New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

31st May 2019

Health and Disability System Review

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The New Zealand College of Midwives is the professional organisation for midwifery. Our members are employed and self-employed and collectively represent over 90% of the practising midwives in this country. There are approximately 3,000 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to, on average, over 60,000 women and babies each year. New Zealand has a comprehensive and efficient maternity service model which centres care around the needs of the woman and her baby.

Midwives undertake a four-year equivalent undergraduate degree to become registered followed by a mandatory first year of practice program which includes full mentoring by senior midwives, access to additional clinical support and ongoing education. The undergraduate curriculum meets all international regulatory and education standards. Midwives are authorised prescribers in relation to their Scope of Practice as determined by the Midwifery Council.

Midwives provide an accessible and primary health care service for women in the community within a continuity of carer model as Lead Maternity Carers. Midwives can also choose to work within secondary and tertiary maternity facilities, providing essential care to women with complex maternity needs.

The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and wellbeing.

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The New Zealand College of Midwives (the College) welcomes the opportunity to provide feedback on the New Zealand Health and Disability Strategy.

The right to health was described in a Ministry of Health report in 2018.[1] This statement recognised the accountability of governments to provide equal opportunities for *"all people to be healthy, meaning that all people attain the highest possible level of mental and physical wellbeing."* The College supports this statement, which is underpinned by human rights principles, and is hopeful that this government will meet their obligations to work speedily and urgently towards an end to poverty, and an end to racial discrimination in health care, to actively promote and support the wellbeing of all people in Aotearoa, to support secure warm housing for all citizens, to remove barriers to health care access, and to move towards a full recognition of what the statement "giving every child the best start in life" means in its entirety. A review of the health system alone will not improve health outcomes without a broader approach that takes into account the social determinants of health.

The College strongly supports a significant investment in the first 1000 days of life, which requires a dedicated focus on health and wellbeing in pregnancy, and early childhood. There is a growing body of evidence showing maternity care is a critical building block for the foundation of health. Giving every baby the very best start in life is crucial to preventative health care and to reducing health inequalities across the life course. If fully supported, midwives and midwifery care do have the potential to reduce the inequities that continue to threaten health and wellbeing, and this would make a significant valuable contribution to the pathway to health and wellbeing in Aotearoa New Zealand.

[1] Ministry of Health. (2018) *Achieving equity in health outcomes: highlights of important national and international papers*. Wellington, MOH.

Executive summary

Underpinning a positive move towards improvements and sustainability in health, disability services and wellbeing, these are key points from the College submission:

- Proportionate Universalism – equity and health. Inequity creates overwhelming barriers within the context in which we are aiming to make positive changes for health**.** Addressing the social determinants of health, inequity, hardship and poverty is urgent.
- First 1,000 Days **-** evidence shows clearly that investment into pregnancy and the early years is effective and also cost-effective as it reaps significant positive returns in the short and long-term.
- Maternal wellbeing is essential to child wellbeing, and needs to be at the centre of decision making at policy level across all sectors such as health, social services and education. A healthy confident mother provides the essential environment for a healthy nurtured baby.
- Promoting and protecting birth improves the health and wellbeing of mothers and infants, while avoiding unnecessary and costly interventions that can have short and longer-term negative impacts on health and disability. Promoting birth in primary maternity settings for well women, contributes to better maternal and child health outcomes for both the short and long term.
- Preventive health services and public health services ensure that wellness creation is valued with the aim of keeping people well and preventing disease, rather than treating them for sickness.
- Midwifery is both a preventative and an acute response health service which impacts positively on maternal, infant and child wellbeing, both short and long-term. The College urges more attention be paid to the preventative potential of midwifery, which has the potential to reduce the access and cultural equity gap. [2]
- Support for health professionals (midwives and well child) home visiting services, and childbirth / parenting education, are strongly evidence-based in terms of having positive influences on infant wellbeing in the first year.
- Health workforce planning needs to be holistic across professions, with a 'patient centric' focus as opposed to a provider or 'profession centric' focus.
- The structure of the health system needs to maximise system enablers for all services and health care delivery. There needs to be a careful balance between the efficiency of national frameworks and responsiveness to local needs in decision making and infrastructure investment.

