BPW NZ: Health and Disability System Review

30 May 2019

To the attention of:
Ms Heather Simpson, Chair of the review
Ministry of Health
E-mail: systemreview@moh.govt.nz

Re: Health and Disability System Review Phase 1

Thank you for the opportunity to provide comments on the New Zealand Heath and Disability System review and providing specific recommendations. The focus of this Review is to ensure that we make recommendations of changes which will improve the equity of outcomes and looking to the future to ensure that the system is able to meet the technological, demographic, workforce and other challenges that will confront the system over the coming years.

> ***Our interest in this submission is because women and men's access to health and disability system is a core priority for BPW NZ, and influencing more just and equitable policies is an important strategy of this work. We advocate for international instruments that support and improve access to and effectiveness of health and disability services for all in creating a rights-based framework where women seek human rights, including wellbeing, by way of entitlement.***

Members of BPW NZ have their voices heard at the local club, national and international levels of our organisation.

General Comments

1. While significant steps have been made to improve the equity of New Zealand's health and disability system across population groups, still achieving universal health care coverage in primary and dental care, ensuring healthy lives and well-being for all need further consideration. BPW NZ applauds some of the initiatives underway such as child and youth well-being, with the Department of the Prime Minister and Cabinet leading development of a strategy to improve the wellbeing of children and young people.

2. BPW NZ believes that the recently completed inquiry into mental health and addiction, with the purpose of identifying unmet needs and develop recommendations for a better mental health and addiction system is a positive and promising step. The new National Cancer Action Plan being developed by the Ministry of Health demonstrates that people-centred, integrated solutions and partnerships contribute to positive outcomes in the right direction.

3. The set of health systems enhancements initiatives that are underway, including drinking water regulation, improving maternity care and midwifery, strengthening our District

Health Board performance framework, road safety planning, and a National Hepatitis C Action Plan ensure resilient and healthy community and improve prevention.

BPW NZ Policy:

Code of Health & Disability Consumer's Rights in School Programmes

- THAT the New Zealand Federation of Business and Professional Women Inc. urges the Ministers of Education and Health to ensure that the Code of Health and Disability Consumer's Rights is included in school health education programmes for students in Years 11 and above. (2010)

- THAT the New Zealand Federation of Business and Professional Women (BPW NZ) Inc. urges the New Zealand Government to provide schools and community groups sexual abuse education workshops that focuses on empathy, support and reducing stigma for the sexual abuse survivors. (2015)

Sustainable Development Goals

THAT the New Zealand Federation of Business and Professional Women (BPW NZ) Inc. urges the New Zealand Government:

- to work in collaboration with Local Government New Zealand (LGNZ), non-government organisations (NGO's) and businesses, towards the implementation of the Sustainable Development Goals (SDGs) as signed at Commission of the Status of Women (CSW), United Nations, New York, March 2015;

- to undertake regular Voluntary National Reviews to the High Level Political Forum (HLPF) meeting under the auspices of ECOSOC, involving LGNZ, NGOs and businesses in the review, and to set a time for the initial review. (2018)

BPW International Policy

CEDAW Article 26 – Discrimination against Women and Children with Disabilities

- THAT BPW NZ urges the New Zealand Government to request, under Article 26 of Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW), that a further Article be included to address the elimination of all forms of discrimination against women and girls with disabilities. (2011)

Optional Protocol to UN Convention on Rights of Persons with Disabilities

- THAT BPW NZ urges the New Zealand Government to sign and then ratify the Optional Protocol to the United Nations Convention on the Rights of Persons with Disabilities. (2011)

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) General Recommendation 18

"To ensure its full implementation, BPW NZ strongly urges the New Zealand Government to address General Recommendation 18 (10th session 1991) – Disabled Women, in its Periodic Reports to the CEDAW Monitoring Committee.

CEDAW General Recommendation 18 - Quote: “State Parties provide information on disabled women in their (CEDAW) periodic reports, and on measures taken to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life.” (2014)

UN Convention on the Rights of Persons with Disabilities (CRPD)

The Sustainable Development Goals

Goal 3. Ensure healthy lives and promote well-being for all at all ages.

Health equity resonates with the SDGs’ overarching principle of leaving no one behind and the implicit moral imperative of social justice. Health is universally valued, and health for all is a societal goal justifiable on moral grounds. BPW NZ believes that the overarching goal of New Zealand’s health action is to help ensure long, healthy lives and well-being for all in line with the targets of SDG3.

