Submission on 30year Infrastructure Strategy: Health & Disability Infrastructure

What are your views on the proposed 2050 infrastructure vision for NZ?

Our health and disability investment is significant, taking up about one fifth of total government spending.

The National Asset Management Programme stocktake in 2020 confirmed that much health infrastructure in Aoteoroa New Zealand is tired and outdated. Health infrastructure is not being built at a pace sufficient to meet the unabated demands placed on it by our growing (in number and diversity), ageing and increasingly unhealthy population. In 2018 Treasury estimates of investment needed over the ensuing decade in DHB buildings and supporting infrastructure was around $14 billion, and for DHB information technology, $2.23 billion. However, the funding provided via subsequent Budgets for priority capital projects has continued to fall short. Is it realistic to believe that we can build our way out of the health crisis we face? Can we afford to refurbish or rebuild our regional and central hospitals with billion-plus dollar price tags as is happening in Dunedin? And even if we stumbled across a reliably laying golden goose and had the labour resources to deliver these capital projects, are the timeframes realistic and will the outcomes still be fit for purpose?

We seem to have proven without doubt that our current 'treatment' model of care needs an overhaul, hence the Health and Disability reforms underway. This is our once-in-a-generation opportunity to not only change our models of care, but to ensure that we have the appropriate support including infrastructure, in place to optimise delivery, uptake and outcomes for all.

A long-term health infrastructure strategy needs to focus on improving population health while reducing demand for healthcare. As things currently stand, our growing demand for care is unmatched by supply, resulting in intensifying health rationing and a widening gap of unmet need – a gap being filled with unwell and untreated New Zealanders.

We recognise it would be much better to prevent sickness. Non-communicable diseases (NCDs) remain the single largest cause of morbidity and mortality burden in developed countries, NZ included. NCD examples include Type 2 Diabetes, Cardiovascular disease, and many cancers. These are commonly lifestyle-related chronic conditions which we know can be prevented, treated and in many cases reversed simply by leveraging evidence based, therapeutic approaches in areas including diet, movement, sleep, stress management and so forth. We know that lifestyle and health habits are amongst the most important determinants of positive health outcomes. Our medicalisation of lifestyle related problems is not and should never have been the answer. We can no longer afford to consider conventional medicine approaches and models of care as our mainstay to wellness for our lifestyle induced ills. Lifestyle-focused interventions must be considered our first line and most important therapy with other modalities being adjuncts where necessary. This approach is consistent with Te Waihanga's principal of considering non-build alternatives to physical infrastructure, an approach which I strongly endorse.

With a preventative model of care front of mind, how does or should our health and disability infrastructure look from here? Can we provide best outcomes by tweaking what we have or do we need to be rethinking health infrastructure completely? Perhaps there is a balanced approach somewhere in-between. My recommendation is that Te Waihanga promotes a variety of preventative healthcare measures building on this non-build solution concept given the prospect of scaling the traditional 'treatment-centric' model of care looks increasingly difficult.

Possibilities could include supporting a Sugar Tax on the premise that any additional tax revenues are used to subsidise locally grown wholefoods such as vegetables, meat, and eggs. Sugar taxes are not new; they have been implemented with success in several overseas countries. Take Sugar Sweetened Beverages (SSBs). There are no nutritional and wellbeing benefits from consuming SSBs. There is however an unequivocal association between SSBs and increased energy intake, body weight, dental caries, metabolic dysfunction, the list goes on. Responsibility at the state and community level is needed. We cannot expect individuals to be solely responsible for harm reduction behaviour change, especially when many don't have the luxury of affordable healthy substitutes aka 'choice'. Our progressive Tobacco excise tax has proven to reduce harmful behaviours and reduce the impact of poor lifestyle choices on our stretched health system. Similar excise taxes for other harmful vices could also be considered e.g. a meaningful increasing in alcohol excise, and an excise on ultra-processed 'food like substances'.

Not only do we need to change 'how', but we also need to review 'where' we are treating and supporting our unwell. Traditionally hospitals were established around European settlements. With Maaori health and disability being a priority, we need to consider whether healthcare services should be moved to our most vulnerable communities. This can be done by increasing marae, workplace, home-based and virtual 'clinics'.

Our hospitals are bursting at their cracks, trying to manage the burden of our largely preventable NCDs and the associated complex health demands they bring. The best place to prevent and treat lifestyle related illness is in the home and community, not in hospitals. Medicalisation simply encourages reliance on a system which is not equipped or appropriate to deliver the remedy it desires. We need to invest in bottom-up measures which will ebb the flow of preventable illness through our hospital doors and instead make space for those (more complex) illnesses and issues which are less preventable or manageable by lifestyle interventions.

Medical advancement is ensuring we live longer, but not necessarily healthier. StatsNZ estimates that by 2050, approximately 23% of NZers will be over 65y and that the number of 85+ year olds will more than triple over this time period. Age brings with it its own complex nuances and illnesses. Health infrastructure with a geriatric focus is likely going to be needed.

How will we measure wellbeing in terms of outcomes? What does wellbeing and Quality of Life truly mean?

