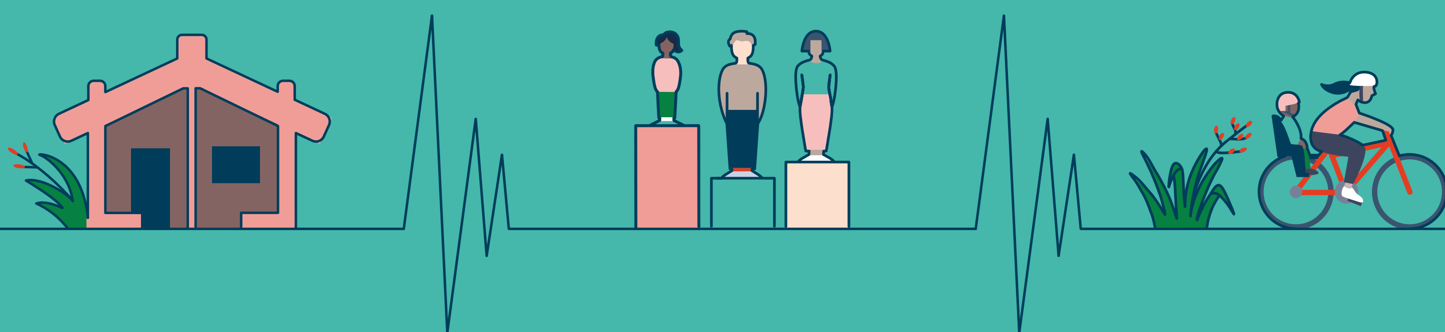
Creating Solutions
Te Ara Whai Tika

A roadmap to health equity 2040



ASMS
TOI MATA HAUORA

CANTERBURY CHARITY HOSPITAL TRUST
"By the Community - For the Community"

Tūngia te ururua kia tupu whakaritorito te tupu o te harakeke

Clear away the overgrowing bush so that the new flax shoots will spring up

Foreword

In July 2021 the Association of Salaried Medical Specialists and the Canterbury Charity Hospital Trust joined forces to host a virtual conference – *Creating Solutions*: *Towards health equity outcomes for all* – the brainchild of Charity Hospital Trust founders Phil Bagshaw and Dame Sue Bagshaw.

It was born out of frustration over what they considered the failure of successive governments to take action and deliver universal access to comprehensive health care.

As Dame Sue Bagshaw says, "when you live in a relatively first world country, which is supposedly providing the same services, but one group of people dies eight years sooner than the other – that is shocking".

ASMS was excited to support the conference as a means of building debate and momentum around the need to address health equity.

"As the union for salaried senior doctors and dentists we are committed to advocating for the best health system we possibly can. We cannot ignore the failings of the current system and cannot afford to keep looking the other way while so many New Zealanders are missing out on the healthcare they need," says ASMS Executive Director Sarah Dalton.

The aim of the conference was for health professionals to take a hard look at the stark and growing health inequities in Aotearoa New Zealand along with the social determinants which feed into them. It encouraged them to reflect on their own practice in relation to health equity and come up with solutions.

More than 200 people from across the health workforce attended.

It featured presentations from health and social sector leaders, the Health Minister Hon Andrew Little, along with prominent experts in their fields, including one of the world's leading authorities on health equity, Sir Michael Marmot.

As individuals, organisations, and members of our communities, we all need to show leadership over progressing and achieving health equity and put that firmly at the top of the national and political agendas.

We New Zealanders like to think that ours is a land of equal opportunity. However, equal opportunity in accessing and benefitting from our health system has not addressed an inequity of health outcomes. It is not simply the health system that has perpetuated inequitable health outcomes, there are socio-economic issues at play too. In a recent study the groups of people with only fair or poor health were people not in the labour force and the unemployed, those aged 75 years or older, sole parents, and Māori and Pacific peoples. I congratulate the conference organising team for setting an agenda to look at the health system and how it could be better applied to address the inequities in health outcomes for all New Zealanders.

Conference patron Sir Jerry Mateparae GNZM, QSO, KStJ, Former Governor-General of New Zealand

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Introduction

Once upon a time New Zealand was an egalitarian, universally prosperous 'classless' society. But like most fairy tales, this was never true.

In 1950s New Zealand, Māori life expectancy was more than 15 years behind that of non-Māori. Similarly, whatever levels of poverty existed were out of sight and out of mind.

Fast-forward half a century to the year 2000 and the gap in life expectancy between Māori and non-Māori is eight and a half years. But poverty rates have grown due to the cumulative effects of the economic downturn in the 1970s, the neoliberal policies introduced in the 1980s and benefit cuts in the 1990s. This has resulted in a staggering 10-year differential in life expectancy between the poorest New Zealanders (including a disproportionate number of Māori) and the wealthiest.

Two decades later, despite the policy intent of the New Zealand Health Strategy of 2000 to give priority to addressing health inequity, Māori life expectancy remains more than seven years less than for non-Māori, and the poorest New Zealanders can still expect to live nearly 10 years less than the wealthiest. In some other indicators of health, the inequity has worsened.

The causes of such health inequity are well known – socioeconomic conditions and the distribution of power, money, and resources which influence conditions of everyday life.

For example, three recent UNICEF reports have ranked New Zealand in the bottom third of countries for indicators of equality in education and overall childcare measures and bottom on indicators of child wellbeing. In the face of significant child poverty, data shows the richest 1% of New Zealanders have over $140 billion stashed away in trusts and nearly 70 times more assets than the rest of the population.

But there are ways to reverse the widening social and economic gaps and address health inequity.

The recommendations in this publication are inspired by the presentations made to the *Creating Solutions*: *Towards better health equity for all* conference, along with the live Q&A sessions, and feedback from participant group discussions. They are by no means exhaustive. Sitting behind them is a broader range of recommendations from the government-convened Welfare Expert Advisory Group's report of 2019, most of which were still awaiting implementation according to a 'stocktake' undertaken by the Child Poverty Action Group published last November.

The recommendations here focus on key areas for immediate action to set us on a path to health equity and better health for all. They will be submitted to the government as a roadmap and for ongoing advocacy to achieve health equity by 2040.

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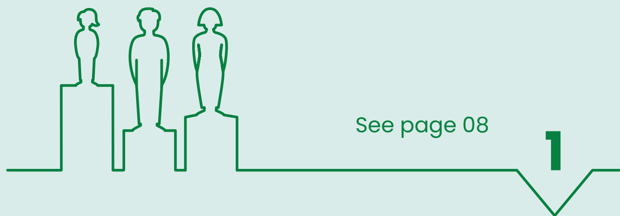
Recommendations



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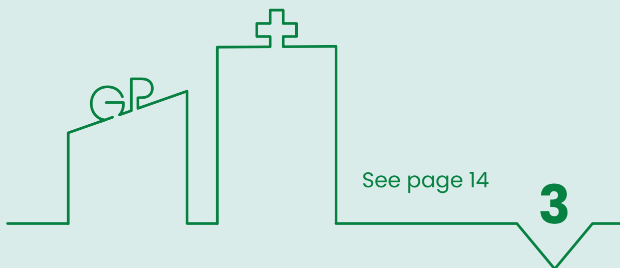
Achieve health equity by 2040

That gaps in life expectancy and other key health status indicators, by ethnicity and deprivation level, reduce annually towards the goal of health equity by 2040.

See page 11

Adopt proportionate universalism

That proportionate universalism is adopted by all relevant government sectors to achieve health equity.



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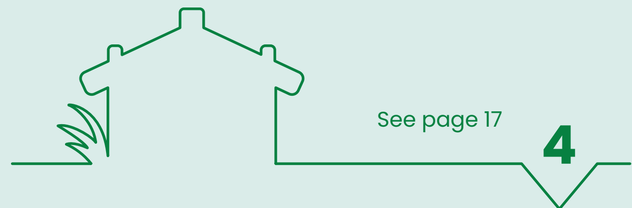
Address unmet need for health care

- That user charges for primary care services are abolished.
- That primary care services are fairly distributed nationally, in partnership with local communities, based on local needs.
- That regular independent comprehensive population surveys of unmet need in secondary elective healthcare are undertaken and funding decisions on secondary care are based on that need.



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Strengthen policies to improve cultural safety and address racism

- That the government has policies in place requiring public health and social organisations to demonstrate how they are supporting health professionals to achieve culturally safe practice and address racism.
- That adequate resources are provided for all government services to achieve cultural safety at every level, including sufficient staffing to allow time for learning and self-reflection.
- That the collection, monitoring, analysis, and reporting of quality ethnicity data – both from an organisational performance and workforce perspective – is substantially improved.

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Strengthen policies to address poverty

- That the minimum wage be set at the same level as the voluntary 'living wage'.
- That the current policy of 20 hours of free early childhood education (ECE) for 3–5-year-olds is extended to 1–2-year olds as a first step towards addressing the cost barriers to accessing ECE.
- That benefits are set so people who depend on them are not living in poverty.

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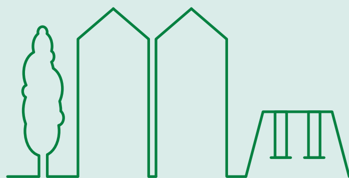
Strengthen action on the impact of climate change on health

That a Sustainable Development Unit is established to better understand the links between health, healthcare, and climate change.



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7

Strengthen policies to ensure healthy and affordable social housing

That there is greater and urgent investment in state house building along with stronger measures to ensure compliance with healthy homes standards, including a mandatory rental housing 'warrant of fitness'.

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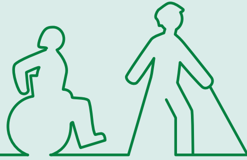
8

Strengthen policies to improve health education

- That policies are introduced for schools to close the gaps in educational performance between the lowest and highest educational performers.
- That health education, focusing on health literacy and health within Te Ao Māori, is a compulsory part of the curriculum for every part of the school system for years 1–13.
- That all schools have access to multidisciplinary health teams, including nurse, counsellor, health teacher pastoral care dean, youth worker and social workers.



