NEW ZEALAND COLLEGE OF PUBLIC HEALTH MEDICINE

30 May 2019

Submission to the Ministry of Health:

Health and Disability System Review Panel

The New Zealand College of Public Health Medicine would like to thank the Health and Disability System Review panel for the opportunity to make a submission regarding the System Review.

Who are we?

The New Zealand College of Public Health Medicine (the College) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 222 members, all of whom are medical doctors, including 185 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine.

Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The College partners to achieve health gain and equity for our population, reduce inequalities across socioeconomic and cultural groups, and promote environments in which everyone can be healthy.

Introduction

The College understands that the purpose of the Health and Disability System Review is to identify opportunities to improve the performance, structure and sustainability of the New Zealand Health System with a goal of achieving equity of outcomes and contributing to wellness for all, particularly for Māori and Pasifika peoples.

There is widespread agreement that New Zealand has considerable challenges to address if this goal is to be achieved. The College believes that changes to the Health System in isolation from other sectors who are responsible for societal determinants of health is a recipe for failure. In 2017, the College identified what it believes to be the eight key priorities for the attainment of health and wellbeing for all New Zealanders.[1] We believe these priorities are still relevant today. These priorities are:

   i.   **Improving Māori health.** Achieving health equity for Māori as a focus for health policy and action by policymakers and practitioners working at all levels of the health and disability sector.[2]

   ii. **Achieving health equity.** Take a whole-of-government approach to improving health and reducing health disparities.[3]

   iii. **Reduce child poverty rates and improve child health**. Obtain cross-party agreement for a whole-of-government plan to reduce child poverty which identifies greater, sustained investment in policies and services for children, particularly in early childhood, and which has active surveillance and reporting of measurable targets.[4]

iv. **Mitigate climate change.** Generate urgent action from the public, institutions and government to address climate change across society, fairly.[5]

v. **Improve the quality and quantity of New Zealand's housing stock.** Develop and implement a long-term housing plan that prioritises healthy housing for our population.[6]

vi. **Support New Zealand to be smoke-free by 2025.** Urgently develop a smoke-free 2025 action plan, including specific measures to ensure that Smokefree 2025 is achieved for Māori and Pacific peoples.[7]

vii. **Address childhood obesity.** Take leadership and commit further to tackling childhood obesity and coordinate contributions and policy across all government sectors and institutions.[8]

viii. **Reduce harm from alcohol consumption**. Strengthen measures to change New Zealand drinking culture and reduce the hazardous consumption of alcohol.[9]

These priorities were outlined in a Briefing to the Incoming Minister, which we have provided, for your information, as Attachment One. A further priority area for action is (ix.) to **improve the mental health and wellbeing** of our communities, by taking a public health approach to mental health and prioritising and funding mental health prevention and mental wellbeing promotion.[10]

The College also believes that **increased and sustained investment in the appropriate public health infrastructure that facilitates and supports effective public health policy and programmes and services** across all areas of government is needed to improve the health and wellbeing of the New Zealand population[3, 11, 12], specifically:

- **Partnerships** that explicitly address the **societal determinants of health**, through:
  o Political commitment and leadership expressed through government policies
  o Strong governance with public health representation at all levels of government
  o An intersectoral, whole-of-government approach to social investment
  o Management of commercial conflicts of interest in policy development and implementation.

- A **health-in-all-policies approach**[13, 14, 15] with health impact assessments[16] across the policies of government entities and ministries;

- **Investment of political capital** to implement policies that improve public health, including the World Health Organization (WHO)'s 'Best Buys' for non-communicable diseases.[15, 17, 18]

Further detail is available in the College's Policy Statement on Public Health as an Investment, which we provide as Attachment Two.

We also acknowledge the significant current and future challenges to public health in the broader national and international context in which this System Review is taking place. These challenges include the growing burden of chronic severe health conditions, climate change-related health issues, antimicrobial resistance, inequity of health outcomes, influenza pandemic risk, and a weakened primary health care system, amongst others.[19]

The College believes that the current **structures for leadership, governance and policy implementation of Public Health activity** are inadequate to meet the challenges described. Other submitters have addressed possible ways of restructuring current public health agencies (we note in

particular the work of the Department of Public Health, University of Otago, Wellington and the specific suggestions made by the Health Coalition Aotearoa). This submission does not specify what a new approach might look like but does call for a separate process to address this fundamental issue, which will require broad and deep engagement with the sector. We believe all parties share a common vision of better health and wellbeing for New Zealanders; but achieving a common understanding of the required public health infrastructure to achieve this will take careful consideration and the ability to move beyond vested interests (whether business-related or political).

