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The Royal Australasian College of Physicians' briefing to the incoming Minister

Whiringa-ā-Rangi 2020
November 2020

Kupu whakataki | Introduction

He aha te kai ō te rangatira? He Kōrero, he kōrero, he kōrero
What is the food of the leader? It is knowledge. It is communication

Congratulations on your appointment as Minister of Health. This briefing paper covers the Royal Australasian College of Physicians' (RACP) priorities for health equity and system reform in Aotearoa NZ.

About the RACP

The Royal Australasian College of Physicians (RACP) is the professional medical college of over 17,000 physicians and 8,000 trainee physicians, often referred to as medical specialists, in Australia and New Zealand. In New Zealand, the RACP represents over 2,000 physicians and paediatricians, and over 1,000 trainees.

The RACP trains physicians in more than 33 medical specialties, including paediatrics and child health, internal medicine, respiratory medicine, neurology, oncology, dermatology, rehabilitation medicine, occupational and environmental medicine, addiction medicine, sexual health medicine, public health medicine and palliative care medicine.

Beyond the drive for medical excellence, the RACP is committed to advocating for health and social policies which bring health equity and vital improvements to the wellbeing of patients and populations.

Health equity: #MakeItTheNorm

Good health is dependent not only on a sustainable, equitable health system and culturally-safe workforce, but the wider conditions in which we are born, grow, live, play, work and age: the social determinants of health. These conditions affect the health outcomes of children, young people, adults and older people, including their wider whānau.

Tamariki like Nina, age four and living in a crowded house, whose strep throat infection has developed into rheumatic fever.

People like Mark, a 47 year-old father of two, who works a physically-demanding job as a cleaner for minimum wage and is struggling with addiction.

And Maria, aged 21, whose baby was stillborn due to undiagnosed syphilis.

The common threads weaving these outcomes together is that they are the result of systemic inequity and are influenced by the social and economic determinants of health; but most importantly, they are preventable if Aotearoa works together to make health equity the norm.

Doctors prescribe medicines to treat or manage acute or chronic health conditions, but what we know will make the greatest difference to the health and wellbeing of people and whānau is a prescription for change to the social determinants.

The RACP sees this prescription for the health of Aotearoa NZ in the words of Prime Minister Norman Kirk:

> *"People want somewhere to live, someone to love, something to do and something to hope for"*

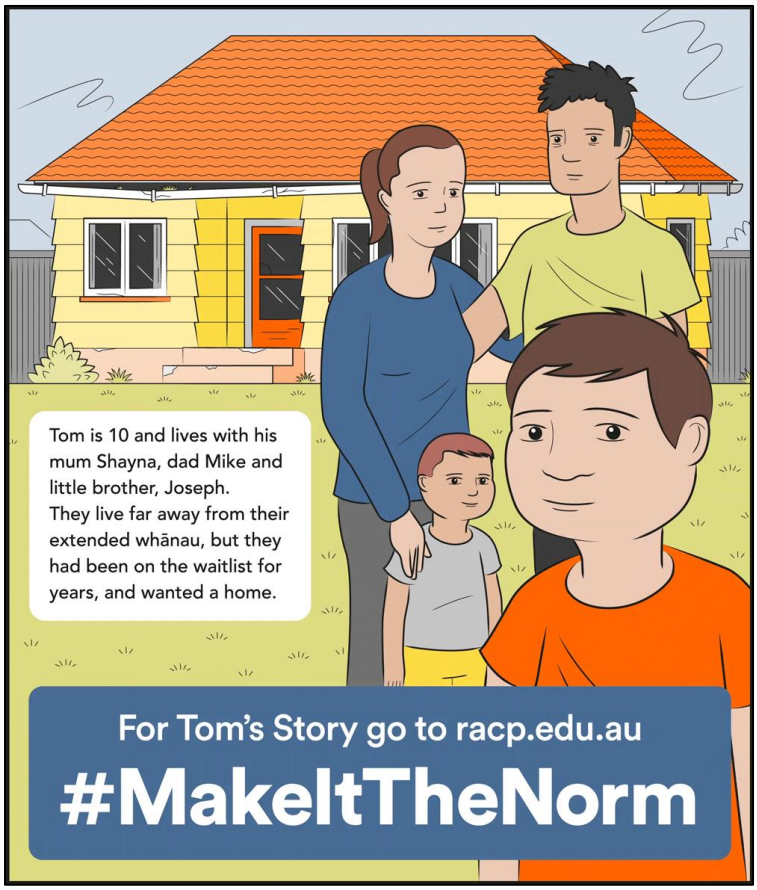
Through our campaign #MakeItTheNorm, we call for healthy housing, good work, whānau wellbeing and health equity to be the norm for all people in our nation.

