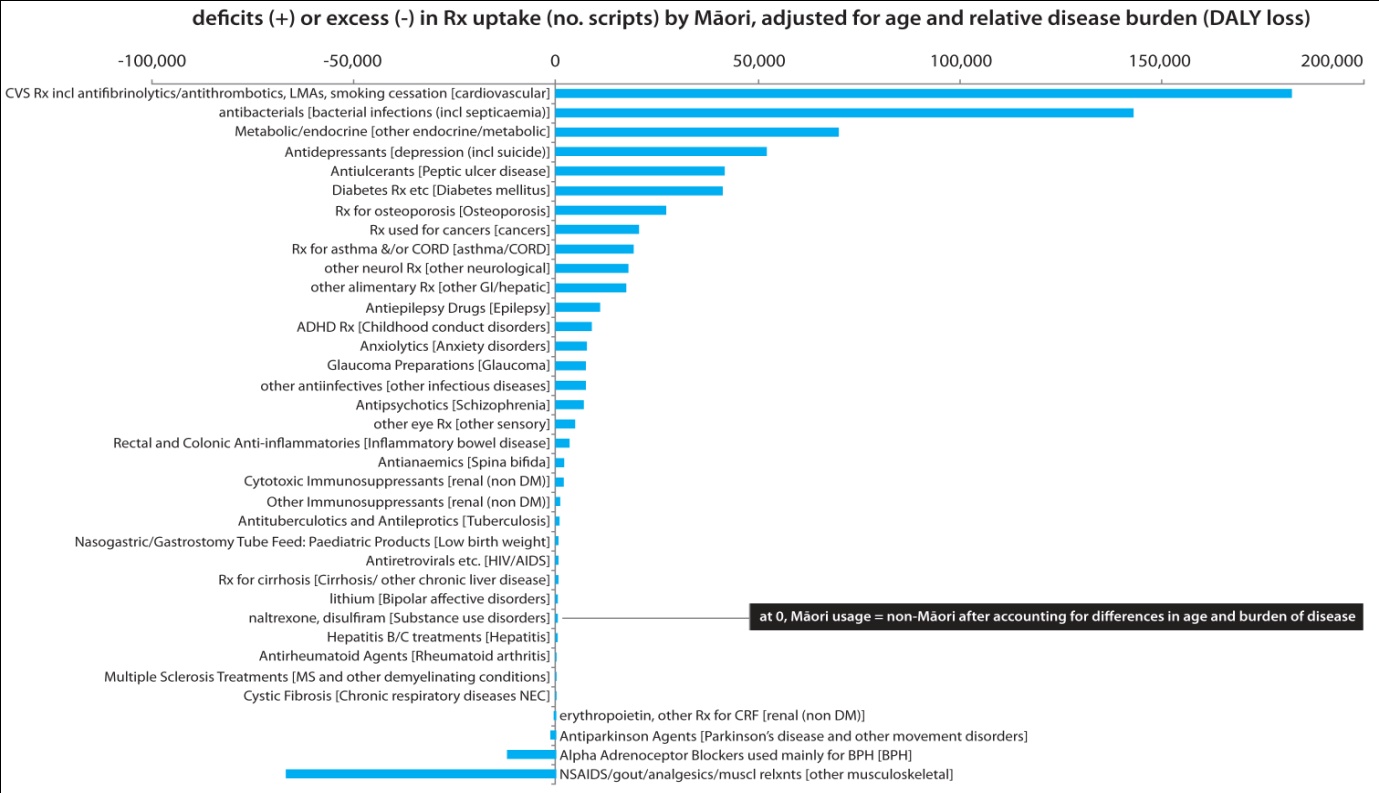
1. NZNO would welcome that commitment to a strong public health system being repeated in the Strategy.
2. Treasury’s document looked at three broad areas for change: improving the performance of the health system, managing the demand on the health system, and making adjustments to what the public health system covers (which has flow-on effects to the balance of public and private financing), and recognised in relation to managing demand that:

… the potential fiscal gains may not be large. Only a limited number of preventive initiatives have cost-saving potential, and increases in co-payments tend to have a one-off effect on spending and therefore do not fundamentally alter the growth path. The design of demand-management initiatives is critical. Both preventive initiatives and co-payments can impact negatively on fiscal sustainability if poorly designed (New Zealand Treasury, 2013 p41).

1. Such clarity is admirable as is the implicit acknowledgement of the inherent value of preventing suffering and ill health, in addition to cost-saving. This is consistent with trends to recognise factors other than finance, which contribute to people’s wellbeing eg Treasury’s Living Standards Framework, Statistics New Zealand’s Sustainable Development Approach and the Ministry of Social Development’s evaluation of well-being in the 2010 Social Report.
2. Figure 1.4, the graph showing life expectancy at birth by ethnicity (p6), raises the following question: what happened in the 1980s-90s that first flattened and then abruptly reversed the trend of Māori and Pacific people ‘catching up’ to average life expectancies? Why have the policy initiatives that delivered these disastrous results not been fully explored and evaluated to avoid the same mistakes?
3. We question the point of including Figure 1.5 showing projected government health spending to **2057** in a strategy looking ahead for the next **five** years, especially since we are still within the period covered by Treasury’s explicit statement:

“we are not suggesting that a tighter growth path is necessary in the short term. (New Zealand Treasury, 2013 p40)

1. We suggest a more relevant graph in terms of identifying challenges would be the following identifying disparities in access to medicines for Māori.



***Maori access to medicines. Courtesy Marama Parore. PHARMAC 2012.***

1. We agree with the opportunities identified ie. a focus on prevention, early intervention, utilising workforce and community skills more effectively, IT, automation and suggest that the Roadmap needs to be more specific about utilising workforce and community skills.

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.*

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

1. In general we support the statement, but acknowledge the following specific comments received from members.
2. *All New Zealanders* –strong support for the affirmation of universality, but concern that it doesn’t acknowledge tangata whenua and some concern that it is meaningless in the current context of health disparities and structural discrimination (Human Rights Commission, 2012).
3. *Live well, stay well, get well* – doesn’t encompass the beginning and end of life where health demand is often highest.
4. The Roadmap actions focus on the “get well”. If this slogan is to be adopted the actions should deliver on each part of it.
5. Does the emphasis on wellness exclude disability? Some people will never be well in the conventional sense, but all people should be supported to reach their health potential.
6. *People powered* This is a very different concept from people-centred health care, and is not the same as empowering people. It implies self-direction and self-management, but this predicated on a very high degree of health literacy, and equitable access to appropriate care which is not reflected in the Strategy.
7. *Services closer to home* – this is a vision that can’t be met; specialist services are already being rationalised. Not all services are available to all people in all locations. Not all people have homes!
8. *Designed for value and high performance* –the system needs to be “fair and responsive to all people” as well as efficient. The health system isn’t a motorbike!
9. *One team smart system*. Nurses have reacted very negatively to this ‘marketing’ language here and elsewhere, though there is support for a more unified system. Suggested alternatives included “working together” and “integrated system” “aligned”.

**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**.

**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. NZNO supports retaining the original principles, although we wonder if there is a need to express the principles in terms of values and objectives, since the actions identified in the roadmap do not reflect these principles.
2. We strongly object to the displacement of the principle relating to te Tiriti o Waitangi from first to fourth position. As the founding document for relationships between Māori and the Crown, te Tiriti is the cornerstone of public policy in Aotearoa New Zealand and its primacy should be acknowledged.
3. The additional 8th principle “collaborating with others” doesn’t express the strong cross government, intersectoral action on health previously flagged and supported during the consultation. “Others”, for instance, is sufficiently vague to encompass any entity - private, public, NGO, multinational, not for profit - and it is not clear what is intended.
4. There is considerable concern that this is “privatisation by stealth” and “corporatisation” of the health system, as well as concern that Aotearoa New Zealand health services will continue to be divested into private, potentially foreign ownership and control, as is already the case with aged residential care and some district nursing services. That signals a basic mistrust in the sector (hardly surprising given the significant restructuring the health system has seen since the 1980’s) which should not be ignored.
5. There are fundamental issues here that need to be honestly canvassed, rather than glossed over. There is a significant difference between commissioning services to be delivered by/for local empowered communities, for instance, and facilitating the amalgamation, or even takeover, of services by organisations or corporations whose priorities may not be aligned with the communities being serviced, who may be susceptible to funding cuts, who may ‘cherrypick’ profitable sections of services etc. And, regardless of how organisations are classified – trusts, charities, not for profits, cooperatives, PHOs - they all have specific agendas, values and responsibilities which are not the government’s. Ultimately the government has to consider all New Zealanders and cannot devolve risk.
6. Size is also an issue, since even national organisations in Aotearoa New Zealand are relatively small and lack the capacity and capability needed to run complex multifactorial services catering to all people. The government ran up against exactly this problem when trying to divest itself of a sizable portion of state houses: there were no local organisations able to fulfil the contract.
7. There are legitimate fears that overseas/private ownership of health services could leave New Zealanders, especially the most vulnerable, exposed, if conditions /owners were to change. There are also significant workforce implications in having a largely publicly trained health workforce moving into the private sector.
8. There are numerous examples of excellent commissioning of community services eg hospices as well as those that have failed to deliver, often due to a lack of community capacity, capability, or resourcing, or that have led to unequal outcomes, cost overruns.

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).

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

**People powered**

1. As above, this differs from well-established concepts of people-centred health care, and empowering people, which are articulated in many service frameworks eg DHB frameworks.
2. Equating individuals’ ‘needs and wants’, referring to a ‘customer focused approach’, and ‘partnering with people to design services’, denotes a commercial focus on the business of health which does not sit well with a government strategy to improve population health.
3. Where are the clinicians? A high degree of engagement, empowerment, and communication between *people* is important. **People** include individuals, families, communities, clinicians, service providers, yet the approach is centred on individual consumers and their IT connections and ignores the connection they need to clinical expertise. Are personal therapeutic relationships to be replaced with apps?
4. The ‘digital divide’ is also ignored; an IT focus may exacerbate disparities and be a further access barrier to a health practitioner.
5. We strongly object to the cynical juxtaposition of ‘evidence-based health advice’ and it being easier to make ‘healthy choices and stay well’ when the Strategy eschews following the evidence and advocating regulation for a healthier environment.
6. The Strategy needs to be realistic: the 10 year vision for a high degree of health literacy, autonomy, and access to evidence-based information, and an array of smart devices already exists for the affluent and is largely irrelevant for those who are currently not empowered by having timely access to *affordable* expertise and treatment.
7. It is an unlikely, but worthy, aspiration for our most vulnerable populations, but there will also be people for whom it is not appropriate – what is the vision for them? We note that individualised funding can work very well in some instances, mainly when people have information, capability and choice, and poorly in others eg where health literacy is lacking, where there are no services to ‘choose’.
8. We support services being delivered where it is most appropriate to do so; we also support the focus on consistency.
9. We recommend that access to affordable services and treatment should be part of the ten year vision.

**2. Closer to home**

1. We strongly support this theme and its focus on: integrated health and public services; investment in children; care closer to where people live especially for the management of long term conditions; and wellness and prevention through population-based and targeted initiatives.
2. We note the high percentage of adults reporting unmet need for primary health care 2013/14 and welcome recognition of the need to work collaboratively across wider government and community sectors to meet the multiple needs of those disadvantaged with high health needs.
3. We support ‘by Māori for Māori’ services and note the need to ensure that they are properly resourced, and realistically evaluated (see earlier comments).
4. The 10 year vision *is* ‘great’, however, it is not supported by the roadmap actions.

**3. Value and High performance**

1. An ‘outcomes-focused framework’ is meaningless unless referenced to identified goals and specific objectives, such as those articulated in the Goals and Objectives Framework of the 2000 Strategy.
2. An outcomes-focused framework can also be problematic and difficult to manage in a complex multifactorial environment such as health. Outcomes, successful or otherwise, are usually influenced by a number of confounding factors many of which are difficult to assess, particularly over meaningful time frames eg a reduction in rheumatic fever may be due to improved housing rather than an early intervention programme of testing and treatment of sore throats – which expenditure represents the “best value for public health system resource’?
3. This is why we do not support the “use of investment approaches to address complex health and social issues” which we assume refers to social investment/impact bonds (SIBs), where private investors lend money to governments, only to be repaid, with interest, if agreed goals are met. Such experiments have failed all over the world. eg Healthcare provider Circle found that the flagship Hinchingbrook hospital NHS contract was "unsustainable due to pressure on A&E and funding cuts" and has now handed the hospital back to the NHS, including an extra £10 million deficit.
4. As Professor Nicholas Mays, an international expert in the establishment and evaluation of SIBs, stated earlier this year "there was no reliable indication yet of the efficacy of this very new model" (Mays et al., 2015). Indeed interim findings were that there were high set up costs, potential conflicts of interest, that service ‘innovation’ meant tailoring services via individual assessments & care plans which is what clinicians already do, and that ‘Savings’ and tend to be linked to hoped for reduction in use of health services (GP visits or A&E admissions) and are hypothetical (p29). This does not sound like value and high performance.
5. Nevertheless, following the entirely opaque process of developing similar experiments on the back of various social sector trials, the government has budgeted $28.5m for four SIBS projects, one of which has been announced, though apparently none have been confirmed by Cabinet.
6. Despite the Official Information Act (OIA) and repeated requests over almost two years, NZNO was unable to find *any information* about the long or short listed proposals, much less have an opportunity to contribute by means of consultation, until the final four had been selected.
7. As noted in our email:

NZNO is not asking for commercially sensitive financial or contractual information; all we are (and were) interested in is in knowing what areas are under consideration so that we could consider the potential health, health services and health workforce implications. We think those factors are important in developing initiatives to improve outcomes for highly vulnerable people. Knowing the areas under consideration would give us and others an opportunity to highlight potential risks and opportunities from the expert perspective of nurses (and others) working in the field, or at least be assured through a transparent process, that they were being considered by the appropriate people. We are very surprised, for instance, at the choice of the first approved SIBs project, mental health and employment; the disparately poor physical health that people with mental health issues generally have is deeply problematic and we would like to know how this will be addressed. Once again, NZNO requests general information about the seven tenders and the four that have been selected. We would also like to know what clinical input there has been to the decision making process.

