



NEWSLETTER

December • 2023

a voice for women's health

The Beauty Industry is a Women's Health Issue

"Being a healthy woman isn't about getting on a scale or measuring your waistline. We need to start focusing on what matters — on how we feel, and how we feel about ourselves."

— Michelle Obama



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What Goes on in the Beauty Industry is a Women's Health Issue

By Sue Claridge

Throughout history women have been told that they are “not enough” as they are; that they should be thinner, taller, paler... or in the western world in the 20th and 21st centuries, more tanned.

Women are constantly admonished by society for not being “pretty enough”; told that they are too curvy, are not curvy enough; that their hair is too straight, too curly, the wrong colour; that their buttocks are too big or not big enough.

God forbid that they should have stretchmarks, cellulite or hairy armpits. Not to mention hair on their face.... except for eyebrows — which are always too thick or too thin — and eyelashes, that are never long enough or curly enough.

History is rife with examples of toxic and lethal practices imposed on women in the name of making them more beautiful, as if somehow, meeting someone else’s ideal of beauty would make her enough. A mere sample of toxic and lethal beauty practices include:

- Corsets worn in futile efforts to achieve a 14-inch (35 centimetre) waist restricted breathing, and long-term could cause muscle atrophy, a deformed ribcage, and misaligned spine.¹
- The use of extracts from deadly nightshade as eyedrops to dilate women’s pupils for a “striking, wide-eyed look they thought was seductive,” which caused blurry vision, vertigo, headaches, and blindness if used too much or too often.¹

- Lead-based face powder to cover blemishes and ensure a fashionably (in the 1700s) white face caused eye inflammation, tooth rot, and baldness, and over time caused the skin to blacken, not to mention the ultimate adverse effect — death.¹ In the Middle Ages women also used to resort to bloodletting to achieve the desired pale look.²
- Consuming arsenic — which has multiple disastrous health impacts, including cancer, thyroid disease and death — to “produce a blooming complexion, a brilliant eye, and an appearance of *embonpoint**.”³
- Radioactive creams were advertised in the 1920s and 30s for revitalising “the skin with its luminous energy”, imparting serious risk of harm, including cancer, radiation sickness and death.² Meanwhile, a toothpaste containing radium was produced during World War Two and was purported to increase the defences of teeth and gums and gently polish the dental enamel so it turned white and shiny.²
- Pills containing tape worm eggs were advertised for weight-loss in the late 19th and early 20th centuries with the idea that the tapeworms would offset weight gain by eating the food that people consumed.² However, the risks of this has not sunk in and the desire to be thin has kept alive the belief in some people that swallowing

* stoutly sexy.

tapeworms is a suitable solution to the struggle to lose weight. The tapeworm treatment has found a home on the internet and in 2013 it was reported that the practice was alive and well with people in both Hong Kong and the US swallowing tapeworms to lose weight.^{4,5} The tapeworms can grow up to nine metres long and weight loss is not the only thing they can do to you, causing abdominal pain, stomach upset, malnutrition and occasionally death.

The epitome of obscene practices in the pursuit of “beauty” must be Chinese foot binding, in which girls as young as three and four, repeatedly had their toes broken and curled under their feet, and the arch strained as the foot was bent double, then bound in a long strip of silk.⁶ The practice effectively crippled women forcing them to take tiny steps to limit pain as much as possible, changed their gait, and many suffered from infection, ulceration and gangrene.

“Foot-binding symbolised a girl’s willingness to obey, just as it limited the mobility and power of females,

kept women subordinate to men, and increased the differences between the sexes.”⁷ It seems to be not very far removed from female genital mutilation.

It would be easy enough to consign these extreme measures in the name of beauty to the history books, and placate oneself with the idea such dangerous practices have been banished. After all, no-one would subject themselves to such potentially disfiguring and fatal practices in the name of beauty, would they?

However, the 21st century drive to be beautiful and skinny proffers clear and present dangers to both mental and physical health.

Women face a constant barrage of messages through social media, the press/mainstream media and advertisements that tell them what is considered beautiful and sexy, and that success in virtually all aspects of life can only come from conforming with the current ideal of beauty and what a woman should look like.^{8, 9, 10, 11}

“The ideal for feminine beauty is a concept that has been socially created by depicting that physical attractiveness encompasses the most vital qualities for a woman and that all women must do anything possible to acquire and maintain this attractiveness.”³⁴

Women today are constantly being reminded of what is considered beautiful. There are thousands of advertisements that promote this elusive beautiful image to women of all ages, shapes, and sizes.... By creating advertisements with unrealistic images of beauty, it has resulted in anxiety, low self-esteem, and low self-confidence in many women. Most of these negative emotions stems from unhappiness among body and appearance.³³

One of the most serious impacts of this constant barrage of messages, both overt and subliminal, is the influence of a culture of thinness on the development of eating disorders, particularly among teenage girls and young women, and also women who are peri- or post-menopausal. While being overweight or obese is a significant health issue in Aotearoa New Zealand and many other developed countries, unchecked and untreated eating disorders that result in dramatic and severe weight-loss can far more rapidly become fatal.

For example, anorexia nervosa is a complex and deadly psychiatric disorder with a high rate of

mortality and a relatively low rate of remission. Physiological changes include cardiac, bone, obstetric, and gynaecological changes, as well as endocrine, gastrointestinal, haematological, and skin changes, and electrolyte imbalance. Damage to the heart muscle can rapidly lead to sudden death.¹²

An extensive body of medical literature and research has documented the influence of widespread body dissatisfaction among women, attributed to sociocultural factors, on the development of eating disorders such as anorexia nervosa and bulimia nervosa.^{10, 11, 12} Media and advertising have driven the phenomenon of social comparison theory in

which “women evaluate their own appearance by comparing themselves with the cultural ideals of beauty and thinness presented in the media. Almost invariably this will be an upward comparison by which women fall short, resulting in dissatisfaction with their own appearance and body.”¹⁰ Researcher Lana Cleland (Otago University), and



colleagues, write in their 2017 paper on eating disorders and body image research in New Zealand, that disordered eating is often tightly intertwined with body dissatisfaction and that body dissatisfaction can be seen as almost normative among young women and, increasingly, young men.¹³

Sheila Jeffreys discusses the negative impacts of the beauty industry in her book, *Beauty and Misogyny: Harmful cultural practices in the West*, arguing that many beauty practices are “harmful to women, and that they are created from, and serve to maintain, women’s subordinate status,” that they are not related to individual female choice or creative expression, but represent instead an important aspect of women’s oppression.¹⁴

She writes that while first-wave feminists of the 1970s criticised pervasive beauty regimes such as dieting and depilation, a later feminist “argument took hold that beauty practices were no longer oppressive now that women could ‘choose’ them.”

It is not just the underlying oppression and subjugation of women, or the impact on mental health of constant demands from society and the media to conform to largely unachievable standards of beauty, that is at issue. There is also the significant issue of physical harm, sometimes serious physical harm and injury, that is inflicted on New Zealand women/wāhine seeking to defy aging and improve their appearance.

The personal care products, cosmetics and beauty products that we apply to our skin carry a range of potential dangers. For example, endocrine disrupting chemicals, such as phthalates, parabens and triclosan found in many products can cause a range of adverse health effects such as increasing the risk of breast cancer,¹⁵ and interfering with

fertility and reproduction, foetal growth and infant development.¹⁶ This is a significant topic with an enormous and increasing volume of research behind it, and it will not be further discussed here. However, it may be the subject of an article in the near future.

Sheila Jeffreys writes that “the brutality of the beauty practices that women carry out upon their bodies has become much more severe. Today’s practices require the breaking of skin, spilling of blood and rearrangement or amputation of body parts.”¹⁴

The increase of certain practices over the last two to three decades — foreign bodies in the form of breast implants; women’s labia being cut to shape; liposuction of fat from the thighs and buttocks to be injected into other sites such as cheeks and chins; cutting and piercing of tongues, and piercing of nipples, clitoris and bellybuttons, for ‘body art’ — are all listed by Jeffreys as much more dangerous prescriptions for women’s health than the practices common in previous decades.¹⁴

Whether or not women truly are making choices for themselves, or just responding to the constant messages that they are “not enough” as they are, and can only be acceptable to the rest of society as the result of various and often invasive practices and procedures to change their appearance, any woman who seeks out some sort of appearance therapy should be able to have faith that they are in safe and qualified hands and will suffer no harm.

