

Submission on the:

*Update of the New Zealand Health Strategy*

*All New Zealanders live well, stay well, get well*

*Consultation draft*

On behalf of Women’s Health Action Trust

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Women’s Health Action is a women’s health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policy makers and other not for profit organisations to inform government policy and service delivery for women. Women’s Health Action is in its 31st year of operation and remains on the forefront of women’s health in Aotearoa New Zealand.

We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women’s health (including screening), public health and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, women’s sexual and reproductive health and rights and body image.

In 2014 we published a case for creating a Women’s health Strategy[[1]](#footnote-1) and in 2014-2015 we undertook a stock take and review of recent literature in regards to the health of women over the age of 65 in Aotearoa New Zealand[[2]](#footnote-2). We also made a submission on the Older Person’s Health Strategy in 2015[[3]](#footnote-3). Based on this evidence we have identified some of the key strategic policy issues relating to the health of women and girls in Aotearoa New Zealand including the effects of gender and age discrimination.

We therefore welcome the opportunity to give feedback on the *Update of the New Zealand Health Strategy*. Because our area of expertise is the health of women and girls we have focused our comments on strategies for improving the health of women and girls in Aotearoa New Zealand.

**General Comments:**

*“To achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities”* (World Health Organisation, 2002).

The New Zealand Public Health and Disability Act 2000[[4]](#footnote-4) both sets out the purpose of the New Zealand health system, and mandates the development of health strategies (section 8). Section 3 of the Bill refers to the objectives the Government is required to achieve for all New Zealanders including the improvement, promotion, and protection of their health, the promotion of the inclusion and participation in society and independence of people with disabilities, the best care or support for those in need of services, a reduction of health disparities by improving the health outcomes of Māori and other population groups and the provision of a community voice in matters relating to personal health services, public health services, and disability support services. It also includes reference to mechanisms to enable Māori to contribute to decision-making and service delivery with a view to improving their health outcomes. We therefore believe that the consultation draft requires additions and changes in order to meet these objectives, which we have commented on below followed by our comments on the specific consultation questions.

* **Further development of the guiding principles:**

We believe the guiding principles should contain specific reference to the Ottawa Charter[[5]](#footnote-5)as well as Te Tiriti o Waitangi, as crucial underpinning frameworks for development and implementation of any health strategy in New Zealand. This would also reinforce the principle of broadening the view of health and addressing wider determinants of health.

* **Inclusion of a gender lens:**

Planning and delivery of health services and health research must include all New Zealanders and prioritise the needs of those with the highest risk of poor health. The World Health Organization’s definition of health includes *“complete physical, mental and social wellbeing and not merely the absence of disease and infirmity. Women’s Health involves their emotional, social and physical wellbeing and is determined by the social, political and economic context of their lives, as well as biology”[[6]](#footnote-6).* We are disappointed that specific mention of including a gender lens is lacking from the draft strategy as sex and gender are basic determinants of health, which give rise to different health outcomes and different health care needs for women and men[[7]](#footnote-7).

There are health issues that are unique to women including chronic illness and injury; violence against women; mental health; and sexual and reproductive health are particular health issues for women and girls. Aotearoa New Zealand has high levels of violence against women and children, there is a significant income gap between men and women, and women are often held responsible for the health of their families. Women can also expect to live 14 percentof their lives in poor health or with a disability[[8]](#footnote-8). Improving women’s health requires recognition and respect for women’s unique natural life courses including, menstruation, fertility, pregnancy, childbirth, breastfeeding and menopause. In fact, similar jurisdictions to Aotearoa New Zealand such as Australia, Canada and the USA have specific women’s health policies or strategies which address sex and gender differences in health, emphasise prevention and health promotion, and take into account the social determinants of health and the diversity of their female populations[[9]](#footnote-9).

The 2004 Action Plan for New Zealand Women noted that inequalities exist between men and women across a wide range of indicators including health[[10]](#footnote-10). Women are the majority of health consumers, the majority of health service providers and the majority of carers in our society. Increasing participation and decision making at community, government and service level and involving women in both the development and delivery of services improves service provision for everyone[[11]](#footnote-11).

