Update of the New Zealand Health Strategy: All New Zealanders live well, stay well, get well Submission form

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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
- ☐ Pacific
- ☐ Asian
- ☐ Education/training
- ☐ Service provider
- ☒ Non-governmental organisation
- ☐ Primary health organisation
- ☐ Professional association
- ☐ Academic/research
- ☐ Regulatory authority
- ☐ Consumer
- ☐ District health board
- ☐ Local government
- ☐ Government
- ☐ Pharmacy professional association
- ☐ Other professional association
- ☐ Other *(please specify)*:

Consultation questions

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

Challenges and opportunities

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

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

The front of the document should state clearly that the NZ Health Strategy should be read alongside:

- The NZ Disability Strategy
- He Korowai Oranga - NZ's Māori Health Strategy
- The Primary Health Care Strategy

The future we want

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

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

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

- We support inclusion of the suggested 'die well' addition to the tagline 'Live well, stay well, get well'. Perhaps it could be re-ordered to 'Live well, get well, stay well, die well'.
- More needs to be included about the impact and importance of climate, ecology and environmental factors.
- Scope for effective use of legislation, taxation and government incentives/ disincentives to influence corporate behaviour is missing from the document – government already uses taxes and duties on tobacco and alcohol to limit use of these harmful substances and collects funds through ACC levies and road user/vehicle registrations to help cover costs related to injuries/harm caused by various items/activities. The Strategy needs to include scope for similar approaches to minimise harm caused by other potentially harmful substances such as sugar, salt and pollution as evidence of their harm grows.
- Equity (of access and outcomes) for different groups based on ethnicity, location, economic status etc needs to be strengthened in the document.
- Despite the inclusion of 'live well' and 'stay well', the Strategy still has a very clinical focus to it and there is not sufficient focus on population-level prevention activities that will have the biggest health impact, reduce inequalities and deliver value for money.

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

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

- We are comfortable with the eight proposed principles and particularly support thinking beyond the narrow definitions of health, as this will help to address determinants such as poverty, housing, environmental factors, etc.
- Many of those currently disadvantaged in their health outcomes are not able to live well due to environmental factors such as poor housing, limited employment opportunities, social exclusion, or community and whanau dislocation and isolation – working intersectorally across traditional boundaries is the only way to address these. As many of these determinants are outside the direct influence of health organisations, greater cross-agency partnering (particularly between health, housing, the justice system, education, child protection and whanau support services) will lead to better health outcomes and to more people living well.

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?

- A **smart system** is about more than just technology – there also needs to be a focus on making aggregated anonymised information widely available to all those working to improve health outcomes as this will help provide an evidence base for initiatives. (The Statistics NZ model is an example of how this can be done effectively.)
- All providers also need opportunities to up-skill to make use of new IT and keep pace with fast-changing technology, as currently few outside the medical professions have access to continuing education.
- For the system to be truly **people-powered**, resources need to follow the individual so they can access the services they choose. Existing capitation and population-based models do not currently support people power effectively and changes will be needed to ensure this theme is a reality. Current under-valuing of the under-trained and underpaid unregulated workforce was a theme that was strongly made in the Ministry's engagement workshops – there is a need to address this through the Strategy's themes and actions.
- Openness and trust and a move away from competitive funding models will be needed to ensure a **one team** approach.
- **Closer to home** sounds great, but the reality for many (especially rural-based consumers) is that expectations of what they can access locally is diminishing.
- To ensure sufficient ongoing focus on preventing illness and disease, consider adding a sixth theme around **prevention** or **investment in 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?

- The importance of environment and prevention are not sufficiently covered in the roadmap of actions. There need to be more actions at a population health level as these have the potential to have the greatest impact due to their preventative approach.
- Action 4 recognises the value added by **all people working in the health system**, but there is scope for other actions to also maximise the contributions of all health providers (not just clinicians) – especially those actions with a community or prevention focus.

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?

- More resourcing directed to prevention and public health services will be needed to make the investment approach a reality. (Again, effective use of data and rich information will be vital to support the investment logic.)
- Investment into health literacy will be needed – not just to support individuals, but to ensure clinicians use language that people understand. Opportunities to improve health literacy through the education system should be explored.
- Explore overseas concepts such as Choosing Wisely (http://www.choosingwisely.org/) to improve patient-provider interactions and enhance health literacy and targeting of services. There needs to be a national approach to considering the evidence for effective treatments and services. Such services require high levels of technical expertise and these should not be fragmented across DHBs. Evidence resources need to be provided to policy makers, consumers and providers and should support health literacy initiatives, as well as purchasing decisions.
- Reviewing ineffective services will encourage re-consideration of investment options and consideration of ways to improve value and performance throughout the health system. It is not always possible to continue to try and deliver the same services for lower costs - so we need to look at whether we are purchasing services that are the most effective.
- Long term conditions such as diabetes and obesity cannot be addressed solely through initiatives designed to influence personal choice – we must consider controls on potentially harmful products such as sugary foods/drinks and salt.
- Some targeting and additional resourcing for those with the worst health outcomes is needed. Look for opportunities to expand the types of services provided through individuals' existing interactions with health providers (e.g. some people with mental health issues have regular blood tests due to the psychotropic medication they are on, but currently they are not routinely offered blood pressure or diabetes checks etc at these regular appointments, so early opportunities to address potential health issues are lost.) More comprehensive regular physical health checks and/or development of individual care plans would improve health outcomes for groups such as those with serious mental health and addiction issues, whose overall health outcomes are currently worse than any other group.
- Traditional ways of purchasing services will need to change to support innovation, flexibility and collaboration. A greater degree of flexibility will be needed to support better outcomes for highly vulnerable, hard to reach people with various co-morbidities.

