ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

TOI MATA HAUORA

ASMS submission to Manatū Hauora Ministry of Health on the Women's Health Strategy

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The Association of Salaried Medical Specialists (ASMS) welcomes the opportunity to provide a submission to Manatū Hauora Ministry of Health as part of the development process for a new Women's Health Strategy (the Strategy) for Aotearoa New Zealand.

ASMS is the union and professional association of salaried senior doctors and dentists. We were formed in April 1989 to advocate and promote the industrial and professional interests of our members, most of whom are employed by Te Whatu Ora Health New Zealand as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. We have over 5,600 members.

ASMS is working for an equitable, accessible public health care system that meets the needs of all New Zealanders.

Our submission considers the following aspects for the Strategy, and makes a series of recommendations. These are summarised here as well as at the end of each section.

Principles guiding the Strategy

- The imperative for an intersectional approach to understanding service acceptability and accessibility, inequities in disease prevalence and outcomes, and emphasise the diversity of women and people assigned female at birth[1] in Aotearoa New Zealand

Trends

- Life expectancy must be adopted as a key indicator to measure change over time, and the success of policy interventions
- Equitable access to culturally safe, holistic mental health and addiction services must be a priority for the Strategy
- Incorporating specific indicators for under a women's health topic in the New Zealand Health Survey, and initiating a regular, in depth survey on women's health in Aotearoa New Zealand

Areas of focus

Maternal mental health, with a particular focus on preventing maternal suicide

- Maternal mental health is identified as an initial strategic priority, with a kaupapa Māori (by Māori, for Māori, as Māori) approach
- Health workers supporting pregnant people and whānau have the knowledge, expertise and empowerment to engage in culturally safe ways
- Expand the definition for reporting to include the first year after the end of a pregnancy, noting the changes in symptoms for the Growing Up in NZ parent cohort at 9 months post-partum

Chronic pain

- Gaining current prevalence data is essential to inform policy and clinical guidelines

[1] Throughout this submission we have used references to women, girls and people assigned female at birth. ASMS acknowledges that gender and sexual identities are self-determined constructs existing on a spectrum.

- Review United Kingdom clinical guidance for feasibility and transferability in the Aotearoa New Zealand context on urological chronic pelvic pain
- Improve understanding, recognition, testing, diagnosis and management of chronic pain conditions

Workforce

- Include the health and wellbeing of women in health workforce in the Strategy as a key enabler
- Prioritise female-dominated specialities and workforces for retention initiatives, including obstetrics and gynaecology, and gynaecological oncology

Principles guiding the strategy

ASMS expects that the principles informing the Strategy will be aligned to Te Tiriti o Waitangi and its principles of Tino Rangatiratanga, partnership, active protection, equity and options. In addition, the health sector principles set out in s 7 of the Pae Ora (Healthy Futures) Act 2022 establish expectations for equitable outcomes, engagement, health promotion and emphasises the importance of lived experience – "the direct experience of individuals".

The imperative for an intersectional approach

Equality of access to health care and services is premised on a one-size-fits-all approach: this model fails to recognise that resources need to be distributed according to need to generate equitable access and outcomes for people, whānau and communities.

Intersectionality is a critical analytical framework emerging from Black feminist, Indigenous, queer, and postcolonial theory in the late 1980s[2]. Intersectionality is premised on interpreting interlocking power relationships, and how layers of experience are mediated through social, cultural, political, and economic determinants – often simultaneously. An intersectional approach to public health policy allows for heterogeneity and uneven distribution within an (assumed) homogenous group[3]. Because intersectionality is a tool for analysis and action, it enables interventions to be developed and designed with greater reference to power, privilege, advantage and disadvantage that inform lived experiences at individual, whānau and community levels[4].

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[2] Crenshaw KW. Mapping the margins: Intersectionality, identity politics and violence against women of color. Stanford Law Rev; 1991: 43(6):1241-1299. https://www.berkeleycitycollege.edu/slo/files/2021/05/Crenshaw-Mapping-the-Margins-Intersectionality-and-Vioence-against-WOC.pdf.

[3] Bowleg L. Evolving intersectionality within public health: from analysis to action. Editorial. Am J Public Health 2021; 111(1):88-90. https://pubmed.ncbi.nlm.nih.gov/33326269/.

[4] Kapilashrami A, Hankivsky O. Intersectionality and why it matters to global health. The Lancet 2018; 391(10140):2589-2591. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31431-4/fulltext.

A Women's Health Strategy must acknowledge, represent, and include the diversity of identity and experience of women in Aotearoa New Zealand. This includes members of the LGBTQIA+, Takatāpui and MVPFAFF+ communities[5]. The Strategy must also incorporate anatomy-based care, for people assigned with female anatomy at birth who identify with another gender/s.

An intersectional approach will value and emphasise the diversity of women in Aotearoa New Zealand, and ASMS believes this approach would support the Strategy's intended outcomes.

Trends

Life expectancy

Life expectancy for women is generally greater compared to men: for example, a female child born in 2021 will have a life expectancy of 91.1 years, compared to 88.3 years for male children[6]. Life expectancy by ethnicity and socioeconomic decile shows greater variation. For women, this variation underscores the existing, perpetuated inequities in health outcomes, and the need to ensure resources are distributed equitably according to need.

