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## **The Royal Australasian College of Physicians**

Submission to the Health and Disability System  
Review

May 2019

## Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback to the New Zealand Health and Disability System Review.

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

### Q1. What are the key values you would want to underpin our future public health and disability system?

The RACP supports a public health and disability system for Aotearoa New Zealand underpinned by the following values:

- Ōritetanga (equity)
- Justice
- Manaakitanga (compassion and kindness)
- Whanaungatanga (connection and strengthening of relationships)
- Mōhiotanga (knowledge, insight and understanding)
- Sustainability (including the responsible use of resources)
- Quality

#### *Tikanga Māori values*

The values listed above are intentionally aligned with tikanga Māori and kaupapa Māori ways of doing and being. Our College recognises that to begin to address over 200 years of inequity – widening gaps in health, education and employment outcomes, enforced and systematic alienation from traditional practices, language and culture – the system will require a fundamental shift to values and principles derived from Te Ao Māori (the Māori world).

Values that underpin the health and disability system should actively seek to address ongoing disparities in health outcomes for Māori, for Pasifika and for people experiencing hardship and poverty. Values bound to any system will be mediated by the impact of Social Determinants – the conditions in which we are born, live, grow, work and age – on individual and whānau experiences of systems, including the health care system<sup>1</sup>. Underpinning our health and disability system with values like ōritetanga (equity) will reframe programmes and resources to reduce the risk of poor outcomes by improving access to warm, dry and safe housing; to embed culturally safe, whānau-centred models of care; and strengthen systems through Māori input into system and service design<sup>2</sup>.

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<sup>1</sup> Commission on the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. [Internet] Geneva: World Health Organization; 2008. Available from [https://www.who.int/social\\_determinants/publications/9789241563703/en/](https://www.who.int/social_determinants/publications/9789241563703/en/). Accessed 24 May 2019.

<sup>2</sup> Came H, McCreanor T, Manson L, Nuku K. Upholding Te Tiriti, ending institutional racism and Crown inaction on health equity. N Z Med J [Internet] 2019; 132(1492):61-6. Available from <http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2019/vol-132-no-1492-29-march-2019/8746>. Accessed 24 May 2019.

A common pattern has emerged in Indigenous experiences of colonisation globally: loss of culture, loss of land; loss of voice, loss of population, loss of dignity, loss of health, loss of wellbeing<sup>3</sup>. The principles of te Tiriti o Waitangi (the Treaty of Waitangi) of partnership, participation and protection go some way to articulate the government's obligations and responsibility to Māori, but these should be augmented by embedding values of Te Ao Māori, Mātauranga Māori (Māori knowledge) and kaupapa Māori. In Aotearoa New Zealand, Indigenous researchers have used the interface between science and Indigenous knowledge as a source of inventiveness – they have access to both systems and use the insights and methods of one system to enhance the other<sup>3</sup>.

## ***Quality and Sustainability***

The RACP is a strong supporter of clinical excellence, and best practice informed by the highest-quality available evidence to improve outcomes for the people we serve. Similarly, we support the values of quality (excellence, safety and efficacy) and sustainability (responsible use of resources) as being foundational values to the future health and disability system.

Society must adapt and mitigate the challenges thrust forward by the climate crisis and global heating: health systems are high emitters of greenhouse gases and achieving a maximum of 1.5-degrees Celsius rise in average temperatures by 2100 will require a whole-of-system response<sup>4</sup> <sup>5</sup>. As a key value of our health and disability system, sustainability and responsible use of available resources would not be limited to climate crisis mitigation strategies: it should be integrated as a design principle in the commissioning of new system infrastructure; in information technology systems planning; and in community public health initiatives. Sustainability and sustainable development values should inform purchasing and procurement criteria for major medical devices, and how models of care such as telemedicine can be integrated to reduce the system's carbon footprint.

Both values are underscored by an emphasis on evidence to inform improvements in quality and safety, driving research, development and innovation. Systems must be informed by evidence-based best practice and sustainability to ensure the survival of our health and disability system in an era of climate crisis. The 17 Sustainable Development Goals (SDGs) agreed by the United Nations in 2015 offer a framework to guide values for our health system which are responsive and aligned to global priorities, including the development of resilient and sustainable infrastructure and communities and responsible resource consumption<sup>6</sup>. Our objectives for a values-based health and disability system should take into account aspects of public health which are unique to Aotearoa New Zealand (particularly Te Tiriti and addressing Māori health inequities) but also incorporate clear references to global sustainable development agreements, including the aforementioned SDGs and the 2015 Paris Climate Change agreement.

## ***System Review in context***

As this Review begins to explore different (and not necessarily novel) ways to reorient our public health system for the future, there are examples from the past which could inform this direction. Our existing health and disability system is grounded in values and principles of universalism. In the Act –

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<sup>3</sup> Durie M. Understanding health and illness: research at the interface between science and Indigenous knowledge.

<sup>4</sup> Malik A, Lenzen M, McAlister S, McGain F. The carbon footprint of Australian health care. *Lancet Planetary Health* [Internet] 2018; 2(1):e27-35. Available from [https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(17\)30180-8/fulltext](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(17)30180-8/fulltext). Accessed 24 May 2019.

<sup>5</sup> The Royal Australasian College of Physicians. Environmentally sustainable health care – position statement. Sydney: The Royal Australasian College of Physicians; 2016. Available from [https://www.racp.edu.au/docs/default-source/advocacy-library/environmentally-sustainable-healthcare-position-statement.pdf?sfvrsn=2834361a\\_4](https://www.racp.edu.au/docs/default-source/advocacy-library/environmentally-sustainable-healthcare-position-statement.pdf?sfvrsn=2834361a_4). Accessed 24 May 2019.

<sup>6</sup> United Nations. Sustainable Development Goals. [Internet]. New York: United Nations Development Programme; 2015. Available from <https://sustainabledevelopment.un.org/sdgs>. Accessed 25 May 2019.

health was understood as a human right. Ninety-eight years prior in 1840, te Tiriti o Waitangi stated that health is a taonga (treasured thing) that should be protected; reaffirmed tino rangatiratanga (unimpeded authority and self-determination) and promised Māori ōritetanga with British subjects<sup>2</sup>. It is critical to note that a colonial founding document (the Treaty) as well as subsequent legislative instruments (such as the Social Securities Act) derived from the Westminster model have contributed to establishing systems, policies and practices which perpetuate institutional racism and result in worse outcomes for tangata whenua (people of the land).

The 1938 legislation stated health care should be available to all New Zealanders, with no barriers to access; the same standard of treatment should be available to all; the system should emphasise preventive measures rather than a curative focus; and services (namely between primary health and hospital-based care) should be integrated<sup>7 8</sup>. As Robin Gauld notes, these principles are closely aligned with the goals of contemporary health system design today – including from the World Health Organization’s World Health Report<sup>7</sup>. The RACP supports the objectives of universalism, preventive emphasis and integrated health and disability services, and we believe there is value in weaving the original intentions of the Social Security Act into the next iteration of the system.

## **Q2. If you imagined the ideal health and disability system for New Zealand in 2030, how would people’s experience differ from today?**

The RACP supports a vision for a health and disability system which is ideal but not idealised; aspirational but achievable. An ideal system has the potential to positively influence experiences within the system for patients, whānau and the health and disability workforce.