We therefore believe that any successful health strategy must be responsive to the needs of women and actively promote participation of women in health care. This requires a gender analysis in health care strategies, policies and research and greater understanding of gender as a key determinant of health.

The strategy should also be consistent with the principals of the Treaty of Waitangi and other relevant Aotearoa New Zealand legislation such as the Human Rights Act and the international human rights conventions to which we are signatories[[12]](#footnote-12).

* **Clear commitment to address health inequalities and a human rights approach:**

Health inequities are *“the avoidable inequalities in health between groups of people within countries and between countries”[[13]](#footnote-13).* These include the effects of colonisation, culture, affluence and deprivation, political and economic systems, and socioeconomic characteristics, such as education, employment and income as key determinants of health. Addressing health inequalities requires a targeted approach and a health system that is responsive to the specific needs of all. This is not reflected in the draft strategy.

There is ample research that suggests positive changes in the adverse conditions of people’s lives reduce avoidable health inequalities[[14]](#footnote-14). For example, women are over represented amongst lower income New Zealanders, and are more likely to be receiving a benefit, providing unpaid care, sole parenting and receive lower incomes than men. It is the adverse social and economic circumstances of people’s lives that lead to high levels of stress and unhealthy behaviors that then lead to high rates of disease and injury. Issues such as poverty, homelessness, transportation and accessibility impact on women’s health service use. Women on a low income are less likely to prioritise their own health and dental care, and have a poorer nutritional intake[[15]](#footnote-15).

Research also describes persisting health inequities for Māori in New Zealand. Māori women experience poorer health across almost all health areas and age groups compared to other women[[16]](#footnote-16). In general social exclusion and the effects of stigma and discrimination have also been found to have negative impacts on health. A further example is the studies that have found that LBTI women experience higher rates of physical and mental illness and have reduced levels health service access. Being part of any socially or economically disadvantaged group may mean there are barriers to healthcare access including a lack of affordable health care services or female doctors, or a lack of Māori and Pacific service providers. Discrimination and prejudice such as the racism, homophobia or transphobia of health care service staff may also prevent certain groups accessing health services[[17]](#footnote-17).

The draft strategy describes ‘the health and disability system’ but barely mentions people with disabilities many of whom struggle not only to access essential disability support services to allow them to participate in society, but to get equitable health care[[18]](#footnote-18). Similarly, lack of public transportation, language barriers and poor disabled access to buildings may affect access to healthcare of migrant, rural, or older women. Health policy must therefore be designed to meet the needs of women of all ages and backgrounds, take account of the diversity of cultural and ethnic backgrounds and be culturally and linguistically appropriate.

The International Covenant on Economic, Social and Cultural Rights includes as a central provision *“the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”* as part of international human rights law[[19]](#footnote-19). Any health strategy must be informed by human rights obligations which should be explicitly stated as goals.[[20]](#footnote-20)

* **The problematising of age:**

Concepts of aging and attitudes towards older people and being older are variable and culture based. By the twentieth century western popular culture began to present an increasingly negative view of older people and for the first time in history, long life had become a problem[[21]](#footnote-21). By 2051 older New Zealanders will make up 26 out of every 100 people, and the majority of those older New Zealanders will be women. This pattern of increasing longevity of people throughout the industrialised world has generated a substantial body of new policy and theory and this growing group are often discussed with by problematising aging and focusing on perceived economic and other burdens and gender and age discrimination.

Similarly, in cultures where both sexism and ageism are present older women face the “*double jeopardy of exclusion related to both*[[22]](#footnote-22) ”. The problematising of age creates another challenge in constructing successful health strategies and the older adult population can become the target for cost control or feel blamed for increases in healthcare costs. The increasing focus on the health care ‘burden’ of the aging populations means a reduction in state funded benefits can become a real risk. What is often ignored is the contribution ageing women make to the social and economic well-being of their families, communities and nations[[23]](#footnote-23). We would therefore like to and less problematising of certain groups such as older or bigger New Zealanders and more focus on environmental and economic challenges to health.

