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The Royal Australasian College of Physicians' submission to the Ministry of Health

Well Child Tamariki Ora review
August 2019

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback as part of the Ministry of Health's review into the Well Child Tamariki Ora (WCTO) programme.

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.

The RACP acknowledges the work of its Members in developing this submission, notably Dr Russell Wills, Dr Peter McIlroy, Dr Pat Tuohy, the Aotearoa New Zealand Paediatrics and Child Health Division Committee and the Māori Health Committee.

Key points

- Te Tiriti o Waitangi, te ao Māori values and tikanga Māori practices should be integrated across the programme
- Early engagement and involvement of whānau, hapū and iwi is essential in co-design of interventions and programmes
- Equity programmes should be strengths-based, not perpetuate deficit models
- Data infrastructure must be a priority
- The experiences of parents, caregivers and whānau must be listened to, acknowledged and incorporated into the next iteration of the framework

What would the ideal Well Child Tamariki Ora programme look like?

Summary

- The WCTO programme should embody tikanga Māori (Māori practices) and mātauranga Māori (Māori knowledge).
- Children should be viewed as a part of their unique whānau, whether these are biological relationships or not.
- WCTO must emphasise the needs of the whānau and the needs of the community as this is what will help reduce family violence and realise the potential for integrated services.

An ideal Well Child Tamariki Ora (WCTO) programme would embed tikanga Māori (Māori practices) and mātauranga Māori (Māori knowledge) as foundational principles – namely, an emphasis on Whānau Ora ways of being, doing and service delivery. Principles including whanaungatunga (relationship-building), manaakitanga (kindness), and rangatiratanga (self-determination and autonomy) should underscore the programme, its delivery and how healthcare practitioners engage with whānau to practice in a culturally safe manner.

The name of the programme could be altered, from the current English/te reo of Well Child Tamariki Ora to simply "Tamariki Ora" – in 2019, particularly with the increasing use of reo Māori and visibility of initiatives such as Whānau Ora, these concepts are well-understood. Further, including reference to whānau would give greater significance of the importance of the child within the collective context of its whānau.

An ideal WCTO centralises whānau wellbeing. A child is never in isolation from their whānau – those around them that provide love, care and protection; recognising that this may not always mean biological relationships. In our *Make It The Norm* campaign, we identify Whānau Wellbeing as a key tenet of healthy and well communities contributing to a productive society[1].

An ideal WCTO programme is informed by an awareness of social and community contexts, and is adept at collaboration and integration, with the needs of whānau at the centre. WCTO must emphasise building strong communities, parental and whānau relationships, reducing family violence and realising integrative potential across mental health, addiction services, and social services. Where whānau are in distress, the programme should employ a trauma-informed approach.

Our members agreed the following aspects would be essential from a user perspective as part of an ideal WCTO programme. It is important to recognise that users of WCTO are diverse – incorporating the child, parents, grandparents, siblings, extended whānau and other caregivers to different degrees.

- "The programme is fully integrated with all other aspects of my health user experience, so I don't have to tell my story more than once"
- "There are many ways my voice can be heard and can influence the care my whānau and I receive"
- "I am informed about WCTO services during my pregnancy, know what my options are, have the opportunity to meet with my WCTO provider antenatally if I wish, and I am handed over by my Lead Maternity Carer well before six weeks postpartum"
- "WCTO is provided close to me, in my community or in my home if necessary"
- "The providers reflect the community in which I live, and deliver culturally-safe care"
- "WCTO services are well-connected to other services that are relevant to my needs"

What are your suggestions on how to create an ideal programme?

Summary

- Co-design with whānau, hapū and iwi must be a foundational principle of the programme, embodied from the beginning to the end of the design process, and reflecting the principles of Te Tiriti o Waitangi.
- Existing successes such as in Children's Teams, Strengthening Families and High and Complex Needs should be built upon.
- The system should be standardised and easily interpretable for people from all backgrounds.
- Information should be shared within systems to increase availability of data and streamline processes.

Embedding Te Tiriti o Waitangi

The WCTO programme is co-designed with whānau, hapū and iwi voices from the beginning, not as an afterthought. Engagement with mana whenua and iwi health providers must be a priority to ensure the programme is responsive and relevant to the needs of whānau in any rohe in Aotearoa.

