New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

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Chair
Health System Review Panel

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Health and Disability System Review

Dear Heather

The New Zealand Medical Association (NZMA) wishes to provide feedback to help inform stage one of the Health and Disability System Review. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Board, Advisory Councils and wider membership.

General Comments

1. We strongly support the review of the Health and Disability System (the review) and agree that it represents a "once in a generation opportunity to improve equity and outcomes for New Zealanders". Earlier this year, we welcomed the opportunity to engage with you in person and we look forward to continuing our engagement with you as the review progresses. We note that the purpose of the review is to identify opportunities to improve the performance, structure, and sustainability of the system with a goal of achieving equity of outcomes, and contributing to wellness for all, particularly Māori and Pacific peoples. These are laudable goals and we welcome the commitment made in the review's scope to understand the drivers of inequities, including understanding the broader social determinants of health. We also welcome the review's terms of reference, particularly consideration of the role of public health and prevention in supporting health and wellness, and the importance of primary health care as the foundation of a person-centred Health and Disability System.

2. In an environment of changing societal expectations, workforce pressures, and significant scientific and technological advancements, we believe that the medical profession has an important and unique role to play in the health system of the 21st century. While doctors share several attributes with other health professionals, doctors are trained to regularly take ultimate

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responsibility for medical decisions and diagnoses in situations of complexity and uncertainty, drawing on scientific knowledge and principles, clinical experience, and well developed judgement.[1] Given the wide-ranging nature of this phase of the review, we have opted, at this stage, to focus on three key system issues that we believe the review must address but which also represent areas where the NZMA is uniquely positioned to offer its pan-professional perspective. These areas include the following: i) addressing the social, economic and environmental determinants of health; ii) identifying and mitigating vulnerabilities during transitions of care; iii) enhancing General Practice as the cornerstone of our health system. We also provide detailed responses to each of the nine questions that the panel is asking in an appendix to this submission.

Addressing the social determinants of health

3. The greatest impact on equity of health outcomes and well-being can be made by addressing the upstream social, economic and environmental determinants of health. These comprise the conditions in which people are born, grow, live, work and age, and include factors such as early life conditions, education, employment, housing, income and the built environment, for example. For a more detailed consideration of health equity through action on the social determinants of health, we direct the panel to the final report of the WHO Commission on Social Determinants of Health[2] as well as our own position statement on Health Equity.[3] As most of the social determinants of health lie outside the health sector, inter-sectoral and whole-of-government approaches to addressing the social determinants of health are required, but we believe that the panel has an important role in influencing action across these determinants. In many cases, the greatest impacts on health outcomes are achieved by strengthened regulation to provide healthier environments. For example, we draw attention to the importance of better regulation with respect to tackling obesity[4] and reducing the harms from alcohol,[5] and of effective legislative and regulatory measures to mitigate climate change,[6] which has been described as the greatest threat to global health in the 21st century.

Identifying and mitigating vulnerabilities during transitions of care

4. As a patient encounters and progresses through the health system, they will transition from or through various facilities / providers / settings. For example, a patient might be referred by their GP to the Emergency Department, be admitted as an inpatient, discharged to residential care and referred for further follow up at an outpatient clinic. Other transitions include from paediatric to adult care, from hospital to rehabilitation services to residential care, from General Practice to psychiatric services, and from rest home to acute hospital services to geriatric care. We believe that there is considerable scope to improve performance of the health system (and outcomes, including improved equity) by addressing shortcomings in these transitions of care. For example, following discharge from a hospital ward or Emergency Department, patients are

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[1] Consensus statement on the role of the doctor in New Zealand. November 2011. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0006/16980/Consensus-statement-on-the-role-of-the-doctor-in-New-Zealand-November-2011.pdf

[2] CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization. Available from https://www.who.int/social_determinants/thecommission/finalreport/en/

[3] NZMA. Health Equity. Position Statement. 2011. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0016/1456/Health-equity-2011.pdf