In 2030, people would experience a health and disability system which

- Has ended institutional racism within the system
- Has ended all forms of bias and discrimination which can cause people to disengage with health services
- Values people and their whānau, and places them at the centre of health care
- Is making the best use of technology to support person and whānau-based models of care

Health outcomes are impacted by institutional racism and bias. It is critical for the Review to understand and recognise how institutional racism and bias affect the entire trajectory of a person’s health care journey. Structures established by the dominant or mainstream culture can be, by design, ignorant of the needs of others. How bias manifests and negatively marks people’s experience of the health and disability systems is one facet the RACP wants eliminated from the system by 2030.

### ***Institutional racism***

Institutional racism and bias are, by definition, embedded in our systems, making long-term change difficult and open to complicit or active resistance. Interventions to address racism within systems such as education, health and social services are often limited in their scope, duration and address

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<sup>7</sup> Gauld R. Questions about New Zealand’s health system in 2013, its 75<sup>th</sup> anniversary year. N Z Med J [Internet]. 2013; 126(1380):68-74. Available from <http://journal.nzma.org.nz/journal/126-1380/5775/>. Accessed 24 May 2019.

<sup>8</sup> Gauld R, Atmore C, Baxter J, Crampton P, Stokes T. The ‘elephants in the room’ for New Zealand’s health system in its 80<sup>th</sup> year: general practice changes and ownership models. N Z Med J [Internet]. 2019; 132(1489):8-14. Available from <http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2019/vol-132-no-1489-1-february-2019/7795>. Accessed 24 May 2019.

individual behavioural change and personally-mediated racism rather than enacting structural change. Education alone cannot address structural elements of racism, and positive, constructive change requires holistic thinking, flexibility, engaged stakeholders and a long-term focus<sup>2</sup>.

To decolonise within systems and structures is to actively and intentionally reframe and redesign models to move away from the naturalised dominance of the coloniser's epistemologies and continued denial of Indigenous knowledge systems – to work against institutional and systemic racism. In New Zealand, as in other settler-colonial societies, institutional racism

“...is the outcome of mono-cultural institutions which simply ignore or freeze out the cultures of those which do not belong to the majority. National structures are evolved which are rooted in the values, systems and viewpoints of one culture only”<sup>9</sup>.

The research base exploring Māori patient and whānau experiences of institutional racism in New Zealand is growing<sup>10 11</sup>. This evidence base offers qualitative analysis of the systemic inequities and injustices that result in persistent disparities in health outcomes for Māori. One research paper which highlights whānau experiences of the treatment and management of acute rheumatic fever (ARF)/rheumatic heart disease diagnosis in Northland, repeatedly highlights the racism inbuilt into our existing health system, as well as instances of overt racism from health professionals directed towards whānau. Whānau relate lack of timely access to general practitioners, dismissive attitudes of health care professionals, and delays in diagnosis of ARF, despite meeting guideline criteria for receiving a throat swab to check for Group A Streptococcus. Whānau described feeling discriminated against, and when these experiences compounded across multiple presentations, contributed to their distrust in a system that was not designed to meet their needs, nor the needs of their whānau<sup>12</sup>.

### ***Stigma and bias within health care services***

People, whānau and health care professionals may experience stigmatisation and bias in their interactions with the health and disability system. Addressing stigma is critical to improving access to health care and improving health outcomes. People's experience of the health and/or disability system should be free from implicit or explicit judgement, design or environmental factors that fail to accommodate a person and their needs.

Stigma experienced by people and whānau in the health care system could be towards people's weight or size; diagnosis or condition – particularly mental health conditions, addiction, and infectious

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<sup>9</sup> Paradies Y. Defining, conceptualising and characterising racism in health research. Crit Public Health [Internet]. 2006; 16(2): 143-57. Available from <https://www.tandfonline.com/doi/full/10.1080/09581590600828881>. Accessed 24 May 2019.

<sup>10</sup> Whakauae Research for Māori Health and Development. [Internet] Available from <https://www.whakauae.co.nz/>. Accessed 25 May 2019.

<sup>11</sup> Tōmaiora Māori Health Research Group. Te Kupenga Hauora Māori. [Internet] Faculty of Medical and Health Sciences, University of Auckland. Available from <https://tomaiora-research-group.blogs.auckland.ac.nz/>. 31 May 2019. Accessed 25 May 2019.

<sup>12</sup> Anderson A, Mills C, Eggleton K. Whānau perceptions and experiences of acute rheumatic fever diagnosis for Māori in Northland, New Zealand. [Internet] N Z Med J. 2017; 130(1465):80-88. Available from <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1465-10-november-2017/7411>. Accessed 25 May 2019.

diseases; gender; sexual identity; ethnicity; or socioeconomic status, among other drivers<sup>13 14 15 16</sup>. Moreover, stigma can be intersectional – that is, the convergence of multiple drivers of discrimination in one person’s identity and in turn impact all aspects of health and wellbeing<sup>17</sup>. People who experience stigma in health care contexts may be subject to additional or arbitrary barriers to accessing care; may receive poor quality care, undermining diagnosis, treatment and management; and ultimately can lead to people disengaging from health care systems altogether due to the negative interactions they have experienced.

A recent review of interventions to reduce stigma in healthcare settings found that interventions at the structural level tended to focus on policies, service integration, and changing protection materials or systems (particularly in addressing infection and contaminations stigma). The authors stated that “further investigation of the potential for structural interventions to reduce stigma is needed, particularly around how the physical layout or space within a facility can contribute to, or mitigate, the experience and anticipation of stigma in facilities”<sup>15</sup>.

People with overweight and obesity frequently report experiencing stigma and bias in their interactions with health practitioners, and in health care environments which fail to accommodate them safely, and with dignity<sup>18</sup>. How the health and disability systems accommodate people living with overweight and obesity needs to be addressed, particularly as the prevalence of obesity Class II and III and co-morbid conditions increases over time<sup>19</sup>. People with severe obesity are less likely to engage with health services, and their experiences are often negative because hospital and clinic facilities cannot meet their needs for larger beds, pressure-relieving mattresses, commodes, hoists and other equipment<sup>20</sup>. Ensuring that people’s dignity is maintained through health care interactions is essential, and all health care facilities, regardless of location, should be appropriately resourced to cater for people who may face barriers to quality health care.

### ***Person and whānau-centred care***

Person and whānau-centred care describes a model of care drawing on kaupapa Māori frameworks and values. Whānau-centred care gives meaning to the life of Māori and works against systems and structures which have historically undermined and discriminated against Māori experiences<sup>12</sup>. Whānau-centred care is incorporated in current health and social policy as whānau ora: families

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<sup>13</sup> Olson CL, Schumaker HD, Yawn BP. Overweight women delay medical care. [Internet] Arch Fam Med 1994;3(10): 888-92. Available from <https://triggered.clockss.org/ServeContent?url=http://archfami.ama-assn.org%2Fcgi%2F reprint%2F3%2F10%2F888.pdf>. Accessed 26 May 2019

<sup>14</sup> Earnshaw VA, Quinn DM. The impact of stigma in healthcare on people living with chronic illnesses. [Internet] J Health Psychol. 2012;17(2):157-68. Available from [https://journals.sagepub.com/doi/abs/10.1177/1359105311414952?rfr\\_dat=cr\\_pub%3Dpubmed&url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&journalCode=hpga](https://journals.sagepub.com/doi/abs/10.1177/1359105311414952?rfr_dat=cr_pub%3Dpubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&journalCode=hpga). Accessed 26 May 2019.

