9 December 2021

Pae Ora (Healthy Futures) Bill: Birthright New Zealand Submission

Thank you for the opportunity to provide a submission relating to the Pae Ora (Healthy Futures) Bill.

Birthright New Zealand is a registered charity with 11 affiliate organisations throughout NZ. Birthright have a history which spans 65 years in New Zealand, working to strengthen and enrich the lives of children and families. We specialise in working with families led by one person. Our vision is for nurtured, resilient, inspired children and families. Birthright puts family and whānau at the centre of what we do.

Birthright delivers a variety of social services to children and their families, particularly those families which are led by one person. We work closely with other community service providers to ensure children and families who need support can access the appropriate services for their needs. We believe children have a 'birth-right' to the same opportunities regardless of their family circumstances. We want children, and their families, to live quality lives.

We see the responsibility of our health system in New Zealand to be a shared responsibility of the government and community. Our health system needs to be safe, equitable and beneficial for all New Zealanders. We agree with the Health and Disability System Review's findings that the system is "fragmented and complex", resulting in poor health outcomes. We see an opportunity that exists to develop a modern health system for New Zealand which meets the diverse needs of our population now, and into the future.

A Modern Health System for New Zealand

The Pae Ora (Healthy Futures) bill proposes a new structure and new accountability arrangements for the publicly-funded health system, in order to protect, promote, and improve the health of all New Zealanders through the establishment of new agencies, including Health New Zealand and the Māori Health Authority. Some policy objectives of the Bill, as given in its explanatory note, are to;

> *"protect, promote, and improve the health of all New Zealanders; and achieve equity by reducing health disparities among New Zealand's population groups, in particular for Māori".*

We are strongly in support the Bill's aim to give effect to Te Tiriti o Waitangi, the most important evidence of which is the establishment of functions which will better meet the health and wellbeing needs of those needing support via the establishment of a Māori Health Authority. We believe that in order to be effective, that there needs to be system wide integration. For too long, Māori have experienced poorer health outcomes overall than the non-Māori population and therefore need to be a priority group.

Whether centralised or decentralised, the health system that supports New Zealanders needs to be effective at supporting the needs of modern-day New Zealanders. It currently doesn't consistently meet the needs of all New Zealanders.

The Current State

The current state of healthcare for highlights that a range of groups are marginalised in Aotearoa New Zealand. The Ministry of Health's 2020 NZ Health Survey finds that, overall, women are worse off than men when it comes to health outcomes, and that health inequities are worse for different groups of

women and girls, especially wāhine Māori and disabled women. While the Survey doesn't detail the experience for single parent led families, it would be reasonable to extrapolate that the experience for families led by one person, and their children, would be strongly reflected in the health inequity data.

Applying a gender and cultural lens to the health system is crucial to reduce the health disparities among New Zealand's population groups, in particular for wāhine Māori (Clause 3(b). There are many factors that influence the health the population. These include inequitable resource allocation, a lack of inclusive infrastructure, racism, income, access to services and family and sexual violence victimisation, with health impacts felt in terms of mental health and wellbeing needs. (anxiety, depression, PTSD/CPTSD, panic attacks etc), which we see in the 2021/21 Health Survey results have also risen in demand, or physical health needs such as injury care, head trauma, gyno/maternal/pregnancy health and chronic inflammatory conditions. Some research suggests that cancer is linked to high rates of stress over a sustained period – many single parents have heightened stress levels.

Reducing inequalities is a priority for the government. The New Zealand Health Strategy acknowledges the need to address health inequalities as 'a major priority requiring ongoing commitment across the sector' (Minister of Health 2000). Inequalities in health are unfair and unjust. They are also not natural; they are the result of social and economic policy and practices. Therefore, inequalities in health are avoidable.

When designing systems (and policies) in New Zealand, a common flaw has been that the lens of the needs of New Zealander's hasn't been central to the development. Too often systems and policies are developed in isolation, or with a pakeha 'nuclear family' lens. This creates problems when developing solutions for disadvantaged groups.

A number of structural inequalities exist for many disadvantaged groups in New Zealand. These inequalities combine with those stemming from race, ethnicity, socioeconomic status, age, disability and chronic disease. The reality for many single parent led families in New Zealand is that their needs and the needs of their children, are not adequately reflected across a range of public sector agencies where policies and practices have been developed with the pakeha, nuclear family lens referred to. Sadly, this is also reflected in our current health system.

Statistics New Zealand's General Social Survey (2017) to assess whether someone is disadvantaged in eight life domains;

- Income,
- Material Wellbeing,
- Employment,
- Education,
- Health,
- Housing,
- Safety, and
- Connectedness.

