Submission to Hon Tony Ryall, Minister of Health, on the Ministerial Review Group report

From the *Department of Public Health, University of Otago, Wellington*
September 18, 2009

The Department of Public Health, University of Otago, Wellington, have consulted with department staff about the Ministerial Review Group report. The Department and the Dean of the Wellington School of Medicine and Health Sciences would like to submit some comments.

We find much to commend in the recent Ministerial Review Group report, for example the focus on new models of service delivery, stronger clinical networks, changing clinical culture to more patient-centred care, and a greater focus on prioritisation of health care interventions. However, we also have some concerns about the report.

In particular, our concerns relate to (i) the lack of focus on the role of preventive and public health interventions in improving health and well-being, (ii) the lack of emphasis on equity-related issues in the discussion about improvement of the delivery of health services, and (iii) the conceptions of how public health interventions and improvements in health status should be assessed. We note the MRG Terms of Reference; nevertheless, the MRG's relative silence on the issues of social determinants of health, preventative measures, inequalities and intersectoral activities is concerning. We would be especially concerned if these Terms of Reference led to reduced prioritisation of these activities over the next few years.

1) Lack of focus on the role of preventive and public health interventions

In paragraph 2, the report notes that the focus of the public health and disability system is on "providing for the health and well-being of New Zealanders". We fully agree with this statement. We note that there is a high level of agreement that to maximise health status of populations, a *combination* of both high quality treatment and preventive services, and action to create and maintain a health promoting socio-economic and physical environment is required.

We note the Terms of References and paragraph 32 of the MRG report, and that section 14.5 which addresses prevention very briefly, is presented in the report as one of seven areas for further work, however, we are surprised that there is not a clearer statement within the report that *as well as* health care services, preventive and public health interventions and broader policy measures which promote health are required to improve and maintain population health and well-being.

2) Lack of emphasis on equity in the discussion about improvement of the delivery of health services

We are generally supportive of many of the many of the detailed proposals about improving the delivery of health care. For example, expanding regional clinical networks, and promoting models of care delivered closer to home and through primary care services.

However, in evaluating the place of these interventions and models of care, we believe that there should be a specific consideration of the impact on inequalities in health care access and quality and health outcomes. We note that there is an almost complete lack of discussion of improving health service delivery for Māori, and addressing inequalities in health care access and outcomes was not included in the terms of references despite the evidence noted in the report of inequalities in access and outcome by ethnicity (para 46). We strongly believe that reducing inequalities should be a specific aim of health service quality improvement. Indeed in para 46 it is noted that reducing inequalities requires 'a systematic approach which addresses many barriers simultaneously'. Yet in the recommendations for section 5 on 'new models of care', there is no mention of the need for incorporating such a systematic approach to addressing inequalities in the new models of care. Furthermore, the emphasis on improving information systems is discussed in relation to individual patient experience, there is no discussion of using information systems to describe and monitor the extent of inequalities in access to and outcomes of health care between social and ethnic groups.

We also strongly support the emphasis within the report of a reinvigoration of national-level prioritisation processes. However, we note that prioritisation is just not a technocratic exercise – although the quantitative assessment of health effects, cost and cost effectiveness is a key component. Second level filters around social values, equity, capacity, and such like will be essential. Indeed, there is a need to continue, and deepen research on, explicit inclusion of equity in prioritisation. Again this is not discussed or acknowledged in the report and its recommendations.

3) Conceptions of public health and health status

We are concerned about the possibly inadequate analysis and possible worrying future implications arising from paragraphs 113 to 115 in section 14.5 (emphasis added):

> **14.5 Prevention versus Cure**
> 113 It is reasonable to assume that New Zealand's relatively strong commitment to preventative and public health has helped improve life expectancy, delay the onset of disability associated with chronic disease, and reduce inequalities. Opinion is divided, however, on the much narrower question of the extent to which further spending in this area at the expense of more immediate health needs might help reduce future health costs or improve the country's economic performance, thus making future health spending more affordable.
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> 114 On the question of cost, it is not clear that living longer and generally healthier lives will necessarily reduce our demand on health and disability services over our lifetime. Half of all health spending goes on the last year of life and the older we are the more likely we are to suffer from multiple conditions. In addition, many of us will live longer with long-term chronic conditions, like diabetes, that are expensive to treat and increase the risk of multiple conditions later in life. Information is needed on the impact of preventative and public health interventions on lifetime health and disability costs to guide future investment decisions in these areas.
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> 115 On the question of health as an investment in growth, there is also a balance to be struck between the negative effects of the taxation required to finance health spending and the benefits of a more productive and longer lived workforce. Even if the potential benefits are significant, the effect of other policies on realising this potential will often be far more important. For example, the potentially large productivity benefits from people living

healthier lives into older age will not be realised unless people also delay retirement.37

As a Department of Public Health, we wish to make several comments about the above wording:

1. Prevention is cost-effective. For example, recent cost effectiveness analyses in Australia show that physical activity interventions do not actually cost money to secure health gains, but rather money is saved and health is gained (Cobiac et al. 2009) – a win-win (or 'dominant' intervention in economic jargon). We note a recent international review stated 'in almost every case … tobacco control programs and policies are either cost-saving or highly cost-effective'(Kahende et al. 2009).

2. We are also concerned about the different standards that these paragraphs suggest are being applied to preventive and public health interventions. Paragraph 114 seems to imply that successful preventive interventions need to be investigated for impact on future health and disability costs, but does not make the same argument for successful health care treatment interventions. The reason for this is unclear.

3. On the question of whether living longer lives results in living healthier lives, a recent report, whilst highlighting the methodological challenges in measuring *healthy* years of live lived, found that 2/3rds of the gained years of life expectancy between 1996 and 2006 were in good health (Ministry of Health and Statistics New Zealand 2009). Other New Zealand work has found a 'dynamic' scenario, whereby as life expectancy *increases* the proportion of life in severe disability *contracts* (Graham et al. 2004). That is, increasing life expectancy does not necessarily mean more disease and disability to treat and support. Furthermore, there is no reason that gains in healthy life expectancy should not be accompanied by increases in the age of entitlement to superannuation – the current age of 65 was first set in New Zealand when the non-Māori life expectancy was 20 years less than it is today, the Māori life expectancy perhaps 40 years less than it is today.

4. More fundamentally, we question the general tone of the above three paragraphs from the report (113-115) which suggest a narrowly focused assessment of the impact of (preventive) health interventions – in which their impact is assessed only in relation to economic effects such as on health care costs and productivity.

   Whilst we agree that saving lives and preventing morbidity and disability (whether through prevention, treatment or cure) will have knock-on economic impacts through effects on future productivity and health and disability costs etc, we also firmly believe that improving current and future health has a considerable value in itself to individuals and to society. We do not live to support the economy. Rather, the economy exists to ensure our freedom to live healthy and fulfilling lives.

   Instances where investment in Vote: Health also leads to economic growth are nice win-wins (and there is ample evidence from countries like Cuba and South Korea, and Kerala in India, that social investment lead improvements in life expectancy which lead to

improvements in GDP). But this should be far from a precondition for Vote: Health expenditure.

The danger of taking too narrow an economic perspective is illustrated by the tobacco industry, which has argued that smoking saves money for the economy through early death resulting in lower lifetime health and social care costs and reduced pensions. We doubt that increasing smoking (or perhaps reducing expenditure on preventive health care) in New Zealand *is* a solution that the Ministerial Review Group would support, but it is implied that it *might be* by the content of these paragraphs.

We hope these comments are helpful and look forward to the response of the Minister of Health and his team to the Ministerial Review Group report.

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