[4] NZMA. Tackling Obesity. Policy Briefing. May 2014. Available from http://www.nzma.org.nz/publications/policy-briefings/tackling-obesity

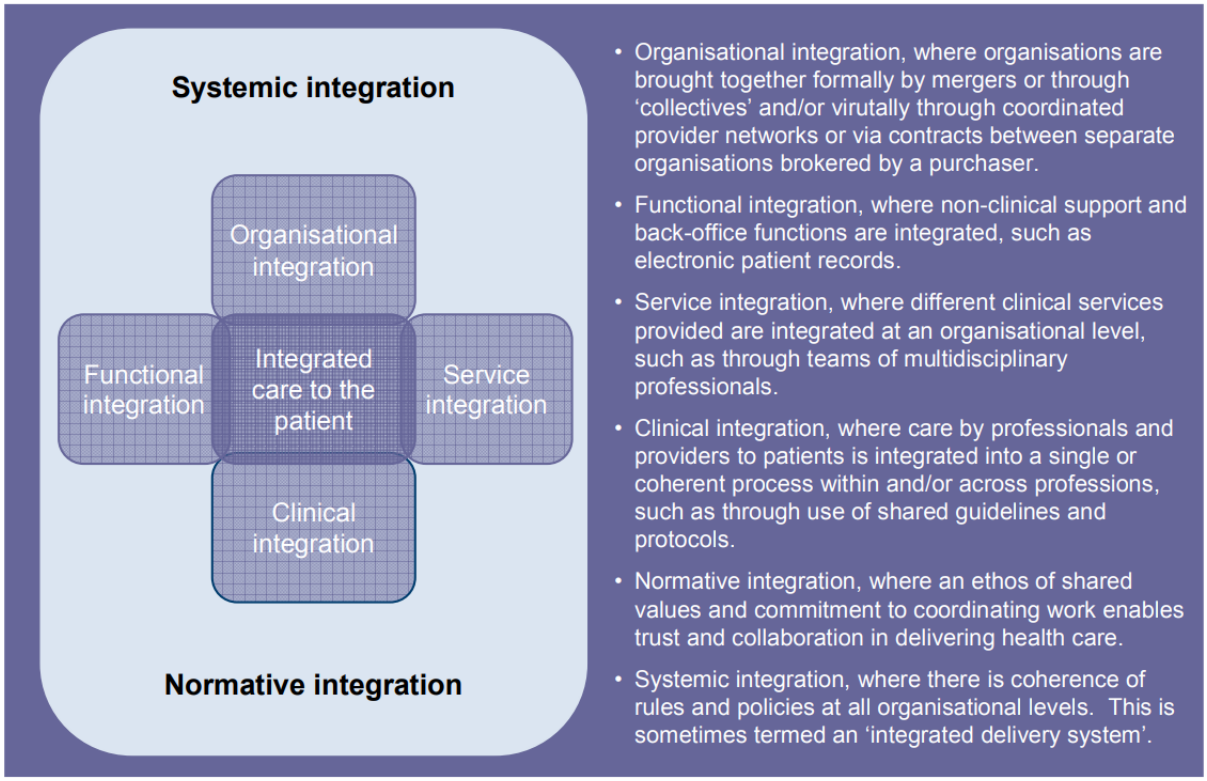
[5] NZMA. Reducing harm from alcohol. Policy Briefing. May 2015. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0017/42542/Alcohol-Briefing18.may.FINAL.pdf

[6] NZMA. January 2019. Health and Climate Change. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0009/87318/Health-and-Climate-Change_January-2019.pdf

sometimes referred back to their GPs for radiological investigations that GPs are unable to access. Likewise, GP referrals to a specialist psychiatrist sometimes come back from a Nurse Practitioner or a social worker without advice from a specialist psychiatrist. Other issues relate to a lack of clarity over who is responsible for the next step of care such as follow up investigations following discharge from hospital, and the large regional differences in how referrals (including discharge letters) are done. As a pan-professional organisation with members coming from General Practice and hospitals (at all stages from RMOs to SMOs), the NZMA is well placed to help the panel identify, and mitigate, existing failings in these transitions of care.