The beauty industry in Aotearoa New Zealand grew 12% between 2006 and 2010.¹⁷ While the Covid-19 pandemic negatively affected the hair-dressing and beauty services industry, in the five years to 2023 the industry employed almost 12,000 people across 4,785 businesses¹⁸ rising from 3,850 businesses in 2010,¹⁷ with growth in beauty therapy workers of almost 25% over the same period. There has also been a rise in beauty therapy techniques that employ potentially harmful and or invasive equipment, such as lasers, dermabrasion, microneedling and cryolipolysis,¹⁹ and clinics offering such treatments appear to have become quite commonplace.

In this article, we are most concerned with the beauty treatments that women seek from commercial providers, from the salons and ‘therapists’ [and we use that term in its broadest, most generous sense]. Here we are concerned with what happens and how safe New Zealand women are when they pay for a range of treatments believing that those treatments will leave them looking and feeling more beautiful.

A good, safe experience with a beauty industry provider, one that leaves them feeling and looking more beautiful than before, is not always what women walk away with. Regular reports of beauty treatment injury in the media are, no doubt, just the tip of a very large and problematic iceberg:

Auckland woman scarred after beauty treatments gone wrong²⁰

Clients of an Auckland beauty salon say they were infected by unsafe practices²¹

Burns, scars and infections: How to avoid getting injured at the beauty salon²²

Beauty spa gives client first-degree wax burns²³

Woman’s face burned after Auckland beauty therapist makes ‘significant error’ during laser hair removal²⁴

Woman’s face burned after Auckland beauty therapist leaves hair removal laser on wrong settings²⁵

Julie Martin, Chair of the New Zealand Board of Professional Skin Therapies, agrees that these stories are indeed only the tip of the iceberg and she says that the problem is an unregulated, multi-million-dollar industry that has no mandatory regulations in place (see Professional Skin Therapists Work to Ensure Client Safety on page 9).

“This means anybody can purchase skin therapy equipment and hospital grade devices, and with

no formal training or qualifications, can start treating the public.”

While beauty therapy is not brain surgery, it is likely that most women/wāhine in Aotearoa New Zealand are under the illusion that all the providers they see are trained in the therapies and services that they offer.

Samantha Wilson, a tutor at Elite International

Informed Consent: The Dangers of Beauty Treatments

It is vital that consumers do their own research on the potential harms and adverse effects of beauty treatments as it is evident that without regulation beauty therapists may not have the training, qualifications or knowledge to properly advise clients of the risks of treatment. The adverse effects of some popular beauty treatments include:^{27, 29}

Microdermabrasion

- Swelling and redness
- Surface scratches or abrasions
- Potential for infections
- Development of scars
- Alterations in pigmentation



Laser Treatments

- Burns or blisters
- Pigmentation changes
- Reactivation of cold sores
- Scarring
- Infection

Chemical Peels

- Burns or scarring
- Persistent redness
- Pigmentation changes
- Infection
- Allergic reactions



Botox

- Drooping eyelids or eyebrows
- Muscle stiffness or weakness
- Difficulty swallowing or speaking
- Breathing problems
- Headaches or flu-like symptoms
- Allergic reactions
- Watery or dry eyes
- Infection at the injection site

Dermal Fillers

- Infection
- Lumps or nodules
- Filler migration
- Skin discolouration
- Vascular occlusion (blockage of blood vessels)
- Skin necrosis (tissue death)

School of Beauty & Spa Therapy, told *Te Waha Nui* in 2016 that people don't realise that salons do not have to employ trained professionals.

"People just assume that when you walk into a salon that the people doing the treatments are trained and qualified," she said.²⁶

In 2020, Consumer NZ published the results of a "mystery shop" investigation of ten beauty clinics.

They found that the clinics recommended invasive treatments without fully explaining the risks and harms including sometimes serious side-effects.²⁷ In the article, New Zealand Association of Plastic Surgeons' president Dr Jonathan Wheeler said patients should be told about all the potential dangers of a cosmetic treatment in the first consultation.

“You should be told of the main risks upfront, as well as significant but rare complications in full,” he said.²⁷

However, none of the ten clinics visited in the mystery shop did a good job of this.²⁷

Consumer NZ revealed two issues with inadequate regulation; both the lack of regulation of practitioners and the fact that beauty products “such as dermal fillers don’t require any pre-market approval before they can be used.”²⁷

A 2018 survey by Wellington Regional Public Health²⁸ of 57 nail and beauty salons offering nail services found that salon staff and clients have low awareness of the potential risks that nail treatments can pose:

- in over half of the salons there was a lack of recognised formal qualifications;
- there is limited understanding about blood borne viruses and other infections and how they

are spread/controlled and there was limited understanding about protection from hepatitis B infection;

- some salons continue to use heel blades to remove calluses or hard skin, which is associated with a high risk of cutting the underlying tissue and bleeding;
- There is a lack of understanding about cleaning, disinfecting, sterilising and hygienically storing instruments;
- salons with an adequate number of trained staff were twice as likely to ask clients about pre-existing health conditions.

Well into the 21st century women are still being harmed by beauty products and “therapies” and are often not made aware of the risk of harm when they seek beauty services from providers that they often incorrectly assume are trained and qualified practitioners.

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Professional Skin Therapists Work to Ensure Client Safety

By Julie Martin, Chair New Zealand Board of Professional Skin Therapies

If you were to ask the average person what they thought beauty therapists did, the reply would probably be, relaxing facials, waxing, lash tints, manicures, and body massages. Although that is somewhat true, there have been significant changes and advancements in treatments offered to the public by beauty/skin therapists in the last ten years, that correct and/or manage significant skin conditions.

With the fast-growing advancements, and the blending of beauty/skin therapy and appearance medicine, the skin therapy industry has transitioned into a more therapeutic and results driven profession. At the entry level of the spectrum, we do cater for basic treatments but also provide more advanced skin treatments, such as topical products, intense light/laser, electrolysis, ultrasound, cosmetic micropigmentation, dermal therapies, and needling technologies that erode, abrade, penetrate the skin to affect the dermal and/or sub dermal layers of the skin. These treatments bring relief or cure to conditions such as rosacea, other inflammatory conditions, aging, hirsutism, and acne, all of which addresses clients' confidence, self-worth, mental health, and physical health and well-being.

However, while technologies have evolved, the basic infrastructure to support and protect the therapist and the health and safety of the public has not.

As an unregulated, multi-million-dollar industry, there are no mandatory regulations in place. This means anybody can purchase skin therapy equipment and hospital grade devices, and with no formal training or qualifications, can start treating the public. Although the industry does have health, hygiene and safety standards for the New Zealand aesthetic industry, and a Code of Ethics and professional conduct standards in place, there is no mandatory requirement to follow them.

With the number of complaints and severity of injuries increasing every year from unqualified, untrained operators, there has been an increasing call from qualified professional therapists wanting recognition for the corrective professional work that we do, regulations and better education.



Julie Martin, NZBPST

In 2019, the New Zealand Board of Professional Skin Therapies (NZBPST) was formed.

As the only watchdog organisation in New Zealand, the role of the NZBPST is to observe and monitor the activities of government agencies, local authorities, industry bodies, and other organisations, and alert members and industry when we detect actions that go against the best interests of therapists or their clients, or risk damaging the standards and reputation of our profession. The NZBPST is a non-profit organisation that stands independently, is completely neutral and has no conflicts of interest.

As an organisation, our principles have always been to represent a credible profession based on professionalism, transparency, experience, integrity, and accountability, and we reflect these attributes and professionalism to government agencies and the public we engage with.

To date the NZBPST has supported industry during the Covid pandemic, with Covid alert bulletins on surviving lockdowns, financial assistance for business owners, information on what different



THE NEW ZEALAND BOARD OF PROFESSIONAL SKIN THERAPIES

It is imperative that professional therapists belong to an impartial and expert organisation that can represent them; not only to be the voice for industry but also to provide independent advice, support, mentoring and guidance when it is needed.

