



# Restoration of the health system must not neglect medicines – but who has the power of reform?

Leanne Te Karu

Department of General Practice and Primary Healthcare, University of Auckland, Private Bag 92019, Auckland Mail Centre, Auckland 1142, New Zealand. Email: Leanne.Te-Karu@auckland.ac.nz

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The broad changes to Aotearoa (New Zealand's) health system recently announced are arguably the most significant for Māori to date.<sup>1</sup> The disestablishment of District Health Boards and creation of a new dedicated public health agency and an independent Māori Health Authority provide hope for improved hauora (health and well being) in this country. Hope comes with caution: this reformation must be more than the proposed structural changes outlined. It must also reframe approaches to rangatiratanga (sovereignty) and create synergy and strategic partnership.

British colonisation of Aotearoa saw the introduction of systems of government, services and institutions founded on inherent belief in the superior knowledge and practice of the colonisers. This belief of superiority is, by definition, racism. Te Tiriti o Waitangi – the Treaty between Indigenous Māori and the Crown – created a framework for Aotearoa promising a continuation of rangatiratanga for Māori in exchange for governorship by the Queen of England. Instead, it delivered and delivers anguish and intense dispute.<sup>2</sup> In recent times, Treaty 'principles' developed by the Court of Appeal have been criticised as consolidating the power of the Crown, reversing sovereignty attribution and watering down Crown commitments.<sup>3</sup> Even if this 'watered-down' or 'blind to rangatiratanga' view of principles is applied, it is hard to see where partnership exists horizontally, valuing equally the worldview of both parties.

Dr Moana Jackson has recently promoted use of the word 'restoration' as a better alternative to 'decolonisation'.<sup>4</sup> The premise of restoration is that addressing the plague of inequities in health processes and outcomes for Māori will require a change of minds and hearts as much as a change of health system structure.<sup>5</sup> Failure to achieve 'partnership'

with equal governance, equal resourcing, and self-determination has been an intergenerational blight on Tangata Whenua of Aotearoa, not only denying all residents of this country an Indigenous holistic health approach but also underpinning a plethora of inequities in health outcomes.

The absence of adequate partnership has led to monocultural biomedicine and missed opportunity for the richness of a holistic approach and deep appreciation of interdependence with each other and the environment that is common to Indigenous cultures. To consider physical health as the sole aspect of hauora is a reframing of the all-inclusive perspective necessary to respond and recreate balance for individual people in their collective context. For Māori, whanaungatanga, or the centrality of kinship and careful attention to relationships, means something can never be viewed in isolation but only with reciprocity that is mutually enhancing.

Contemporary Western thinking is finally exploring this view of the interdependence of individual, context, and relationships as crucial to the resilience of both individuals and systems.<sup>6</sup> The contemporary reality for whānau in our health system is that their perspectives of health are invalidated by our western health system which, rather than co-existing and cross-pollinating, competes with (and historically has banned) traditional Māori perspectives and healing practices.

I am a prescribing pharmacist based in general practice, working to decrease morbidity and mortality from health conditions and from medicines. Medicines are foundational to health systems so a truly partnered, well regulated medicines system is long overdue and should be a key indicator of successful restoration that delivers for Māori.

## The current health system's approach to medicines

There is overwhelming evidence that a coherent, responsive, holistic medicines system is not currently in play. Antibiotics, gout management, non-steroidal anti-inflammatory drugs (NSAIDs), and medicines costs provide illustrative examples of current inequities in medicine policy and practice.

### Antibiotics

Māori are less likely to receive medicines to prevent illness yet more likely to receive potentially more toxic medicines for symptomatic disease.<sup>7</sup> Diseases for which antibiotics are indicated affect Māori and Pacific peoples more than people of other ethnicities<sup>8–13</sup> yet Māori do not receive antibiotics when needed.<sup>7,14</sup>

### Gout and NSAIDs

Gout is a health condition characterised by layers of inequity that change the entire trajectory of lives without access to low-cost preventive medicines.<sup>15</sup> The heaviest burden of gout weighs on Māori and Pasifika whānau and communities. There is mismanagement and consequently long-term inequities in outcomes.<sup>16–18</sup> I have previously advocated a holistic approach to gout management where people are not 'managed' in isolation of other health conditions or their social circumstances and ignoring their worldview and the socio-historic context that informs that worldview.<sup>19,20</sup> I have used gout as an example of the barriers and enablers both of the medicines system and the health system more broadly.<sup>21</sup>

Allopurinol, for example, the drug of choice for gout prevention, can cost as little as NZ\$0.02 per tablet yet there are instances of the ravages of poorly managed gout making people become unemployed and reliant on emergency department care.<sup>15</sup> People report seeking symptomatic relief from potentially dangerous NSAIDs available over the counter in pharmacies and supermarkets.<sup>15</sup> Pharmacy dispensing rates of NSAIDs to Māori and Pacific peoples with gout are higher than for other ethnic groups, with all the attendant risks.<sup>22</sup> Widespread access to NSAIDs has led to ethnic disparities in hospital admissions of Māori and Pacific peoples for

serious adverse outcomes – including upper gastrointestinal bleeding, heart failure, and acute kidney failure.<sup>23</sup>

Māori and Pasifika are less often the recipients of medicines optimisation and are paying the price.