5. An important aspect of mitigating shortcomings in transitions of care is working towards ensuring integrated patient-centred care at all stages in a patient's journey through the health system. Integration is a heterogeneous concept, having a number of dimensions and the potential to be advanced in many ways. A useful typology (see figure 1) highlights the different types of integration which can occur: organisational, functional, service and clinical, all with the ultimate aim of providing integrated care to patients. In addition, integration can occur horizontally at different levels of the system, or vertically, and in real or virtual ways. Horizontal integration is when two or more organisations or services delivering care at a similar level come together. Vertical integration occurs where two or more organisations delivering care at different levels come together such as primary, community and hospital services. More effective IT solutions are a key enabler of ensuring integrated patient-centred care, and of mitigating existing shortcomings in transitions of care. There is a pressing need for a nationally available, standardised, shared electronic health record that all healthcare providers can access and update.

Figure 1 Typology of integration[7]



[7] Adapted from Fulop N, et al. Building integrated care: Lessons from the UK and elsewhere. London. The NHS Confederation. Available from https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Building-integrated-care.pdf?dl=1&dl=1

Supporting General Practice as the cornerstone of our health system

6. It is our view that General Practice is the cornerstone of successful primary healthcare, which underpins population health outcomes and is key to ensuring we have a high-quality, equitable, and sustainable health system. There is good international evidence regarding the efficiency of General Practice. For example, the Australian Medical Association (AMA), commenting on a report from the National Health Performance Authority of Australia, said that "general practice is the most efficient and cost-effective part of the health system but requires greater support to continue providing high quality primary health care to the Australian community".[8] In the UK, the Chair of the Royal College of GPs welcomed new research by King's College London, published in the British Journal of General Practice, that shows that stronger investment in primary care in England would lead to significant savings for secondary care.[9] A recent study in JAMA Internal Medicine found that greater primary care physician supply was associated with lower mortality—a total of 10 additional primary care physicians per 100,000 population was associated with reduced cardiovascular, cancer, and respiratory mortality by 0.9 to 1.4%.[10] Importantly, GPs have a profound influence on both health outcomes and health expenditure. The AMA reports it has been estimated that primary health professionals control or influence approximately 80% of health care costs, which means they have an important role to play in ensuring that health expenditure remains sustainable.[11]

We urge the panel to recognise the efficient, cost-effective and quality care that General Practice provides in New Zealand. To ensure that General Practice is equipped to meet the challenges of providing care to an ageing population and the growing burden of complex and chronic disease, we believe there needs to be increased resourcing to frontline GP services. We acknowledge there is scope to refine models of service delivery and funding of General Practice, and we elaborate on our views on these aspects in our responses to question 9 (see appendix).

Appendix. Responses to specific questions

1. What are the key values that you would want to underpin our future public health and disability system?

We believe the key values that should underpin our public health and disability system include the following: equity,[12] efficiency / cost-effectiveness, compassion and caring, justice / fairness, quality (defined by its traditional domains—ie, safe, timely, effective, equitable, efficient, patient-centred, sustainable). With respect to equity, there are ethnic and socioeconomic structural inequities that must be addressed. In addition, DHBs introduce inequity by having different priorities rather than nationally agreed ones to reduce inequity.

Efficiency / cost-effectiveness relates to the goal of allocating resources to optimise health impact. It is important for health impact measures to go beyond average health outcomes across the entire population and extend to measuring equity / distribution of benefits across different ethnic and socioeconomic groups. The aim should be to improve / optimise across all these

[8] https://ama.com.au/media/report-shows-general-practice-efficient-and-cost-effective
[9] https://www.rcgp.org.uk/about-us/news/2017/september/investing-in-primary-care-is-cost-effective-for-the-nhs-and-good-for-patient-care-says-college.aspx
[10] Basu S, et al. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. JAMA Intern Med. 2019 Feb 18:506-14
[11] https://ama.com.au/sites/default/files/budget-submission/AMA_Budget_Submission_2019_20.pdf
[12] NZMA. Health Equity. Position Statement. 2011. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0016/1456/Health-equity-2011.pdf

measures. When considering efficiency and cost-effectiveness, it is important to include Rawlsian values, for example, that taken into account egalitarian equality of outcomes. Current cost-benefit analyses / return-on-investment / budget setting methodologies implicitly favour utilitarian philosophical approaches (greatest good for the greatest number) which disadvantage people with poorer health to begin with.

