4 December 2015

New Zealand Health Strategy Update Consultation
New Zealand Health Strategy Team
Ministry of Health
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Re: Submission on New Zealand Health Strategy

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

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

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

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

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

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Kind regards

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Challenges and opportunities

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

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

1.1. We suggest a reflection and analysis on outcomes of the original 2000 strategy and the primary health care strategy would be useful: what lessons have we learnt about the impact of the different components of these strategies: what worked well and what did not, and why? We note that Treasury's 2014 briefing noted the limited impact of health strategies, reinforcing the need for Health to determine what makes an effective health strategy.

1.2. Whilst Te Tiriti o Waitangi and health equity are mentioned, they need more focus. For example, how could the strategy help address institutional racism? We suggest that the strategy could articulate further about how to address the various dimensions of equity as well as Te Tiriti obligations.

1.3. In terms of equity, we note some vulnerable populations continue to face challenges in accessing primary care. In addition to the cost barrier, there are also cultural barriers, access out of working hours, and sometimes communication barriers. This is well illustrated by the challenges that refugees face in accessing health care, given their high health needs, communication challenges, and lack of income there is a need to develop actions linked to this issue. An example is learning from the 'one stop' shop model of providing youth social and health care to address challenges in primary care.

1.4. Primary care for mental health and positive well-being remains an under-resourced area with growing need and is not specifically addressed in the strategy.

1.5. The health strategy has identified the role of education and social services in meeting equitable health and social outcomes. But the impact of social determinants of health is only partly addressed. The impacts of intergenerational poverty, poor housing, and unhealthy environments need specific strategic roadmaps in order to address the complex interdependencies created by social determinants of health. The role of the Education sector in developing life skills, such as health literacy, is another omission – especially important given the current review of the Education Act. The Strategy could also be strengthened by incorporating the links with social services such as budgeting advice, food banks and housing services, which directly impact on health and well-being.

1.6. The role of the Ministry in policy-making can aim to align incentives for providers to improve the wellbeing of clients and those affected by their decisions. Noting

the wider social determinants of health, policy strategies should move towards the maxim of reducing barriers and making healthy choices the easiest for all people. This type of leadership at Ministry level would strengthen the principle of 'Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing' and any associated actions.

1.7. We suggest the health strategy note our collective responsibilities for the health of our Pacific Island neighbours; and the pragmatic implication for New Zealand's health system from climate change refugees and the increased risk of infectious disease outbreaks. In order to have a resilient health system we need to ensure that strategic steps are in place to mitigate and adapt to unforeseen emergencies.

The future we want

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

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

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

2.1. The statement captures important broad concepts, but it is unclear what direction this gives for the wider health sector. It provides positive goals, but the statement does not help with the inevitable trade-offs. For example, how does the statement support prioritising staying well versus getting well; or living well versus staying well? It is also not explicit what the health system will NOT provide and why it is not provided – for example dental (adults) and optometry are not included.

2.2. The universality captured in the 'All New Zealanders" is to be commended. We acknowledge though that there are certain situations where targeting would be a more prudent approach, for example for at-risk groups with individually modifiable risk factors. We suggest that a strong universal prevention programme (live well) should underpin the targeted strategies for staying well and getting well. This is to ensure that healthy choices are the easiest choices to make.

2.3. The second critique of the statement is that it is difficult to measure progress. For example, what indicators will be chosen to measure how we 'live well' or even 'get well' – many diseases are managed rather than cured; or is the intention to focus just on well-being rather than disease? Whilst not all that is important can be measured, 'what's measured gets done.' We note that wellbeing is not solely dependant on alleviation of illness or disease, but has causal factors in economic, environmental and social factors. There are regional examples of how to measure 'live well', such as the Greater Wellington Regional Council's – Genuine Progress

Indicator[1], which the Ministry could explore further. The multi-dimensional framework of the indicator allows a retrospective analysis of economic, environmental, social and cultural outcomes. Such a tool allows for quantitative data to support the subjective self assessed outcome of 'living well'.

2.4. An alternate suggestion for the health strategy would be: "Government commits to maximising the health and well-being of its people by ensuring 'health in all policies'; resources to support healthy life choices; and only providing cost-effective treatment services." We support the Ministry aim to be cost-effective. The vision, to take steps towards a smart system that enables multidisciplinary care across primary, secondary and tertiary services; care that is close to home and patient-centred and designed around human needs, are all needed for cost-effectiveness.

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

3. **Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?**The focus on equity is positive but does not appear adequately articulated in the roadmap actions. Would the roadmap be better organised by the principles rather than the five strategic themes?

