NCIWR Submission on the New Zealand Health Strategy Update

Introduction

1. The National Collective of Independent Women's Refuges (NCIWR) is a non-governmental organisation delivering services to women and children affected by domestic violence in New Zealand. NCIWR provides support, advocacy, legal, and health services to 16,507 clients annually. 52 percent of these are women, and 48 percent are children. Last year, 2,852 women and children needed to be admitted into our safe houses to protect them from ongoing violence.

2. NCIWR supports in principle the proposed vision for 2026. However, we submit that the Strategy should incorporate a stronger focus on social determinants of health and on collaboration with community and non-profit actors that influence population health outcomes.

Specific Points

3. NCIWR applauds and supports the commitment to growing New Zealand's body of knowledge on Maori and Pacific populations. However, we would like to see the commitment to working with Maori groups on any projects involving Maori made more explicit.

4. NCIWR submits that while coordination and integration between DHBs and regional governing bodies is desirable in gathering data on direct experiences of health, this cooperation should also occur between governmental and non-governmental organisations in order to facilitate access to data, or methods of data collection, relevant to social health determinants with vulnerable population samples.

5. We argue that as healthy social environments are recognised as paramount in the pursuit of physical health, there should be a corresponding commitment to addressing the social determinants of health, such as poverty, housing, inequality, and physical and sexual violence, and that these be embedded throughout health research priorities.

6. We further recommend that prevention efforts specifically target the social determinants of health, as ample evidence exists to support the positive correlations between substandard housing, insufficient household income, exposure to adverse or traumatic events (often early abuse or exposure to violence) and subsequent negative health outcomes. It is widely acknowledged that prevention is less costly than providing treatment; however, preventive strategies need to take place at the societal and community levels in order to be effective.

7. While we are in favour of the 'one team' theme, we argue that this is, in the main, limited to health sector workers and agencies only, and consequently disregards other important workers and agencies in determining health outcomes; for example, victim help organisations, preventing violence groups, community addiction and mental health groups, housing and income advocacy agencies, and providers of emergency housing or community development. These contributors to individual well-being play a substantive role in both short- and long-term health outcomes, and should be incorporated into strategies on research collaboration, ideally led and resourced by the Ministry of Health.

8. The Strategy as it stands is predominately focused on the direct provision of health services, largely disregarding the influence of social factors and the relative health (and cost) benefits of addressing these. For example, the current estimated costs of family violence per annum in New Zealand is between 4.1 and 7 billion dollars, and a substantial proportion of this falls to the health sector. Moreover, sexual violence is estimated to cost New Zealand $1.2 billion per year, with a significant portion of this financial burden also being carried by the health sector.

9. Research aimed at prevention and immediate intervention that may ameliorate the effects of social conditions that precipitate this expenditure should therefore also be prioritised in the Strategy, alongside the more traditional areas of focus such as smoking, diet, and physical activity. While this is mentioned in the Strategy, insufficient attention is given to the intersection between these individual determinants and other health considerations. This could be strengthened by including a focus on social determinants of health alongside each medical-focused priority.

10. In Strategic Priority Example One, point two emphasises the preference for large-scale data sets and widespread applicability of findings. We argue that this disadvantages those most at risk of experiencing poor outcomes through lack of specific focus and representation, and that in many cases qualitative or in-depth approaches may be more appropriate for capturing data imperative for developing prevention initiatives, and, accordingly, should be equally incentivised.

11. We applaud point two of the Strategic Priority Example Two; in particular, the inclusion of family violence. Social determinants of well-being are often underfunded as research subjects. We therefore propose that these be explicitly included and prioritised within any health research plan. As previously discussed, social marginality is closely associated with poor health outcomes.

12. To align with World Health Organisation best practice guidelines, we recommend that any research undertaking involving individuals or groups experiencing marginalisation, such as through violent victimisation, poverty, homelessness, or mental health status, be researched in conjunction with specialist agencies to maximise data validity and minimise adverse impacts on the population sample. The paramountcy of this inclusion of specialist agencies is not sufficiently set out in any of the Example Priorities.

13. Specialist agencies such as those working with the social conditions listed above are commonly excluded from the production of large-scale, robust research due to resource constraints. We therefore argue that specialist agencies working with members of marginalised populations are resourced to undertake partnerships with universities, in order to capture data that may be unique to individual agencies' work.

For any further information, please do not hesitate to contact NCIWR's Policy Advisor at Natalie@refuge.org.nz.