It is important that access to health care as a basic human right be reflected across age groups and genders. The ageing of our population also has implications for how we protect the human rights implications particularly for the frail, disabled or ill elderly. Older women who are poor or disabled or belong to minorities often experience multi‐sectored discrimination. Similarly, older women in prison, older sex workers and older disabled women can face neglect and abuse or financial insecurity. Prohibitive costs, lack of transport or the absence of geriatric medicine, primary health or mental health services often prevent older women from enjoying their human right of access to health care.

New Zealand’s Age Concern’s Elder Abuse and Neglect Prevention (EANP) notes that older people who are dependent on others are particularly vulnerable to abuse and that for many their health was significantly affected by the abuse they experienced[[24]](#footnote-24). In addition, the health care reforms of the last decade have also had a negative effect on poorer people, including the closing of acute-care beds, and early release from hospital without a corresponding increase in support in the community which has left ageing women with an increased and unrecognized burden of caring for partners and other family members who are ill or frail[[25]](#footnote-25). We would also like to see mention made in the strategy to the role and support of caregivers many of whom are women[[26]](#footnote-26).

Health strategies must take a human rights approach to health care and address issues such as income support and access to appropriate housing and transport. The United Nation’s “Between gender and aging” report recommends certain strategies for addressing older women’s health including a life course approach, providing supportive policies and activities at key transition points in a one’s life, addressing gender and age discrimination and addressing the underlying determinants of health[[27]](#footnote-27). Our Health Strategy should also include reference to intersectoral objectives that enable full and equal participation in society and encouraging intergenerational solidarity and respect.

* **Including data collection, privacy and informed consent strategies and research**

Government statistical data and the data of organisations such as ACC and HDC must be disaggregated by sex and age to provide gender specific information about health. Gender sensitive research is also required into cost-effective ways to help older and disabled people remain in their homes in the community and address the health issues faced by specific groups and the impact of health care reform on gender equity.

Specific reference needs to be made to consumer involvement and informed consent including as a target on the ‘roadmap’. Along with this specific strategies need to be added to embed privacy and consumer rights into the strategy.

**Consultation questions**

**Future directions-Health in its wider context**

Health is treated throughout this section as an input, with little recognition that is also a significant outcome, to which income, social support, inclusion and exclusion, housing, power and participation all contribute. For this reason, we believe the strategy should be assessed for impact on health outcomes and on equity and from a human rights perspective.

The draft strategy starts with a positive view of New Zealand’s health system, reflecting apparently high levels of New Zealanders self-reported sense of good health, access to services and satisfaction with care. We believe this is not entirely accurate and that New Zealand’s performance is mixed and we perform poorly in many areas including avoidable hospital admissions, re-admissions to hospital for mental health disorders and survival rates for some cancers. The OECD notes that NZ’s health spending has slowed significantly since 2009.

The health strategy and intersecting strategies need to address high risk illnesses and chronic disabilities experienced by women as well as men by developing gender sensitive health interventions and include measures that enhance quality of life and support independence.

Local government has an important and often inadequately recognised role in the health of New Zealanders – creating and maintaining healthy environments that are unpolluted, safe and which encourage physical and social activity. Therefore the strategy explicitly includes local government in the whole of government goals. We also believe that local government, NGOs and Consumer support organisations are inadequately recognised in the draft strategy and the role of the private sector is not clearly described.

### Challenges and opportunities

*The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.*

1. **Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?**

We agree that New Zealand’s health system continues to be relatively strong but in fact, most of the challenges identified in the 2000 strategy are still with us, and some have worsened. In addition there is concern about the costs of health but other than containment no initiatives to ensure all New Zealanders are provided with accessible health care. There is no cost assessment of the various targets or initiatives.

We also believe that the role of the Ministry and the whole health system structure must be made clearer in the strategy. We would support the inclusion of specific targets for the MOH and its obligations. We would prefer a diagrammatic representation of the system that is a matric with consumers/ patients who are also the funders (taxpayers) of this system at its core. The relationship expected between DHBs and NGOs and the roles of Consumer groups, unpaid health carers and the private sector should also be represented.