It is useful to look at how the health workforce supports efficiency and cost-effectiveness. Particular consideration should be given to the composition and distribution of this workforce in addition to their future roles and cost-effectiveness to the system. Specific workforce issues that need to be addressed include SMO shortages, fatigue and burnout. Strategies should be developed to retain older doctors, including transition to less onerous duties and other roles (eg, less operating and more teaching).

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

There would be a pervasive recognition that physical health and mental health / well-being are inextricably linked, and our systems (and culture) would be designed with this in mind. There needs to be a holistic focus across all components underpinning our systems of healthcare delivery, recognising patients as people rather than pathologies. The system would be underpinned by the recognition that people's subjective experience of healthcare matters and can ultimately affect objectively measured health outcomes. The system should be more proactive in supporting people to take increased responsibility for their own health. General Practice already takes a holistic approach and recognises the psychosocial (and spiritual) influences in people's health. It is important to recognise the importance of GPs as generalists and to nurture the value of the GP-patient interaction which, in itself, has therapeutic value. We believe that GPs should be at the centre of the health care system, helping people maintain healthy lives, preventing disease, treating acute illnesses, and caring for people with chronic diseases.

In an ideal system, there would be a free-flow of communication between healthcare providers throughout the country by way of ready access to standardised electronic clinical records. This would improve efficiency and reduce errors, leading to better health outcomes and better health experiences. The community and hospital health-pathways model / approach showcased in the South Island (or something similar) would be rolled out nationwide. Systems and processes would be in place for continuously updating and improving these pathways. Healthcare workers including doctors would be under less time pressure, with the length of consultations better reflecting the complexity of patients that are seen and enabling more time for compassionate care as well as enhancing the autonomy of patients.

We suggest that it would be useful to define the purpose of the health and disability system. This could include contributing to people, families and communities achieving optimal well-being and reaching their potential—both for themselves and the nation. This could align with the work being done as part of Treasury's Living Standards Framework as well as with the Government's well-being budgets. A healthcare system needs to sit in the broader context of a comprehensive and systematic approach to fostering and maintaining well-being and health. This requires the alignment of social policies across health, employment, housing and poverty reduction, for example. It is essential that all policies are informed by the best available evidence. From a patient's point of view, health and disability services would be seamless and there would be clarity about where people seek help and how they are referred to ensure the best outcomes. Acute care providers would operate in clinical networks across DHB boundaries, and regional services and local communities would be supported through telehealth networks based on strong relationships of trust between providers.

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?

We believe that the greatest impact on equity of health outcomes and well-being can be made by addressing the upstream social, economic and environmental determinants of health. We recognise that many of the policy levers to address the determinants of health sit outside of the healthcare sector. For example, they extend to policies on taxation, housing and education. The NZMA has a longstanding interest in addressing the social determinants of health.[13] In many cases, the greatest impacts on health outcomes are achieved by regulation to provide healthier environments. For example, we draw attention to the importance of regulation with respect to tackling obesity[14] and reducing the harms from alcohol.[15] We also draw attention to measures to tackle climate change that have been described in the Lancet as representing "the greatest global health opportunity of the 21st century".[16]

We recommend greater networking and decision making at a central level. Clinical networks can be a powerful tool for cooperation, communication, coordination and efficient decision-making practice at the national level. Existing examples include the New Zealand Microbiology Network and the New Zealand National Antimicrobial Susceptibility Testing Committee. Much of Canterbury's success, as acknowledged by the King's Fund Report,[17] is attributed to very strong and active clinical networks. In addition to clinical networks, institutions such as the HQSC are also very useful in terms of overseeing successful national programmes particularly when it comes to best practice and quality improvement / assurance programmes.