CONNECTED
AND SUPPORTIVE

TRANSPARENT
AND ETHICAL

PROACTIVE
INDUSTRY MANAGEMENT

alerts meant for business owners, interpretations and advice on mandatory vaccination monitoring, providing a pandemic response plan, an international pandemic hygiene qualification and initiatives on screening clients when opening businesses again.

The NZBPST represented the beauty/ skin profession during the Tertiary Education review and was successful in advocating for our profession to be identified as a health profession not a cultural, creative profession in tertiary education. This was a ground-breaking move as it helped to highlight our health status when dealing with Ministry of Health.

We were also there to protest and prevent the deletion of our level 5 beauty therapy diploma course, and special electrical epilation course, and prevented the removal of key components of theory and the reduction in required training by 300 hours in some courses. The qualification framework will now stay the same until its next review in 2025.

As advocates for best practice, protection and support for therapists and the public, the NZBPST has created a complaints process for the industry and the public. This process enables us to monitor incidents and injuries, while we assist with appropriate advice to those affected.

Our latest move is to have therapists recognised by Ministry of Health as Skin Therapists and placed under the Health Practitioners Competence Assurance Act.

By achieving this we will be recognised as health professionals alongside podiatrists, acupuncturists, and other allied professional health providers. Based on the New Zealand Nursing Council's

structure, we will be able to provide sound infrastructure to establish a professional workforce that is highly trained, knowledgeable, disciplined, and safe to treat the public. Under the act we will be able to:

- form a recognised registration board to register and identify therapists who have acquired the necessary standards and qualifications to treat the public safely and professionally;
- provide a registration exam for new entrants and overseas applicants who wish to work in New Zealand; provide educational audits to maintain high theory and practical training standards in educational institutions;
- provide a disciplinary board to hear complaints; and
- give professional support and advice to therapists on a day-to-day basis.

As we work through this process, the New Zealand Board of Professional Skin Therapies is reaching out to other like-minded professionals and organisations who represent the same ideology and principles we do and ask for support by [signing our petition to be recognised as skin therapists](#) by Ministry of Health and come under the HPCA Act.

By signing our petition, people will be supporting us to establish a succession line of industry expertise in management, governance, and representation above and beyond the treatment room, as well as a professionally structured sector that delivers fully trained therapists who can deliver the best possible care to their clients in a safe environment.

Where's the Action Plan?

The Women's Health Strategy not walking the talk.

By Sue Claridge

The Women's Health Strategy¹, one of five specific health strategies* required under the Pae Ora (Healthy Futures) Act 2022, was released on the 12th of July 2023.

Initially a women's health strategy was not included in the Pae Ora (Healthy Futures) Bill, and in our written and oral submissions^{2, 3} AWHC argued in the strongest possible terms for it to be included in the Act. As an organisation we contributed our views in a meeting between AWHC and the strategy team at the Ministry of Health | Manatū Hauora, and made a substantial written submission on what we wanted to see in the Women's Health Strategy.⁴

In our submission we set out very clearly what we believed the strategy must be. We said that the women's health strategy MUST focus on more than sexual and reproductive health. It MUST focus on the leading causes of loss of quality of life, death and disability for women and the factors that influence women's health.

* The others are the [Pae Tū: Hauora Māori Strategy](#); [Te Mana Ola: The Pacific Health Strategy](#); [Rural Health Strategy](#); and the [Provisional Health of Disabled People Strategy](#)



It also must:

- take a life course approach that addresses health needs in different stages in a woman's life;
- focus on achieving and maintaining health not just treating ill-health;

Key Points from the Women's Health Strategy

Pros

Addresses most of the 'must do' items in the AWHC submission on the women's health strategy.

Commitment to a health system that works for women, that is welcoming, respectful and responsive.

Repeatedly acknowledges gender bias, racism and other forms of discrimination as a major problem facing women/wāhine in the health system.

Recognises many of the barriers to women needing health care, including social barriers such as childcare, transport and availability outside working hours.

Recognises and addresses the social determinants of health, including poverty, homelessness, family and sexual violence, tobacco and alcohol, and problem gambling.

Cons

No mention of a national health needs assessment for women, provision for gender analysis in any assessment of population health needs, or a gendered approach to the collection and utilisation of health data.

No action plan and we have to wait until 2027 to get one.

No accompanying report collating all the lived experience response and submissions on the women's health strategy.

While LGBTQI+ are included in this strategy they are there because the MoH doesn't know where else to address their specific health needs. They need a health strategy that meets their needs, instead of always being tacked on to the plans for other sectors of our community.

No mention of the complex health needs of some women, particularly those with multiple and rare, or often misunderstood disorders, and little mention of addressing the needs of women who live in chronic pain and are dismissed by doctors.

- acknowledge the factors that influence women’s lives and health, such as ethnicity, disability, sexual identity and background;
 - address the social determinants of health;
 - include a national health needs assessment for women and provide for gender analysis in any assessment of population health needs; a gendered approach to the collection and utilisation of health data;
 - facilitate the examination of the pathways and quality of care for women within the health system, and identify evidence-based strategies that could be implemented to ensure women receive the best available care;
 - consistently recognise, promote and allocate resources to address a broader, integrated women’s health agenda;
 - address the barriers to women seeking early care (which include time, responsibilities, care of other family members, childcare, jobs and transport, as well as financial considerations), and develop and implement strategies to improve timely access to care;
 - require that all medical and health research in Aotearoa New Zealand is appropriately designed to facilitate the inclusion of gendered analyses, and that appropriate and representative numbers of women are included in clinical trials;
 - be consumer and patient-centred: consumers must be involved in monitoring and reviewing the progress of the women’s health strategy, and assessing how the health system has performed against the strategy.
- be empowered to have ownership over their health;
 - receive high quality, evidence-based care and support that is appropriate to their gender, culture, context, age, and life stage;
 - have more options, including access to kaupapa Māori services for wāhine Māori.

Overall, the strategy addresses many of our “must dos”. It does, by and large, take a life course approach, with a strong focus on maternity and early motherhood, as well as aging and the peri- and post-menopausal period of women’s lives. There is naturally, still a strong focus on sexual and reproductive health, pelvic and menstrual health, and gynaecological conditions and cancers – those health issues that affect only women/wāhine and those assigned female at birth.

The strategy acknowledges that while women generally live longer than men, they also spend more of their lives living in poor health and with disability. It also acknowledges the wider determinants of health, including income, family and sexual violence, homelessness, access to healthy food, tobacco, alcohol, drugs and gambling, and more broadly gender bias, racism, ableism, transphobia and homophobia within the health system. The strategy also acknowledges the barriers to women seeking health care.

Disappointingly there is no mention of a national health needs assessment for women, provision for gender analysis in any assessment of population health needs, or a gendered approach to the collection and utilisation of health data. However, the strategy acknowledged that “women’s needs and experiences are not equitably considered in the design and operation of the health system or prioritised in health research”.

Also disappointing is the failure to specifically mention the needs of women/wāhine with complex health needs, often involving multiple or rare conditions about which little is known, or for which there are few experts in Aotearoa New Zealand. These women/wāhine are the ones who have been most let down by the current health system and culture within it, and who, as a result, are most disenfranchised and have entirely lost faith and trust in the system or that anyone in it has their best interests at heart.

