



# AUCKLAND WOMEN'S HEALTH COUNCIL

## NEWSLETTER

JULY 2016



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- Cartwright Collective Conference on the control of cervical cancer and the future of cervical screening in NZ - Friday 5 August 2016

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PO Box 99-614, Newmarket, Auckland. Ph (09) 520-5175  
Email: [awhc@womenshealthcouncil.org.nz](mailto:awhc@womenshealthcouncil.org.nz)  
Website: [www.womenshealthcouncil.org.nz](http://www.womenshealthcouncil.org.nz)

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## **NEW ZEALAND HEALTH STRATEGY: FUTURE DIRECTION**

In April 2016, following an extensive consultation by the Ministry of Health, the government published a “refreshed New Zealand Health Strategy.” Minister of Health Jonathan Coleman stated in the foreword that “the Strategy sets the framework for the health system to address the pressures and significant demands on its services and on the health budget.” (1) It is the first review of the health strategy undertaken since 2000. The 39-page document sets the direction for development during the next 10 years and features the words “All New Zealanders live well, stay well, get well” on the front cover.

The Health Strategy refers to the opportunities and challenges faced by the health system, outlines the future we want, and then describes the five strategic themes –

- People-powered
- Closer to home
- Value and high performance
- One team
- Smart system

Significantly, the word ‘poverty’ is not mentioned anywhere in either this document, or in the second part – “Roadmap of Actions 2016.” It is hard to believe that poverty wasn’t mentioned in numerous submissions on the revision of the strategy, especially in connection with child health.

The word ‘investment’ appears frequently throughout the document, as in “investing in health and well-being early in life and focusing on children, young people, families and whanau” – described as setting the foundation for lifelong health – which

is one of four goals listed under the “Closer to home” theme.

For children and young people who are struggling with health and/or social problems, the document states that “it will be important to take a social investment approach and co-ordinate activities across agencies.”

Each of the sections on the five strategic themes ends with a vision of what the health system could look like in 2026. Note the use of the word “could” rather than “should.” So no pressure, even though the second part of the Strategy, the Roadmap of Actions, sets out concrete action areas to focus on over the next five years, and states that the roadmap will be updated annually.

Parts of the vision for “Closer to home” include statements such as:

- People are safe, well and healthy in their own homes, schools, workplaces and communities.
- We have well-designed and integrated pathways for the common journeys people take through our health and disability system (eg. cancer, maternity, diabetes), starting and finishing in homes.

The government’s vision for “Value and high performance” includes:

- The health system provides high-quality, accessible health services that help people live well, stay well, get well, at the lowest cost it can and within the resources available.
- The health system minimises harm to people, by openly tracking harm when it occurs, and learning from mistakes, so that the system as a whole can improve.

Given the current government's emphasis on delivering "more extensive services within the resources available," while expecting the whole health sector to do more for less money, it is impossible not to feel somewhat cynical while reading the "refreshed" Health Strategy.

It is also impossible to ignore actions such as the Minister's expectations that DHBs will meet the health targets set by the government despite evidence that some come with unintended consequences (eg. over-treatment), the government's withdrawal of funding from NGOs such as the Problem Gambling Foundation, ASH, LifeLine, and women's health groups, as well as the Ministry's refusal to take action when confronted with evidence of the huge amount of harm done to patients by medical devices such as breast implants, metal-on-metal hip joint replacements, the mesh, and pregnancy test kits.

Add to this the Ministry's refusal to support or fund life-saving devices such as pepi-pods which have been credited with producing the first drop in Maori infant mortality rates in a decade (see article on page 4). When the statement about "the need for a fair and responsive health system that improves health outcomes for key groups, including Maori...who are not currently gaining the same benefits from the health system as other New Zealanders" (1) is placed alongside the refusal to fund pepi-pods it doesn't count for much.

#### Reference

1. <http://www.health.govt.nz/publication/new-zealand-health-strategy-2016>

## ***GENDER EQUALITY***

### ***Driving Cultural Change***

**The National Council of Women NZ** is holding its annual conference at

**Te Papa, Wellington**

**15-17 September 2016**

Inspiring speakers and panellists from New Zealand and overseas will discuss and explore how we as a nation can move forward to improve the lives of people everywhere through achieving Gender Equality.

Gender equality is not only a fundamental human right, but a necessary foundation for a peaceful, prosperous, and sustainable world. The National Council of Women NZ is committed to empowering and supporting women in the first instance, but more broadly promoting the idea that everyone gets an equal chance at succeeding in life.

Inspiring speakers include:

- **Amelia Kinahoi Siamomua**  
Head of Gender Section  
Commonwealth Secretariat.
- **Shamubeel Eaquib**  
Economist
- **Maree Crabbe**  
Coordinator of the Violence Prevention Project: Reality & Risk pornography, sexuality and young people.