There must be a change of the conditions that make health fail in the first place. Every day in clinics and on the wards in our hospitals, we see the harm caused by cold, mouldy and damp housing; by whānau living on subsistence incomes; by unsafe and precarious jobs – and most perniciously, by inequity – the uneven access to resources that leads to avoidable and unjust loss of health.

When the distribution of resources is uneven, adverse health and social outcomes are disproportionately experienced by people and whānau who are at the lower end of the health and resources gradient. They are more likely to experience barriers to health, compounded by the traumatic legacy of colonisation and racism within our health and social systems.

We see an urgent need to take decisive, pro-equity action to build a system that responds to the health needs of Aotearoa; but also to cast forward and commit to sustainable change that addresses inequity and meets our climate challenges.

Our vision for 2040 – the year Aotearoa will commemorate 200 years since the signing of Te Tiriti o Waitangi – sees all New Zealanders thriving in warm, dry and safe housing; all work (including unpaid work) is valued; and health services are equitable and accessible, delivered by a sustainable health system with Te Tiriti at its heart.



Our College wants healthy housing, good work, whānau wellbeing and health equity to be the norm in Aotearoa NZ.

This animation tells the story of Tom and his whānau, and how housing, work, learning, health and wellbeing are all intertwined.

See it at https://www.racp.edu.au/advocacy/make-it-the-norm/toms-story

Our recommendations to realise this vision include

Make Healthy Housing the norm

→ Bring forward Kāinga Ora compliance with Healthy Homes Standards to July 2022
→ Interest from Residential Tenancies bonds are invested in Tenancy Advocacy services
→ All new public housing is built to universal design standards

Make Good Work the norm

→ Changes to social security legislation to enact the principles under Te Tiriti o Waitangi, and enable dignified lives; including raising main benefit levels and abatement rates, reforming relationship clauses and Working For Families so that it is fit for Aotearoa in the twenty-first century
→ Double mandatory available sick leave to 10 days; allow for use if dependents are unwell, for example half days, or allowing advance use/carrying over allocations into following years
→ Policies and programmes actively support the importance of unpaid work, which is valued as a productive and net benefit to societal wellbeing

Make Whānau Wellbeing the norm

→ Whānau experiencing family violence have access to wraparound support to assist with health, counselling, and accessing the justice system
→ Primary mental health and wellbeing initiatives must be implemented as a priority, especially in the wake of COVID-19
→ The marketing and advertising of unhealthy foods are centrally regulated
→ Recommendations of the Law Commission's 2010 Review of alcohol legislation are revisited

→ Harm reduction and health-centred approaches to addiction
→ No advertising or marketing of payday and high-cost lenders on TV, radio, print or Internet

Make Health Equity the norm

→ Health resources must be prioritised according to equity and need, delivered by a culturally safe and pro-equity health system
→ People who experience long-term conditions and/or disabilities are supported to enjoy a good quality of life
→ Establish an independent public health agency

Hauora Māori me Ōritetanga | Māori health and equity

"*It is not sufficient to aspire only to reduce Māori health disparities along with other sections of the New Zealand population when the Crown is fully aware that, overall, Māori suffer from the worst health status of any population group in New Zealand*"

Waitangi Tribunal, *Hauora*

Our health system must be avowedly and unapologetically pro-equity and anti-racist, and the Articles of Te Tiriti set the direction.

In 2019, the RACP welcomed the refresh of He Korowai Oranga, and the incorporation of five principles (Tino rangatiratanga, options, equity, active protection and partnership), as the Three Ps are no longer fit for purpose. We see these principles as guiding the total programme of health reform in Aotearoa NZ, because the existing health system does not currently deliver equitable outcomes for whānau Māori. Nor does it operate consistently with Te Ao Māori, mātauranga Māori or tikanga Māori because it was never designed in this way. Retrofitting and adapting a system that was premised on, and maintained, a deficit approach to tangata whenua will not deliver health equity or close the average 7-year gap in life expectancy between Māori and non-Māori.

The Wai 2575 inquiry findings – both published and forthcoming – set a wero for the Government. The *Hauora* report was unequivocal in its castigation of a system which has failed to protect Māori health – and in many instances, actively harmed it. The Waitangi Tribunal found that the Crown breached Te Tiriti o Waitangi principles of partnership, active protection, equity and the duty of good governance.

