



6 December 2019

Heather Simpson
Chair: Health and Disability Review Panel

Via email: c/o Sarah.Prentice@health.govt.nz

Dear Heather

Issues for further consideration by the Health and Disability Review Panel

Thank you for attending the New Zealand College of Public Health Medicine's (the College's) Annual Scientific Meeting in September and providing us with an overview of the Interim report of the Health and Disability Review Panel.¹ We understand that the Panel is not putting out a formal request for submission on the Interim Report, but that contributions on issues raised by the Panel in its report and discussions with the sector are welcome.

The College welcomes the Interim Report, and in particular, the emphasis in the report on the need for the system to be more focussed on preventing ill health and promoting wellbeing. We agree that the health system cannot address all of the challenges that it faces by focusing on curative services alone, and that investment in public and population health will provide the foundation for a healthy and productive society. As our Public Health as an Investment Policy Statement says,²

Spending on health, including public health, is highly beneficial for society. In addition to bringing improvements in health, wellbeing, and quality of life, it is associated with increased labour supply and productivity, and health has been shown to be a major contributor to economic growth. Furthermore, evidence indicates that public health interventions are cost-effective (with some being cost-saving for healthcare systems and even revenue-raising for government) and contribute to improvements in health outcomes in the short, medium, and long term. A systematic review from 2017 assessed return on investment of public health interventions in high-income countries with universal healthcare (including New Zealand).³ This review indicated that local and national public health interventions contribute to long-term health gain, with a median return on investment of 14:1 for health spending. Considering these benefits, it is important that governments view and consider public health spending as a high-value investment, rather than a budgetary cost.

We strongly support the emphasis given in the Report to the need to develop an effective Tiriti / Treaty-based partnership within the health system.

We agree that what is lacking in the system at present is long-term thinking and coordinated planning, better data infrastructure and stronger integration across providers.

Responses to the issues raised in the Interim Report

[The College's submission to the Panel in May 2019](#) included nine identified priorities for the attainment of health and wellbeing for all New Zealanders, all of which are included in some form in the Interim Report. Our submission also provided an answer to the question of the values that should underpin and guide the future public health and disability system.⁴

We do not wish to repeat issues raised on our original submission.

We do however have a small number of issues that we would like to raise for your consideration:

1) Tiriti / Treaty-based approach to governance

The Panel asks: *In taking a Tiriti / Treaty-based approach in health, what are the implications for the role of Māori and iwi in leadership, governance and decision making at national or local levels and how should these roles be provided for?*

The College considers that taking a Tiriti / Treaty-based approach to governance and decision making in health requires meaningful partnership with Māori in governance at all levels of the system.⁵ This will require:

- Implementation of Waitangi Tribunal recommendations arising from WAI2575.⁶
- Significant capacity building at all levels of educational system to strengthen and support Māori health workforce and leadership.
- Ongoing strategies to mitigate systematic racism and implicit bias in the health and disability sector.
- Practical recognition of the significant resourcing pressures of what is a precious and scarce resource – being the expertise, experience, networks and mana of health practitioners, policy-makers and organisations who are Māori. These people are needed to effectively partner under te Tiriti, which has consequent opportunity costs to the day-to-day mahi of direct service provision etc. to tangata whenua and their other responsibilities to their whānau and communities. This practical recognition will require both funding that respects the mana of Māori Tiriti partners and commitment from non-Māori Tiriti partners to “do the heavy lifting”.

At a bare minimum, we urge that the Panel support the Tribunal recommendations (i) that an investigation be conducted into the formation of an independent Māori health authority to plan and amply fund Māori health providers and kaupapa Māori services, and (ii) that a thorough review of the funding of primary health care be conducted with a view to ensuring sufficient funding to address the current excess, unfair and unjust burden of disease carried by Māori.

2) System structure

The Panel asks a number of related questions on system structure in the Interim Report:

- *Where should responsibility for developing and implementing the system-wide long-term plan lie?*
- *What should be the balance between national decision-making to guide the entire system and local autonomy to ensure services are designed to meet the needs of communities?*
- *Should development of the health and disability system into a cohesive, integrated system with greater clarity of mandate be driven centrally by the Ministry of Health or by a different agency?*
- *If population health is to be more central to all planning and delivery in the system, should this change be driven by the local DHB or at a regional or national level?*

The College's view is that a system based on coordinated long-term planning will require strong policy-setting capacity at the national level. This is particularly important to ensure the prioritisation of issues such as health promotion, disease prevention and commitment to upstream prevention.