Te Tiriti o Waitangi (the Treaty of Waitangi) is incorporated as an organising framework, embedding the principles of partnership, participation and protection to all aspects of the programme's development, implementation and delivery.

[1] The Royal Australasian College of Physicians. Make it the Norm: Equity through the Social Determinants of Health. 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 22 August 2019.

Integrating user experience

The WCTO programme builds on the successes and strengths of existing multidisciplinary service models including Children's Teams, Strengthening Families and High and Complex Needs.

Needs Assessment processes should be aligned and standardised, to ensure whānau do not have to repeat their stories.

Clinical pathways must be interpretable for healthcare practitioners and provide clarity to whānau around health care journeys and navigating the health system.

Enhancing services through technology

High quality, well-designed information systems can support the delivery of effective and efficient services, for example a shared mobile-based clinical record would empower whānau to provide data at point of contact. Robust information systems and data collection form the foundation of quality data, which in turn contributes to effective interagency clinical governance.

Whānau-centred

Summary

- Not enough distinction is drawn between different degrees of need in the current system. A new intermediate level of need is required to improve whānau experience and outcomes.
- Cultural competence is uneven within agencies, which creates uncertainty and a lack of equity in outcomes.
- There is a need for increased investment to enable WCTO providers to deliver effective and sustainable services which embody these principles.

What is your opinion on the current state? What may be missing? What is working well?

There are limited options for the voice of service users, whānau, hapū and iwi to influence the design, delivery and monitoring of care. It is not clear how these voices lead to change ("You said, we did").

At present the service primarily concentrates on the mother and the baby to the exclusion of fathers, partners, family and non-European cultural family structures. The Whānau Ora approach would move us away from the dominant western dyadic approach towards a more inclusive, whole-of-family approach to whānau ora (family wellbeing). This enables whānau to define themselves in a way that applies to them, rather than conforming to a narrow set of identifiers.

Currently services operate in isolation, meaning whānau are forced to tell their stories many times to many people; visits and appointments aren't co-ordinated across services; there are many plans, rather than a single plan; and clinical governance occurs in isolation rather than as a whole-of-system approach. The rigidity and siloed structure of the current system particularly affects outcomes for whānau with more complex needs.

While there has been an attempt to stratify WCTO clients into high- and low-need, this distinction is insufficient. Specifically, there is a need for a three-tier stratification, to identify whanau with intermediate-level needs greater than low-need whanau, though not at the level of high-need whanau. The current framework allows for more service to those with greater needs (proportionate

universalism) but three tiers with appropriate funding based on the actual costs to deliver high-quality care to each group would improve whānau experience and outcomes, as it has in Healthcare Homes and the Southcentral Foundation's Nuka model of care[2] [3].

While cultural competence has improved over time, it remains variable, which compromises agencies' ability to engage whānau and effect change. The RACP strongly recommends WCTO weaves the language and framing of cultural safety into the next iteration of the programme. Cultural safety centralises the experiences of the person and their whānau, their assessment of the competence and safety of the clinical encounter, and the ability of the healthcare practitioner to critically reflect on their practice, behaviours and biases[4] [5].

There also needs to be more of a community development approach built into the new approach.

To you, what does the desired system look like?

An integrated, community-based programme, delivered by a multidisciplinary team (MDT) of health, education and social service practitioners. The Children's Teams are a model to consider, with representation from a range of professional groups and strong governance which includes iwi Māori as partners. As well as horizontal integration across health and social services, we also need vertical (life course) integration from preconception and maternity and into school-age and youth health.

A true whānau ora approach would identify and address the needs of the whole whānau; although the focus may be on the child, the context of that child's whānau must be considered. The WCTO practitioner must consider the needs of the child in the context of the needs of other whānau members, and to do so effectively requires additional skills and networks. It is unlikely any one individual practitioner could have the skills to meet the needs of more complex whānau; hence the need for a MDT approach.

WCTO practitioners will require a greater level of cultural competence than at present, in order to enable the delivery of culturally-safe care. Partnerships between mainstream providers and kaupapa Māori providers, whānau, hapū and iwi will need to be more developed than presently: engagement should be early in the scoping and development phase, and mainstream services must be cognisant of the need to build in a sustainable relationship involving partnership, participation and protection at each level of programme development and implementation, rather than a one-off encounter or tick-box exercise.