[2] Continuity of midwifery care provides more effective emotional support and improves outcomes for women with mental health and addiction issues, including higher rates of referral to domestic violence and mental health services and lower rates of pre-term labour low birth weight in comparison with traditional models of care. See, McRae, D. N., Janssen, P. A., Vedam, S., Mayhew, M., Mpofu, D., Teucher, U., & Muhajarine, N. (2018). Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. *BMJ*, 8(10): e022220.doi: 10.1136/bmjopen-2018-022220

Feedback

The College has answered the questions posed within the consultation document below:

1. What are the most important values for our future public health and disability system?

Proportionate Universalism – Equity and health

1.1 The most important value for future health and disability systems is one of equity. Health inequalities result from social inequalities. Any health and disability strategy is unlikely to be effective where there are conditions of serious inequity, hardship and poverty, despite the best of intentions. Socioeconomic and environmental conditions need to be addressed urgently within the development of any strategy concerned with wellbeing, as inequity creates overwhelming barriers within the context in which we are aiming to make positive changes.

1.2 Integral to the health and wellbeing of infants and children is the wellbeing of mothers. Maternal wellbeing needs to be at the centre of decision making at policy level across all sectors such as health, social services and education. The health and wellbeing of pregnant, birthing and postnatal women requires the social, physical, emotional, psychological, cultural and spiritual needs of women to be valued, recognised and addressed in the context of health. Poverty and inequity reduce the chances for healthy beginnings for babies in Aotearoa.

1.3 Valuing and supporting parenting. Evidence shows clearly that investment into pregnancy and the early years reaps significant positive returns in the short and long-term. This represents an issue of fairness and justice alongside the argument about this early year's investment making sound economic sense.

1.4 The Families and Whānau Status Report 2016, highlights how financial and psychological stressors impact on the ability of families to function well.[3] The stress of unsafe and unhealthy living environments and the highly likely deterioration in physical, spiritual, and psychological health places an unacceptable burden on pregnant women, women with newborn infants and young children and their families. A major determinant of a range of successful outcomes, including health wellbeing and education, is the well-supported family /whānau.

[3] Social Policy Evaluation and Research Unit. (2016). *Families and Whānau Status Report*. Wellington, Superu.

1.5 The New Zealand Human Rights Commission's 'thematic snapshot report' on inadequate housing in New Zealand and its impact on children described the prevalence of New Zealand children living in substandard housing conditions as a major public health and children's rights issue.[4] This contributes to acute and chronic ill-health and impacts on wellbeing and education.

1.6 Continued focus on individual behaviour change being viewed as a panacea to solve health problems is an inadequate response. A shift towards recognition and acknowledgment of the inequalities and injustice within society, and the challenges experienced by many people due to inequity, poverty, racism, and system will have a greater impact on health outcomes, and should be considered a building block towards achieving health equity

1.7 Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need. Funding frameworks which support this concept need to be developed and invested in for all health services, as a means to enable practitioners to respond to the unmet health care need and inequity that they face in practice.

Investment in the first 1,000 Days

1.8 The Global Initiative, the 'First 1,000 days', has the stated mission of making the wellbeing of women and children in the first 1,000 days a policy and funding priority. The College supports all the key indicators described in the 'First 1,000 days' framework which includes social investment in infants and children, and their statement which draws attention to the need to care for pregnant women and mothers, "*The first 1,000 days between a woman's pregnancy and a child's second birthday are universal. No matter where they live, all mothers and children need the same "building blocks for a healthy future."* [5]

[4] New Zealand Human Rights Commission and He Kainga Oranga / Housing and Health Research Programme. (2016) *Inadequate housing in New Zealand and its impact on children: Thematic snapshot report to the United Nations Committee on the Rights of the Child*. University of Otago, Wellington, NZURC, He Kainga Oranga.
[5] The First 1,000 Days. *An urgent opportunity: a healthy first 1,000 days for mothers and children everywhere*. https://thousanddays.org/the-issues/

1.9 The G20 initiative for Early Childhood Development, which is aimed at building human capital to break the cycle of poverty and inequality, provides a template for action.[6] Point 10 specifically mentions quality primary healthcare, and the importance of pregnancy, childbirth and breastfeeding to health and wellbeing.