[NZNO email to s[ocialbonds@moh.govt.nz](mailto:ocialbonds@moh.govt.nz), 28 august, 2015]

1. Clearly there is a need for this theme’s focus on having a culture of transparency, honesty and trust.
2. We draw your attention to the ITPI’s resource [A Guide to Evaluating Pay for Success Programs and Social Impact Bonds](http://click.actionnetwork.org/mpss/c/5gA/kLwXAA/t.1ss/CZWDLMf6RFipe7HDNad_Mw/h2/kfIftxJNM-2BJaToEteCBytQlndIxKmy88ikymOzgxIljb7rPcyHU9DV-2FQCMmN75vfcSlbDIN2dPrquCqCrOhEzFTcsHK22Zo9cAoA6qCO-2F-2BKhPJOoeDBA4wzHjBdErY-2FHOGuq37Ga21wugNCO9fOPEuqofMUqAXa-2BaFhRrvoSEvEmB9GtxHM-2FjfvE-2BNzF7uUvGl-2BCdo-2BAHAinCYSgFrxOjACtrmRsMxn9xDZd-2FB3slildRRpaL1DS5ButXF5YmuuBzKYIM7ui-2FzYXY-2B33kX2jllod-2BqV1TW6qDOWOfwo-2F-2F4AUphxpEesQZChkIo9fK1T3hyLa-2Fh4F0wFXGAHDb-2BYoo8M4J-2FPt-2BS6EnHUEBQdw8fj2lNl6h9vUY4hvSy-2FPNvGOjRAzNwcvTdD7XPwHuOISiJvkfweKNiTVnLhszz-2BaPa2uBQeSbO1E-2FFiDRo0afmumCr9cUJG5AE0JU6bOPlFQWfBP67LnlYTCVJ37-2BDV5sFFbD67nMeYMKCWj2YhbRUi1UnjJlU-2F9dzsKxHmebPKdjUD1H-2BEBKdiStR5haTH97n9QGKcFk7BWVIsTdHgzt3Cv), which provides robust analysis of these schemes, and raises key questions for lawmakers and communities considering PFS and SIBs as an alternative to public financing of services (ITPI, 2015).
3. PHARMAC is a good model for this theme, though we note its value is limited by a very constrained budget, and that it is likely to be adversely affected by provisions in the Trans Pacific Partnership Agreement, delaying competition from follow-on generics and biosimilars, and therefore delaying access to affordable medicines (Gleeson, 2015) .
4. With the exception of the bullet point around funding – it is not clear what is meant by ‘multiple bottom lines’, we believe the 10 year vision is well framed and realistic; we particularly welcome the explicit vision of a “clear lift in health outcomes experienced by previously disadvantaged population groups”.

**4. One team**

1. As indicated NZNO supports a comprehensive approach to the health workforce, including both regulated and unregulated workers, and a team approach which utilises intersectoral and multidisciplinary skills and knowledge. We particularly welcome greater collaboration with scientists and researchers at all levels.
2. However, we are astonished at the lack of reference to health workforce education, training, qualifications and regulation, which underpin the quality and safety of the health system. A high performing health system does involve “more than just a skilled workforce” but it certainly can’t perform without one! Nurses are not the only clinical group to feel invisible in the Strategy.
3. The vision talks about talent and leadership, working together and investing in capability and capacity, but not about addressing the workforce challenges identified earlier eg aging workforce, overreliance on immigration, or having a sustainable workforce able to meet New Zealanders’ health needs.
4. This includes having a Māori workforce to meet Māori needs. There are numerous government strategies, eg Primary health care strategy (2001); He Korowai Oranga: Māori Health Strategy (2002); Raranga Tupuake Māori health workforce development plan (2006); Whānau ora: Report of the Taskforce on Whānau centred initiatives (2010), focused on improving Māori health inequalities, and all are reliant on a Māori workforce to deliver a ‘Māori by Māori health service.
5. NZNO insists that the Strategy include a vision for the Māori health workforce, including addressing the under and over representation of Māori in the regulated and unregulated health workforces, respectively.
6. ‘One team’ should not mean homogeneous; the full diversity of Aotearoa New Zealand’s demography should be reflected in the health workforce.
7. We agree that it will be important to have an operating model which allows effective use of all roles, providing integrated clinical pathways for patients, though not necessarily linked to disease conditions, co-located services where possible, and co-ordination with other social services.
8. With regard to vertical integration and service planning we note that increased training and employment of workers in a wide range of care and support roles, some of which replace and/or overlap traditional clinical roles, has had adverse health and employment consequences in some areas, eg mental health and aged care, where there has been inadequate provision for clinical assessment and oversight. The provision of health and social services may be integrated, but there are human resource requirements specific to, and within, each.
9. NZNO also welcomes recognition of the need to support carers beyond the formal workforce, including families, whānau and volunteers.
10. We **do not support** the limited 10 year vision for the one-team approach.

**5. Smart system**

1. This theme is entirely centred on IT and makes no provision for people, communities, and circumstances where digital technologies are not accessible. It cannot measure up to the Strategy’s statement of being applicable to ‘all New Zealanders’.
2. A smart health system is not about IT, it is about people. IT supports data collection, access to information and some forms of communication but it cannot make personal choices nor replace face to face relationships with health practitioners.
3. Ironically, the Strategy does not identify the value of IT in being able to be located anywhere, and could therefore be used to drive regional capability and capacity. Eg in our several submissions to Health Benefits Limited (HBL) on their proposals for national infrastructure we noted the advantages of decentralised services and the disadvantages of increasing centralisation:

We have in several previous submissions urged you to consider the significant cost and health benefits of locating rationalised national services in the regions where possible, yet we are not convinced that alternatives to Christchurch and Auckland have been seriously considered. We note, for instance, that in the South Island, Venture Southland is looking for opportunities to attract IT investment to build on its impressive record of national and international IT collaborations. It has excellent connectivity with a POP connection to the REANNZ network, has dual-redundant route-diverse circuits, a strong relationship with New Zealand's two largest telecommunications carriers, and a sustainable, reliable energy supply. It is also not coping with an earthquake rebuild! What investigation/ consideration was given to locating the South Island data centre in other areas, such as Invercargill?

We also query the decision to locate the North Island data centre in Auckland, for obvious reasons: there are significant, well documented pressures on virtually every aspect of Auckland's infrastructure. Meanwhile, there are several regions in the North Island currently disadvantaged by lack of IT infrastructure which would stand to benefit enormously from an investment project of this nature. **As we have pointed out, the health of rural and regional communities and the individuals living in them is closely related to having sustainable employment opportunities**. What consideration was given to the health benefits/costs of the data centre location, and what other locations were considered? Was any consideration given, for example, to linking with the clinical regional and health education hubs being established?

As it is, we believe there are significant health, security and cost advantages in reducing the number of sites for, and integrating, stored health data and would welcome assurance that quality (i.e. accuracy, security, accessibility, disaster protection etc.) rather than speed and cost will guide decisions around implementation. Given New Zealand's exposure to weather and geo hazards, we particularly welcome the fact that, for the first time, national health data will be backed up by having dual connectivity from all sites to each data centre.

1. While we support all the 10 year vision statements for a smart system, we strongly recommend that provision is made for those who cannot or do not use digital technologies, and consideration to be given to using IT to enhance rather than reduce rural/regional capability.

Roadmap of Actions

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

**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?**

**Section A**

**People Powered**

1. The 5 year vision is about information rather than health or access to healthcare. While there are references to diversity and catering to “all people at all points in the system”, the actions are almost entirely exclusive to users of IT, without acknowledging inequitable access. There is no recognition of the people and communities that are not ‘connected’. Coverage in Aotearoa New Zealand is not universal and though we do note and applaud the government’s Rural Broadband and Ultrafast Broadband Initiatives which will be critical to realising this aspect of the Strategy, connectivity doesn’t equate to capability or affordability. This has the potential to exacerbate health inequity by excluding those who already lack access to basic health care unless the intention really is to “equip” people with the IT they need. However we note there are no actions around that.

**Action 1**. Improve coordination and oversight and expand delivery of information to support **self-management of health** through a range of **digital technologies**.

1. The idea that access to electronic information will somehow improve health literacy, change people’s lifestyles, and enable them to ‘self-manage’ conditions is fundamentally flawed. Evidence indicates that in both health and social services, it is the therapeutic relationship that is most helpful to people. The exclusive focus on encouraging the use IT could lead to diminished opportunities to develop interpersonal relationships and the ability to interact and bond, that underpin mental and emotional health, and that are essential to health professionals being able to assess, screen, treat and educate patients.
2. The need for models of care to focus on the relational aspects of care and whānau ora approaches is carefully explored in NZNO’s document *Beyond 2020: a vision for nursing project* (2014) and followed by a *Models of Care Policy Framework* [[22]](#footnote-22) (2014). The latter provides a useful framework for identifying new, evidence-based models, and coordinating the various approaches, ideas, and interventions, including any required changes to funding mechanisms, to ensure safe innovation.
3. b. Why restrict using social media to information about diabetes? Social media should focus on holistic health messages, rather than particular illnesses. Moreover, modern health science supports the Māori world view that illness should not be treated as an isolated event and indeed comorbidities are common in our most vulnerable communities.
4. c. We support strengthening telehealth services including providing 24 hour coverage for services such as Lifeline, Youthline and improving referral processes to accessible, affordable face to face services from them.
5. d. We support shared information systems but again note that patient portals are irrelevant in areas where they don’t have phones, or IT connections; however a single patient record is essential in all cases.

**Action 2**. **Promote people-led service design** by collecting and sharing good examples of it from design laboratories and practices; focus especially on those examples that effectively reach and understand high-need priority populations.

1. a) We have got a myriad of excellent examples of where ‘people-led’ services are working eg Victory Schools. We do not need to reinvent the wheel, we just need to implement what is already there.

b) Clinician led collaborations – the intent is not clear here. Is this focused on engaging with high-need priority populations with clinical networks for specialist services around specific diseases eg diabetes, cancer, or more broadly? We support community engagement in service design but the ‘support’ must be linked to a specific outcome i.e. accessible, affordable services for high need priority populations.

**Closer to Home**

1. The 5 year vision indicates strategic planning will be done regionally – how does this align with DHB planning/ control?
2. As indicated we are strongly opposed to investment approaches that shift public funding to private/social sector particularly for vulnerable and at risk children and families.
3. A strong public sector is essential for ensuring good decision making and direct government accountability, and it is important that investment in the skills and infrastructure required to provide this oversight is continued.
4. Core public health services i.e. primary health, child health, mental health, hospital services, disability services, aged care (all potentially impacted by these changes), serve the most vulnerable in our communities; changes must be well resourced and planned so as not to jeopardise the delivery and essential integration of care. Nurses, regulated professionals with a strong social service ethic, need to be supported to deliver care to those in need. Funding used to establish and reward these experimental programmes ultimately reduces available funding for existing services.

**Action 3** To maximise value for people and achieve the **best health outcomes**, the Ministry of Health, with input from the system, will ensure the **right services are delivered at the right location** in an equitable and clinically and financially sustainable way.

1. This action, under the title “**Shift Services**”, appears to signal an intention to reconfigure services nationally (according to some design principle) and specify where local and specialist services will be available. We suggest much wider engagement than just DHBs will be needed to establish “service configuration design principles” for the location of primary and specialist services which will affect all health settings and all communities. Indeed design principles that will ensure equity and fairness, and consider the full costs/benefits of reconfiguring services, including individual costs/benefits to individuals (eg travel, employment); communities (eg changes to capacity and capability, social cohesion), and the nation (eg impact on infrastructure, environment, sustainability, etc.) need everyone’s input.
2. Our concern is that population density will drive further concentration of health services/infrastructure to fewer cities, and especially to the North, increasing the rural/urban, North/South divide and leaving many communities underserviced and with diminished capacity. This was the approach taken by Health Benefits Limited (HBL) in its proposals to centralise services, by ACC in reducing the number of its contractors, and by the Ministry of Health’s consolidation of Māori and iwi providers, with adverse outcomes all round: Southland DHB ‘importing’ food from Auckland; no brain injury assessment capability in the south Island; and small Māori rural communities more disenfranchised than ever.
3. This is a downward spiral which as indicated earlier, ironically fails to capitalise on the potential of IT to revitalise rural and regional communities.

**Action 4** Enable all **people working in the health system** to add the greatest value by making sure they are providing the right care at the earliest time while **fully utilising their health skills and training**.