Our 2021 report *Creating Solutions – He Ara Whai Tika* identifies life expectancy as a key metric amenable to intervention through policy and the social, commercial and economic determinants of health. Life expectancy disparities are distributed across a 10.8-year gap between wāhine Māori and Asian women.

Socioeconomic and resource deprivation has a profound impact on life expectancy: for women, there is a growing gap between decile 1, the wealthiest, and decile 10, those experiencing the greatest levels of material hardship. Rather than narrowing over time, life expectancy gaps between women living in the wealthiest and women in the most deprived areas of New Zealand are increasing. In 2005/07 the gap between deciles 1 and 10 was 5.4 years, by 2017/19 it had increased to 9 years[7].

[5] LGBTQIA+ is an umbrella acronym for lesbian, gay, bisexual, trans*, queer, intersex and asexual community. Takatāpui is an inclusive term encompassing all tangata whenua who identify with diverse genders and sexualities. MVPFAFF+ is an acronym describing Pasifika identities: Mahu (Hawai'i and Tahiti), Vaka sa lewa lewa (Fiji), Palopa (Papua New Guinea) Fa'afafine (Samoa) Akava'ine (Rarotonga), Fakaleiti (Tonga), Fakafifine (Niue). Definitions from the Rainbow Directory Glossary, https://rainbowdirectory.co.nz/glossary/.

[6] Stats NZ. New Zealand cohort life tables: March 2023 update. https://www.stats.govt.nz/information-releases/new-zealand-cohort-life-tables-march-2023-update/.

[7] ASMS. Creating solutions: He ara whai tika: A roadmap to health equity 2040. Wellington: ASMS; 2021. https://issuu.com/associationofsalariedmedicalspecialists/docs/asms-creating-solutions-fa-web_-_final.

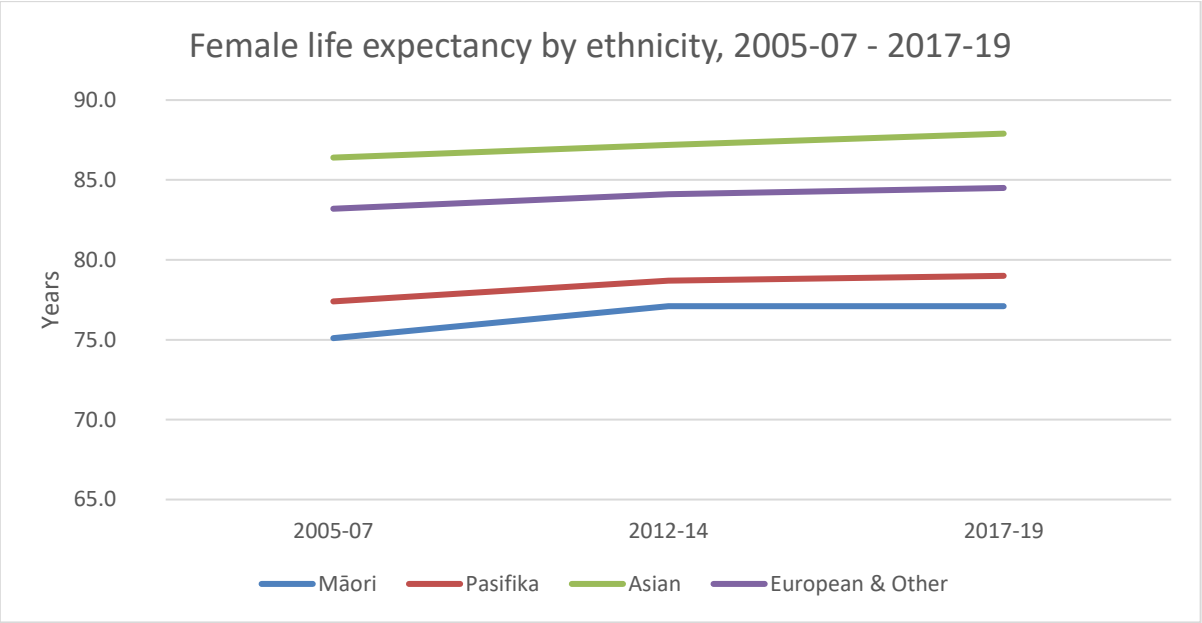

Fig 1. Female life expectancy by ethnicity, 2005-07 – 2017-19

Life expectancy data by ethnic group became available in 2005. By 2017, life expectancy gaps continued to persist between ethnic groups, with a marginal decrease between NZ European females and wāhine Māori of 0.7 years during the 12-year period. At this rate, it would take into the 22nd century – around 127 years – for wāhine Māori to achieve life expectancy equity with NZ European females. Life expectancy equity between NZ European females and Pasifika females will take approximately 220 years to be achieved[7].

We recommend that life expectancy is adopted as a key indicator to measure change over time, and the success of policy interventions.

Mental health

Unmet need for mental health is increasing, despite renewed political interest (2018 Mental Health and Addiction Inquiry, 2019 Budget announcements) and acute societal awareness of mental wellbeing, particularly following major events like the Canterbury earthquakes, the 2019 Mosque Terror Attacks and the onset of the Covid-19 pandemic.