For more information go to <http://ncwnzconference2016.grow.co.nz/>

## REDUCING THE MAORI SUDI RATE

On 9 July 2016 the *Weekend Herald's* Review featured an article describing the Ministry of Health's refusal to fund or support simple bed baskets and sleeping pods for babies so that they can safely sleep alongside their mothers. (1) (2) This was followed by two further articles (3) (4)

New Zealand has one of the worst rates of Sudden Unexpected Death in Infancy (SUDI) in the world. Around 50 babies die unexpectedly in their sleep each year. At least half are unintentionally smothered by their parents while sleeping in the same bed. The rate for Maori babies is eight times that of the general population.

Bed baskets have been credited with helping to produce the first drop in Maori infant mortality rates in a decade. There are two forms – the wahakura, a bed basket made out of woven flax, and the \$100 pepi-pod which is made out of plastic. They were created in 2006 by Hastings GP Dr David Tipene-Leach “who was sickened by the unrelenting rate of Maori accidental asphyxiation deaths.” (1) Maori babies represent around 20% of the population but make up 65% of SUDI cases because they are more likely to be exposed to cigarette smoke, to alcohol-affected parents who bed-share, and to live in low-income households.

The bed baskets allow Maori mothers – and others whose culture or beliefs include the practice of co-sleeping – to safely share their bed with their babies by giving the baby its own

sleeping space in the bed. The *Herald* article described how “the device has been revolutionary” in that “the Maori community has embraced it, leading SUDI experts have vouched for it, grassroots organisations have fundraised for it, coroners from all over the country have recommended it and international health networks have praised it.”

In addition to this, research has revealed that Maori infant mortality rates have started to fall in regions with the highest number of pepi-pods. Funding from community groups and 14 of the 20 District Health Boards has seen around 15,000 pepi-pods distributed to at-risk families.

“Professor Jeanine Young of the Sunshine Coast University, who has worked on sudden infant death for 25 years, now helps to give pepi-pods to at-risk Aboriginal families in Queensland. “It will be two to three years before we start seeing the same sorts of infant [mortality] reductions that have been achieved in New Zealand,” Young said. “You’ve got four years of data showing a reduced infant mortality and I’m not sure how many years of data your Ministry of Health needs.” (4)

The *Herald* investigation resulted in documents obtained under the Official Information Act which showed that “the Ministry of Health – the sole agency with the power to roll out safe sleep devices nationwide – turned its back on pepi-pods in 2012 because of fears about their safety. It secretly tore up a \$250,000 contract with the health advocacy group that was distributing the devices to at-risk families.” The contract was for a year's supply of pepi-pods. However, an internal meeting resulted in a decision that the pods might be worse than nothing,

although they had to go to great lengths to come up with some possible hazards. In 2015 the Ministry gave out \$800,000 of funding for eight DHBs to create “holistic prevention strategies” to SUDI rates, but the funding was conditional. The money was not to be used to buy pepi-pods or wahakura. This raises the question as to what proof the Ministry required about the effectiveness and safety of the “holistic prevention strategies.”

The Ministry’s contracts outraged advocacy groups, health experts, academics and coroners alike. The funding that was withdrawn in 2012 could have seen 300 Maori babies settled to sleep in pepi-pods rather than laid to rest in coffins.

Dr Pat Tuohy, the Ministry’s chief adviser on child and youth health, is quoted as saying “to invest in pepi-pods it would need ‘a greater level of evidence of effectiveness and safety than is currently available.’” (4)

However, as previous articles about other medical devices featured in the AWHC newsletters have shown, the Ministry has very different standards when it comes to breast implants, hip replacement joints, the mesh and pregnancy test kits.

#### References

1. [http://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=11670826](http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11670826)
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## **BLOODLETTING: the 3,000-year-old placebo**

As referred to in the June issue of the AWHC newsletter in the article on Ian Harris’ book on “*Surgery: the ultimate placebo*,” bloodletting holds a special place in the history of medicine. It is important because few people outside university medical and history departments understand how recent evidence-based medicine actually is, despite the fact that doctors have been practising medicine for hundreds of years. Even as short a time period as a century ago doctors had very few treatments to offer their patients. In fact bloodletting was very often the only one.

In his book Ian Harris writes that bloodletting provides a good introduction into the world of the surgical placebo because it is related to the very beginnings of surgery as a craft.

“The story probably dates back to the Mesopotamians and Egyptians, but certainly to the Greeks and Romans. The idea was to purge the body of bad humours, or balance them, or something. (Humours were thought to be the basic substances that made up the body, and illness was thought to be due to an imbalance in those humours). Although the initial reasons were a bit hazy, by the Middle Ages the ‘science’ around bloodletting had become very elaborate: what part of the body to bleed, what day of the week, the season, the weather and the date, and of course, how much to take (based on further, ridiculous variables).