To achieve the overarching goal, focus should be placed in three main result areas:

- Creating societal conditions for good and equitable health
- Health systems that are effective, sustainable and resilient
- Improved preparedness and capacity to detect and manage outbreaks of diseases and other health threats.

Sexual and reproductive health and rights are key components of all three result areas.

From the 9 questions provided, we selected 4 questions for consultation with our membership.

Question 1: What are the most important values for our health and disability system?

BPW NZ believes the most important values for our Health and Disability system are:

1. The values enshrined in the Code of Health and Disability Services Consumers' Rights: the rights to be treated with respect, to be treated fairly, to dignity and independence, to have good care and support that fits your needs, to be told things in a way you can understand, and to be told everything you need to know about your care and support, to make choices about your care and support, to have support, to decide if you want to be part of training, teaching or research, to make a complaint.

2. Equity of service fit for the New Zealand context, aligned with Te Tiriti o Waitangi obligations, which is principled based, inclusive, reflecting the definition put forward by the World Health Organisation.

3. The strengths of the model lie in its ability for local organisations and health providers to meet the needs of the local people living in their communities.

Question 2. What changes could make our health and disability system more fair and equal for everyone (but especially for women with particular reference to those on low/no income, to the aged, to Maori and Pacific women and to women with disabilities)?

BPW NZ sees an opportunity

4. To improve performance, structure, and sustainability of the system holistically, achieving equity across population groups with the purpose of future-proofing New Zealand's health and disability services.

5. Change the model of how health is delivered – find out from those with difficulty accessing health and disability service, what would work for them than just deciding what "seems sensible". Put the patient at the centre of care. The present system of service delivery needs to be re-evaluated and improved. The present system of prioritising for treatments and operations also needs to be improved. Patients do not understand why their treatment or operation is delayed – better reasoning required.

6. Address resilience challenges around the health workforce. Shortages persist and may be exacerbated by difficulties in staff retention with realistic wages and acceptable working hours for care professionals in the country. By improving patient flows this could be mitigated.

7. Ensure equity of access to services through quality to women with low or no income, women with independent children, women with disabilities and the elderly or infirm women, including those in rest-homes/retirement homes or villages, who may have, for a variety of reasons, limited access to medical consultations including difficulty in getting appointments with own or institution GP, especially now with emphasis on appointment-making "on-line", transport hurdles due to not driving and having to book transport.

8. Address audit wastage and bureaucracy. This can lead to a waste of scarce resources.

9. Performance improvements of the system, with a focus on equity of healthcare for anyone and contributing to wellness for all, including Maori, Asian and Pacific people. No matter their gender, location, age, income or complexity of illness/condition and must include ethnic groups. This inclusiveness should encompass beliefs – so all religions and non-religious beliefs, as well as those in the LBGTQ community and all those groups that may also have one or more visible or invisible disabilities.

10. Importance of primary health care as a foundation of a person-centred Health and Disability system.

11. Enhance the role of preventive systems focussing on prevention rather than interventions, including greater health education and nutrition.

12. Ensure effective relationships between the Health and Disability system and accountability with DHBs, ACC, primary health insurance, the MidCentral Prototype and in primary healthcare. Pharmac does this well and could be used as an effective case study for replication across the system.

13. A focus and investment in children's health – from neo-nates through to teens. Education about personal health and responsibilities to prevent premature births, newborn health issues from parental habits, weight, smoking and drinking.

14. Achieving universal health care coverage. Although all New Zealand citizens are covered by a public health system, challenges remain in accessing primary care and dental care, with a fee-for-service structure presenting a barrier to many.

15. Improve mental health outcomes for all community.

16. Improve systematic inequity in the treatment of women in healthcare, particularly aged women and those from low income backgrounds, or women from Maori, Pacific or migrant backgrounds. Women face various hurdles when gaining trust from healthcare professionals regarding their pain levels and symptoms. Provide women more platforms to share their idiosyncratic concerns.

17. Increase awareness of health issues – real information with actions rather that exaggerating health cases – e.g. measles outbreak.

18. Customisation - every person who walks through the door is approached as having idiosyncratic needs and is treated appropriately. Reduce a homogenous approach to health, which is typically built on stereotypes. People seeking care or advice should not be brushed aside. They must be listened to. Also improve culturally-responsive practices. Inclusiveness is vital to consultation and access to all services, physical and psychological. Funding for preventative as well as responsive mental health services will have to improve considerably to bring this about.

19. Improve engagement in health by individuals –legal literacy important.

20. Humanity and empathy from professionals towards patients/clients, particularly from more senior professional. Integrity and respect demonstrated at all times from all professionals.