1.10 The Australian Government has developed a document focussed on the social and emotional development and wellbeing of infants in pregnancy and the first year of life. This document is underpinned by discussion of relationships with parents and caregivers and also uses the GRADE approach to assess quality of evidence for effectiveness of interventions.

1.11 This document summaries the evidence for benefits of antenatal and postnatal education, in terms of infant cognitive and social development, infant mental health, parenting quality and couple adjustment, reduction in maltreatment, and health promoting behaviours. Home visiting interventions were also found to be of benefit starting before birth and in the first year of life. These are all aspects of care delivered by midwives and delivered in homes around New Zealand. For further results of the interventions assessed using the GRADE approach the link to this document is in a footnote.[7]

1.12. A recent study from Canada highlighted the inequity in maternity care in terms of women in lower socioeconomic positions being more susceptible to poorer infant birth outcomes, and the aim of this study was to determine if antenatal midwifery care could minimise the risks of adverse outcomes. The study demonstrated significant reductions in small for gestational age birth, preterm birth and low birth weight births for women of lower socioeconomic position who received antenatal midwifery versus physician led care.[8] Women cared for by midwives were also more likely to have mental health needs identified. New Zealand's experience and data shows similar patterns of client access and usage and the College urges more attention be paid to the equity and prevention potential of midwifery to do more to reduce the access and cultural equity gap.

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[6] United Nations G20. (2018). *Initiative for Early Childhood Development: Building human capital to break the cycle of poverty and inequality.* Argentina. https://www.g20.org/sites/default/files/documentos_producidos/g20_initiative_for_early_childhood_development.pdf

[7] Australian Government / National Health and Medical Research Council. (2017). NHMRC Report on the evidence: Promoting social and emotional development and wellbeing of infants in pregnancy and the first year of life. https://aifs.gov.au/cfca/2017/05/08/report-evidence-promoting-social-and-emotional-development-and-wellbeing-infants

[8] McRae, D. N., Janssen, P. A., Vedam, S., Mayhew, M., Mpofu, D., Teucher, U., & Muhajarine, N. (2018). Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. *BMJ*, 8(10): e022220.doi: 10.1136/bmjopen-2018-022220.

1.13 Protecting birth physiology has been a cornerstone of midwifery practice, with the aim of improving the health and wellbeing of mothers and infants, while avoiding unnecessary and costly interventions that can have short and longer-term negative impacts on health and disability.

1.14 A recent randomised control trial provides a timely example of the short and long-term repercussions of routine practices that disregard physiology. Mercer et al. studied the effects of the timing of umbilical cord clamping on infant ferritin levels, brain myelin content and neurodevelopment.[9] Midwives have long been supporters of delaying cord clamping at birth and the results of the Mercer et al. RCT has provided more evidence for this practice. Babies in the delayed cord clamping group had greater ferritin levels and increased brain myelin in areas important for early life functional development. The endowment of iron-rich blood cells from the placenta, obtained through a delay in cord clamping may offer a longitudinal advantage for early white matter development.

1.15 An expanded discussion about population health and wellbeing indicators within a health and disability strategy is necessary within the context of pregnancy and birth. The health of future generations depends on recognising the importance of pregnancy, birth, mothering, parenting, and the early years, and not only addressing the inequities, but in preventing them in the future. The aim should be to ensure that all mothers and babies are thriving and that pregnancy, birth, and transition to motherhood experiences are positive and fulfilling.

2. Think about how the best health and disability system for New Zealand might look in 2030. How would that be different from the system we use today?

2.1 More people are seen, supported and treated within their own communities, including rural communities. This means support for more patient centred primary health services, which include outreach services and home visiting models rather than centralised services.

2.2 There will be recognition of how people need support during critically important life transitions such as pregnancy and parenting.

[9] Mercer, J. S., Erickson-Owens, D. A., Deoni, S. C. L., et al. (2018). Effects of delayed cord clamping on 4-month ferritin levels, brain myelin content and neurodevelopment: A randomised controlled trial. *The Journal of Pediatrics*, 203:266-272.