### Costs

For medicines more generally there is evidence that, even when funded, costs are prohibitive or mean that people receive only the medicines they feel they can afford.<sup>24</sup> The duty of co-payment collection has fallen to community pharmacists who wrestle with this issue. Nearly 1 in 5 (18%) of Māori and Pacific adults did not collect a prescription due to costs in 2019, which is nearly three times the percentage of non-Māori, non-Pacific and non-Asian adults.<sup>25</sup> These data include only direct medicine costs – not costs associated with prescribing, transport and time off work. The ability to collect medicines is further restricted for adults living in the most socioeconomically deprived areas. An estimated 18,000 children were denied access to medicines due to cost in 2019–2020.<sup>26</sup> A study investigating prescriptions written at discharge from Midmore Hospital in South Auckland found 48% of people did not fill at least one medication item on their prescription. Younger age and Māori ethnicity were strong predictors of not receiving medicines.<sup>27</sup> I do not advocate a universalist approach to abolishing co-payments as there is evidence that this builds inequity where resourcing is unnecessarily distributed and not targeted.<sup>28</sup> The situation needs addressing, however, and perhaps targeted subsidies facilitated through Māori health providers or prescribers, as deemed necessary, could be usefully introduced.

If medicines are not publicly funded, people or their whānau are left to raise their cost and associated administration fees; otherwise, they go without. Some medicines (eg ventolin inhalers) are partially funded so they incur the government co-payment fee plus the shortfall in funding and any mark-up from where the medicine is dispensed. Some medicines (eg sacubitril-valsartan) require recipients to meet certain clinical criteria to be subsidised under the Pharmac Special Authority scheme. Similarly, applications can be made under an 'exceptional circumstance' scheme to obtain unfunded

medicines but extra criteria must be met. Additionally, although some medicines currently are fully funded, administration costs can prevent access: examples are intravenous iron and long-acting reversible contraceptives (LARCS).<sup>29</sup> This means these medicines remain out of reach, regardless of funding.

Whether it is cost, complexity or quality of medicines care, the inequities are clear.

### **The inequitable legislative context and its consequences**

Medicines are the most-used common intervention in primary care and our legislation is a barrier to an integrated, fully functional medicines system that enables equitable access and medicines optimisation.

In Aotearoa, the process for 'availability' of medicines generally starts with approval from the medicines regulatory and safety authority, Medsafe. It is primarily a reactive process, initiated by drug companies who make a financial decision to invest in the approval process followed by an application for subsidy from the funding process.

In assessing these applications Medsafe must critically evaluate pre-existing drug trials in cohorts of people that never mirror our population. This is an ongoing problem related to the size of this country: where possible, we need trials that are conducted here. The lack of Indigenous involvement globally is well recognised, with scant evidence of authentic partnering to address suspicions of Indigenous involvement being any more than providing specimens to be studied and reported upon.<sup>30</sup> Where health conditions disproportionately affect populations, these populations need to be over-represented and studies powered to enable assessment by ethnicity. Not the reverse, as is the case with a health condition like gout, where there is genetic variance in urate handling (the greatest risk for development of the disease).<sup>31,32</sup> Medsafe must also classify medicines according to the level of access deemed appropriate: general sales, prescription, pharmacy only, or restricted access (eg where pharmacist input is required).

Legislation in the Medicines Act 1981<sup>33</sup> and Medicines Regulations 1984<sup>34</sup> defines these processes

and the composition of the committees that help make these decisions. Committees are required to provide technical expertise but if we consider the premise of Te Tiriti as a partnership these Medicines laws should as a minimum also require a Te Ao Māori worldview or pro-equity competence, or even public health expertise. They do not. Thus, unpartnered legislation and policy directly impacts approval, manufacture, marketing, registration, procurement, acquisition, advertising, distribution, prescribing, and dispensing of every medicine in Aotearoa. This results in a systematically unbalanced system.