Responses to the System Review consultation questions

1) **What are the three or four values that you would want to underpin our future public health and disability system?**

The top values which the College believes should underpin the future public health and disability system are:

- *Equity*, with a focus on equity of health outcomes for all New Zealanders.[2, 3]
- *Promotion of good health and the Prevention of disease*, because a high proportion of ill-health is avoidable.[11]
- *Quality* in all aspects of clinical care and population health.[20]

Implicit in these three values are explicit attention to and operationalising:

- *Partnership*, and explicit commitment to honouring te Tiriti o Waitangi obligations.[2]
- *Access*, to affordable, culturally safe, primary and secondary services.
- *Sustainability*, especially environmental sustainability, since the health impacts of climate change on our society will be significant, and climate, health and equity are interlinked[5, 20]; and fiscal sustainability.[20]
- *Compassion* and respect, taking account of patient needs and preferences, including in the provision of care for those with end-of-life conditions.
- *Evidence-based practice*[20]
- *Responsive, cost-effective systems*[20] that do not exclude people unable to gain as much health (ie. egalitarian equality of outcomes vs. utilitarian) and that manage efficiency-equity trade-offs[21].[i]
- *Anti-racism praxis,* where we refer to the submission made by our colleagues at Stop Institutional Racism (STIR) calling for a national plan/strategy to end racism in Aotearoa, tailored specifically for the health system[22]: *"The Committee for the Elimination of all forms of Racial Discrimination[23] in their concluding recommendations on the New Zealand State report in 2017 recommended New Zealand urgently develop a national action plan. Came and McCreanor[24] have articulated four pathways to addressing institutional (and everyday) racism that could begin to populate such a plan. These include i) addressing historical racism, ii) enhancing racial climate, iii) transforming public institutions and iv) mobilising civil society."*

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[i] Current cost benefit analyses/Return on Investment/Government budget-setting methodologies required by Treasury (such as the Treasury CBAx Tool) implicitly favour utilitarian philosophical approaches. Utilitarianism values each QALY gained as equal regardless to whom; to gain maximum QALYs ('the greatest good for the greatest number'). This is 'double jeopardy', where co-morbidities lower the QALYs gained from treatment. This disadvantages those with poorer health to begin with (already ill or disabled). Māori are affected disproportionally. By contrast, Rawlsian values (egalitarian equality of outcomes) favour patient groups with relatively poor health over groups with better health; to equalise the groups' health. This is the efficiency-equity trade-off, maximising QALYs versus the different needs of people to whom those QALYs accrue. More detail is in references 7-22, 24 of https://link.springer.com/article/10.1007/s40273-014-0208-0 on distributive justice – eg Singer et al 1995

2) If you imagined the ideal health and disability system for New Zealand in 2030, how would people's experiences differ from today?

The health and disability system in 2030 would ideally differ in the following ways:

- A **focus on promoting health and wellbeing**, not just treating disease:
  - Prevention of non-communicable diseases[17]
  - A shift in focus from illness response to risk management[25]
  - Policy and legislation, to regulate and tax unhealthy industries – creating an environment in which healthy choices are easy choices.[1]

- A **health in all policies**[12, 13] approach would be adopted across Government departments. There would be a policy environment that addresses the social determinants of health[26] which includes:
  - Good housing for all[6]
  - Appropriate work and a social welfare system that enables everyone to have their basic needs met
  - High quality education for all, including health literacy education
  - A focus on early childhood years[27] and support for families
  - Inclusion of HIA[16] and equity tool such as the Health Equity Assessment Tool (HEAT)[12] to identify the health and equity impacts of all new policies.

- **Climate change mitigation and adaptation** would be incorporated into all policy, including in the health sector and in management of people's health.[5, 28]

- **Public and primary health care services** would be sustainable and of a high quality:
  - Service delivery would be designed to be easily navigable by the public, and people-centered
  - There would be a more holistic, whānau-based, approach to health care, including increasing/strengthening approaches and programmes like Whānau Ora
  - There would be better links between primary, secondary and tertiary care
  - Cost-effective public health interventions (both clinical and non-clinical) that also include Rawlsian value judgements (equality of outcomes) would have priority for funding
  - There would be reduced variation in quality of services and outcomes relating to geographic location. This could be achieved variously eg. by reducing the number of DHBs, and associated PHOs to increase efficiency or actively promoting and supporting best practice initiatives ie. projects that have been shown likely to achieve the required goal of improving equitable health and well-being outcomes.