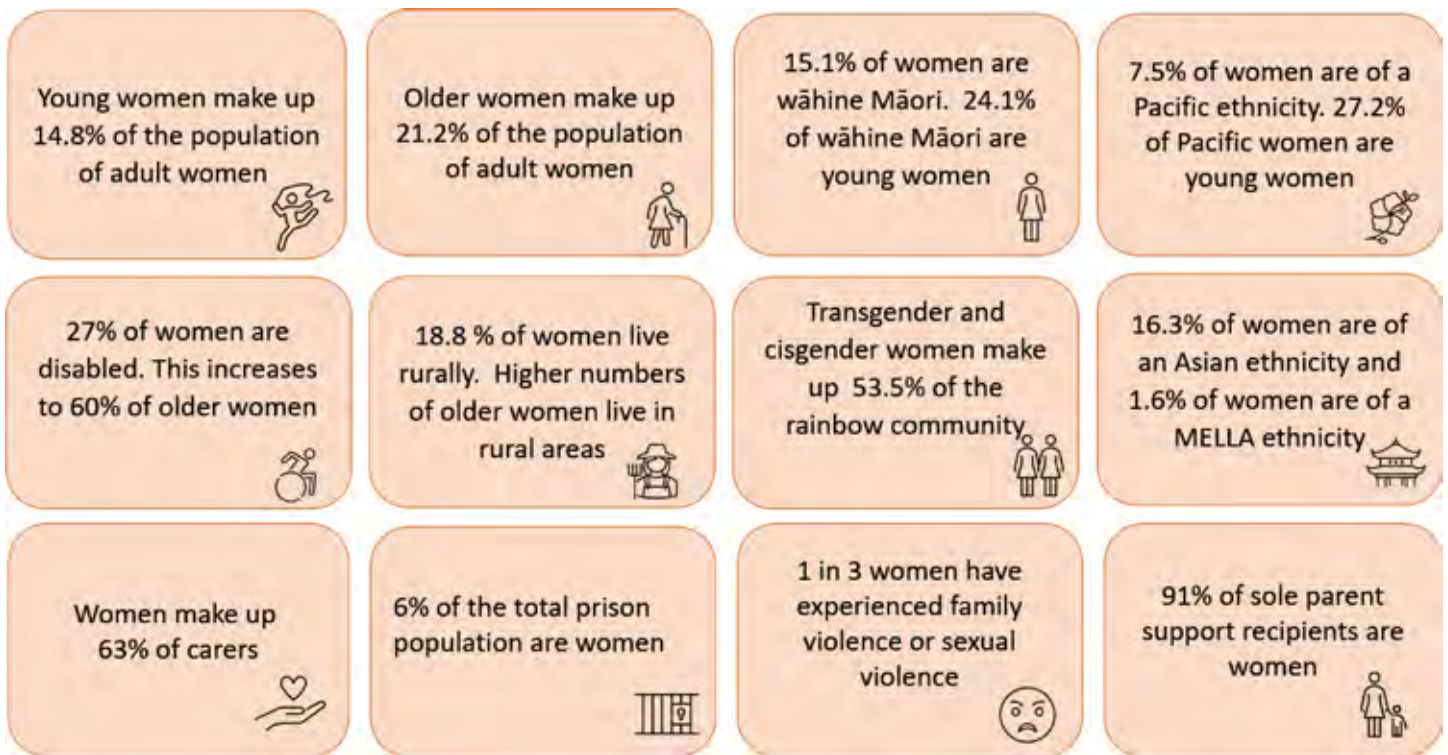
While pain is frequently mentioned in the lived experience of women/wāhine quoted in the document, there is scant emphasis on the very real need to address severe and chronic pain in women/

How Well Does the Women’s Health Strategy Address Our Stated Needs?

The vision of the Women’s Health Strategy is pae ora | healthy futures for women; that all women will live longer in good health, have improved wellbeing and quality of life, and be part of healthy and resilient whānau and communities within healthy environments that sustain their health and wellbeing.

Early on the strategy sets out that it aims to ensure women/wāhine experience equitable health outcomes and that they will:

- feel welcomed and valued by the health system;
- not experience gender bias, racism, or other discrimination within health care;



A snapshot of New Zealand women/wāhine presented in the Women's Health Strategy.¹ (Sources: Stats NZ 2022, Stats NZ 2014, Stats NZ 2021, Ministry of Social Development 2019, Department of Corrections 2021, Ministry of Justice 2018, and Manatū Wāhine 2022.)

wāhine. All too often women/wāhine have their experience of severe or chronic pain dismissed, are told that it is in their heads, or are accused of being malingerers or drug-seekers and are far less likely to be prescribed adequate pain relief than men.⁵ It is unconscionable that New Zealand women/wāhine are forced to live in pain because of archaic and misguided views of health professionals and this must be addressed in the strategy.

The strategy states that in the future (no timeframe provided) “women’s health leadership and the voices of diverse women will be present at all levels of the system, including in governance, service design, delivery, and system monitoring,” and “there will be equitable prioritisation and resourcing of women’s health services, health and wellbeing support services and women’s health research.”

In addition, the strategy says that in the future (again, no timeframe provided) a gender lens will be applied to health research to ensure there are no significant research gaps in women’s health and that women’s health services, pathways and treatments will be based on evidence of effectiveness for women.

In discussing ongoing evaluation, the document says that the MoH will continue “to work with women in monitoring and evaluating progress within the health system towards the goals and vision set out in the Women’s Health Strategy”. However, that is as far as it goes and there is no detail on how this will be done, how frequently, who will be involved and in what sort of timeframe.

The Strategy!

The main part of the Women’s Health Strategy document is divided into four parts:

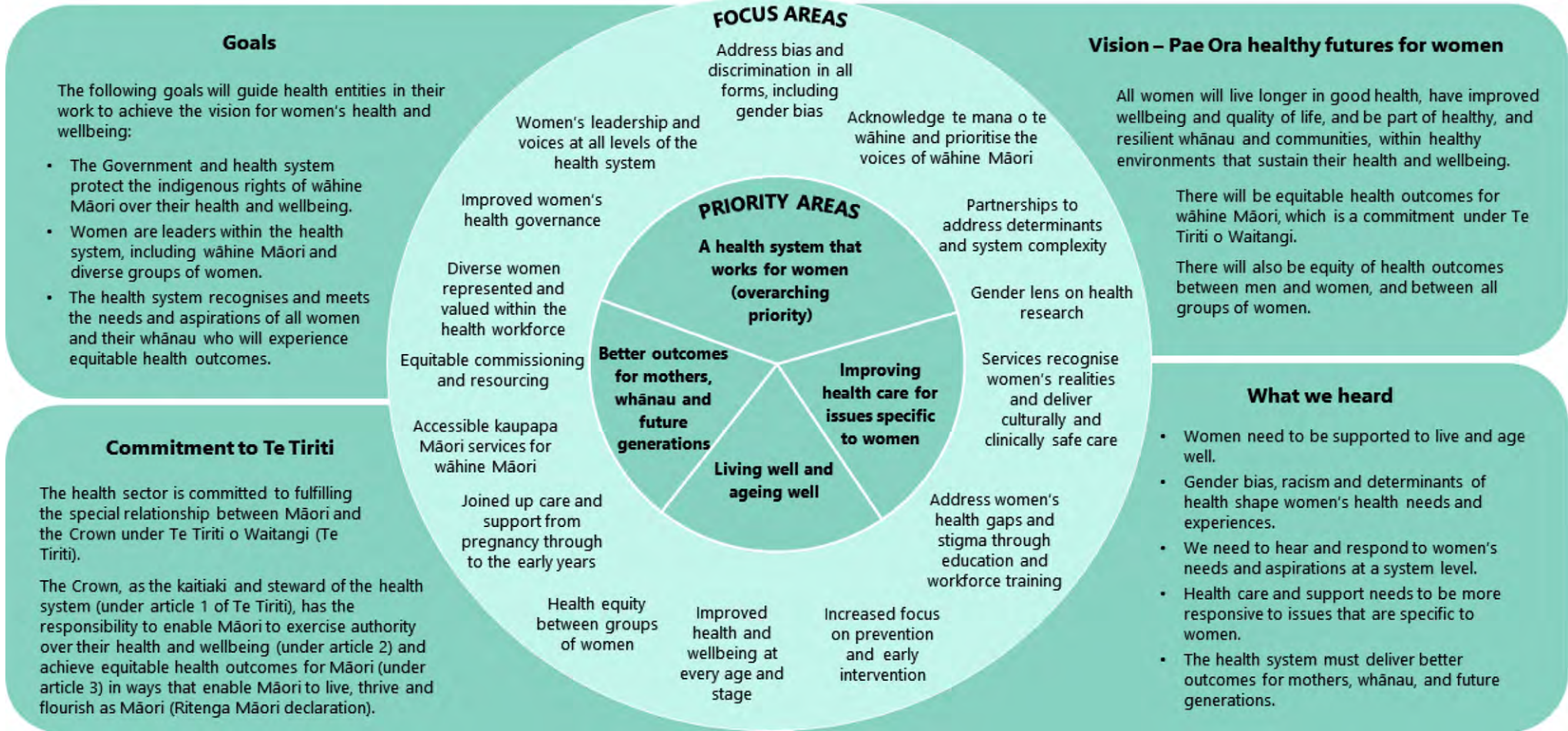
- the long-term vision for women’s health and goals that guide the progress towards this vision.
- an assessment of the current state of women’s health and wellbeing, and health system performance for women, as well as key themes from engagement with health consumers and stakeholders.
- the priority areas and the changes needed in these areas to achieve the 10-year vision for women’s health and wellbeing.
- the next steps for how these changes can be delivered, including how the strategic direction will inform actions for health entities.