<sup>15</sup> Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, McLean R et al. Stigma in health facilities: why it matters and how we can change it. [Internet] BMC Med. 2019; 17(1):25. Available from <https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-019-1256-2#Abs1>. Accessed 25 May 2019.

<sup>16</sup> Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D et al. Evidence for effective interventions to reduce mental-health-related-stigma and discrimination. [Internet] Lancet 2016;387(10023):1123-32. Available from [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00298-6/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00298-6/fulltext). Accessed 26 May 2019.

<sup>17</sup> Turan JM, Elafros MA, Logie CH, Banik S, Turan B, Crockett KB et al. Challenges and opportunities in examining and addressing intersectional stigma and health. Correspondence [Internet] BMC Med. 2019; 17(1):7. Available from <https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-018-1246-9>. Accessed 26 May 2019

<sup>18</sup> The Royal Australasian College of Physicians. Action to prevent obesity and reduce its impact across the life course: Evidence review. Sydney: The Royal Australasian College of Physicians; 2018. Available from <https://www.racp.edu.au/advocacy/policy-and-advocacy-priorities/obesity>. Accessed 25 May 2019.

<sup>19</sup> Ministry of Health. NZ Health Survey: Annual update of key results 2017/2018. Adults: Body size. [Internet] Available from [https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/\\_w\\_0811ceee/\\_w\\_fe42da23/#/explore-topics](https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/_w_0811ceee/_w_fe42da23/#/explore-topics). Accessed 25 May 2019.

<sup>20</sup> Thomas SA, Lee-Fong M. Maintaining dignity of patients with morbid obesity in the hospital setting. Bariatric Times [Internet] 2010; 8(4):20-25. Available from <http://bariatrictimes.com/maintainingdignity-of-patients-with-morbid-obesity-in-the-hospital-setting>. Accessed 26 May 2019.

supported to achieve their maximum health and wellbeing. Whānau-centred care seeks to empower and strengthen individuals and their whānau and rejects modes that perpetuate cultural deficit understandings<sup>21</sup>.

Despite Māori models of health – notably Te Whare Tapa Wha – being widely utilised in policy and service design since the 1980s, the experiences of many whānau in accessing health care, disability support and social services are underscored by institutional racism, bias and stigma. The RACP calls for an approach to person and whānau-centred care that is premised on:

- Whanaungatanga – informed by partnership and connectedness
- Shared decision-making which empowers whānau
- Holistic understand of health and wellbeing based on Māori models of health
- Seamlessly integrated with health, disability and social support services and systems
- Utilising existing models for whānau-centred workforce development, such as Te Hau Mārire: Māori Addiction Workforce Strategy 2015-2025<sup>22</sup>

Te Hau Mārire states that whānau-centred practice encompasses more than just the inclusion of Māori values and practices, and it does not exclude using a wide range of therapeutic tools and approaches. Pōwhiri Poutama, Paiheretia, motivational interviewing and cognitive behaviour therapy can all be utilised within the broader paradigm of whānau-centred practice. Further, screening, brief interventions and referral can all occur within a whānau-centred context<sup>22</sup>.

The potential for improved patient and whānau outcomes through innovative models of care is supported by the evidence base for integrated care – a model which examines and reorients the organisation and delivery of health services to provide coordinated, efficient and effective care that responds to a person's needs. Integrated care involves collaboration and cooperation between providers and services; it is stratified across primary, secondary and tertiary care and extends into the 'medical neighbourhood' of a person or whānau – incorporating primary care providers, specialists, hospital services and allied health providers. Further, we see the move to whānau-centred models of care having a natural analogue in the "third space" of clinician practice – a hospital-devolved setting which has an emphasis on physician practice within communities<sup>23</sup>.

Innovative models of care can be augmented and supported by digital health platforms and systems. The RACP supports the implementation of digital health solutions which eliminate the siloing effect of multiple autonomous IT systems – currently found across District Health Boards, Primary Health Organisations, and other practice management systems used across New Zealand.

By 2030, the RACP envisions a health system which is amplified by digital technology, which includes mobile health (mHealth) and electronic health (eHealth) strategies which have improved network function, public health capability and system integration as priorities. Health technologies have the potential to support models of care which place the person and whānau at the centre of their health care journey, and we see both elements enhancing and reinforcing the other.

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<sup>21</sup> Boulton A, Tamehana J, Brannelly T. Whānau-centred health and social service delivery in New Zealand: the challenges to, and opportunities for, innovation. MAI Journal 2013; 2(1):18-32. Available from [http://journal.mai.ac.nz/sites/default/files/Vol%202%20\(1\)%202024%20Boulton.pdf](http://journal.mai.ac.nz/sites/default/files/Vol%202%20(1)%202024%20Boulton.pdf). Accessed 26 May 2019.

<sup>22</sup> Te Rau Matatini. Te Hau Mārire: Māori Addiction Workforce Strategy 2015-2025. [Internet] Hamilton: Te Rau Matatini; 2015. Available from <https://teora.maori.nz/sites/default/files/The%20M%C4%81ori%20Addiction%20Workforce%20Strategy%202015-2025.pdf>. Accessed 29 May 2019.

<sup>23</sup> The Royal Australasian College of Physicians. Integrated care: Physicians supporting better patient outcomes. Discussion paper. Sydney: The Royal Australasian College of Physicians; 2018. Available from <https://www.racp.edu.au/advocacy/policy-and-advocacy-priorities/integrated-care>. Accessed 26 May 2019.

### Q3. What system level changes would you recommend to improve equity of health outcomes and wellbeing? What impact would you expect these changes to make?

The RACP calls for change at the systems-level that makes health equity the norm. Our 2017 Election Statement called for comprehensive government legislation, strategies and policies to take action on the social determinants of health, which evidence shows have a profound impact on health, education and employment outcomes<sup>24</sup>.

We see the current Review process as an opportunity to make system-level changes:

- Prioritisation of preventive public health
- Integration of health care services into communities through public and active transport links, urban design and therapeutic architecture
- Universal health care for health and wellbeing: addressing unmet need

#### *Preventive-focused*

The intentions of the Public Health and Disability Act 2000, remain, like the 1938 Social Security Act, under-realised. While the Public Health and Disability Act states its objectives are (among others) “to achieve for New Zealanders the improvement, promotion and protection of their health”; as Williams et al find “there has been no agreed core functions framework for public health services in New Zealand”<sup>25</sup>.

The RACP strongly encourages the Review to recommend significant strengthening of New Zealand’s public health infrastructure, its value and visibility within the all sectors of government (not just health) and prioritise a Health in All Policies (HiAP) approach as a method of implementing these goals. The ethos underpinning HiAP recognises that the provision of medical care is a comparatively minor determinant of health – rather, it recognises that health is influenced by a broad range of determinants that exist outside the healthcare remit, which include social, economic, political, cultural and environmental determinants<sup>26</sup>.