1. We strongly support this Action and warmly recognise the leadership of the Chief Nurses Office in progressing the removal of legislative barriers to nurses not only for prescribing, but also for improved access to diagnostics, processes for verifying and certifying death etc. primarily through the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill, and look forward to the Bill’s enactment.
2. We also acknowledge the significant work of the Nursing Council, and other Responsible Authorities (RAs) under the HPCA Act 2003 in ensuring the safety and competence of health practitioners as they adapt to new opportunities and demands, such as prescribing. The flexibility, quality and public safety afforded by the robust regulation under the HPCA is a strength of Aotearoa New Zealand’s health system.
3. b. While we support increasing telehealth approaches, we note than eg shifting services from doctors’ surgeries into homes is an adjunct to the provision of services and cannot replace face to face assessment. The consequences of DHBs replacing nurse visits with telephone calls to assess the home and health care needs of the elderly have led to some poor and unsafe decision making, for instance. Unless it is actually improving access to health services for people who have no or limited access at present, we would strongly question whether this is a priority.
4. We note that Family Planning New Zealand (FPNZ) has just developed telehealth services to support access to fertility services in the many areas where FPNZ’s services are not offered because of entirely inadequate funding for this critical service supporting people’s right to control their fertility. FPNZ’s initiative is effective in ensuring *some* access to people who currently have none, but underlines the fact that access to a telehealth service is *not* the same as having access to a health service in the community, where the big gains from comprehensive primary health care are to be made.
5. In this context we recommend that the Strategy includes the SDG Target 3.7 “By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.”
6. Services for youth could be considered separately. Eg WAVES, an integrated youth and health service established in 2007 by Louise Roebuck, a Nurse Practitioner in Primary Health Care and Youth Health, with help from charitable trusts and corporate sponsors was a highly successful integrated service used by thousands of young people. Following successive funding cuts it was forced to close its nurse led clinics in October 2012!

**Action 5** The Ministry of Health and DHBs will increase the effort on **prevention, early intervention, rehabilitation and wellbeing** for long-term conditions such as diabetes, cancers, cardiovascular disease, chronic respiratory conditions, mental health conditions, musculoskeletal disorders, and for obesity, addressing common contributors or risk factors of these conditions and focusing efforts on points in the lifecourse with the greatest opportunity for success.

1. We strongly support the prevention, early intervention, rehabilitation and wellbeing focus.
2. a. Note our caution around the use of an outcomes framework.
3. c. Agreed
4. d. It is not clear what “requiring partnerships” means. Is it the intention of the Ministry to order eg PHOs, DHBs, local communities to partner with specific organisations or agencies? How will “the best and most equitable” outcomes be evaluated, by whom, over what period? We do not support this action.
5. e. Over time? This is a 5 - 10 year plan (already a very limited timeframe in terms of health). To “progressively target other aspects of long term conditions” would require almost immediate action. And while we strongly support tackling “emerging conditions”, we are not confident it is possible to do so in the short term. In this context we note the absence of robust national occupational health surveillance scheme which doesn’t allow current OH issues to be identified, let alone emerging ones. We would strongly support the Ministry leading the development of such a scheme in partnership with WorkSafe.
6. f. We support capturing the service users care plan in electronic form with the usual proviso that you ensure that paper based plans are also available for access by all health providers who make up the care team.
7. g. We strongly support collaboration with other agencies but why should collaboration be limited to vocational rehabilitation? Presumably this refers to the SIB announced by Minister Coleman which basically places employment officers in GP practices to assist people with mental illness getting employment. Why is there not cross sector collaboration on health-related platforms such as climate change, housing, and occupational health?
8. It is disturbing that the only four references to employment in the Strategy are about getting people off benefits and into employment; these include the most vulnerable who have mental health problems, disability etc. They are not about health and safety in employment; about job security or sustainability; about fair pay and conditions; or about equity, all of which have a significant impact on health.
9. We draw your attention to a recent Treasury working paper[[23]](#footnote-23) *The Employment and Income Effects of Eight Chronic and Acute Health Conditions* (Sylvia Dixon, 2015) which finds evidence of significant employment rate reductions, income support increases, and income losses in the four years after first diagnosis for six of the eight conditions: stroke, traumatic brain injury, coronary heart disease, diabetes, chronic obstructive pulmonary disease (COPD) and breast cancer. We strongly suggest that the Strategy focuses on the ‘big population health issues’ ie prevention and treatment of prevention of these conditions, rather than experimental SIBs.
10. h. We assume that is the child obesity plan which we support with the recommendation that that you act on all the WHO Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity and regulate to improve the current highly obesogenic environment.

**Action 6** The Ministry of Health will continue to **collaborate across government agencies, using social investment and lifecourse approaches**, to improve and make more equitable the health and social outcomes for all children, families and whānau, particularly those at risk.

1. NZNO strongly supports a “great start for children, families and whānau”.
2. Two important focus areas that are missing are: pre-pregnancy planning and nutrition, and breastfeeding.
3. We recommend that an action to reach the target set by SDG 3.7i.e. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
4. We also recommend the government act on measures to improve the nutritional environment for men and women of reproductive age eg folate fortification, health promotion, including labelling, and regulation on alcohol and other drugs, smoking, high fat high sugar foods etc.
5. The Strategy should ensure a supportive breastfeeding environment by rigorously enforcing the WHO Code on marketing breastmilk substitutes. We note that the Commerce Commission recently approved a formula industry application to restrict competition for products for infants under 6 months, and that the Ministry has sought to tighten labelling requirements for exported formula consistent with our own standards. However, there are numerous breaches of the Code, which are not monitored, or followed up. The Ministry should demonstrate leadership in this area and be proactive about maintaining the Code, promoting breastfeeding through a comprehensive suite of evidence-based messages including benefits to infants, mothers and the environment, and advocating for breastfeeding friendly community facilities and workplaces.
6. The Ministry should also ensure it collects accurate and useful information about breastfeeding, including using “exclusive breastfeeding” as an indicator across all age bands. Currently the indicator[[24]](#footnote-24) changes at three months from “exclusive” to “any” breastfeeding, so it is difficult to see whether infants in Aotearoa New Zealand receive the optimal nutrition of exclusive breastfeeding for the first six months, as recommended by the WHO.
7. We strongly support actions to promoting healthy housing – it is not clear what ‘support’ is intended.
8. d and e. While it is always useful to improve collaboration between education services and health services, there is inequitable access to, and use of, preschool education, by the most vulnerable. These are both priority actions which will improve quality for those already accessing services but do nothing for those who don’t. We note and deplore the fact that there is **no** action to help the latter despite the huge resources and energy invested in developing and implementing the Vulnerable Children’s Act (VCA) 2014.
9. Currently nurses are being expected to act as lead navigators of the special children’s teams set up under the Children’s Action Plan to care for children identified as at high risk of abuse, with no funding or provision for the extra time involved or training needed!
10. In the context of the government’s considerably strengthened requirements for people on benefits to return to work sooner and to ensure children are enrolled in early childhood education regardless of the availability of jobs, transports, and ability to pay, we are concerned that these actions both miss the mark and may be seen as punitive.
11. f. this is a sensible initiative. Prison nurses are aware of the close relationship between prisoners’ health needs and prisoners’ families’ health needs. Visiting times provide opportunities for health checks, immunisation and counselling.
12. g. We support all evidence-based initiatives aimed at preventing and reducing sexual and family violence, but note that ACC is usually focused on remediation and similarly the CAP appears to be focused on identifying abuse. We recommend that the Strategy focuses on proactive approaches to promoting healthy non-violent attitudes to sexual and family relationships.
13. h. We support developing a plan to lead a response to Fetal Alcohol Spectrum Disorders, presumably along the lines identified in the National Drug Strategy 2010-2015 ie improved diagnosis and clinical management of affected children, appropriate individual and family support, and coordinated education and information campaigns. We recommend the actions referred to above in relation to improving the nutritional environment.

**3 Value and high performance**

1. Note our earlier comments about the risks of an outcomes-based framework and a SIB investment approach where the intention is to transfer risk to the ‘investors’ (eg NGOs, industry, communities - “others”) rather than the commissioner (the government).
2. It is the government and the taxpayer who ultimately pick up the tab for the costs of failure of private investment to society as a whole.
3. The way in which social services are commissioned and purchased affects employment in health and social services, and thus has a significant impact on workforce quality and sustainability. Short-term funding and resultant job insecurity risks repeated, wasteful cycles of establishment and disestablishment of positions, programmes and services.
4. We further caution that the goodwill of volunteers cannot be taken for granted when aimed at for-profit sectors. As an example: when food for meals on wheels (previously delivered by volunteers in Otago happy to help out "their" DHB) was privatised, the volunteers declined to continue to give their labour for free. In any case, levels of volunteering are already declining, partly as more and older women in particular remain in the workforce. Likewise, NGOs (for example Hospice) may find their charity donations and bequests affected by having to respond more closely to a government agenda in search of funding.
5. We are pleased that the Strategy recognises that there are some funding issues but we suggest the most important is the reduction in health funding in real terms over the last few years of an estimated $1 billion (Rosenberg & Keene, 2015).
6. There is a considerable difference between a “health investment mind-set” focused on primary health care, and one focused on the business of health care.

**Action 7**\* The Ministry, working with the HQSC, will develop and implement **service user experience measures**. This could build on the HQSC’s existing work with online patient experience surveys

**Action 8** –.\* Develop and implement a **health outcome-focused framework**, with involvement from the health and disability system, service users and the wider social sector. The framework will reflect the links between people, their needs, and outcomes of services and will shift the focus from inputs to outcomes. This work will build on the Integrated Performance and Incentive Framework work to date, and aims to increase equity of health outcomes, quality and value

**Action 9** Work with the system to develop a **performance management** approach that makes use of streamlined reporting at all levels, to make the whole system publicly transparent. This will draw on service user experience results (developed through action 7), operate within the outcomes framework (developed through action 8) and involve approaching planning, monitoring and continuous improvement in a tight–loose–tight way (ie setting specific target outcomes, making service delivery options flexible, and being tight on achieving health and equity outcomes) and supporting innovation.

**Action 10** Align funding better **across the system** with a rolling programme focused on getting the best value from health investment (including incentives where relevant to support Strategy direction).

1. We strongly support (a) improving access to health services for those most in need through financial support eg very low cost access. However we would like to draw attention to the inequitable outcomes that can arise from well-intentioned initiatives. Eg $90 million allocated over three years to support access to GPs for under 13 year olds has according to many of our primary health care nurses improved access to the “white worried well”, but not to much more vulnerable group. Moreover not all GPs provide free access, and there are not enough GPs to provide the service in some areas.
2. It is important that the right services are funded, in this case improving access to nurse-led clinics in community settings, pharmacies, schools, and after hour’s services outcomes would have delivered better fairer results for a fraction of the cost.
3. b. with regard capital expenditure we note that HBL arose from a similar centralised government approach and the results were disappointing and divisive to say the least. The new “DHB owned” Health Partnership Limited should be encouraged to develop the expertise indicated and be able to call on government advice rather than have it imposed.
4. Note comments above re commissioning
5. d. We support aligned IT funding

**Action 11** Develop and use a **health investment approach** with DHBs. This could be used to target high-need priority populations to improve overall health outcomes, while developing and spreading better practices. This will increase knowledge about population segmentation, drive collaboration, build skills in developing investment cases in the system, improve visibility of value for money, and build on the New Zealand Productivity Commission’s recommendations around a learning system.

1. As above re investment approach and trials.

Action 12 Continuously improve system quality and safety

1. We support these actions. Note the recent *Adverse Events Report* from the Health Quality and Safety Commission, which notes nurses keep patients safe in care.

**4. One Team**

1. Nurses strongly object to being called “actors in the system”.
2. The 5 year aim appears to be aimed at improved systems but delivering what, in terms of workforce, ‘new’ models of care? How does the Strategy take into account the IT changes that could happen ahead and the consequent staffing/role change implications that will ensue?
3. There are identifiable workforce gaps, and challenges but the actions do not address them.
4. PLANNING is the missing ingredient. What is needed is coordinated delivery – education, health employment regulations support – and identified, realistic objectives to improve workforce sustainability, develop and enhance integration and teamwork health workforce implement new models of care, and improve safety and quality.
5. Some of these things are happening; it is not clear that the amount of restructuring of committees, refining of roles and responsibilities etc at this high level will be translated into anything useful on the ground.

**Action 13** Improve **governance** and **decision-making processes** across the system, through a focus on **capability, innovation and best practice**, in order to improve overall outcomes.

1. More reviews! This should not be a new action but should be embedded in the system.

**Action 14** The Ministry of Health will work with leaders in the system to improve the cohesion of the health system, including by **clarifying roles and responsibilities/accountabilities** across the system as part of the planning and implementation of the Strategy.

1. We agree with implementing some systems for accountability. Over the past 7 years the Ministry has introduced and disestablished several committees with no accountability for costs or (failed) outcomes. The lack of workforce planning delivered by Health Workforce New Zealand, for example, and the cost and lack of evidence supporting some of its decisions, has been very disappointing. However the strengthening of the Chief Nurses office after a prolonged period when there was no CNO has delivered real gains.
2. b. What is the point of stating that DHBs will carry out their roles and responsibilities? How is this an action that will improve population health?