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Invest in the health and disability workforce

- That a comprehensive health and disability workforce plan is urgently developed to address workforce shortages, education, training, distribution, recruitment and retention, along with workforce equity and diversity.
- That training places for health professionals are increased, based on a workforce census and current and forecast health and disability needs.
- That all training is carried out under affirmative action selection policies which include increasing numbers of Māori, Pasifika, and those from rural communities, low socioeconomic and refugee backgrounds.
- That all training and professional development support a biopsychosocial model to provide more holistic health care.

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10

Strengthen collaborative leadership

- That health policies support a leadership model to nurture a collaborative culture and create conditions in which responsibility, power, and decision-making are distributed throughout organisations and communities rather than a 'top down' hierarchy.
- That a senior Minister for Public Wellbeing and a dedicated Ministry are established with responsibility for whole-of-government action on public health and wellbeing.

See page 34

11

Address the commercial determinants of ill health

That there is stronger commitment to addressing the harmful effects of tobacco, alcohol, and unhealthy foods, such as promoting healthy food programmes in schools, tighter marketing and advertising regulations, and developing stronger tax incentives for healthy living.

See page 37

12

Strengthen public health policy implementation

- That an independent Public Health Commission be established.
- That health impact assessments become mandatory, supporting 'Health in All Policy' approaches.

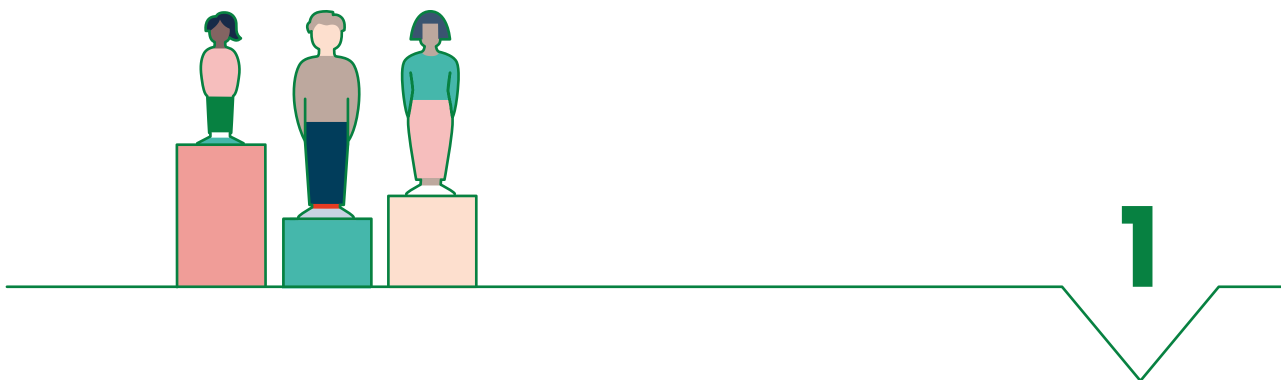
See page 39

13

Fund health and social services to match wellbeing goals

- That health and social services are funded as an economic and social investment based on 'wellbeing economics' that directly address fundamental issues affecting wellbeing.
- That legislation is introduced so the state of national wellbeing is regularly reported to Parliament to inform policy.

Note:
Brief bibliographies accompany each recommendation. These are not exhaustive. More comprehensive lists of references can be found in other ASMS publications which cover many of the topics here, including *Path to Patient Centred Care, Health Matters: Framing the full story of health*, and *Building the Workforce Pipeline, Stopping the Drain*. All are available on the ASMS website.



Achieve health equity by 2040

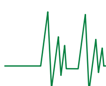
That the gaps in life expectancy and other key health status indicators, by ethnicity and deprivation level, are reduced annually towards the goal of health equity by 2040.

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Ministry of Health 2019

Health inequities have existed for many years. They have been rightly described as immoral, because for many years governments have known what is needed to be done to deal with them. Two decades ago, the New Zealand Health Strategy 2000 included the goal of addressing health inequities as “a major priority”, recognising the “clear international evidence” supporting policies focusing on the broad economic and social determinants of health, including access to healthcare.

There have been some improvements, such as a drop in the number of smokers, but in general the public health issues needing urgent attention today are the same ones identified in 2000. The gap in life-expectancy between Māori and European/Other has narrowed by 1.3 years for males and 0.7 years for females over a 12-year period – from 2005–07 (when data first became available in four ethnic groups) to 2017-19. The gap in the latest period is 7.6 years for males and 7.4 years for females (Figure 1).



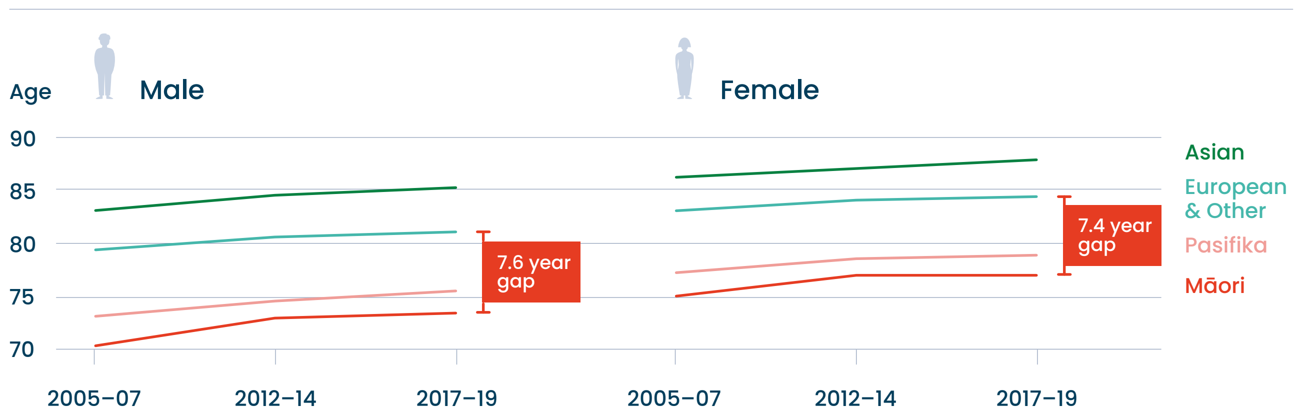


Figure 1: Life expectancy at birth

Source: Statistics NZ

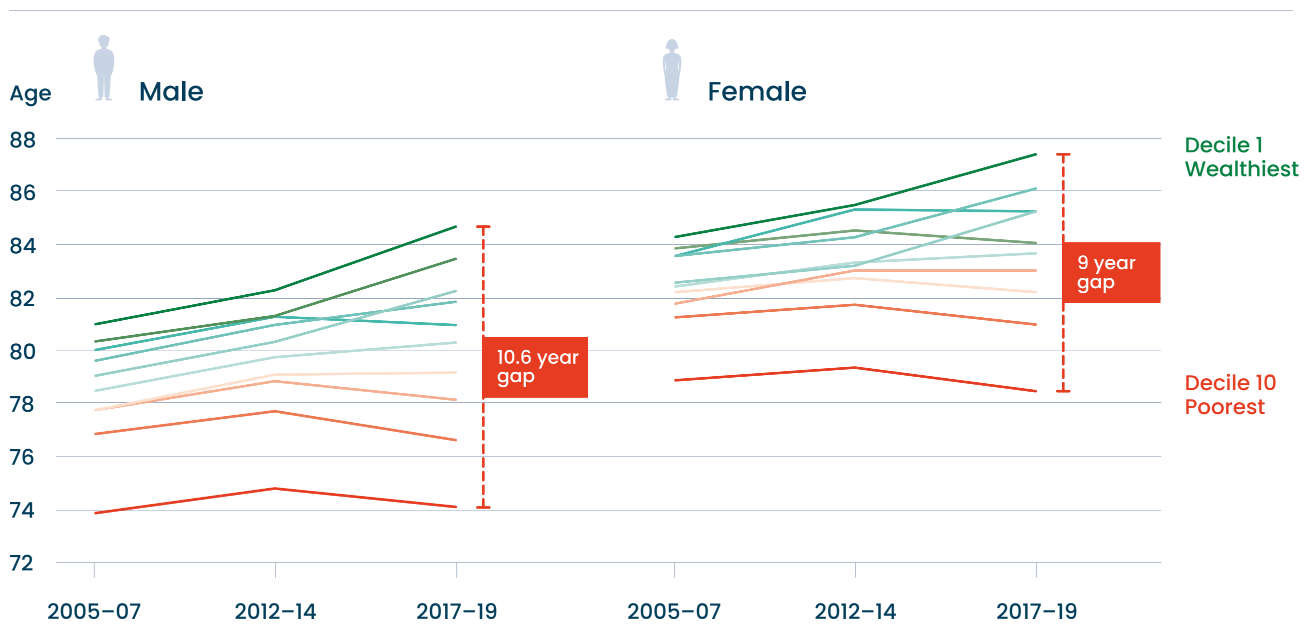


Figure 2: Life expectancy at birth by deprivation deciles

Source: Statistics NZ

The life expectancy gap between Pasifika and European/Other in 2017–19 was 5.6 years for males and 5.5 years for females – an improvement of 0.5 years and 0.3 years respectively over the 12-year period.

At this rate of slow progress, Māori males would achieve equity in life expectancy with European males by around 2090 – taking approximately 70 years. For Māori females and Pasifika males, equity with European/Other would not be achieved until well into the 22nd century – taking approximately 127 years and 134 years, respectively. Pasifika females would need to wait approximately 220 years.

Comparisons of life expectancy between the poorest and wealthiest New Zealanders over the same 12-year period show a widening gap (Figure 2).

In 2005–07 males in the wealthiest decile could expect to live 7.2 years longer than those in the poorest decile. By 2017–19 the gap had widened to 10.6 years. Life expectancy gaps for females were 5.4 years in 2005/07, increasing to 9 years in 2017–19. The widening gaps are due to a life expectancy increase in the wealthiest groups – especially over recent years – and a drop in the life expectancy of the poorest groups in recent years.

These trends are partly due to failures to overcome the barriers in delivering public health policies, including those listed on page 38. Changes in policies and priorities as governments change will also have had a negative impact.