The strategy is summarised in a diagram (on the next page) that sets out the purpose, vision, priority areas, focus areas, and goals, as well the commitment to Te Tiriti and a broad summary of what the strategy team heard from women.

There are several places in which the strategy describes women/wāhine having shared experiences of not being heard or prioritised when they seek care for their health and the health of their whānau. It is great that they have heard this concern and acknowledged it; it is a recurring theme with women that AWHC has contact with. However, it remains to be seen whether the priorities and focus areas in the strategy, translate into changes

WOMENS HEALTH STRATEGY

Purpose
The Women's Health Strategy sets the direction for improving the health and wellbeing of women over the next 10 years.



Goals

The following goals will guide health entities in their work to achieve the vision for women's health and wellbeing:

- The Government and health system protect the indigenous rights of wāhine Māori over their health and wellbeing.
- Women are leaders within the health system, including wāhine Māori and diverse groups of women.
- The health system recognises and meets the needs and aspirations of all women and their whānau who will experience equitable health outcomes.

Vision – Pae Ora healthy futures for women

All women will live longer in good health, have improved wellbeing and quality of life, and be part of healthy, and resilient whānau and communities, within healthy environments that sustain their health and wellbeing.

There will be equitable health outcomes for wāhine Māori, which is a commitment under Te Tiriti o Waitangi.

There will also be equity of health outcomes between men and women, and between all groups of women.

Commitment to Te Tiriti

The health sector is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi (Te Tiriti).

The Crown, as the kaitiaki and steward of the health system (under article 1 of Te Tiriti), has the responsibility to enable Māori to exercise authority over their health and wellbeing (under article 2) and achieve equitable health outcomes for Māori (under article 3) in ways that enable Māori to live, thrive and flourish as Māori (Ritenga Māori declaration).

What we heard

- Women need to be supported to live and age well.
- Gender bias, racism and determinants of health shape women's health needs and experiences.
- We need to hear and respond to women's needs and aspirations at a system level.
- Health care and support needs to be more responsive to issues that are specific to women.
- The health system must deliver better outcomes for mothers, whānau, and future generations.

Summary diagram of the Women's Health Strategy¹

in the embedded culture within our health system; a culture that all too often dismisses, fobs off, demeans or trivialises, and gaslights women.

All Talk and No Walk

Despite the fact that Part 4 of the document sets out “next steps for how these changes can be delivered, including how the strategic direction will inform actions for health entities”, there is no action plan.

One of the most worrying paragraphs in the document states:

“Strategies do not make commitments to particular actions or require health entities to undertake specific activities – instead, they describe potential choices and issues to be considered, to inform the decisions that the Government will make on what actions are taken forward, and when. Health entities must take the strategies into account in carrying out their responsibilities.”

So, addressing the failures and inadequacies in the way the health system responds to women’s health is a choice, not an obligation!

All the talk about their priorities and vision and goals and there is nothing concrete on the action they are going to take to achieve them. In fact, it seems that we may not get an action plan until 2027. The strategy states that “As the Government determines the first three-year [Government Policy Statement on Health] for 2024–2027, and in subsequent cycles, the strategies will be turned into clear expectations and actions that will provide the opportunity to achieve the changes set out.”

There is a lack of clarity around this part of the strategy and AWHC emailed a MoH staff member who worked on the women’s health strategy team, Mr Steve Barnes, regarding this.

He responded⁶ that under the Pae Ora (Healthy Futures) Act the Women’s Health Strategy sets out five to ten year priorities for women’s health.

The Government Policy Statement on Health, also required under the Pae Ora Act, sets the government’s three year priorities and there’s a specific requirement in the Act that the Government Policy Statement must include the government’s priorities for improving the health outcomes of women for that period.⁶

Te Pae Tata (which is referred to as the New Zealand Health Plan in the Act) is an operational document that must give effect to the Government Policy Statement. There are a number of specific requirements of Te Pae Tata, but one is for the

plan to describe how Health New Zealand and the Māori Health Authority will provide and commission services to achieve the desired improvements.⁶

This means that in effect Te Pae Tata does the work of an action plan for each three year period. The benefit of this approach is that because Te Pae Tata is required by law and that it must give effect to the Government Policy Statement it means that there will always be a plan that includes specific priorities for women’s health (rather than a standalone action plan without legal standing).⁶

Mr Barnes also noted that, while this is the formal process for implementing the Women’s Health Strategy, this doesn’t preclude agencies undertaking work outside of this process.

We entirely understand that there are complicated machinations at work within legislation and that how the legislation is written exerts enormous control over everything that comes under that legislation. However, it seems overly waffly and convoluted and has the effect of not providing women health consumers with a clear idea of what is actually being done to improve women’s health and address the long standing problems in women’s health.

This is in stark contrast to the Scottish Women’s Health Plan (that we reviewed in our [October-November 2021 Newsletter](#)). The Scottish Women’s Health Plan⁷ set out a very clear action plan for each priority and set of aims, stating in detail what the actions would be in the short term (delivery within one year), medium term (delivery within one to three years) and long term (delivery within three years or more), including actions that cut across all their priority areas.

Another concern is just how women are going to be enabled to respond to the strategy and provide insight to the MoH as to whether they have got it right. The document states that the “Women’s Health Strategy sets the direction for improving the health and wellbeing of women over the next 10 years”. The strategy was released cold, with no public consultation or consumer stakeholder consultation on the draft document.

The documents states that “We have listened to what is most important to women for their health and wellbeing and these voices sit at the heart of the strategy.” Yet we have no idea who they listened to, who made submissions on the strategy, what did their engagement with women and listening to their lived experience actually look like. On several occasions AWHC corresponded with the women’s health strategy team and expressed our thoughts on the need to engage with a very broad range of

women/wāhine around Aotearoa New Zealand and especially hard to reach women/wāhine: those who lived in isolation, those without easy internet access or understanding of how to use online surveys and apps; those for whom English is a second language or who have other communication barriers; and those who have entirely lost faith and trust in the health system. There is no information about who was consulted, or how they acquired the lived experience feedback from women.

We do know that across the five strategies the MoH held “over 120 meetings, fono and hui with the sector and communities, including a number of sector and community engagements targeted at key groups of women.”⁸

Across all five strategies they achieved “over 30,000 online engagements collectively through the online engagement programme and Tātou the Ministry’s online discussion platform.”

They also received around 700 written submissions on the Women’s Health Strategy, but as far as we are aware there is no public report that provides a summary or collation of the views presented in the submissions.

Again, it is hard not to compare this with the Scottish Women’s Health Plan, which included a list of the people who were involved in the development of the health plan, and a number of supporting documents, including a report on the results of their lived experience engagement with women,⁹ and a Women’s Health Plan event report which set out very clearly in advance how the Women’s Health Group was going to develop, promote and implement a women’s health plan.¹⁰ The latter document included a list of Health and Social Care Alliance members and non-members to “ensure the reach necessary to cover the breadth of women’s health.”

There was transparency and accountability in the process of developing the Scottish Women’s Health Plan that we have no hint of in the development of our Aotearoa New Zealand Women’s Health Strategy. In fact, our strategy smacks of a document that has been put together in a rush, without adequate design and planning, and undertaken by a small group of people in a back room of the Ministry of Health in order to meet a legislative requirement, and with the bare minimum of real engagement with the women/wāhine who most need a women’s health strategy.

We engaged on several occasions with MoH staff involved with the development of the Women’s Health Strategy. They were all genuine people who gave every impression of working hard to develop

a very good document. They were substantially hampered by the incredibly short time frame in which to design and develop a strategy that would address decades of a health system that has inadequately responded to women’s health needs in this country. While the Māori, Pāsifika and disabled people’s health strategies were part of the original Pae Ora (Healthy Futures) Bill, a women’s health strategy was not. So, there was a far shorter lead in time in which to undertake the background research and engage with women/wāhine to canvas their lived experiences.