**Action 15** \* The Ministry of Health, with input from the system, will establish a simplified and **integrated health advisory structure** that oversees health system changes and incorporates or takes into account relevant existing national committees (eg, the National Health IT Board, the Capital Investment Committee, Health Workforce New Zealand, the National Health Board, and the National Health Committee).

1. As above. A simplified structure would be useful and perhaps that could be rolled over to the rest of the health system so that there is a more open and shared relationship with the health users/ people /population?
2. This could include clearly setting out people’s rights and responsibilities in relation to the health system, so that they understand and have realistic expectations of what the system will and won’t deliver? Does the Strategy, for example, plan to clarify for consumers across the country how they access healthcare across the public/private (eg GPs) interface with the DHB services? Does it speak to the many and varied public and private funding streams that currently exist providing very different 'incentivisations' for the owners, including government appointed (mainly) Boards/Chairs?

**Action 16** Put in place a **system leadership and talent management programme** and **workforce development** initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.

1. We support actions to develop leadership and suggest that this will be dependent on establishing supported career pathways and aligning education and employment opportunities.
2. b. We welcome this action developing skills and capability in the NGO primary and volunteer sector. We would like to see at least equal investment in the clinical workforce.
3. d. We strongly support the work of the HQSC.
4. e. We welcome an action supporting the carer and support workforce – we assume this refers to the Kaiāwhina Action Plan jointly developed by HWNZ and Careerforce?
5. f This action only needs to say the Ministry will identify and use workforce data to inform workforce planning and development.

**Action 17** To create a **‘one-team’ approach for health in New Zealand**, the Ministry of Health will **facilitate whole-of-system forums annually** (in advance of DHB planning), to discuss government priorities, share international and New Zealand best practices and build leadership. Forums will inform advice to the Minister of Health on system priorities on an annual basis and contribute to a culture of trust and partnership.

**5. Smart system**

1. As indicated – we support the health benefits that come from robust integrated IT systems, accessible shared records, strengthening national analytical capability etc.
2. However, the Strategy fails to recognise the downside of IT eg inherent inequity and also its role in promoting ill health eg encouraging sedentary lifestyles and increasing exposure to unhealthy activities such as sexual violence from internet dating, bullying, addiction etc.
3. It also fails to identify the potential of IT to strengthen regional development. .

**Action 18**. Increase New Zealand’s **national data quality and analytical capability** to improve transparency across the health system.

**Action 19** The Ministry of Health will establish a **national electronic health record** that is accessed through certified systems including: **patient portals**, health provider portals, and mobile applications.

**Action 20** Develop capability for **effective identification, development, prioritisation, regulation and uptake of knowledge and technologies**. This action area seeks to improve the health system’s service effectiveness, reduce cost, and improve engagement with people who access health services, promote healthy behaviours and self-management, and aid people-led design. It includes use of new technologies (medicines, medical devices from dressings to robotics, cell and tissue therapies), service design/models of care, and information technology.

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

1. Coherent planning and engagement with the workforce, communities, local government and providers.

Any other matters

1. NZNO recommends that the Strategy

* Refers to the Public Health Association of New Zealand’s *Policy on Reducing Health Inequalities*, (2002);
* adopts an overarching public health model of care focused improving population health and equity;
* reprioritises actions to address health disparities;
* identifies actions to strengthen community capability to support integrated social and health care services that meet the needs of the individuals/whānau and families in that community;
* considers costs in the total context of the costs of health / ill-health to individuals, family and whānau, businesses, and government;
* invests in evidence-based programmes supporting primary health care;
* incorporates actions for long-term health workforce planning that are consistent with global human resources in health;
* includes an objective for the Māori health workforce, including addressing the respective under and over representation of Māori in the regulated and unregulated health workforces;
* includes an action to use exclusive breastfeeding as an indicator across all age bands;
* prioritises alternative information and communication channels, including access to health expertise, for those who cannot or do not use digital technologies;
* includes actions to minimise negative impact of digital technologies eg addiction, bullying, sexual violence;
* endorses WHO Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity commission and regulate to improve the current highly obesogenic environment;
* includes specific actions to address the goals outlined in the World Health Organisation’s *Draft Global Strategy for Human Resources in Health: Workforce 2030* including a target of 90% workforce sustainability;
* identifies access to affordable services and treatment as part of the ten year vision
* provides alternative access for those who cannot or do not use digital technologies;
* identifies ITopportunities to enhance rather than reduce rural/regional capability
* includes the SDG Target 3.7 “By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
* act on measures to improve the nutritional environment for men and women of reproductive age eg folate fortification, health promotion, including labelling, and regulation on alcohol and other drugs, smoking, high fat high sugar foods etc.; and
* focuses on proactive approaches to promoting healthy non-violent attitudes to sexual and family relationships.

[redacted]

**Senior Policy Analyst**

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APPENDIX 1: NZNO letter to Director General re Update of health strategy, dated July 30, 2015.

Tēnā koe Chai,

**Update of the New Zealand Health Strategy 2000**

Thank you for the opportunity to contribute to the update of the health strategy, and the allied health systems reviews of funding and capability and capacity. We appreciated the opportunity to meet with, and respond to the questions from, the capability and capacity review panel, including stating our position in areas we strongly believe need to be given priority focus through the reviews. We also participated in the sector workshops in May and June. We want to take a further opportunity to reaffirm directly to you the priority areas we believe need to be reflected in an updated Health Strategy.

We strongly support the principles and goals of the 2000 health strategy. We welcome the notion of proposing a roadmap to provide clearer sense of direction and priorities to achieving them. Stronger emphasis must be placed on implementation which removes and addresses the barriers that have hindered progress in some areas, for example, the funding barriers that have limited development of community based nursing services. Harnessing leadership and input from the nursing profession will be a critical success factor to achieving the highlighted move from an illness to a wellness focus, in line with the principles and goals of the strategy.

NZNO’s priorities - a sustainable, fully utilised, nursing workforce, investment in public health, a primary health care approach to population health improvement, best start for children, safe clinical environments, social and health equity, and safe and fair employment (New Zealand Nurses Organisation, 2014) - are entirely consistent with the strategy. It is pleasing to see the extent to which they are reflected in the common themes identified at sector workshops as part of the strategy update. We endorse the focus areas and system enablers identified in the second workshop and a vision which embraces wellness. This is consistent with the World Health Organisation (WHO) Millennium Goals (MDG) and the Sustainable Development Goals (SDG) specifically Goal 3. It is our view that a refreshed strategy should reflect a roadmap which includes actions to address MDGs and SDGs.

Similarly, with regard to the supporting reviews, we welcome the proposed operating model which offers clarity and accountability, and agree that accelerating new funding pathways to support new ‘citizen centric’ models of care is critical to implementing the strategy. The most important change to funding must be to open up the existing PHO funding for GP practice to allow new, integrated models of care utilising the full range of health practitioners’ skills to emerge. In particular funding streams must allow affordable, community access to primary health care and services provided by the non-governmental sector to complement access to primary medical care.

New models of care require careful workforce planning and development, and while this is partly recognised in the review, particularly with regard to developing the unregulated workforce, the lack of focus on comprehensive long term health workforce planning is a major concern. The current disconnect between education, employment and immigration strategies is evident in Aotearoa’s endemic skills shortages in key areas of health, our abysmally low retention of migrant practitioners and inequitable workforce distribution and ethnic/gender composition. The global context in which health workforce resources must be developed and maintained, to have the capacity and capability to respond to threats such as climate change, or to leverage the benefits of global migration, is complex and demands a comprehensive and systematic approach to health workforce planning.

Finally, while we acknowledge the need for new funding approaches, and strongly support cross sector funding for improved social, education and health outcomes, the plethora of evidence-based programmes - Family Start, Waves, Victory Schools etc. - obviate the need to experiment with highly contentious investment models such as social impact bonds. Nor do we support funding being taken from DHBs for this purpose, in view of the cumulative reduction in funding to DHBs – an estimated $1 billion since 2009 (Rosenberg & Keene, 2015).

We have previously expressed our concern on the pace and timing of the reviews, the impact this may have on constructive engagement and potential to create a perception of a lack of transparency and predetermined outcomes. We are still of this view. Whilst we have had the opportunity to contribute to this stage, we ask that during the next phase you provide us and other health colleagues the opportunity to comment on any substantive reports on the reviews and sufficient consultation time so we can seek input from our members. As we have highlighted previously in the absence of information, speculation fills the vacuum.

We trust the above is useful and look forward to further engagement with you and the Ministry.

Nāku noa, nā

Memo Musa

**Chief Executive**

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| **355** | Submitter name | Don Matheson |
| Submitter organisation |  |

**The NZ Health Strategy: refreshed or eviscerated?**

**Don Matheson**

30/11/15

Many people I have talked to have had difficulty engaging with the “refreshed” NZ Health Strategy. They ask, what is it really on about?

To help answer this question, I read the strategy in conjunction with the background financing and accountability document. The latter is important, as the strategy is rich in the language of economics (financial risk, cost escalation) but generally avoids the language of health. Clearly the financing and accountability document holds the detail that the strategy alludes to, but does not explicitly state.

My main questions on the strategy are:

1. **Why has the refreshed strategy lost the focus on lower socioeconomic groups and equity?**

The strategy is weak on equity. There is limited reference to Maori and Pacific populations, but no focus on the health impact of low incomes on other New Zealanders. It does not recognise the health impact of poverty.

The current strategy says:

* ensure accessible and appropriate services for people from lower socioeconomic groups
* ensure accessible and appropriate services for Mäori
* ensure accessible and appropriate services for Pacific peoples.

The “refreshed” strategy has no similar articulation of these goals.

1. **Why are the population health priorities not mentioned in the “refresh” Does this mean they are no longer a priority?**

The priorities in the current strategy are population health problems:

* reduce smoking
* improve nutrition
* reduce obesity
* increase the level of physical activity
* reduce the rate of suicides and suicide attempts
* minimise harm caused by alcohol and illicit and other drug use to both individuals and the community
* reduce the incidence and impact of cancer
* reduce the incidence and impact of cardiovascular disease
* reduce the incidence and impact of diabetes
* improve oral health
* reduce violence in interpersonal relationships, families, schools and communities
* improve the health status of people with severe mental illness
* ensure access to appropriate child health care services including well child and family health care and immunisation.

The refreshed strategy mentions obesity, but only in relation to certain populations, studiously vague on national policy responses. Huge opportunities for public health gain such as a Tobacco-free New Zealand do not get a single mention in the strategy[[25]](#footnote-25).

1. **The “refresh” introduces the idea of an “investment approach”. Does this mean that private insurance companies may be the key decision makers in our future health service?**

The “refresh” talks about an “Investment Approach”. According to the background documents this will involve:

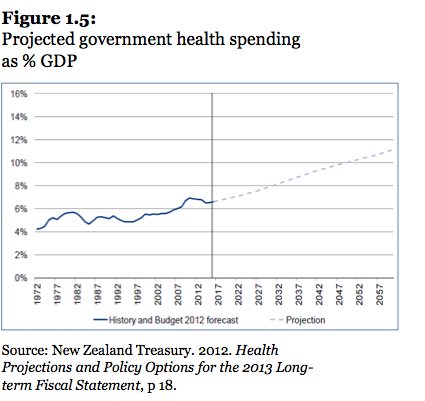
1. removing the universal aspects of capitation payments for primary care;
2. allowing organisations other than DHBs to hold funds and purchase services for populations;
3. supporting large private international insurance type companies to compete with DHBs; and
4. shifting decision making over health care from doctors and DHBs to actuaries working in DHBs and large multinational insurance companies.

The wider implications of this new approach are discussed in detail below.

1. **How will the focus on new information technology avoid making equity worse?**

The new strategy emphasises the advantages that Information Technology will bring. Right now, the rich have far greater access to technology than the poor. Society at large has realised that the access and ownership of their data can be abused by governments and advertisers alike. The refresh emphasises the advantages of better data use, and does not mention the risks of data sharing, how they will be managed, or the steps to make IT access equitable.

1. **Why is the Treasury advice about future health expenditure not up to date, and why does it only cover government expenditure?**



**?**

**?**

The main problem the “refresh” is trying to address is government health expenditure. The graph presented has data that is now three years old. It predicts that government health expenditure will reach 11 percent of total government expenditure in 42 years’ time, and presents this as a rationale for the “refresh”.

This predictionreflects the pattern since 1997 and not 1972 as the graph implies. The pattern since the GFC in 2008 would look quite different, with lower growth in health expenditure. The GFC itself was also a timely reminder of how wide of the mark out-year financial predictions can be.

If private spending goes up, that is as much of a problem for consumers as increased government spending. Total health expenditure is not on the graph, which sheds light on the nature of this refreshed strategy. It is no longer a “Health Strategy”, but a “Government Expenditure on Health Strategy”.

Contrary to Treasury’s view, the NZ public may feel that, with an ageing population, the government should spend more on health. If the government says it can’t support growth in public health system expenses in the face of increasing demand and rising costs, then what happens to the health needs that the rising expenses represent? Either people must go untreated or inadequately treated, or they must pay for treatment privately (individually or through private insurance).

Some of the first option (leave people untreated) is feasible but is likely to reduce potential quality of life and/or productivity. The second option (private payment) means the economy still has to stand the cost of the increase in health expenditure – it is just that the government doesn’t pay for it. The government may be happy to shed this responsibility but it may not be better for people, the country and the economy.