2.3 The need for mental health support services will be reduced as people are better supported during life transitions and low socioeconomic circumstances such as those related to poverty and housing stressors are ameliorated.

2.4 Preventive health and public health services ensure that wellness creation is valued with the aim of keeping people well and preventing disease, rather than treating them for sickness (pathology). Salutogenesis, as a theory of generating wellness developed by Antonovsky [10] [11] is grounded firmly in preventative public health services and work towards optimal health and wellbeing. The salutogenic model, "*proposes that the goal of health research should be to identify, define, and describe pathways, factors, and causes of positive health to supplement our knowledge about how to prevent, treat, and manage negative health or pathogenesis."* [12]

2.5 Health workforce planning is holistic, based on the patient journey, and includes all professions in all settings. Traditionally, medical education has been isolated from the rest of the health system and this segregated disconnected model can have a negative impact on timely and early diagnosis, medicalising primary health care, organisational responses, workforce stress and recruitment and retention. A future vision will see a big picture approach with integration, communication, collaboration and attention to issues such as student numbers and placements across health settings and professions to avoid the medical education model displacing students from other disciplines and destabilising the whole of the health workforce potential.

2.6 Health care systems and services are fully enabled with infrastructure to enable connectivity and access to information. Technology is fully enabled and supports access to timely health care and treatments.

2.7 There is the 'right' balance between nationally derived service frameworks and infrastructure development, and regionally or locally devolved decision making and investment. Governance arrangements across all relevant health service delivery organisations include a consumer voice and are not dominated by any one health care profession. All health professionals are able to practice to the top of their scope.

[10] Antonovsky, A. (1979). Health, stress and coping. San Francisco, Washington, London: Jossey-Bass.
[11] Antonovsky, A. (1993). The implications of salutogenesis: An outsider's view. In A.P. Turnbull, J.M. Patterson, S.K. Behr et al., Cognitive coping, families and disability, (pp. 111-122). Baltimore: Paul H. Brookes.
[12] Antonovsky, A. (1979). Health, stress and coping. San Francisco, Washington, London: Jossey-Bass.

2.8 Decision making for patient care decisions is devolved to lowest possible level within appropriate regulatory frameworks to enhance accessibility of care and promote self-efficacy and individuals taking charge of their own health and wellbeing.

3. What changes could make our health and disability system fair and equal for everyone?

3.1 Addressing issues of injustice, unfairness, poverty, housing, discrimination, racism, gender bias, and pay equity, while raising benefit rates, and implementing a living wage, and at the same time addressing the failure to recognise the needs and rights of a diverse population in the health system.

3.2 Sir Michael Marmot identified that reducing health inequalities requires action on six policy objectives:[13]

1. Give every child the best start in life
2. Enable all children young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

3.3 As outlined by Marmot these policy objectives will not work without effective local delivery systems focused on health equity in all policies, and this in turn can only happen by enabling effective participatory decision-making at a local level, which can only happen by empowering individuals and local communities. In Aotearoa New Zealand these actions also need to recognise the self-determination of Māori and direct facilitation of the models that support Māori health, and will require work on eliminating structural and institutional racism across all health and disability services.

4. What changes could most improve health for Māori?

4.1 More work is needed to provide appropriate, effective and accessible health care and support to Māori to reduce inequity. A whānau ora approach, whānau focus and increased support for Māori communities, Māori health professionals, kaupapa Māori community health organisations and primary care across New Zealand is necessary.

[13] Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair Society*, *Healthy Lives: The Marmot Review*. Strategic Review of Health Inequalities in England post 2010.

4.2 In regards to institutional racism with Crown funding and contracting practices, identified by Came et al. in 2015, discrepancies in funding are "a contemporary breach of Te Tiriti o Waitangi and a colonial legacy of missed opportunities to improve Crown practice." [14]

4.3 Access to sustainable long term funding and ongoing support enables medium to long term planning, which is essential when working in areas of health promotion and wellbeing, and it also improves the likelihood of increased staff capacity, mentoring and the retention of experienced workers.

4.4 Improving outcomes for Māori requires issues of structural racism and inequity to be addressed within society, and within health and disability and child care and protection services.