The responsibility for the ridiculously short time frame — twelve months — in which to create a worthy women’s health strategy out of practically nothing, falls squarely on the shoulders of the writers of the legislation and the Government that passed it into law.

It is entirely possible to retrieve the situation and ensure that this Women’s Health Strategy truly improves the health system and experience in it for women. The MoH must treat this as a draft document, seek feedback from stakeholders including a wide range of health consumers, and re-issue it complete with a proper action plan. They must also set a regular review period of no more than five years, and undertake a thorough audit of progress made against the vision, priorities and focus areas, and the action plan, in a way that authentically involves engagement with, and participation and feedback from the women/wāhine whom the strategy is supposed to benefit.

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How Safe are New Zealanders in Our Health System?

By Sue Claridge with Denise Astill, Charlotte Korte and Katherine Gibbons



How safe are health consumers in our health system?

The short answer is we may not be.

Our health system is meant to protect us but, upon delving into our harm reporting systems, the Health Consumer Advocacy Alliance (HCAA) found the exact opposite — our health system is actually enabling this harm. Not one health entity can confidently say they are doing a good job of protecting our people.

There are eight agencies in Aotearoa New Zealand that claim to take some responsibility for patient/consumer safety, including those responsible for collecting data on, monitoring and responding to/reporting on adverse events and patient harm that occurs in the health system. However, there are massive gaps in the communication of serious harm between health agencies and also to health consumers, and there are failures to swiftly and adequately respond when serious harm is identified.

Serious harm in both the private and public sectors of our health system is enabled through failures in competency, governance, independence, accountability, transparency, and integrity within and between health entities and organisations.

Where is the scrutiny, where is the accountability, where is the transparency?

The Burden of Medical and Treatment Injury

Medical error, treatment injury and harm caused to consumers/patients in the course of receiving health care and medical treatment, imposes a significant financial and productivity burden on individual consumers, their family/whānau and community, as well as on the health system.

In reviewing this issue over the last twenty or more years, it is evident that little has changed to improve harm reporting processes, and there has been scant reduction in medical error, treatment injury and harm caused to consumers/patients in the course of



receiving health care and medical treatment.

In a New Zealand study published in 2006, Auckland University School of Population Health lecturers Mary Seddon and Alan Merry found more than 1500 people were killed or permanently disabled annually in this country through preventable medical error. They wrote:

“The evidence is incontrovertible—we are inadvertently harming an unacceptable number of our patients by the very healthcare intended to help them.”¹

An earlier New Zealand study² found that “up to 30% of public hospital expenditure goes toward treating an adverse event”, and that does not take into account the cost to individuals in both direct and indirect costs, loss of quality of life etc., and to the community in loss of productivity and participation. Brown *et al.* found in 2002 that “adverse events are estimated to cost the medical system \$NZ870 million, of which \$NZ590 million went toward treating preventable adverse events.”²

For example, “FACS* has a life-long impact on affected children and their family/whānau. It can cause physical malformations such as heart defects, cleft palate, and spina bifida, as well as learning and behavioural difficulties. The average lifetime cost to ACC of a single FACS claim is estimated at \$7 million. A single severe claim is estimated to cost ACC between \$5 million and \$25 million, which is an indication of the impact on the person.”³

It is important to remember that our population and the number of accepted ACC claims is increasing, so financially speaking, on that measure alone, the cost is significant.

Focusing on the ACC cost per individual, of harm from medical injury for issues such as FACS and surgical mesh, grossly underestimates and understates the total financial burden of that harm, which must consider the financial burden on families/whānau, loss of productivity, loss of quality of life, disability-adjusted life years (DALYs), years lived with a disability (YLDs) and years of life lost due to premature mortality (YLLs).

In the past the total burden of injury in Aotearoa New Zealand has been calculated,⁴ including treatment and rehabilitation costs, lost economic contribution and human costs (including the cost of pain and suffering). However, it appears that no such investigation of the total burden of *medical harm* and *treatment injury* has been carried out in this country.

Despite that, it is possible to gain some understanding of the extent of the burden of medical harm and treatment injury through other means. In 2021/22, the Health and Disability Commission (HDC) received 3,413 complaints — an unprecedented increase of 25% on the previous year. The Advocacy Service received 2,971 complaints.⁵

The total number of adverse events reported to the Health and Safety Commission (HQSC) in 2019/20 was 975 (916 in 2018/19).⁶ The report *National summary of adverse events reported to the Health Quality & Safety Commission 1 July 2019 to 30 June 2020* reveals that the number of reported serious harm DHB adverse events (non-mental health), has climbed steadily from 181 in the 2006/07 year to 627 in the 2019/20 year.

While HQSC state that the increase in overall reporting demonstrates an open culture of reporting,⁶

* Foetal Anti-Convulsant Syndrome occurs when the anti-seizure medication that was taken by the childbearing person during pregnancy crosses the placenta and into the developing foetus, causing harm to the unborn child. Individual syndromes can occur when exposed to a single anti-seizure medication during pregnancy.

the reality is reporting of adverse events is largely not mandatory and we have no real idea if the increase in adverse events reflects an increase in reporting or an increase in incidents of harm or both.

ACC treatment injury data is available from 1 July 2005, when treatment injury provisions came into law. In 2019/20 ACC made a cover decision on 16,604 claims for treatment injuries and accepted 11,285 claims. Each of these claims represent a person who was harmed during treatment.³

Davis *et al.* found that in Aotearoa New Zealand, adverse events were associated with 12.9% of hospital admissions, of which approximately 35% were classified as highly preventable.⁷ In their paper, Davis *et al.* cite research from the US and the UK, published in both governmental reports and in the peer reviewed medical literature. Despite there being an acknowledgement in some quarters that medical harm is an issue, there is little evidence that the issue is being adequately addressed.

An Aotearoa New Zealand study into incidence of harm within general practice, published in 2021, which involved 9076 study patients with 115,797 unique general practice visits, 212,963 prescriptions of 833 different pharmaceuticals and 2,578 hospital admissions, found 2,972 harms experienced by 1,505 patients.⁸ The researchers found that, while most harm was considered minor, general practice records reveal the extent of severe harms, including preventable deaths.

A 2017 OECD report found that “adverse events are estimated to be the 14th leading cause of morbidity and mortality in the world. This puts patient harm in the same league as tuberculosis and malaria, and makes it a genuine global public health concern.”⁹ The report also found that “many adverse events are preventable. Furthermore the costs of prevention are dwarfed by the cost of failure.”⁹

In 2016, Makary and Daniel estimated that medical error is the third biggest cause of death in the US, and that medical error leading to patient death is under-recognised in many other countries including Canada and the UK.¹⁰ Makary and Daniel call for better reporting, saying that problem of medical error should not be exempt from a scientific approach and that there should be more appropriate recognition of the role of medical error.

The World Health Organisation^{11, 12} states that:

- Around 1 in every 10 patients is harmed in health care and more than 3 million deaths occur annually due to unsafe care. In low-to-middle income countries, as many as 4 in 100 people die from unsafe care.

- Above 50% of harm (1 in every 20 patients) is preventable; half of this harm is attributed to medications.
- Some estimates suggest that as many as 4 in 10 patients are harmed in primary and ambulatory settings, while up to 80% (23.6–85%) of this harm can be avoided.
- Common adverse events that may result in avoidable patient harm are medication errors, unsafe surgical procedures, health care-associated infections, diagnostic errors, patient falls, pressure ulcers, patient misidentification, unsafe blood transfusion and venous thromboembolism.
- Patient harm potentially reduces global economic growth by 0.7% a year. On a global scale, the indirect cost of harm amounts to trillions of US dollars each year.
- Investment in reducing patient harm can lead to significant financial savings, and more

importantly better patient outcomes. An example of a good return on investment is patient engagement, which, if done well, can reduce the burden of harm by up to 15%.

The burden of medical and treatment injury is a global problem. A paucity of recent and comprehensive scientific research into the scale of medical harm in Aotearoa New Zealand must not be taken as evidence of absence, and it must be assumed that we have as significant a problem as those countries that we habitually compare ourselves with (US, UK, Canada and Australia).

