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**“UPDATE OF THE NEW ZEALAND HEALTH STRATEGY: ALL NEW
ZEALANDERS LIVE WELL, STAY WELL, GET WELL”**

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Introduction

The Department of Public Health University of Otago is pleased to have the opportunity of input into the *Update of the New Zealand Health Strategy Consultation Draft* (Draft strategy)

The Department welcomes the development of a new draft strategy, timely given the fifteen years since the 2000 Strategy. The development of a new strategy provides an opportunity to take stock of how we are doing, identify current challenges, and clarify what is needed for the future.

This submission is based primarily on a public health perspective with two main starting points: the purpose and objectives of the New Zealand Public Health and Disability Act 2000; and an evidence-based analysis of the causes of ill-health in New Zealand.

General comments

We consider that the draft strategy provides many opportunities to develop a document which will help set meaningful directions for New Zealand’s health future. The draft strategy includes phrases like a system moving ‘from treatment to prevention’ and ‘a focus on prevention’; and notes that ‘Population-based strategies can also make healthier choices easier for all New Zealanders and help prevent and manage long-term conditions.’ It also espouses as one of its eight principles “collaborative health promotion and disease and injury prevention by all sectors”.

However, despite these worthy phrases, it is very disappointing that the strategy contains few if any meaningful preventive strategies and interventions to improve health at the population level. The five strategic themes (people powered, closer to home, value and high performance, one team and smart system) all focus on the health care system, with the only population-level preventive elements buried within the ‘closer to home’ section. Although the strategy claims to describe ‘the future we want’, unlike the 2000 Health Strategy it includes no population health goals, and even fails to acknowledge such critical goals that the Government has adopted such as Smokefree 2025.

The strategy also acknowledges the Treaty of Waitangi and includes equity focused principles, such as “An improvement in health status of those currently disadvantaged’, and “Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay”. However, these principles are not well reflected in the strategic themes and action

areas, which rarely provide any specific actions targeted at improving equity in health and health care.

Areas where the Draft Strategy could be strengthened include:

- Greater coherence across the principles, the challenges, the themes and the actions. Currently the logical links between these different elements of the strategies are not readily apparent.
- A more comprehensive and evidence-based outline of the population health challenges faced by the New Zealand health system.
- Inclusion of measurable outcome-based population health targets to give focus to the Strategy.
- A clear commitment to equity in health outcomes and in access to and delivery of high quality health care, and an outline of actions and strategies to achieve these goals .
- Providing commitments to develop and implement evidence-based and cost-effective preventive strategies and interventions to address the population health challenges and achieve the population health goals.

Guiding principles

The guiding principles from the 2000 Health Strategy have been augmented with an eighth – ‘Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing’. In our view these principles remain apt and the new principle is a useful addition. However, the principle acknowledging the centrality of the Treaty of Waitangi has been moved from first to fifth in the list. Furthermore, unlike in the 2000 Health Strategy there is no elaboration of these principles or how they are reflected in the new draft Strategy. As a result the strategy lacks coherence across the principles, challenges and actions and strategies.

Population Health Goals

The new draft Strategy includes no population health goals. The 2000 Health Strategy listed 13 priority population health objectives with a rationale for why each was chosen. The objectives (e.g. ‘reducing smoking’ and ‘improving oral health’) were limited as they were non-specific and did not include timeframes. However, they did at least set out the overall priorities for population health interventions. The 2015 new draft Strategy fails to do this, and does not even mention existing goals such as the world-leading Smokefree 2025 goal to which the Government is committed. There are also no specific goals for reducing or eliminating inequalities in health, health outcomes and health care access and delivery.

Challenges and strategies

The list set out in the box on p 5 of the Strategy includes many major health and sustainability challenges which we agree face New Zealand including those of an ageing population, increases in long-term conditions and the health and social effects of climate change. However, the extent and scope of these challenges is not elaborated and the challenges themselves are not comprehensive. There is also no description or even acknowledgement of the substantial disparities in health that

exist by ethnicity, particularly for Māori and Pacific, and by socio-economic status; and there is little in the way of suggested actions to address these disparities. The action areas include little in the way of population-based preventive strategies, and even the prevention action areas that are mentioned are mainly health system led interventions focused on high risk individuals rather than interventions to reduce population levels of key risk factors or address underlying determinants like poverty and poor housing.