Achieving health equity by 2040 will require:

- Commitment to a range of policies tackling the broad determinants of health, such as those included in this document
- Cross-party agreement and long-term commitment to deliver the policies
- Data improvements to enable annual monitoring of progress.

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MCNZ. *He Ara Hauora Māori: A Pathway to Māori Health Equity*, October 2019.

Health Quality & Safety Commission. Equity Links. www.hqsc.govt.nz/our-programmes/partners-in-care/health-equity

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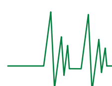


2

Adopt proportionate universalism

That proportionate universalism is adopted by all relevant government sectors to achieve health equity.

"

The route to achieving equity will not be accomplished through treating everyone equally. It will be achieved by treating everyone justly according to their circumstances.

Race Matters Institute, USA, 2014

It is well recognised that health, wellbeing, and equity are strongly influenced by the socioeconomic, political, and cultural environments that people are exposed to. This includes the quality of education, food, housing, employment, transport, and physical environment, along with factors such as race, gender, and social exclusion. Also, as emphasised by the World Health Organization (WHO), health is influenced by the distribution of power, money, and resources, which influence conditions of everyday life.

The influence of these determinants on health outcomes is well established in 'universal' health systems internationally. Research has found the health status of different groups classified by deprivation produce similar social gradients; the more deprived the neighbourhood the worse the health – and worse still when the effects of institutional racism and cultural alienation are added to the mix.

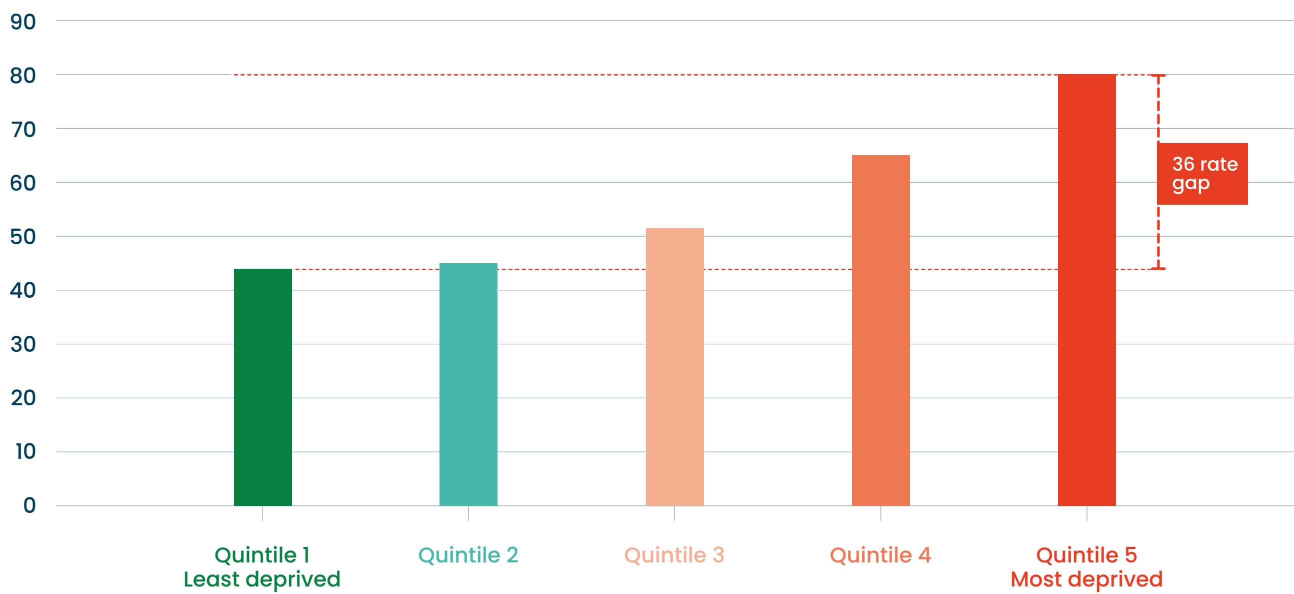


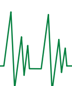
Figure 3: Standardised potentially avoidable hospitalisation rates

Source: Child Poverty Related Indicators Report, 2020

Figure 3, on potentially avoidable hospitalisation rates for children, presents a typical social gradient (Quintile 1 being the least deprived).

To a large extent, New Zealand's health system is having to cope with policy failures and consequent inequities from other sectors. To compensate, the common default position in public health systems when they are under-resourced is to focus on the worst off – to ration health care. But targeting, by definition, addresses the consequences of inequities rather than their causes. Health inequities will not be addressed substantially until the broader socioeconomic determinants of health are dealt with.

'Proportionate universalism,' is a concept introduced by British health equity expert Sir Michael Marmot in the Strategic Review of Health Inequalities in England in 2010. It involves universal interventions that are implemented with a scale and an intensity proportionate to the level of need across the social gradient as opposed to solely targeting the least disadvantaged groups. It aims to improve the health of the *whole* population while simultaneously improving the health of the most disadvantaged fastest.



The proportionate universalism approach "implies a need for action across the whole of society, focusing on those social factors that determine health outcomes". It requires a whole-of-government response with strong partnerships across six key areas:

- early child development
- education
- employment and working conditions
- having enough money to live on
- healthy environments in which to live and work
- a social determinant approach to prevention.

For Prime Minister and Minister for Child Poverty Reduction Jacinda Ardern, proportionate universalism to improve child wellbeing "is something I feel quite strongly about." A 2018 cabinet paper proposing a child wellbeing strategy explained: "A programme of joined-up (across sector *and* life-stages) evidence-based interventions supported by the state … and delivered according to proportionate universalism principles, is empirically supported." Consequently, the Child and Youth Wellbeing Strategy, released in 2019, takes a proportionate universalism approach. The Minister of Health has also supported this approach for mental health.

Race Matters Institute. *Racial Equality or Racial Equity? The Difference it Makes*, RMI, Baltimore USA, 2014.

Marmot M. *Fair Society, Healthy Lives*: *The Marmot Review*: *Strategic review of health inequalities in England post-2010.* London: The Marmot Review.

Marmot, M. *The health Gap*. London: Bloomsbury, 2015.

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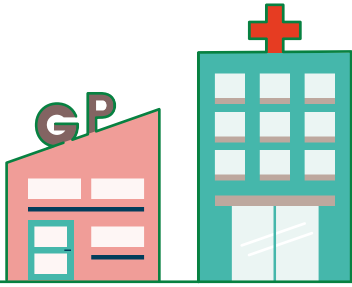


3

Address unmet need for healthcare

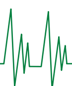
That user charges for primary care services are abolished.

That primary care services are fairly distributed nationally, in partnership with local communities, based on local needs.

That regular independent, comprehensive population surveys of unmet need in secondary elective healthcare are undertaken and funding decisions on secondary care are based on that need.

> *Charging people upfront fees for healthcare is an ideological 'zombie idea' that leads to higher costs and worse health outcomes...*
>
> Sir David Nicholson, former chief executive of Britain's NHS, 2015

> *The issue of point-of-service fees is critical. Anyone who has provided health care to poor people knows that even tiny out-of-pocket charges can drastically reduce their use of needed services. This is both unjust and unnecessary. Countries can replace point-of-service fees with a variety of forms of sustainable financing that don't risk putting poor people in this potentially fatal bind.*
>
> Jim Yong Kim, World Bank Group President, 2013



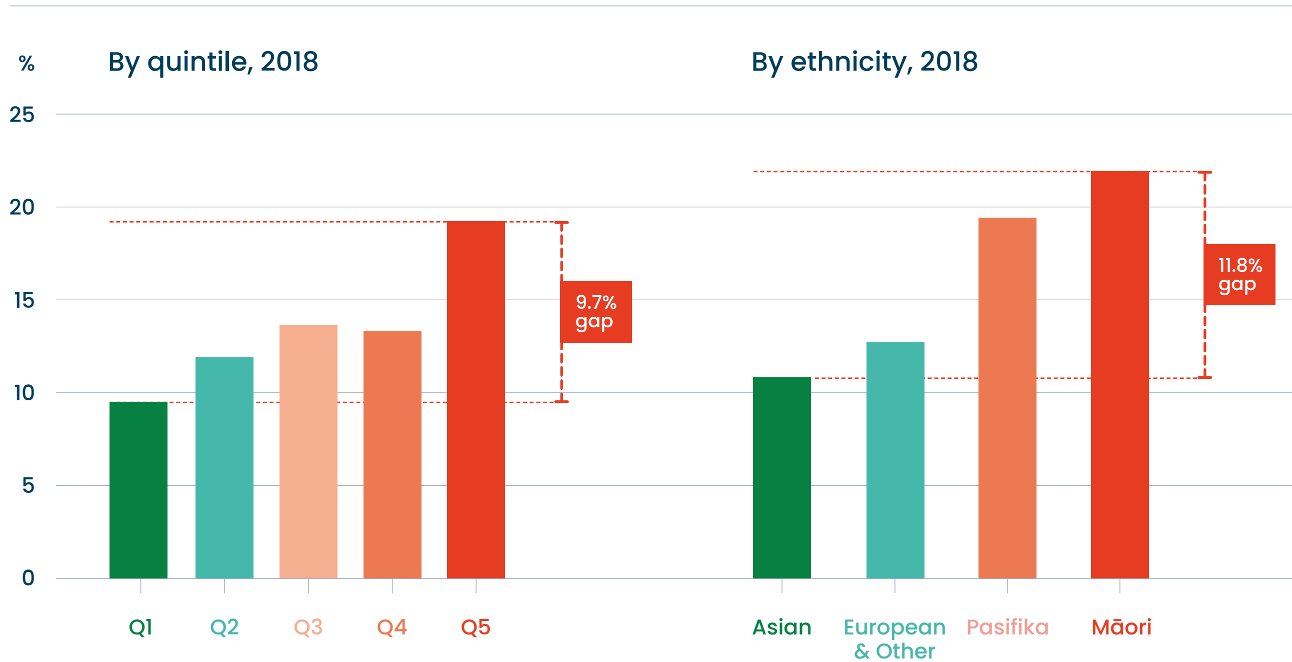


Figure 4: Adults reporting unmet need for GP service due to cost

Source: NZ Health Survey

Primary care

Cost barriers to primary care create significant health inequity. While free access to GPs for under-14s has improved primary care access for children, many adults continue to miss out, especially those with greatest need (Figure 4). Those with the greatest need – the poorest, Māori and Pasifika – have higher preventable hospitalisation rates than other groups.