Increased investment from the Ministry of Health is essential to enable all WCTO providers to deliver effective and sustainable services, which promote health and wellbeing for children, parents, caregivers and whānau. *Hauora*, the first report from WAI 2575, the Waitangi Tribunal's Inquiry into health services and outcomes for Māori has starkly depicted the need for Māori to have authority and involvement in how their people access and engage with health services[6]. Enabling kaupapa Māori

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[2] The Royal Australasian College of Physicians. Integrated care: Physicians supporting better patient outcomes. Discussion paper. [Internet] Sydney: The Royal Australasian College of Physicians; 2018. Available from https://www.racp.edu.au/docs/default-source/advocacy-library/integrated-care-physicians-supporting-better-patient-outcomes-discussion-paper.pdf. Accessed 21 August 2019.

[3] Southcentral Foundation. Nuka system of care. [Internet] Available from https://www.southcentralfoundation.com/nuka-system-of-care/. Accessed 21 August 2019.

[4] The Medical Council of New Zealand has recently consulted on updates to its statements "Cultural competence and the provision of culturally-safe care" and "Achieving the best health outcomes for Māori". These will be released later in 2019.

[5] The RACP acknowledges the work of Irihapeti Ramsden in the development of cultural safety and the efforts of the Nursing Council of New Zealand to embed cultural safety as a concept in its standards and competencies.

[6] Waitangi Tribunal. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington: Waitangi Tribunal; 2019. Available from https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/. Accessed 22 August 2019.

healthcare providers to deliver services to whānau is essential. The RACP strongly recommends the findings of this report inform the WCTO review.

What are your suggestions on how to create the desired service?

The RACP recommends the Ministry builds on what is already working well in this space in Aotearoa New Zealand: better integration rather than wholesale reconfiguration is likely to be more effective and achieve more rapid outcomes.

It is important to recognise the strengths of the existing services, which would be expensive to recreate if lost. Plunket for example has, over 100 years, built a robust national infrastructure of frontline clinical skills, leadership, professional development, quality improvement and information technology, and has strong support from communities, business and philanthropy. It would be very costly (tens of millions of dollars) to lose or attempt to recreate this.

Primary and community care for people who are pregnant, infants, toddlers and pre-schoolers must adopt a whānau ora approach. This means investing in cultural safety and partnerships; additional skills; working in multidisciplinary teams; shared information systems including a common clinical record; stratification of the WCTO client group by need; and improved infrastructure and funding to allow these improvements.

Organisational cultures will also need to change. “Us and Them” attitudes and behaviours of many organisations obstruct communication, fragment and impair care and make change difficult. Strong national and local leadership from clinical leaders, managers, service and programme commissioners, and policy makers working collaboratively will be required to overcome these challenges, reduce professional hegemony and grow a willingness to work together for the good of whānau. Continued “Us and Them” attitudes will not inspire and promote organisational cultural change.

Equity

Summary

- Inequities are persistent across all of health and are reinforced by system and organisational structures.
- Conscious action and analysis is required to eliminate institutional problems, and personal biases.
- Cultural competence and cultural safety based out of Te Tiriti o Waitangi should be embedded as minimum requirements for WCTO providers.
- Continued feedback and improvement must be at the forefront of the system.
- The system as it is, is a relic and requires fundamental change to embody tino rangatiratanga, active participation, partnership, and protection. Funding to kaupapa Māori organisations must be guaranteed and secure into the future.

What is your opinion on the current state? What may be missing? What is currently working well?

There are persistent inequities across all areas of health. These are designed and maintained by system and organisational structures, and reinforced by the personal biases of individuals manifested through racism and classism, and other forms of discrimination.

