Council of
Medical Colleges
in New Zealand
TE KAUNIHERA O NGĀ KĀRETI RATA O AOTEAROA

Briefing to the incoming Minister of Health

November 2020

Welcome and introduction

Congratulations on your appointment as Minister of Health. You take on this portfolio at a critical time for Aotearoa New Zealand's health sector as it deals with upheaval from the COVID-19 pandemic and prepares for potential further spread.

You also arrive at a time where decisions need to be made about major health system reform. The review of the Health and Disability System identified Aotearoa New Zealand has a strong public health system. However, it also identified the system is under significant stress; perpetuates inequities for Māori and Pacific populations, and disabled people; does not meet commitments to Te Tiriti o Waitangi; and lacks long-term strategy and planning.

There is significant scope for health system reform. The Council of Medical Colleges welcomes you to your role as Minister and looks forward to working with you to strengthen the health and disability system.

This briefing:

- explains what the Council of Medical Colleges (CMC) is, and its role in the health sector.
- highlights significant health sector issues the CMC considers a priority.

About us

The CMC is the collective voice of 15 medical colleges in New Zealand, representing over 8000 medical practitioners. Medical colleges are responsible for the vocational training and assessment of doctors, and for setting standards of practice in New Zealand. Medical colleges ensure New Zealand has a skilled medical workforce that provides safe, high-quality care for patients and their whānau.

The CMC is a forum where colleges collaborate and share knowledge. It is a key group where Ministers and government officials can access well-informed opinions and advice. Each medical college has significant expertise and understanding of medical education; the patient populations they serve; and systemic issues and barriers to good care.

More detailed information about each of the medical colleges and their priorities for the health sector is provided in the appendix.

CMC's top priorities for the health sector

1. Health equity and commitment to Te Tiriti o Waitangi

CMC considers the health and disability system must meet its obligations under Te Tiriti o Waitangi and achieve health equity for Māori, in line with recommendations from Stage One of the WAI2575 inquiry. This requires a strong, whole-of-government approach to address social determinants of health across housing; education; employment; income; justice; and access to high quality health care that reflects tikanga and mātauranga Māori.

The CMC has set its own goal of health equity for Māori. Medical colleges have undertaken initiatives such as embedding cultural competence and safety within curriculums; including Māori expertise in governance structures; and mentoring Māori doctors within training programmes. Work to foster a culturally safe workforce will be ongoing. CMC values a

collaborative partnership with Te Ohu Rata o Aotearoa (Te ORA – the Māori Medical Practitioners Association) as this work progresses.

2. **Workforce**

CMC supports the call for a national health and disability workforce plan, as recommended by the Health and Disability System Review (the Review). The plan must consider how to address persistent workforce shortages and increase the number of Māori and Pacific health practitioners to better serve New Zealand's population.

Workforce funding must also be addressed. The health workforce training budget has not increased for years, despite known workforce shortages and increasing numbers of health practitioners being trained each year. A national health and disability workforce plan, backed by adequate funding for training, must be seen as a worthwhile investment in New Zealand's health and disability system. As noted in the Review, "the people who make up the Health and Disability workforce are the backbone of the system."

3. **Choosing Wisely**

The CMC facilitated Aotearoa New Zealand's involvement in the international Choosing Wisely campaign. Choosing Wisely seeks to reduce harm from unnecessary and low-value tests and treatments; and provides resources to support shared decision-making between health practitioners and consumers. Choosing Wisely involves doctors, nurses, midwives, pharmacists and other professional groups, as well as consumers and their whānau. The campaign has been supported by Pharmac, the Ministry of Health, Health Quality and Safety Commission (HQSC), Pacific Radiology and Consumer NZ. The HQSC has recently taken over the campaign. However, further funding will be needed to keep the campaign running.

Choosing Wisely partnered with Te ORA to commission a report on Māori health consumers and health providers perspectives on the campaign. *Choosing Wisely means Choosing Equity* was published in July 2020 and makes recommendations to support a more equity focused Choosing Wisely campaign.

4. **COVID-19**

Medical colleges have supported practitioners at the front-line during the COVID-19 pandemic. Colleges have developed clinical guidance on issues such as personal protective equipment (PPE); infection control; and planning and triage, in response to practitioners seeking guidance during a rapidly evolving situation. Colleges have also worked collaboratively with government on issues such as ICU capacity, PPE, and drug supply.

The COVID-19 pandemic has disrupted medical training, with delayed or cancelled examinations, and changes to training rotations. Colleges are working to mitigate impacts on the training pipeline while maintaining the integrity of their training programmes. Initiatives include virtual examinations; examinations being held in Aotearoa New Zealand instead of Australia; and flexibility for trainees who cannot meet training requirements due to COVID-19. The CMC has also advocated for District Health Boards to shift rotation dates for 2021, allowing more time for trainees to complete training in 2020.

Appendix

Australasian College for Emergency Medicine

The Australasian College for Emergency Medicine (ACEM; the College) is responsible for the training of emergency physicians, and the recognised peak representative body for emergency medicine (EM) in New Zealand (NZ) and Australia. This includes the advancement of professional and clinical standards in EM across both countries. ACEM has more than 6000 members, including 3041 active Fellows of ACEM (FACEMs) across NZ and Australia, of which 338 reside in NZ. There are also 2474 FACEM trainees, of which 226 are based in NZ[1]. According to the Medical Council of New Zealand (MCNZ), EM is not only the youngest recognised speciality (vocational scope), but also its second fastest growing[2].

1. Training and the workforce

The College is accredited by both the MCNZ, as well as the Australian Medical Council (AMC) on behalf of the Medical Board of Australia (MBA), to train and develop EM specialists (vocationally registered doctors) in NZ and Australia. However, there are key issues currently impacting the steady supply of a skilled EM workforce in NZ and are briefly discussed below.

1.1. Increasing number of trainees

With support of the College, the FACEM Training Program[3] primarily occurs within hospitals that provide teaching and learning opportunities, and clinical experiences necessary for trainees to obtain fellowship – the specialist qualification. As such, training is a partnership between training sites, specialist (vocational) trainees, Fellows and the College to support the provision of quality patient-centred care. Regrettably, this partnership is now under pressure. To date, government has failed to adequately determine the actual EM workforce needs in NZ. Left to the discretion of district health boards (DHBs), and due to competing priorities, EM workforce needs remain unmet, particularly in rural and remote communities[4]. Even though NZ increasingly retains more of its own graduates[5], government demands an increased number of registered specialists per year[6]. Specialist trainee numbers have increased significantly across all scopes, including for EM[7]. However, access to training positions, and positions once graduates receive fellowship, have not. Government must consider the country's EM workforce needs, the growing number of specialist trainees, the available positions for trainees and Fellows, and associated funding, as a matter of urgency.

1.2. The impact of COVID-19 on the future workforce

Due to COVID-19, there has been a significant impact on national rotations, redeployment, rostering, and recruitment of specialist trainees and doctors. Similarly, overseas-trained professionals account for almost half of the total NZ healthcare workforce, and international medical graduates (IMGs) are well represented herein[8]. This reliance has been further highlighted by current travel restrictions. While it is still unknown how this will impact the broader EM workforce in the long term, it remains a significant concern to the College. It will require close monitoring and quick action to ensure that existing workforce wellbeing is maintained, and patient care not significantly impacted.

2. Policy priorities

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[1] As on 17 July 2020
[2] Medical Council of New Zealand (MCNZ). 2019. The New Zealand Medical Workforce in 2018. Wellington. Available at: https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/434ee633ba/Workforce-Survey-Report-2018.pdf
[3] ACEM. 2020. FACEM Training Programme Handbook. 2020. Melbourne. Available at: https://acem.org.au/getmedia/5651dae4-bbf4-4a80-b68d-cd402912577b/FACEM_Training_Handbook_1-12-2
[4] American Academy of Emergency Medicine (AAEM) Resident and Student Association (RSA). N.d. Emergency medicine in New Zealand. Pp 21-24https://www.aaem.org/UserFiles/file/novdeccommonsense-06_em-newzealand.pdf
[5] MCNZ, 2019
[6] Ministry of Business, Innovation and Employment. 2020. Healthcare Jobs. Available athttps://www.newzealandnow.govt.nz/work-in-nz/nz-jobs-industries/healthcare-jobs (retrieved 29 July 2020).
[7] ACEM. 2019. FACEM and FACEM Trainee Demographic and Workforce 2019 Report. Melbourne. Available at: https://acem.org.au/getmedia/974b8982-9e78-44ce-bfd2-12f1a7bab0b4/2019_FACEM_and_Trainee_Demographic_and_Workforce_Report>
[8] MCNZ, 2019