21. Trust and transparency – this allows people to understand what help they can access within the system.

22. Good planning for transitioning people from inpatient care to the community is critical in supporting them effectively.

23. Respect for patients' confidentiality of information and personal privacy.

24. Quality care - keeping up-to-date with best practice internationally to ensure those that need specific medications to improve their health and lifestyle receive them, not just the targeted few. Pharmac prevents this through its pharmaceutical funding policies. Some very effective medications are not subsidised because of costs but are available for those who can afford them. DHBs can establish trials to receive these medications and to treat those who are willing to take part – for free.

25. Avoid wastage of medications – professionals in hospitals and medical practices to be more careful in prescribing to avoid overprescribing.

26. Increase the capacity of doctors and nurses to appropriately improve equitable access to healthcare. If the recommended actions from this review cannot be implemented by health professionals, then it will not be successful. This is a bottleneck with the current system.

27. Easier access to affordable health and disability services. Innovative actions to encourage and promote health check-ups and reduce DNAs (did not attends) – discover the reasons for DNAs and address these for positive outcomes. Early diagnoses and treatment cost less than advanced care/treatment.

28. Equity of access – have secondary care clinics in primary care facilities to enable patients to be seen in familiar surroundings and not have to travel and wait in hospital clinics. Important for rural and smaller urban centres. This has precedent in obstetrics and gynaecological clinics and specialists who visit outreach clinics.

29. Have an integrated service within large medical practices i.e. one stop centre with the performance of those one stop centres regularly audited for efficiency.

30. Aged population can find it difficult to access healthcare services due to transport difficulties, cost of consultation – more services are required that facilitate easy access, address any cost disincentives.

31. Higher subsidies for GPs/primary care providers to cover visiting costs properly so that elderly/infirm women (and men) can receive priority care/consultations. Care assistants paid to transport patients where possible/appropriate, to GP/medical practice. Practice nurse with geriatric training to do telephone or visiting triage to make appropriate appointments.

32. Provide support to employers to encourage employment of disabled – as an example, businesses are reluctant to employ a hearing-impaired person if new telephone equipment is needed to assist that person to complete their duties.

33. Encourage expansion of captioning services and extension of 111 emergency text service to include new 105 non-emergency number to aid hearing impaired.

34. Equity of access for parents (usually mother) of young children, living in areas of low income who walk long distances with babies in buggies and children in tow, for urgent or routine consultations, need heavily subsidised or free transport/taxi or a medical practice minivan to primary care provider of choice. Easily bookable by phone/text/on-line. This is also true for some patients with disabilities – public transport is seldom physical disability friendly. Not all areas have a Total Mobility Card service for which only some people qualify.

35. Community Cards to assist people with particular needs to access services do not appear to provide the access and support that was promised on their introduction.

36. Improved co-ordination of services and improved communication with family/whanau of patients/clients with all classes of disabilities.

37. More realistic communication in both directions with family/whanau of patients/clients with moderate to severe intellectual disabilities, understanding that the family/whanau knows the person best. It is imperative to have excellent communication between patient and healthcare professionals. There needs to be a clear pathway of communicating information to low income families who may not have a clear understanding of the health and disability systems and how to access free/subsidised services, prescriptions etc.

38. Increase consistency between NGO and DHB relationships – enabling leverage of support and resources. Facilitate community voice within regional healthcare provision and systems. Do not take funds from community groups to put back into clinical areas - this is wrong.

39. Hubs in the community staffed by people of the community with outreach workers to do home visits. These hubs coordinate with marae, churches and mosques etc.

40. A reliable confidential website for people to look up all sorts of health questions quickly and easily - direct them to appropriate services and agencies that may assist them to resolve problems early before resorting to self-harm/suicide etc. Promote this website.

41. Improve access to Mental Health assessment, treatment and ongoing professional and community support. There are many areas in New Zealand where there are appalling gaps in services and support causing acceleration and deterioration of symptoms. This affects not only the patients but their family, employers and community. The rural communities are very poorly serviced – many areas are setting up their own networks of support to ensure a commitment of service from providers.

42. More access to mental health services for women who are suffering from perinatal depression and anxiety. Better screening and recognition of the condition (see PADA – Perinatal Antenatal Depression Aotearoa) but with more mental health professional to help in managing the symptoms. It is hugely under-recognised for women being pressured to return to work for financial reasons or career dedication, without appreciating the personal costs of these goals resulting in their own mental health and wellbeing. For some new mothers without support, it can lead to child abuse.