If someone is found to be disadvantaged in three or more of these life domains, they are classified as experiencing multiple disadvantage. Single parent led families, and their children, are heavily represented in the data as most likely to experience multiple disadvantage;

- New Zealand has one of the highest rates of single parent led families in the OECD.
- New Zealand has the third-highest rate of children living in single-parent homes in the OECD.
- One in four Kiwi children are growing up in single-parent homes.
- Children in New Zealand are four times more likely to be living under the poverty line if they were being raised by a single parent. Child poverty includes going hungry and living in poor housing that we know can lead to poor health, and negative health outcomes.
- there is a gendered lens on single parent led families in New Zealand, as 86% of single parent led families in New Zealand are led by women. Women profile heavily in the 2020/21 Health Survey results. Birthright are in support of the Gender Collective's submission which has detailed the needs of women, and other vulnerable groups whose needs are not currently represented in the health system.

Just under half of sole parents (49.5%) were classified as disadvantaged in three or more domains compared with a little over one in six (17.6%) of New Zealand adults overall. This is particularly concerning as while sole parents represent only 5% of working aged adults in New Zealand, they account for nearly a quarter of New Zealand families with dependent children. Our health system needs to better address the needs of these families and children.

Food insecurity is real for many New Zealand families. We have seen an increased dependency on food banks, with the cost of quality food being out of the reach of many families. The 2020/21 Health Survey results in 2020/21;

- 12.2% of children lived in households that sometimes or often use foods banks. This is similar to previous years.
- Children living in the most deprived areas were at least six times as likely to experience food insecurity as children living in the least deprived areas.
- Children living in the most deprived areas were 2.5 times as likely to be obese as children living in the least deprived areas, after adjusting for differences in age, gender and ethnicity.[1]

New Zealand's statistics on mental health and wellbeing are poor, and for single parents even worse. Sole parents are twice as likely to experience issues relating to mental health and wellbeing. Left unsupported, these parents meet the criteria for mental health disorder In a New Zealand cross-sectional study 43% sole parents met criteria relating to a mental health disorder. This heavily impacts the children who are in the care of parents who have mental health and wellbeing needs.

Findings published in 2016 by Otago University detailed that childhood disadvantage strongly predicts costly adult life-course outcomes. Researchers determined that the 'high cost' group (those who experienced disadvantage and adversity in childhood) accounted for 81% of criminal convictions, 66% of those receiving welfare benefits, 78% on prescription medications and 40% of those classified as obese[2].

We see these reflected in our health statistics. If we want better for New Zealand in the future, we need to take a heavy investment in ensuring the future looks brighter.

While we applaud the intentions of the reforms set out in Part 1, Clause 3, we encourage the Select Committee to include a necessary focus on modern-day New Zealand in order to achieve the reform's

[1] https://www.health.govt.nz/publication/annual-update-key-results-2020-21-new-zealand-health-survey
[2] https://www.otago.ac.nz/news/news/otago629355.html

desired outcomes. We note that separate strategies are being developed to address the needs of priority populations - Māori, Pasifika and disabled people - on the understanding that a 'one size does not fit all' when it comes to designing effective policy. We suggest that in order to bring full effect to these strategies, they must be complemented by a strategy that addresses the specific needs both across the current and future population as a whole and within priority and vulnerable groups. This includes ensuring that the system recognises the needs of single parent led families, and children of single parent led families.

While health disparities affect population groups, we know that within population groups, single parent led families (86% of which are led by women) are often most impacted, as are children of single parents. Maori and Pacifica appear even more negatively in the data. An intersectional approach is required that takes into account the multiple dimensions of systemic discrimination - i.e. due to race, disability, gender - which result in inequitable health outcomes currently experienced by many New Zealanders.

We need to do better. We can do better.

The role of Ministry of Health

There has been, and continues to be, an opportunity for the Ministry to step up and play that steward role more effectively, without expending billions of dollars on a change programme to centralise health services. Dr Chai Chua outlined very clearly in the National Strategy that "together with other leaders in the system, we can bring about the necessary changes to make the future envisaged in this strategy into a reality and achieve even better health outcomes for all New Zealanders."

We continue to believe that that would be possible with the current DHB structure, if the Ministry of Health took stewardship in the way which was intended, without the disruption to the health sector.

In its role as system leader, the Ministry of Health was intended to be responsible for keeping a **whole-of-system** view, which would be supported by an annual forum where others in the system were intended to feed into **annual planning**. We are currently unaware of any work led by the Ministry of Health where it can be evidenced that this approach was attempted to be delivered upon.

Specifically, under Action 19 of the New Zealand Strategy, One Team: Kotahi te tīma sought for a more integrated and cohesive system was recognised as being necessary for future success. A system that placed people and their families and whānau at the centre of care was seen as central to the success. This remains entirely relevant for today's system. We don't want to *'throw the baby out with the bath water'*

by embarking on an expensive change process which will create disruption to a service which so many New Zealanders rely upon. This is of particular importance against the backdrop of the devastating child poverty results in New Zealand, a housing market which continues to be unaffordable.

Building the capability and diversity of the workforce will help it to meet the demands for more integrated health care, prevention, self-care and care closer to home. Ensuring sustainability could

also include developing and drawing on skills in the wider NGO and volunteer communities. This is something that Birthright would strongly encourage, and welcome.