These issues have been well-covered in the Waitangi Tribunal's Wai 2575 *Hauora* report. We support the Tribunal's recommendations, while noting that there must remain options for Māori to access well-funded, culturally safe, mainstream WCTO services if they wish, as many currently do.
The RACP identifies the following steps as essential to promoting equity for Māori, Pasifika and other groups experiencing health inequities as a result of the mainstream system:

- Identify and eliminate institutional structures and systems that perpetuate deficit models and concepts
- Identify, work through and eliminate personal biases which reinforce inequities
- Embed cultural competence and the language of cultural safety as minimum competency requirements for WCTO providers
- Develop programmes and resources which are designed to specifically promote equity through strengths-based approaches built on kaupapa Māori and Te Tiriti o Waitangi frameworks
- Co-design programmes, interventions and service delivery with communities experiencing inequity – this should be active and inclusive partnership, not left to a single individual on an advisory group

To you, what does the desired service look like?

For a parent or caregiver, a safe, fit-for-purpose system would encompass the following characteristics:

- I am informed about the WCTO service early in my pregnancy and have the opportunity to meet my WCTO provider antenatally if I wish
- My information is held safely and securely shared by providers, so I don't have to tell my story many times
- My WCTO team communicate regularly with each other and I have a lead worker/navigator who I can talk to at any time and who coordinates my care, so I can see the practitioners in a coordinated way, including in my home if I need. When hospital care is needed this is also well-coordinated.
- All those who care for me, my baby and our whānau have high cultural competence and practice in a culturally-safe manner; they pronounce our names properly, greet us in our language and use correct cultural approaches/tikanga
- All practitioners have the clinical skills they need; they can assess my medical, parenting, addictions, mental health, family violence and other needs sensitively and effectively, alongside my strengths and with a model of health such as te Whare Tapa Wha
- They include me when planning for my needs to be met so I always know who has my information and what the plan is for treatment and care for myself or my baby.

For a clinical leader, WCTO would incorporate:

- Comprehensive assessments where all issues are noted, summarised, synthesized and contribute to the formulation of the plan
- Assessments are conducted in a culturally safe manner, and practitioners demonstrate cultural competence
- Whānau participate in shared decision-making and informed consent processes, and are involved in formulating action plans
- There is a strong pro-equity culture across all organisations
- Data is regularly and robustly collected, disaggregated by ethnicity and analysed, and used to eliminate inequitable differences in outcome to the maximum degree they are remediable

- Where causes of remaining differences lie outside of health (particularly the social determinants of health, such as cold and damp or crowded housing) organisations advocate collectively to address the issues using the data to inform recommendations
- Staff are regularly surveyed for their professional development needs. Multi-agency, multidisciplinary training is provided regularly and there is a clear expectation that new skills will be implemented into practice
- Whānau are regularly surveyed for feedback, and responses are used to improve practice. The changes are reported back to whānau so they know their voices are heard, and contribute to positive improvements
- All staff contribute to quality improvement activities such as audit, morbidity review, review of adverse events and improvement projects. Wherever possible these activities are multi-disciplinary and cross-sector. Quality improvement projects should have an explicit equity focus, and be reported on to contribute to the research and evidence base
- Paid, dedicated time is made available for these non-clinical activities, not less than one-tenth of a practitioners working week.

What are your suggestions on how to create the desired service?

Significant change is imperative if our health system is going to deliver equitable outcomes for all people in Aotearoa New Zealand. The system in place is largely a colonial relic, unresponsive and unyielding to ways of doing and being outside a Western, biomedical structure focused on the nuclear family and the individuals contained within.

There is an immediate and fundamental need to address the core issues identified in the WAI 2575 report, including legislative, structural, policy and finding mechanisms.

Tino rangatiratanga and active participation, partnership and protection should be driving principles. Systemic change must acknowledge that whānau have the right to choose the health services that best support mana motuhake (self-determination) for themselves and their whānau – noting that this could encompass kaupapa Māori health services, mainstream health services, or a combination of both.

A key component in delivering on the report's recommendations will be investment in lifting the cultural competence and safety capability of frontline tauiwi practitioners and leaders, and in developing partnerships with kaupapa Māori organisations, whānau, hapū and iwi. Early, committed partnership with groups experiencing inequity is critical to ensure the voice of service users, whānau, hapū and iwi informs service design and delivery.

Kaupapa Māori organisations must receive guaranteed funding to enable them to deliver a range of services to whānau, and undertake future planning to ensure the ongoing sustainability of services. Kaupapa Māori services receive less funding than mainstream health services, are required to complete more frequent audit and compliance activities, and are funded for shorter periods of time, making it difficult for services to plan for the longer term.