Despite countries such as the UK providing free GP services, the recent Health and Disability System Review declined to recommend removing fees, saying free care can occur only "in an ideal world". However, aside from the moral imperative for removing this acknowledged barrier to healthcare, the effects of user charges directly conflict with the government's commitment to address health inequity.

Other cost barriers (such as prescription charges, travel costs and dental fees) also require attention, and solutions will necessarily involve social welfare and other sectors.

Reform is also needed to address the uneven distribution of GPs. Under the current small-business model for primary care, Nelson-Marlborough for example, has almost twice the number of GPs per capita as the Manawatū and the West Coast.

Similarly, a broader range of health and social services are needed in under-served (and most in need) communities, to address health inequities. Active collaborations between indigenous researchers, community partners and services providers are a key pathway to support the development of culturally appropriate, high-quality health services for those deemed 'hard to reach' .

Secondary care

There is plenty of support in the literature for unmet need to be recognised as a key indicator of the success of a health system. If unmet need is not routinely and comprehensively measured, how do we know how well the health system is doing and how to improve it?

From the limited data currently available in New Zealand, we know that many thousands of patients each year are rejected for hospital treatment, despite being assessed by medical specialists as needing treatment. These patients are turned away largely because of insufficient hospital capacity. Instead, they are referred back to their GP for monitoring. They may receive treatment later but only when their condition has deteriorated sufficiently. Many more are deemed 'not eligible' for treatment.

These figures are incomplete as there are gaps in district health board (DHB) data. It is likely that GPs may be reluctant to refer patients for hospital specialist assessment due to the high threshold of acceptance for treatment. In addition, many people, especially the poor and Māori and Pasifika for various reasons cannot access GP services in the first place. There is also no information on how long patients who are deemed 'not unwell enough' for treatment remain in limbo.

A pilot study of methods for measuring unmet need for hospital care, involving interviews with over 1,200 adults in Auckland and Christchurch, conservatively estimated a total unmet need of about 9% of the population. This comprised unmet need for surgical, non-surgical, dental, and psychiatric care and included people on official waiting lists. A 9% rate of unmet need, assuming rates are similar for the under 18s, equates to about 430,000 people who need treatment but can't access it, as of March 2021.

Routinely measuring unmet need for hospital care is crucial. Without it, it is impossible to assess hospital service funding requirements to address the need for treatment. While the Ministry of Health is planning to add two questions on unmet hospital care need to the New Zealand Health Surveys, these will not provide the comprehensive data required to accurately assess unmet need.

Unmet need for hospital care is a cost to the New Zealand economy. It shifts costs to other parts of the health system. It imposes a heavy burden on primary care and patients and creates health inequity.

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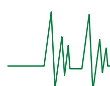
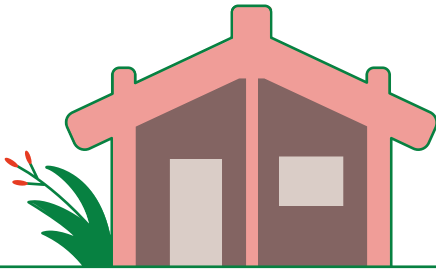




4

Strengthen policies to improve cultural safety and address racism

That the government has policies in place requiring public health and social organisations to demonstrate how they are supporting health professionals to achieve culturally safe practice and address racism.

That adequate resources are provided for all government services to achieve cultural safety at every level, including sufficient staffing to allow time for learning and self-reflection.

That the collection, monitoring, analysis, and reporting of quality ethnicity data – both from an organisational performance and workforce perspective – is substantially improved.

Cultural bias and racism

Health inequity is characteristic for indigenous peoples in colonised countries, even when socioeconomic factors are considered. The underlying causes reflect systematic social, political, historical, economic, and environmental factors, accumulated during a lifetime, and transferred across multiple generations. For individuals, they lead to cultural misunderstanding, unconscious bias, and racism.

To the extent that health professionals engage with patients with positive intent, misperception and lack of connection between patients from non-dominant ethnic groups and medical professionals is not uncommon. Studies have consistently demonstrated that doctors treat Māori differently from non-Māori. Lack of cultural awareness, latent biases and institutional racism often leads to poorer health outcomes.

For example, analysis of health service data suggests bias against Māori receiving cardiac revascularisation procedures even though their clinical need is much greater. Similar evidence of bias is available for outcomes following stroke, obstetric intervention, heart failure and asthma. Studies in primary care have produced similar findings, where GP consultation times have been found to be shorter with Māori patients, and Māori patients are referred less frequently for further investigations than non-Māori.

The Medical Council of New Zealand's approach to addressing this is to improve integration of cultural and clinical competence through recertification and continuing professional development processes. These include Council-approved programmes which must include audit, peer review and team-based assessments to verify that individual practitioners practise competently and have an understanding and respect of cultural competence.

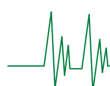
Whichever approach is taken by individual health professionals to develop their cultural competency, the literature suggests it must be viewed as an ongoing process. Information components are generally well-received and can be developed over a relatively short period of time, but changing attitudes and sensitivities requires gradual and progressive engagement, effort, and time for self-reflection.

Resources and time to develop cultural safety

A study examining how doctors learn in the workplace suggests the kinds of endeavours needed for developing cultural competence requires protected time for "deliberate practice", away from the direct demands of patient care. This enables focused efforts to reflect and develop performance aspects that need improvement, highlighting the importance of full access to time for continuing education.

The priority is to create a group climate for learning. Management can contribute by initiating work procedures that facilitate knowledge exchanges and identifying recurrent organisational problems to improve practices and free up precious time for learning.

The important role for government is to have policies and strategies in place that require public health and social organisations to make genuine cultural safety a priority – that is, not a 'tick-box' exercise. It must engage the hearts and minds of entire organisations and government must ensure organisations are resourced to do that. It is critical that workplace environments are conducive to achieving cultural safety. The commonly reported time-pressured work environments that leave little time for critical reflection must be high on the list for attention.



Quality ethnicity data

The government also needs to improve the collection, monitoring, analysis, and reporting of quality ethnicity data – both from an organisational performance and workforce perspective.

Performance indicators should require health care organisations to demonstrate:

- How they are responding to Treaty-based requirements to deliver effective and equitable healthcare to Māori and ensuring these requirements are reflected in organisational planning and accountability documents.
- Where they are incorporating Māori models of care, or mātauranga Māori (Māori knowledge), as appropriate.
- The extent to which Māori are included in governance and decision-making.
- The extent to which they are identifying and addressing structures and processes that limit Māori health development.
- A commitment to supporting a strong Māori health workforce.
- Evidence of transformation with respect to, cultural safety.

Finally, as the Medical Council says in its Statement on Cultural Safety: *"Cultural identity is not restricted to indigenous status or ethnicity, but also includes age or generation, gender, sexual orientation, socioeconomic status, religious or spiritual beliefs. Culture also reflects the values, norms, and behaviours that impact on decision-making within those population groups. Cultural safety is expected to benefit all patients and communities."*

Allen + Clarke 2020, Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives, Medical Council of New Zealand and Te Ohu Rata o Aotearoa, Wellington.

MCNZ. Statement on Cultural Safety, October 2019.

MCNZ. He Ara Hauora Māori: A Pathway to Māori Health Equity, October 2019.

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5

Strengthen policies to address poverty

That the minimum wage be set at the same level as the voluntary 'living wage'.

That the current policy of 20 hours of free early childhood education (ECE) for 3–5-year-olds is extended to 1–2-year olds as a first step towards addressing the cost barriers to accessing ECE.

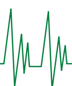
That benefits are set so people who depend on them are not living in poverty.

Minimum Wage vs Living Wage

The adult minimum wage rates are set by government and reviewed each year. The current adult rate is $20 per hour.

The 2020/21 Living Wage was $22.10 at the time of writing, increasing to $22.75 on 1 September 2021.

The Living Wage rate is voluntary and is paid by employers who want to make sure their workers have enough money to pay for the necessities of life and participate as active citizens in the community. It reflects the basic expenses of workers and their families such as food, transportation, housing, and childcare, and is calculated independently each year by the New Zealand Family Centre Social Policy Unit.



Better support for those in precarious employment

A significant section of the New Zealand workforce has insecure employment. This includes uncertainty over how long a job lasts; fluctuating hours; low or variable pay; limited access to leave benefits; limited opportunities to gain skills; and lack of union representation. Addressing insecure work involves a combination of measures, including fairer employment law and, not least, a welfare system that has a substantially greater employment support function than the current system has, reflected in the recommendations of the government-convened Welfare Expert Welfare Group.

Affordable childcare

A June 2021 UNICEF report on childcare rates the quality of services available in New Zealand as third best out of 41 wealthier nations, but also among the most unaffordable. It ranks countries based on national childcare and paid parental leave policies, including accessibility, affordability, and quality of childcare for children from birth to school age.

New Zealand's 3rd ranking in quality is overshadowed by low rankings in affordability (36th), parental leave (39th) and access (27th), giving us an overall ranking of 33rd.

Currently, New Zealand parents are entitled to 20 hours of free early childhood education (ECE) per week for children aged three to five. By contrast, Denmark, near the top of the table, has unconditional free access to ECE, starting before the age of one and lasting up to five years. UNICEF suggests in its recommendations that: "Fee systems, ranging from free to a nominal charge for wealthier parents, will allow public providers to recoup some costs of provision, as well as limit unintended effects on earnings inequality." The priority for UNICEF's New Zealand branch is to get the 20 hours of free ECE per week extended to also cover one and two-year-olds.

Poverty-free benefits

Budget 2021 lifted the weekly main benefit rates by between $32 and $55 per adult. The move was welcomed by the Child Poverty Action Group (CPAG), which said the rises would be a step towards income adequacy for many children in need, especially in those families where both parents receive a benefit.