43. Ensure awareness of mental illness needs and challenges to be increased through community education initiatives.

44. More openness and knowledge about alternative treatments and lifestyle/dietary changes/home remedies that should also be able to be used while in hospital. Talk therapy should be available as an alternative to prescription drugs.

45. Funding of children less than 13 years of age has been beneficial as low income women are more likely to seek medical assistance themselves, but extending free visits to those less than 18 years of age would improve healthcare for low income families and prevent

more serious health issues developing at a greater cost to all. If further services required from such visits, such as an x-ray, these should also be free as unaffordable to low income and many middle-income families.

46. Barriers to access - for women (or men if care-giver) with children, the visit is free for those under 13 years, but time off work is not accounted for, and travel may be a barrier to access. School clinics funded to deliver healthcare could prevent poor health outcomes and prevent/treat some infections – e.g. sore throats/rheumatic disease, skin infections/cellulitis, tooth care checks/tooth decay.

47. Improve infrastructure - improvement in technology that would provide real-time visibility of patient flow, especially for acute care. Trial bed numbering system to track when beds become available - use e-device to notify ED – wards must pull patients from ED, without admitting patients as “outliers” to wards that are not best suited to manage their care, which delays ultimate discharge and can result in worsened clinical outcomes.

48. If you want people more involved in their own health care, it may be necessary to meet them on their terms of space, i.e. Pasifika groups, Islamic Women’s groups, Maori groups, Salvation Army groups, Age Concern, retirement villages, Council and Government housing estates etc. Co-ordinate with these groups so they can point medical professionals towards the needy.

49. Ensure culturally appropriate care for Maori, Pacifica and Asian populations.

50. Breast and cervical screening targets are not met by some women from some cultures – more promotions to include men/families persuading wife/partner/mum to have the checks – she is needed/wanted alive to spend years with family. Vaginal smear testing would improve targets for rural and culturally sensitive women – they can do these themselves and caregivers can undertake it for disabled women rather that visiting a medical practitioner – Rural Delivery can drop off/pickup samples.

51. Quality care – ensure that medical providers and nursing staff are rewarded at higher level if they are maximally qualified, audited and peer reviewed as being endorsed quality providers. Much time is spent being involved with CME/CNE, with Cornerstone assessment and with meeting standards. This needs to be recognised so that the level of expertise continually improves and those doctors and nurses working in the highest needs areas are recognised for the long hard hours and the extraordinary outcomes they provide when facing patient challenges which include poverty, homelessness or substantial housing, language issues, poor education, limited or no employment, cultural issues and intergenerational or gang violence.

52. Educate New Zealanders about the New Zealand Disability Strategy and continue to promote it along with the United Nations Convention on the Rights of Persons with Disabilities. DHBs have commitments within the Disability Strategy and must honour them and practice service delivery complying with them. Facilities and services required by disabled people within medical centres including hospitals must be accessible.

Question 3. What are the most important changes that would make the biggest difference to New Zealanders?

53. A public health system with financial and professional resources to ensure little difference between public and private health services – to provide everyone prompt, accessible, efficient, professionally competent, safe medical attention, treatment and aftercare.

54. Integration of care and a holistic approach is central to improving efficiency and keeping patients in the most appropriate (and lowest cost) setting. New models of (place-based) care could deliver better coordinated, more efficient and cheaper care outside hospital, but also that they will address prevention upstream so as to reduce the long-term call on health services.

55. Improve relationship building between healthcare professionals and patients. Build capacity for healthcare professional to do this. Technology used in a way to improve communication with patients and consolidate communication between professionals – this is paramount towards patient health care and safety.

56. Health inequalities persist despite being a focus of attention, particularly for Maori and vulnerable people, including women and elderly. Seeing Family Violence as well as child abuse and neglect as health-related equity issues. Ensuring all providers complete free MoH/Medsac training, and PHO's have systems which provide a practical structure to support practice teams to routinely enquire about family violence and know how to safely assess and make referrals for families suffering or at high risk of suffering family violence, including getting help for perpetrators who are prepared to engage in appropriate "stopping violence programmes". It is time to implement the recommendations which have been made in the Ministry of Health Guidelines and the Family Violence Death Review Committee reports. This is one of the changes that could make the biggest difference to women's health, both physical and mental, to the health and safety of women with disabilities, Maori women and the elderly.

57. Overhaul of the Mental health system which is failing those who are seriously distressed. New Zealand's persistently high suicide rate is a major concern. Stronger action around alcohol and drugs is needed, while reforming the Mental Health Act and the transformation of primary health care.