At least one in five New Zealanders will experience mental illness in their lifetime. The latest results from the New Zealand Health Survey indicate that this prevalence is increasing, with 23.9 per cent (nearly one in four) having ever being diagnosed with a mood disorder and/or anxiety by a doctor[8].

Prevalence of anxiety and/or mood disorder (such as depression or bipolar disorder) has increased in Aotearoa since 2011/12, with a steadier ascent since Covid-19. While this trend can be observed across age, gender, ethnicity and disability status, wāhine Māori and disabled women have the highest rates at 33.7 per cent and 44.5 per cent respectively[8].

[8] Manatū Hauora Ministry of Health. Females aged 15 years and over diagnosed with an anxiety or mood disorder by ethnicity, 2011/12 – 2021/22. NZ Health Survey: Annual update of results 2021/22.

Recent surveys have highlighted unmet mental health need for Asian New Zealanders and a lack of up-to-date data (previous research in Asian mental health was undertaken in 2002).

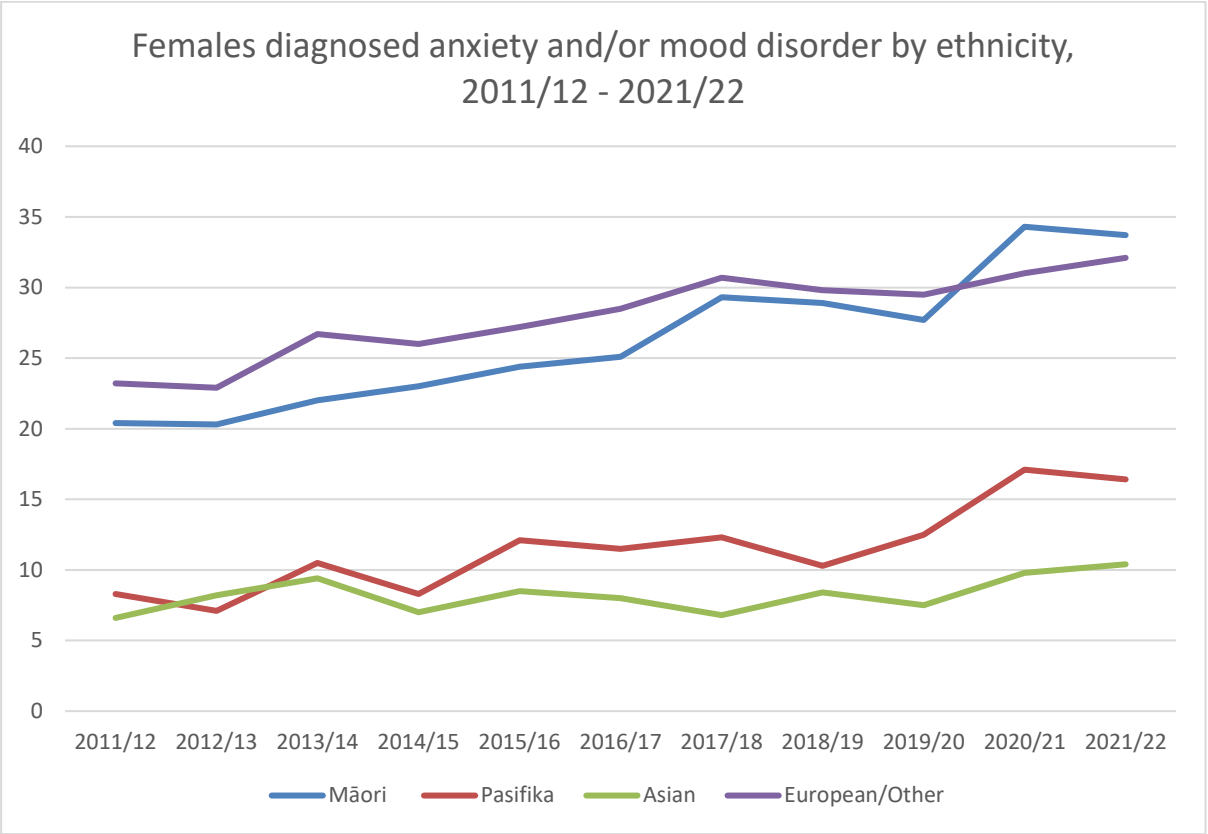

Fig 2. Females >15 years diagnosed with anxiety and/or mood disorder 2011/12 – 2021/22

Data from the NZ Health Survey clearly shows the need to continue to invest in mental health and addiction services at all levels. While European/Other women have a higher prevalence of ever-diagnosed mental health conditions, they are less likely to have experienced high or very high levels of psychological distress than wāhine Māori and Pasifika women (12.8 per cent compared to 20.6 and 17.6 per cent, respectively). Further, European/Other were less likely to experience unmet need for mental health and addiction services in the previous 12 months compared to wāhine Māori and Pasifika women (10.7 per cent compared to 14.5 and 13.5 per cent, respectively). Disabled women were most likely to report unmet need for mental health and addiction services at 19.5 per cent[9].

There are persistent gaps in access to mental health and addiction services for all women, but Māori, Pasifika and disabled women are more likely to be impacted and have difficulty accessing mental health care. Equitable access to culturally safe, holistic mental health and addiction services must be a priority for the Strategy.

[9] Manatū Hauora Ministry of Health. Topic: Mental health. NZ Health Survey: Annual update of results 2021/22.