4.5 The development of more community and marae based services.

4.6 The Te Pae Mahutonga health promotion model (Durie, 1999) highlights significant components of public health and health promotion, as they apply to Māori health.[15] The principles also provide a framework for improving the health of all New Zealanders. In the context of health and disability discussions and the first 1000 days this framework can highlight the key issues that government and policy makers need to consider to effect any improvements in health; *Leadership*, in terms of implementing increased funding for services involved in the first 1000 days mahi, including the use of preventative services, evidence based research, evaluation and accountability frameworks; *Autonomy*, to implement equitable access to all reproductive services and including culturally appropriate support for parents; *Environment*, which considers not only issues of housing, including over-crowding of existing homes and access to housing for families, but also a wider environmental picture which encompasses water quality, climate crisis and food security; *Cultural identity*, which considers how services that are culturally appropriate represent the most effective and cost effective approach, and how developing relationships and connections enhances and supports better health outcomes; *Participation*, which aims to improve access and create the conditions for equity, including gender equity, to reduce barriers to services, to provide care continuity to support wellness, to reduce stigma and alienation, and to eliminate racism; and *Healthy Lifestyles,* which includes access to midwifery continuity of care, support for preconception care and healthy pregnancies,

[14] Came, H., Doole, C., Lubis, D., & Garrett, N. (2015). *Benchmarking Crown Practice: Public Health Contracting and Funding. Preliminary report for public health providers*. Auckland University of Technology, Massey University, Keruru Research and Evaluation Associates

[15] Durie, M. (1999*). Te Pae Māhutonga: A Model for Māori Health Promotion*. https://www.cph.co.nz/wp-content/uploads/TePaeMahutonga.pdf

supporting breastfeeding, and removal of the barriers to healthy lifestyle access, which requires an in-depth look at food deserts, the corporate determinants of health, inappropriate marketing of unhealthy food and regulatory measures.

5. What changes could most improve health for Pacific peoples?

5.1 Work is necessary for the development and provision of culturally appropriate, effective and accessible health care and support to Pacific people to reduce health inequity. Health initiatives will be culturally appropriate and utilise indigenous Pasifika concepts, knowledge, values, and practices while addressing the social, cultural and economic factors that prevent Pacific peoples from achieving optimum health and wellbeing.

5.2 More support to promote and support recruitment and retention of a Pasifika workforce.

6. What changes could make sure that disabled people have equal opportunities to achieve their goals and the life they want?

6.1 Redesigned health services throughout Aotearoa which are manageable, accessible and culturally appropriate, and taking account of population diversity when designing health services, community services and developing new city design.

6.2 Recognising the need to involve people with disability, and / or their carers or support people, in all aspects of decision making regarding health, access, options for treatment if applicable, alongside the development of services that can improve quality of life, including employment opportunities, living wages and suitable manageable living spaces.

7. What existing or previous actions have worked well in New Zealand or overseas? Why did they work, and how might they make things even better in the future?

7.1 A midwifery continuity of care model provides evidence for better and more effective health and wellbeing outcomes for mothers and babies which are ultimately not only life-enhancing but cost-effective. Health policy by WHO, UNICEF, UK NHS, and Canada all promote this model of care.

7.2 As a public health initiative the WHO UNICEF Baby Friendly Initiative has successfully contributed to a rise in breastfeeding initiation globally in countries who have championed this programme, including in Aotearoa New Zealand. Evidence for the Ten Steps to Successful Breastfeeding, the economic benefits of supporting women who plan to breastfeed and the significant impact of breastfeeding on infant and maternal health, both short and long term, and supported by evidence-based research, is now indisputable. [16] [17] [18] [19] [20] [21]

7.3 The four Schools of Midwifery and their collaborative approach to clinical placement and rural education. All four schools meet annually to ensure they have a sustainable nationally consistent education system accessible and appropriate for all women interested in taking a midwifery degree. Their discussion and planning includes curricula issues and sustainable clinical placements for students. Schools offer an outreach "spoke and hub" regional system for rural students and have done successfully for many years.