- **Access block:** The most significant issue facing EDs is their inability to admit acute patients to hospital wards when their care in the ED is complete. Access block[9], whereby an admitted patient spends longer than eight hours in the ED from their time of arrival, adversely impacts all aspects of the acute health care system and is linked to increased patient harm.[10]
- **Mental health:** Presentations to EDs of people in mental health crises is also increasing in relative and absolute terms, particularly during 'out of office' hours. In addition to alternative and more appropriate community and home-based services, Government must ensure that EDs that are properly resourced to cope with existing and future demand and address the dangerously long waits faced by people who need emergency mental health care (more information here[11]).
- **Māori health equity:** ACEM has made a commitment to achieving equity for Māori patients, whānau and staff in EDs. ACEM's Māori Equity Strategy, Te Rautaki Manaaki Mana [12], has a particular focus on ensuring te Reo me ngā tikanga Māori is embedded in ED practice and contains actions to grow, support and retain the Māori ED workforce.
- **Improving data collection and reporting:** Currently there is a paucity of national, publicly available data sets in NZ. We need improved data, evidence, reporting on mental health prevalence, services provided, and outcomes to set national benchmarks and hold key decision makers accountable for ED presentation numbers and waiting times. ACEM supports the introduction of SNOMED-CT.
- **Alcohol and other drug Harm:** EDs are at the forefront of dealing with the harmful effects of alcohol and other drug (AOD) harm, and an ACEM survey found 17% of all NZ ED presentations at the time of surveying were alcohol harm-related[13]. AOD related-harm ED presentations have significant effects on other patients, workforce morale, and the functioning of the ED. Government must invest in reorienting EDs to include models of care appropriate to patient demand and case mix that integrate mental health, general medical and alcohol and other drug /toxicological care. Changes are needed to the design and resourcing of EDs to better prevent, minimise and manage violent behaviours that often accompany AOD harm-related presentations.

3. Supporting practitioners during the COVID-19 pandemic

ACEM has been undertaking a significant amount of work in supporting its members and trainees during COVID-19. Some initiatives are listed below.

3.1. COVID-19 Clinical Guidelines

ACEM published its COVID-19 Clinical Guidelines for EDs in NZ and Australia, which are continually updated[14]. Other initiatives include the COVID-19 Toolkit for Rural and Remote EDs in NZ and Australia[15], and ACEM's joint statement with Tumu Whakarae and Te Ohu Rata o Aotearoa on supporting Māori patients and whānau in EDs during COVID-19.[16]

3.2. Webinars

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[9] ACEM. 2020. Position statement: Access block. Melbourne. Available at: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block

[10] Research from Professor Peter Jones in 2019, an emergency physician who works with the Ministry of Health on acute patient access measures and has a PhD on this matter. Also see: https://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing-2017-18

[11] ACEM. 2019. Communique: Mental Health in Aotearoa New Zealand Emergency Department Summit. Melbourne. Available at: https://acem.org.au/News/May-2019/Mental-Health-in-the-Emergency-Department-Summit-C

[12] ACEM. 2019. Te Rautaki Manaaki Mana: Excellent in Emergency Care for Māori. Melbourne. Available at: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand

[13] ACEM. 2019. Alochol and Other Drug Harm Snapshot Survey 2018. Melbourne. Available at: https://acem.org.au/getmedia/3e940b76-3215-4b6f-a6ae-97b4d30d1d95/2019-Alcohol-and-methamphetamine-snapshot-survey_R2

[14] ACEM. 2020. Clinicial Guidelines for the management of COVID-19 in Austalasian emergency departmnets. Melbourne. Available at https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/COVID-19/Resources.

[15] ACEM. 2020. COVID-19 Toolkit for Rural Emergency Care Facilities in Australasia v1.0. Melbourne. Available here https://acem.org.au/getmedia/3ecc6790-6751-478a-9114-080040282476/Rural-Emergency-Toolkit-v1-0.

[16] ACEM. 2020. Media Release: ACEM Joint Statement with Tumu Whakarae & Te ORA. Melbourne. Available at: https://acem.org.au/News/April-2020/ACEM-Joint-Statement-with-Tumu-Whakarae-Te-ORA

ACEM conducted a number of webinars on a range of topics as the COVID-19 situation evolved[17] and we will continue to explore this as a mode of teaching and information sharing going forward.

3.3. Support for ACEM New Zealand Faculty

ACEM held regular meetings with the NZ Faculty Board and its members to share concerns, solutions and identify opportunities for the College to provide support. A case-by-case approach was adopted to support our trainees, and ACEM has undertaken significant advocacy work, as required. All these initiatives are still ongoing as this pandemic, and its impacts unfold.

[17] More information available at https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/COVID-19/COVID-19-Events-(1)

Australasian College of Sport and Exercise Physicians

Background

The ACSEP is the pre-eminent professional body representing Sport and Exercise Physicians and Sport and Exercise Medicine in Australasia. ACSEP is accredited by the Medical Council of New Zealand (MCNZ) and the Australian Medical Council (AMC) to deliver training and professional development programs in Sport and Exercise Medicine across Australia and New Zealand. College members are committed to excellence in the practice of medicine as it applies to all aspects and levels of physical activity. While the management of medical issues in sporting settings at all levels is a major focus, Sport and Exercise Physicians also facilitate the safe and effective use of physical activity in the prevention and treatment of musculoskeletal injuries and many chronic conditions such as osteoarthritis, heart disease, obesity, diabetes, hypertension, mental illness, and cancer.

Key Issues

Equitable funding for ACSEP training

Unlike the majority of medical specialties, Sport and Exercise Medicine trainees and the practices that support them do not receive any financial support from the government for training. Sport and Exercise Physicians primarily work and train in community-based private practices. As such, the speciality has historically been overlooked in both workforce planning activities and hospital-based funding models.

There are high levels of consumer demand for Sport and Exercise Physicians' services in New Zealand with long waiting lists in many areas. Without adequate workforce planning and a financially sustainable training program, the speciality will be unable to meet consumer demand. ACSEP seeks financial support for training to support and build workforce capacity.

Increased recognition of the role of Exercise as Medicine

The New Zealand Government's Ministry of Health has acknowledged the increasing health burden of long-term conditions, such as heart disease, diabetes, depression, dementia, and musculoskeletal conditions.[18] Physical activity is widely recognised as an effective means of preventing and treating many of these conditions, including reducing risk factors such as obesity.[19] Despite this, physical inactivity remains the fourth leading cause of death worldwide and has been recognised as serious concern for New Zealand, with a Lancet study ranking New Zealand as the 27th most inactive country (out of 122).[20]

Sport and Exercise Physicians are able to provide patients with evidence-based, cost-efficient, non-surgical health care options outside the hospital system, which may serve as an alternative treatment to surgery and other costly interventions. There is evidence to suggest that exercise prescription can be more effective than metformin for type II diabetes[21], than chemotherapy for the

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[18] Ministry of Health (2013). *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016*. Wellington: Ministry of Health.

[19] World Health Organization. *Global action plan on physical activity 2018–2030: more active people for a healthier world.* 2018.

[20] Lee, I-M., Shiroma, E., Lobelo, F., Puska, P., Blair, S. Effect of physical inactivity on major noncommunicable diseases worldwide: an analysis of burden of disease and life expectancy. *The Lancet.* 2012, Vol. 380(9838): pp. 219 – 229.

[21] Baptista, L.C., Machado-Rodrigues, A.M., Martins, R.A. Back to basics with active lifestyles: exercise is more effective than metformin to reduce cardiovascular risk in older adults with type 2 diabetes. Biology of Sport. Dec 2018. 35(4): pp. 363–372.

prevention of some types of cancer recurrence[22] and can prevent or delay the need for joint replacements[23] for those with osteoarthritis.

Health equity, with a focus on improving health outcomes for Maori peoples.

ACSEP believes the inequity in health outcomes for Maori peoples is unacceptable and supports a strong, whole-of government approach to addressing social determinants of health as well as access to high-quality, culturally appropriate health care. ACSEP supports a treaty-based approach to improving Maori health and, through partnerships considers its position in leveraging the high participation of Maori in sport to improve the service and access to health pathways through its fellowship. ACSEP is committed to further developing self-reflection and cultural education resources for its members and increasing the number of Maori doctors joining the training program and attaining Fellowship. The inclusion of Sport and Exercise Physicians in public medical services and DHBs would help address barriers to access.

Impact of COVID-19 pandemic

ACSEP Fellows have played a key role in supporting and guiding national sporting codes to navigate the rapidly changing health and safety landscape of elite sport during the COVID-19 pandemic.

However, for a specialty operating almost exclusively in private practice COVID-19 has presented unique challenges to training and financial stability for ACSEP members. Sport and Exercise Physicians were classed as non-essential workers during the initial lockdown which negatively impacted referrals and the ability for private practices to cover their costs. Without a steady patient load, training was also impacted during the lockdown period.
To help support members, the College:

- Increased telehealth education resources such as webinars and eLearning modules. This has assisted members to provide continuity of service to patients through the COVID-19 pandemic.
- Adopted a flexible approach to accrediting registrars' training time during lockdown periods where trainees were redeployed or experienced reduced patient numbers. This approach has also been extended to key assessments, with the College investigating online examination options.
- Reduced fees for registrars in recognition of financial hardship caused by COVID-19.