However, capacity for public health action at the Ministry level will require considerable strengthening to enable a strong national policy-setting approach with prevention at its core. Our view is that this capacity should ideally be built within the Ministry, rather than as a stand-alone agency, as such agencies have historically been subject both to instability born of largescale policy shifts and to funding constraints.^{7,8}

The scale of the 2019 measles outbreak in New Zealand is an example of the result of a limited capacity to deal with population health issues nationally. This has affected not only New Zealand but has also posed a serious threat to Pacific Island countries and territories. Planned and coordinated responses focussed on prevention to address both national and international challenges of this nature are crucial.

As most of the social determinants of health lie outside the health sector, we also consider that even greater attention must be given to inter-sectoral and whole-of-government approaches to addressing the social determinants of health.⁹ We support, amongst other things:

- A strong focus on addressing poverty and ensuring adequate safe, healthy and secure housing. In this regard, we note the recent release of the Interim Report of the Health Homes Initiative Outcomes Evaluation. In one year, the programme is "estimated to have resulted in 1,533 fewer hospitalisations, 9,443 fewer GP visits and 8,784 fewer filled prescriptions", providing an estimated saving to the health system of approximately \$10.4 million.¹⁰
- Mandatory assessment of the health and equity impacts of the proposed policies for all Ministries.^{11, 12}
- Partnerships that include public health practitioner involvement in governance, e.g. the creation of a public health advisory and leadership role in each Ministry similar to the science advisor roles already there.

We strongly urge that the Panel findings address the development of capacity at national level to coordinate and support a health-in-all-policies approach in New Zealand.

At the regional and local levels, greater investment in health protection and promotion will also be required.

3) Public Health Medicine workforce

If the system is to focus on addressing the determinants of health, and on upstream actions to address health inequities and avoidable disability-adjusted life years (DALY) loss, an adequately trained and resourced public health workforce will be required to lead this work.

Public health medicine specialists (PHMS) play a crucial role in this regard, as Medical Officers of Health, in Planning, Strategy and Funding positions, as researchers and policy analysts, and as managers of large health institutions and organisations. PHMSs contribute significantly to the delivery of national priorities such as health equity, improved child and youth wellbeing, and mental health, and in implementation of health protection and prevention strategies such as securing safe drinking water, healthy food and drink, the delivery of quality screening programmes, and the mitigation and management of climate change effects.

Yet, and despite increased interest from candidates wishing to enter the field, Health Workforce funding for public health medicine training has been restricted in recent years, leading to reduced intake rates to the College's training programme.

The PHMS workforce has been declining since 2015: the New Zealand Medical Workforce in 2017 report showed a 4.5% decline in doctors with vocational registration in public health medicine between 2015 and 2018.¹³ This is the only medical speciality (of greater than 100 doctors) to have shown a decline in numbers in this period. Several DHB public health units (PHUs) have struggled in recent years to recruit to vacant Medical Officers of Health positions.

Unless urgent action is taken, this situation is expected to continue. Health Workforce projections indicate that, at current rates and taking into account projected retirements as well as the number of international medical graduates entering the country, the number of PHMSs is expected to decline from 170 in 2017 to 153 in 2027 (with an FTE decline from 165 to 148). The number of PHMSs per 100,000 population is expected to decline from 3.55 in 2017 to 2.87 in 2027 (with an FTE decline from 3.44 to 2.78).¹⁴

The Panel asks: *How can training and regulatory regimes be developed so the workforce can gain and use the skills needed to adapt to the changing demand for services*

We would argue that, in public health medicine, there is currently no failure to adapt. In fact, flexibility and ready adaptability is a core part of the PHMS practice. The public health medicine workforce is at the forefront of urgent issues such as health equity and the health effects of climate change. A failure to invest in this workforce will mean a loss of this capacity in the future.ⁱ

ⁱ As an important aside, we caution that some of the discussion relating to workforce flexibility and ability to change career mid-stream fails to understand the detailed and in-depth nature of the training programmes that prepare specialists for the roles that they undertake. Whilst some cross-recognition of training might be appropriate where the two disciplines are closely related, where they are not, in order to prepare the doctor for a role as a specialist in a new field would require attaining the competencies of the appropriate training programme. Since a large proportion of the training of specialist doctors is necessarily done through apprenticeship, rather than by means of modular didactic courses, time spent in training is crucial to attaining these competencies and cannot be reduced without compromising the standards that will be attained.

