Voices for health: going, going, going…

Boyd A Swinburn

This time last year, I was feeling quite optimistic about the potential for real action on improved public health from this Government. We were entering a new phase for health as the Simpson report[1] was about to be implemented on steroids, with its explicit priorities on population health and joined-up health structures for improved health equity. Voices for health were heard from within and outside the healthcare system and the Labour Government seemed open to listening to ways to tackle the big health questions of our time—not only the acute infectious disease pandemics, like COVID-19, but also the chronic pandemics of obesity and non-communicable diseases. Consideration was also being given to the capacity and resilience of our wider societal and infrastructural systems to cope with health threats from the multiple climate, economic and social disruptions we will be facing in the future as a nation.

Health Coalition Aotearoa, which I co-chair, argued strongly for the two new health entities, Health New Zealand (Te Whatu Ora) and the Māori Health Authority (Te Aka Whai Ora) to have a legislative responsibility in the new Pae Ora health structures to address the underlying social determinants of health.[2] It was therefore pleasing that the *Pae Ora (Healthy Futures) Bill* was amended to explicitly include these responsibilities. The Simpson report noted that about 80% of our population's health and health equity status is determined by factors outside the healthcare system,[1,3] so it is appropriate that the healthcare system should be a strong advocate for prevention policies beyond the hospital walls—the ambulances at the bottom of the cliff should have a strong voice in the need for fences at the top of the cliff. It is also pleasing to see that Associate Minister of Health, Barbara Edmonds, has the specific responsibility for "health in all policies". This is in keeping with the purpose of the Pae Ora health reforms, whereby the health sector needs to influence health-relevant policies under other ministers' jurisdictions.

However, the last 12 months has also seen a progressive, and concerning, loss of voices for public health with the firing of Rob Campbell, chair of Te Whatu Ora's Board, as a recent, visible, example.

In May 2022, the New Zealand Medical Association (NZMA) went into receivership after 136 years of service as a highly respected advocacy voice for improved healthcare services and prevention policies. While not related to the changes in health structures, the timing of this significant loss of independent voice for health was very unfortunate. NZMA was a true champion for health, but we have now lost that valuable platform for doctors working at the clinical and public health coalface to bring their experiences and calls for action to the national policy table.

Independent, evidence-based health advocacy is essential for improving clinical care and public health. The health experts who conduct research in New Zealand, understand the international evidence and deliver health on the clinical and public health frontlines need to be able to bring this knowledge and these insights into the public arena for debate. This is especially true for commercially available products backed by strong counter-lobby voices, like alcohol and ultra-processed food, that are creating such health harm.

Shortly after the change to the new Pae Ora health structures in July 2022, the then Health Minister, Andrew Little, shut down the ability of these new structures to continue to provide a range of public submissions on government consultations, including Select Committee processes. This came as a shock to the sector because it was not signalled as part of the new regime. This has closed off a critically important avenue for various parts of the healthcare sector to publicly comment on consultations that involve the underlying determinants of health that lie outside the jurisdiction of the healthcare sector (e.g., justice, housing, education, tax, social welfare). Mechanisms are apparently underway within Te Whatu Ora to collate the plurality of expert comments across the government-funded health sector into a single, corporate submission. However, this runs the risk of burying the diversity of evidence, stories and perspectives within a single, centralised submission. For example, the impacts of alcohol policies are experienced very differently in emergency departments, mental health services, licensing processes and paediatric

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services, and their voices are likely to be more impactful if they can be heard separately.

As a further illustration, the Ministry of Education ran a consultation in mid-2022, just prior to changing to the Pae Ora health structures, on whether schools should be required to ensure that any foods and drinks they sell or provide to students would be healthy.[4] Such a policy was obviously seen as very important by the health sector that is dealing with the downstream consequences of childhood obesity, dental caries and poor mental health. Among the 52 submissions from health organisations, there were 12 from government health agencies (e.g., public health units, district health boards and the Ministry of Health), 10 from government-funded organisations and programmes (e.g., Healthy Families NZ, regional sports trusts) and six from NGOs, which receive some government funding.

If this consultation had been held a few months later, all the health agencies and probably the government-funded programmes would have been barred from publicly submitting to this important health consultation conducted by the Ministry of Education. Now there is the added bureaucracy and time delays involved in organising the inputs from the myriad parts of Te Whatu Ora into a single corporate submission under central control and the loss of the diversity of frontline perspectives, both of which risk a weakening of the health voice.

While it is true that Chris Hipkins, as the then education minister, did not heed the concerns of the health sector and allowed schools to continue to feed or sell unhealthy food to their students, the fact that we previously heard the variety and number of expert voices from within the health system on behalf of children's health, and now we won't, signals a significant loss of health democracy.

In late-2022, two senior health people were admonished by the health minister for supporting an important piece of preventive legislation—Chlöe Swarbrick's Private Member's Bill to strengthen Local Alcohol Plans and buy-out alcohol sponsorship of sports and events. Minister Little argued that Dr Gary Jackson, Director of Population Health at Counties Manukau Health, and Rob Campbell, chair of Te Whatu Ora's Board, had overstepped the mark in voicing support for a non-Government Bill.[5]

Minister Little may have been technically correct in his judgment, but the public nature of Dr Jackson's telling off and Mr Campbell's subsequent firing (triggered by his later comments on managing water systems) have sent negative ripples through staff and boards of the new health entities—the message seems to be "*no matter how important the population health issue is, do not speak up in favour of preventive action the government should be taking*".