We need to deeply consider whether ongoing heavy investment into bricks and mortar infrastructure will make best use of our health care dollar. Will the benefits (overall reduction in morbidity and mortality) of having more or newer buildings be superior to the same dollar investment into 'non-built' comprehensive health and wellbeing programmes that address the root causes for many of these Non communicable health issues? Imagine if instead of another mental health unit build, our policy makers agreed to invest into an evidenced based Nutritional Health programme rollout specifically targeted to the 1 in 5 NZers who are struggling with mental health.

To ensure more effective and equitable health and disability support, we should be looking at other options that deliver care 'to' the consumer rather than expecting the consumer to arrive at care. The Health Care Home (HCH) integrated care management model already rolled out in many areas of Aoteoroa aims to bring healthcare to people's homes and communities and if not there, to under one health hub roof. I suspect many of the limitations of this models' effectiveness to date is due to paucity of supporting and/or reliable infractructure – IT/technology/teleconnectivity etc.

Prioritising reliable and fit-for-purpose technological infrastructure that allows ongoing digitisation of health will continue to improve access and efficiencies especially to our rural and remote communities. Of course, attention needs to be given to data security and cyber-risks, but the benefits outweigh the risks.

It is suggested that when infrastructure fails or functions poorly that the most disadvantaged are most impacted, and disproportionally so compared to better resourced individuals and communities, where choice is a reality. We need to mitigate this disadvantage by ensuring our infrastructure remains appropriate, productive, sustainable and equitable.

Should we be more open to resource sharing and resource investing with other sectors to which we are all co-dependant on e.g. transport, IT/tech, telecoms/connectivity, physical spaces, waste management? An example would be considering investment in culturally appropriate shared physical spaces such as dedicated medical facilities on marae to improve access for those who currently struggle to access conventional healthcare.

Should we be considering direct investment into physical environments that we know are functioning poorly and have direct impact on health outcomes? For example, we know that cold, damp and mouldy homes are directly linked to increased respiratory disease and poor mental health. Perhaps investment into healthy homes is a smarter way of preventing these health and disability ills associated with our poor housing stock.

Perhaps we need to see health infrastructure as less about big buildings and more about smarter, innovative investment into adjacent infrastructure and/or non-built solutions. It's clear that we will continue to need hospitals, but there is no way we can scale the conventional model of care in line with demand forecasts.

It is vitally important to ensure that experts in infrastructure planning are given a governance seat within the health and disability sector. We need to ensure that future infrastructure plans align with service models and planned provision of care. Fit for purpose infrastructure will optimise outcomes for NZers.

I agree with Te Waihanga's statement that "Getting the Infrastructure right is vital as it is the foundation (tuaapapa) for our way of life". This certainly holds true for our health and disability system.

While we will need ongoing investment in bricks and mortar health infrastructure, this needs to be matched by serious investment in preventative approaches. It is projected that over the next 20 years, nearly 60% of NZ population growth will be in Auckland and Northland, meaning another 2055 beds and 40-odd theatres will be required – these are staggeringly costly investments. Back in 2019 the adjacent Waikato region projected they would need to add more than half a Waikato Medical Hospital (i.e. additional 440 beds) by 2030 unless something radical changed. Waikato DHB described this idea as neither 'sustainable or desirable'.

Covid-19 pandemic has highlighted the importance of a well-functioning public health service to deliver a 'prevention strategy' given the inability of our health infrastructure to deliver a 'treatment' solution if covid were to become widespread in the community. This isn't only true of pandemic response, its also true of chronic illnesses and preventable disease.

In summary:

- New Zealand is aging rapidly and the elderly have complex health needs.
- New Zealanders are unhealthy and growing sicker by the day.
- Lifestyle choices are a huge determinant of our poor health – obesity, type-2 diabetes and many cancers are a function of choice.
- We need to shift from an illness focus to wellbeing and preventative models of care
- Excise taxes are proven solutions to assist people with making better lifestyle choices, these are critical tools that policy makers must employ as part of any infrastructure strategy.
- Immediate implementation of a comprehensive and broad-based sugar excise tax and massive increase in the rate of alcohol excise tax would 'bend the trend' away from a treatment-based health future we simply can't afford.
- Even if we favoured the sickness-treatment model of care, our health infrastructure cannot scale at the rate required to build our way out of the health crisis. We don't have the construction or medical workforce necessary to build and staff the necessary expansion of facilities this would entail. Training and retaining a health workforce of these proportions would be incredibly costly and would have huge trade-off effects.
- The cost of traditional medicine, both the infrastructure and the operating costs, are increasing at such a rate that New Zealand simply cannot afford any strategy which isn't underpinned by a solid foundation of preventative medicine. The capacity and capability within primary and community health sectors needs continually optimised.
- Prevention should extend across the built environment to include the dire state of our building stock, the poor state of our building code and the high incidence of accidents and injuries in key sectors like transport and agriculture.
- Non-build solutions are not an 'option to be explored', they are the only legitimate solution to a challenge of this magnitude and must be the strategic bedrock of our approach to healthcare.

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