- **Access to primary care** would be easy and affordable for all:
  - Cost sharing for use of first contact health services only for those who can afford it
  - Primary care practitioners would be funded to effectively provide interventions that promote equitable health outcomes, complementing diagnosis and treatment
  - Increased primary health capacity in the areas of population health, long term condition management, and mental health
  - Improved primary health integration with mental health and community/social services

- o Inclusion of primary dental care as part of subsidised primary health care services
- o Inclusion of wellness programs in primary health services.

- **Disability services** would have a higher profile, recognising that those living with disability are the highest users of the system currently and need more assistance both to navigate systems and to get timely health advice and care. In many cases, early intervention would lead to reduced personal and societal costs.

- **Technology** would be used in appropriate ways to achieve system efficiencies:
  - o Patients would be able to access personal health advice (including both wellbeing and illness), medical care, and palliative care/pain relief simply and rapidly, often from home
  - o People would have immediate visibility of the progress of referrals and the provision of appointments online
  - o People would have a comprehensive medical record available for themselves or their health practitioners to access whenever required
  - o Increased shared understanding between healthcare funders, providers, patients and communities that not all new expensive technologies (without sufficient evidence of good effectiveness and cost-effectiveness for high population need) can be provided in the public system.

- **Patient-centered palliative care** would be proactively involved from the initial diagnosis of people with end of life diagnoses (e.g. severe progressive diseases and cancers). Increasing advanced care plan development and utilisation in primary care could be facilitated by increased funding. Quality of life would thus be improved, and unnecessary high cost interventions would occur less frequently.

3) **What system level changes would you recommend to improve equity of health outcomes and wellbeing? What impact would you expect these changes to make?**

System level changes needed are:

- A strong cross-government **focus on the social, economic and structural determinants of health**[26]:
  - o There should be a strong focus on addressing poverty and ensuring adequate safe, healthy and secure housing
  - o Mandatory assessment of the health and equity impacts of the proposed policies for **all** Ministries[12, 16]
  - o Partnership that includes public health practitioner involvement in governance, e.g. the creation of a public health role similar to the science advisor role in each Ministry.

- A greater focus on **health promotion and disease prevention** (including financial support for prevention activities) at all levels, from Ministry to DHBs and including the non-Health sectors. This should include action on tobacco,[7] alcohol[9] and unhealthy foods, and actions to reduce exposure to other health risks and increase exposure to health promoting factors[25]:
  - o The appointment of an Associate Minister of Public Health

- o Increased and ring-fenced public health funding for Public Health Units within DHBs.

- A focus on the drivers of **climate change**, especially health-sensitive sectors of transport and food systems, to prevent the development of further climate-change-related health inequities.[5, 28]

- Reduce barriers to **accessing primary care:**
  - o Free oral health, vision health and first-point-of care services for low income people
  - o Potential for the use of technology to increase points of access for referral to specialist services and connectivity between primary and secondary healthcare
  - o Greater integration of mental health and primary health services
  - o Include primary dental care as part of subsidised primary health care services.

- Better developed **evaluation capacity** and **routine monitoring of equity** of health care services and outcomes, including programmes which evaluate the equity and effectiveness of screening, diagnosis and treatments across geographic areas and programmes[20]:
  - o The inclusion of disability as an independent risk factor in analysis, alongside other more traditional views of equity
  - o Those individuals with multiple equity risk factors should have high priority for risk management and for treatment
  - o Social impacts should be actively considered in prioritising care e.g. limited social engagement/ limited physical exercise/ unemployment because of disability[29]
  - o The potential for physical and/or mental deconditioning in the elderly as a risk factor
  - o All health outcome targets and outputs should be equal for all population groups, unless there is exceptional reason for differential outcomes.

- Work to **eliminate systematic racism** and implicit bias from the health and disability sector:
  - o Māori need to be leaders and true partners in the design, governance and delivery of services. This will require increased support and capacity building to enable Māori to fulfil these roles.
  - o Health workforce development to support a workforce which reflects the population served and promotes equity

- Careful examination and reduction of the incentives that lead to the growth of the private sector at the cost of the public health sector.

4) What would make the biggest difference to improving health outcomes for Māori?