8. What are the most important changes that would make the biggest difference to New Zealanders?

8.1 Resolving issues of inequity, poverty and poor housing, provision of a living wage, fair taxes, valuing women's work both in the paid workforce and the unpaid work involved in mothering and breastfeeding, and investing significantly in the early years of life which includes comprehensive support for parenting.

8.2 Effectively addressing issues such as cold, damp housing for families and for people with existing health conditions who have been living with low incomes has the potential to reduce health inequalities and subsequently reduce health and social care costs.

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[16] Pokhrel, S., Quigley, M. A., Fox-Rushby, J., McCormick, F., Williams, A., Trueman, P., Dodds, R., & Renfrew, M. J. (2014). Potential economic impacts from improving breastfeeding rates in the UK. *Arch Dis Child*, doi:10.1136/archdischild-2014-306701

[17] Renfrew, M. K., Pokhrel, S., Quigley, M., McCormick, F., Fox-Rushby, J., Dodds, R., Duffy, S., Trueman, P., & Williams A. (2012). *Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK*. UNICEF UK commissioned report.

[18] Stuebe, A. (2009). The risks of not breastfeeding for mothers and infants. *Reviews in Obstetrics and Gynecology*, *2*(4):222–231

[19] Bartick, M. C., Schwarz, E. B., Green, B. D., Jegier, B. J., Reinhold, A. G., Colaizy, T. T., Bogen, D. L., Schaefer, A. J., & Stuebe, A. M. (2017). Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs, *Maternal & Child Nutrition*, 13, e12366. doi: 10.1111/mcn.12366

[20] Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., Piwoz, E. G., Richter, L. M., & Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? *The Lancet*, 387(10017):491-504.

[21] Victora, C. G., Bahl., R., Barros, A. J. D.,Franca, G. V. A., Horton, S., Krasevec, J., Murch, S., Sankar, M. J., Walker, N., & Rollins, N. C. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet*, 387(10017):475-490.

8.3 The importance of preconception, pregnancy, birth and postnatal experiences should not be discounted. Good resourcing and funding of services, particularly midwifery services and the well- respected, evidence-based midwifery continuity of care model will make a significant and lasting positive change to the health and wellbeing of New Zealanders.

9. Is there anything else you wish to add?

Refugee, migrant and asylum seeker populations

9.1 The College has some concerns about the absence of discussion concerning the health and wellbeing of refugee, migrant and asylum seeker populations in Aotearoa within consultation documents. The terrorist attack in Christchurch has highlighted the lack of understanding of the needs of migrants and Muslim populations in New Zealand, along with deficits in services which are often related to significant lack of funding and government support. We look forward to equal opportunity and health discussions that include migrant, refugee and asylum seeker people and hope that this will include the development of language resources, not only to support these diverse populations, but to support midwives and other health professionals working with them. The health and wellbeing of refugee, asylum seekers and migrant peoples requires the introduction of culturally appropriate and specifically tailored services to ensure long term effective solutions and a broad policy approach that encompasses health, social services, welfare, economic policy, education, gender equity and employment policy.

Workforce planning

9.2 The College recommends urgent attention to workforce planning, particularly in the area of midwifery recruitment, and retention alongside recognition of the need to deliver culturally appropriate services and the development of workforce planning across all health sectors.

9.3 The evidence does not support a watering down of health service delivery by the use of unregulated workers. Good outcomes depend on knowledgeable and competent professionals educated to a degree standard and supported by well organised administrative, social and cultural support systems.

9.4 Sequential to this is the need for DHBs and PHOs to have workplaces that promote equity and team work rather than hierarchies, work to eliminate bullying, and provide supported work conditions in what are highly complex and stressful workplace settings.

9.5 Improve affordable professional development opportunities for managers to assist and support their skills, and confidence to manage in more complex environments.

9.6 The health workforce is predominantly women and the gender inequities that continue to face women in this workforce represent an urgent priority for action. The Health and Disability System Review provides timely opportunity to consider the effects of gender inequality, while also recognising and addressing economic and social inequalities that affect health and wellbeing. Health systems and society are reliant on the caring professions but health systems often fail to promote, protect, support and reward those who do the caring. Gender-transformative policies and measures must be implemented and addressing gender inequality in the health workforce must be a priority. [22]

Further consultation / evidence-based programmes / implementation / priorities

9.7 The College would be interested to see further consultation of an evidence-based implementation plan for the development and delivery of any proposed health and disability services.

