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**Committee Secretariat**
**Finance and Expenditure Select Committee**
**Select Committee Services**
**Parliament Buildings**
**Wellington**

**re: Submission to the Finance and Expenditure Select Committee on the**

# Budget Policy Statement 2019

Dear Committee Members,

## Background

I am a Vocationally Registered ("specialist") GP in South Taranaki, the most under doctored District in New Zealand. Also, as one of the few General Practitioners (GPs) who have chosen to remain Independent of the VOLUNTARY Primary Health Organisation (PHO) system and one of the few remaining solo rural GPs, having remained loyal to my patients for 38 years, I believe I view health and wellbeing issues differently to health organisations and most politicians, so I hope you will note my concerns, and hopefully at least look at the "low hanging fruit" to start to address the serious health, wellbeing and mental health issues that have been identified.

## Specific Budget Priorities this submission addresses:

- **Reducing child poverty and improving child wellbeing, including addressing family violence**
- **Supporting mental wellbeing for all New Zealanders, with a special focus on under 24-year-olds.**

I will bring your attention to six concepts that go a long way to improve these priorities, using low cost, simple and practical budget changes which are often "cross portfolios" as most health and welfare determinants are wider than any one ministry.

### 1. Dental Health

For middle to low income New Zealanders, including young adults, students and many Maori, there are significant financial barriers to accessing adult (over 18) dental care services. This is a serious and increasing health and wellbeing issue which is not easily solved but reversing the increasing incidence is relatively simple.

Basically, the science has confirmed that Community Water Fluoridation (CWF) is safe and effective but we have yet to see this Government move on making it mandatory for local authorities to introduce (or re-introduce) it. The Local Authorities see the legal costs and trouble caused by anti-Fluoride groups to my local authority, the South Taranaki District Council over the last six years and are afraid to make a move despite the STDC winning every legal objection. I can see the same thing happening to District Health Boards.

There are children in Patea and Waverley now going to school having had no CWF and having significantly worse dental caries who would have had better dental health if the STDC had been allowed to fluoridate in 2012. Meanwhile dental caries has been rising in New Plymouth since CWF was stopped in 2011.

**Suggestion: Labour should do what it argued for, to have CWF decided by the Ministry of Health and introduce this as a priority.**

## 2. The missing 300,000

Statements such as "300,000 **children** live in poverty or hardship in New Zealand" do not identify how this 300,000 can be targeted. In health and social welfare, the Community Services Card (CSC) seems to be the most effective, but is clearly flawed, so it needs to be updated. Providing free or low-cost GP services in Very Low-Cost Access (VLCA) and Access practices (using the CSC) is also useful, although increasing (foreseen by GPs) adverse outcomes such as:

- High income NZers attending VLCA clinics are subsidised while middle to low income adult NZers attending non-VLCA (Access) and adults and children attending non-Capitated practices (see below) do not have any benefit.
- Reduced patient access, as we do not have enough GPs, particularly rural Vocationally Registered GPs, so lower fees generate higher workloads for already over-stretched GPs, resulting in shorter consultations and/or longer waiting times and counter-intuitively, greater use of Emergency Departments (EDs).
- GPs are not psychologists and struggle with the increasing demand for psychological services. Often, unless someone is in an acute crisis, the only funded services are non-evidence based counselling, and that is restricted by practice or PHO membership.
- Even less motivation for NZ graduates to train for General practice, so many areas only survive by importing Overseas graduates for medium term (1-2 year) locum positions.

**There are a missing 300,000 plus NZers** (including many Māori), namely those who are not registered with a Primary Health Organisation (PHO) and so receive no Capitation subsidy (and other benefits) and are denied any of the increase in funding for primary care because the General Medical Service (GMS) Subsidy for those with a CSC has not risen for over 16 years. The usual figure for PHO membership averages at 93% so this means AT LEAST Seven percent do not have access to Government benefits and subsidies channelled through PHOs exclusively. 7% of the current NZ population estimate of 4,934,129 [Thursday, 10 Jan 2019 at 11:30:08 am http://archive.stats.govt.nz/tools_and_services/population_clock.aspx ] is **345,389**.