A HiAP approach cites ‘health’ as “a key decision-making factor in all areas of policy, by systematically taking into account the health and health-system implications of policy decisions, by seeking synergies between policy portfolios, and by avoiding harmful health impacts, in order to improve population health and health equity”<sup>27</sup>.

As an approach to improve population health and reduce the impact of the social determinants of health, HiAP can make significant contributions to achieving the goals of other government sectors, including improving productivity, education and employment outcomes, and increased workforce

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<sup>24</sup> The Royal Australasian College of Physicians. Make it the Norm: Equity through the social determinants of health. Election Statement 2017. Sydney: The Royal Australasian College of Physicians; 2017. Available from <https://www.racp.edu.au/fellows/resources/new-zealand-resources/new-zealand-election-statement-2017>. Accessed 25 May 2019.

<sup>25</sup> Williams D, Garbutt B, Peters J. Core public health functions for New Zealand. [Internet] N Z Med J. 2015; 128(1418):16-26. Available from <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vo-128-no-1418-24-july-2015/6592>. Accessed 26 May 2019.

<sup>26</sup> The Royal Australasian College of Physicians. Health in All Policies. Position statement. Sydney: The Royal Australasian College of Physicians; 2016. Available from [https://www.racp.edu.au/docs/default-source/advocacy-library/health-in-all-policies-position-statement.pdf?sfvrsn=4bd1391a\\_4](https://www.racp.edu.au/docs/default-source/advocacy-library/health-in-all-policies-position-statement.pdf?sfvrsn=4bd1391a_4). Accessed 26 May 2019.

<sup>27</sup> World Health Organization. Health in All Policies: Framework for country action. Geneva: World Health Organization; 2013. Available from <https://www.who.int/healthpromotion/frameworkforcountryaction/en/>. Accessed 26 May 2019.



participation. The table below identifies four areas of government and the health and societal benefits derived from various interventions:

**Table 1: A cross-government Health in All Policies approach for equitable health outcomes**

<b>Health in All Policies approach</b>			
<b>Public sector focus</b>	<b>Intervention</b>	<b>Health benefits</b>	<b>Societal benefits</b>
Housing	Retrofitted insulation, installation of high-efficiency heating devices	Reduced colds, asthma and respiratory symptoms	Children and adults less likely to be absent from school or work due to illness
Taxation policy	Reduction of Goods and Services Tax (GST) to 10 per cent	People on lower incomes (who are disproportionately affected by GST) will have reduced stress and anxiety	People on lower incomes will have more money to support their families
Climate change	Reducing fare charges on public transport to increase use	More people using mass transit systems, less reliance on cars – can lead to reductions in noncommunicable diseases (NCDs)	Reduced traffic and accidents in urban areas, reductions in greenhouse gas emissions
Food and beverage regulation <sup>18</sup>	Volumetric tax on sugar-sweetened beverages (SSBs)	Reduced SSB consumption reduces risk of obesity and dental caries – particularly in children	Lower rates of childhood obesity lead to lower adulthood obesity and reduced prevalence of (NCDs)

### **Occupational and Environmental Medicine – an opportunity to scale up**

Occupational and Environmental Medicine (OEM) takes a preventive approach to health and safety in the workplace by looking at how a person’s work environment might affect health and wellbeing; and how their health and wellbeing can affect their work<sup>28</sup>. Work and workplaces are an important social determinant of health – it is not simply a matter of being employed or unemployed, but the quality of the work environment (physical and cultural) as well as role aspects which have an impact on our health, and whether we find work meaningful, fulfilling and enjoyable.

Work is increasingly diverse, mobile and demands near-constant engagement from employees. This dynamic can contribute to workers feeling increasingly burnt-out, insecure (in regard to the longer-term viability of their role) and experiencing greater precarity. Additionally, workplace culture – particularly negative factors such as bullying and harassment – can have a profound impact on the health and wellbeing of workers.

Occupational and Environmental Physicians can support individuals, teams, workplaces and companies develop preventive strategies to support the health and wellbeing of workers. The RACP sees OEM as an all-too absent component of our health and disability system, and the System Review presents an important opportunity to implement change.

<sup>28</sup> The Royal Australasian College of Physicians. Australasian Faculty of Occupational and Environmental Medicine. [Internet]. Available from <https://www.racp.edu.au/about/college-structure/australasian-faculty-of-occupational-and-environmental-medicine>. Accessed 29 May 2019.

System-level changes could include

- Building OEM capacity and capability into publicly-funded primary care (referrals for individuals) and public health units (referrals for teams and workplaces) to improve productivity, presenteeism, absenteeism and retention
- Monitoring of occupation-related disease through disease registers for silicosis, asbestosis, and burnout through the Ministry of Health as lead agency<sup>29</sup>
- Include OEM within the Health Workforce directorate of the Ministry of Health to monitor mental health and burnout within the health workforce, and develop strategies to mitigate high rates seen in many professions within the health sector
- Encouraging more widespread use of preventive tools like the psychosocial safety climate to explore the origins of job demands and effects on worker's stress<sup>30</sup>

The RACP sees workplaces as an important venue for health promotion and intervention<sup>24</sup>. Public and private sector workplaces should be encouraged to take a preventive approach to workplace health and safety and the Health and Disability System Review has an opportunity to show leadership.

### ***Equity – address the Social Determinants of Health for Māori***

The RACP acknowledges that the poor health outcomes experienced by Māori are multifaceted and complex, but stem from the intergenerational trauma and compounding inequities wrought by colonisation. Inequities are systemic, avoidable, unjust and unfair, and result in Māori having lower life expectancy: on average, Māori women will die 6.8 years and Māori men 7.3 years sooner than non-Māori, non-Pasifika populations<sup>31</sup>.

A recent study published in the New Zealand Medical Journal has attributed the majority of the gap in life expectancies to avoidable causes of death: between 2013-15, 75 per cent of all deaths for Māori aged 0-74 were potentially avoidable. Further, 28.4 per cent of the avoidable deaths for Māori were preventable and amenable – in other words, comprehensive policies to address the wider upstream social, environmental and economic determinants of health would have prevented mortality; and access to timely, high-quality medical treatment and intervention would have made a difference to amendable mortality rates<sup>32</sup>. The impact of institutional racism will underscore the drivers of preventable or amendable mortality, particularly at the interface with health services<sup>32 33</sup>.

### ***Universal***

An ideal health and disability system in New Zealand would be free. People and whānau accessing primary and secondary health services in their communities would receive the service free at point of use. The system would be free from barriers which currently prevent all New Zealanders from

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<sup>29</sup> World Health Assembly. Burnout an 'occupational phenomenon: International Classification of Diseases. Media release. 28 May 2019. Available from [https://www.who.int/mental\\_health/evidence/burn-out/en/](https://www.who.int/mental_health/evidence/burn-out/en/). Accessed 30 May 2019.

<sup>30</sup> Dollard M, Bakker AB. Psychosocial safety climates as a precursor to conducive work environments, psychological health problems and employee engagement. [Internet] J Occupational Organizational Psychol. 2010; 83(3):579-99. Available from: [https://www.isonderhouden.nl/doc/pdf/arnoldbakker/articles/articles\\_arnold\\_bakker\\_220.pdf](https://www.isonderhouden.nl/doc/pdf/arnoldbakker/articles/articles_arnold_bakker_220.pdf). Accessed 29 May 2019.