The key question is whether it is more efficient and equitable to pay for health needs privately or publicly. There are good reasons to conclude that health care is more efficiently and equitably provided publicly even if it requires higher taxes (which save individuals private health costs). Even Treasury seems to concede this. ACC has shown it may be considerably cheaper for the state to fund services than private insurance.

The state is also likely to be much better than private agents at preventative measures to reduce future costs, especially if it faces these costs. The enthusiasm of the government to represent the interest of the people in the face of the “needs” of tobacco, alcohol, the health damaging part of the food industry and their associated marketing arms, is related to its ‘skin in the game’. A reduction of government engagement in health will enable the government to wash its hands, leaving citizens exposed to the full onslaught of these health destructive industries.

To properly inform the strategy an up to date graph is required that shows both private and public expenditure over the period. The assumptions behind the future predictions need to be clearly spelled out. The modelling needs to demonstrate not only how it has dealt with both public and private expenditure, but the relationship between them. Health care costs are related to the proportion of private expenditure – as it rises, total costs rise. Equity is inversely related – as the private sector proportion grows, access equity deteriorates. Once that information is presented, then the refresh needs to consider if the Treasury view is actually view of the people of New Zealand.

**More about the “Investment Approach”**

There are a number of concepts in the “Investment Approach” that are expressed in the background documents but not in the strategy itself. The “devil is in the detail” of the Investment Approach discussion.

* The approach converts health and health care into its dollar value before decisions are made.
* The system moves to managing sub populations, rather than the government paying for specific services.
* The new health organisations focus on managing “financial risk” - not the risk to your health specifically, but the financial risk of your health requiring future health or other government expenditure.
* The removal of subsidies (such as capitation) for the middle and upper classes, so that government spending on health is only focused on the poor. Who is poor is then determined by the information held on individuals by MSD and IRD. The middle class will move to take out private health insurance and will no longer be of concern to government. In turn this will reduce their willingness to pay taxes for a public health system, making it more difficult to fund the services for the “poor”. A downward spiral will result, driving greater inequality in the system.
* The approach includes the introduction of private companies (referred to as “Other” in the documents) to compete with the DHBs, as it is assumed that in many cases the “Others” will be more able to manage the financial risks. It is likely that these “other” organisations will be large (managing care for 500,000+ people, and few companies in New Zealand will be big enough) so they are likely to be foreign owned – a move strongly supported by the recently negotiated TPP. The TPP is fundamentally about international trading of services.

The nature of the contract with these “other” companies needs to be closely considered as that is the only tool the government will have to ensure that the poor actually do get promised service improvements. Health management companies have vast experience in making a profit from their businesses – far greater experience than the Ministry of Health has of entering into a good contract. If the contract is weak, the companies will:

* “cream skim” (only pick well poor people to join their schemes);
* price gouge, so that only the lowest cost service providers survive;
* compromise on quality as it is very difficult to measure; and
* hold payouts to the black letter of the contract, getting legal checks of every claim (typical in health insurance – the grim reality of this approach has already been experienced by the people of Christchurch, post-earthquake).

The background document recommends that these new contracts be “tight, loose, tight” in nature. This usually refers to the way organisations are run- where management tightly controls the purpose of the organisation, employees are given a wide scope (loose) as to how they fulfil this purpose with few organisational rules, and the management has a “tight” focus on getting the right results. The refreshed strategy refers not to “purpose” for the first ‘tight’, but to “targets”. This is an untested departure from what is commonly understood by tight/loose/tight. The “loose” bit in the refreshed model will include decisions as to who gets what services, when and from which providers - decisions to be taken by “Others,” almost certainly large private financial risk managing healthcare companies, and some DHBs if they prove able.

So, in summary:

The government focuses its health expenditure on the poor – as it defines it. The services for the non-poor will move to the private sector. Large financial risk managing companies and some DHBs are paid by the government to manage the sector on the basis of controlling future government expenditure. These companies then buy services from providers, with a loose government contract, but making sure that they make a profit, and the government’s outcome are met.

**What could possibly go wrong?**

*There are major problems in translating health needs/events into monetary value.*

* A fundamental problem is that costs to the government (fiscal) are relatively easily quantified whereas benefits and other costs to patients, society and the economy are not. They get neglected or completely omitted as they are in the MSD “Investment Approach”, as noted by the Productivity Commission.
* It is not an exact science, as the meaning (and monetary value) of a particular illness differs markedly between individuals and populations so the monetary value is an approximation. The monetary value of future health expenditure is more measurable than the monetary value of the relief of suffering and quality of life.
* The strength is in taking actions now to reduce future government health expenditure. The weaknesses is that investing in some groups of people (such as the terminally ill or the permanently unemployed) may not reduce future health expenditure so these groups could be excluded from care.
* The strength is in better managing young people with potential economic value in future. The weakness is in the tendency to neglect older people, as they may be judged as having little economic value.
* The technology revolution is changing the economic value of labour and consequently, people. Efficiencies through technology use are not translating into increased wages. Tying health decision making to the ‘economic’ value of citizens will over time mean reduced resources for human health as people’s economic value drops.
* The economic value of Aucklanders is much greater than the economic value of people in Timaru. So Aucklanders would justifiably get more health services than those on the margins of the economy.

*The size of the population does not lend itself to this model.*

New Zealand is a small country. The country is not symmetrical - it has one moderately sized urban centre, and the rest of us are scattered over large distances. The model being suggested does not acknowledge these different circumstances. At the centre of the proposed model is the transfer of “risk” of the cost of illness from the public sector to the private sector. In order to effectively manage these risks, large populations are required, (so one person getting an expensive illness like severe burns does not financially crash the company). This means that big companies will be involved, and big populations. In the New Zealand context, with a small population, this means that there will be effective monopolies as there will not be enough poor people for more than one or two companies.

*Shifting risk to the private sector is expensive*

The private sector does not take on risk for nothing. The bigger the risk, the more the company will charge the government for holding that risk. This will push the price of health care up – for no benefit in service provision. Then if something catastrophic happens, (as we have seen in Christchurch and with Serco private prisons) it is not the insurance or private companies that are likely to wear the bill. The risk and cost will fall back to the government.

*The removal of universal access always creates problems at the margins*

Currently the government supports universal access for children and young people to primary care and many other services, and universal access to hospital services. Recent government moves to lower price barriers to care have shown benefits, with better use of services and better access. According to the background document, there is to be a move away from this universal provision. This means there will be a sharp division between those who get government assistance and those who don’t.

In the American health system, where they have strong divisions of this nature, the major problem that developed was for the lower middle class – not poor enough to get subsidies, and not rich enough to pay for private insurance. Obamacare is trying to reverse this as we speak, at great cost and not nearly as effectively as a publicly funded universal system. But there is no mention of this fundamental flaw in the refreshed strategy.

*Effective responses to our main public health problems are ignored in the ‘refresh’*

The consultation draft only mentions tobacco once, then only in relation to its relative importance compared to obesity, and the entire “Road Map of Actions” does not have a single mention of tobacco. Alcohol is only mentioned in relation to pregnant women. This is a most extraordinary omission for a national health strategy but fully consistent with the intent of the “refresh”, to position government outside of difficult debates with key commercial interests. It reflects an ideological purge that has also occurred in terms of Public Health more generally, through crafting such approaches as “the nanny state” and weakening its functions across the Ministry of Health. Public Health, and public health approaches, are very weak in the “Road Map of Actions”.

It is assumed that such functions will be picked up through the “Investment Approach,” where profit maximising insurance companies and some DHBs will see that it is in their best interests to pursue these approaches. Yeah right! Any one company has little incentive to reduce population health risks because most of the benefit will accrue to other companies or the state. It can work only if it is regulated – by the state - but then you have similar problems of specification, auditing, accountability as described previously.

This means we are placing all our eggs in the experimental “investment approach” basket. The government is effectively signalling its exit from directly exercising its authority to improve the health of the people. This ignores the last few thousand years of human development, where the ‘organised efforts of society’ have proven time and again to be effective in improving the health of populations. The missed opportunities in the face of a non-communicable disease epidemic is a gaping strategic hole.

**An alternative approach**

An alternative approach would value humanity in its own right, and be built on the primacy of values such as prevention of disease, protection, and caring. Such an approach would value all people, irrespective of their future health care liabilities. These values should frame the strategy, and not be distorted through a ham-fisted translation of human health need as fiscal ‘liability.’

Public Health, and public health approaches, need to play a major role. There is a proud history of success using these approaches in New Zealand. This experience should be built on to improve health in the future, to address, for example, problematic alcohol consumption, obesity, climate change etc. This requires national capacity and capability. As much of health is generated outside the health sector, it also requires national health leadership to support health in all policies, and assess health impacts of other sectors.

New Zealand also has a history of successful innovation in health service delivery. We should support innovation, both organisational and technical –in particular, services that have effectively addressed equity, services of high quality, services that are carbon neutral, services that effectively leverage technology improvement to further health goals. We should be identifying the factors that have led to successful providers, PHOs, DHBs, departments within DHBs, and build on these. The roots of their success will be complex, not reducible to a single ideological model. At its core is the relationship between services and the people.

Success is also highly context specific – not identical in Auckland and the West Coast, not the same in the health sector as the disability sector. A new strategy would use our comparative advantage, our small size, to identify and foster new models of service delivery, be they public, private, or from the NGO sector.

Rationing decisions in health care are tough in any system. No one wants to miss out. Decision makers have to make a call when at the individual level the true benefits of a particular decision are unknown and currently unknowable. The proposed model would have these rationing decisions sitting within an actuary’s table. An alternative would be to acknowledge the uncertainty and complexity, and make a judgement on who is best placed to make these decisions. Clinicians, patients, provider organisations and communities can all usefully play a role in this. Moving to a brave new world based alone on the wisdom of the actuarial table would, in my view, be a grave mistake.

The DHBs as public institutions are in a reasonable position to respond to this complexity. They currently have well known limitations[[26]](#footnote-26), but given the perfect health system does not exist, it should not be beyond our ken to strengthen their successes and address their weaknesses. They have in fact been remarkably successful in containing costs, a point that is not acknowledged. They have not been successful at addressing equity or getting a better balance between prevention, primary and hospital care. There are obvious and relatively straightforward steps that can be taken to address these current shortcomings.

The positive aspect of a true ‘investment approach’ is that it contemplates taking action now for better outcomes in the future, to save money while increasing, or at least not reducing, benefits. Targeting is a possible tool in this process but it has been made an end in itself, and as currently proposed will undermine the whole system. Similarly privatisation is not a pre-requisite for an investment approach – it is just another possible tool whose use has to be justified.

The New Zealand Productivity Commission in its final report on commissioning more effective social services, (New Zealand Productivity Commission, 2015, pp.224-37), draws a distinction between MSD’s investment approach (calling it MIA) and an investment approach with the qualities it desires. It says that the MIA is ‘not a cost–benefit analysis’, and recommends that it ‘should be further refined to better reflect the wider costs and benefits of interventions’. It warned that ‘*slavish application of an investment approach based purely on costs and benefits to government might lead to perverse outcomes’*, giving as an example that early deaths from obesity would reduce future fiscal liability.

The refreshed strategy rightly emphasises the importance of evidence, but then suggests a course of action that is not evidence based. It ignores the evidence supporting effective public health approaches and successful local innovation. Instead it puts forward an untested, experimental approach, calling it the “Investment Approach” as though it was accepted wisdom.

The use of evidence in a future strategy needs to be closely linked to honesty, transparency, and acknowledgment of conflicts of interest. The reduction of advisory inputs into the Ministry of Health, as foreshadowed in the refreshed strategy, may lead to a narrowing of the interpretation of evidence, or even of the role of a Ministry.

An emphasis on quality, with a strong equity dimension, is a welcome element in a modern strategy. Once again its use should be genuine. The trade-offs and synergies between equity, efficiency, effectiveness, safety and person centeredness are the real issues in any health system. This complexity gets lost in the application of a narrowly defined investment approach.

**Conclusion:**

The NZ Health Strategy has not been refreshed, instead it has been the subject of an ideological purge. The management of the risk of future health expenditure has replaced health improvement and addressing health inequalities through the organised efforts of society. It has lost its heart.

**Acknowledgement:**

The views expressed in this document are my own. I wish to acknowledge the work of Bill Rosenberg for his helpful comments and his commentary on the use of the investment approach in the social sector.