[22] Cormie, P., Zopf, E.M., Zhang, X., Schmitz, K.H., The Impact of Exercise on Cancer Mortality, Recurrence, and Treatment-Related Adverse Effects. *Epidemiologic Reviews,* 2017*,* Vol 39(1): pp.71–92

[23] Jonsson, T., Eek, F., Dell'Isola, A., Dahlberg, L.E., Ekvall Hansson, E., The Better Management of Patients with Osteoarthritis Program: Outcomes after evidence-based education and exercise delivered nationwide in Sweden. *PLOS One.* 2019 Sep 19;14(9)

Australian and New Zealand College of Anaesthetists

The Australian and New Zealand College of Anaesthetists (ANZCA) is one of Australasia's largest specialist medical colleges. Along with the Faculty of Pain Medicine, ANZCA is responsible for the training, examination and specialist accreditation of anaesthetists and specialist pain medicine physicians, and for the standards of clinical practice in Australia and New Zealand. The college also plays a significant role in the advancement of anaesthesia in South-East Asia and the South Pacific. There are almost one thousand anaesthetists and trainees in New Zealand covering every private and public hospital in the health system.

Highlighting the potential for inequity in health care at smaller district health boards with proposed role substitution

The college is very concerned about plans by the West Coast District Health Board to move away from employing vocationally registered medical practitioners, to a model of care provided by rural General Practitioners with an extended scope of practice. The DHB has indicated that it will no longer advertise for vocationally registered anaesthetists. Instead, it will staff departments with generalist medical practitioners with an extended scope of practice, which includes anaesthesia. This is inequity of care and needs to be addressed before it goes further.

ANZCA considers that a full consultation is required both with the communities involved (as the college understands, was required in the business plan) and the specialist colleges involved.

Advocating for equity in chronic pain services throughout Aotearoa New Zealand

The Ministry of Health's report on health loss in New Zealand shows that four of the top six causes of disability in New Zealand are chronic pain conditions - chronic low-back pain; migraine; chronic neck pain; and other musculoskeletal disorders.[1] The other two major causes are anxiety and depression, with which chronic pain is associated.

More than one in five adults in New Zealand - around 770,000 people - experience chronic pain, and this number is expected to rise to around 1.26 million people by 2048 as the population ages. Chronic pain is a driver of poverty – often leading to unemployment, welfare, and early retirement.

All patients should be able to access multidisciplinary pain services that are staffed by qualified pain management professionals, in a timely manner. Specialist pain medicine physicians have in-depth knowledge and skills to use evidence based good practice to treat chronic pain conditions. There is an enormous unmet need in New Zealand, with a limited number of multidisciplinary pain services across New Zealand staffed by few Specialist Pain Medicine Physicians (SPMPs). This is inequity of care. It is worth noting that the DHBs with the highest opioid prescribing do not have specialist pain clinics.

We would like to advance the conversations regarding workforce planning in this area, which will also include ACC, the Royal Australian and New Zealand College of Psychiatrists, physiotherapists and other key stakeholders. ANZCA would like a commitment to the equitable distribution of specialist pain medicine services throughout the Aotearoa New Zealand.

The Ministry could actively assist the Faculty to establish more registrar training posts and create more specialist pain medicine physician consultant posts in the DHBs to improve patient access to treatment.

The Ministry could also consider the following:

- Funding of training.
- Funding development of pain services nationally.
- Improving access at primary level.

The Ministry could require DHBs to provide pain services to their population, and report on inputs and outcomes (including using EPPoC - the bi-national electronic Persistent Pain Outcome Collaboration) for benchmarking and demonstrating outcomes achieved through chronic pain management.

Support for perioperative medicine to increase patient safety before, during and after surgery

ANZCA is developing a formal perioperative medicine qualification as part of a major ANZCA-led multi-disciplinary collaboration that aims to establish an effective, integrated and collaborative perioperative care model, harnessing the strengths of anaesthetists as leaders in patient safety and quality.

Perioperative medicine is an emerging area of patient care that involves a wide range of healthcare professionals working together with an integrated, planned, and personalised approach to improve the patient experience, reduce postoperative complications, reduce inpatient hospital days and reduce early re-admissions following surgery. Global estimates suggest that at least seven million people suffer complications following surgery each year, including at least one million deaths, a magnitude that exceeds both maternal and AIDS-related mortality. As many as 50 per cent of these deaths and complications are preventable (Weiser and others 2008).[2] Adopting a perioperative care model can improve the care of all patients - but the greatest benefits will be to vulnerable patients such as the very old; the very young; and those with underlying health conditions.

ANZCA is seeking the support of the Ministry of Health to encourage collaboration across specialities on perioperative medicine, which is a cost effective way of enhancing patient safety and saving lives.

College of Intenstive Care Medicine

The College of Intensive Care Medicine of Australia and New Zealand (CICM) is the body recognised by the Medical Council of New Zealand and Australian Medical Council to be responsible for Intensive Care Medicine (ICM) training and education in Australia and New Zealand (ANZ). CICM is also recognised as the body that outlines the minimum standards relating to work practice, caseload, staffing and operational requirements for Intensive Care Units (ICUs).[24]

ICM specialists are trained and rigorously assessed to have an appropriate range and depth of clinical knowledge, with the skills and proficiency to recognise and manage adult and paediatric patients with life-threatening organ system failure, those at risk of clinical deterioration, and to diagnose and treat the conditions that cause critical illness and organ dysfunction. ICM specialists are also involved in the management of deteriorating and seriously ill patients outside the intensive care unit including transport within and between hospitals. ICM specialists are experts in end of life care including the identification, care and support of the potential organ donor.

Issues and recommendations

Both the application of appropriate training, organisational and practice standards and ensuring adequate ICU capacity are essential to enable the high standard of patient care and patient outcomes that New Zealand patients deserve. The adequacy of ICU capacity should not simply be defined by the availability of specific pieces of equipment and/or ad-hoc requisitioned bed-spaces. Nor should a compromised practice standard be an acceptable basis for the development of an ICM service.

CICM respectfully highlights three issues and corresponding recommendations in order to achieve equitable and excellent outcomes for the people of New Zealand.

Recommendation 1
CICM recommends that District Health Boards (DHBs) are required to take steps to ensure that all people within NZ have access to ICM specialists vocationally trained to the standard expected of a Fellow of the CICM, within a service framework that meets the minimum standards for service provision as outlined by CICM.

A significant proportion of the New Zealand public does not have access to a trained ICM specialist or an ICU that meets the accepted minimum standard. The viewing of the minimum standards as aspirational leads to inequality of access to expertise and service. Only eight New Zealand DHBs meet the minimum standard required to train ICM specialists.

Recent outcome data released on 440 COVID-19 patients (almost all from Australia) who required admission to ANZ ICUs that meet our bi-national training and service standards[25] highlights a survival rate of almost 90% was reported for patients admitted to our ICUs, with 82% of those requiring ventilation surviving to discharge. Conversely, around 50% of ventilated patients in the United Kingdom survived, and only 37% in Asia.[26] [27]This data provides an

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[24] College of Intensive Care Medicine of Australia and New Zealand: IC-1 Minimum Standards for Intensive Care Units. https://www.cicm.org.au/CICM_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf.

[25] Australian and New Zealand Intensive Care Society Combined Report on COVID Admissions to Australian and New Zealand Intensive Care Units. Jan-Mar 2020: https://www.anzics.com.au/wp-content/uploads/2020/06/ANZICS-CORE-SPRINT-SARI-combined-report.pdf.

[26] Intensive Care National Audit and Research Centre (ICNARC), UK. COVID Report 2020-07-03. Available at https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports.

[27] Characteristics and Outcomes of COVID-19 and suspected COVID-19 patients in national registries. Available at https://www.icubenchmarking.com/.

indication of the lives that might be saved by the utilisation of a defined model of care operating within a system which meets CICM standards, at least when capacity is not overwhelmed.

Recommendation 2
CICM recommends that staffed ICU capacity is increased within this standard such that all New Zealanders can expect equitable access to ICU and equitable outcomes.

New Zealand has one of the lowest ICM capacities (staffed ICU beds per 100,000) in the OECD, with service expansion not being aligned to areas of population growth. Existing capacity is at crisis level as evidenced by the cancellation of emergency surgery, delay in ICU admissions, early and out-of-hours ICU discharge and unnecessary (resource-driven) inter-hospital patient transfers all occurring during 'business as usual' without the impact of disasters, terrorism and pandemics[28].