RACP Indigenous Strategic Framework 2018-2028

The RACP's Indigenous Strategic Framework (ISF) establishes Indigenous health and education as core business of the College across advocacy, education and training, continuing professional development, organisational cultural safety and the requirements of the regulating authorities.

In Aotearoa NZ the RACP is prioritising action on the social determinants of health; increasing the Māori and Pasifika medical workforce; and strengthening the cultural safety within the Pākehā and tauiwi workforce.

Growing the numbers of Māori and Pasifika medical graduates is critical to the future of the health system – not only to improve whānau experience and outcomes, but to shift the dominant framing of

the health system from one rooted in Western biomedical paradigms to one founded on Te Tiriti, embedding mātauranga Māori, and premised on person and whānau-centred models of care.

Ōritetanga means extending the age range for Māori and Pasifika in the National Bowel Cancer Screening Programme

The existing Bowel Cancer Screening Programme (BCSP), which continues its implementation nationally, screens people for colorectal cancers between the ages of 60 and 74. The RACP sees the failure of the Government to screen Māori and Pasifika from age 50 as active inaction in the face of profound need and persistent inequity in cancer outcomes.

- 50 per cent of colorectal cancers in Māori will be diagnosed before age 60, and 30 per cent of these diagnosed before age 50
- Māori and Pasifika are less likely to receive access to timely, quality care and treatment for colorectal cancers (REF HQSC)
- Socioeconomic inequity and poverty are causatively associated with poor cancer outcomes for Māori – around half of all health inequity is directly attributable to the impact of the social determinants of health

The evidence is there. Extending the screening age range to 50 for Māori and Pasifika will make a tangible difference to whānau Māori: cancers can be detected, diagnosed and treated, and people can recover to spend more time with their whānau.

The RACP calls on the incoming Minister to take immediate, pro-equity action by extending the age to 50 for Māori and Pasifika in the existing and scheduled roll out of the BCSP.

Māori health equity is health system reform

"Mana Motuhake is the critical change that is urgently needed. Mana Motuhake means Māori determination and funding of health services for whānau, hapū and iwi".

RACP Aotearoa NZ President Dr George Laking

In 2019 the RACP made a submission to the Māori Affairs Select Committee's Inquiry into Māori health inequities, concluding that

1. the solution for Aotearoa NZ must begin with Te Tiriti o Waitangi
2. a person is never separate from their whānau, and further is never alone from the significance of place, of land, of landscape
3. Māori doctors and health practitioners must be part of the solution
4. The environment of training and practice will define performance – safe systems not only mediate unsafe practitioners but make it challenging for these practitioners to continue to function in biased, discriminatory ways

Pro-equity actions are indivisible from health reform. The series of Inquiries and reports commissioned by the previous government, most notably the Health and Disability System Review chaired by Heather Simpson, constitute a platform for widespread change in the health sector. Equity for Māori must be the outcome regardless of whānau entry into or pathway through the health system.

> *"System-level change to prioritise equity of health outcomes will be shaped by societal mandate, and political will … To make health equity the norm,* ***system-level change is urgently needed****."*
>
> *RACP submission to the Health and Disability System Review*

The RACP's submission to the Health and Disability System Review stated calls 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
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 looks forward to engaging further with this significant programme of work throughout this government term and contributing to shaping a health system that meets the needs of Aotearoa NZ.

The two-tiered system for disability

"The lines of demarcation that were drawn in the current legislation are technical, difficult and sometimes unfair"

Sir Geoffrey Palmer

Our disability system is premised on a profoundly inequitable and arbitrary distinction: the origin of the illness, condition or injury that has caused the long-term disability.

For people and whānau with physical, intellectual and/or sensory conditions, the Ministry of Health's Needs Assessment and Service Coordination (NASC) process is the pathway available; while for people injured through accidents at work or recreationally the Accident Compensation Scheme through the Accident Compensation Corporation (ACC) meets their ongoing costs.

The primary distinction between the two systems is played out through levels of funding, resource and support.

While our system must recognises that illness, disability or accident is rarely the “fault” of a person, the roll of the genetic dice should not leave people and whānau at significant disadvantage because ACC is far more generous than what is funded by the Ministry of Health. For example, A 55 year-old woman cannot carry out everyday household tasks or work due to debilitating symptoms of multiple sclerosis. She receives three hours a day of in-home help, but a person incapacitated to the same degree could receive 24/7 care if funded through ACC.