Sir Liam Donaldson, Patient Safety Envoy, WHO, stated at the 5th Global Ministerial Summit on Patient Safety, “We need to acknowledge that no news is not necessarily good news, meaning that just because there aren’t adverse effects/harm being reported does not mean it isn’t occurring. In fact, we can go further by saying that not only is history repeating itself, but the same harm is happening to different people in different places.”¹³

Are Our Medical Harm Reporting Systems Effective? Are People Safe?

“Safe health care should be seen as a basic human right.”²²

Are Our Medical Harm Reporting Systems Effective? Are People Safe? is a discussion document written by the co-founders of the Health Consumer Advocacy Alliance (HCAA).¹⁴

Every day the HCAA trustees hear from New Zealanders from all walks of life who have been harmed when seeking treatment. They know that there is ongoing and repeated harm inflicted upon many New Zealanders across the health system in many disciplines.[†]

The Health Consumer Advocacy Alliance want closer scrutiny over our harm reporting processes because too many New Zealanders have been harmed or have died due to intractable systemic failures that have not been properly addressed for decades. Robust harm reporting systems ensure that patients are kept

safe. However, there is no evidence at all that patient harm is being identified and successfully monitored, with explicit action taken to stop harm when it occurs and to prevent further harm. While some medical harm is being reported there is no consistency in what is being reported, and these reports seem to disappear into the ether, with no transparency regarding follow-up and action. This is exacerbated by a failure of all health entities to identify and track practitioners who are repeat offenders in causing harm to multiple patients. No-one in Aotearoa New Zealand is competently tracking individual practitioner harm.

Multiple health entities talk about working together to make improvements to our harm reporting systems; however, actions to date fall well short of what needs to be done to ensure the public are safe. Incredibly, there is no one with the legislative mandate or enforcement power over the private health sector; there is no doubt that this is perilous. How, in 2023, can this still be a problem?

Addressing Serious Medical Harm in Aotearoa New Zealand

The discussion document *Are Our Medical Harm Reporting Systems Effective? Are People Safe?* was written with a focus on the eight health entities that

[†] The Auckland Women’s Health Council acknowledge that the current health workforce crisis exacerbates not only the likelihood of harm occurring in the health system, but also reduces the likelihood that harm will be reported because of the time and resources required to report incidents. However, the HCAA report focuses on the way in which the higher-level health agencies respond to reports of serious harm. The HCAA Report also acknowledges the burden on health professionals when harm occurs, that it is “clinicians who are left ‘picking up the pieces’” when health consumers suffer harm, and that not all health practitioners are fully protected under the Protected Disclosures Act 2022 if they disclose harm caused by other practitioners.

have some responsibility for recording, tracking and responding to patient harm:

- Ministry of Health | Manatū Hauora
- Medsafe
- Centre for Adverse Reaction Monitoring (CARM)
- Accident Compensation Corporation (ACC)
- New Zealand Medical Council | Te Kaunihera Rata o Aotearoa
- Te Whatu Ora | Health NZ
- Health Quality Safety Commission (HQSC) | Te Tāhū Hauora
- Health and Disability Commissioner (HDC) | Te Toihau Hauora, Hauātanga

The report is not just about data and statistics, and clinical responses. It is about humanising the harm. People are not just numbers. You cannot — and should not — separate the human factor from the cold, hard data. Behind every number is a person.

The two case studies presented in the report — surgical mesh procedures and anti-seizure medicine(s) *in utero* — represent just a fraction of the harm and life-long devastation caused to New Zealanders by medicines, devices, procedures, individual practitioners, health system culture and institutional providers; but they illustrate the enormity, complexity and severity of the problem of serious medical harm.

These case studies detail serious harm from surgical mesh and anti-seizure medicines *in utero* and highlight the lack of consistency in our harm reporting processes, the poor co-ordination between health entities who crunch the data in different ways, and the incomplete datasets used to justify how effective our systems are. If this is the case for serious harm caused by just two medical treatments, it is not hard to imagine the breadth of harm and the failures across our entire health system.

The lack of reporting of adverse events is a huge problem, and it is negatively impacting not just consumers and future generations, but also clinicians who are left ‘picking up the pieces’. Reporting of adverse events is not mandatory, and the heavy reliance and onus on health professionals is not working. The definition of a “Risk of Harm” event is subjective and what is being reported doesn’t reflect the significant harm that is occurring in many cases.

Few New Zealand registers track patient outcomes effectively, if at all, and there is scant evidence that shows anyone is effectively monitoring or successfully addressing practitioner competency?

Potential competency reviews, authorisation decisions and education are hamstrung because learnings are not available to medical practitioners from the available harm reporting processes. The roles and responsibilities of all health entities to establish effective prevention strategies need to be more clearly defined with transparency a priority.

The main issues addressed in the report¹⁴ are:

1. The case studies show that there is no accurate data on mesh injuries and *in utero* harm from anti-seizure medicine. Repeat medical harm in Aotearoa New Zealand is extremely difficult to identify owing to poor reporting system processes.
2. Our health entities should all be collecting data and monitoring repeat harm caused by individual practitioners, but they aren’t. This needs to change, urgently. Collecting ‘themed’ data is not enough; all health entities should be tracking, monitoring and reporting harm caused by individual practitioners.
3. Our health system relies heavily on health consumers to report harm to both HDC and ACC, or CARM (a system that was never designed to capture foetal harm), and health practitioners rarely report harm or even disclose harm to the patient.
4. Not all health practitioners are fully protected under the new and improved Protected Disclosures Act 2022, so cannot raise the alarm on ‘red flag’ health professionals without being identified. “The Medical Council or HDC would have a high threshold to meet before being able to identify disclosers, and identification must be essential for the investigation to be effective, meaning there is no alternative. However, a surgeon is unlikely to be protected under the Act when reporting harm caused by a colleague at a different hospital, even if they have reasonable grounds to believe the serious wrongdoing occurred”.
5. When considering the surgical mesh and anti-seizure medication harm Risk of Harm notifications that have been made in the last decade, it is clear that large numbers of reports have not been made. It may be that health professionals have insufficient knowledge about how to make a Risk of Harm notification, and therefore don’t do it.
6. Health practitioners rely on relevant entities to collect and report this data. However, ACC can only collect data from claims lodged, and if a serious harm incident is not lodged as an ACC

claim, ACC has no data on the incident so it cannot be notified.

7. Post-marketing surveillance systems are flawed, under-regulated, passive and antiquated.
8. Individual practitioner harm caused through a lack of informed consent is not being identified or reported, even when it is known to be caused by repeat offenders. The health, accident compensation and disability agencies in Aotearoa New Zealand are failing to monitor or track repeat offenders who do not obtain *informed* consent or discuss choices in potential treatments, despite increasing complaints to the HDC on failures of practitioners to obtain informed consent.
9. Previous correspondence with health entities regarding harm reporting processes specific to mesh use reveals that multiple health agencies state they have been working together for several years to improve their harm reporting processes: adverse events, Severity Assessment Code (SAC) and Risk of Harm notification reporting. Despite claims of process improvements, these are not able to be verified, owing to a complete lack of transparency about the level of harm occurring, and inconsistency and lack of co-ordination between responsible authorities.
10. From official information requests that are included in the report, it is clear that Medsafe, HQSC, HDC and ACC state they are collecting data (grouped into themes), but once reported there is no transparency about the use of the data.
11. There is a systemic lack of accountability for medical practitioners, especially operating in the private sector. We need comprehensive legislation and an effective authority with the ability to enforce professional standards of competency or restrict modes of practice. For example, surgical mesh procedures continue unregulated in the private sector.
12. There appears to be no urgency to address and remedy the multiple failures, the inconsistencies and lack of standardisation of reporting between agencies responsible for monitoring and collecting harm data.
13. The purpose of 2023 National Adverse Events Policy from HQSC is “to encourage national consistency in the way harm is reviewed and reported.”¹⁵ The Health Consumer Advocacy Alliance is extremely pleased with the restorative approach and provider education being included in this report. Educating providers on how to report harm is essential. However, providers are only ‘encouraged’ to use the newly developed

harm reporting templates, and although reporting of adverse events is deemed ‘expected’, it is not mandatory. Once again, lack of transparency is an issue, and public scrutiny of this reporting format is not possible as these reporting templates are not available in the public domain. Without public scrutiny it is difficult to gauge if this new system will be effective, if health professionals will feel safe enough to proactively report harm, and if reporting rates will improve.