Recommendation 3
CICM recommends that, in recognition of the unique and specific roles performed by ICM specialists, Intensive Care Medicine is recognised as a medical specialty by the Ministry of Health.

Despite the extensive training and expertise of ICM specialists, CICM is **not currently** listed as a medical speciality by the Ministry of Health Specialist Medical and Surgical Services Specification. The expertise of our specialty is not only required to facilitate 'routine' emergency and elective healthcare, it has been specifically called upon following the Christchurch shooting attack, the Whakaari/White Island eruption, and the COVID-19 pandemic.

College's response to the COVID-19 pandemic

CICM has collaborated with the Australian and New Zealand Intensive Care Society to produce COVID-19 guidelines that provide recommendations to ensure continued high-quality clinical care in the setting of a pandemic. The CICM President is part of a collaborative group called the COVID-19 Critical Care Coordination Collaborative to deal with issues related to the management of critically ill COVID-19 patients.

CICM has initiated online education sessions to ensure minimal interruption to training and examination planning. These sessions connect trainees and educators from across Australia and New Zealand in an interactive and novel format.

CICM has adapted an assessment approach that does not involve travel interstate or internationally, with locally run written exams, hot cases and local face to face or online vivas. All trainees will receive dedicated support for any online vivas that occur.

[28] de Lange DW, Soares M, Pilcher D. ICU beds: less is more? No [published online ahead of print, 2020 May 26]. *Intensive Care Med*. 2020;1-3. doi:10.1007/s00134-020-06089-0.

New Zealand College of Public Heath Medicine

The New Zealand College of Public Health Medicine (NZCPHM) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 205 current members, all of whom are medical doctors, including 184 fully qualified Public Health Medicine Specialists with the remainder being registrars training in the specialty of public health medicine.

As the medical specialty at the forefront of dealing with the COVID-19 pandemic, we are crucially aware of the impact that this has had on lives and the economy. Now, more than ever, we believe that a system focus on the upstream determinants of health is crucial: public health interventions which address the causes of ill health have shown cost-effectiveness ratios better than those of the health care required to address the problems caused.[29]

We believe targeted action in the four priority areas below would make the greatest material difference in health outcomes for all New Zealanders:

- **Achieve health equity**

The failure to achieve health equity, and with urgency, breaches the Crown's Tiriti o Waitangi (the Treaty of Waitangi) obligations to Māori.[30, 31] In addition, the health inequities experienced by Pacific people in New Zealand, compared with non-Pacific people, is a failure to protect their rights as citizens and to respond to New Zealand's responsibilities to the broader geographical region.[32]

Poor health status and life expectancy is strongly related to inequities in the determinants of health, including in education; employment; income; housing; income support; dealings with the criminal justice system; health literacy; deprivation; experiences of racism; and access to, and quality of, health care in New Zealand. [33]

We strongly support and encourage prioritisation of health equity as a focus for health policy. This will require investment in areas known as socioeconomic determinants of health and a whole-of-government approach which looks at the health implications of all policies adopted.

- **Address child poverty and health**

We are extremely concerned by the extent and entrenched nature of child poverty in New Zealand and its compounding negative impact on individual children, their families and the health of our society.[34]

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[29] New Zealand College of Public Health Medicine. Public Health as an Investment Policy Statement. Wellington: NZCPHM, 2019. (https://www.nzcphm.org.nz/media/126101/2019_02_20_ph_as_an_investment_policy_statement.pdf)

[30] Waitangi Tribunal. Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry Wai 2575. Lower Hutt: Waitangi Tribunal, 2019. (https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf)

[31] New Zealand College of Public Health Medicine. NZCPHM Māori Health Policy Statement. Wellington: NZCPHM, 2015. (https://www.nzcphm.org.nz/media/89786/2015_11_30_m_ori_health_policy_statement_.pdf)

[32] New Zealand College of Public Health Medicine. NZCPHM Pacific Peoples' Health Policy Statement. Wellington: NZCPHM, 2019. (https://www.nzcphm.org.nz/media/87942/2019_12_05_pacific_peoples_health_policy_statement.pdf)

[33] New Zealand College of Public Health Medicine / New Zealand Medical Association. NZCPHM Policy Statement on Health Equity (adopting, with added public health medicine context, the NZMA Position Statement on Health Equity 2011). Wellington: NZCPHM, 2016. (https://www.nzcphm.org.nz/media/58923/2016_11_17_nzcphm_health_equity_policy_statement.pdf)

[34] New Zealand College of Public Health Medicine. Child Poverty and Health Policy Statement. Wellington: NZCPHM, 2017. (https://www.nzcphm.org.nz/media/137839/2017_12_7_nzcphm_child_poverty_and_health__reviewed_12_2017_.pdf)

Children living in deprivation are much more likely to suffer from preventable disease, poor nutrition, and injury from abuse, maltreatment, or neglect, all of which result in short-term health impacts and are reflected in the high rates of certain health conditions in New Zealand, compared with other developed countries. In addition, children who grow up in poverty are more likely to face economic hardship as adults which means, in turn, their children are also more likely to experience restricted access to the resources needed for optimal development. This creates a poverty cycle in which the impacts of deprivation are passed from one generation to the next.

Investing in the health and wellbeing of children should be a high priority for New Zealand, and, in the long term, will result in benefits to adult health and wellbeing.

- **Invest in public health infrastructure**

The COVID-19 response has exposed a large shortfall in New Zealand's public health infrastructure, resulting from under-resourcing and under-investment over many years.[35] This has resulted in public health events such as the 2016 Havelock North campylobacter outbreak and the 2019 measles epidemic – both of which were preventable had the health system had capacity to manage upstream risks. Sustained investment is crucial to ensuring a strong and cost-effective health system. This should include:

  - Information systems that can capture population health data needs, from clinical and laboratory notification through to case and contact management, as well as real time monitoring and centralised reporting.
  - Increased investment to public health services, which includes the Public Health Units at the forefront of dealing with infectious disease crises like the evolving COVID-19 pandemic.
  - Investment in the Public Health workforce. The Public Health Medicine Specialist workforce has declined since 2015 due to restricted funding and is projected to decline further unless additional investment is made in training and the availability of training places.

- **Rapidly protect our climate**

Climate change is contributing to major health issues, a growing burden of disease and increased premature death for populations around the world. New Zealand will not be immune from these consequences.[36,37] Climate change is also an equity risk, as Māori are at risk of disproportionate impacts compared with non-Māori, not only because of differences in health, socio-economic status, and differential access to care, but also due to indigenous relationships with the environment and impacts on customary practices such as collection of kaimoana (seafood).

We believe that well-planned action to reduce greenhouse gas emissions can bring substantial health gains – tackling climate change could be the greatest global health opportunity of the 21st century due to health co-benefits that could result from actions to develop a sustainable economy.

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[35] Brown E. COVID-19: Public Health Laid Bare. The Specialist, 123, June 2020, pp 3-4 (https://www.asms.org.nz/wp-content/uploads/2020/06/The-Specialist-Issue-123.pdf)

[36] New Zealand College of Public Health Medicine. Climate Change and Health in New Zealand Policy Statement. Wellington: NZCPHM, 2018. (https://www.nzcphm.org.nz/media/125461/2018_09_06._nzcphm_climate_change_substantive_policy___2018_update-provisos.pdf)

[37] New Zealand College of Public Health Medicine. Priority Actions for Climate Health. Wellington: NZCPHM, 2018. (https://www.nzcphm.org.nz/media/125650/priority_actions_for_climate_health.pdf)

Royal Australasian College of Medical Administrators

Helping to Build New Zealand's Health System for the Future

RACMA is a specialist medical college whose focus is to support sound health systems stewardship, through training medical practitioners in leadership and management to improve systems of patient care and service delivery. RACMA has more than 1,000 Fellows, Associate Fellows and trainees in public and private health settings principally across Australia, New Zealand and Hong Kong. RACMA's Fellows and Associates occupy senior roles in central agencies and health services that drive and enact health system change.

In New Zealand, we are fortunate to have a publicly funded universal health system however, the evidence is clear that inequities in the determinants of health including in education, employment, income, housing, income support, health literacy, and access to health care exist between both Māori and Pacific peoples, and non-Māori, non-Pacific populations. COVID-19 has highlighted this. RACMA Fellows have been involved in COVID-19 responses working in health leadership roles including Ministry of Health, ESR, Pharmac, ACC, Health Quality & Safety Commission, and DHB CE and CMO roles. The College COVID resource page is accessible at https://racma.edu.au/resources/covid-19-resources/

Making a difference requires rethinking the position of health in society, and the way healthcare is delivered in the community. RACMA Fellows use their clinical knowledge, skill and judgment combined with post graduate leadership and management training, to engage with other health professionals, managers, policymakers, and most importantly with patients and their families/whānau to develop health systems that deliver safe, equitable, efficient and effective, patient-centred care.