Rehabilitation services

There are fewer rehabilitation centres in Aotearoa NZ now than there were 25 years ago. Few critical health care services have regressed through successive funding failures to the extent that rehabilitation services have. Examples of current challenges include:

- Stroke survivors, amputees, patients with a range of neurological conditions such as Gullian-Barre or those with non-traumatic brain injury who are under the age of 65 years have to be transferred to a geriatric ward because there is no specialist rehabilitation medicine units to monitor and manage their medical care.
- A teenager with spina bifida who is turning 18 years old and needs transitioning from paediatrics to adult services will not receive the care she needs. She has complex needs and these are well-coordinated by the paediatrics spina bifida service, but no such service is in place for adults.
- The absence of any transitional service for paediatric patients with chronic health conditions such as stroke, amputee and other neurological conditions is evident nationwide.
- The need to nationally recognise the importance of supporting and developing trauma, amputee, cancer and bariatric rehabilitation pathways.

Māori and Pasifika peoples are more likely to experience stroke at younger ages than other population groups. Without appropriate rehabilitation and respite care, many of these younger people are faced with aged residential care. Rest home care for survivors of stroke in their thirties, forties and fifties cannot be the solution for these whānau. Enabling people to be in their own homes must be the gold standard.

For equitable health outcomes to be the norm, the original vision for ACC must be realised: a unified system covering disability irrespective of cause, funded at equitable rates, for the life of the person.

Health workforce

The reintegration of Health Workforce as a Ministry of Health directorate has, understandably, taken some time to re-establish within the machinery of the Ministry. However, we contend that the Ministry's interest and oversight of Health Workforce has remained short-sighted, irrespective of its operational arrangements.
The RACP would welcome constructive, open and strategic engagement with the Minister and the Ministry on workforce matters. It takes at least 13 years of post-secondary education and training to produce a medical specialist. The training 'pipeline' from medical school through to district health boards and/or community settings should be viewed as a continuous pathway with multiple interested parties, rather than a series of disconnected stages.

The workforce pipeline is important because there are a multitude of challenges in planning for and building a sustainable health workforce. These include an ageing population, increasing rates of complex and comorbid conditions, an ageing specialist workforce, and the new environment wrought by COVID-19.

The average age of a medical specialist is now nearing 60. Although numbers of house officers entering specialist training programmes continues to increase, there is concern at the capacity of the senior specialist workforce to train the numbers of specialists required to mitigate senior doctors retiring, particularly in regional centres. Consequently, demands placed on senior clinicians continue to grow, with rates of burnout, and poor mental and physical wellbeing many times higher than other sectors.

Medical recruiters are reporting extremely high interest from overseas-trained doctors and nurses in relocating to Aotearoa NZ in response to COVID-19. While overseas-trained specialists and international medical graduates have long been a mainstay of the health workforce, the short and long-term impacts of the pandemic are unknown. Workforce shortages may be particularly pronounced in areas like aged care, nursing and mental health, addiction, and disability support.

Prior to the onset of the pandemic, the Association of Salaried Medical Specialists (ASMS) estimated that one in every four public hospital specialists were looking to leave their roles within the next five years. ASMS have projected marginal net gains of fewer than 10 doctors when numbers of incoming medical graduates are compared to senior doctors retiring.

There are important links between workforce planning and strategy and Māori health equity, particularly in relation to cultural safety. Te Kaunihera Rata o Aotearoa, the Medical Council of New Zealand has championed work in this area for medical practitioners, joining the Nurses Council who have embedded cultural safety as a cornerstone of best practice for over a decade. The RACP is working to embed cultural safety across its training curricula and continuing professional development programme to ensure our members have the knowledge, attitudes and skills to critically reflect on their own biases, understand their power and privilege and support equitable health outcomes for whānau Māori.

Congenital syphilis: workforce gaps have a knock-on effect

Aotearoa NZ has seen a dramatic rise in the prevalence of infectious syphilis in the past decade, and in the last 5 years increasing rates of congenital infection. Tragically, these congenital cases have resulted in 6 stillbirths since 2016.

Congenital syphilis has been eliminated in Cuba and Malaysia. It is unacceptable that Aotearoa NZ continues to tolerate the incidence of this preventable disease which can have such devastating consequences for whānau.

- ***Sustainable workforce***
  In Tāmaki Makaurau Auckland – a city of over 1 million people – contact tracing for syphilis and other sexually transmitted infections is carried out by two nurses, on top of their other duties. Appropriate resourcing to tackle the ongoing syphilis outbreak is urgently needed.

- ***Equitable, safe access to health services must be a priority***
  The Ministry's own NZ Health Survey shows that 1 in every 3 New Zealanders experiences barriers to accessing primary health care, including costs and lack of transport. Anecdotal evidence from clinicians reveals that several pregnant people diagnosed with syphilis had no contact with antenatal maternal care.