Health outcomes will best improve for Māori from the following:

- **Adequate funding for Māori health providers .**We support the kaupapa of our colleagues as outlined in the STIR submission to the inquiry, calling for Māori health providers being funded in a manner reflective of their status as Tiriti partners and the amount of work required to remove the current burden of disease carried by Māori whānau. *"Analysis of*

health disparities in Aotearoa show that current funding levels to Māori providers are clearly inadequate to meet cultural health needs as defined by Māori."[30, 31]

- **Accountability and transparency.** We support the kaupapa of our colleagues as outlined in the STIR submission to the inquiry, calling for accountability and transparency to enable Māori to enact their right to monitor the Crown's progress.[32] *"Non-performance in relation to Māori health outcomes would not be acceptable. In the current racial climate, transparency is critical as is a planned response to implementing te Tiriti, ending institutional and other forms of racism and improving Māori health outcomes. All sectors within generic service delivery need to be monitored in relation to Māori health equity, Tiriti responsiveness, and anti-racism plans.*"[33]

- Greater focus on the **social determinants of health**[26], including inter-ministry collaboration:
    - Honouring Te Tiriti o Waitangi and restoring economic and cultural sovereignty (as part of tino rangatiratanga)
    - Education, housing and employment policies that reverse existing discrimination and facilitate Māori success
    - Specific support for Māori women.

- Māori health equity being included in **key performance indicators** for healthcare providers, with organisations committing to, funding and being accountable for equity targets. This needs expertise, support, guidance, collaboration and engagement with affected communities and others in the health system.

- **Partnership with Māori** in service design, delivery and governance.

- **Cultural safety** as the standard for all health workers, including administrative staff and overseas-trained staff (particularly those from other English speaking, Western countries who may not be immediately visible as overseas-trained). We note that cultural safety is wider than 'just' cultural safety for Māori, but also acknowledge the rights that Māori have as indigenous people and the particular relationship between Māori and the Crown under te Tiriti o Waitangi.

- Lowering barriers to **access** and improving the standard of culturally acceptable primary care, mental health services and antenatal care. Increased support is required for existing Whanau Ora initiatives that have proven their value in well-designed evaluations.

- Strengthen and support the **Māori health workforce** and Maori leadership. Māori health workforce capacity should be proportionate to Māori health need. To achieve this will require a significant capacity building focus at all levels of the educational system

- The development of a **pan-sector system approach** to addressing inequities (including beyond the health sector)

- A focus on **setting health system equity targets** and further tools and research, including:

- o Leadership and commitment by the health system, health organisations and health practitioners, with the expectation that all New Zealanders will have equity of health outcomes[34]

- o Everyone working in the health system understanding their role in reducing inequities

- o Using frameworks like the Ministry of Health's Equity of Healthcare for Māori framework, and others including a Māori implementation framework (He Pikinga Waiora)[35, 36]

- o Strengthen Māori researchers' and health providers' kaitiaki role with good data governance, including dissemination and accountability for progress within kaupapa Māori research principles[37, 38]

- o All parts of the health system implementing the revised Ethnicity Data Protocols—collecting ethnicity data accurately, appropriately, and often.[39]

5) **What would make the biggest difference to improving health outcomes for Pacific people?**

This requires:

- The development of a **pan-sector system approach** to addressing inequities (including beyond the health sector).

- A focus on setting **health system equity targets** and further tools and research.

- A focus on the development of **cultural competence** across the entire system, for services that are culturally safe.

- **Increased and ring-fenced funding** for Pacific community NGOs, PHOs and other healthcare providers.

- **Culturally appropriate health promotion** with a focus on reducing exposure to health risk factors and preventing non-communicable diseases.

- Lowering barriers to **access** and improving the standard of culturally acceptable primary care, mental health services and antenatal care.

- Strengthen and support the **Pasifika health workforce.** Pasifika health workforce capacity should be proportionate to Pasifika health need. To achieve this will require a significant capacity building focus at all levels of the education system.

- **Climate mitigation strategies** to protect the future of Pasifika nations, and clear pathways for New Zealand to support people displaced by climate change, suffering consequent health impacts.

6) **What health and disability system changes would have the most impact on ensuring that disabled people have equal opportunities to achieve their goals and aspirations?**

This requires:

- The development of a **pan-sector system approach** to addressing inequities (including beyond the health sector), and a focus on setting system targets and on wide commitment, including further tools and research.

- A focus on the development of **cultural competence** across the entire system, for services that are culturally safe.

- Ensuring that disabled people are considered key stakeholders within the healthcare system
    - **Representation** on district health boards and consumer panels.
    - **Partnership** and co-design in disability services
    - **Respecting autonomy** as a key value.

- A **life-course approach** to disability services to ensure that disabled people:
    - Are financially supported over a lifetime if unable to work
    - Can access advice and care, including but not limited to
        - Reducing the discrepancy between ACC supported clients and all other disabled people
        - Increased capacity of primary care to meet disabled people's needs: training, funded time, advocacy
    - Are treated with respect in health care settings
    - Are accommodated in health system facility design (including considering a very much wider range of disabilities in building design)
    - Are accommodated in civic design
    - Are treated as equals by their peers at school and elsewhere.

- Adequate financial and pastoral **support for caregivers**, including adequate and appropriate respite care services.