The main priorities that RACMA identify in New Zealand are those of workforce and advocating for system change to achieve Māori health equity.

The final report of the Health and Disability Review noted that "the further work of the Review reinforced the view that the health and disability system needs more active leadership at all levels. The Review concludes that this cannot be achieved through any one action or decision, but would require a clearer definition of functions and structures, more collective responsibility and more deliberate upskilling throughout the sector, from kaiāwhina to DHB board members" RACMA, unlike other medical specialities does not receive HWNZ funded positions so registrar posts need to be funded through surplus training monies. This does not support the development of specialist medical Fellows within the New Zealand healthcare system who will be equipped to support the system change to advance Ministry and government priorities and initiatives, and with skills to support the impact of these on their medical colleagues. RACMA's Fellowship training program was recently accredited by the Australian Medical Council (AMC) for six years with minimum conditions and this accreditation was accepted by the Medical Board of New Zealand.

AMC noted the overwhelming view of health departments and services of the high value of RACMA fellows' special skill in health systems management. Many stakeholders interviewed reported that RACMA programs and members providing strong clinical governance foundations that have assisted in providing an integrated model of health service management across many disparate sites and across all health professions.

In improving the quality and experience of healthcare, it is important to bring together medical and management expertise to drive strategic system design across domains that will ultimately enable effective responses to be developed and delivered to meet the health needs of different people that make up New Zealand's population. RACMA's Fellows possess this expertise and offer to be actively involved and work with government to build New Zealand's health system for the future.

Royal Australasian College of Surgeons

RACS is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees across nine surgical specialties: cardiothoracic surgery, general surgery, neurosurgery, orthopaedic surgery, otolaryngology head and neck surgery, paediatric surgery, plastic & reconstructive surgery, urology, and vascular surgery.

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities we serve and, as part of this commitment, we strive to take informed and principled positions on issues of public health relevant to surgery.

Current issues for RACS include:

Unmet Surgical Need
All New Zealanders deserve good access to planned care. While significantly more funding has been put into the public health system over the last three years and substantial progress has been made on effectively prioritising elective surgery, tens of thousands of New Zealanders continue to miss out on or wait too long for assessment and elective surgery. And, again despite a funding injection, this will be exacerbated by the disruption to elective surgery during the COVID-19 lockdown. RACS recommended a significant increase in the funding allocation for surgery for those in need.

Māori Health Equity
The continuing significant gap in health outcomes between Māori and non-Māori is unacceptable. Variances in access to health services and treatment options, significantly worse outcomes following treatment, and under-representation in the health workforce, compounds the inequity. RACS is committed to addressing health inequity and improving Māori representation in the surgical workforce. RACS recommends that the Government acknowledge and address inequality in health outcome.

Health Workforce
The provision of quality healthcare in New Zealand depends on an ongoing and adequate supply of health practitioners to meet the changing needs and growth of our population. RACS recommends that the Government review the health workforce to ensure it meets the needs of the community.

Infrastructure
There needs to be an on-going investment in infrastructure and facilities to ensure that New Zealanders' surgical needs can be adequately met. A national health asset audit completed last year found that DHBs operate with an accumulated under-investment in assets and many believe their assets to be in poor condition and no longer fit for purpose. Investments of $14 billion for buildings and infrastructure and $2.23 billion for Information Technology are needed over the next 10 years. RACS recommends that the Government expend more funds on existing and new health infrastructure.

A Single Electronic Health Record
Effective sharing of patient-centric information across the continuum of care, via a single Electronic Health Record (EHR), would improve collaboration between providers, and improve patient safety and care. Unlike many other countries around the world, New Zealand has yet to develop an EHR system. RACS recommends that the Ministry of Health develop a single Electronic Health Record that can be appropriately accessed by all health practitioners and patients.

More Consistency and Collaboration Amongst District Health Boards
The Health and Disability System Review Panel recommended recently that operational policies be applied more consistently across DHBs. The lack of consistency was brought into stark relief during the COVID-19 pandemic as each DHB created its own interpretation of guidance issued by the

Ministry of Health around national directives. The allocation of personal protective equipment and patient prioritisation, for example, varied significantly from DHB to DHB and hospital to hospital. RACS recommends that the Government ensure that all DHBs work more consistently and collaboratively to avoid duplication of effort and resources.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is dedicated to the establishment of high standards of practice in obstetrics and gynaecology and 'excellence in women's health'. The College trains and accredits doctors throughout Australia and Aotearoa New Zealand in the specialties of obstetrics and gynaecology. In New Zealand there are around 330 specialist obstetrician and gynaecologists, and around 120 trainees.

The College also supports research into women's health and advocates for women's healthcare. In New Zealand RANZCOG's Te Kāhui Oranga ō Nuku supports College activities, taking into account the context of the New Zealand health system and the needs of women in Aotearoa New Zealand. A particular focus of Te Kāhui Oranga ō Nuku, and its sub-committee He Hono Wāhine, is recognising Māori as tangata whenua and supporting initiatives that will improve equity of outcomes.

RANZCOG believes the major focus for the health system in New Zealand should be on improving equities in health outcomes, addressing both ethnic and gender inequities and wider social issues such as disempowerment, domestic violence and systemic or institutionalised bias.

Some specific priorities for action, that will make a difference for women's health in New Zealand and improve equity in health outcomes are:

1. **Maternal mental health services**
   Suicide is the leading cause of maternal death in New Zealand and it is estimated that 10-20% of women will experience mental distress (most commonly depression) during pregnancy and/or the first year after birth. These women are often not identified and access to mental health services is variable, inequitable and limited. Maternal mental health is a wider issue because of its impact on the health and well-being not just of women but also their partners, children and wider family. Investment in a perinatal assessment/screening programme for maternal mental health, combined with greater access to specific maternal mental health services is urgent.

2. **HPV testing and self-testing**
   Cervical cancer is preventable and yet women die each year because it is not detected early enough. Māori women are more than twice as likely to be diagnosed with cervical cancer and almost three times as likely to die of cervical cancer than Pākehā women. The National Cervical Screening Programme currently screens women by collecting and analysing cells on the cervix – a cytology test commonly referred to as a cervical 'smear'. The Ministry of Health's National Screening Unit (NSU) has for some years been planning to change from cytology screening to Human Papillomavirus (HPV) primary screening. Evidence shows that HPV primary screening is superior to cytology in reducing cervical cancer incidence and mortality and this approach has been adopted by other countries including Australia in 2017. Local studies show that this test, which offers the possibility of self-screening, is more acceptable to the currently under screened population of women, including Maori. The delay in adopting HPV primary screening in New Zealand is linked to the limited ability of the National Cervical Screening Programme Register. HPV primary testing, and in particular the ability to offer self-testing, has been found to increase the uptake of Māori women giving significant potential to improve Māori health outcomes and prevent disproportionate Māori deaths.

3. **Addressing co-morbidity**
   Active and focused approaches to addressing co-morbidity including obesity, smoking, alcohol and recreational drug use will make a difference to the health outcomes of women and children of the future. RANZCOG would like to see a forward-thinking approach which

focuses on healthier food and drinks for children which will result in healthier mothers in the future.

4. **Access to contraception**
   Prevention of unintended pregnancy should be a priority including broad community education (including in schools) in sexual and reproductive health, relationships, safe sex and contraception. Ready and equitable access to a wide a range of safe and reliable contraceptive measures, including long acting reversible contraceptives, is key. Progress has been made with the Mirena and Jaydess levonorgestrel intrauterine systems funded since late 2019, however the cost of insertion is not funded and is still a barrier, creating significant inequity of access. Costs for insertion of long acting reversible contraceptives should be fully funded.

5. **Enactment of abortion legislation changes**
   Abortion legislation changes came into force in March yet there is important work to do to fully enact the changes. New standards for abortion services need to be developed, which ensure safe care for women in line with improved access. Provision of second trimester abortion services is vulnerable with planning required around service accessibility and workforce retention and succession.

6. **Workforce planning and capacity building**
   There are current workforce shortages in obstetrics and gynaecology and midwifery that put services at risk, particularly in regional areas and in tertiary centres for the provision of sub-specialty services such as gynae-oncology and fetal medicine. Increases in the complexity of patient needs means the demands on the workforce and the resource needs will continue to grow. Ensuring a culturally safe workforce requires both increasing the diversity of the workforce and developing the cultural safety of clinicians. Adequate resourcing is required, as is development of strategies to address regional workforce shortages and encourage more Māori into medicine and to specialise in obstetrics and gynaecology.

7. **Create a strong focus on Women's health and maternity matters within the Ministry of Health**
   We understand that the task of prioritising how health dollars are spent is difficult. Women's health provides the foundation for the health of the community. For the issues outlined above to be progressed women's health needs a strong focus within the Ministry of Health structure. It is also important that advisory groups which contribute expertise on women's health, such as the National Maternity Monitoring Group (NMMG) and Perinatal and Maternal Mortality Review Committee (PMMRC), continue to be funded and that their role is strengthened.