Using the New Zealand Health Survey to track progress against outcome measures

The New Zealand Health Survey is a rich source of data, including trends over time, on New Zealanders' experiences of health conditions and access to health services. Although gender is included as a subgroup by which data is reported and trends can be analysed over time, there are no indicators or topics that explore women's health conditions. To support the Strategy's outcomes focus, we recommend the inclusion of women's health conditions and indicators in future iterations of the New Zealand Health Survey, though this should not exclude the Ministry of Health undertaking a regular in-depth survey of women's health outcomes in Aotearoa New Zealand, in partnership with Te Aka Whai Ora, the Māori Health Authority.

Areas of focus

A new Women's Health Strategy for Aotearoa New Zealand should be inclusive; however our submission identifies two broad areas of focus – maternal mental health and chronic pain, which we argue are fundamental both strategically and as a means of addressing significant unmet need.

Maternal mental health care

The *Growing Up in New Zealand* longitudinal study assessed maternal mental health at the antenatal and 9-months postpartum stages. 16 per cent of pregnant people experienced depressive symptoms before their babies were born; this fell to 11 per cent at 9 months. However, at 9 months 4.7 per cent noted persistent symptoms, while 5.8 percent stated new depressive symptoms. Of the parents who reported anxiety more than weekly (n= 1621), 39 per cent said their feelings of anxiety made caring for their babies somewhat, very, or extremely difficult[10]. It is essential that maternal mental health screening does not miss symptoms of postnatal and perinatal depression and anxiety throughout the pregnancy and postpartum period, and that screening is opportunistic, safe, and free from stigma.

Maternal suicide

The leading cause of death for pregnant people in Aotearoa New Zealand is suicide[11]. Since 2006, 31 deaths have been attributed to maternal suicide (22.1 per cent of all maternal deaths in the 2006-2020 period). Aotearoa New Zealand has a much higher rate of maternal deaths directly or indirectly attributed to suicide than other countries, including Australia, the United States and the United

[10] Growing Up In New Zealand. Report 2: Now We Are Born. Auckland: The University of Auckland; 2012. https://www.growingup.co.nz/sites/growingup.co.nz/files/2019-10/report02.pdf.

[11] Perinatal and Maternal Mortality Review Committee. 15th report of the Perinatal and Maternal Mortality Review Committee. Wellington: 2022. https://www.hqsc.govt.nz/resources/resource-library/fifteenth-annual-report-of-the-perinatal-and-maternal-mortality-review-committee-reporting-mortality-and-morbidity-2020/.

Kingdom[12] [13] [14]. Aotearoa uses the International Classification of Diseases (ICD-10) definition of maternal death (death of a woman while pregnant or within 42 days of the end of pregnancy (miscarriage, termination, or birth)) which consequentially, may under-report postpartum suicide[11]. The United Kingdom includes pregnancy and up to one year after the end of pregnancy in its maternal suicide reporting[13]; research has found that extending the definition to one year postpartum will include between 13 and 36 per cent of maternal deaths due to suicide (direct and indirect)[14] [15].

The overrepresentation of wāhine Māori in maternal suicide statistics (both absolute numbers and rate of death due to suicide) show that the Crown and the health system are failing their obligations under Te Tiriti o Waitangi. Wāhine Māori were 2.91 times more likely to die by suicide than women of NZ European descent[11].

Maternal mental health and maternal suicide are urgent health equity issues. Research notes that although pregnant people and whānau may have a greater number of interactions with the health sector during pregnancy, this does not always translate to safe, equitable or whānau-centred engagement. Data shows that wāhine Māori and Pasifika women were less likely to be enrolled with a Lead Maternity Carer in the first trimester of pregnancy or be enrolled and receive service from a Well Child Tamariki Ora provider, compared to NZ European and Asian women[16] [17]. This means that opportunities for mental health and wellbeing screening, and potentially support and intervention, are missed.

ASMS recommendations for maternal mental health

1. Maternal mental health is identified as an initial strategic priority, with a kaupapa Māori (by Māori, for Māori, as Māori) approach
2. Health workers supporting pregnant people and whānau have the knowledge, expertise and empowerment to engage in culturally safe ways
3. Expand the definition for reporting to include the first year after the end of a pregnancy, noting the changes in symptoms for the Growing Up in NZ parent cohort at 9 months post-partum

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[12] Australian Institute of Health and Welfare. Australia's mothers and babies: Maternal deaths. https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-australia

[13]. Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J et al. (Eds). On behalf of MBRRACE-UK Saving lives, improving mothers care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-2019. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2021. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

[14] Chin K, Wendt A, Bennett IM, Bhat A. Suicide and maternal mortality. Curr Psychiatry Rep. 2022 24(4):239-275. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8976222/

[15] Lommerse K, Knight M, Nair M, Deneux-Tharaux C, van de Akker T. The impact of reclassifying suicides in pregnancy and the postnatal period. BJOG 2019; 126(9):1088-92. https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.15215

[16] Te Whatu Ora Health New Zealand. Maternity clinical indicator trends in New Zealand 2009-2020. https://tewhatuora.shinyapps.io/maternity-clinical-indicator-trends/

[17] Ministry of Health. Well Child Tamariki Ora Review Report. Wellington: https://www.health.govt.nz/publication/well-child-tamariki-ora-review-report.