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| **356** | Submitter name | Professor Des Gorman |
| Submitter organisation | Health Workforce New Zealand Board |

**Health Workforce New Zealand Board Feedback - New Zealand Health Strategy**

1. The Health Workforce New Zealand Board fully supports the development of a new Health Strategy and notes the clarity of the core elements of it. However, the links between the Strategy and He Korowai Oranga, the Ministry of Health’s Maori Strategy are not clear.
2. An update of the current national health strategy is overdue and this draft is both welcome and supported. Subsequent specific comments should be seen in the context of this overall endorsement.
3. In contrast to the fiscal and operational dominance of the workforce in any health system, this update is relatively quiet on workforce issues.
4. The problem definition for the New Zealand health system's workforce and the solutions proposed by the Minister's Review Group in 2008-9 are still strongly endorsed and supported respectively (with a few caveats).
5. The national health workforce milieu is disparate and complex; there are more than 500 stakeholder groups, organisations etc., engaged in health workforce 'activities' and that have some 'working' relationship with HWNZ.
6. Consequently, in the absence of a health workforce or health system manager Crown Entity (the original preferred solution), it is essential that there is a dedicated health workforce business unit in the Ministry of Health (MOH) - along with an oversight group (i.e., a Section 11 Committee acting as a HWNZ Board) that engages the broader public and private health sectors, and both key international health workforce agencies and educational providers, and that provides contestable advice to the Minister of Health.
7. HWNZ has a strong track record in its current set up, is well regarded internationally, and is well-positioned to play a critical role in development of a sustainable future workforce with the capability and capacity to meet the expectations of the Strategy. However, to enable HWNZ to deliver on the workforce requirements for implementation of the Strategy, a well-resourced business unit is needed and a much stronger alignment of workforce, IT and capital work plans in response to national, regional and district models of care and service configurations is agreed as being necessary. This alignment should not, and cannot, be done in a way that compromises the core cradle to grave and whole of workforce mission scope that HWNZ has.
8. Reflecting more specifically on the Strategy, a strength of the Strategy is the focus upon an investment approach. However, the Strategy is light on the elements of an investment approach and in particular the need to actively support organisational, infrastructural and workforce capacity, as well as the already mentioned governance and managerial leadership.
9. There is strong support for a partnership approach to be adopted between the Ministry and DHBs, in the truest sense. This will mean critical examination of the Ministry’s role in relation to DHBs. It may also mean changes in how the Ministry operates. Comment is made about the Ministry’s role as an advisor, policy maker and monitor of service delivery. The Ministry may well need to adopt a facilitative role in the future which involves partnership and influence.
10. A key question is whether focus only upon DHBs, and thereby only indirectly to services outside DHBs, is the appropriate one. As services move closer to communities, direct engagement is necessary with other parts of the sector to build workforce capability to deliver new models of care. The Strategy does signal the importance of inter-sectoral work in addressing health and wellbeing needs of the population but may need to make this more explicit.
11. The Strategy focuses upon clinician-led collaborations to meet patient care needs. The Board acknowledges the importance of clinicians playing a more active leadership role in the health sector. However, the Strategy directs little attention to the development of new models of care that must involve all parts of the diverse health workforce - including primary, community, allied health, science and technical workforces, aged care and home care and support workers.
12. There is a risk in referring to a shift of services out of specialist centres without balancing this with emphasis upon increased early intervention, particularly at primary and community levels. Further, it is not expected that there will be a reduction in service demand on specialist centres in the future, rather that early intervention by primary care may enable an increase in the number of acute cases able to be addressed in specialist care.
13. A key priority must be integrated healthcare with increased collaboration and cooperation across primary, secondary and tertiary services and a focus on patients’ experience of the continuum of care. The Strategy is largely silent on these points.
14. In making reference to primary care, it may well be that primary care needs to change how services are delivered in the future. There will need to be much stronger integration and collaboration more generally with all other parts of the health sector, than is currently the case.

1. The Board notes that the Strategy is largely silent on end-of-life care. With an ageing population, increased palliative care, as well as enhanced end-of-life care, will be required. A Strategy focused upon delivery of future services needs to be cognisant of this trend.
2. The Strategy also needs to reflect the trend towards patients seeking out the services of allied health professionals (e.g., dieticians, physiotherapists) ahead of general practitioners. This will have an impact on the role of general practitioners in the future. Indeed, with the move towards say, optometrists delivering more of front-line initial care, the traditional definition of primary care (as being delivered principally by general practitioners) may need to be revisited.
3. While it will be important that strategic planning is conducted at local level, it must be with a view to what is nationally important. Failure to do so, may well give rise to duplication and increased cost, thereby compromising the quality of care able to be delivered across all dimensions of healthcare need. The Health Workforce New Zealand Board considers that reference to the need for healthcare services to reflect best practice and to be of high quality should be emphasised strongly in the Strategy document.
4. HWNZ has already progressed pharmacist prescribing and progress is being made to enable government decision-making in regard to registered nurse prescribing. Emphasis needs to be on removing legislative and regulatory barriers more generally.
5. Reference to vocational rehabilitation and working in partnership with other government agencies needs also to make reference to working more closely with ACC.
6. While the Strategy has made reference to increased engagement with ACC, the Ministry will need to work very much more closely with ACC on ensuring alignment of health workforce to patient needs.

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| **357** | Submitter name | [redacted] |
| Submitter organisation | ASH New Zealand |

***ASH New Zealand’s’ submission in response to the Update of the New Zealand Health Strategy Consultation Draft***

*Submission prepared by* [redacted]*, Director*

Introduction:

This submission is on behalf of Action on Smoking and Health New Zealand (ASH), a registered charity which produces and collects sound evidence to enable policy makers and communities to contribute to a Smokefree New Zealand. Collaboration is the heart of what we do because we understand the value that partnership brings to achieving a shared vision of a Smokefree New Zealand by 2025.

We would like to take this opportunity to acknowledge the proposed update of the New Zealand Health Strategy. We support 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.

**ASH’s recommends:**

* A stronger focus on population health goals such as Smokefree New Zealand 2025 with set actions and commitments provided.
* A focus on preventative measures is commended, especially where there are preventative measures to address tobacco use. Smoking is New Zealand’s major cause of preventable illness and death.
* Cost effective preventative measures in tobacco control that lead to reduced health care costs over time and reduce disparities between population groups.
* A stronger focus on Māori and Pacific, and reducing health disparities.

**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?

ASH would like to congratulate the priority focus given to both Māori and Pacific population health needs.

A major opportunity that must be added is a reference to the Government’s goal of a Smokefree New Zealand by 2025. As a member state to the Framework Convention on Tobacco Control, a reflection of this commitment should be included as background to the Strategy. This is currently no reference to this.

The most important preventable risk factor for the loss of health in NZ is tobacco smoking, which also is a main contributor to health inequalities within populations. Current projections (BODE modelling Otago University) show that SF2025 goal is not going to be met on current trends and will be missed by Māori and other groups.

**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 strongly suggest that to ensure that all New Zealander’s live well, stay well and get well is to ensure that New Zealand is Smokefree by 2025. This is a basic necessity for the most important preventable cause of early death, disability and health inequalities in New Zealand.

Poverty continues to plague our communities and ensuring that we achieve Smokefree 2025 is a people powered, high value intervention.

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?

ASH would support the following additions to implement the Strategy by;

* Broadening the scope of “collaboration with others to achieve wellbeing” to include Multi-sectorial approaches such as non-health sector cooperate organisations, Non-government agencies, professional networks, Primary Care, Alternative and Tertiary Education providers and regional authorities as key service providers to achieve community outcomes.

**Five strategic themes**

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

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

These themes should include specific objectives and measures to reduce tobacco related harm for individuals, families and communities. The government has adopted an aspirational goal of Smokefree 2025. This should be included in the strategy as a key focus for action.

**Roadmap of Actions**

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

The Strategy’s “Roadmap of Actions” does not include any plans on how to achieve the Smokefree Goal with;

* Plain packaging
* Higher tobacco taxes
* Retail licensing
* A revision of Regulation around alternative sources of nicotine
* intensifying mass media campaigns

**Turning strategy into action**

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

There are a number of approaches that can include face to face community consultation and other innovative approaches such as online and through social media.

**Any other matters**

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

ASH would like to acknowledge the Ministry of Health on this draft New Zealand health strategy. To benefit this strategy we need to have the Smokefree 2025 goal included to acknowledge the devastating harm caused by tobacco use. This would enhance all New Zealanders to live well, stay well and get well.

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| **358** | Submitter name | [redacted] |
| Submitter organisation | Counties Manukau Health |



## 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.

**Overarching comments**

In our more detailed feedback we come back several times to the Triple Aim. Currently the Triple Aim is highlighted on P 18 in ‘The Future we Want’ as a way to structure the focus on outcomes and a system approach to making improvements in services. We believe the Strategy would be strengthened considerably by bringing this part forward to the front end, **so that the whole Strategy is grounded firmly in the Triple Aim**.

If the Triple Aim featured at the very front of the Strategy, this would then become the touch-point reference for all aspects of the Strategy, the Future Direction and the Roadmap of actions. Since there **will always be choices and trade-offs** to be made in planning, coordinating and developing health services, describing how the specific actions will contribute to achieving the Triple Aim would be helpful to mitigate inadvertent actions that result in ‘hitting the target but missing the point’ of the Strategy.

Stronger alignment to the Triple Aim would also ground the (appropriate) emphasis on people-centred care in the **wider population and system context**, which is important for health system and community sustainability. This would help to mitigate risks of unrealistic expectations that ‘everything can be delivered for everybody, everywhere’.

While there are many references in the Strategy to the health and disability system, **people with disabilities** are largely invisible. Is there intent to also refresh the NZ Disability Strategy? If not, then this Strategy would need strengthening to better reflect the issues for people and the system in relation to disabilities.

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| **Specific points of feedback:**  **Challenges:**  The Strategy identifies **wider determinants of health** as important on P 3, but under Challenges on P 6, the way it is worded seems to imply the unequal benefits from the health and disability system are the only drivers of the difference in life expectancy (LE). It is important to highlight the importance of addressing inequities in health system, but we think it would be better to say it is multifactorial and **make the links here to the importance of intersectoral collaboration,** so that we encourage people to explore a wide range of possible solutions to improve equity. This is particularly pertinent for CM Health, given the strategic goal of our own refreshed strategy is about achieving health equity for our population.  The discussion about challenges on P 6 equates older age with more need for social and health services. We think it would be more appropriate to talk about **healthy LE and unhealthy LE.** Improving healthy life expectancy is often associated with a minimal increase in overall health care costs considering that people remain healthy without any symptoms. However, an increase in unhealthy life expectancy is often associated with a rapid increase in health care costs, and health care utilisation is often correlated with morbidities. So it is **health state (and interventional threshold) rather than age per se which are the cost/service use drivers.**  Living with cancer can be considered a long term condition, and given the high impact of cancer people’s health and system resources, it would be good to add it to the list of LTC names under the Global challenges (P5).  The point about affording new technologies under the Global challenges (P5) could be strengthened by talking about affording new technologies and new uses for existing technologies; scope creep – passive changes in intervention thresholds - can be a substantial cost driver.  In highlighting the increasing population identified with dementia, it is important to acknowledge the increase in dementia is partly related to improved diagnosis and the ageing population, rather than necessarily an increase in the disease process itself. CVD risk factor management remains one of the key areas in preventing dementia (in the absence of clearly effective primary therapy).  The issues raised by the independent review of New Zealand’s health funding system about lack of visibility of results highlights the value of building capacity for evaluative thinking upfront in planning and delivering services.  **Opportunities:**  We absolutely support an emphasis on **prevention** but believe it is important to **frame the benefits as** **wider societal benefits** (many of these being non-financial) rather than specific cost savings in health, so that people don’t have unrealistic assumptions about potential for reallocations within the ‘health pot’.  The opportunities to improve care by improved information sharing across organisations are many; the **health sector has many strengths to share with other sectors about the ethical use of information** to support people’s well-being and the importance of robust processes to govern information sharing and related service improvements. |

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Stronger alignment to the Triple Aim would also ground the (appropriate) emphasis on people-centred care in the **wider population and system context**, which is important for health system and community sustainability. This would help to mitigate risks of unrealistic expectations that ‘everything can be delivered for everybody, everywhere’.