This non-PHO figure is likely to be much higher, given the estimated 10% not providing a Census return, who in turn include many of the disaffected, unengaged, mentally troubled, itinerant, and homeless, the very people this Budget is trying to reach. In South Taranaki the proportion of the population not registered with a PHO is 24%, half of which are Maori.

To ignore the health needs of this missing 300,000 plus is unacceptable and just trying to get more enrolled is not the answer as the 7% non-PHO figure has been fairly stable over the last decade.

**Suggestions:**

- **GMS needs to increase significantly to allow cheaper (or free) dental and non-PHO registered medical care at any GP or A&M clinic for low income adults and children without the requirement of PHO registration.**
- **WINZ staff automatically provide a CSC to all eligible beneficiaries to ensure health and social funding is available to all who need (but can't afford) it.**
- **Where a health or social welfare benefit is aimed at ALL New Zealanders, the funding distribution should be centralised (i.e. not channelled through PHOs) as we see with Immunizations, Maternity, ACC etc.**
- **GP access to evidence-based therapy (such as Cognitive Behaviour Therapy) should have better and universal (or CSC based) funding, instead of the current patchwork access to non-evidence based counselling.**

## 3. Housing Costs

Friends from overseas countries with little or no social welfare cannot understand how we can have poverty when there are the range of benefits for unemployment, domestic purposes, sickness etc. here in NZ. From a health professional's perspective, the problem is largely the high cost of housing (rent or mortgage) using up most of the benefit.

Clearly there appears to be a supply-demand problem which will not be solved by building a few $600,000 homes. I may be naive, but surely Government social housing construction should concentrate on providing a lot more smaller, mass produced (?prefab) homes and apartments (ensuring they are not slums) to reduce the demand (and thus reverse the need for high rents and mortgages?

**Suggestion: Government social housing needs to increase by thinking smaller and taller with the aim of reducing rent burden.**

## 4. Tax Thresholds

Low to middle income earners will benefit if tax thresholds were lifted, while not significantly affecting higher income earners. This will allow more lower income people (including superannuitants) to have more disposable income and be able to afford dental/medical care and healthier food.

**Suggestion: Tax thresholds need reviewing.**

## 5. Childhood Poverty

If children are going to school unfed, unclothed etc, it may be that there are other priorities facing the parents, such as rent, petrol, cigarettes etc. This is a complex issue solved overseas by providing extra money to the school to provide for these children, not to the parents. Volunteers from the community (and School Fees from the better off), not the teachers, can organise school breakfasts (or lunches), recycled uniforms, shoes etc. Children should not miss out because of the circumstances of their parents, including rising costs.

**Suggestion: Fund schools for free school breakfasts.**

## 6. Educational Level and Content

Finally, the prospective “Dunedin Study” clearly showed that the major determinant of child health was the educational level of the mother. This has huge implications for our education system to make education relevant for non-academic children in years 11 & 12.

As a GP I have often seen young mothers who had no evidence based contraceptive and sexually transmittable infection knowledge, no evidenced based knowledge of childcare and behaviour management and no ability to cook healthy food (even vegetables) but they can all make cupcakes! Our unwanted pregnancy rates are falling because of contraceptive implants (Jadelle), our obesity levels are rising in parallel with fast food consumption and our domestic violence is increasing because there is no education about non-smacking behaviour management.

**Suggestion: Educational policies need to be linked to health and social issues such as nutrition, transmittable disease, unwanted pregnancy and non-violence to others, particularly children.**

## Conclusion

To achieve the lofty goals of improving **youth mental wellbeing** and **Reducing child poverty, improving child wellbeing, and addressing family violence** the Government needs to look at what can be achieved most easily, effectively (evidence based) and within reasonable cost restraints, the “low hanging fruit” (LHF). Dental health has an obvious LHF answer – get on with mandatory Community Water Fluoridation; the absolute bottom of the social spectrum is being missed by focusing on the 93% registered in Primary health Organisations, the LHF answer here is to increase the General Medical Service subsidy for all those with a Community Services Card; to fund GP referral for evidence based psychological therapy for those with a CSC; more low end, high rise social housing; fund schools (not parents) for meals; and most importantly, link education to social and health needs for the next generation parents.

Yours sincerely

Dr Keith Blayney