We are concerned that the creation of Health New Zealand and the disestablishment of the District Health Boards will further detract from the existing health priorities for New Zealanders. In particular, the increasing demand for psychological services in New Zealand. The 2020/21 Health Survey results

highlight an increase on the existing demands. Psychological distress among adults has increased over time;

- Nearly one in 10 adults (9.6%) had experienced psychological distress in the four weeks prior to the 2020/21 survey, an increase from 7.5% in 2019/20.
- Adults living in the most deprived areas had higher rates of psychological distress (15.2%) than those living in the least deprived areas (6.1%).
- Psychological distress was more common in disabled adults (27.3%) than non-disabled adults (7.9%).

On that basis we suggest that any implementation plan be carefully considered to ensure that the service delivery of the health sector is not impacted, irrespective of what model is determined.

Kotahi te tīma: One Team and the Regional Voice

We are disappointed that the current proposal appears to somewhat undermine the work which was developed in partnership with community stakeholders in 2015, and which was used to develop the specific actions that were intended to follow. Our concern with centralising the health sector under the Ministry of Health is that the local or regional understanding will be diluted, and also impact or dilute specific community-based health care needs.

The independent review of New Zealand health system back in 2015 identified that New Zealanders' needs and expectations are themselves changing. These changes are happening not only because the population is ageing but also because it is becoming more ethnically diverse. In Auckland, for instance, around 39 percent of residents were born overseas; Asian populations are growing the fastest and now represent almost one in four people living in Auckland.[3]

Compare the needs of Aucklanders, to the needs of Otago – and you have an example which highlights the need to ensure that local understandings are not lost. The very process of centralising of any organisation runs the risk of losing the local voices of communities.

The New Zealand Health Strategy closely aligns with the New Zealand Disability Strategy, He Korowai Oranga: The Maori Health Strategy, and Ala Mo'ui: Pathways to Pacific Health and Wellbeing.

[3] https://www.health.govt.nz/about-ministry/what-we-do/new-zealand-health-strategy-update

Significant funding will be required to enable the disestablishment the District Health Boards and create a centralised agency, Health New Zealand.

We ask the Select Committee to give serious consideration to if that funding could be better directed towards the current immediate health and wellbeing needs within the community.

The Advisory Group

The Bill sets out that when preparing a health strategy, the Minister must

> "consult health entities or groups that the Minister considers are reasonably likely to be affected by the health strategy" (clause 41, subpart 5).

On this, we ask that vulnerable communities , youth and their representatives are consulted with, in order to better understand their specific needs. We consider that it is vital to ensure that there is a wide stakeholder engagement from across New Zealand, and every day New Zealanders as well as from the decision-makers.

Key recommendations in relation to the Pae Ora (Healthy Futures) Bill:

1. To apply a lens across the health system reforms which reflects those who appear in the health statistics (disabled, Maori, Pacifica, aged, Asian and single parent-led families), in the interest of achieving equity by reducing gendered health disparities and inequities and better meet the needs of these groups;

2. For analysis to be incorporated as part of the health system redesign so that the services better meet the needs of families led by one person, women, those who are particularly vulnerable including those with disabilities, Māori and Pacifica so that health outcomes for these groups, caregiving parents and children of single parent led families are improved.

3. That a national health strategy is developed where the needs of New Zealanders is better reflected. This is intended to complement the New Zealand Health Strategy, Hauora Māori Strategy, the Pacific Health Strategy and the Disability Health Strategy ("the Strategies");

4. That in support of the above, a health needs assessment is conducted (as a part of the assessment of the current state of health outcomes and health system performance (Subpart 5, clause 37 (3);

5. That the New Zealand Health Plan (subpart 5, clause 45) includes gender analysis and family configuration analysis in its assessment of population health needs;

6. We support the Gender Collective's recommendation that New Zealand adopts a similar approach as has been developed in the UK, Ireland, Australia and Canada where Women's Health Strategies are all structured around age and life stage.

7. We are calling for an integrated, hauora-based framework to improve health outcomes. That the Expert Advisory Committee on Public Health (clause 86) includes gender experts and advisors in women's, children and youth health and wellbeing;

8. We recommend that the Expert Advisory Committee on Public Health (Clause 86) includes experts and advisors in health and wellbeing.

9. That the NGO sector be engaged with as knowledgeable specialists, with a deep understanding of multi-generational disadvantage and its impact.

10. That multi-year funding is prioritised for this work.

11. At a practical level, we ask for the Committee to consider the timing of any changes to the health system, considering the current global pandemic.

Conclusion

Birthright welcomes the creation of a health service in New Zealand where New Zealanders can have their health needs met. We applaud the intentions behind the Pae Ora (Healthy Futures) Bill with relation to the establishment of the Maori Health Authority in order to ensure that the needs of Maori can be better met.

We are committed to, and supportive of, protecting, promoting and improving the health of all New Zealanders and removing the existing inequities and disparities within the health system in Aotearoa. We welcome the opportunity to present the above and speak to our submission in more detail.

Ngā mihi nui,

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