<sup>31</sup> Ministry of Health. Ngā mana hauora tūtohu: Life expectancy at birth, by gender, Māori and non-Māori 1951-2013. [Internet]. Available from <https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/life-expectancy>. Accessed 26 May 2019.

<sup>32</sup> Walsh M, Grey C. The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand – a decomposition analysis. N Z Med J [Internet] 132(1492):47-60. Available from

<sup>33</sup> Hurley E. Māori and Pasifika whānau experience racism and 'rough handling' in hospital – study. [Internet] NewsHub. 9 May 2018. Available from <https://www.newshub.co.nz/home/health/2018/05/m-ori-and-pacific-wh-nau-experience-racism-and-rough-handling-in-hospital-study.html>. Accessed 26 May 2019.

accessing timely health services. In 2017/2018, the NZ Health Survey found that more than one in three New Zealanders (31.3 per cent) experienced one or more forms of unmet need for primary health care, with costs, transport and availability of appointments all cited as major barriers<sup>34</sup>.

### ***Unmet need – dental treatment***

The greatest levels of unmet need for adults over 15 years are in relation to dental care: nearly 44 per cent of adults (around 1.6 million people) delayed accessing dental care due to cost in a 12-month period<sup>34</sup>. Oral health is an important indicator of overall health, and socioeconomic factors are strongly correlated with poorer oral health outcomes, including dental caries and periodontal disease<sup>35</sup>. The New Zealand Health Survey 2017/2018 results show that only 46.8 per cent of people over 15 years visited a dental care worker in the previous 12 months, and around 272,000 had one or more teeth removed due to decay, abscess, gum disease or infection during the same period<sup>36 37</sup>.

Interventions which can improve oral health such as community water fluoridation, and preventive measures such as taxes and reduced marketing and availability of sugary drinks will reduce the future incidence of disease at the population level. Improving access to dental treatment across the life course, however, will have a positive benefit for the 53 per cent of New Zealand adults (around 1.9 million people) who will only seek dental treatment when an obvious problem or severe pain arises, rather than seeking regular, preventive check-ups<sup>38 39</sup>.

The RACP strongly encourages the Review panel to consider ways in which to improve the provision of universal dental treatment and care to all New Zealanders. Dental hygiene and oral health has strong associations with mental health and wellbeing: people who cannot communicate, smile or interact with others out of shame of poor oral health are more at risk of depression and anxiety, as well as experiencing chronic pain. An incremental approach, whereby resource is initially focused on communities with the greatest levels of unmet dental need should be implemented before being scaled up over time to cover all New Zealanders over 18 years of age by 2030.

### ***Unmet need – mental health and addiction***

The New Zealand Health Survey 2017/2018 shows statistically significant increases in all mental health indicators except diagnosed bipolar disorder, and a comprehensive survey of mental health and addiction in New Zealand has not been undertaken since Te Rau Hinengaro in 2003/04<sup>40</sup>. The 2018 Government Inquiry into Mental Health and Addiction in New Zealand found significant unmet need across all levels of the mental health and addiction system. Service users, whānau and mental health professionals all expressed concern that many people are unable to access appropriate

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<sup>34</sup> Ministry of Health. NZ Health Survey: Annual update of key results 2017/2018. Adults: Barriers to accessing health care: unmet need. [Internet] Available from [https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w\\_a04772ad/ w\\_cdf1214/#!/explore-topics](https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w_a04772ad/ w_cdf1214/#!/explore-topics). Accessed 24 May 2019.

<sup>35</sup> WHO Oral health fact sheet. [Internet] Available from <https://www.who.int/news-room/fact-sheets/detail/oral-health>. Accessed 26 May 2019.

<sup>36</sup> Ministry of Health. NZ Health Survey: Annual update of key results 2017/2018. Adults Oral health indicators: dental care worker visit. [Internet]. Available from [https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w\\_0811ceee/ w\\_7537bfd5/#!/explore-indicators](https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w_0811ceee/ w_7537bfd5/#!/explore-indicators). Accessed 26 May 2019.

<sup>37</sup> Ministry of Health. NZ Health Survey: Annual update of key results 2017/2018. Adults Oral health indicators: one or more teeth removed [Internet]. Available from [https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w\\_0811ceee/ w\\_7537bfd5/#!/explore-indicators](https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w_0811ceee/ w_7537bfd5/#!/explore-indicators). Accessed 26 May 2019

<sup>38</sup> NZ Health Survey. NZ Health Survey: Annual update of key results 2017/2018. Oral health indicators. [Internet] Available from [https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w\\_0811ceee/ w\\_7537bfd5/#!/explore-indicators](https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w_0811ceee/ w_7537bfd5/#!/explore-indicators). Accessed 26 May 2019.

<sup>39</sup> Jones N. Time for free dental care? Queues at hospital pain clinics as Waitemata DHB backs 'comprehensive' dental service. [Internet] Herald on Sunday 4 March 2019. Available from [https://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=12208822](https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12208822). Accessed 26 May 2019.

<sup>40</sup> Ministry of Health. New Zealand Health Survey: Annual update of key results 2017/2018. Adults: Topic: Mental Health. Available from [https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w\\_0811ceee/ w\\_fe42da23/ w\\_b2bee712/ w\\_63b14c34/#!/explore-topics](https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w_0811ceee/ w_fe42da23/ w_b2bee712/ w_63b14c34/#!/explore-topics). Accessed 27 May 2019.

support, if any, other than medication. It is clear that the existing mental health and addiction system in New Zealand is under severe pressure and is unsustainable in its current form<sup>41</sup>.

The integration of dental services and mental health and addiction services must be examined as part of the Review. Snapshot analysis through the Ministry of Health’s own Annual Survey and qualitative insights gathered through the inquiry process have shown inequities in access to diagnosis, treatment, the provision of culturally appropriate services and health outcomes.

***What impact would these changes make?***

Our response to this question has focused on high-level, system changes to improve equity of outcomes and wellbeing. We recognise that these goals will require the collaboration and participation of everyone – whole of government, and whole of society (including industry, communities and individuals) to make a difference. Table 2 below posits potential outcomes from system-level changes we have proposed.

**Table 2: System changes and potential health outcomes**

System change	Potential health outcomes
Emphasis in public health system is preventive rather than curative	<ul style="list-style-type: none"> <li>• Reduced admissions to hospital</li> <li>• Improved self-rated health scores in national annual Health Surveys</li> <li>• Reductions in noncommunicable diseases</li> <li>• Initiatives outside of the health system are designed to have direct and measurable health benefits – for example, increasing public transport use</li> </ul>
Addressing Social Determinants of Health as a strategic priority	<ul style="list-style-type: none"> <li>• Reductions in poverty and hardship</li> <li>• Improvements in employment, education outcomes, and productivity</li> <li>• Reductions in noncommunicable diseases which have a social gradient</li> <li>• Improvements in self-reported health, mental health and wellbeing</li> </ul>
Dental Services are funded nationally as part of the public health system	<ul style="list-style-type: none"> <li>• Reductions in numbers of prescriptions for chronic pain associated with dental pain</li> <li>• Improved self-reported mental health and wellbeing</li> <li>• Fewer people delay visiting dental care workers</li> </ul>
Mental Health and Addiction services are funded, supported and integrated into the public health system	<ul style="list-style-type: none"> <li>• Reductions in self-reported psychological distress in national annual health survey</li> <li>• Suicide and intentional self-harm rates reduce</li> <li>• Gaps in health outcomes for communities experiencing persistent inequity are closed</li> </ul>

<sup>41</sup> Government Inquiry into Mental Health and Addiction. He Ara Oranga: Report of the Government inquiry into mental health and addiction. Wellington: Government Inquiry into Mental Health and Addiction; 2018. Available from [www.mentalhealth.inquiry.govt.nz/inquiry-report/](http://www.mentalhealth.inquiry.govt.nz/inquiry-report/). Accessed 27 May 2019.