Most fundamentally, the analysis of challenges is not based on the science around health loss: specifically the 10 top risk factors for health loss in New Zealand (See Table 1). There is scarcely any mention of tobacco in the strategy – the country’s top risk factor for health loss (and also a major contributor to health inequalities). This lack of attention to tobacco is inconsistent with the ‘value for money’ imperative and ‘investment approach’ that are important themes of the new draft Strategy. For example, tobacco smoking results in huge economic costs to society and NZ modelling work suggests that higher tobacco taxes would be highly cost-effective and save substantial health dollars ¹.

The word “obesity” gets some mentions, and the degree of the health problems caused by obesity are briefly acknowledged, and unlike other areas of prevention some attention is given to actions to address this issue. However, the specific actions listed are targeted individual interventions for those who are obese or at risk of becoming obese, and unspecified broad population-based strategies. There are no plans presented to tackle the obesogenic environment (eg, the words “marketing”, “outlets” and “tax” are not mentioned) for example by implementing key recommendations of the WHO report on ending child obesity. ²

Brief mentions are given to the risk factors high blood glucose (in relation to diabetes), physical inactivity (‘exercise’ is mentioned once), and also the word “alcohol”. But there are no substantive primary prevention plans outlined for these risk factors. The lack of focus on alcohol is of note given that this is an area where there is ready scope for large health gains – while also saving health system costs ³.

Top 10 risk factors which are not discussed at all include: “high blood pressure”, “high blood cholesterol”, “high sodium intake”, “high saturated fat” intake”, and “adverse health care events”. From a value for money perspective this also seems unfortunate – given the NZ modelling work that suggests that population-level dietary salt interventions would generally produce large health gains while also saving health dollars ⁴. Similarly, for NZ work on the benefits of taxing high salt foods ⁵, and sugary drinks ⁶.

In addition, neither the summary box nor the text refer at all to structural issues such as poverty, food systems, poor housing, transport issues, built environments, nor issues relevant to income, tax and benefits.

Next steps

The new draft Strategy offers scope for development to achieve both “prevention” and “value for money”. Effective population based preventive strategies are highly effective and cost-effective, generally much more so than treatment interventions. For example, among the major interventions modelled by the BODE³ Programme (University of Otago) the health gain from population based preventive interventions such as regulations to reduce food content of foods and tobacco taxes dwarf those of clinical and health systems interventions such as increased use of Herceptin for breast cancer and cancer care coordinators.⁷ Effective prevention can make a substantial contribution to reducing health system costs and help address the issue of health care funding sustainability outlined on page 6 and figure 1.5. Prevention is therefore a core component of an ‘investment approach’.

Our ideas for ‘next steps’ would build on the themes in the new draft Strategy, with the addition of a sixth theme to enable implementation of the first concept in the overall vision: to ‘live well’, and some aspects of the ‘stay well’ component. We suggest this would be achieved by adopting a sixth main theme: *‘Prevention focused’, or ‘prevention to live and stay well’*.

The theme of ‘prevention’ would set out measurable population health goals and provide, in brief, details of existing planned interventions and strategies to address these goals and reduce disparities in health, or in their absence, a commitment to develop such strategies. Interventions and strategies would reflect current knowledge on effectiveness and cost-effectiveness, give effect to international mandates and requirements, and impact on the identified current challenges (in particular long term conditions, financial sustainability, and healthy aging). As page 17 notes, ‘population-based strategies can also make healthier choices easier for all NZers and help prevent and manage long-term conditions.

For example, in relation to tobacco, we already have an explicit governmental goal to reduce smoking prevalence and tobacco availability to minimal levels by 2025 in New Zealand. This world-leading goal should be mentioned, along with a commitment to developing a comprehensive evidence-based strategy to achieve the Smokefree 2025 Goal (eg, via higher tobacco taxes⁸, restricting outlets⁹, revising regulation around alternative sources of nicotine¹⁰ etc). This is particularly important given evidence that current approaches will not be sufficient to achieve the 2025 goal, particularly among Māori¹¹.