We recommend serious consideration be given to reducing the number of DHBs. Managerial and administrative efficiencies across the DHBs could be used to channel more funding into frontline clinical care. Other suggestions include stopping pharmacy charges to encourage adherence, particularly among Māori and Pasifika. We also believe that it is important to better match the ethnicities of the health workforce with those of the populations they serve, and to ensure an ongoing dialogue with disadvantaged communities about how they envisage better outcomes happening. Ideally, the majority of services would be provided in the community in settings that are appropriate for the communities that are in need of them. Improving health literacy is also vitally important to improve equity of health outcomes and well-being across all population groups.[18]

4. What system level changes would have the most impact on improving health outcomes for Māori?

We believe that addressing the upstream social, economic and environmental determinants of health is likely to have the most impact on improving health outcomes for Māori. There is a need for pan-sectoral systems approaches that extend beyond the health sector and include setting systems targets and having wide commitment (as catalogued by PHARMAC with respect to

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[13] Ibid
[14] NZMA. Tackling Obesity. Policy Briefing. May 2014. Available from http://www.nzma.org.nz/publications/policy-briefings/tackling-obesity
[15] NZMA. Reducing harm from alcohol. Policy Briefing. May 2015. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0017/42542/Alcohol-Briefing18.may.FINAL.pdf
[16] https://www.thelancet.com/climate-and-health
[17] Timmins N & Ham C. The quest for integrated health and social care A case study in Canterbury, New Zealand. The King's Fund. 2013. London. Available from https://www.cdhb.health.nz/wp-content/uploads/c476aa13-canterbury-kings-fund-report.pdf
[18] NZMA. Improving health literacy. Policy Briefing. March 2017. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0019/56053/Health-Literacy-Policy-Briefing-web.pdf

Māori access to medicines).[19] It is important to better understand, and reduce, barriers to seeking healthcare including financial, social, cultural, and logistic barriers, for example. Other suggestions include the following:

- Listening to Māori and implementing their suggestions with respect to addressing barriers and improving outcomes
- Continuing cultural training for all health workers
- Enabling Māori to choose booking times and initiate clinics at nights and weekends so as to avoid time away from childcare and other work commitments
- Abolishing pharmaceutical charges that increase inequity and contribute to decreased adherence
- Having a health workforce that is Māori.
- Devolving appropriate decision making and service provision to Māori.

5. What system level changes would have the most impact on improving health outcomes for Pacific peoples?

As for Māori, we believe that addressing the upstream social, economic and environmental determinants of health is likely to have the most impact on improving health outcomes for Pacific peoples. It is important to better understand, and reduce, barriers to seeking healthcare including financial, social, cultural, and logistic barriers, for example. Other suggestions include the following:

- Listening to Pacific peoples and implementing their suggestions with respect to addressing barriers and improving outcomes
- Continuing cultural training for all health workers
- Enabling Pacific peoples to choose booking times and initiate clinics at nights and weekends so as to avoid time away from childcare and other work commitments.
- Abolishing pharmaceutical charges that increase inequity and contribute to decreased adherence
- Having a health workforce that is Pacific
- Devolving appropriate decision making and service provision to Pacific peoples.

6. What system level changes would have the most impact on ensuring that disabled people have equal opportunities to achieve their goals and aspirations?

This requires a fuller understanding of inequities among persons with disabilities. However, underpinning any solutions should be addressing the social, economic and environmental determinants of health. Also important is ensuring equal access to supportive care and resources. More specific suggestions include public health measures such as fortification of bread with folic acid and addressing primary risk factors for stroke such as hypertension.

7. What existing or previous initiatives have best delivered improved and equitable health outcomes and wellbeing in New Zealand or overseas? Why have these approaches worked, and what is their potential to deliver further improvement?

