The draft NZ Health Strategy: Will it enable New Zealanders to “live well, stay well and get well”?

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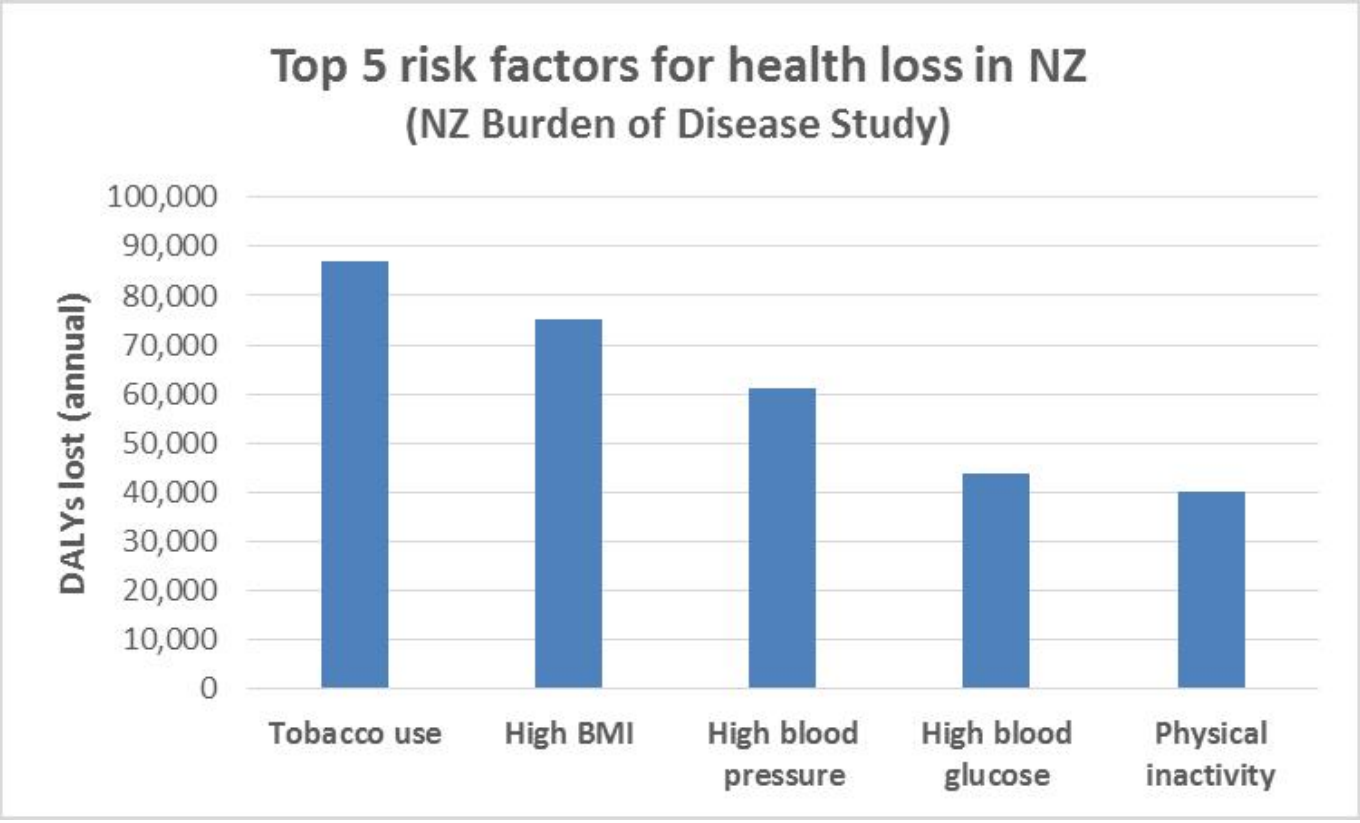
The new draft NZ Health Strategy is strong on strengthening the health care system and has some strong population health aspects, at least rhetorically. It includes phrases like a system moving “from treatment to prevention”. But how does it fare when considering the science around burden of disease and interventions to address the 10 top risk factors for health loss in NZ? Unfortunately not well at all. There are no population health goals and minimal evidence of concrete action to address the major preventable causes of poor health and premature death. In summary, there seems plenty of scope for upgrading the draft Strategy if it is going to enable New Zealanders to “live well, stay well and get well”.