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### Challenges and opportunities

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

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### 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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| As noted previously, we think it would be helpful to ground the whole Strategy more firmly in relation to the three dimensions of the Triple Aim.  From that, we would then suggest **‘closer to home’ could be reshaped to ‘improving peoples’ experience of health services’**. This would align more strongly to the Triple Aim and mitigate the risks associated with assumptions that closer to home will necessarily lower cost and/or improve experience and/or health outcomes. |

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

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

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| We believe there is opportunity to shape these principles to **take more account of whole of system, whole of society stewardship to align with the Triple aim** objective of balancing population health and equity, people’s experience and value for money.  In particular, in refreshing the principles and using the seven from the previous Strategy, we wondered whether there had been any challenges raised to the first principle, ‘The best health and wellbeing possible for all New Zealanders throughout their lives’, from the perspective of acknowledging the importance of stewardship that takes into account the **choices and** **trade-offs** that need to be made to provide affordable, high value services. These trade-offs are mentioned on the next page in relation to the themes, but we think they need to be taken into account in the principles.  People working in the **health system need to see their stewardship in the context of needs across the whole systems (not just the part they are working in)** and also that every dollar that is spent in health is a dollar that is not available for education, housing, other determinants of health the we recognise are fundamental to preventing disease and enabling good health.  This also relates to principle five, - access to all NZers to a comprehensive range of services, regardless of ability to pay. While this is worded to focus on equitable access, there are also issues about **what is an affordable** range of services. |

### 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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| From a population health and equity perspective, **social and physical environments** are key shapers and constrainers of people’s choices; there is an opportunity to acknowledge and strengthen the role of those environments across the five themes of the Strategy.  Under the People-powered theme, there is quite a strong emphasis on **the role of technology** in enabling self-management and giving access to evidence-based health advice. From examining the evidence to support technology enablement across the CM Health system, we would suggest some of the languaging **be modified to reflect ‘potential benefits’ and ‘innovation areas’ rather than assumed benefits**. It is our understanding these technology interventions hold substantial promise but in the main have yet to demonstrate improved outcomes (both in patient outcomes and savings of time and dollars to the system) – see similar comment under the Roadmap comments below.  Further to the notes under point 2 above, we would suggest ‘**closer to home’ could be reshaped to ‘Improving peoples’ experience of health services’.** This would align more strongly to the Triple Aim and mitigate the risks associated with assumptions that closer to home will necessarily lower cost and/or improve experience and/or health outcomes.  Under the Value and high performance theme, **people with disabilities** are referred to in relation to the population health and equity domain of the Triple Aim. While there are many references in the Strategy to the health and disability system, people with disabilities are largely invisible. Is there intent to also refresh the NZ Disability Strategy? If not, then this Strategy would need strengthening to better reflect the issues for people and the system in relation to disabilities.  The Smart system theme could be strengthened by emphasising **the importance of a** **joined up IT system** that supports the entire patient’s journey or intervention pathway, across their life course, rather than looking at the many components in siloes. The description of what great might look like in 10 years would require considerable health literacy to take up the full potential of the 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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| 1. As previously, in framing the action areas on P 32, it would be very helpful to ground the Roadmap firmly in the **Triple Aim.** This would then become the touch-point reference for the whole suite of actions (how will this action contribute to achieving the Triple Aim). Since there will always be trade-offs to be made in planning, coordinating and developing health services, describing how the specific actions will contribute to achieving the Triple Aim would be helpful to mitigate inadvertent actions such as ‘hitting the target but missing the point’.  2. There seem to be some significant **assumptions of benefit in relation to information technologies** (spread across the action areas), which we believe would be better framed as innovation areas that hold promise but in the main have yet to demonstrate improved outcomes (e.g. self-management using digital technologies, telemonitoring for most conditions). This highlights the importance of building evaluation and improvement methodologies into planning.  3. Combining the use of the Triple Aim with a **strong focus on planning taking into account the entire intervention pathway**, would also support active consideration of where the new technologies may contribute to overdiagnosis and over utilisation without demonstrating health gain.  4. The emphasis on **targeting high risk populations** would be strengthened by contextualising the risk concept as part of an intervention pathway. We would suggest the pathway described on P 39 about population health management would be better framed as   * starting with understanding population health needs, * identifying effective interventions to address those needs, * prioritising within the group of people eligible for the interventions based on the highest amendable risk and taking inequities into account.   This would **focus attention on matching indications and interventions** and defining and addressing service gaps.  5. The **importance of information being used for action** is an area that could be strengthened. E.g. on P 39, under ‘Value and high performance’ there seems to be an assumption that transparent use of information will, in and of itself, lead to immediate benefits. It is the actions taken, the process of improvement, that has the potential to bring benefits.  There is reference to HQSC, and this could be used as an example, where there is a large amount of information available which helpfully describes variations in care through the Atlas of Healthcare Variation. However, the next important step is to develop and refine clinically actionable indicators (e.g. identifying people with gout not on allopurinol for review). This clinically actionable information can then be embedded as part of QI processes, and has better potential to lead to benefit across all three domains of the Triple Aim.  6. **Information Technology needs to support the entire patient’s journey or intervention pathway,** across their life course so that is all joined up, and automated. E.g. shared care plan needs linkage to patient portals, clinical pathways that considers common co-morbidities, e-referrals, primary and secondary health records, lab and radiology request etc. Clinical change management would be much easier if the IT system was able to auto-populate the right clinical information for referrals and collaborative care as appropriate.  7. There is a need to **consider population churn when targeting services for population segments** (action 11b). Our analysis of 2013 Census data on residential mobility demonstrated that only half of those aged 5 years and over were living at the same address they were at five years previously. Even when considering the broader issue of living in the same geographical locality for service planning (CM Health is divided into four localities), 40% of people were not living in the same locality as they had been 5 years previously. We are aware this needs to be taken into account for our service planning, and believe it needs to be highlighted as an important planning issue more broadly in moving services closer to home. |

### 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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| See comments above. |

### Any other matters

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

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| On page 16, in relation to obesity being a preventable risk factor for various conditions, it would also be good to mention osteoarthritis and respiratory illness, such as obstructive sleep apnoea (OSA).  P 22 there is a typo in naming the Health Quality and Safety Commission (HQSC) – there is a ‘y’ on the end of Health.  On P 33, it would be good to consider rewording the reference to Pacific churches being an appropriate place for engagement. Talking about them as ‘convenient access points’ sounds very utilitarian and as if we have a right to decide this is how churches will be used (even acknowledging that it talks about designing in partnership with communities). |

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| **359** | | Submitter name | Simon Everitt | | |
| Submitter organisation | Bay of Plenty DHB | | |
| This submission was completed by: *(name)* | | | Simon Everitt / Janet McLean |
| Address: *(street/box number)* | | | BOPDHB Private Bag 12024 |
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| Organisation (if applicable): | | | Bay of Plenty District Health Board |
| Position (if applicable): | | | General Managers Planning and Funding |

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

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

x on behalf of a group or organisation(s)

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

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

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

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

Māori  Regulatory authority

Pacific  Consumer

Asian x District health board

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*:

### Challenges and opportunities

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

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

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| The Bay of Plenty District Health Board (BOPDHB) commends the Ministry on the refresh of the New Zealand Health Strategy (NZHS), in particular for providing a strategic backbone in the future development of health services, building a more efficient and competent workforce and a smarter health system.  However, the strategy appears to be more of a “healthcare” strategy rather than a “health” strategy. While the section on Health in its Wider Context is strongly supported, the strategy does not then offer a strong enough direction around its crucial role in creating healthy communities. The need to address the causes/determinants of illness, injury, disability and why a community has disparities or inequities in health and wellbeing is where we believe the focus must be.  Addressing the determinants of health requires a strategic multi-sectoral approach, in which Health must be a key player. The NZHS should advocate for health and wellbeing in all policy decisions, by all ministerial departments, and should reflect and be more explicit about He Korowai Oranga - Pae Ora – healthy futures and its three interconnected elements: mauri ora; whānau ora; and wai ora.  The concept of *Health in all Policies* is particularly important and effective within a centralised government system. Furthermore, national Public Health policies make a big impact on local action and change (e.g. tobacco taxation led centrally versus fluoridation led locally).  These challenges should be posed in the background section of the NZHS. The Strategy should have a stronger overall direction and a greater emphasis on reducing inequities in health, prevention of ill health and advances towards universal health and wellbeing.  The areas / populations where we would like to see greater visibility and emphasis;   * Achieving equity needs to be carried through more strongly throughout the strategy. * Mental health and wellness appears to have been omitted from the strategy. * There is little emphasis on health of older people and aging well yet a significant proportion of health expenditure is in this area and for the Bay of Plenty is a significant population demographic. * In line with the point above as well as keeping older people healthy, a significant proportion of resource also goes into end of life care and we think there should be a stronger focus on end of life care – ‘dying well’ with an appropriate emphasis on advance care planning in the strategy.   We recognise the national Health of Older People Strategy is currently being updated and would like to highlight the importance of aligning national strategies to the NZHS where they exist.  **Specific amendments suggested:**   1. The NZHS should include a new nationally accepted definition of health, as a strategic 10 year document. This should be a widely accepted definition eg. the WHO definition of health, or the Whānau Ora definition of wellbeing. 2. This strategy should provide strong alignment to the three elements of achieving Pae Ora – Healthy Futures. 3. The background section needs to clearly define the state of health inequity in NZ. The NZHS should state how inequities will be reduced over the 10 year period. Making healthy choices an easy option is a good outcome of a population health approach; however this assumes that everyone has equal opportunities to make choices in the first place which we know is not always the case. 4. There needs to be a demography section embedded in the background section explaining the present population profile as well as demographic projections over the life of the strategy. 5. Details on the current health spend and investment profile of the NZ health system should be detailed in the background section. 6. The workforce profile is vaguely mentioned on page 7. More information around the NZ health workforce profile should be presented in the background section (especially with reference to career pathways and the number of and job profiles of the Maori health workforce). This could be presented in an infographic or graph. 7. A health investment approach is mentioned throughout the body of the document; however it is not clearly defined. The general principle of investing for future gain is supported however the concept needs to be clearly defined. 8. If an investment approach is deemed the most effective way of achieving equal health outcomes for all, it should be clearly stated in the Roadmap of Actions how this will be achieved. For example, a funding focus on the early years, children and young people and people with physical or social derived inequalities has the potential to yield certain results for this cohort in terms of health gain. 9. As a key priority, the health of older people should be made more visible throughout the document, particularly under the strategic theme ‘Closer to Home’. 10. An action should be added to the Roadmap of Actions around ensuring we are working with our communities around “ageing well” principles. 11. There should be reference to competing demands and values between different parts of the health sector or between aspects of government, industry and the wider community. This reference should be supported by a steer as to how we will collaborate for better health outcomes (rather than a focus on competing for inputs), as reflected in the NZ Productivity Commission’s report on More effective social services August 2015. 12. Footnote 2 on page 1 needs to include all of clause (1) section 8 of the NZ Public Health and Disability Act 2000. The following text should be added to the end of the sentence in the footnote, “in improving the health of people and communities.” |

### 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 believe that, from a health literacy viewpoint, this vision statement includes too much ‘health speak’. As a national strategy, we recommend it be easy to understand and suggest it simply read: “The future we want from the health system is that **all** New Zealanders **live well, get well, stay well and die well.**”  The current vision statement is quite focussed on individual health and the role of health in service provision. We believe it should incorporate community and whānau ora concepts around improving the health and wellbeing of the population, empowering healthy communities, and achieving equity of health outcomes for both population and individuals.  It would also be useful if the strategy identified how we will know when we’ve got there.  A suggested amendment is to utilise an appropriate whakatauki (proverb) or translation, which is tied into the elements of He Korowai Oranga. |

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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| Overall, these guiding principles are on the right track to being strong guiding principles for the NZ health system. The wording could, in some places, be strengthened to produce more action and emphasis on reducing inequities, focussing on health equity as the optimal outcome.  **Specific amendments suggested:**   1. Principle 1: “The best health and wellbeing outcomes possible for all New Zealanders throughout their lives” 2. Principle 2: “Improvement of health by reducing inequities throughout life” 3. Principle 4: ‘A commitment to the special relationship between Maori and the Crown under the Treaty of Waitangi’ 4. Principle 5: Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services. 5. Principle 8: Comment; The NZHS should provide the leadership with an accepted definition of health. Therefore, ‘thinking beyond narrow definitions of health’ is too weak. The words “and equitable health outcomes” should be added to the end of this principle. 6. New Principle 9: A commitment to improving the determinants of health and primary prevention. |

### 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 strategic themes provide some focus for action.  There is reference to the sustainability of the health and disability workforce in the “One Team” strategic theme however there is no specific reference to the significant pressures of an ageing workforce and how this is to be addressed. In terms of actioning the One Team theme, the Ministry should model the One Team approach as it rolls out system leadership.  Additionally, there should be a sixth strategic theme that leads coordinated action in the area of Health in all Policies, primary prevention and achieving equity of health outcomes.  This theme could be called : Strong Foundations and cover a commitment to:   * Primary prevention, * Health in all Policies, * Application of the five approaches of the Ottawa Charter, * Achieving equity of health outcomes, and * Increasing the influence of the Ministry of Health across government.   The advent of new technologies and increasing demand reflects the growing pace of change in the health system. This is only going to increase over the next 10 years. In light of this the ‘what great might look like in 10 years’ vision statements read as constrained, with many of the statements being expectations of what we should see in most health services today (eg. patient centred care, timely, convenient services) rather than a more future-focused approach.  A vision statement of ‘what great might look like in 10 years’ that should be included is:  That health and wellbeing is a mandatory consideration in all planning, policy and decision making processes made by any ministerial department (eg. in the same way that finance is always considered).  As mentioned in section 1, as the health of older people is a key priority, it should be made more visible under the strategic theme ‘Closer to Home’.  **Specific amendments suggested:**   * Under ‘People Powered - What great might look like in 10 years’ - add ‘Mauri Ora’ to the first point and an example relating to an intervention from whanau ora programmes. * ‘Closer to home’ could weave the Wai Ora – Healthy Environments theme to show strong alignment to He Korowai Oranga which then could be used to align to the ‘Ngati Hine Trust’ and ‘Key tips for warmer homes’ example. * Under ‘Value and high performance’ provide a link to the Maori Health web based tool – Trendly.co.nz or the Health Equity Assessment Tool (HEAT). * Under ‘One team’ reconsider that ‘One team’ is inclusive of the horizontal integration as opposed to being within Health. |