However, CPAG's Budget analysis found few families receiving benefits will be lifted over the poverty line. And while disabled children and those in households with disabled members are more likely to live in material hardship than others, they have not received extra catch-up funding.

The Welfare Expert Advisory Group (WEAG), set up by the government in 2018 to advise on the future of the social security system, recommended that all children supported by benefits should have access to all tax credits in Working For Families (WFF), and that these should be indexed to wages. According to the CPAG analysis, this is missing in the 2021 Budget:

"If government forecasting is correct and 19,000 to 33,000 children are lifted out of poverty by these changes, that will still leave 180,000 to 190,000 children in poverty. With the changes announced in the Budget, Treasury forecasts child poverty will reduce from 18.4% to only 17.0% by 2023. This is not yet the transformation that WEAG hoped for three years ago."

Living Wage Movement Aotearoa New Zealand: www.livingwage.org.nz

Gromada A, Anna, Richardson D. *Where do rich countries stand on childcare?*, UNICEF Office of Research – Innocenti, Florence, 2021.

Daly M. NZ childcare: quality rated highly but near bottom in other areas, UNICEF says, *Stuff*, 18 June 2021.

NZ Government. *Child Poverty Report*: Wellbeing Budget 2021, 20 May 2021.

Duncanson M, Richardson G, Oben G, et al. *Child Poverty Monitor 2020 Technical Report*. Dunedin. NZ Child and Youth Epidemiology Service, University of Otago.

Child Poverty Action Group. *CPAG Budget Analysis*, 20 May 2021. www.cpag.org.nz/resources/budget

6

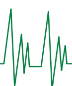
Strengthen action on the impact of climate change on health

That a Sustainable Development Unit is established to better understand the links between health, healthcare, and climate change.

“

Current ministerial directives to address both health inequities and DHB greenhouse gas emissions present DHBs with the opportunity to ensure they systematically address both priorities at the same time. In doing so, Aotearoa/New Zealand has the potential to lead the world in demonstrating pro-equity climate change and sustainability action in health systems.

Researchers, *New Zealand Medical Journal*, 2018



According to the World Health Organization:

- Climate change affects the social and environmental determinants of health – clean air, safe drinking water, sufficient food, and secure shelter.
- Extreme high air temperatures contribute directly to deaths from cardiovascular and respiratory disease, particularly among elderly people. In the 2003 summer heatwave in Europe for example, more than 70,000 excess deaths were recorded.
- High temperatures also raise the levels of ozone and other pollutants in the air that exacerbate cardiovascular and respiratory disease.
- Globally, the number of reported weather-related natural disasters has more than tripled since the 1960s. Every year, these disasters result in over 60,000 deaths.
- Climatic conditions strongly affect water-borne diseases and diseases transmitted through insects and animals.
- Changes in climate are likely to lengthen the transmission seasons of important vector-borne diseases and to alter their geographic range.

While there is increasing evidence of climate change's health impacts internationally, there needs to be better understanding of the risks and effects on health in New Zealand. This could be done through the establishment of a national 'Sustainable Development Unit' for the health and disability sector. It would be a centre of public health expertise and include roles to encourage local action on sustainability, influence policy and make the case for sustainable health care.

The unit could also manage the development of a climate and health action plan that adopts an integrated cross-sectoral approach. This would be a critical step towards ensuring the co-benefits of climate and health action are realised. In addition, the unit could help develop policies relating to waste from health services and their contribution to carbon emissions.

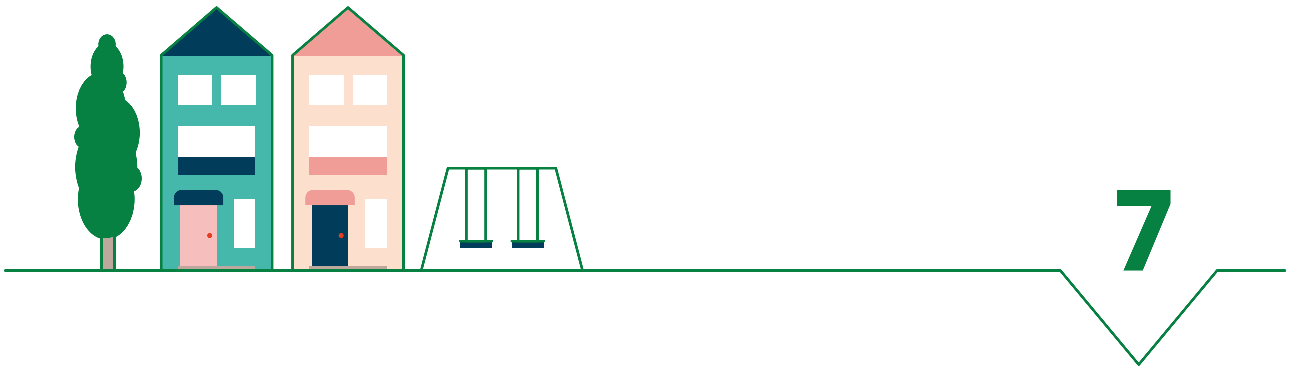
To support the work of a Sustainable Development Unit, sustainability managers with expertise in health equity need to be established in each DHB or region, so action can be coordinated, and a pro-equity lens consistently applied to all initiatives.

WHO. Climate Change and Health www.who.int/news-room/fact-sheets/detail/climate-change-and-health

Bennett H, King P. Pro-equity climate change and environmental sustainability action by district health boards in Aotearoa/New Zealand, *NZMJ* 2018; 131 (1481).

Human Health Impacts of Climate Change for New Zealand: Evidence Summary, Royal Society Te Apārangi, October 2017.

Parise I. A brief review of global climate change and the public health consequences, *Australian Journal of General Practice*, 2018; 47 (7), 451-6.



Strengthen policies to ensure healthy and affordable social housing

That there is greater and urgent investment in state house building along with stronger measures to ensure compliance with healthy homes standards, including a mandatory rental housing 'warrant of fitness'.

Number of people on waiting list, September 2014 to April 2021

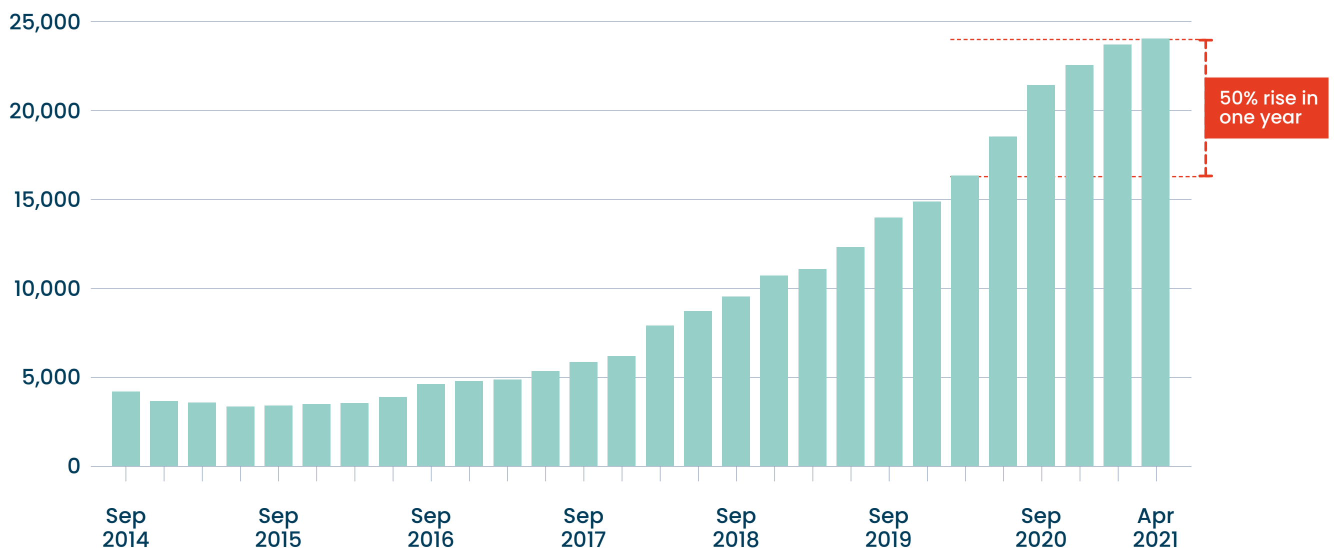
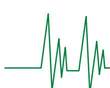


Figure 5: Quarterly waiting lists for public housing

Source: Ministry of Housing & Urban Development 2021



Urgent need for investment

Over 24,000 households were on the public housing waiting list in April this year – a rise of nearly 50% in just over a year (Figure 5). Meanwhile, rents continue to rise steadily across the country.

The government's state house build programme is well ahead of schedule and will probably exceed its plan to build 2,282 houses in the year to June 2021. However, the growing demand for housing is far outstripping new supply. Between March 2020 and March 2021, nearly 7,400 more households joined the waiting list.

The government's housing package, announced in March 2021, included a $3.8 billion 'infrastructure accelerator' for local councils, more barriers to property speculation and additional $2 billion borrowing capacity for Kāinga Ora, the government's primary housing and urban development delivery arm. However, many economists and housing advocates viewed the package as simply "tinkering at the edges" and would not address the scale of the housing shortage.

There is no single silver bullet. Many things need to happen at once but there is a common view that much greater public investment is needed.

Healthy Homes compliance

New Zealand has one of the highest excess winter mortality rates in the world, with around 1,600 people dying each year from diseases related to the cold.

About 6,000 children are hospitalised every year for 'housing sensitive' diseases, disproportionately Māori, Pasifika, and children in the most deprived deciles.

A report on the state of housing in New Zealand by the Building Research Association of New Zealand (Branz) found 21.5% of the country's homes were sometimes or always damp and 16.9% had visible mould larger than an A4 sheet of paper at least some of the time. Renters were more likely to experience dampness and mould than homeowners and Housing New Zealand homes were even more likely to be damp or mouldy (or both). More than two in five Māori and Pasifika lived in damp housing and were more likely to live in mouldy homes, it said.