4) Accountability measures and outcomes

The College would support the introduction of a set of public health outcome measures for the system, similar to the [public health outcome framework](#) used as a benchmarking tool in the United Kingdom.¹⁵ This framework sets its primary goals as being to increase life expectancy and to reduce differences in life expectancies between communities. It brings together in one place indicators covering health behaviours and risk factors (such as those covered in the New Zealand Health Survey)¹⁶, and also multiple indicators covering the wider determinants of health (including education, violent crime, homelessness, employment); health protection measures including immunisations, exposure to air pollution and antibiotic prescribing; and avoidable mortality rates. The creation of a similar framework for New Zealand would enable much stronger monitoring, not only of the current health of the nation, but also of the factors likely to impact on future health. This would fit well with, inform and enhance the public sector's wider focus on wellbeing under the Living Standards Framework.¹⁷ ⁱⁱ

5) Pacific health equity

The College is aware of the substantial body of work on Pacific health and health equity undertaken for the Panel by Drs Corinna Grey and Debbie Ryan in preparation for the interim report. We are disappointed that this work, and the large health equity issues affecting Pacific People in New Zealand,¹⁸ has not been given more prominence in the interim report. We urge the Panel to seek an opportunity for dialogue with the Pacific sector, so that this can be remedied and Pacific views on how to address these issues can be incorporated, before the Panel's final recommendations.

6) Climate change

Although climate change is mentioned in the Interim Report as a challenge facing the system, we are concerned that the Report does not cover the full complexity of the challenges that climate change will bring to the health system and the considerable repositioning of workforce and infrastructure that will be required to deal with its consequences.

Climate change is a significant contributor to the global burden of disease, disability and premature death, with larger health impacts expected over coming decades.¹⁹ These impacts include malnutrition, deaths and injuries from extreme events, vector-borne disease such as dengue fever, cardiorespiratory effects from air pollution, and diarrhoeal disease.^{19,20} More diffuse effects include mental health problems, migrant health issues and the health issues resulting from civil tension and conflict.^{19,20} Climate change also has serious implications for health equity in New Zealand:^{19,20} Māori, Pacific, vulnerable, and lower socioeconomic populations are at risk of disproportionate health impacts from climate change.^{19,20}

ⁱⁱ For further information, see New Zealand College of Public Health Medicine's Submission to Finance and Expenditure Select Committee on the Budget Policy Statement 2019. Wellington: NZCPHM, 2019. (https://www.nzcpm.org.nz/media/125704/nzcpm_submission_budget_policy_statement_2019.pdf)

Māori are at risk of disproportionate impacts compared with non-Māori, not only because of differences in health and socio-economic status, but also because of indigenous relationships with the environment, customary practices such as collection of kaimoana (seafood) with exposure to food-borne disease risk, and differential access to and quality of health and social services.

Preparedness for the impacts that climate change will have on health in New Zealand will require planning for an increased burden on the health system and for a necessary reorientation of health services; promotion activities to strengthen the health, social cohesion and resilience of communities; public health surveillance and early warning systems for new and emerging diseases, coupled with adequate response capability; vector surveillance and control; and emergency preparedness.

On the other hand, climate action has the potential to hugely improve health, by avoiding negative health impacts and by realising significant health and equity co-benefits from well-designed climate policies that reduce greenhouse gas emissions in ways that are fair and that actually strengthen communities.^{19,20,21,22,23} These co-benefits arise because some emission reductions measures impact on important determinants of health, especially energy intake (nutrition) and expenditure (physical movement).

But perhaps even more fundamentally, wider societal co-benefits may arise because how society mitigates climate change fairly can translate to other public policy good. These public policy goods include achieving overall equity and generating true Tiriti partnerships. This is by society better recognising the wealth of innovation and knowledge across the diversity of all New Zealand. For instance, with climate change, the large body of indigenous knowledge has enabled Māori to develop sustainably in Aotearoa for centuries, with significant potential to contribute to national action on climate change.²⁴ Tangata whenua have also adapted to a variety of environmental challenges and worked collectively to develop innovative solutions to social problems.²⁴ Aside from being the right thing to do, partnership approaches that better embed tikanga / Te Ao Māori paradigms (eg greater valuing of kaitiakitanga (guardianship), aroha (love/compassion), manaakitanga (caring), whakatipuranga (future generations), hauora (health and wellbeing), and tika (integrity/doing what's right)) could generate co-benefits across society that are unforeseen.

We suggest that a unit with dedicated responsibility for management of climate change-related health policy and planning be established within the Ministry of Health. Responsibilities of this unit would include:

- Ensuring that climate change mitigation and adaptation strategies are better incorporated into all national health policies and strategies.
- The development of 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.
- Greater collaboration with other Ministries and government departments to ensure 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.
- Greater monitoring and coordination of activities taken at regional level to minimise the carbon footprint of the health sector.

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.

Yours sincerely



Dr Felicity Dumble
President

About the NZCPHM

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. It has 222 members, all of whom are medical doctors, including 183 fully qualified Public Health Medicine Specialists, with most others being registrars advanced 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, eliminating inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.

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