## Oral submission – Healthy Futures (Pae Ora) Amendment Bill
## Dr Luke Bradford, President RNZCGP

Thank you for the opportunity to speak to our submission on the Healthy Futures Amendment Bill.

The Royal New Zealand College of General Practitioners has a membership of 6,000 GPs and is responsible the training and ongoing quality assurance of General Practice in NZ. We ensure the quality of both practices and GPs.

We will take our submission as read but would like to highlight two key elements.

Firstly, our concern that the amendments tabled seriously undermine the Health Systems focus on the poor health outcomes which are specifically attributable to ethnicity, and secondly that new clauses seek to prevent clinicians from speaking openly about concerns they have around care provided to our communities.

The College recognises its role in upholding Te Tiriti o Waitangi, Māori health rights and prioritising the pursuit of Māori health equity. Whilst it may be an uncomfortable truth that race is an independent indicator of health outcomes, it is undoubtedly so.

Māori across quintiles have a 7-year lower life expectancy than non-Māori in New Zealand. Māori have 3 x the population rate of Diabetes, they have higher rates of ischaemic heart disease, chronic kidney disease and cerebrovascular disease. Māori have higher mortality and later presentations for most cancers but especially lung, cervical and stomach. Māori have higher rates of suicide and substance abuse, they have poorer oral health, lower immunisations rates and face increased barriers to seeking care.

All of these factors speak to a health service which is failing to properly care for Māori whānau. Our members see the inequity daily and recognise the difficulties Māori face in engaging with a system which is seen as doing to them rather than doing with them.

The Pae Ora act looked to recognise a vital partnership for Māori in designing and delivering care to their communities. It recognized the findings of Wai 2575 and its call for stronger accountability to Te Tiriti and to approaches that are Māori led. The proposed changes dilute, disempower or deliberately remove this focus.

The way we have been doing it so far does not work for Māori. The overriding piece of legislation which governs our health system needs to be brave enough to recognise our failings thus far and empower a different strategy, one which Māori communities have told us they see as vital.

Co-design, Iwi led service delivery and accountability must exist in order to lower the burden of disease which are attributable to ethnicity and regain the trust of our Māori and Pacific whānau. This must occur at local as well as national level recognising that autonomy and participation must be available to all. Iwi Māori Partnership Boards are an appropriate vessel for this stewardship.

We must retain health strategies for Māori, for Pacific peoples and for disabled persons as outcomes for all are unacceptable and removing the strategies removes the onus to focus on these poorer outcomes.

Secondly, we have concerns that the new clause 11 moves to silence medical expertise and is a political power play designed to restrict clinical expertise, autonomy and voice. Clinicians, experts in their field, and trusted by society, must be free to speak out when necessary, regardless of how it looks for the government of the day. The addition of clause 11 is clumsy at best and cynical and authoritarian at worst.