3.2. The value of having health care that is patient-centred could be strengthened within the principles. Within the current principles this is more a focus on active participation by people and communities, rather than health care being closely aligned with the needs of the community. An example of how this principle might impact on what actions are taken, is noting how traditional opening hours of health services often do not meet the need of the community.

3.3. Within the principles there will be situations when it is not possible to apply all of these equally. We are uncertain about the challenges of managing trade-offs between the principles – both for population level decisions and individual care. Ministry guidance within the Strategy on how to manage such trade-offs would be helpful.

Five strategic themes

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

[1] http://www.gpiwellingtonregion.govt.nz/

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**?Each of the five themes is sound and appropriate. There is capacity to fit most ideas under one or more of the five themes. For clarity we request a logic model be created, linking these to the desired outcome of 'live well, get well, stay well'?

4.2. The 10 year vision describes an average, rather than the results for the most vulnerable and high needs groups; this can lead to worsening of equity.

4.3. A possible concern about 'people-powered' is the over-reliance on individuals and whanau with limited resources; but it encapsulates well the concepts of 'by Māori, for Māori'. We note that there is a potential transfer of risk s from the state to the individual by the focus on personal responsibility. This has the potential to create poverty traps or stagnate social mobility, in which individual responsibility is the only incentivised route of alleviation. Moreover, such a focus on personal responsibility might lead to increased expenditure downstream, in the form of state funded targeted alleviation of ill health outcomes.

Roadmap of Actions

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

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?It is not clear that the critical actions to achieve the desired changes have been identified.

5.2. Additional actions could include:

5.2.1. Policy and funding changes to incentivise health services to better work with other social services to address the social determinants of health. Tightly prescribed policy and funding instruments constrain active collaboration and project development. Prudent, as they may be in the short term, in the longer term the constrained environment has exacerbated the issue of silos in the health and social sectors. We suggest a common funding pool approach to alleviating complex health issues such as obesity. For example, this could incentivise collaboration between urban planners in local government and advisors in public health units to help design and create built environments conducive to everyday physical activity.

5.2.2. Building on the successful pilots in multisectorial work – many of which are described in the paper – into national programmes. From the perspective of Regional Public Health, this includes the Porirua Social Sector Trial; increasing access to preventing serious skin infections; fruit and vegetable co-operatives; healthy homes coordination service; healthy schools and

early childhood centres. Such pilots could be integrated into the core contracts, to support and sustain the initiatives from the pilot health programs.

5.2.3. Having clear policies and procedures that guide both investment and *disinvestment* to make sure the principles of equity and Tiriti obligations are met. This might mean the adjustments of discount rates based on the scope and scale of the health investment programmes and the effects they would have on population health outcomes versus modifying individual health outcomes.

5.3. Public health units are not visible in the document, but could have a number of key roles in the strategy, including inter-sectorial work at the local level. Public health units are integral to the monitoring of population health and evidence-based action and responding to emerging challenges and preventing illness (e.g. working closely with other sectors like local authorities to influence the environment and determinants of health). This role of public health units and other organisations involved in population health approaches needs to be expanded on within the Strategy.

5.4. We suggest that the growing recognition of sustainability, climate change, and environmental stewardship be better incorporated into the Health Strategy. Actions taken from improving sustainability and environmental stewardship have feedback effects not only on operating costs, but in creating resilient and adaptable systems. Furthermore, such actions are part of the complex network of achieving and maintaining equitable social and health outcomes.

Turning strategy into action

6. **What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?**Tracking of progress requires first defining measurable indicators, which is included as a sub-activity only in one of the actions. Indicators are needed for the principles as well as the themes.

6.2. Tracking of progress on the actions themselves will not indicate how effective they are at achieving the overarching aims.

6.3. New Zealand already has an excellent information infrastructure to track progress, including the linkage of datasets between sectors. We support the introduction of the Integrated Data Infrastructure (IDI). This would allow better analysis of investment and their effectiveness across state sectors. We suggest that the IDI could form the backbone of a multi-dimensional outcomes framework, which would better assess success of the multiple actions needed for complex health issues.

Any other matters

7. Are there any other comments you want to make as part of your submission?The strategy and consultation process reflect well on New Zealand's high quality health system. It also highlights the constraints regarding the potential to do even better. More work is needed especially on equity and Tiriti obligations.

7.2. We recommend a greater emphasis on the prevention aspect of the strategy and actions specifically aligned with work of public health units, NGOs and other agencies delivering population health and prevention services.

7.3. We would like to see stronger Ministry of Health leadership (e.g. consistent messaging for health and health promotion, pilots sustained into national projects, leading collaboration between the Ministries etc.), especially to enable and/or facilitate local intersectoral work.

7.4. A stronger focus on all aspects of health and wellbeing in government policy making ('health in all policies') with more resources in the health sector for the under-funded areas such as mental health and health promotion.