The draft NZ Health Strategy (1) has a strong focus on strengthening the health care

system. As such it addresses the “Get well” part of the “Live well, stay well and get well” goal that it espouses for New Zealanders. It also appears to have some strengths from a population health perspective, at least in its use of language and terminology. Phrases like a system moving “from treatment to prevention” are used and the word “prevention” is mentioned 13 times. It also describes an investment approach focused on long-term benefits. One of its eight principles is “Collaborative health promotion and disease and injury prevention by all sectors”. It also stresses the theme of “value and high performance” with the word “value” appearing 28 times. It even mentions “inequalities” (albeit just once). But here we look at the draft Strategy document from mainly just one perspective – the degree to which it acknowledges the 10 top risk factors for health loss in NZ, sets out population health goals and proposes strategies to reduce their impact (2) (see Table below).

The number one preventable risk factor for health loss in NZ is tobacco smoking (see Table and Figure). It is also a major contributor to health inequalities. Neither is apparent in the draft Health Strategy, which scarcely mentions tobacco. The Government’s world-leading Smokefree 2025 Goal (3) is not mentioned in any form. Nor does the draft Strategy’s “Roadmap of Actions” include any plans on how to achieve the Smokefree Goal (e.g., via higher tobacco taxes (4), restricting outlets (5), revising regulation around alternative sources of nicotine (6), intensifying mass media campaigns (7) etc). The Government recently committed to developing a comprehensive strategy for achieving the 2025 Smokefree Goal. This too goes unmentioned. These omissions are difficult to understand given the Government’s commitments to Smokefree 2025 and the rhetoric in a Strategy that claims to be moving ‘from treatment to prevention’. From a value-for-money and investment approach perspective this also seems unfortunate – given NZ modelling work suggesting that tobacco control interventions are highly cost-effective and that higher tobacco taxes, for example, would save health dollars (8) and would probably have other substantial economic benefits (9).

The challenge of increasing levels of obesity is at least acknowledged and described. The word “obesity” gets 13 mentions, and the “Roadmap of Actions” states the intention to “implement a package of initiatives to prevent and manage obesity in children and young people up to 18 years of age”. However, once again there is no population health goal for reducing obesity and the proposed actions do not include any substantive plans to tackle the obesogenic environment (e.g., the words “marketing”, “outlets” and “tax” are not mentioned). Even physical activity only gets one mention with the word “exercise”.

Brief mentions are given to the high blood glucose risk factor (in terms of diabetes), and also the word “alcohol”. But there are no population health goals or 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 (10).

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 an investment approach and 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 (11). Similarly, for NZ work on the benefits of taxing high salt foods (12), and sugary drinks (13).

Where to from here?

In summary, from the perspective of population health and prevention, the draft Strategy is highly inadequate. There is plenty of scope for the draft Strategy to be upgraded to be better based on the science of health loss and to set out a coherent set of priority population health goals and actions to achieve them. Given the clear indication of the cost-effectiveness and substantial economic benefits of such measures, including the benefit of constraining rising health care costs (identified as a major long-term funding issue in the challenges section of the draft Strategy), it is puzzling that the draft Strategy is so bereft in these respects. The final version of the Strategy needs to take a more balanced approach in which key causes of health loss are fully acknowledged and addressed by an appropriate range of strategies and actions to ensure that New Zealanders do indeed "live well, stay well and get well".

Risk factors for the top 10 causes of health loss in NZ (from the NZ Burden of Disease Study (2))

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", "campaigns", "mass media", "warning labels", "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", "campaigns", "mass media". (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".

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)	
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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