- To support the **one team** approach, greater opportunities for workforce development must be accessible to community and non-profit providers as they are not currently resourced at the same levels as DHBs, PHOS etc. Funding models must also be equitable across the sector so community providers can offer salaries, conditions and career opportunities to attract and retain workers.
- While being responsive to local needs is good, there is also a need for national approaches for services for specific small groups that are not sufficiently numerous to warrant local strategies (eg: Deaf mentally ill people, people with eating disorders, Hep C, refugee trauma etc).
- Targeted resourcing will be needed to get all providers to the same baseline with technology to support the **one team, smart system** approaches – some government resourcing may be needed for community providers, but government should not necessarily lead development of ICT tools as it is not nimble enough – instead it should look for opportunities to harness local innovation that is responsive to user requirements and make this more widely accessible (eg: purchasing new Apps created by individuals/ innovators, etc). All users will need training and education in technology so they use it as intended.
- Government also needs to have the ability to mandate that providers receiving public funds must be required to share health information with other providers. It is not sufficient to encourage shared information.
- The impact on health needs to be considered in the development of ALL policies across government.
- In the current health system, DHBs wield significant power and influence over the services delivered to their communities (eg: approx 48% of the Vote Health funding non-profit NGOs receive comes via DHB contracts for service), so we would like to see accountability where DHBs fail to address challenges and actions identified in the Strategy or do not engage in the direction of the Strategy.

Any other matters

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

- We commend the Ministry on its consultation process so far, with realistic timeframes and various opportunities for people to contribute face-to-face, in writing and online. The genuine attempts to engage and incorporate feedback received so far are reflected in the draft document's content and we hope submissions received during this second phase of consultation will also be evident in the final Strategy.
- We endorse the inclusive and easy to understand language used throughout the document.
- We recommend that those finalising the Strategy re-read the NZ Productivity Commissions report on the *More Effective Social Services* review to ensure key insights and ideas (such as strengthening the commissioning and national outcomes frameworks) are reflected in the Strategy. http://www.productivity.govt.nz/inquiry-content/2032?stage=4

About the NGO Health & Disability Network

Origins

The NGO Health & Disability Network (formerly the Health and Disability NGO Working Group) has partnered with the Ministry of Health since 2002 to implement the *Framework for Relations between the Ministry and Health and Disability NGOs*.

The Framework identifies key areas (communication, consultation and capacity/capability building) where working together can strengthen the sector and achieve better health outcomes. It complements the *Kia Tutahi Standing Together Relationship Accord between the Communities of Aotearoa NZ and the Government of NZ,* which was signed by the Prime Minister and many others in 2011.

Network membership

We had 508 NGO members and 114 affiliate members on 1 December 2015. (These NGOs range from small providers with one FTE employee, to large multi-million dollar agencies with more than 2,400 paid staff.)

98% of Network members are registered charities. Based on data from the Charities Register[1], we know the following about these members:

- Member NGOs received $1.54 billion in combined annual government funding.
- Member NGOs paid more than $1.3 billion in annual salaries and wages to 18,830 full-time staff and 15,695 part-time staff.
- In an average week, a total of 1.25 million hours were worked by paid staff and 124,196 hours provided by over 28,426 unpaid volunteers.
- 36% of member NGOs had a net annual operating deficit in their last reported financial year, so had to draw on reserves to continue delivering services.

The Network's membership represents about half of those not-for-profit NGOs that receive Vote Health funding to provide services in New Zealand communities.

The activities of the NGO Network extend far beyond the voting membership as many non-members attend Forums and workshops and provide feedback via Network projects and surveys.

About the NGO Council

The elected NGO Council connects with health and disability organisations to hear views and convey issues and ideas to the Ministry. The Council is made up of three Māori Health representatives, and two representatives from: Pacific Health, Mental Health and Addictions, Personal Health, Public Health, and Disability Support Services.

NGOs that receive Vote Health funding (i.e. have contracts with the Ministry of Health and/or DHBs) can register in a maximum of two categories, and are registered to vote as follows:

☐ 224 in Disability Support Services

☐ 112 in Māori Health

☐ 142 in Mental Health and Addictions

☐ 102 in Personal Health

☐ 114 in Public Health

☐ 25 in Pacific Health

The current elected members of the NGO Council are:

[1] Charities register data downloaded 19 July 2015. Data is only as accurate as the information provided by listed charities.

Disability Support	Victoria Manning	Deaf Aotearoa	Wellington
	Mark Brown	LIFE Unlimited	Hamilton
Māori Health	Karaitiana Tickell	Purapura Whetu Trust	Christchurch
	Josie Smith	Te Kotuku Ki Te Rangi Trust	Auckland
	Donna Matahaere-Atariki *(Chair)*	Arai Te Uru Whare Hauora Ltd	Dunedin
Mental Health	Marion Blake	Platform Charitable Trust	Wellington
& Addiction	Barbara Disley	Emerge Aotearoa	Auckland
Pacific Health	Pesio Ah-Honi Siitia	Problem Gambling Foundation	Wellington
	Robert Muller	Village Collective/Family Life Education Pasefika Services Trust	Auckland
Personal Health	Kathryn Jones	Laura Fergusson Trust (Canterbury)	Christchurch
	Catherine Marshall	Takapau Community Health	Hawkes Bay
Public Health	Jackie Edmond *(Vice-Chair)*	Family Planning NZ	Wellington
	Warren Lindberg	Public Health Assn of NZ	Auckland