Once again, we point to addressing the social, economic and environmental determinants of health as a key approach to delivering improved and equitable health outcomes. Multimodal approaches are needed that address education, poverty, social support, employment, and housing, for example, to address intergenerational health and well-being disparities. It is also necessary to

[19] Metcalfe S, et al. Te Wero tonu—the challenge continues: Māori access to medicines 2006/07–2012/13 update. NZ Med J 2018;131(1485). Available from https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1485-9-november-2018/7737

make regulatory changes to support measures to tackle obesity and reduce the harms from alcohol and smoking. In addition, it is helpful to identify the health outcomes that we want to improve—for example, is it longevity, days alive and out of hospital, patient satisfaction, a reduction in non-communicable diseases, or reduced Emergency Department (ED) attendance? The healthcare homes initiative has reduced ED attendance in some studies. Other suggestions include the more widespread provision of automated external defibrillators in the community including in settings such as marae.

We point to the initiatives in Canterbury as an example of what is working well. The King's Fund report concluded that Canterbury has made the transition from fragmented care to integrated care with a degree of measurable success.[20] Key factors behind this success include strong leadership, clinician input into all decision making, the 'one pot of money concept', strong and active clinical networks, a united, seamless and no-ego team environment, and a connected-up system with the patient always at the centre. Other examples of successful existing initiatives include the work of the Alcohol and Other Drug Treatment Court. This example is of interest for the management of people with long-term conditions. Particular aspects of note include the initiative's agreed sense of purpose, co-ordinated care, peer support case management, and the fellowship of peers. While there is a judicial component at play, it represents a behaviour change model where positive lifestyle choices lead to reintegration back into a meaningful and productive life.

An international example worth highlighting is telehealth in Alaska.[21] This has resulted in major improvements in the quality of care and health outcomes of people in remote locations. It has improved the confidence of health care workers in remote places and decreased the costs associated with transferring patients to Anchorage. Alaska's telehealth system is considered to be the most refined telehealth system in the world and offers lessons on how New Zealand could rationalise services but maintain high quality services in regions and smaller towns.

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

The health system is made up of many interrelated components, each of which are important to the functioning of the whole. Accordingly, an argument can be made that all of the parts are a priority, or that the priority is the integrity and integration of the system. A more useful approach could be to first map the system, identifying the parts and their relationships, and then target resources in a way that is most appropriate.

In addition to the suggestions we have already made, we recommend the following priorities for system level change:

- Identifying and mitigating vulnerabilities in transitions of care
- Value the unique role of General Practice as the cornerstone of the health system and fund it adequately to reflect its true value and potential
- Reduction in number of DHBs
- Greater use of Regional Alliances
- Increasing funding and adjusting the Population Based Funding Formula
- Improving health IT with the priority of a nationally accessible standardised electronic health record

[20] Timmins N & Ham C. The quest for integrated health and social care A case study in Canterbury, New Zealand. The King's Fund. 2013. London. Available from https://www.cdhb.health.nz/wp-content/uploads/c476aa13-canterbury-kings-fund-report.pdf

[21] http://www.afhcan.org/; https://anthc.org/what-we-do/telehealth/

9. Is there anything else you wish to add?

We believe that spending on health and the determinants of health should be viewed as an investment in the health, wellbeing and productivity of New Zealanders, and cost saving to other sectors, not as simply a drain on the economy. We refer the panel to an article in the New Zealand Medical Journal on an investment approach to health[22] as well as our 2017 position statement on health as an investment[23] for further details about this approach. Importantly, 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). 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.[24] 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 believe there is a need to critically re-examine the model for delivery and funding / reimbursement of General Practice. The role, function and purpose of PHOs needs to be clearly defined before evaluating whether they are fit for purpose and considering alternative models. The goal should be to maximise the cost-effectiveness of funding allocated to primary care and General Practice. In other words, maximising beneficial health / health equity impacts and avoiding inefficiencies along the way. This means ensuring the model ensures access to primary care while ensuring GPs and other primary care workers are appropriately reimbursed.