The draft acknowledges certain ‘global’ challenges in particular the ‘burden’ of providing health and social services to increasing numbers of older people who are living longer and specific local challenges, including ‘obesity, especially among children. We believe the targeting of certain groups-including older people and bigger people and the ‘disadvantaged’ is contrary to the promotion of good health, inclusiveness and promotes a health culture that wrongly places the blame for illness on the individual. For example, individualising the causes of obesity and blaming bigger people has already given rise to discrimination and stigma here and there is now evidence of ‘hate crimes’ targeting bigger people[[28]](#footnote-28).

We believe the health strategy should include addressing some of the significant global and local factors contributing the marketing of food and alcohol in ways that promote obesity and poor nutrition. Other significant global challenges to health such as climate change and terrorism are absent. In addition, if any section of our society is seen a burden or disposable their rights may be eroded. In addition, we believe the strategy should also include intersectoral targets that enable full and equal participation in society and encouraging intergenerational solidarity and respect. This includes dispelling misconceptions, negative attitudes and stereotypes about aging and addressing sexism and violence against women.

The use of such language as ‘some of New Zealand’s population groups receive unequal benefits’ (p6) implies among other things that the health and disability system is the primary reason for disparities in life expectancy or that access to the system is not a right. The strategy should indicate that all New Zealanders must be able to access decent income and housing which support healthier lives, as well as making services accessible, safe, relevant and appropriate. For this reason, one of our major recommendations is that the strategy explicitly commits the New Zealand health and disability sector, including the Ministry of Health, to reducing inequalities in health and taking an intersectoral approach to addressing wider determinants of health.

### The future we want

*The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system: So that all New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system.*

1. **Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?**

The draft starts with a discussion of its overall goal: “All New Zealanders live well, stay well, get well” is a laudable aim but we would like to see the inclusion of an explicit commitment to reducing inequalities.

*A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.*

**3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?**

We support many of the existing strategy’s principles, in particular the proposed shifts from the current mode of competition to trust, cohesion and collaboration, and from ‘fragmented health sector silos to integrated social responses’. However, we suggest the current wording ‘from treatment to prevention and support for independence’ should be changed to include such values as interdependence and mutual support, which are central to Māori as well as to other New Zealand populations.

At present, the draft strategy is heavily weighted towards treatment and the sector consultations strongest themes centred around a shift to primary prevention, which has not been well reflected in the strategy. The challenges of improving performance in the treatment area (‘get well’) do not override and overwhelm the challenges of living and staying well and health prevention and we believe promotion strategies and intersectoral collaborations are currently not given enough weight.

### Five strategic themes

*The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).*

* **People power**

Despite its focus on "people power" the strategy fails to comment on where people will get reliable sources of evidence-based information to inform their decision making. We do not think positioning the patient/consumer as a ‘customer’ necessarily improves their “people power” particularly when no mention is made of consumer advocates or representatives or processes for complaints or auditing of performance of both the MOH and health services.

Page 12 mentions an award winning evidence-based app but gives no real detail about cost or how it would work and page 13 notes " *People access practical evidence-based health advice that makes it easier for them to make healthy choices and stay well. Technology tools such as mobile devices, smartphones and wearable devices are options for everyone".* However, the app/s seem to be designed to make appointments or get prescriptions and test results, while they may save money and time, do not to improve understanding. There is also no comment about how privacy would be protected.

On page 19 the draft notes *“But in general we need to get better and faster at sharing the best new ideas and evidence and putting them to work throughout the system. This will help us avoid unwarranted variations in the quality, safety and sustainability of services, and will also mean that effort is not wasted when regions or organisations independently develop solutions to common problems. This can be achieved if we take the learnings from successful implementations and apply them systematically to areas in need of improvement."* We believe the evidence translation process must be New Zealand based and independent.