9.8 As previously noted the College supports more community-based care models that include recognition of culturally appropriate needs and an increase in support for health models that support a continuity and relational based practice.

9.9 Interventions to reduce health inequalities may require action at different times, across a specific time period or for longer periods as necessary. Interventions need to be sustainable and systematically delivered to have meaningful impact.

Breastfeeding, infant and young child feeding and nutrition

9.10 Investment in health requires significant investment in support for women who breastfeed. Up to 98% of women initiate breastfeeding in New Zealand and breastfeeding is a public health initiative. Individual behaviour change and 'educating' women is not the issue. The majority of reasons why women discontinue breastfeeding are due to issues totally outside of their own control. [23] [24] [25] [26]

[22] World Health Organisation. (2019). *Delivered by women, Led by men: A gender and equity analysis of the global health and social workforce*. Human Resources for Health Observer Series No 24, Geneva, WHO.
[23] Brown, A. (2015) Milk supply and breastfeeding decisions: the effects of new mothers' experiences. *NCT Perspective*, 29:1-11.

9.11 Breastfeeding protection, promotion and support is an integral part of a health and disability strategy and what this means is better support for breastfeeding women, which includes more funding into postnatal care services, breastfeeding supportive workplaces and early childhood centres, increasing paid maternity / parental leave, breastfeeding friendly communities and environments, culturally appropriate services and education provision for all health professionals working with families and infants.

Climate emergency and unnatural disasters

9.12 Work on reducing climate emergency impact, increasing environmental threats, and threats to water quality need to be significantly important parts of any health and disability strategy.

9.13 There are regular and too frequent significant threats to public health due to poor management of water supplies and a lack of attention to sustainability and a future-proofing vision.

Conclusion

Marmot notes, "*Individuals' opportunities to control their lives, to be empowered, and to participate fully in society are heavily determined by the way we organise our affairs in a society."* [27]

The College hopes for significant, transformational, structural and social change, with the use of evidence-based policies and the necessary political will to address issues of inequity, poverty, gender and racial discrimination, and the social and corporate determinants of health. Transformational change requires courage and determination on behalf of policy makers, and it needs to take into account consultation with key actors, evidence of effectiveness, cultural acceptability, feasibility, and sustainability. At the same time it needs to recognise issues of justice, fairness, gender, equity, human rights, and infant and child impact.

[24] McFadden, A., Gavine, A., Renfrew, M. J., Wade, A., Buchanan, P., Taylor, J. L., Veitch, E., Rennie, A.M., Crowther, S. A., Neiman, S., & MacGillivray, S. *(2017)*. Support for healthy breastfeeding mothers with healthy term babies. Cochrane Database of Systematic Reviews, 2, *Art. No.: CD001141. DOI: 10.1002/14651858.CD001141.pub5.*
[25] Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., Piwoz, E. G., Richter, L. M., & Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? *The Lancet*, 387(10017):491-504.
[26] Payne, D. and Nicholls, D. A. (2010), Managing breastfeeding and work: a Foucauldian secondary analysis. *Journal of Advanced Nursing*, 66: 1810–1818. doi:10.1111/j.1365-2648.2009.05156.x
[27] Marmot, M. (2006). Health in an unequal world. *The Lancet*, Harveian Oration, 368(9552):2081-2094.

It is critical to start at the very beginning and this means recognition of the urgent need to consider how Aotearoa can provide the very best start in life for every baby, as this is crucial to preventative health care and reducing health inequalities across the life course. Unfortunately, if this beginning step is under-resourced and under-funded, and the significance of care in pregnancy, and the breadth and scope of midwifery care is misunderstood, or the potential it has to reduce inequities not fully realised, this represents a significant threat to health and wellbeing. It may also mean that funding investments in services targeting health issues in later years are much less effective. Interventions need to be transformational and with an intergenerational focus. Investment in preventative health initiatives and the provision of support for pregnant women, parenting and child health, as described in the first 1,000 days, will provide a pathway to health and wellbeing in Aotearoa New Zealand.

Ngā mihi

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