The issue of obesity is mainly discussed in the new draft Strategy under the theme of ‘closer to home’, with the suggestion that primary and community services can work together to prevent obesity in individuals at risk and manage obesity in those already obese. Just released data from the 2015 Health Survey indicates that child obesity rates continue to rise alarmingly¹². This emphasises the need for primary prevention of obesity. We suggest actions to reduce obesity should be located in the prevention theme and interventions should include more clearly population-based approaches to prevention. The recent WHO Commission on Ending Childhood Obesity, co-chaired by Sir Peter Gluckman the Prime Minister’s Science Advisor, recommends tackling the obesogenic environment with fiscal measures (such as sugary drinks

taxes) reducing children's exposure to unhealthy food marketing and creating healthy food environments such as schools, sports facilities and urban environments
² Explicit government commitments and goals are needed in these areas.

Other priority areas should be included, reflecting the major preventable causes of health loss such as excessive alcohol consumption and other nutritional risk factors such as high dietary salt intakes.

In addition to non-communicable diseases and their risk factors, some additional issues that are mentioned but not otherwise discussed should be acknowledged as requiring attention: in particular new infections and antibiotic resistance. We also suggest that actions should relate to *existing* communicable conditions, far from vanquished in New Zealand. Actions here should relate to known preventive strategies, but also protective strategies such as those relevant to resilience of society as a whole, relevant particularly to the possibility of new pandemics and emergencies in general.

Some of the health system organisational ideas included in the new draft Strategy such as stronger primary health care services, better DHB collaboration and integration, greater inter-sectoral coordination, and improved prioritising could also be reflected in the prevention theme, through the complementary actions of the health care and social sector in the provision of preventive services.

Finally, the principle of equity in health and health systems should be much more clearly articulated throughout the document, including through high level goals and through specific actions and strategies to reduce and eliminate inequalities in health, health outcomes and access to and the delivery of health care.

Conclusions and recommendations

We acknowledge the extent of work that has gone into developing the new draft Strategy and the many good ideas that are contained in it, particularly for improving the health care system. However, we believe it would benefit from a more coherent and logical approach in which the stated principles are more clearly reflected in the strategy. There should be much stronger focus on prevention with priority population health challenges informed by the burden of disease identified, together with related priority goals and evidence-based strategies to achieve them. Achieving equity should be a key principle reflected throughout the document.

In summary, we recommend that the revised version:

1. Elaborates the principles and ensures they are fully reflected in the health strategy.
2. A more thorough-going analysis of present challenges that are population health priorities and germane to long-term sustainability of the health care system.
3. Adoption of a sixth '*prevention*' theme which includes measurable priority population health goals with explicit timeframes and sets out evidence-based strategies to achieve the goals and reduce health disparities.
4. Achieving equity to be a key key principle and theme throughout the Strategy.

Table 1: Risk factors for the top 10 causes of health loss in NZ (from the NZ Burden of Disease Study ¹³)

Risk factor (top 10)	DALYs (disability-adjusted life-years) lost in 2006		Mentioned in the draft “Health Strategy” (word search terms used)
	Number	% (of all health loss)	
1) Tobacco use	86,900	9.1%	“smokefree” (n=2), “tobacco” (n=1), “smoking” (n=0), All nil for: “tax”, “outlets”, “2025” (the latter is the year for the Smokefree Nation goal”).
2) High BMI	75,100	7.9%	“obesity (n=13). All nil for: “overweight”, “BMI”, “diet”, “obesogenic”, “marketing”, “tax”, “outlets”. (See also “physical inactivity” below).
3) High blood pressure	61,000	6.4%	All nil for: “blood pressure”, “hypertension”, “salt”, “sodium”, “unhealthy” (food)
4) High blood glucose	43,800	4.6%	“glucose” (n=0); “diabetes” (n=12) – but the latter contexts do not seem to address the obesogenic environment (see above under “high BMI”).
5) Physical inactivity	40,000	4.2%	“exercise” (n=1), “inactivity” (n=0). But the obesogenic environment is not considered (see “High BMI” above).
6) Alcohol	37,000 (net of benefits & harms)	3.9%	“alcohol” (n=4), “binge” (n=0). All nil for: with regards to: “marketing”, “tax”, “outlets”.
7) High blood cholesterol	30,900	3.2%	All nil for: “cholesterol”, “lipid”, “dietary fat”, “fatty acids”, “diet”
8) Adverse health care events	30,300	3.2%	All nil for: “adverse”, “adverse events”, “hospital acquired”, “health care events”.
9) High sodium intake	16,300	1.7%	All nil for: “sodium”, “salt”
10) High saturated fat intake	11,400	1.2%	All nil for: “saturated fat”, “cholesterol”, “lipid”, “dietary fat”, “fatty acids”, “diet”

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