There is also no clarity about how health literacy will be improved and how independent evidence will be compiled and used and who by. As health care has become more complex, health literacy and obtaining independent, evidenced based information can be difficult. Lack of informed consent procedures, media based misinformation, medication or treatment-induced illness, unsubstantiated statistics (for example mortality rates following hip fracture) along with patient disempowerment, all add to health challenges. People’s power to maintain health is often limited by the power of big business, the media, the pharmaceutical and food industries and alcohol companies. We would like to see more commitment to promoting health literacy - both for consumers and in teaching health practitioners how to support consumers to make evidence-informed decisions. We would also like to see a commitment to transparency around what ‘best practice’ evidence is and how the outcomes of overarching strategies such as the early stage diabetes strategies and the obesity reduction initiative.

In general, this section seems to be less about people power or “the process of enabling people to increase control over, and to improve, their health” (Ottawa Charter, WHO 1996) than about health professionals leading the system, and treating people as ‘customers’ (p11). We believe ‘people-power’ should focus on healthy public policy, supportive physical and social environments, as well community action, personal skills and re-orienting health services. This section should include targets to reduce health issues such as heart disease or infection with a focus on the external environment and regulation not the individual. For example, regulations to ensure rental accommodation is secure and comfortable or to prevent the marketing of unhealthy processed foods to children or controlling sexist or exploitative advertising.

* **Closer to Home**

We strongly support the concept of bringing services closer to communities and believe we should also include providing services to specific disadvantaged communities. We support the focus on wellness and prevention of long-term conditions. However, nurses and doctors at consultation meetings on the strategy identified one of the ‘demotivators’ constantly having to send people back to damp, cold, or unsafe housing in the knowledge that the person will be returning to the health service again soon. While we support such local initiatives as DHBs and local authorities working together on home insulation programmes, more is needed to make sure that people with health problems can heat their homes, and that houses are accessible.

This section should describe partnerships with other sectors to support a healthy start, like housing, local government, early childhood education, primary prevention of violence (including sexual violence), access to safe housing, older persons and disability support services, employment, and income support.

We note that many small rural areas will also have considerable difficulties delivering primary care nursing services in a sustainable way partly because of the capitation funding arrangements which are not always shared by GPs. Service integration will require specific strategies and changes to funding arrangements. There are also major workforce issues around the perception of nurse practitioners amongst other providers. There needs to be more encouragement to use these skilled practitioners in all areas particularly rural and remote areas and the use of new technologies such as telemedicine.

* **High Value and Performance**

Value for money is vitally important. However cost/benefit analysis of investing in activities such as prevention have been included. Similarly there is no discussion of how we fund our health care system. PHARMAC is, quite rightly in our opinion, applauded for the savings in health care dollars but no attention is given to our increasing use of medical devices and implants and how both their safety and cost effectiveness will be guaranteed.

We believe an active review of over-servicing/ over-diagnosis and inappropriate care is called for. For example, the US, Canada and Australia have embarked on programmes called "Choosing Wisely" where ineffective care/ practices are identified by professional colleges and form a part of campaigns to improve practice.

Better information, clear accountability, better research and evaluation will all help measure high performance but won’t actually produce equitable outcomes. We believe the strategy must contain clear and measurable targets and to report on them. It would have been helpful to include information about how we have met the targets set in the 2000 strategy. Priority setting in health care services must be based on evidence that is free from systematic gender- bias.

We believe not enough attention has been given to workforce issues in the draft. There is no strategy or goal related to the training of additional nurses and doctors despite reference to the aging workforce. We would like to see some strategy for investment to be made in this area before the expertise of this groups is lost. Nor should the sector continue to rely on the work of unpaid carers particularly in areas such as the care of frail elderly or disabled people. Simply transferring formal care to the unremunerated care which is often provided by ageing women without providing compensation for lost wages and community support services is discriminatory. People, whānau/ families and communities are often more than carers. They are also the volunteer NGO governors, volunteer drivers and emergency staff. We need to ensure the system does not compromise their wellness by failing to recognise and support them.

The strategy should also recognise the need to invest in people’s health. Intersectoral strategies such as creating housing designs that enable multigenerational living and assistance with home modifications and repairs, accessible housing; hazard-free streets and buildings; safe, accessible public transportation; creating public spaces that encourage active leisure and socialization along with all age-friendly cities and communities and education about new technologies can address many of the factors in the physical environment that help determine the state of people’s health.