The ideal model of General Practice needs to maintain the autonomy of clinical practice and provide innovative and patient-centred care in settings that suit the patient, at times that are mutually acceptable and convenient, to enhance patient outcomes and satisfaction. This model needs to be equitable and recognise the value and cost-effectiveness that General Practice offers the health system. There may be a place to shift funding from expensive hospital-based disease-related care to holistic community-based care in a more wholehearted way that reduces the perverse incentives inherent in our current system. It could be useful to look at budget holding in primary care and commissioning secondary care subject to complication rates /choice of hospital or procedure, for example. The existing system perversely incentivises people to turn up at EDs and seek hospital care because it is free.

We ask the panel to look at different payment models for General Practice and to carefully evaluate the risks and benefits of the different approaches including salaried versus capitation-funded and the role of co-payments. The value of ownership in General Practice needs to be considered along with the partnership model. There is a strong view that co-payments should continue to exist because they have value, but that they should be varied according to patients' needs. Co-payments should be used to facilitate targeted subsidies for those who need it. Experience from jurisdictions where there is no co-payment suggests that patients are more likely to present with one problem per consultation which in turn is iniquitous as they need to incur the

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[22] Metcalfe S, et al. Time for healthy investment. N Z Med J. 2017 Oct 27;130(1464):7-10. Available from http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1464-27-october2017/7390

[23] NZMA. Health as an investment. September 2017. Position Statement. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0003/77277/Health-as-an-investment_FINAL.pdf

[24] Masters R, et al. Return on investment of public health interventions: a systematic review. J Epidemiol Community Health. 2017 Aug;71(8):827-834

costs of transport and taking time off work. There is a concern that this could contribute to poorer adherence with follow up appointments, and therefore lead to worse health outcomes. It is worth noting that co-payments are not the only barrier to accessing GP consultations. We support further refining and developing the concept of funding that follows the patient.

While there will always be a requirement for a meso-level organisation that sits between General Practice and primary care, and the DHBs, there is a strong sense that we do not need the current numbers of DHBs or the current number of PHOs. We need to move some way from the local focus which has reached epic proportions and regionalise to make better use of human resources both in DHBs and PHOs. The pool of effective personnel in New Zealand is limited and using less effective personnel means the system is also less effective. The concept of regional alliances should be expanded (particularly if the existing number of DHBs are retained). A successful example of this approach is the single clinical IT system across the South Island.

We ask the panel to consider the question of integration—both at a workforce level involving undergraduate training and inter professional collaboration /integration, but also in a vertical and horizontal way to maximise cost-effectiveness in the health system. This would involve contemplating where people would be seen and in how many settings, enhancing their experience of their care but maintaining cost-effective integrated care, and not fragmenting or dispersing their care such that outcomes are jeopardised.

Additional suggestions include the following

- a national health IT system with a fully integrated electronic health record is urgently needed
- New ways of doing things including the use of artificial intelligence should be embraced only after review by an expert central committee
- Clinical research needs to be encouraged and be part of the funding and KPIs of DHBs. International clinician-initiated trials are very important for advancing health care in New Zealand
- It is important to recognise the importance of adverse childhood experiences and give priority to health services at the start of life
- Acknowledge and address health inequities of people with serious mental illness
- Invest in better and nationally consistent palliative care and encourage advance care planning
- Fund and provide better and affordable access to mental health support and psychologists
- Fund and provide comprehensive and affordable dental care
- Depoliticise Health Service Delivery. Reconfigure the Ministry of Health such that a Department of Health can focus on the day to day process of health service delivery while a smaller Ministry can concentrate on policy, with frank and fearless advice from the Department where necessary
- Expand the provision and funding of public health initiatives to reduce the prevalence of disease.

We hope our feedback has been helpful and look forward to the panel's interim report to the Minister of Health. We would like to continue our engagement with the Panel and would welcome the opportunity to meet with you again to discuss any of the matters we have raised in this submission.

Yours sincerely

Dr Kate Baddock
NZMA Chair