In a bid to increase the quality of New Zealand's substandard rental housing, Healthy Homes Standards were introduced into law in 2019. Private landlords had a deadline of July 2021 to get their new or renewed tenancies compliant, and July 2024 for all rental homes. Kāinga Ora has a deadline of July 2023 for all tenancies.

However, housing advocates have called for a housing 'warrant of fitness' to help ensure the standards are complied with. Researchers have developed an evidence-based warrant of fitness that would cover the standards for heating, insulation and ventilation as well as other basic necessities. They point out that as well as the health benefits of a warrant of fitness, there are also potential fiscal and economic advantages of the scheme, including reduced hospitalisations and increased productivity.

NZ Government. Housing Package Detail: www.beehive.govt.nz/sites/default/files/2021-03/Housing%20Package%20Detail.pdf

Ministry of Housing & Urban Development. Public Housing Reports: www.hud.govt.nz/news-and-resources/statistics-and-research/public-housing-reports

Johnson A, Howden-Chapman P, Eaqub, *A Stocktake of New Zealand's Housing*, New Zealand Government, February 2018.

White, V. Assessing the condition of New Zealand housing: Survey methods and findings. *BRANZ Study Report SR456.* Judgeford, New Zealand: BRANZ Ltd, 2020.

Telfar-Barnard L, Bennett J, Robinson A, et al. Evidence base for a housing warrant of fitness, *SAGE Open Medicine,* Vol 7: 1–7, 2019.

Fyfe C, Telfar-Barnard L, et al. Association between home insulation and hospital admission rates: retrospective cohort study using linked data from a national intervention programme, *BMJ* 2020;371:m4571.

Regional Healthy Housing Response Group, Strategy and Action Plan, September 2019.

8

Strengthen policies to improve health education

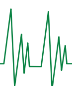
That policies are introduced for schools to close the gaps in educational performance between the lowest and highest educational performers.

That health education, focusing on health literacy and health within Te Ao Māori, is a compulsory part of the curriculum for every part of the school system for years 1–13.

That all schools have access to multidisciplinary health teams, including nurse, counsellor, health teacher pastoral care dean, youth worker and social workers.

Finland, Latvia and Portugal have the most equal education systems across all three indicators of equality in education in the [UNICEF] league table. Australia, New Zealand and Slovakia are in the bottom third for each of the three indicators of equality in education.

UNICEF Innocenti Report Card 15, 2018



Closing the gaps

According to UNICEF, New Zealand has one of the most unequal education systems in the world and the gap between the highest and lowest performing students is being made worse by poverty. In its 2018 Innocenti Report Card, it ranked New Zealand 33rd out of 38 countries for educational inequality across preschool, primary school and secondary school levels.

The report author, Jess Berentson-Shaw, said under-resourced and stressed families and communities, combined with racism and bias in the educational system contributed to these inequities. Solutions included fairer distribution of high-quality learning across different communities, increasing resources and reducing stress in families and communities.

Research shows that Māori children who have a strong sense of connectedness to their families and communities experience greater wellbeing including educational wellbeing. A large part of this is being connected to your culture.

Improving health literacy

Health literacy is a determinant of health, a significant driver in sustaining health equity, and a key empowerment strategy. Therefore, the enhancement of health literacy and health competencies should be addressed early on in schools. The health literacy of educators is equally important and must also be considered.

The Ministry of Health's report, *Kōrero Mārama* (published in 2010), found:

- 56.2% of adult New Zealanders have poor health literacy skills, scoring below the minimum required to meet the demands of everyday life and work.
- Four out of five Māori males and three out of four Māori females have poor health literacy skills.

More recent reports suggest little has changed since then.

Health professionals also have a key responsibility for ensuring their patients are well-informed and understand the relevant information so they can genuinely participate in decisions about their care.

UNICEF. *An Unfair Start: Inequality in Children's Education in Rich Countries*, Innocenti Report Card 15, UNICEF Office of Research – Innocenti, Florence, 2018.

Okan O, Paakkari L, Dadaczynski K. *Schools for Health in Europe*, Factsheet No. 6, 1 September 2020.

Ministry of Health. *Kōrero Mārama: Health Literacy and Māori Results from the 2006 Adult Literacy and Life Skills Survey*. Wellington: Ministry of Health, 2010.

Elmer S, Nash R, Kemp N, et al. HealthLit4Kids: Supporting schools to be health literacy responsive organisations, *Health Promot J Austral*. 2021;32(S1):17–28.

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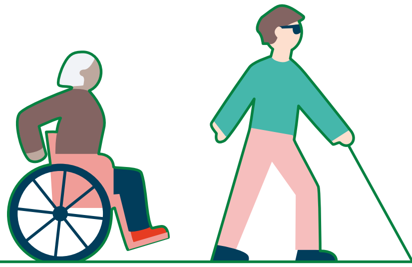


9

Invest in the health and disability workforce

That a comprehensive health and disability workforce plan is urgently developed to address workforce shortages, education, training, distribution, recruitment and retention, along with workforce equity and diversity.

That training places for health professionals are increased, based on a workforce census and current and forecast health and disability needs.

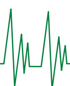
That all training is carried out under affirmative action selection policies which include increasing numbers of Māori, Pasifika, and those from rural communities, low socioeconomic and refugee backgrounds.

That all training and professional development support a biopsychosocial model to provide more holistic health care.

“

The idea there is no plan for workforce renewal and development seems criminal to me.

Hon Andrew Little, Minister of Health, ASMS Annual Conference 2020



Health workforce planning

The health and disability workforce is the health system's most valuable asset, accounting for close to 70% of its spending. But it is facing significant challenges including:

- Entrenched shortages across many professions
- Poor distribution, with regional areas especially disadvantaged
- A looming wave of retirements
- High dependency on overseas recruitment when there are increasing international shortages
- Lack of coordination between providers of education, training, and service delivery
- Barriers to workforce innovation – a key one being barriers to clinical leadership
- Not least, an increasing need for more services as the population ages.

There is strong evidence pointing to an urgent need to train more health practitioners across a broad range of professions and in ways that are fit for health and cultural needs. This requires not only greater investment but careful planning. For example, it can take up to 18 years to train a medical specialist, and the apprenticeship model means specialist training positions must be matched with enough senior staff to do the training.

Before future workforce needs can be assessed, we must be clear about the current state of play. A good model for this could be the first nationwide stocktake of our hospital buildings and facilities which was released last year as part of the National Asset Management Plan. It provides a standardised register of assets to help prioritise capital spending and planning.

Just like an inventory of building assets, we need a detailed health and disability workforce census and centralised database. It needs to be one we can all use and from which we can map future need in a joined-up way. It also needs to look at our workforce through multiple lenses: acute and planned care demand, by specialty, by region and in relation to current supply.

Health workforce training

New Zealand has the second-highest dependency on overseas-trained doctors and the highest dependency on overseas-trained nurses in the Organisation for Economic Cooperation and Development (OECD) – and there are international shortages in both professions. Despite this, New Zealand has low per capita rates of medical graduates and a middling number of nursing graduates compared to other OECD countries.

Greater investment in training more people is required to enable New Zealand to be more self-sufficient in the supply of future health professionals. It will also help address projected workforce shortage and secure a more sustainable health workforce.

To achieve health equity, it is essential the future health workforce reflects and serves our diverse community. Currently, several sections of the population including Māori, Pasifika and those from rural and low-income communities are grossly under-represented in the health workforce.

In 2019, Māori made up 16.7% of the population and Pasifika 8.1%. By contrast, only 3.8% of New Zealand's doctors and 8% of nurses were Māori, while 1.8% of doctors and 4% of nurses were Pasifika. The same under-representation exists across all health professions.

Diversity of the health workforce is beneficial for meeting the health needs of diverse populations. Mounting international evidence suggests that patients with the same racial or ethnic background as their doctor are likely to have better health outcomes.

In addition, the sociodemographic characteristics of health professional students influence future career choices in terms of place of practice and types of population they serve.

All training and professional development also need to support a biopsychosocial model of health care, recognising that psychological and social factors influence biological functioning and play a role in health and illness. The biopsychosocial model is important for developing genuine patient centred care, with all its potentially substantial benefits, including better quality care, health equity and better health outcomes.

Health and Disability System Review. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR, 2020.

Ministry of Health. *The cost and value of employment in the health and disability sector,* Wellington: Ministry of Health, 2020.

Ministry of Health. *Health Workforce Advisory Board 2020 Annual Report to the Minister of Health*, Wellington: Ministry of Health, 2021.

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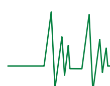
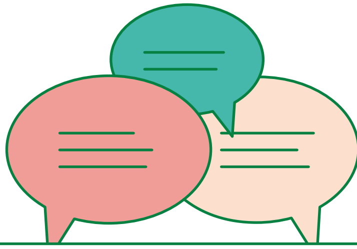
OECD Health Data 2021.

NCNZ. *The New Zealand Nursing Workforce*: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2018-2019. Wellington: Te Kaunihera Tapuhi o Aotearoa/ Nursing Council of New Zealand, 2019.

MCNZ. *New Zealand Medical Workforce 2019*, Te Kaunihera Rata O Aotearoa/Medical Council of New Zealand, 2020.

Crampton P, Weaver N, Howard A. Holding a mirror to society? Progression towards achieving better sociodemographic representation among the University of Otago's health professional students, *NZMJ*, 2018; 131 (1476).





10

Strengthen collaborative leadership

That health policies support a leadership model to nurture a collaborative culture and create conditions in which responsibility, power, and decision-making are distributed throughout organisations and communities rather than a 'top down' hierarchy.

That a senior Minister for Public Wellbeing and a dedicated Ministry are established with responsibility for whole-of-government action on public health and wellbeing.

The complete dedication of the board and leadership team to empower all staff as leaders, and trust in the process of collaboration in the organisation as the foundation for its leadership culture are keys to success.

The Kings Fund, 2015

Distributed leadership

Achieving health equity requires the involvement of communities and individuals in health decision-making.