Clinical doctors have a duty of care to speak up on behalf of patients. If there are evidence-based, effective practices in hospitals that would really benefit patients, we expect them to advocate for those practices to be implemented. We still hear from some courageous senior doctors in the media about ways the hospital system should act to improve patient outcomes, despite a perception that speaking out may affect their career. Similarly, the public has come to expect advocacy from public health physicians who have a duty of care to the populations they serve. If there are evidence-based, effective policies to prevent death and disease, we expect public health physicians to speak up on behalf of their communities.

Unfortunately, public health physicians who are classified as public servants may feel constrained in their ability to advocate by the rather outdated 2010 *Standards of Integrity and Conduct* managed by the Public Services Commission.[6] Statements such as "*We must avoid any activities that may harm the reputation of our organisation*", "*We must always be careful that our actions do not compromise our organisation or our Minister*", "*The importance of keeping politics out of our job and our job out of politics is undiminished*" are problematic when these aspects of the code clash with doctors' ethical duty to speak up on behalf of the health of patients and communities. There is no distinction between "party politics", which public servants should clearly not be commenting on in their professional roles, and "politics" in general—most systemic clinical and public health decisions are intrinsically political because they involve resource allocation and policy-making. Much greater clarity is needed on these matters from the Public Service Commission.

In addition, Medical Officers of Health used to provide free, frank and relatively independent public health advice to their communities through the media, but we now rarely hear from them. The centralised public health messaging, which was so valuable during the COVID-19 pandemic, appears to be now entrenched, including through a new section of the *Health Act* (s7A[9]), which was inserted in July 2022 giving explicit powers to the Director-General to revoke the designation

of a Medical Officer of Health for reasons unspecified.[7] The centralisation and control of communications and the clamp downs on senior doctors speaking out for health has created a chill effect on health democracy and it is a serious impediment to improving the health of New Zealanders.

These negative ripples have also impacted the way that public health services operate. For example, some public health units work in collaborative alliances with NGOs and community organisations to improve population health locally. This is what they should be doing, but there is a palpable nervousness within those services about whether they are allowed to participate in wider community efforts to advocate for healthier environments. In addition, Health Coalition Aotearoa has heard concerns from some of its members about Te Whatu Ora's heavy-handedness if an NGO is undertaking advocacy activities, even if advocacy is part of their government contracts. The fear of losing government contracts has further dampened the voices of the NGO sector for addressing the determinants of health.

In such a short space of time, we have lost many important voices for health and the nervousness about speaking up for health has become pervasive. This is the opposite of what my hopes were for population health under the new health structures a year ago. I believe this has been a backward step for public health in New Zealand. We desperately need policies to prevent the huge harm from products like alcohol and ultra-processed foods. For decades, the lobbying from these harm industries has dominated the political power dynamics resulting in no meaningful government policies for many years despite overwhelming evidence of their harm.

The obesity epidemic and appalling dental health in this country have remained untouched by government policies to tax sugary drinks, subsidise healthy food, ban junk food marketing to children, require healthy food provision in schools or even have a useful front-of-pack food labelling system. The voices for public health action have historically been swamped by industry opposition and now this imbalance is even worse.

Health Coalition Aotearoa was established in 2019 to bring the voices of the health sector together for improved health and health equity through reductions in harm from tobacco, alcohol and ultra-processed foods, as well as through strengthening public health infrastructure to better address the commercial causes of ill health. These three harmful products cause almost one third of our population's premature death, disease and disability, as measured by disability-adjusted life-years lost,[8] and there are many evidence-based policies recommended by the World Health Organization,[9] New Zealand's own experts[10] and government reports,[11] which are simply not being enacted.

The approach being taken by the current Minister of Health, Ayesha Verrall, gives some hope for action. As Associate Minister of Health, she implemented some excellent policies around folate in flour to prevent neural tube defects, fluoridation of water supplies to prevent dental caries, and, of course, the new world-leading legislation for tobacco control. All of these public health policies have been preceded by years of advocacy from health professionals. Minister Verrall will definitely need the strong, diverse voices of the health sector to back her on reducing the harm from alcohol and ultra-processed foods, given the formidable lobby power behind those harmful products.

The Health Coalition does not take government funding so that it can have an independent voice backed by its membership of individual health professionals and health organisations. The rapid demise of advocacy voices for health that I have outlined means that the collective voice of the Coalition is needed now more than ever. Having doctors and other health professionals—who spend much of their working lives managing the consequences of preventable diseases—as Health Coalition members is essential for the sustainability of the organisation. Previous NZMA members know the value of this input.

The loss of advocacy voices or activities from within the new health structures runs counter to the promises of joined-up action for improved population health and health equity under the new Pae Ora health system. The commercial lobbyists for health-harm products not only get direct, non-transparent access to ministers due New Zealand's lack of lobby regulations and monitoring, but they now face a diminished public health voice calling for the regulation of these products. It is the responsibility of the Minister of Health, leaders of the Pae Ora health organisations and the Public Services Commission to create a stronger, safer environment for the experts on the clinical, public health and research frontlines to advocate for better health and health equity outcomes for Aotearoa New Zealand.

COMPETING INTERESTS

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