Consequences of absent mapping and partnership are plentiful. One small example is the global medicine supply issue heightened due to the Covid-19 pandemic. Medicines are sought through different suppliers when shortages occur and may be acquired as 'Section 29'. This means the medicines have not received regulatory assessment and approval, thereby carrying inherent risk at one level and limiting access at another. Only a 'medical practitioner' (doctor) can prescribe section 29 drugs, excluding nurse practitioners and pharmacist prescribers who serve many rural and underprivileged communities – where the need is potentially greater for full and continued access to medicines.

### **A pro-equity approach**

Pro-equity attention needs to be paid to the value of medicines across the lifetime of people, including and especially societal costs; to clinical trials protecting and promoting Indigenous peoples; to the intricacies of approval and funding of medicines; to distribution and patient acquisition of medicines; to prescribing of medicines; to pharmacovigilance; to monitoring that includes medicines purchased without prescription, and to public administration and education and empowerment. The vision for medicines optimisation needs to be co-created with Māori, not siloed.

I have not considered the in-depth complexities of the medicines funding system nor access to immunisations and medical devices in this article. I have also left out workforce planning requirements covering both direct and indirect care (eg cardiac monitoring post certain chemotherapeutic agents)

due to word limitation. Similarly, I have not discussed Rongoā (traditional Māori healing beliefs and practice<sup>35</sup>) and its place in our health system. Only to say self-determination and autonomy of Māori must be prioritised in the restoration of health decision making and provision, so that the benefits of such thinking and knowledge can be drawn upon.

### **A change in the system needs a change of mind and change of heart**

Just as the western view of patient healthcare delivery is compartmentalised and does not consistently or holistically see each person, their health needs, social circumstances, and health beliefs, so it goes for our medicines system. There is no current medicines strategy, and the 2015–2020 plan lacked vision.<sup>36</sup> It did not include proactivity in planning the types of medicines that may be required. There has been no shared community vision of the value of medicines at a societal level and the activities that must be undertaken to achieve that vision. There is little cross-government mapping of medicines use – for example, antibiotics for non-human use. There is no single centre of excellence for applied pharmacotherapy expertise in Aotearoa to aid prescribers with individual decisions and monitoring of medicines. There is no single entity encompassing clinicians and non-clinicians with overall responsibility to monitor the single most used tool in our health system. There is no consistent programme addressing medicines literacy. There is no formal and structured facilitation of Māori and other peoples of Aotearoa to use Rongoā alongside western medicines, if desired.

Existing legislation will require redrafting before reforms occur. That cannot and should not be done without a place at the table for people who can interpret the impacts for Māori and Pacific peoples and I strongly recommend at a minimum the critical treaty analysis framework of Came *et al.* to be applied.<sup>37</sup> No single person, professional discipline or skillset can ensure medicines achieve best possible health outcomes.

I question whether our health system has ever been wholly fit for purpose given its founding on a dominant worldview that denies a partnership of mutual advantage. The genesis of equity in health is embedded in Te Tiriti o Waitangi. Te Tiriti itself is a

statement of equality where the authority of the Crown and mana of Māori come together. Sadly, this aspiration has not been realised and the country as a whole has suffered. The disadvantage spans multiple domains including the economy and well being. To achieve holistic health care that values more than one worldview, a medicines system needs to be developed with consideration across the breadth of the health system and for future generations.

A medicines system that achieves equity of access to high-quality appropriate pharmacological agents, minimal wastage, maximum adherence, minimal drug mortality and reduced morbidity from medicines use (at least 45,000 people are currently conservatively estimated to suffer 'severe harm' from medicines annually<sup>38</sup>) is a barometer of the wider health system. Further, how we position pharmacological against non-pharmacological value can be a window onto societal values, such as in pain management, opioid addiction and mild depression, where medicines should not necessarily be the first intervention to trial. Things like 3D printing of medicines, pharmacogenomics and immunotherapy are but a few examples of a rapidly changing landscape. These advances are fraught with ethical issues making it more crucial that partnership, restoration and a community approach to decisions are interwoven. If we do not strategise for such changes, reactivity will be our only available response.

Cultural alignment for achieving medicines optimisation in a general sense – let alone as a core outcome with a pro-equity, Indigenous approach – is rare. The cost of this to our health system and to society is immense and must be the impetus to adopting a health system and societal approach to the value of medicines.

Substantive health reform is welcomed as opposed to yet another retrofit and the announced changes present a real opportunity for recreation from within, rather than added on to the existing malfunctioning system. The Māori Health Authority is an unprecedented development in the history of Aotearoa health provision: in its development, partnership must be framed authentically with co-creation in structure, legislation, policy and delivery.

A change of mind and heart alongside a change of structure is well overdue for Māori, but for all peoples of Aotearoa, surely it is also time.

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