At a high level, the planned restructuring of the New Zealand health system includes national, regional, and local "consumer forums" that will connect with Ministry of Health and the new Māori Health Authority and the new Health New Zealand. The system will "work towards a single mechanism" for two-way communication, so communities can see how their voice is being heard and acted upon.

The evidence shows that community voice can be effective when there is formal government support, including dedicated funding, for organisations representing services users and communities. It also works where there is a strong government policy framework, supportive ministers and officials, a government focal point for promoting participation, and a partnership approach between community organisations and government. Access to high quality health information is critical. Some of the most effective models have linkages between community organisations and researchers.

At the local level it is important that health professionals engage with communities and individual service users and to involve them as partners in the planning and delivery of health care.

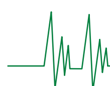
Addressing poor health literacy is fundamental to achieving effective service user engagement. It requires a range of responses, including in mainstream education (See page 26). It also calls on health professionals to step up and ensure service users and their whānau/family are well-informed and understand information to effectively participate in decisions about their care.

Health professionals, in turn, also need better support in the decision-making affecting their patients.

There is strong international consensus that to meet the challenges facing today's healthcare systems, traditional top-down managerial leadership approaches are not fit for purpose. A new type of leadership is needed which is distributed to those with intimate knowledge of the day-to-day workings of health care. These leaders – healthcare professionals – are best placed to understand how to improve organisational performance and influence care practices.

The planned channel for community voice in the planned restructuring of the health system is not replicated for clinical voice. There is no sign of a clear means for front-line health professionals to have a say in how services are planned and run. This is a significant oversight that must be corrected.

Globally, health systems employ many of the highest achievers in the labour force, yet their skills and knowledge are often bypassed by policymakers attempting system improvements. What could be achieved if 95% of employee-generated ideas were put to practical use, as reported by one of the world's leading car manufacturers, instead of just 10%, as reported in a one health system study?



The case for a Minister & Ministry of Public Wellbeing

- The solutions to many health problems will not be found within the health care system alone.
- New Zealand has had for decades some very good policies to support good health (e.g., NZ Health Strategy 2000) but in most cases they have failed to be implemented as intended.
- The policy failure is due to a lack of political will and failure of under-resourced public sector managers to implement programmes which cross departmental boundaries.
- Achieving health improvements requires whole-of-government action across a range of portfolios, non-government organisations and communities. This kind of cooperation can only be driven by the authority of Cabinet, not by a department or inter-departmental committees. It is a case of effective partnerships supported by executive authority.
- The government has declared: "This government is committed to putting the wellbeing of current and future generations of New Zealanders at the heart of everything we do" (*Budget 2020 and the Wellbeing Approach*). A Minister, supported by a Ministry, would ensure this happens.
- To succeed, the new portfolio must have high-level status led by a senior Minister.

Core functions of a Ministry of Public Wellbeing

- Setting clear direction and strategic policies
- Being the centre of expertise for effective policy implementation
- Providing population health and wellbeing leadership and coordinating multi-sector action
- Developing and overseeing wellbeing legislation and regulations
- Defining long-term health and wellbeing outcomes and monitoring and evaluating progress
- Producing a regular *Public Health and Wellbeing Report*, including an assessment of the results and the more long-term effects of interventions, as well as recommend measures. The report should also include the economic impact of interventions
- Supporting other ministries' budget bids relating to wellbeing initiatives.

West M, Armit K, Loewenthal L, et al. *Leadership and Leadership Development in Healthcare: The Evidence Base,* The King's Fund, London, February 2015.

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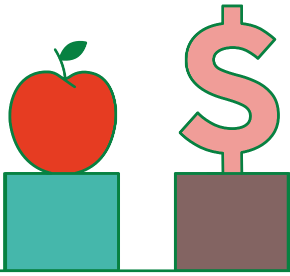


11

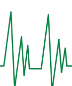
Address the commercial determinants of ill health

That there is stronger commitment to addressing the harmful effects of tobacco, alcohol, and unhealthy foods, such as promoting healthy food programmes in schools, tighter marketing and advertising regulations, and developing stronger tax incentives for healthy living.

The 'commercial determinants' of ill health – tobacco, alcohol, and unhealthy foods such as soft drinks and processed foods which are high in salt, fat, and sugar – contribute about one third of the overall preventable health loss (premature death and disability) in New Zealand. There are also wide inequities in preventable health loss by ethnicity and levels of disadvantage.

Tax and regulation

A major five-year study evaluating the cost-effectiveness of 150 preventive health interventions in Australia found the largest impact on population health through prevention can be achieved by a limited number of interventions, including taxation on tobacco, alcohol and unhealthy foods, and a mandatory limit on salt in basic food items (bread, cereals, and margarine).



Unhealthy food

Unhealthy diet and high Body Mass Index (BMI) (leading to overweight and obesity) are the biggest preventable health risk factors in New Zealand. Jointly they account for 17.5% of premature death and disability. New Zealand is **not on track** to meet the WHO targets of no increase in adult obesity and diabetes from 2010 levels. Further, dental caries is a continuing and significant health problem in New Zealand.

Evidence shows that a tax on sugary drinks that would increase their price by 20% can lead to a reduction in consumption of around 20%. Low-income consumers and young people get the greatest health benefits from taxes. In Mexico, two years after the introduction of a tax on sugary drinks, households with the fewest resources reduced their purchases of sugary drinks by 11.7%, compared to 7.6% for the general population. An OECD review of obesity prevention interventions concluded that taxes and other fiscal measures are the only interventions that consistently produce larger gains for the poor.

Alcohol

At least 5% of premature death and disability in New Zealand is attributable to alcohol. Māori children are more exposed to alcohol marketing in their schools and residential communities compared with other ethnic groups. New Zealand is **not on track** to achieve a WHO target of a 10% relative reduction in the harmful use of alcohol.

In 2018, the cost of alcohol abuse to society was estimated at around $7.85 billion. This greatly outweighs the annual tax revenue generated from alcohol excise taxes which was $1.07 billion in 2019.

Increasing alcohol excise taxes has been shown to be the most effective approach to reduce alcohol consumption and related harm across the population. Current rates of alcohol excise do not come close to reflecting the true social costs of alcohol harm. To reduce consumption and harm across society, Alcohol Watch is calling for alcohol excise rates to be increased by at least 50% to bring about an overall price increase of 10%.

In addition to increasing prices, the WHO's recommended strategy for reducing the harmful use of alcohol includes decreasing availability and access, having tight regulation on advertising and drinking and driving, and improving treatment and rehabilitation facilities.

Smoking

While overall smoking prevalence is reducing in New Zealand, due largely to increases in tobacco tax, large disparities remain. Again, New Zealand is **not on track** to achieve the government's target of 2025 Smokefree Aotearoa (less than 5% prevalence). High rates of smoking continue to undermine the health of Māori (29%), Pasifika (18%) and people experiencing greater deprivation.

The Ministry of Health has proposed a 'Smokefree Aotearoa 2025 Action Plan'. It points out that while price rises have contributed significantly to reduced smoking, some groups, including Māori, Pasifika and low-income earners who continued to smoke, experienced resulting hardship. At present, excise tax and GST accounts for about 80% of the price of cigarettes, compared to approximately 35% for beer and 28% for wine.

The proposed action plan includes alternative measures to further reduce smoking, such as strengthening Māori governance of the tobacco control programme, supporting more community initiatives, and restricting the availability of tobacco products. It is due to be released following analysis of submissions.

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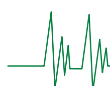

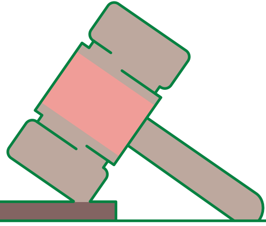

12

Strengthen public health policy implementation

That an independent Public Health Commission be established.

That Health Impact Assessments become mandatory, supporting 'Health in All Policy' approaches.

The extensive lobbying power of the sugar industry is legendary (it is often referred to as the second most political commodity in the world – after oil)

Credit Suisse, 2013

The observed tactics and arguments presented by the food and drinks industry in opposition to sugar taxation have striking similarities with those previously used by the tobacco industry.

Researchers, Scandinavian Journal of Public Health, 2018

A Public Health Commission

Despite the strong social and economic evidence to support public health action, and good stated intent from politicians, public health has suffered from what has been described as 'policy inertia'.

Barriers to public health action include:

- Limited and unstable funding
- Lack of coordinated leadership
- Poor monitoring
- Lack of research
- Workforce limitations
- Politically motivated short-term policy approaches
- Public resistance to change behaviours
- Opposition from powerful interest groups
- The crowding out of public health activities by more urgent needs.

To help overcome these barriers and complement the roles of a Minister and Ministry for Public Wellbeing, an independent Public Health Commission would:

- assess and report publicly on public health and public health policy action
- provide independent advice to Ministers on the effectiveness of policies
- be a public voice and advocate on important population health issues.

The Commission would work alongside the Mental Health and Wellbeing Commission and have regard to the experience of, and outcomes for Māori when performing its functions.

Health Impact Assessments

Health Impact Assessment (HIA) is a practical approach used to judge the potential health effects of a policy, programme, or project on a population – particularly on vulnerable or disadvantaged groups. Recommendations are produced for decision-makers and stakeholders, with the aim of maximising the proposal's positive health effects and minimising any negative health effects. The approach can be applied in diverse sectors and uses quantitative, qualitative, and participatory techniques.

HIA provides a way to engage with members of the public affected by a particular proposal. It also helps decision-makers choose between alternatives and improvements to prevent disease or injury and to actively promote health. It is based on the four interlinked values of democracy (promoting stakeholder participation), equity (considering the impact on the whole population), sustainable development and the ethical use of evidence.

The Ministry of Health states on its website: *"Ideally policy-makers and planners across all public sectors should use HIA for assessing significant policies, programmes and plans."*

International evidence indicates making HIA mandatory is a key facilitator for implementation, along with ensuring workforce and skills capacity, political commitment, funding, and structures for intersectoral collaboration.

The establishment of a Minister and Ministry for Public Wellbeing would assist with enabling implementation of HIA. A programme for building public health capacity, including greater investment in the public health workforce, is critical.