Robust information technology systems and analytic capability, all data disaggregated by ethnicity, published and used to reduce and eliminate inequities to the extent that they are remediable, and to inform advocacy where causes lie outside of health.

The RACP encourages regular reviews of organisational culture to identify and address institutional bias and racism.

Workforce

Summary

- The workforce is very variable in its cultural competence.
- Clinical and cultural competence and safety training is rare. One or the other is more common.
- The United Kingdom's Sure Start model is an example that could be considered which delivers a clear plan where the members of the team are working to their best.

What is your opinion on the current state? What may be missing? What is currently working well?

Cultural competence varies widely across the WCTO workforce, from practitioners newly-arrived in Aotearoa New Zealand to practitioners who have worked in kaupapa Māori organisations for several years and are fluent in te reo. All practitioners have a responsibility and an obligation to practice culturally-safe care, regardless of patient demographics and the model of care in service's design and delivery.

Integration of clinical competence and cultural safety into training is rare. Training tends to focus on one or the other, often informed by organisational culture and supervisory practices. How to integrate cultural competence into clinical care and vice versa, e.g., how to integrate tikanga concepts such as rangatiratanga or tuhonotanga (linking and connecting) into mental health and addictions, domestic violence or child protection assessment is rarely taught, but essential.

This is made more complex by the variety of preferred learning styles across this diverse workforce. Some practitioners prefer online learning, others prefer group learning in wānanga. Some like role play to practice new clinical skills like assessment of domestic violence, while others may find it daunting. This challenges trainers but can be overcome, for example, in the Ngātahi vulnerable children's workforce training programme in Hawke's Bay.

There is a need to identify opportunities to expand the skillsets and build the capability of the existing WCTO workforce, while incorporating other practitioners and professional groups into the workforce; for example, general practitioners, practice nurses, early childhood educators, lead maternity carers, social workers and community health workers/kaiawhina.

To you, what does the desired service look like?

One model the Ministry could consider is the United Kingdom-based Sure Start model. Sure Start, launched in 1998 uses locality-based MDTs to deliver a programme of child-centred healthcare, early education and family support, with a focus on the first thousand days[7]. Sure Start sets clear professional boundaries, while building on the strengths, skills and expertise of team members. All members of the team are working to the top of their scope to a clear plan. For this model to be successful, effective management, access to support staff and excellent cross-agency governance are essential elements.

What are your suggestions on how to create the desired service?

[7] Cattan S, Conti, G, Farquharson, Ginja R. The health effects of Sure Start. London: Institute for Fiscal Studies; 2019. Available from https://www.ifs.org.uk/publications/14139. Accessed 22 August 2019.

The Ministry should prioritise building on what is already present but may not be operating to its potential. Invest in building cultural safety capability in the incoming workforce and upskilling those already engaged as WCTO practitioners. Implement carefully: monitor and make adjustments but build a foundation of strong governance as an immediate priority. Develop policies, tools and resources to support culturally-safe practice. If there are gaps, identify how issues will be addressed

Consider trialling in areas with existing strong intersectoral networks, joint training and a history of joint working for example, with High and Complex Needs, Intensive Wraparound, Strengthening Families and Children's Teams, where successful. The Ministry should consider how it communicates and presents information about the service design review and should include presentation of audit results and pilot trial findings at clinical grand rounds, District Health Boards (DHBs) and multidisciplinary meetings as part of its ongoing evaluation and monitoring strategy.

Data and information

Summary

- Overall the WCTO data and information system is severely lacking.
- Few organisations use their data for improvement, or publish their data – which is compounded by competitive funding models.
- Indigenous data sovereignty and data stewardship is not acknowledged in current systems.
- Piecemeal investment in information technology has disadvantaged the system.
- Investment is needed on a local level for analysis capability.

What is your opinion on the current state? What may be missing? What is currently working well?

The RACP finds the data and information capability of the existing WCTO system to be severely lacking. While some areas are well-developed – for example, General Practice and Plunket services – overall interconnectivity between services and across sectors remains poor. Although analytic capacity is very variable, from non-existent to good, few organisations use their data for improvement and very few publish their data. There is fear in the sector that comparative data will be used to judge, rather than to improve. This is compounded by competitive funding models.