Chronic pain

Health conditions which include chronic pain as a symptom are prevalent in women and people assigned female at birth. These include fibromyalgia; migraine; chronic pelvic pain conditions like endometriosis, inflammatory bowel disease, and chronic urinary tract infections; and rheumatoid arthritis[18] [19]. In Aotearoa New Zealand, chronic pain presentations for any cause have increased over time: in 2011/12, 17.4 per cent of women reported they experience pain of varying intensity almost every day; by 2021/22 this had increased to 23.8 per cent[8].

Our aging population will contribute to an increase in chronic pain prevalence over time. In 2018, a report commissioned by the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists estimated that the prevalence of chronic pain based on aging alone would rise to 22.2 per cent by 2048[20]. As of 2022, the New Zealand Health Survey reports that this prediction has already been exceeded, with 22.6 per cent of New Zealanders living with chronic pain, and as noted above, this higher again for women at 23.8 per cent.

Chronic pain is highly individualised. "There are no objective tests for pain; it is a subjective experience, and its complexity can make assessment challenging, even when using accepted measures"[21]. Chronic pain is an area of medical practice shown to be impacted by gender bias, which casts women and people assigned female at birth as having a psychological or psychosomatic cause of their pain, rather than a physiological or biological one. As a result, their experience becomes conflicted with the biomedical knowledge of a health professional, contributing to diagnostic delay, reductions in presentation and eroded trust in the health system[22].

Chronic pelvic pain

One in four New Zealand girls, women and people assigned female at birth will experience chronic pelvic pain (CPP) during their lifetimes, and half will remain undiagnosed. For those that receive a diagnosis, pain can be attributed to many causes, including endometriosis[23]. Although at least 10 per cent of people with uteruses in Aotearoa will likely have endometriosis, diagnostic delay is common. A 2022 Aotearoa NZ paper found an average 8.7 years from first presentation to diagnosis prior to 2005; while this had decreased to two years after 2012, delays in diagnosing endometriosis can have

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[18] Casale R, Atenzi F, Bazzichi L, Beretta G, Costantini E, et al. Pain in women: a perspective review on a relevant clinical issue that deserves prioritisation. Pain Ther 2021; 10(1):287-314. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8119594/.

[19] Jiménez-Trujillo I, López-de-Andrés A, Del Barrio JL, Hernández-Barrera V, Valero-de-Bernabé M, Jiménez-García R. Gender Differences in the Prevalence and Characteristics of Pain in Spain: Report from a Population-Based Study. Pain Med. 2019; 20(12):2349-2359. https://pubmed.ncbi.nlm.nih.gov/30789640/.

[20] Moore D, Davies P. The problem of chronic pain and scope for improvements in patient outcomes. Report to the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists. Wellington: Sapere Research; 2018. https://www.srgexpert.com/wp-content/uploads/2019/03/The-problem-of-chronic-pain-and-scope-for-improvements-in-patient-outcomes.pdf.

[21] Swain N, Parr Brownlie L, Lennox Thompson B, Darlow B, Mani R et al. Six things you need to know about chronic pain. N Z Med J. 2018; 131(1486):5-8. https://journal.nzma.org.nz/journal-articles/six-things-you-need-to-know-about-pain.

[22] Samulowitz A, Gremyr I, Eriksson E, Hensing G. "Brave men" and "emotional women": a theory-guided literature review on gender bias in health care and gendered norms towards patients with chronic pain. Pain Res Manag 2018; 2018:6358624. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5845507/.

[23] Grace VM, Zondervan KT. Chronic pelvic pain in New Zealand: prevalence, pain severity, diagnoses and use of health services. Aust NZ J Public Health 2004; 24(4):369-75. https://onlinelibrary.wiley.com/doi/10.1111/j.1467-842x.2004.tb00446.x.

a debilitating impact on quality of life[24]. Further, the same study found that regardless of the aetiology of the pain, the impact on individuals undertaking activities of daily life is similar – yet for people *without* a diagnosis of endometriosis, their presentation with CPP is often invalidated.

Endometriosis has gained attention globally in recent years, as people living with the condition (including some high-profile individuals) are increasingly open about their experiences, which has likely contributed to reductions in diagnostic delay over time[25] [26]. At a policy level, the introduction of clinical guidelines for the diagnosis and management of endometriosis will contribute to increased understanding of the disease and access to multidisciplinary support. The guidelines note the importance of improving research into endometriosis in priority populations, including wāhine Māori, and the involvement of a multidisciplinary team [27].

Urologic chronic pelvic pain syndrome as an example of gender inequity

Urologic chronic pelvic pain syndrome (UCPPS) is increasingly used as an umbrella term for people of all genders to cover conditions including chronic urinary tract infection (CUTI), interstitial cystitis or painful bladder syndrome[28]. The exact cause of these long-term conditions is often unknown but can include an auto-immune reaction, or a bacterial infection becoming embedded in the epithelial lining of the bladder wall. It causes severe and debilitating pelvic pain, yet symptoms will often present as uncomplicated urinary tract infections (UTI), such as frequency and urgency to urinate[29]. Women are affected at a rate of 2-3 times that of men, with a prevalence in the United States of between 3-8 million women and 1-4 million men; however people of all genders are likely to be undiagnosed despite ongoing and disabling symptoms[30]. Prevalence in Aotearoa is unknown, though 14.1 per cent of women with chronic pelvic pain had presented to a health care practitioner with symptoms of cystitis in 2004[23].