### Roadmap of Actions

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

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

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| We would like to commend the inclusion of Actions 5 and 6 which highlight the need to look at health early in life and prevention. We also support Action 16 and note that Allied Healthcare is a good example of this with its current, well established multi-disciplinary professional and inter-sectorial approach.  An overall comment on the actions is that some are very broad while others are quite specific and possibly should be derived at a local level according to a population needs assessment. In any case, it may be useful for actions to be ordered from the start at the highest level and cascade down to the more specific.  The NZHS should maintain a broader set of actions that result in the greatest, most cost-effective change in the health status of the whole population. As it stands the actions are, in some cases, disconnected to the ‘what great might look like in 10 years’ vision statements.  **Specific amendments suggested:**  Action 6 b) To support the reference to the system leadership role of the Ministry of Health the action could be amended to read: Lead on national policy and health and social system changes to support healthy nutrition and activity for pregnant women and children to reduce the prevalence of childhood obesity.  Action 6 h) Amend to read: The Ministry of Health to lead on population level initiatives to reduce the 19% of women (28% of pregnant women aged 15-24) who report drinking in pregnancy and provide guidance to practitioners to identify children who have Fetal Alcohol Spectrum Disorders (FASD). Finance and support DHB’s to commission local services to and support children and their families who are living with FASD.  Action 3: Add that services should be delivered by a workforce profile that is reflective of the needs of the population (eg. ethnicity).  An action for increasing health literacy should be included under the People-Powered strategic theme to assist with the focus of this theme - communication, self-management and understanding people. |

### Turning strategy into action

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

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| We would like to see a health system dashboard where we can easily see the headline health outcomes and also key determinants. A good example of this is the [Public Health Outcomes Framework](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049) in the UK or the [Trendly Maori Health Indicator tool](http://trendly.co.nz/Home/DHBSelection). An easy to use dashboard can provide insight into the population characteristics and indicators of health at a glance. It can be used to compare to other regions, eg. a region may have changed a trend towards improved health outcomes and best practice can be offered as to how this change occurred.  A dashboard requires a strong data set and this type of monitoring system could enable being informed by ‘smart systems’.  Tracking of actions could also be achieved through Annual Plans.  We would like to see the Ministry reporting to the sector on its actions around the One System/System leadership. There should be tracking and reporting of shared data and improved understanding of population need on Real Time basis. Data should be easily shared across government agencies. |

### Any other matters

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

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| Overall, the refresh of the NZHS makes for an easy to follow, sound approach for guiding the future of NZ’s health system. It does seem to be focussed on health care and health services, whereas it is considered that it should be on the health and wellbeing of the population. To achieve improved health and wellbeing for our population, the focus needs to be on recognising and addressing the wider determinants of health. This is where the real capacity for change sits.  In line with the Minister of Health’s direction towards providing high-quality health services; healthy communities; a strong and engaged health workforce; quality aged care and mental health services - the NZHS needs to strengthen its role in strategically guiding the future of health and wellbeing and recognising the benefits and cost savings that can be made by preventing ill health and reducing inequities.  **Additional points for consideration:**  Provide greater visibility of the elements within He Korowai Oranga and ensure Pae Ora is considered in the vision and weaved throughout the NZHS. A suggestion could be that Pae Ora is part of the heading of ‘What does great look like in 10 years?’  Climate change has a large impact on health and wellbeing, however it is not considered in the strategy.  More emphasis is required throughout the document on quality. It is recognised that it appears in several places, along with working with the HQSC, however it needs to be more visible.  Health providers and the wider health system should be considered role models. The NZHS should require that all health providers be health promoting role models, with strong policy and guidance that supports this.  Our final question that should be at the forefront of a strategic document is: **How is the Ministry of Health ensuring that health is on everyone’s agenda?** |

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| **360** | | Submitter name | Simon Everitt and Janet McLean | | |
| Submitter organisation | Bay of Plenty CHB Maori Health Runanga and Te Tumu Whakarae – National Maori General Managers | | |
| This submission was completed by: *(name)* | | | Simon Everitt / Janet McLean |
| Address: *(street/box number)* | | | BOPDHB Private Bag 12024 |
| *(town/city)* | | | Tauranga 3143 |
| Email: | | | Simon.Everitt@bopdhb.govt.nz  Janet.McLean@bopdhb.govt.nz |
| Organisation (if applicable): | | | Bay of Plenty District Health Board |
| Position (if applicable): | | | General Managers Planning and Funding |

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x on behalf of a group or organisation(s)

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Please indicate which sector(s) your submission represents  
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Pacific  Consumer

Asian x **District Health Board**

Education/training  Local government

Service provider  Government

Non-governmental organisation  Pharmacy professional association

Primary health organisation  Other professional association

Professional association

Academic/research  Other *(please specify)*: **Bay of Plenty District Health Board Maori Health Runanga and Te Tumu Whakarae – National Maori General Managers**

### Challenges and opportunities

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

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

This strategy seems to be more a “healthcare” strategy rather than a “health” strategy. Whilst the section on Health in its Wider Context is strongly supported, the strategy does not then offer a strong enough direction around its crucial role in creating healthy communities and reducing inequalities. The need to address the causes/determinants of illness, injury, disability and why a community has disparities or inequities in health and wellbeing is where we believe the focus must be and this strategy must be strongly linked to He Korowai Oranga achieving Pae Ora - healthy futures and its three interconnected elements: Mauri Ora – Healthy Individuals; Whānau Ora – Healthy Families; and Wai Ora – Healthy Environments. The strategy should have a stronger overall direction and a greater emphasis on reducing inequities in health, prevention of ill health and advances towards universal health and wellbeing.

The areas / populations where we would like to see greater visibility and emphasis;

* Achieving equity needs to be carried through more strongly throughout the strategy.
* Weaving the philosophy and threads from He Korowai Oranga.
* Ensuring the concept of proportionate universalism to address areas of high need.

**Specific amendments suggested:**

1. This strategy should provide strong alignment to the three elements of achieving Pae Ora – Healthy Future: Mauri Ora – Healthy Individuals; Whānau Ora – Healthy Families; and Wai Ora – Healthy Environments.
2. The background section needs to clearly define the state of health inequity in NZ. The NZHS should state how inequities will be reduced over the 10 year period. Making healthy choices an easy option is a good outcome of a population health approach; however this assumes that everyone has equal opportunities to make choices in the first place which we know is not always the case.
3. The NZHS should include a new nationally accepted definition of health, as a strategic 10 year document. This should be a widely accepted definition eg. the WHO definition of health, or the Whānau Ora definition of wellbeing.
4. More information around the NZ health workforce profile should be presented in the background section (especially with reference to career pathways and the number of and job profiles of the Maori health workforce). This could be presented in an infographic or graph.
5. There needs to be a demography section embedded in the background section explaining the present population profile as well as demographic projections over the life of the strategy.
6. A health investment approach is mentioned throughout the body of the document; however it is not clearly defined. The general principle of investing for future gain is supported however the concept needs to be clearly defined and should include the concept of proportionate universalism.
7. Details on the current health spend and investment profile of the NZ health system should be detailed in the background section. A suggestion is that this could be separated via ethnicity.
8. As a key priority, the health of kaumatua should be made more visible throughout the document, particularly under the strategic theme ‘Closer to Home’.
9. An action should be added to the Roadmap of Actions around ensuring we are working with our communities around Kaumatua Ora/“ageing well” principles.
10. There should be reference to competing demands and values between different parts of the health sector or between aspects of government, industry and the wider community. This reference should be supported by a steer as to how we will collaborate for better health outcomes (rather than a focus on competing for inputs), as reflected in the NZ Productivity Commission’s report on More effective social services August 2015.
11. If this strategy is to fulfil its legislative requirements, the entirety of clause (1) section 8 of the NZ Public Health and Disability Act 2000 should be quoted in the footnote on page 1. Specifically the words “in improving the health of people and communities.” should be added to the end of the quote. The strategy should therefore provide direction as to how the health of individuals as well as communities will be improved in addition to the delivery of health services.
12. If an investment approach is deemed the most effective way of achieving equal health outcomes for all, it should be clearly stated in the Roadmap of Actions how this will be achieved. For example, a funding focus on the early years, children and young people. Furthermore, there should be explicit direction on how health and the other agencies which are critical in improving Wai Ora (and subsequently Pae Ora) should prioritise their funding via proportionate universalism, and why it is important for agencies beyond health to adopt a health in all policies approach

### 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?**

A suggestion could be to utilise an appropriate whakatauki (proverb) or translation, which is tied into the elements of He Korowai Oranga.

The NZHS statement is very much based on individual health and service provision, it should include concepts that incorporate models such as Mauri Ora – Healthy and flourishing lifeforce/wellbeing; Whanau Ora – Flourishing whanau/families’ and importantly Wai Ora – Healthy environments. These concepts should encapsulate the broader determinants of wellbeing.

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?**

Overall, these guiding principles are on the right track to being strong guiding principles for the NZ health system. The wording could, in some places, be strengthened to produce more action and emphasis on reducing inequities, focussing on health equity as the optimal outcome.

**Specific amendments suggested:**

1. Principle 1: “The best health and wellbeing outcomes possible for all New Zealanders throughout their lives”
2. Principle 2: “Improvement of health by reducing inequities throughout life”
3. Principle 4: ‘A commitment to the special relationship between Maori and the Crown under the Treaty of Waitangi’
4. Principle 5: Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services.
5. Principle 8: Comment; The NZHS should provide the leadership with an accepted definition of health. Therefore, ‘thinking beyond narrow definitions of health’ is too weak. This principle should add at the end “achieve wellbeing and equitable health outcomes”
6. New Principle 9: A commitment to improving the determinants of health and primary prevention.

### 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?**

The five strategic themes provide some focus for action.

There is reference to the sustainability of the health and disability workforce in the “One Team” strategic theme however there is no specific reference to the significant pressures of an ageing workforce and the gaps between Maori and non-Maori and how this is to be addressed.

Additionally, there should be a sixth strategic theme that leads coordinated action in the area of Health in all Policies, primary prevention and achieving equity of health outcomes.

This theme could be called : Strong Foundations and cover a commitment to:

* Primary prevention,
* Health in all Policies,
* Application of the five approaches of the Ottawa Charter,
* Achieving equity of health outcomes, and
* Increasing the influence of the Ministry of Health across government.

A vision statement of ‘what great might look like in 10 years’ that should be included is:

That health and wellbeing is a mandatory consideration in all planning, policy and decision making processes made by any ministerial department (eg. in the same way that finance is always considered).

As mentioned in section 1, as the health of older people is a key priority, it should be made more visible under the strategic theme ‘Closer to Home’.

**Specific amendments suggested:**

* Under ‘People Powered - What great might look like in 10 years’ a suggestion could be adding to the first point ‘Mauri Ora’ and an example relating to an intervention from whanau ora programmes.
* ‘Closer to home’ could weave the Wai Ora – Healthy Environments theme to show strong alignment to He Korowai Oranga which then could be used to align to the ‘Ngati Hine Trust’ and ‘Key tips for warmer homes’ example.
* A suggestion under ‘Value and high performance’ is to provide an example linking to the Maori Health web based tool – Trendly.co.nz or the Health Equity Assessment Tool (HEAT)
* One Team – Suggestion would be to reconsider that one team is inclusive of horizontal integration as opposed to being within Health. Building upon the concept of Wai Ora
* Consider using ‘pathways for action’ to help guide the strategic themes.
* There should be a consideration of cultural competence and how this can fit into one of the five. At strategic level, ensuring the workforce is culturally intelligent (competent) would support attempts to achieve equity.

### 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?**

**Specific amendments suggested:**

* Action 1: Add actions to address health literacy as these actions could focus on - improving communication; building resilience and self-management; and for the sector to be able to understand people’s needs and aspirations. By moving to a model that focuses on being people centred, which is built upon a change in culture about asking clients “What matters to you?” would reinforce the second action on co-design.
* Action 3: Add that services should be delivered by a workforce profile that is reflective of the needs of the population (eg. ethnicity).
* Action 4: Include actions that can enable cultural intelligence, respect and responsiveness. This is building upon themes of cultural competence.
* Action 13: Broaden this to make available actions that can build/improve the capability of DHB partnership Boards to include training that can weave through themes of He Korowai Oranga.
* Action 16: See above comment
* Action 18: Include as part of this action the Maori web based monitoring tool on [www.trendly.co.nz](http://www.trendly.co.nz)

### 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?**

There needs to be some elevation at a national level about  [Maori Health Indicator tool](http://trendly.co.nz/Home/DHBSelection) and for DHB Boards to use this suite as component within existing reports.

We would like to see a health system dashboard where we can easily see the headline health outcomes and also key determinants. A good example of this is the [Public Health Outcomes Framework](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049) in the UK. An easy to use dashboard can provide insight into the population characteristics and indicators of health at a glance. It can be used to compare to other regions, eg. a region may have changed a trend towards improved health outcomes and best practice can be offered as to how this change occurred.

A dashboard requires a strong data set and this type of monitoring system could enable being informed by ‘smart systems’.

Tracking of actions could also be achieved through the Maori Health Plans and Annual Plans.

### Any other matters

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

**Points for consideration:**

Provide greater visibility of the elements within He Korowai Oranga and ensure Pae Ora is considered in the vision and weaved throughout the NZHS. A suggestion could be that Pae Ora is part of the heading of ‘What does great look like in 10 years?’

Climate change has a large impact on health and wellbeing, however it is not considered in the strategy. The environment is critical to the wellbeing of people and should have a stronger emphasis within the NZHS.

More emphasis is required throughout the document on quality. It is recognised that it appears in several places, along with working with the HQSC, however it needs to be more visible.

It is important to reiterate that improving the wellbeing of individuals, family and the environment will take a cross sector approach and should be supported through strong leadership at all levels.

Health providers and the wider health system should be considered role models. The NZHS should require that all health providers be health promoting role models, with strong policy and guidance that supports this.

Our final question that should be at the forefront of a strategic document is: **How is the Ministry of Health ensuring that Pae Ora is on everyone’s agenda?**

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