There is little acknowledgement of indigenous data sovereignty and data stewardship concepts in current systems. These are critical to implementing a framework that is cognisant of and responsive to the needs of Māori to have authority and ownership of data stored about themselves, their whānau, hapu and iwi.

Our members stated the system has been continually disadvantaged by the Ministry of Health's piecemeal approach to information technology development, and ongoing inability to deliver a coherent IT platform in this area. Most of the existing information systems are getting out of date; for example, the National Immunisation Register, Before School Check and the National Child Health Information Programme, although they remain functional. The Ministry must build on these platforms in the short term, but we note this is a stop-gap measure and a fully-integrated, comprehensive platform must be part of the Ministry's longer-term IT strategy.

The RACP sees data and information as a critical part of the infrastructure and none of the proposed improvements can take place unless this is addressed. Progressing without data and appropriate data governance and infrastructure will set up the new WCTO system to fail.

To you, what does the desired service look like?

An ideal service would comprise of an integrated fully functional system which starts with the maternity database and captures key interventions and clinical events in a child's life using a life-course approach to health, development and wellbeing[8]. It builds on the existing systems and allows a comprehensive view of a child's health to be described at any point in their life. It continues through to adulthood as part of an electronic health record.

The system would permit both individual level data to be viewed by the health service user (HSU) and health provider and integration into population level data to inform quality improvement, actions to improve equity, evaluation and policy. It would permit HSUs, parents/caregivers to enter their own data, seek advice and interact with provider systems and receive personalised health advice and support on a digital platform available through a mobile application and desktop web interface.

What are your suggestions on how to create the desired service?

Significant funding to develop and implement this system – which our College sees as an essential service – is required. Beyond this, the Ministry must make a public commitment to the sector to improve on the status quo. Although the technological landscape has evolved since its release in 2003, the Child Health Information Strategy is still a useful baseline. While a comprehensive system is in development, upgrading, expanding and integrating existing systems should be a priority.

Investment in analysis capacity at a local level, for example through DHB Information Services teams, where significant capability and experience already lie could be one avenue for the Ministry to explore regarding data and information. These teams could operate under a nationally-consistent framework and set of principles while interrogating local population data, which could ultimately be collated and analysed centrally by the Ministry to obtain national-level data insights.

Funding and contracting

Summary

- Primary care funding is grossly inadequate and poorly targeted in New Zealand.
- We need equitable, cooperation-based funding.
- The workforce has been under-invested in and lacks core skills.

What is your opinion on the current state? What may be missing? What is currently working well?

As the WAI 2575 *Hauora* report found, primary care funding is grossly inadequate, and poorly targeted to achieve the outcomes we need for our people in Aotearoa New Zealand[6]. We need equitable funding across services, which incentivises cooperation rather than competition, and incentivises providers fairly.

[8] The Royal Australasian College of Physicians. Early childhood: the importance of the early years. Sydney: The Royal Australasian College of Physicians; 2019. Available from https://www.racp.edu.au/docs/default-source/advocacy-library/early-childhood-importance-of-early-years-position-statement.pdf?sfvrsn=e54191a_4. Accessed 27 August 2019.

The commissioning workforce has also been under-invested in and lacks core skills to effect these changes locally and nationally. The skills to identify well- and under-performing providers, facilitate collaboration, analyse and interpret data for equity and improvement, partner with whānau, hapū, iwi and consumers as well as clinical leaders to set the direction and monitor progress, and to develop capability (as noted in *Hauora*) are thinly spread[6]. Double- and triple-reporting, multiple report formats and differing requirements for similar services from different purchasers are the norm, and kaupapa Māori services often experience unfair targeting. This requires immense wasted effort in reporting that rarely leads to improvement or change.

Conclusion

The RACP thanks the Ministry of Health for the opportunity to provide feedback on the Well Child Tamariki Ora Review. The RACP acknowledges the work of its Members in developing this submission, notably Dr Russell Wills, Dr Peter McIlroy, Dr Pat Tuohy, the Aotearoa New Zealand Paediatrics and Child Health Division Committee and the Māori Health Committee.

To discuss this submission further, please contact the NZ Policy and Advocacy Unit at policy@racp.org.nz.

Nāku noa, nā

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