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[24] Tewhaiti-Smith J, Semprini A, Bush D, Anderson A, Eathorne A, Johnson N. An Aotearoa New Zealand survey of the impact and diagnostic delay for endometriosis and chronic pelvic pain. Nature Scientific Reports 2022; 12:4425. https://doi.org/10.1038/s41598-022-08464-x.

[25] Russell E. In her head: Women's health – endometriosis surgery wait times up to three years. NZ Herald 9 May 2022. https://www.nzherald.co.nz/nz/in-her-head-womens-health-endometriosis-surgery-wait-times-up-to-three-years/RERD2QDPEBXY6QEXJM7MY4B4AY/.

[26] Devlin H. Menopause, endometriosis and more: four ways England is failing women. The Guardian 2 June 2022. https://www.theguardian.com/society/2022/jun/02/menopause-endometriosis-and-more-four-ways-england-is-failing-women.

[27] Manatū Hauora Ministry of Health. Diagnosis and management of endometriosis in New Zealand. Wellington: Manatū Hauora Ministry of Health; 2020. https://www.health.govt.nz/system/files/documents/publications/diagnosis-and-management-of-endometriosis-in-new-zealand-mar2020-apr21-update.pdf.

[28] Windgassen SS, Sutherland S, Finn MTM, Bonnet KR, Schlundt DG et al. Gender differences in the experience of interstitial cystitis. Front Pain Res 2022(3). https://www.frontiersin.org/articles/10.3389/fpain.2022.954967/full.

[29] Ratner V. Interstitial cystitis: a chronic inflammatory bladder condition. World J Urol 2001; 19(3):157-9. https://pubmed.ncbi.nlm.nih.gov/11469601/.

[30] Patnaik SS, Lagana AS, Vitale SG, Buttice S, Noventa M, Gizzo S et al. Etiology, pathophysiology and biomarkers of interstitial cystitis/painful bladder syndrome. Arch Gynecol Obstet 2017; 295(6):1341-1359. https://pubmed.ncbi.nlm.nih.gov/28391486/.

Midstream and dipstick urine tests – the gold standard for a UTI diagnosis – will return negative results in a person with a chronic UTI: these tests will miss 90 per cent of cases[31] [32]. However, midstream urine and remain best practice for diagnosis of UTIs in Aotearoa irrespective of complication or history; further, routine dipstick screening for bacterial infection is not encouraged given the risk of antimicrobial resistance[33].

Once the infection becomes established, there are limited options: there is no single test to diagnose UCPPS, and management of the disease is premised on pain management (including referral to a pain specialist), physiotherapy, and counselling[34]. Women will routinely receive a three-day course of antibiotics; however men (in which UTIs are considered more complicated, on the basis of physiology) will receive 7 days[35].

In August 2022, the National Institute for Health and Care Excellence (NICE) in the United Kingdom updated its guidance for antibiotic prescribing for recurrent UTI. This update followed an exceptional review at the end of a randomised controlled trial testing efficacy and cost-effectiveness by comparing three low-dose antibiotic regimens with methenamine hippurate for women with recurrent UTI and UCPPS[36] [37].

ASMS recommendations for chronic pain

Women, girls and people assigned female at birth continue to live with chronic pain as a result of UCPPS, endometriosis, and inflammatory conditions. Many struggle through repeated presentations to health practitioners without receiving a diagnosis, treatment, or management. Women living with chronic pain experience significant psychological impacts including depression, anxiety, self-harm and suicidal ideation; they report lower quality of life, social relationships and connection, and ability to participate in employment, education or training.

1. Prevalence data is essential to inform policy and clinical guidelines. The Strategy must:

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[31] Sathiananthamoorthy S, Malone-Lee J, Gill K, Tymon A, Nguyen TK et al. Reassessment of routine midstream culture in diagnosis of urinary tract infection. J Clin Microbiol 2019; 57(3):e01452-18. https://pubmed.ncbi.nlm.nih.gov/30541935/.

[32] Swarmy S, Barcella W, De Iorio M, Gill K, Khasriya R et al. Recalcitrant chronic bladder pain and recurrent cystitis but negative urinalysis: what should we do? Int Urgynaecol J. 2018; 29(7)

[33] Best Practice Advocacy Centre NZ. Urinary tract infections (UTIs) – an overview of lower UTI management in adults. Dunedin: Best Practice Advocacy Centre; 2021. https://bpac.org.nz/2021/uti.aspx.

[34] National Health Service. Bladder pain syndrome (interstitial cystitis). February 2022. https://www.nhs.uk/conditions/interstitial-cystitis/.

[35] Antibiotic Research UK. Frequently Asked Questions: Why do men have to take longer courses of antibiotics for treatment of UTI compared to women? 8 June 2021. https://www.antibioticresearch.org.uk/ufaq/what-is-misuse-of-antibiotics-2/.