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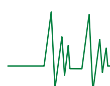
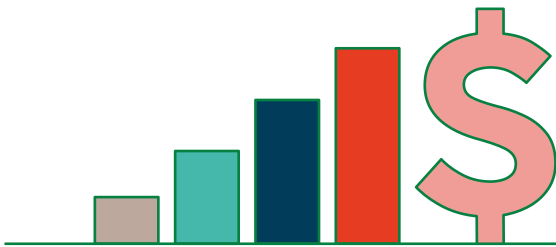




13

Fund health and social services to match wellbeing goals

That health and social services are funded as an economic and social investment based on 'wellbeing economics' that directly address fundamental issues affecting wellbeing.

That legislation is introduced so the state of national wellbeing is regularly reported to Parliament to inform policy.

"

Don't tell me what you value, show me your budget, and I'll tell you what you value.

US President Joe Biden

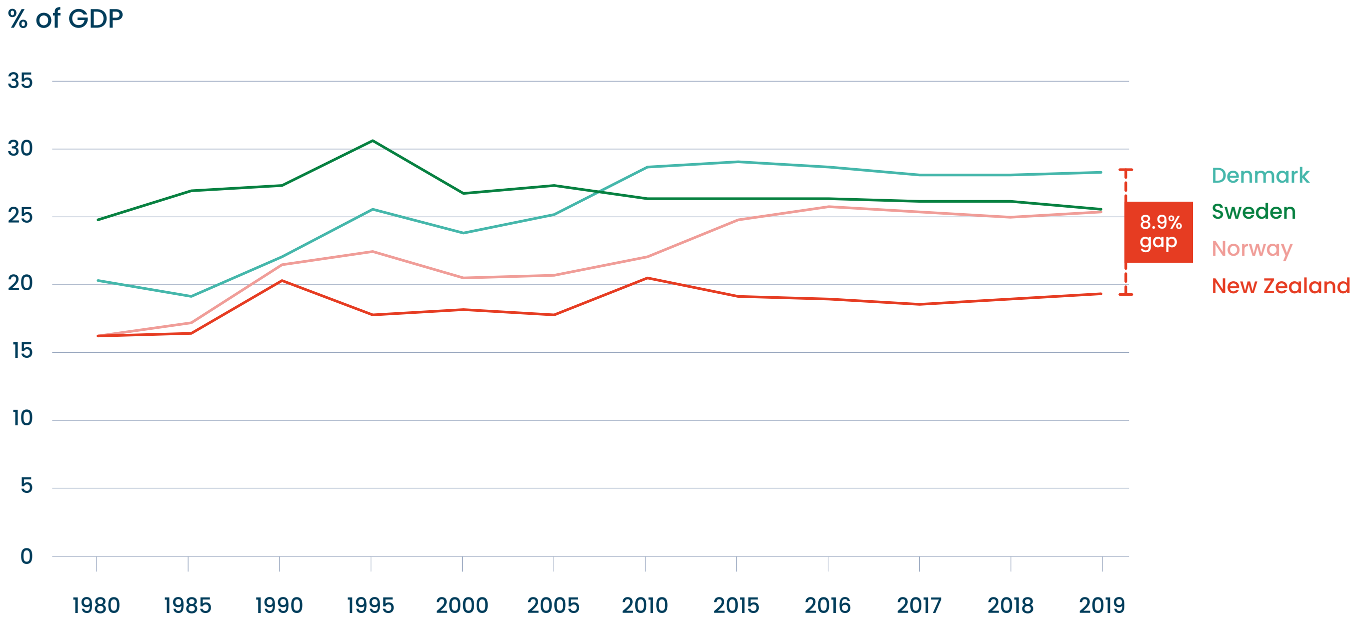


Figure 6: Public Social Expenditure trends for Scandinavian countries and New Zealand

Source: OECD Social Spending Indicator 2021

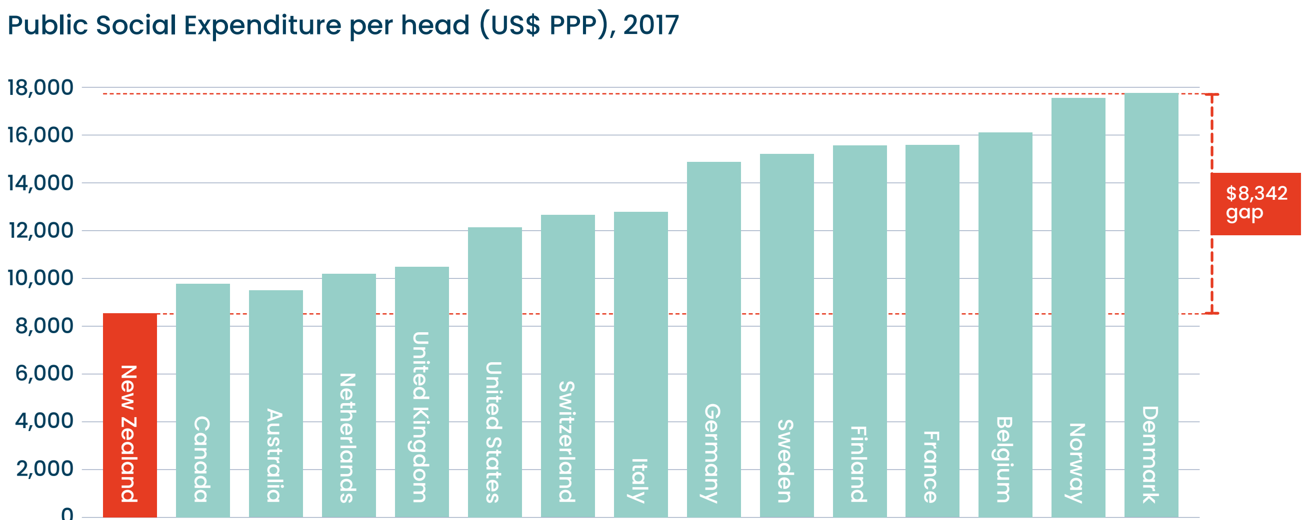
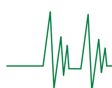


Figure 7: Public Social Expenditure in 15 comparable countries

Source: OECD Social Spending Indicator 2021



OECD social spending definition

Social expenditure comprises cash benefits, direct in-kind provision of goods and services, and tax breaks with social purposes. Benefits may be targeted at low-income households, the elderly, disabled, sick, unemployed, or young persons. To be considered 'social', programmes have to involve either redistribution of resources across households or compulsory participation. Social benefits are classified as public when general government (that is central, state, and local governments, including social security funds) controls the relevant financial flows.

Purchasing power parities (PPPs)

These are the rates of currency conversion that equalise the purchasing power of different currencies by eliminating the differences in price levels between countries. In their simplest form, PPPs are simply price relatives which show the ratio of the prices in national currencies of the same good or service in different countries.

Wellbeing economics

Gross domestic product (GDP) has long been the main measure of a country's 'success'. But while it does not measure health, education, good housing, and a clean environment, it does offer, albeit crudely, an international comparison of how much value a country or its government places on those things.

New Zealand's public social spending (including health spending) in 2019 was slightly below the OECD average. This does not appear to equate with the government's vision for social equity and high levels of wellbeing. Public social spending as a proportion of GDP in Scandinavian countries, which usually rank highly on wellbeing indicators, such as the UN's human development index and UNICEF's child wellbeing rankings, far outstrip New Zealand's (Figures 6 & 7).

While New Zealand made headlines across the world by producing a so-called world-first Wellbeing Budget in 2019, and has improved social spending in recent budgets, it has yet to demonstrate genuine transformational change. This is needed to truly implement wellbeing economics where priorities for public spending are guided by the extent to which a programme can improve population wellbeing given its expenditure requirements.

This requires relinquishing old ways of thinking of political leaders, policymakers and local management (still driven by ideological managerialism in many areas) where health services are viewed in narrow financial terms, as an expenditure that needs to be controlled, rather than with a broader social and economic perspective which recognises the overwhelming evidence for investing in health for potentially substantial social and economic gains.

As the United Nations' High-Level Commission on Health Employment and Economic Growth points out, investing in health is not only good for population health and wellbeing, the health sector is also a key economic sector, a job generator and a driver of inclusive economic growth.

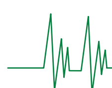
This is reinforced in an analysis of spending by government sectors indicating considerable economic gains from government spending in areas such as health, education, and the environment, largely through the creation of jobs and income. A study based on 25 European countries estimated that every government dollar spent on health services generated more than four dollars in the domestic economy. Spending on education and the environment saw eight-fold returns on investment, while spending on social protection generated nearly three dollars for every government dollar (Table 1).

These differences appear to be explained by varying degrees of absorption of government spending into the domestic economy. For example, defence spending was linked to significantly greater trade deficits whereas health and education had no effect on trade deficits.

Table 1: The Fiscal Multiplier Effect

Every $1 spent in these areas of government	Generates in the domestic economy:
Defence	-$9.83
Community	-$2.5
Economic Affairs	$0.06
General Public Services	$0.62
Social Protection	$2.88
Health	$4.32
Culture & Recreation	$7.57
Education	$8.24
Environment	$8.39
Total Government	$1.61

Source: *Globalisation and Health 2013*



Reporting on national wellbeing

There is no guarantee that 'wellbeing budgets' or national wellbeing will remain on the political agenda. To mitigate against changing political objectives, some countries such as France and Wales have introduced legislation that includes the statutory requirement to report to Parliament regularly on the state of national wellbeing to inform policy. While the New Zealand budget is a potentially useful lever, without measures to enforce public accountability, it could become just another parliamentary process with policymakers not taking genuinely meaningful actions. Indeed, the political narrative in New Zealand remains very focused on the 'fiscal responsibility' of paying off the government 'debt burden'.

Reporting provisions in the *Welsh Well-being of Future Generations (Wales) Act 2015*, provide a valuable example of how to help ensure national wellbeing remains a key political focus.

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- Clin Assoc Prof Phil Bagshaw, Chair, Canterbury Charity Hospital Trust, and University of Otago Christchurch
- Professor Paul Dalziel, Lincoln University, Canterbury
- Dr Rhys Jones, University of Auckland
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