- ***Patient education is not the only answer***
  The Ministry's Syphilis Action Plan describes patient education (prevention and health promotion) as a key component of managing the syphilis epidemic. Health promotion and education can only be effective if it is reinforced by other aspects of the system that are informed by evidence and the needs of our communities.

  Health promotion should be driven by aims of equitable outcomes, rather than increasing population 'health literacy'. Assumed attributes like health literacy are reinforced by a health system which is designed to reflect the overtly clinical, individualised expectations of the mainstream.

  Health literacy implies that only those who have acquired the skills to interpret the system should be able to access it — an acknowledgement that bias is inbuilt.

Make Good Work the Norm: Strengthening the links between work, health and safety

The nature of work is changing, and society has shifted to see health and safety as a series of compliance and regulatory exercises rather than a supportive foundation to promote and protect worker's health.

Our campaign #MakeItTheNorm calls for Good Work to be the norm for all New Zealanders. This means acknowledging the strong associations between work and health and wellbeing, and how workplaces can be powerful venue for health promotion. People should be able to go to work and come home safe and healthy.

The scale of accelerated silicosis remains unknown in Aotearoa NZ

Accelerated silicosis is a progressive and aggressive form of silicosis affecting stonemasons and other construction workers exposed to high levels of respirable crystalline silica (RCS) during the cutting, fitting and polishing of engineered stone for benchtops. The most common form of silica is quartz and engineered stone may contain up to 90 per cent silica compared to 25-40 per cent in granite. RCS is classed as a Group 1 carcinogen by the International Agency for Research on Cancer.

Accelerated silicosis develops over a much shorter period of time (1-10 years) than other diseases linked to workplace-related exposure, such as asbestosis and mesothelioma. As such, the rapid onset of significant lung damage has led to silica exposure being termed *"worse than asbestos"* by some physicians, due to the significant social and psychological impacts of disease onset earlier in life.

Worksafe NZ has confirmed that unsafe practices including uncontrolled dry cutting, poor dust control measures, lack of respiratory protective equipment, and the lack of appropriate health monitoring of workers are present in Aotearoa NZ work sites. This shows that a number of worksites do not comply with workplace health and safety regulations for Persons Conducting Business or Undertaking (PCBUs) handling airborne silica dust under the Health and Safety at Work Act 2015.

Accelerated silicosis is fatal without a lung transplant. In Aotearoa NZ, 20 lung transplants were performed in 2018, with an average wait time of 8 months – these numbers are also contingent on the viability of donor organs. In the event that a significant number of cases are diagnosed, the lung transplant system would be placed under monumental stress and likely lead to many patients failing to receive the only known treatment in a reasonable timeframe.

Aotearoa NZ must learn from the Australian experience

In Australia, accelerated silicosis has reached crisis levels. In the last two years, case-finding activities diagnosed 170 cases from approximately 1000 exposed workers: around 1 in every 6 people. Of these 50 had Progressive Massive Fibrosis and will require lung transplants to survive. These workers are very young (predominantly 20-45 years old) and despite their significant disease, almost all thought they were in good health prior to government-funded co-ordinated case-finding activities. Workers' whānau members are also at risk from exposure to RCS, including through use of the same vehicle, handling clothing or direct contact.

Occupational physicians are uniquely placed to support stronger links between health, safety and work. Accelerated silicosis is a particularly acute example of a disease with occupational exposure, and its high mortality rate underscores the imperative for action. Regulation, monitoring and recommendations could be augmented by retaining specialist occupational medicine expertise within Worksafe and within the Ministry of Health, and ensuring that occupation physicians are engaged in proactive case finding activities.

Kupu Whakatepe | Conclusion

Congratulations once again on your appointment as Minister of Health. The RACP would welcome the opportunity to meet with you to discuss the contents of this briefing and our ideas and priorities for the health and wellbeing of all people in Aotearoa NZ. Please contact Charlotte Baird, Aotearoa NZ Manager, Member Services on 04 460 8140 or via email at charlotte.baird@racp.org.nz.

Nā māua noa, nā

Dr George Laking
Aotearoa NZ President
The Royal Australasian College of Physicians

Dr Sandra Hotu
Chair, Māori Health Committee
The Royal Australasian College of Physicians

Attachments

1. Make Healthy Housing the Norm position statements
2. Make Good Work the Norm position statements
3. Make Whānau Wellbeing position statements
4. Make Health equity the Norm position statements