[36] National Institute for Health and Care Excellence. 2022 exceptional surveillance of Urinary tract infection (recurrent): antimicrobial prescribing (NICE guideline NG112). August 2022. https://www.nice.org.uk/guidance/ng112/resources/2022-exceptional-surveillance-of-urinary-tract-infection-recurrent-antimicrobial-prescribing-nice-guideline-ng112-11187931213/chapter/Surveillance-decision?tab=evidence.

[37] Harding C, Mossop H, Homer T, Chadwick T, King W, Carnell S. Alternative to prophylactic antibiotics for the treatment of recurrent urinary tract infections in women: multicentre, open label, randomised, non-inferiority trial. BMJ 2022; 376:e068229. https://pubmed.ncbi.nlm.nih.gov/35264408/.

a. Include a topic on women's health conditions in future iterations of the New Zealand Health Survey, including questions on gynaecological conditions like endometriosis

b. Commit to a regular national survey on women's health, with particular focus on priority populations including wāhine Māori, Pasifika women, rainbow communities and disabled women

2. Review United Kingdom clinical guidance for feasibility and transferability in the Aotearoa New Zealand context on urological chronic pelvic pain

3. Improve understanding, recognition, testing, diagnosis and management of chronic pain conditions though:

    a. Access to multidisciplinary expertise and approaches through the public health system, including psychologists, pain medicine specialists and physiotherapists

    b. Working with organisations responsible for the education and training of health workers, including Colleges and specialty societies, to provide up-to-date, patient-centred guidance on chronic pain conditions

Workforce

The pace of gender equality in the medical profession has accelerated since 2000, when just 32.6 per cent of practising doctors in Aotearoa were women. The Medical Council of New Zealand (MCNZ) predicts gender equality in the medical profession by 2025 based on current trends. This projection defines the medical workforce as all doctors from postgraduate year 1 onwards, and while the proportion of women in medicine has increased overall, it will take longer to filter through to vocationally-trained specialists – currently the least equal cohort in the MCNZ survey at 38.2 per cent[38].

Data from recent ASMS surveys has noted a 44.7 per cent participation rate for female doctors, compared to 47.4 per cent for women across all groups in the 2022 MCNZ workforce survey. The increasing proportion of women in the medical workforce, sometimes referred to as the "feminisation of medicine" – is itself a problematic framing of what is greater gender equality in a profession historically dominated by men[39].

As numbers of female medical graduates have increased globally, papers in the peer-reviewed literature have warned that greater gender equality will result in lower productivity and fewer hours of work from female doctors compared to their male counterparts[40]. Respondents to this assertion have noted, however, that female doctors were more likely to spend more time engaging in

[38] Medical Council of New Zealand. Annual workforce survey 2022. https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/64f90670c8/Workforce-Survey-Report-2022.pdf.

[39] Roberts JH. The feminisation of medicine. BMJ 2005; 330:s13. https://www.bmj.com/content/330/7482/s13.2.

[40] Weizblit N, Noble J, Baerlocher MO. The feminisation of Canadian medicine and its impact on doctor productivity. Med Ed 2009; 43(5):442-48. https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2009.03309.x.

professional behaviours that support improved patient-centred care, quality, and health outcomes[41]. A move away from highly transactional clinical encounters towards the delivery of more holistic, person and whānau-oriented care will contribute to improved health outcomes, and a greater likelihood that some of the opportunistic screening – such as around mental health (including maternal mental health), substance use, and cancer screening participation – can be realised.

Despite the greater numbers of men in the medical profession historically, the overall health workforce in Aotearoa New Zealand is 77 per cent women and people of another gender[42]. The guidance provided by the Ministry of Health suggests that submitters consider what "support the health workforce may require to meet the health and wellbeing needs of women", yet there are also many actions the Ministry of Health, Te Whatu Ora and Te Aka Whai Ora can take to support their own workforce – the majority of whom are women.

Work (either paid or unpaid) is a major determinant of health and wellbeing. The Australasian Faculty of Occupational and Environmental Medicine recognise that good work – work that is engaging, fair, respectful, balances job demands, autonomy and job security – is beneficial to workers, workplaces, whānau and communities[43]. How the Strategy, which is ostensibly an outward-looking, systems-level lever, can incorporate actions to support the health and wellbeing of its own female-dominated workforce will enhance the goals and outcomes of the Strategy.

The phenomenon of burnout has significant implications for the recruitment and the retention of health workers, and ASMS has undertaken surveys on burnout in the senior medical workforce in 2015 and 2020[44] [45]. Results showed that, although one in every two senior medical officers (SMOs) was experiencing burnout, rates were far higher in female SMOs between 30 and 49. In the second iteration of the survey, the prevalence of burnout in women 30-39 and 40-49 increased, while it decreased for men in the 30-39 age group, and maintained 2015 levels for men aged 40-49.

[41] Jefferson L, Bloor K, Spilsbury K. Exploring gender differences in the working lives of UK hospital consultants. J Royal Society Medicine. 2015; 108(5):184-91. https://journals.sagepub.com/doi/pdf/10.1177/0141076814558523.

[42] Te Whatu Ora Health New Zealand. Districts employed workforce quarterly report: 1 July – 30 September 2022. Wellington: Central Technical Advisory Services, Te Whatu Ora. https://tas.health.nz/assets/Workforce/District-Employed-Workforce-Quarterly-Report-September-2022_FINAL.pdf

[43] Australasian Faculty of Occupational and Environmental Medicine. Consensus statement on realising the health benefits of good work. Australasian Faculty of Occupational and Environmental Medicine and Royal Australasian College of Physicians; 2022. https://www.racp.edu.au/docs/default-source/advocacy-library/afoem-realising-the-health-benefits-of-work-consensus-statement.pdf?sfvrsn=baab321a_16.