58. More awareness-raising at school level – prevention at an early age results in better health outcomes. Nutritional education to be reinstated in schools. All children taught how to budget for a week's meals and able to cook 5 family dinners with soups/desserts, how to use left-overs and awareness of dietary needs i.e. modifying a meal for the elderly, very young children, peanut/dairy/gluten free. Many parents do not have these food and money skills, so are unable to teach their children – learning can be fun as well as essential.

Question 4. Is there anything else you wish to add?

59. The 2030 Agenda offers us a new opportunity to influence and help improve the health situation for people in New Zealand and globally. By acting globally, we create conditions

for positive developments in our own country while also contributing to, and taking responsibility for, positive developments in the world at large.

60. We suggest bringing together and consolidate existing strategies, priorities and policies with the aim of setting out a clear and common agenda and creating the conditions for more effective communications, increased collaboration and, ultimately, more impactful New Zealand action.

61. This review must address the whole of the system and that includes developing a comprehensive, systematic approach to primary prevention. A more holistic approach to align our efforts around a clearly defined purpose is mirrored in the Living Standards Framework being developed by the New Zealand Treasury for this year's Budget.

62. There are many reasons people become unwell; it often reflects lifestyle, poor nutritional habits, poor and inadequate housing where too many people share an unhealthy environment, or not even being able to afford rental accommodation because of poverty/high cost of rental accommodation, unemployment or under-employment, and social unrest/lack of advice. Combine two or more of these inadequacies and a recipe for poor health outcomes is created.

Inspirational stories from our members

Hawera, North Island

> *"I was born partially deaf. I loved school, achieved good grades and especially excelled at music performance despite my deafness. I used the classic coping skills – subconsciously learning to lip read, sitting at the front of class and people were accommodating. My progressively deteriorating hearing was checked periodically throughout my school years and I was eventually fitted with hearing aids in my mid-20s when my deafness started to severely impact my lifestyle and my ability to complete the duties of my employment.*
>
> *Fast forward to 2018 when I needed to upgrade my "second ears" (this is now my fourth set in 25 years). I now have about 45% hearing and suffer tinnitus continuously. I was excited at the technological advances available with my new ears which would help me use a phone much more easily, be part of a group conversation without missing out, attend conferences/work events and be able to sit anywhere to hear the speaker and at home, have a happy husband who could converse with me at "normal" volume.*
>
> *What a shock to be told I did not meet Enable NZ's criteria for full funding, despite my hearing loss since childhood. I found it particularly upsetting to be told that if I could find a copy of childhood hearing tests, there was a remote possibility of re-consideration however in reality, this was unachievable. I was also advised that even if funding was approvable, I would only qualify for a "mid-range" model despite my hearing needs requiring a "superior" model. There would be no option of receiving this lesser level of funding and paying the difference myself to upgrade to meet my actual needs. As a result, I self-funded the purchase of my new ears (less the small subsidy that was available) to meet my hearing needs. Thankfully, I could do this however not everyone has this ability and therefore they are forced to accept a lesser level of hearing assistance.*

The ability to hear is paramount to the well-being of every individual. Life without hearing is very restricted, at times scary and can be very lonely. It concerns me that this is yet another example of our health system failing to meet the needs of all people fairly. Our health system needs to treat everyone with respect and dignity, consistently."

63. BPW NZ welcomes the opportunity of working together with the expert review panel to provide independent advice and analysis and contribute to a progressive, sustainable and inclusive health and disability system and to advance women's rights in New Zealand.

Our Organisation

BPW NZ is an affiliate of BPW International. BPW International is one of the most influential international networks of business and professional women with affiliates in 95 countries in five continents.

Our organisation's aims are to link professional and business women throughout the world, to provide support, to lobby for change and to promote the ongoing advancement of women. We work for equal opportunities and status for all women in economic, civil and political life and the removal of discrimination in all countries. We promote our aims and organise our operating structure without distinction as to race, language or religion.

International Status:

BPW International has General Consultative Status at the United Nations through the UN Economic & Social Council (ECOSOC). This enables BPW International to appoint official representatives to UN agencies worldwide and to accredit members to attend specific UN meetings.

BPW New Zealand speaks strongly for women in international forums and works hard in relation to the advancement to the status of women.

We request the New Zealand Government to consider the noted recommendations on further steps that can be taken to improve our human rights situation and offer advice and guidance on effective implementation.

Thank you for the opportunity to provide our suggestions and we hope that our comments are of use to you.

On behalf of
New Zealand Federation of Business and Professional Women Inc.

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