Royal Australian and New Zealand College of Ophthalmologists

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) is the medical college responsible for the training and professional development of ophthalmologists in New Zealand and Australia. Our mission is to drive improvements in eye healthcare through continuing exceptional training, education, research and advocacy. Underpinning all our work is a commitment to best patient outcomes, aiming to ensure equitable access to the highest quality eye health for all; providing contemporary education, training and continuing professional development (CPD); using research to underpin improvements in education, training and eye health care; working with others involved in the delivery of eye health care nationally and internationally; and supporting trainees and Fellows through all stages of their career.

The priorities of the RANZCO New Zealand Branch are:

1. Variance between different DHBs and increasing wait times

    - The CPAC score for cataract surgery varies from 41 to 61 points around the country, with Auckland being the lowest and Southern being the highest.
    - There is also variability between DHBs in the number of overdue follow ups, the number of which is increasing after having been reduced by a temporary initiative.
    - Permanent solutions and infrastructure may be necessary to address these issues, even were the DHB structure to be replaced by another model. In particular, the Dunedin Hospital redevelopment is of concern as eye health service provision will be negatively impacted were the ophthalmology facilities to be inadequate, as the local ophthalmologists currently fear may be the case; we have been put in touch with Pete Hodgson to try to address these concerns.

2. Māori and Pasifika Action

    - RANZCO is working towards achieving ophthalmic health equity for Māori in Aotearoa through three guiding principles:
        - Forming and enhancing genuine partnerships with Māori. We will continue to seek out Māori as individuals and groups, and we've already formed some very valuable partnerships with organisations including Tumu Whakarae, Te ORA, and LIME.
        - Cultural competence. We are committed to providing a culturally safe environment for all cultures in Aotearoa. We seek to embed cultural competence throughout RANZCO as an organisation, with a focus on the training curriculum and CPD.
        - Improving Māori representation within the ophthalmology workforce. We encourage Māori doctors into a career in ophthalmology and provide scholarship opportunities, mentoring and research development.

3. Training Posts

    - More funding is required to support ophthalmology training posts in New Zealand.
    - RANZCO believes that the shortfall in the number of ophthalmologists will continue. Therefore, we would like to continue to create more training posts so that we are less reliant on overseas graduates to fill vacancies. We would point out that, historically, almost all of these posts have been filled by New Zealanders, as opposed to Australians or people from overseas.

4. Teleophthalmology

    - RANZCO has developed best practice guidelines for eye health practitioners for delivering teleophthalmology services.

- Teleophthalmology, when delivered optimally, has the potential to improve equity in health outcomes and address limitations evident in current delivery models.
- The current infrastructure is not optimised for equitable access to teleophthalmology services for all New Zealanders.
- The RANZCO New Zealand Branch would be keen to explore further the use of teleophthalmology as a strategy to improve health equity in a sustainable manner.

Royal Australasian College of Physicians

The Royal Australasian College of Physicians (RACP) trains, educates and advocates on behalf of over 3,200 medical specialists and trainees across Aotearoa New Zealand. The College represents more than 33 medical specialties including paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and their whānau.

Priorities for the College include:

- **Māori health equity**

The RACP believes the Aotearoa New Zealand health response must centre equity for Māori and honour the principles of Te Tiriti o Waitangi. The RACP is committed to improving health equity for Māori as tangata whenua of Aotearoa New Zealand. Marked health disparities continue to persist between Māori and non-Māori for a range of conditions, including ischaemic heart disease, diabetes, bronchiectasis, rheumatic heart disease and several cancers.

The RACP also supports Māori-led approaches such as Whānau Ora, and participatory programmes founded in co-design principles. A kaupapa Māori approach delivers culturally relevant health care, builds health literacy and promotes strategies to reduce chronic disease among Māori.

The RACP's Indigenous Strategy[38] aims to develop and engage a culturally safe workforce to promote health equity for Māori, Aboriginal and Torres Strait Islanders, and contribute to the development of the Māori, Aboriginal and Torres Strait Islander medical workforce.

- **Achieving health equity through the social determinants of health**

The environments in which people are born, grow, live, work, and age, shape and sustain people's health and wellbeing. RACP members see the impacts of substandard housing and poor work conditions in the increasing prevalence of chronic illness and preventable communicable diseases, leading to long term health issues, disability and adverse outcomes for education and employment for all whanau members. The RACP continues to call[39] for action for healthy housing[40] , good work.[41] and whānau wellbeing[42] to improve health equity in Aotearoa New Zealand.

The RACP believes investment in the early years of children's health, development and wellbeing is the most cost-effective means of tackling long-term health conditions and health inequity and that a comprehensive, coordinated and long-term strategic approach to identifying

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[38] The Royal Australasian College of Physicians. Indigenous Strategic Framework 2018 - 2028: 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 17 July 2020

[39] The Royal Australasian College of Physicians. Making it the Norm: Health equity through the social determinants of health. Wellington: The Royal Australasian College of Physicians; 2019. Available from https://www.racp.edu.au/news-and-events/media-releases/health-equity-still-under-construction-say-doctors Accessed 17 July 2020

[40] The Royal Australasian College of Physicians. Making it the Norm: Report Card – Health Housing. Wellington: The Royal Australasian College of Physicians; 2019. Available from https://www.racp.edu.au/docs/default-source/default-document-library/policy-and-advocacy/racp-nz-making-it-the-norm-report-card-healthy-housing.pdf?sfvrsn=cf0de21a_0 Accessed 17 July 2020

[41] The Royal Australasian College of Physicians. Making it the Norm: Report Card – Good Work. Wellington: The Royal Australasian College of Physicians; 2019. Available from https://www.racp.edu.au/docs/default-source/default-document-library/policy-and-advocacy/racp-nz-making-it-the-norm-report-card-good-work.pdf?sfvrsn=380de21a_0 Accessed 17 July 2020

[42] The Royal Australasian College of Physicians. Making it the Norm: Report Card – Whānau Wellbeing. Wellington: The Royal Australasian College of Physicians; 2019. Available from https://www.racp.edu.au/docs/default-source/default-document-library/policy-and-advocacy/racp-nz-making-it-the-norm-report-card-whanau-wellbeing.pdf?sfvrsn=d90de21a_2 Access 17 July 2020

and addressing disadvantage and vulnerability in children and infants should be considered by all tiers of government to ensure that every child receives the best possible start in life.[43]
The RACP supports giving increasing priority to children's rights and needs under the United Nations' Declaration on the Rights of the Child. The RACP calls for a child equity lens to be applied to all legislation, regulation and policy development, particularly when children and young people are indirectly affected.

- **Building a sustainable and competent specialist workforce**

The RACP acknowledges the challenges in building a sustainable health workforce for Aotearoa New Zealand, including an ageing population, high rates of complex and comorbid conditions, and an ageing specialist workforce. The average age of a specialist is over 53. 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 smaller centres and smaller specialties.

The RACP welcomes opportunities to continue working collaboratively with the Ministry of Health's Health Workforce directorate. The RACP, alongside other specialist colleges, sees its partnership with Health Workforce as a significant relationship in the development of a model for a sustainable workforce which meets the needs of the Aotearoa New Zealand population. This model is challenged to get the right mix of generalist and specialist workforce across the geography of our country. Such a model needs to recognise the continuity of training pathways over six or more years of specialist learning, the challenge of projecting workforce needs in the longer term, and the significant maldistribution of specialist training supervisors and worksites.

RACP COVID-19 response

The RACP formed a COVID-19 Expert Reference Group (ERG) with specialists in infectious diseases, public health, occupational and environmental medicine, geriatrics, paediatrics and respiratory medicine to determine advocacy priorities, review government advice on COVID-19 and identify resources to share with members.
Advocacy activities have included:

- emphasising the importance of government support for our Fellows and trainees at the frontline of this crisis, including suitable access to personal protective equipment (PPE) and health and safety considerations for both those based in hospitals and within the community, and
- amplifying calls for an equity lens and Indigenous self-determination in all COVID-19 decisions – medical unit prioritisation, resource rationing and data collection. He Tangata, He Tangata, He Tangata: Centre Equity and Te Tiriti o Waitangi in all COVID-19 Pandemic Planning, Strategy and Responses[44] stated our support for Te Rōpū Whakakaupapa Urutā, the National Māori Pandemic Group**,** which is providing COVID-19 pandemic response guidance and advice for Māori whānau, hapū and iwi on many aspects, including guidance for tangihanga and for people who have pre-existing conditions, including cancer, diabetes and heart disease.
  The RACP supports Urutā's calls[45] for (1) a pandemic response that centres equity in decision-making, planning, escalation of care, and resource allocation; and (2) high-quality ethnicity data to inform strategic planning and recovery.