[44] ASMS. "Tired, worn out and uncertain" Burnout in the New Zealand public hospital senior medical workforce. Wellington: ASMS; 2016. https://asms.org.nz/issue-12-tired-worm-out-and-uncertain/

[45] ASMS. "My employer is exhausting" Burnout in the senior medical workforce five years on. Wellington: ASMS; 2021. https://asms.org.nz/wp-content/uploads/2022/07/Health-Dialogue-Burnout.pdf

Mean personal burnout scores by gender, 2015 and 2020

	MEAN PERSONAL BURNOUT SCORES 2015 (%)		MEAN PERSONAL BURNOUT SCORES 2020 (%)	
Age group	**Male**	**Female**	**Male**	**Female**
30 – 39 years	49	53	43.6	56.5
40 – 49 years	47	50	47.1	62.1

The 2022 ASMS Future Intentions survey provides some insights into how SMOs are choosing to cope with burnout, and one of these is leaving the profession entirely. SMOs aged 30-49 years and looking to leave medicine or dentistry has increased since the previous survey in 2017[46].

As noted above, gender may influence a doctor's approach particularly from a professional qualities perspective, considering communication, relationships and rapport with patients and whānau. To successfully implement the Strategy, the diversity of the profession must be a consideration. If female doctors early in their career as SMOs are considering leaving medicine, action must be taken to retain them.

Intentions to leave medicine or dentistry entirely by gender and age, 2017 and 2022

	LEAVE MEDICINE OR DENTISTRY ENTIRELY 2017 (%)		LEAVE MEDICINE OR DENTISTRY ENTIRELY 2022 (%)		CHANGE (%)	
Age group	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
30-34 years	0	0	4.7	14.2	+4.7	+14.2
35-39 years	0	1.6	1.4	4.9	+1.4	+3.3
40-44 years	3.8	1.6	4.5	10.7	+0.7	+9.1
45-49 years	4.2	5.4	5.0	10.1	+0.8	+4.7

ASMS has significant concerns at the high vacancy and attrition rates for many specialities and subspecialties which are at once female-dominated (obstetrics and gynaecology; paediatrics; general practice; and family planning) and are more likely to diagnose, manage and treat health conditions in women and people assigned female at birth.

Uterine cancer is a particularly salient example. There are seven gynaecological oncology specialists currently practising in Aotearoa; yet rates of gynaecological cancers have risen steadily in the past two decades, in contrast to the incidence of cervical and ovarian cancers, which have decreased[47]. Māori and Pasifika women are more likely to be diagnosed with, and die from, uterine cancers compared to European/Other women. This gap is likely amplified by their experiences of a culturally

[46] ASMS. "Over the Edge": Future Intentions of the Senior Medical Workforce. 2023. Forthcoming.

[47] Te Aho o Te Kahu Cancer Control Agency. He Pūrongo Mate Pukupuku o Aotearoa 2020 The State of Cancer in New Zealand 2020 (revised March 2021). Wellington: Te Aho o Te Kahu Cancer Control Agency; 2020/2021. https://teaho.govt.nz/static/reports/state-of-cancer-in-new-zealand-2020%20(revised%20March%202021).pdf.

unsafe, inequitable health system. An audit of gynaecological cancer services in Northland in 2015 found that the overall target from GP referral to first treatment was met in just 39 per cent of cases. While this improved in a follow-up audit in 2016 to 45 per cent, it still fell short of the national targets for faster cancer treatment. Just 27.3 per cent of wāhine Māori had treatment within the recommended 62 days, compared to 51.7 per cent of non-Māori women[48].

ASMS recommendations for workforce as part of the Women's Health Strategy

Health is one of the largest female-dominated workforces in Aotearoa New Zealand, and the move to a single operator makes Te Whatu Ora Health New Zealand the largest single employer of women in the country. As a result, the Strategy must look internally to how it can strategically support the health and wellbeing of women in the health workforce.

- Include the health and wellbeing of women in health workforce in the Strategy as a key enabler
    a) Introduce measures to combat burnout and fatigue, and improve retention
    b) Work with health unions to improve conditions, and health and safety, for women in the health workforce
- Prioritise female-dominated specialities and workforces for retention initiatives, including obstetrics and gynaecology, and gynaecological oncology

Conclusion

Thank you for the opportunity to contribute to the development of the Women's Health Strategy – a milestone in the transformation of our health system in Aotearoa New Zealand. As part of the wider health sector ecosystem and networks, we endorse the submissions of by Family Planning New Zealand and the Royal Australian and New Zealand College of Obstetrics and Gynaecology and their recommendations.

Nāku noa, nā

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[48] Ha M, Gangji A. Faster Cancer Treatment pathway in gynaecological malignancy: a repeat clinical audit. N Z Med J 2018; 131(1477):45-55. https://assets-global.website-files.com/5e332a62c703f653182faf47/5e332a62c703f6c35b2fd3ae_Ha-FINAL.pdf.