Bloodletting was often performed by venesection (cutting a vein), but was also done by other methods such as

cutting arteries or using leeches. It was responsible for the rise of the surgeon, or the barber-surgeon, to be precise, because they were the ones with the knives. The barbers and surgeons were the ones cutting hair, shaving, lancing boils and performing surgery, so when physicians became too important to do the bleeding themselves, they prescribed bloodletting, to be performed by the barber-surgeons using a lancet (which is how the famous medical journal got its name). The red and white poles found outside barber shops represent the bloody bandages used as a tourniquet to dilate the veins. Later, the surgeons got too important for the barbers and split away, finding new (often placebo) treatments to perform with their knives.

As more accurate diagnoses developed, like pneumonia, cancer, diabetes and jaundice, bloodletting became the treatment for all of them, partly because there was little else to offer. Also it was a pretty good placebo due to the fact that it was invasive, painful, drastic and shrouded in (pseudo) science.

Eventually people started to question the effectiveness of bloodletting, and in the 1800s Pierre Charles Alexandre Louis, a French physician, published a paper using scientific methods that concluded that bloodletting was ineffective in treating pneumonia. This led to protest from practitioners who 'knew' that it worked. One telling article from the American Academy of Sciences in 1858 stated that physicians 'are not prepared to discard therapies validated by both tradition and their own experience on account of somebody else's numbers.' That is

pretty much what many doctors say today when you show them evidence that their treatments do not work – they'd rather rely on tradition and their own (biased) observations and continue to assume cause and effect where it does not exist.

Bloodletting gradually fell out of favour in the 19<sup>th</sup> century partly because of increasing scepticism (and scientific reports of its lack of effectiveness) and partly because alternative placebos were springing up, like mesmerism and electricity for physicians – the latter being used to pass currents through parts of the body, usually causing muscle contractions – and an array of new procedures for surgeons. This gave doctors a way out, because not treating people at all is rarely an option.

Surprisingly, bloodletting was still being recommended for certain conditions in textbooks in the 20<sup>th</sup> century, including (incredibly) as a treatment for shock associated with blood loss during childbirth, and (yes, still) for pneumonia." (1)

Despite the fact that bloodletting killed far more people than it cured – George Washington, the first US president, died after having well over 3 litres of blood removed (the human body has 5 litres of blood) within a 10-hour period as treatment for a fever and respiratory distress – it took members of the medical community a very long time to accept that the mainstay of their medical practice was worse than useless.

While it is tempting to regard bloodletting as ancient history, part of some pre-scientific era, it is important to note that the practice survived for so

long, not because of an intellectual anomaly, but because of “the dynamic interaction of social, economic, and intellectual pressures, a process that continues to determine medical practice.” (2)

The physicians of the future may look back in astonishment and a degree of disbelief at the overuse of antibiotics, the practice of polypharmacy, and the bluntness of treatments like radiation and chemotherapy.

“In the future we can anticipate that with further advances in medical knowledge our diagnoses will become more refined and our treatments less invasive. We can hope that medical research will proceed unhampered by commercial pressures and unfettered by political ideology.” (3)

#### References

1. Ian Harris. “*Surgery: the Ultimate Placebo.*” NewSouth publishing 2016.
2. Kerridge IH, Lowe M. “Bloodletting: The story of a therapeutic technique.” *Med J Australia* 1995;163:631-633.
3. <http://www.bcmj.org/premise/history-bloodletting>



## AWHC GENERAL MEETING 23 June 2016

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- Submissions due
- Ethics committee meeting
- Cartwright Collective conference
- Succession planning

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.



### AWHC NEWSLETTER SUBSCRIPTION

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Send your cheque to the Auckland Women’s Health Council, PO Box 99-614, Newmarket, Auckland 1149, or contact us to obtain bank account details.

# UP AND COMING EVENTS

**DISTRICT HEALTH BOARD** meetings for July/August 2016:

**Waitemata DHB (Website address: [www.waitematadhb.govt.nz](http://www.waitematadhb.govt.nz))**

The Waitemata DHB Board meeting opens to the general public at 12.45pm on Wednesday 10 August 2016 and will be followed by the Hospital Advisory Committee meeting which starts at 2pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 20 July 2016.

**Auckland DHB (Website address: [www.adhb.govt.nz](http://www.adhb.govt.nz))**

The Auckland DHB Board meeting opens to the general public at 12.45pm on Wednesday 3 August 2016 and will be followed by the Hospital Advisory Committee meeting which starts at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

**Counties Manukau DHB (Website address: [www.cmdhb.org.nz](http://www.cmdhb.org.nz))**

The Hospital Advisory Committee meeting will be held at 9am on Wednesday 27 July 2016 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 17 August 2016 at 19 Lambie Drive, Manukau.



**ETHICS COMMITTEE** meetings – dates for the four MOH ethics committees are at: <http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes>



**The Cartwright Collective in association with Women's Health Action and the Auckland Women's Health Council** is holding a one-day forum on the control of cervical cancer and the future of cervical screening in New Zealand.

**9.30am – 4.30pm Friday 5 August 2016 at 164 Balmoral Road, Balmoral, Auckland.**

Further information is available at <http://www.womens-health.org.nz/the-control-of-cervical-cancer-in-new-zealand-one-day-forum-5-august/>