[43] The Royal Australasian College of Physicians. Early Childhood: Importance of Early Years Position Statement. Wellington: 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 17 July 2020

[44] The Royal Australasian College of Physicians. He Tangata, He Tangata, He Tangata: Centre Equity and Te Tiriti o Waitangi in all COVID-19 Pandemic Planning, Strategy and Responses. Wellington: The Royal Australasian College of Physicians; 2019. Available from https://www.racp.edu.au/docs/default-source/advocacy-library/racp-position-statement-on-the-aotearoa-nz-covid-19-pandemic-response.pdf?sfvrsn=ece2eb1a_8 Accessed 17 July 2020

[45] Te Rōpū Whakakaupapa Urutā. Available from https://www.uruta.maori.nz/policy. Accessed 17 July 2020

The RACP established two new groups to advise on key education and training decisions[46] – COVID-19 Examinations Advisory Group and COVID-19 Training and Accreditation Advisory Group. As recommended by the Advisory Groups, the RACP changed some education and training requirements and created a set of principles to guide our decision-making during COVID-19. The 2020 Divisional Clinical Examination (DCE) was postponed and a provisional Advanced Training (pAT) progression pathway developed to assist trainees to continue with their training. The current DCE delivery format was reviewed to ensure public health risks associated with the exam were reduced. The new modular format separates the Long and Short Cases, so they are not held on the same day and offers the Long Cases virtually to reduce face-to-face contact with patients and whānau and reducing travel for examiners and candidates.

Following advice early in 2020 from the Australian and Aotearoa New Zealand Governments and recommendations for social distancing, the RACP determined to postpone, cancel, or live stream key events and ceremonies for the foreseeable future. Continuing Professional Development deadlines have also been extended.

[46] The Royal Australasian College of Physicians. COVID-19 Education and training. https://www.racp.edu.au/news-and-events/covid-19/education-and-training Access 17 July 2020

The Royal Australian and New Zealand College of Psychiatrists

Our kaupapa is based on four policy platforms: Don't forget the 5%, Let's work together, Look at the evidence and Get the right people in the right places. Under each platform we outline what we want to see happening in mental health and addiction to bring about change to improve the wellbeing of all New Zealanders.

. 	**Don't forget the 5%** ***Kaua e wareware ki te rima paihēneti*** **Ensuring people living with serious mental health and addiction issues receive the right help when they need it** People living with increasingly complex mental health and addiction issues require support and services delivered by secondary care. The 5% have co-morbid presentations that make diagnosis, treatment and support challenging, e.g. they may require admission to hospital. While the RANZCP supports greater integration across the health sector there is still a need for a well-resourced secondary service. The RANZCP is concerned that funding will be directed away from these services resulting in the 5%[1] experiencing greater difficulties in accessing support and services with a subsequent deterioration of their health. To improve the health of all New Zealanders we believe investing in public health strategies as these activities will be cost-effective in preventing many of health issues prevalent in New Zealand.
	**Let's work together** ***Me mahitahi tatou*** **Developing systems to support integrated care** Consumers want a seamless ara (pathway) where they receive optimal care across community, primary care and secondary services. To deliver care in this environment there must be a greater connectivity between the various services and an understanding of each health provider's role in keeping a person well. The COVID-19 situation demonstrated that the sector can work very effectively together as a team. To achieve integration the following support must be in place: redesigning the health IT infrastructures, directing resources to navigator roles to support consumers, funding multi-disciplinary teams who can meet the consumer's complex physical and mental health needs and investing in the Whānau Ora model.
	**Look at the evidence** ***Tirohia nga take*** **Supporting New Zealand research to ensure interventions are cost effective and culturally appropriate** New Zealand has its own cultural and legislative structures that influence how health services are provided and used by people with health problems. Using overseas data to inform our interventions does not always work. Improving health outcomes in New Zealand must be informed by evidence and evaluation based on our own research and data. People with lived experience, Māori and Pacific perspectives should be woven into our evidence-based solutions. e.g. traditional approaches to health and wellbeing are valued alongside the western–biomedical ones.

[1] People with complex and chronic mental health needs e.g. chronic psychosis, people with dementia.

Get the right people in the right places
Kia tika ngā tāngata ki te wāhi tika

Prioritising collecting data that quantifies and describes the mental health and addiction workforce
These data are essential in matching workforce development with specific health needs and new models of care. Early investment in planning and future-proofing the workforce will increase the ability to deliver more choice and greater access**.**
What is needed: good data on each medical speciality including health professionals and all non-registered workers, sub-speciality data e,g. who is working with specific populations such as older people, a comprehensive understanding of the entire medical workforce pipeline, e.g. those who are in training, those moving to retirement.Without this information it is challenging to address workforce shortages and understand future gaps in service delivery.

Supporting kaupapa[2] Māori mental health services
The principles of the Treaty of Waitangi must be operationalised whereby Māori determine what health services are best for them, have ownership of those services and funding models support those initiatives that improve Māori health outcomes Western models of health that underpin our health system have failed to deliver benefits for Māori therefore investment must be urgently directed to kaupapa Māori services.

[2] A Kaupapa Māori paradigm whereby principles such as whanaungatanga,tikanga Māori and the wider context of hauora is integral to a mental health system that improves access for Māori.

Royal Australian and New Zealand College of Radiologists

The Royal Australian and New Zealand College of Radiologists (RANZCR) believes that all New Zealanders have a right to high quality and equitable medical treatment. Leading causes of death, such as cancer and stroke, are no longer untreatable. With early diagnosis and intervention, these patients can continue to live fulfilling lives.

As the population ages, and medical care becomes more effective and more complex, New Zealand must ensure we have the capacity to diagnose quickly and provide treatment. Current waitlists suggest that there is insufficient capacity in the system. A closer look demonstrates that some regions and socio-economic groups are more disadvantaged than others.

New Zealand must ensure that clinical radiology and radiation oncology have enough capacity to meet the current and future health needs of New Zealand. Clinical radiologists are central to the diagnosis of many health conditions, including cancer, and are also key to the treatment of acute presentations such as removal of blood clots. Many cancer cures and palliative treatments are reliant on timely provision of radiation therapy (approximately half of patients with cancer can benefit from radiation therapy).

RANZCR asks that the Members of Parliament who form New Zealand's Government in 2021 continue to prioritise health, building on recent work done in the Cancer Action Plan, the Health and Disability Review and Health Workforce's modelling activities.

RANZCR seeks the support of the Minister of Health for the following key priorities:

- Investment in the medical workforce that supports clinical radiology and radiation oncology services in New Zealand. To ensure New Zealand has the doctors it needs to serve its population, we need to train more clinical radiologists and radiation oncologists and to employ enough to meet patient demand now and into the future.

- Modernise technology and expand capacity to efficiently support the work of New Zealand's radiation oncologists and clinical radiologists. The Health and Disability Review Report and the Cancer Action Plan support a national strategy for investment in technology to drive efficient clinical practice and improve equity, especially for currently underserviced regions and populations throughout New Zealand:

    - New Zealand needs 10 additional linear accelerator (linac) machines[49] and the bunkers to house them in by 2023 to meet patient need and alleviate regional inequalities.

    - Currently many public hospital radiology IT systems (RIS/PACS) are inefficient, struggle to interface with other systems, and are incompatible with other platforms. Developing a nationally interoperable radiology IT system would enhance the delivery of integrated and coordinated healthcare by:
        - helping providers achieve greater collaboration of healthcare information
        - improve data collection and standardise the type of data being collected
        - improve efficiency, storage and transfer of patient information
        - allowing different medical IT systems to inter-connect, communicate and share information and images.

[49] Machines used to deliver radiation therapy to patients

Royal College of Pathologists of Australasia

The Royal college of Pathologists of Australasia (RCPA) is the professional organisation in Australia and New Zealand that oversees the training and accreditation of specialist pathologists. Pathologists are the medical specialists who study the cause and diagnosis of disease. Their roles range widely and include diagnostic and surveillance testing across nine subspecialties: microbiology, anatomic pathology, haematology, chemical pathology, clinical pathology, immunopathology, genetic pathology and forensic pathology. Pathologists perform, interpret and oversee a range of tests – we are a 'panspecialty' in the sense that almost every patient who encounters the healthcare system is affected by what we do. Any blood test or swab and almost every cancer diagnosis will involve, or be made by, a pathologist.

The College recognises a number of issues which have the potential to impact patient care currently:

Workforce

The NZ pathologist workforce is a small workforce with 288 RCPA Fellows in 2016, half of which were anatomic pathologists. Forty percent of this workforce was over 55 years of age in 2016 with almost a third planning to retire within five years. [50] The College undertook an analysis of projected workforce modelling and identified a gap of between 15 to 23 trainee positions across all disciplines in NZ if workload continues to grow at the current pace.