## Q4. What system-level changes would have the most impact on improving health outcomes for Māori?

The RACP recognises health outcomes for Māori have been adversely impacted by the social determinants of health, institutional racism and the intergenerational impacts of colonisation. We support Māori models of health and wellbeing which uphold and build upon kaupapa Māori and tikanga Māori values to empower whānau.

Our submission has outlined a range of system-level changes which would improve health outcomes for Māori:

- Ending institutional racism and bias
- Designing systems and services using tikanga Māori and mātauranga Māori (Māori knowledge) frameworks
- Addressing the social determinants of health
- Embedding references to Te Titiri ō Waitangi in the health system

Beyond these initiatives, the RACP sees increasing the Māori health and medical workforce and eliminating barriers to primary care as system-level interventions which would have positive direct and indirect impacts on Māori health outcomes.

### *Increasing the Māori health and medical workforce*

There are many compelling reasons to promote Māori recruitment, retention and participation in the health and medical workforce. Brown et al identify several opportunities to improve Māori health equity through increasing the Māori health and medical workforce, including:

- Māori health need and the persistent inequities experienced by Māori
- The subsequent gaps in treatment outcomes when compared to non-Māori
- The positive health impacts of ethnic concordance between clinicians, patients and whānau<sup>42</sup>
- Obligations and commitments to Te Tiriti ō Waitangi
- Demand for culturally safe services in mainstream health services which will require kaupapa Māori skills, knowledge and expertise<sup>43</sup>

Although Māori participation in the medical workforce has improved through proactive measures (including targeted admissions programmes at both New Zealand medical schools), Māori representation is still below the population parity milestone of 15 per cent in many medical specialist categories<sup>44</sup>.

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<sup>42</sup> Jansen P, Bacal K, Crengle S. He Ritenga Whakaaro: Māori experiences of health services. [Internet]. Auckland: Mauri Ora Associates; 2009. Available from [http://www.moh.govt.nz/notebook/nbbooks.nsf/0/2A6CAF401ABBEFB9CC2575F4000B6D0C/\\$file/He-Ritenga-Whakaaro.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/2A6CAF401ABBEFB9CC2575F4000B6D0C/$file/He-Ritenga-Whakaaro.pdf). Accessed 27 May 2019.

<sup>43</sup> Ratima M, Brown R, Garrett N, Wikaire E, Ngawati R, Aspin C, Potaka U. Recruitment and retention of Māori in the health and disability workforce. Auckland: Taupua Waiora, AUT University; 2007. Available from [https://www.health.govt.nz/system/files/documents/publications/maori\\_health\\_workforce\\_110708low\\_with\\_cover.pdf](https://www.health.govt.nz/system/files/documents/publications/maori_health_workforce_110708low_with_cover.pdf). Accessed 27 May 2019.

<sup>44</sup> The Royal Australasian College of Physicians. Indigenous Strategic Framework 2018-2028. Sydney: The Royal Australasian College of Physicians; 2018. Available from <https://www.racp.edu.au/about/board-and-governance/governance-documents/indigenous-strategic-framework-2018-2028>. Accessed 27 May 2019.

The RACP is actively undertaking work to grow the Māori medical specialist workforce through our Indigenous Strategic Framework, which will incorporate mentoring programmes, financial support, and provide grants for early-career researchers to undertake Māori health research<sup>44 44</sup>. The Ministry of Health's Workforce and Māori Health Directorates should engage directly with stakeholders including universities, District Health Boards, specialist medical colleges, Te Ohu Rata o Aotearoa and the Medical Council of New Zealand to see how it can proactively collaborate and support strategies within the profession.

There is a clear need for Indigenous data governance to be an integral part of any strategy to increase Māori health and medical workforce participation. Data governance should adhere to Māori data governance frameworks and should be enabled by Māori governance and leadership. A 2012 literature review exploring 'best' practice for recruitment into tertiary health programmes found that quality data is critical to informing strategies across the pipeline of recruitment, retention and completion. This would contribute to building an evidence base to support programmes at further points in specialist training pathways, to ultimately increase the numbers of Māori medical specialists<sup>45</sup>.

### ***Publicly-funded primary care***

Over 1.2 million (31 per cent) New Zealand adults aged 15 years and over experienced one or more forms of unmet primary health care need in 2017/2018. Māori were more likely to report unmet need than non-Māori, and across all sub-indicators exploring unmet need, Māori were significantly worse off than non-Māori, especially for lack of transport and prescriptions remaining unfilled due to cost<sup>46</sup>.

The Review of the Health and Disability System is an opportunity to critically examine whether the existing model of (largely private sector) primary care is the right one for Aotearoa New Zealand. The Review must commit to reform of primary care which centralises equity and removes persistent barriers to quality, timely and accessible health care.

Primary care is provided in New Zealand through a range of organisations including Public Health Organisations (PHOs); general practices; Māori and Pasifika providers; community trusts and voluntary providers. The system can be fragmented, siloed and complicated to navigate for patients and whānau. Fee-for-service and co-payment models remain, meaning it may not be possible to recognise the benefits of innovative integrated care models, particularly in regards to equity, if the existing financial model is not incorporated in Reform conversations<sup>8</sup>.

The RACP supports change to our health and disability system to improve health and wellbeing outcomes for Māori. We believe that

- System-level changes should be co-designed with iwi, Māori health providers, practitioners and consumer representatives
- The social determinants of health must be addressed to support Māori communities and whānau live healthy lives, including
  - warm, dry, safe and affordable housing
  - accessible, affordable and nutritious diets
  - education and employment opportunities

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<sup>45</sup> Curtis E, Wikaire E, Stokes K, Reid P. Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes. [Internet]. *Int J Equity in Health*. 2012; 11(13). Available from <https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-11-13#Sec14>. Accessed 27 May 2019.

<sup>46</sup> Ministry of Health. NZ Health Survey Annual update of key results. Adults: Experienced one or more forms of unmet need for primary health care in the past 12 months. [Internet] Available from [https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w\\_0811ceee/ w\\_3d8f37f8/#/explore-indicators](https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/ w_0811ceee/ w_3d8f37f8/#/explore-indicators). Accessed 28 May 2019.

- Tikanga Māori, mātauranga Māori and kaupapa Māori values must be foundational to reduce institutional racism and enable culturally safe services
- Whānau Ora models of engagement with whānau and services should be prioritised
- The principles of Te Tiriti o Waitangi inform every aspect of governance, strategy, design, development, implementation, evaluation and monitoring of Māori health
- Growing and strengthening the Māori health and medical workforce is an essential element of Māori health equity.