* **One Team**

We support the concept of ‘one team’, although we think the present definition must include the patient/consumer. If you can put the consumer at the centre of all activities then it is more likely that one team could emerge with the consumer as the leader. As we noted above we need to train practitioners into helping consumers understand their health care options, their bodies and the health care system.

We also need to review the funding models to ensure that they support integrated care and service delivery and to ensure all parts of the system are adequately and fairly funded. We suggest that the roadmap set and targets for identifying and urgently addressing what is stopping that goal being achieved. We need to remove barriers to collaboration such as contracting regimes that promote competition between service providers. We would like to see clearer strategies for DHBs, local government and NGOs to engage as well as for intersectoral collaboration. We would like to see consumer groups and others as well researchers identified as part of sector collaboration.

* **Smart Systems**

The key to the smart systems will be the evidence-based information used by the different devices. Along with our comments above we would like to strategy to have ensuring privacy and confidentiality as well as an opt-in informed consent process.

There also needs to be some description of the systemic changes required to ensure practitioners share information with the service providers chosen by consumers. Anecdotally information sharing by GPs and inter-hospital information sharing has been fraught with problems. In addition there have been several well publicised cases of government departments not keeping information secure. The strategy must have privacy and informed consent as a key priority.

We believe this aspect of the strategy in particular will require investment in workforce capability and health literacy. We also think the strategy should clearly indicate that technology is never a substitute for hands on professional care. We would like to have seen greater emphasis in using allied health professionals and nurses both to contain costs and to ensure service delivery can be local and tailored to a patient’s needs.

4 **Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?**

We do not believe this section is extensive enough. Please see our general comments for what we believe is missing.

### Roadmap of Actions

*II. Roadmap of Actions has 20 areas for action over the next five years.*

**5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?**

The Roadmap appears disconnected from, and in some respects contradictory to, the principles of the Strategy and the possible results do not seem to reflect the approach set out in the strategy. It also contains untested initiatives without any reference to establishing they are successful for example “obesity reduction initiative in place”. Simply putting an initiative in place is not an outcome. Similarly the “One Team” theme actions are inadequate and there is no clarity about who is in the team or the roles of the MOH or DHBs are. We note that at the Wellington consultation meeting on the strategy, there was strong support from people right across the health and disability sector, as well as health service users and others, for adopting a Health in all Policies (HIAP) model in the strategy and would support this.

### Turning strategy into action

**6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?**

We would like to see the action areas strengthened to include the role of local government and NGOs in particular in supporting healthy cohesive communities, promoting acceptance of diversity, safety including from violence, all of which have major effects on health. There also needs to be more clarity about how to achieve intersectoral action at national, regional and local levels. In addition, there is an absence of input from consumer organisations. In addition in the first sector consultation in Wellington there was considerable discussion about the inequitable funding of NGO’s compared to the rest of the sector.

The influence of academic work and of the pharmaceutical and medical device manufacturers on the sector and on sector strategies and policies needs to be made clearer and ethical and independence issues identified.

We note that that the roadmap is intended to be a living document co-created via an annual forum. It is not clear who is to be included in this forum, nor what information they are to base this ‘co-creation’ on.

### Any other matters

**7 Are there any other comments you want to make as part of your submission?**

We have covered this question in our general comments above. We would like to stress we believe the strategy must contain specific targets in relation to informed consent and privacy. We think informed consent needs to be a part of health literacy at least and to be added to the roadmap as a goal in the sort and long-term. We also believe another roadmap goal must be the protection of the privacy of all patient data and that reducing inequalities in health must be explicitly committed in our health strategy.

Thank you for the opportunity to comment on the draft strategy.

Please contact us if you require any further information

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25. Alpass et al. (2013). The Influence of Ethnicity and Gender on Caregiver Health in Older New Zealanders [↑](#footnote-ref-25)
26. Alpass et al. (2013). The Influence of Ethnicity and Gender on Caregiver Health in Older New Zealanders [↑](#footnote-ref-26)
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28. See: <http://www.abc.net.au/news/2015-12-01/women-body-shamed-on-london-tube-by-overweight-haters-ltd/6989574> [↑](#footnote-ref-28)