These looming shortages in our workforce are echoed across the world with shortages identified in the UK, USA, Ireland, Canada, South Africa, Europe, and SE Asia . Therefore it is not possible for us to import the specialists we need from overseas. Access to training posts and positions, once qualified, within New Zealand will need to be improved.

Complexity of tests

Recent developments such as the explosion in genomic testing and companion medications has led to an increased demand on laboratories to provide personalised testing of cancers to allow for tailored treatment. This is compounded by an increasing complexity requirement for specimen reporting and multidisciplinary review. In essence, pathologists are required to perform more testing within an ever increasingly constrained budget. A lack of co-ordination for testing across the country also leads to variation and waste within the laboratory ecosystem, with multiple sites developing tests at different rates leading to variable access and standards across the regions.

HPV screening

The delay in the change from cytology to HPV based screening has led to a situation where the cytopathology workforce is dwindling while still being required to provide the current screening requirements. This workforce is strained and the lack of certainty, with frequent delays, places this service at risk.

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[50] Royal College of Pathologists. New Zealand Pathologist Workforce Study 2018. Available from: https://www.rcpa.edu.au/getattachment/5f15f210-30ce-48e7-9332-5538571f74ab/NZPW.aspx

COVID-19

The COVID-19 pandemic has demonstrated the key role that laboratories and pathologists play in the diagnostic pathway. Microbiologists across NZ and Australia have been critical to the management if the pandemic in Australasia more specifically they have lead:

- The development of the genomic tests to enable the diagnosis of COVID19
- The upscaling of laboratories to be able to deliver the over 700,000 tests that have been performed to date.
- Setting up systems to assure the testing is of a high quality with appropriate turn around times that enable appropriate quarantining and contact tracing. .

Initiatives that The College has supported include:

- Guidelines for infection control, testing methodology and quality assurance, post-mortems
- Position statement on testing methodology
- Funding streams for testing in Australia
- Support for trainees and Fellows
- RCPA QAP development of a quality assurance program for the COVID19 test

The Royal New Zealand College of General Practitioners

We are New Zealand's largest medical college with a membership of more than 5,500 GPs. We advocate for equity, access, and sustainable healthcare and believe that regardless of who or where they are, every New Zealander should have access to their own GP.

The College is the post-graduate training organisation for doctors wanting to specialise in general practice. Right now, 871 doctors are training to be GPs in our General Practice Education Programme (GPEP) which covers clinical and practical education and takes around three years.

We set and assess quality standards for general practices and administer the professional development programme our members must complete every year to maintain their practising certificates.

Other College functions include research, assessment, communication, representation, and advocacy.

The College is governed by a Board, which is supported by subcommittees, representative groups, advisory groups, and the College's management team. The Division of Rural Hospital Medicine is a separate, but related, Fellowship which comes under the auspices of the College.

The four most important issues we can assist Government with, in relation to general practitioners and general practice, are:

1. **Value of the GP workforce**
   GPs play a vital role within the New Zealand community and are highly valued. The first-contact care GPs provide means 90 percent of patients' health problems can be dealt with in the primary care setting. Research has found that the higher the ratio of primary care physicians to population, the better the health outcomes for patients. In contrast, an increased supply of secondary care specialists is associated with more spending and poorer care. Evidence also demonstrates that it is more cost effective for GPs to provide care for common illnesses than other specialists.

2. **Health equity and access**
   The standard of health of the most privileged or advantaged groups in New Zealand should be attainable for all New Zealanders, irrespective of their ethnicity, the area they live in, or their ability to pay. In the 2018/19 year 30.4 percent of New Zealand adults and 19.9 percent of children reported one or more instances of unmet need in primary health care. This was largely due to patients not being able to access their normal GP within 24 hours due to cost barriers. Māori and Pasifika were more likely to have unmet needs than the rest of the population.

3. **Advocating for resources**
   Underpinning our priorities is the need for adequate and sustainable funding. The Health and Disability System Review recommends changes to how GPs are paid and puts increased importance on contracting and local commissioning. The College is well positioned to have a strong leadership and advocacy role in the "more flexible arrangements for funding general practice" recommendation of the report (page 122). Our sector has long known, and been vocal about, the capitation model being very 'one size fits all' and that it needs to be reworked to cater to the increasingly complex demands of our patients.

4. **Changing models of care.**
   On 21 March, with just over 48 hours' notice, the College asked our 5,500 GPs across New Zealand to begin remote consultations – seeing patients by phone and video – with a target of 70 percent of consultations happening this way. We made the decision having taken advice from overseas that showed sick patients sitting in waiting rooms had fuelled the rampant spread of COVID-19.Our shift to remote consults has had many implications

for community-based health services, which consistently deal with 90 percent of New Zealand's health needs, COVID-19 or no-COVID-19.The change, although dramatic, shows the nimbleness and flexibility within community medicine.

Underpinning everything we do now is our keenness to be involved in determining the detail of the Health and Disability System Review and how that will work best for general practice.

Our leaders

Dr Samantha Murton | President

Dr Samantha (Sam) Murton is a working Wellington GP with a goal to advocate for the profession at a national level. Her vision for general practice is best reflected in her 2020 work (with collaborators) *A manifesto for general practice: an equitable, accessible health-positive model*. Read a copy of the College's manifesto.

Lynne Hayman | CEO

Lynne has led the College as CEO since June 2019. Good leadership, a strong workforce, and sustainability are priorities for Lynne in her College role. She's also working to better support members and lead the College to achieve ambitious goals.

Dr Bryan Betty | Medical Director

Dr Bryan Betty is a working GP with a clinic in Cannons Creek, East Porirua, a suburb known for its high needs and social deprivation. He often represents clinical interests for the College, speaking regularly to media and writing opinion pieces on topical medical issues. He is also the chairperson of the Primary Care Sub-Group of TAG (Technical Advice Group) for COVID-19.

Royal New Zealand College of Urgent Care (RNZCUC)

Urgent care is the medicine practised in community urgent care clinics. These clinics are open 7 days a week, from at least 8am until 8pm, have x-ray on-site, and treat some conditions that are also managed in emergency departments, such as limb fractures and complex lacerations. Urgent care medicine is a specialist vocational scope, distinct from general practice and emergency medicine.

Urgent care clinics see over 2.5 million cases each year, around double that of the emergency departments in the country. They markedly increase the access for patients because they are open 8am to 8pm (as a minimum), 365 days a year. This access is especially available for under 14s, whose treatment is free at all clinics, and those with injuries, the latter make up on average 40% of the volume.

Urgent care reduces the load on emergency departments by providing community facilities where urgent care doctors diagnose and treat patients generally with higher acuity injuries and medical complaints, with low referral rates to hospital. In Auckland, the referral rate to hospital from urgent care clinics has been lower than 5% for each quarter of the last 5 years.

New Zealand has the lowest rate of emergency department attendance per capita in the developed world. It is the only country in which urgent care is recognised as a branch.

	New Zealand		**Australia**	**UK**	**USA**	**Canada**
	Auckland	Rest of NZ				
Minimum	168	240	291	345	388	468
Maximum	200	260	331	345	428	484
Average	**184**	**250**	**311**	**345**	**408**	**476**

ED admission rates per 1000 (Clearwater, 2014)

Urgent care is a relatively new branch of medicine, first recognised by the Medical Council in 2000. RNZCUC trains doctors in urgent care at a cost to Health Workforce New Zealand of $16,000 for the four-year programme, a fraction of the cost to train doctors in other branches.

During the period of level 4 lockdown almost all urgent care clinics remained open to patients, apart from those converted to a CBAC. At the remaining urgent care clinics, while initial triaging was completed using telehealth (typically a mobile phone call), over 95% of consultations were still in-person. 15 (13%) of the initial CBACs were urgent care clinics, thus urgent care clinicians and staff contributed greatly to the 112,684 screened and swabbed over Level 4.

In Auckland during Level 4 lockdown, urgent care clinics saw on average 1,500 patients per day face to face, in comparison to the 5 emergency departments which saw 500 and St John which attended 375 per day. Afterhours in April, when general practice was not open, urgent care clinics saw over 22,000 face to face patients, more than the emergency departments (13,300) and St John (7,080) combined.

Over the lockdown, those 10 urgent care clinics in Auckland which do not also enrol increasingly were utilised by patients for off-work notices and other certificates, referral letters and updates of long term medications, as the general practices could not provide these for the patients they

receive capitation for. They also increasingly dealt with skin disorders including burns, fractures and ENT diseases which required face to face care including examinations, procedures and management.

Our **overriding challenge** is that, despite urgent care making a significant contribution to the health system, many lay people, the Ministry, health professionals, and administrators are still not aware that urgent care is a branch with a unique scope of practice. During the pandemic, communication with the Ministry was difficult. We believe that it is important to improve communications between Ministry and urgent care, and for planners to understand the differences between general practice and urgent care, giving consideration to utilising urgent care clinics when planning strategic responses.