7) **What initiatives do you believe have delivered improved and equitable health outcomes and wellbeing in New Zealand or overseas? What impacts have these approaches had and what is their potential to deliver further improvement?**

Key features of this are:

- **Advancements in public health** in the last 100 years, such as vaccination, control of infectious diseases through clean water and improved sanitation, and, have led to improvements in health and wellbeing, and a substantial increase in life expectancy.[10, 11, 40]

- Focus on **prevention, risk modification**[25] and the **social determinants of health**[26]:
    - The recognition of tobacco and alcohol use as a health hazard and the introduction of controls, particularly progressive taxation
    - Reducing obesity (primarily through improved diet)
    - Health in all policies approach - cross-sectoral support for 'healthy' ways of living
    - Secure and safe housing for all
    - Initiatives that improve food and urban environments in economically deprived areas.

- Use of **equity indicators** to focus DHB planning processes.[20]

- **Investing in moving further towards Universal Health Coverage** (removing financial barriers to accessing healthcare).
  - This needs to include GP, urgent care, oral and vision health services

- The **DHB system, PHARMAC and ACC** are strengths of our healthcare system.

8) **What are the top priorities for system level change that would make the biggest difference to New Zealanders?**

Top priorities are:

- Focus on **health promotion, disease prevention** and commit to **upstream prevention**.
  - This will require political leadership on issues such as drinking water fluoridation[41] and chlorination, folate fortification, taxes on unhealthy products (at this stage, sugar sweetened beverages[42, 43]), a ban on direct to consumer advertising of pharmaceuticals[44], licensing of tobacco retailers[7], changing the culture of alcohol consumption[9], and increased provision of public transport and infrastructure to enable active transport.
  - Strengthen the capacity for public health action at the Ministry and cross-Ministry level.
  - Targeting income inequality through taxation and regulation of the housing market.

- **Collaboration** with other social service sectors to improve the social determinants of health through a health-in-all-policies approach[45]:
  - Consider the public health and public policy implications of a universal basic income[46]
  - Coordinated, wrap-around services for those who require the use of multiple services, with supporting and building existing Whānau Ora approaches
  - Make health impact and equity key outcomes and reporting requirements for all government agencies, not just those with responsibilities for the determinants of health, in the form of Health Impact Assessments being embedded into all regulatory impact assessments/statements by Government ministries and agencies[47, 48, 49]
  - Greater consideration of the co-benefits of climate mitigation policies for improving health (promoting active transport, plant-based diets, reducing environmental pollutants).

- **Greater investment** in health protection and promotion at the population level. Public sector investment in areas which will yield positive health outcomes over the long-term[11]:
  - Cost-effectiveness analyses that adequately assess longer term benefits against upfront costs. The higher discount rates currently set by the Treasury devalue future life losses from premature death and later suffering/disability, and thus reduce the gains from preventing these now. Public sector discount rates should better incorporate time preference, risk and intergenerational impacts.

- o Using the same value of life calculation in effect across all government sectors, when determining funding
- o The balancing of cost-effectiveness with need, equity, affordability, and sustainability.

- **Equity** as a priority[3]
  - o Rationalise and prioritise the wellbeing and care of people living with disabilities.
  - o Equity key performance indicators linked to funding
  - o Equitable outcomes for all ethnic groups and socio-economic groups

- **Improving quality** of services
  - o Create a health system that the public can navigate
  - o Improve mental health services

- **Restructuring** the healthcare system
  - o Carefully consider the public health and public policy implications (benefits, dis-benefits and costs) of moving away from small business model of primary care towards a national health service approach with alternative ownership models, that have the same geographic boundaries as DHBs.
  - o Develop a change ready, change capable and resilient health sector to respond swiftly to the social changes and technological advances that are imminent.
  - o Removal of financial barriers to accessing healthcare
  - o Carefully consider the public health and public policy implications (benefits, disbenefits and costs) of nationalising primary care to become a fully funded government-owned health system where all staff across the system are salaried

- **Protect existing public health leadership structures** (including ring fencing funding for public health within DHBs) and **build public health leadership and operational activity** to be able to adequately respond to the immense public health challenges New Zealanders are facing. This restructuring will require engagement with all components of the public health system over and above what has occurred in this health system review.

Thank you for the opportunity for the NZCPHM to submit on the Health and Disability System Review. We hope our feedback is helpful, and please contact us if we can be of further assistance.

Sincerely,

Dr Felicity Dumble, President, NZCPHM

Attachments:
1. NZCPHM Briefing for the Incoming Minister, 2017
2. NZCPHM Policy Statement on Public Health as an Investment, 2019

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