## Q5. What system-level changes would have the most impact on improving health outcomes for Pasifika?

The RACP acknowledges the long history of New Zealand and the Pacific Islands, which reinforces New Zealand's own identity as a collection of islands in the Pacific Ocean. New Zealand's relationship has grown and evolved since the Empire-building projects of Britain; through the independence movements of Samoa and Fiji; ongoing interaction with the Kingdom of Tonga; and through Pasifika migration to Aotearoa New Zealand in the second half of the 20<sup>th</sup> century.

In 2013, 7.4 per cent of the New Zealand population (around 295,000 people) identified with at least one Pacific ethnicity, and two-thirds were born in New Zealand. A diverse and young population, just over 46 per cent of Pasifika are under 20 years old. By 2026, Pasifika will be around 10 per cent of the population, and currently the overwhelming majority (over 90 per cent) live in the North Island<sup>47</sup>.

The RACP recognises that 'Pasifika' and 'Pacific' peoples are umbrella terms which fail to convey the heterogeneity and diversity among Pacific ethnicities. There are more than 40 different Pacific ethnic groups in New Zealand; while the majority of Pasifika will identify with Samoan, Cook Islands Māori, Tongan, or Niuean ethnic groups, each with their own language, cultural traditions and history<sup>48</sup>.

The history of Pasifika in New Zealand, particularly in the second half of the 20<sup>th</sup> century, is a narrative plotting increased inequities and disparities in health outcomes. Adverse outcomes are directly and indirectly influenced by the social determinants of health which in turn were and are driven by neo-liberal political ideology. Many Pacific people migrated to New Zealand for jobs in manufacturing and service industries – when these factories were closed through reform policies in the 1970s and 1980s, this led to increased economic and social pressures on Pasifika families.

Overcrowded living conditions and limited resources have contributed to Pasifika families experiencing greater levels of poverty and material hardship than non-Pasifika families, resulting in poor health outcomes across a number of indicators. Pasifika children are more than 50 times more likely than NZ European children, and twice as likely as tamariki Māori, to be admitted to hospital with acute rheumatic fever; and four and a half times more likely to be admitted to hospital with a serious skin infection than NZ European children<sup>48</sup>. Pasifika adults are over represented in noncommunicable diseases, with type-2 diabetes, gout, ischaemic heart disease, and mortality rates from a number of forms of cancer higher than in NZ European groups<sup>48</sup>.

<sup>47</sup> Statistics New Zealand. Major ethnic groups in New Zealand. [Internet] Wellington: Statistics New Zealand; 2015. Available from <https://www.stats.govt.nz/infographics/major-ethnic-groups-in-new-zealand>. Accessed 30 May 2019.

<sup>48</sup> Ministry of Health. Pacific health: Tagata Pasifika in New Zealand. [Internet] Wellington: Ministry of Health; 2014. Available from <https://www.health.govt.nz/our-work/populations/pacific-health/tagata-pasifika-new-zealand>. Accessed 28 May 2019.

The RACP supports change to our health and disability system to improve health and wellbeing outcomes for Pasifika. We believe that

- System-level changes should be co-designed with Pasifika health providers, practitioners and consumer representatives
- The social determinants of health must be addressed to support Pasifika families and communities live healthy lives, including
  - warm, dry, safe and affordable housing
  - accessible, affordable and nutritious diets
  - education and employment opportunities
- The significance of the Church in Pasifika cultures as a locus for community should be acknowledged
- The heterogeneity of Pasifika in Aotearoa New Zealand should be celebrated
- Strengths-based values drawing on community, collectivist and family ways of being are important to end institutional racism and enable culturally safe services
- Whānau Ora models of engagement with Pasifika and services should be prioritised
- Growing and strengthening the Pasifika health and medical workforce is an essential element of Pasifika health equity.

## **Q6. What system-level changes would have the most impact on ensuring that disabled people have equal opportunities to achieve their goals and aspirations?**

The RACP supports the vision and goals of the New Zealand Disability Strategy 2016-2026 – that New Zealand is a non-disabling society where disabled people have the opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen<sup>49</sup>. We support the framing of non-disabling as used by the Office of Disability Issues: rather than seeking to ‘enable’ disabled people to negotiate barriers in society, these barriers should be removed entirely. Our College sees this as an equity-based approach to disability.

Disabled people are more vulnerable to inequities caused by the systems and structures within our society and the social determinants of health than their non-disabled peers<sup>1 50</sup>. Disability covers intellectual, physical, mental and sensory disability; and within these broad categories is a spectrum of need meaning that disabled people may need more or less support depending on their level of impairment. Disability can be congenital or acquired – it impacts people across all stages of the life course, which may also affect how support is made available.

The barriers and inequities disabled people experience in accessing safe, quality affordable housing, education, health care, employment opportunities, civic engagement and participation will vary according to their impairment: it is essential that with a vision to be a non-disabling society, New Zealand’s health and disability system is foundational to eliminating barriers, increasing access to a wide range of services.

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<sup>49</sup> Office for Disability Issues. New Zealand Disability Strategy 2016-2026. [Internet] Wellington: Office for Disability Issues; 2016. Available from <https://www.odi.govt.nz/nz-disability-strategy/>. Accessed 27 May 2019.

<sup>50</sup> Welfare Expert Advisory Group. Whakamana Tāngata: Restoring dignity to social security in New Zealand. Report of the Welfare Expert Advisory Group. [Internet] Wellington: Welfare Expert Advisory Group; 2019. Available from <http://www.weag.govt.nz/weag-report/>. Accessed 27 May 2019.



Many of the inequities in entitlement levels arise from differing approaches and understanding of disability, particularly in how sudden onset disability (for example, following an accident) is compensated differently to disability which is not caused by an accident. Taking a global view of disability is critical to understand the relationships and entitlements available through different agencies.

Disabled people have the right to the highest attainable standards of health and wellbeing in Aotearoa New Zealand. The RACP recognises that an effective health and disability system for disabled people will:

- Treat disabled people with dignity and respect
- Remove barriers to equitable timely access to all health services – not just those associated with a disabled person’s impairment
- Take a life course approach to disability, supporting disabled people at all points but including particular emphasis on childhood and young adulthood, and older age
- Embed collaborative practices between agencies and departments, and instil a culture of leadership and accountability
- Ensure diverse consumer voices are empowered to contribute to disability system reform and service design, development, implementation and monitoring
- Be culturally safe for Māori and Pasifika, who experience disproportionately higher rates of disability
- Empower disabled people and support their autonomy to make choices about their health, wellbeing and the services they receive
- Ensure that financial support received through any agency across the health and social sector is equitable and reflects the actual costs of having a disability.

We see significant opportunities to improve support for disabled people in relation to education and employment. The RACP strongly believes that Good Work is good for health and wellbeing: good work is fair, safe and free of precarity. It fosters wellbeing, personal growth, fulfilment, autonomy and meaning<sup>51</sup>.