14. Despite recent work by the HQSC, it appears that no one agency or person is ‘leading the charge’ to effect change to protect patients from further preventable medical harm, including addressing the discrepancies in data reporting and monitoring between agencies. The Health Consumer Advocacy Alliance propose the establishment of a National Patient Safety Commissioner who would focus on preventing patient harm by:
 - truly representing and giving weight to the consumer voice;
 - analysing the structure of the health system and the reporting systems and improving the way in which medical harm is reported and acted upon;
 - and providing a “fence at the top of the cliff” that would reduce the incidence of medical injury and harm.

A National Patient Safety Commissioner would help reduce the number of complaints to the Health and Disability Commissioner (the ambulance at the bottom of the cliff) and work in tandem with the HDC to effect cultural change within the health system.

Where to From Here?

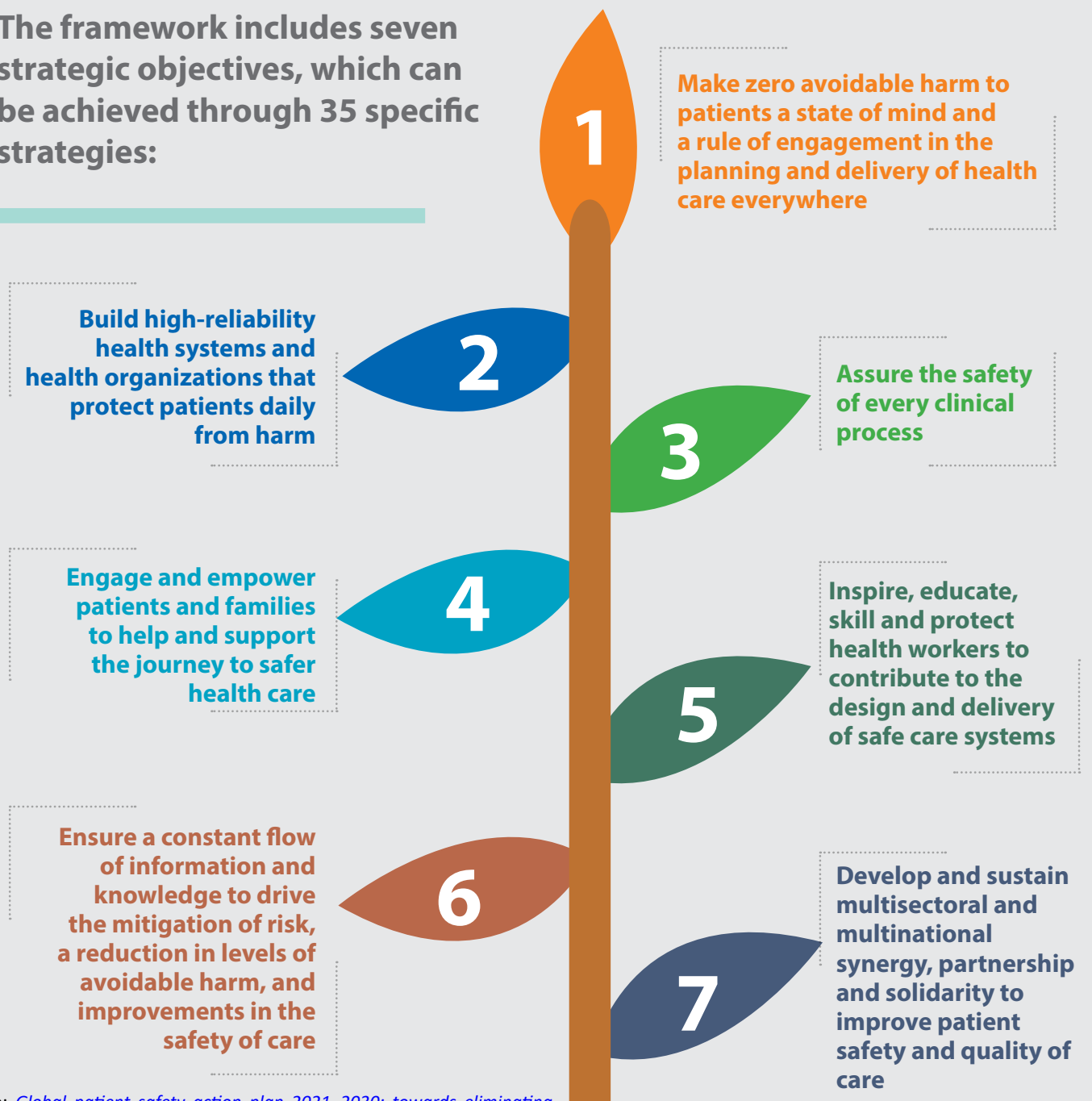
New Zealanders need to know that our health entities will act and do whatever they need to do to ensure we are safe in the hands of our health professionals. Cherry picking individual health issues to focus on without enacting transformative change across the entire system, is just tinkering around the edges; the flaws go beyond individual health issues. Fix the systems, scrutinise the selected measures of reporting, and we can address multiple health issues. We don’t need more talk; we need action!

Aotearoa New Zealand has signed up to the Global Patient Safety Action Plan 2021-2030, a document that provides a Framework for Action that includes seven strategic objectives that can be achieved through 35 specific strategies (see diagram on page 22). HCAA wants to know exactly what has been done on the Framework for Action in Aotearoa New Zealand?

Global Patient Safety Action Plan 2021-2030

Framework for action

The framework includes seven strategic objectives, which can be achieved through 35 specific strategies:



Source: [Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care](#), World Health Organisation 2021.

In February 2023, Denise Astill and Jacki Morris from FACS NZ attended the 5th Global Summit on Patient Safety (held in Montreux, Switzerland). There were more than 600 participants, with over 80 countries represented (including ministers of health or their representatives), as well as representatives from the OECD, NGOs, patient groups, tertiary providers and various medical professionals to enable continued dialogue, and to carry the ministers of health's message.

Astonishingly, Aotearoa New Zealand had no official Governmental delegates at the summit; no-one from the Ministry of Health or Te Whatu Ora or other health agencies. Some of the countries in attendance were third world countries, yet Aotearoa New Zealand has never had governmental representatives at this summit.

It is vital that New Zealand is present at the 6th Global Ministerial Summit on Patient Safety in 2024 in an official ministerial capacity. This would be a clear indicator that patient safety is being taken more seriously. To build consumer and health practitioner confidence, our health entities must be more vocal in the public domain and be more transparent about the improvements being made on a micro/macro level.

The HCAA believes that critically analysing the complexity of our harm reporting system, rather than perpetuating the "current improvement paradigm" is important. Health agencies and individual practitioners accountable for collecting and reporting medical harm must ensure that that harm is reported in ways that identify future risks. Individual practitioners, agencies (including professional bodies), stakeholders and decision makers must prioritise patient safety over professional and privacy boundaries.

Aotearoa New Zealand must follow the lead of other countries where comprehensive registries that obtain quality outcome measures have been established, as previously mentioned in this document. Patients should be identified, contacted and monitored when "red flags" on particular therapeutic products or concerns about specific procedures have been raised internationally. Patient safety should supersede financial constraints.

A Patient Safety Commissioner would truly represent and give weight to the consumer voice. He or she would analyse both the structure of the health system and the harm/adverse event/medical injury reporting systems and ensure improvement in the way in which medical harm is reported and acted upon, providing a conduit between health agencies – effectively removing the siloing that still occurs today, especially in sharing of reports of harm data

– and also between the health system and health consumers.

An independent National Patient Safety Commissioner would act as the "fence at the top of the cliff", over time reducing the incidence of medical injury and harm. They would reduce the number of adverse outcomes, and medical injury and harm complaints to the Health and Disability Commissioner (effectively the ambulance at the bottom of the cliff), freeing up HDC resources to investigate other breaches of patient rights, and work in tandem with the HDC to effect cultural change within the health system.

The impact of unsafe care cannot be underestimated, it affects all New Zealanders receiving and providing treatment in Aotearoa. We must consider 'how can we collectively make the change that is needed, work together, take shared responsibility and ownership to proactively prevent harm?'

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