- Disabled people should be able to earn at least the full-time minimum weekly wage before any abatements affect benefit entitlement
- People receiving the Support Living Payment who are not blind should have abatement rates aligned with that of people who are blind, to address the current inequity
- Employment opportunities should be empowering and meaningful, and remuneration should contribute to disabled people being able to participate in community and live with dignity.

The existing disability support system is fragmented, siloed between departments and agencies with little clarity or transparency. It is often difficult to identify a lead agency within the system. Significant and wide-ranging reform is needed in the disability system. The RACP strongly supports the inclusion of the Welfare Expert Advisory Group’s 2019 recommendations in the Review process<sup>50</sup>.

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<sup>51</sup> The Royal Australasian College of Physicians Australasian Faculty of Occupational and Environmental Medicine. Realising the health benefits of good work consensus statement. Sydney: The Royal Australasian College of Physicians. Available from [https://www.racp.edu.au/docs/default-source/advocacy-library/afoem-realising-the-health-benefits-of-work-consensus-statement.pdf?sfvrsn=baab321a\\_14](https://www.racp.edu.au/docs/default-source/advocacy-library/afoem-realising-the-health-benefits-of-work-consensus-statement.pdf?sfvrsn=baab321a_14). Accessed 29 May 2019.

## Q7. 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?

Improvements in equitable health outcomes require investment, resources and commitment. Poor health and wellbeing outcomes arising from inequities (which are frequently persistent, unjust and unfair) – the ‘wicked problems’ often characterised as complex and difficult to solve – require systems change. Dr Heather Came writes “systems-change is an iterative process that involves cycles of defining and expressing the problem, investigating its causes and developing, revising, implementing and evaluating interventions. This cycle is led by a change team and is supported by socio-political education and, ideally, political will”<sup>52</sup>.

Delivering improvements in equity will take a whole-of-society approach: equitable health outcomes are not predicated on equal access to care. For outcomes to be equitable it will require *more* resources to be made available to some groups in a way that is more effective to deliver the outcomes and improvements. Locally, the RACP sees opportunities to learn from successes in immunisation coverage, and in the innovative Whānau Ora model (table 3).

At a higher systems-level our members cite the Scandinavian countries (Denmark, Sweden, Norway, Iceland and Finland) as international examples of health and social systems which could be emulated in Aotearoa New Zealand. The social democratic political regime of Scandinavian nations promotes social equality through a redistributive social system, which in turn promotes an equality of the highest standards, not an equality of minimum needs<sup>52</sup>. Scandinavian countries emphasise the civic role of the State in facilitating quality of life and wellbeing among its citizens. State-supported parental leave, early-childhood care and education are core components of Scandinavian social policy, which is underpinned by acknowledgement that structured system-level investment in children and childhood yields long-term benefits.

**Table 3: Successful New Zealand initiatives**

Initiative	Why did it work?	How can it continue to deliver improvement?
Childhood Immunisation <sup>53</sup>	<ul style="list-style-type: none"> <li>National childhood immunisation targets aimed to improve New Zealand’s low childhood vaccination rates</li> <li>Barriers to accessing health care were addressed, especially transport, cost, language, health literacy, community engagement</li> <li>Misinformation about vaccination was mitigated through proactive</li> </ul>	<ul style="list-style-type: none"> <li>Preventive public health initiatives should be multidisciplinary and premised on engagement and collaboration with community groups – especially if there are priority populations involved</li> <li>Design and develop overarching principles to enable the intervention to be easily tailored for different priority groups, but maintain messaging</li> <li>Continue to promote and promulgate evidence-based communications which can</li> </ul>

<sup>52</sup> Bambra C. Health inequalities and welfare state regimes: theoretical insights on a public health ‘puzzle’. [Internet] J Epidemiol Community Health 2011; 65(9):740-5. Available from <https://jech.bmj.com/content/65/9/740.long>. Accessed 30 May 2019.

<sup>53</sup> Best Practice Advocacy Centre. Immunisation in Pacific children: a success story. Best Practice Journal [Internet]. 2010; 32. Available from <https://bpac.org.nz/BPJ/2010/November/immunisation.aspx>. Accessed 29 May 2019.

	communication with parents and caregivers	maintain currency with anti-vaccination material
Whānau Ora <sup>54</sup>	<ul style="list-style-type: none"> <li>• Strengths-based, integrated model which is reflective of and responsive to Māori ways of doing and being</li> <li>• Whole of government commitment to Whānau Ora approach but lead by Te Puni Kōkiri, not the Ministry of Health or Ministry of Social Development – Māori leadership is integral</li> </ul>	<ul style="list-style-type: none"> <li>• Look for greater opportunities to promote the Whānau Ora model to whānau who could benefit from its holistic approach</li> <li>• Commit funding and resources to research Whānau Ora outcomes to build the evidence base – demonstrate that the framework is leading to transformative change for Māori and Pasifika whānau</li> </ul>

## Q8. What are the top priorities for system level change that would make the biggest difference to New Zealanders?

System-level change to prioritise equity of health-outcomes will be shaped by societal mandate, and political will. Implementing policies aimed at reducing social inequalities and addressing the social determinants of poor health outcomes will have a salutary effect on population health, and research shows that health indicators such as infant mortality are better in countries which have been governed by pro-redistributive political parties<sup>55</sup>.

The RACP believes that to make health equity the norm, system-level change is urgently needed. The following is not an exhaustive list of priorities, but our College sees the evidence for those stated below as significant and recommend urgency in these areas. We call for

1. Tikanga Māori, mātauranga Māori and kaupapa Māori to be embedded into our health and disability system at every level to improve cultural safety
2. Whānau Ora and whānau-centred models of integrated care to be the norm
3. The social determinants of poor health to be addressed as a priority
4. Barriers to accessing health care, disability and social support for Māori, Pasifika and people on lower incomes to be eliminated
5. A Health-in-All Policies approach to be embedded across government, enabling policy change to improve health and wellbeing through public transport, redistributive taxation strategies, housing and action on climate change
6. Māori and Pasifika health and medical workforces to be increased

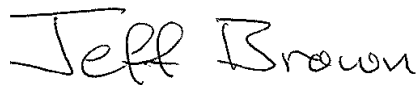
<sup>54</sup> Te Puni Kōkiri. Whānau Ora. [Internet]. Available from <https://www.tpk.govt.nz/en/whakamahia/whanau-ora>. Accessed 30 May 2019.

<sup>55</sup> Navarro V, Muntaner C, Borrell C, Benach J, Quiroga A, Rodriguez-Sanz M et al. Politics and health outcomes. [Internet] Lancet 2006;368(9540):1033-37. Available from <https://www.sciencedirect.com/science/article/pii/S0140673606693410>. Accessed 30 May 2019.

7. Accept and implement the recommendations for structural and systemic change arising from the reports of the Welfare Expert Advisory Group, the Inquiry into Mental Health and Addiction Panel and the Tax Working Group

The RACP thanks the Health and Disability System Review for the opportunity to provide feedback on this consultation and looks forward to the interim Report. To discuss this submission further, please contact the NZ Policy and Advocacy Unit at [policy@racp.org.nz](mailto:policy@racp.org.nz).

Nāku noa, nā

A handwritten signature in black ink that reads "Jeff Brown". The signature is written in a cursive, slightly slanted style.

Dr Jeff Brown  
New Zealand President  
**The Royal Australasian College of Physicians**