Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

18 August 2025

Health Committee

Submission on Healthy Futures (Pae Ora) Amendment Bill

Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tāngata
Tihei mauri ora

He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, anei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora Hinengaro

Tēnā koutou

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

The Mental Health Foundation of New Zealand (the MHF) opposes the Bill on the grounds that it removes:

1. **The majority of the legal mechanisms aiming to support an equal Te Tiriti o Waitangi partnership and expression of tino rangatiratanga, equitable outcomes for Māori, a public health/prevention focus, and a health system enhanced by lived experience.**

2. **The requirement for the health sector to work to improve mental and physical health and diagnose and treat mental and physical health problems equitably.**

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We recommend the Bill be rejected or at least significantly amended to retain much of the status quo of the *Pae Ora Act 2022* (the Act) in its current form.

While the MHF's submission focuses on these areas, we do note other changes proposed by the Bill are of concern. This includes reduced accountability and transparency of the health system (e.g., clause 26 & 27 removes auditing requirements); extending political neutrality obligations (clause 11) to health professionals when it is recognised as being in the public interest for them to comment publicly on matters relevant to their professional expertise and interests; and set targets in legislation that are narrow, short-term focused, inflexible and may incentivise the 'gaming' of outcomes (clauses 21, 23 & 24).

Te Tiriti o Waitangi (clause 8)

Te Tiriti o Waitangi is a fundamental vehicle for improving Māori wellbeing outcomes and resolving inequities between Māori and other ethnic groups in Aotearoa New Zealand. The MHF has an established position which recognises that decolonisation and embedding Te Tiriti-based practices in society is vital for driving positive mental health and wellbeing for Māori, and other equitable outcomes. When Māori are self-determining and able to 'live as Māori' or embody Māori values, beliefs, and practices, they experience more positive and secure identities, less isolation, and better wellbeing outcomes overall (Russell, 2018).

The MHF supports the intentions behind the 2022 Act "to improve outcomes for Māori by placing the Treaty of Waitangi at the heart of the health system so that decisions made by health entities would be genuinely informed by health principles identified by the Waitangi Tribunal in the WAI 2575 Inquiry, and that the legislation will support system-wide accountability for Māori health outcomes" (RIS, p.3). To provide services based on need, the Act supports and requires real Māori engagement and involvement in the design and delivery of services, decision-makers who understand tikanga and Te Tiriti o Waitangi, and a focus on health equity and choice of services.

The MHF strongly opposes one of the policy objectives as outlined in the Regulatory Impact Statement to 'ensure that Health New Zealand at all levels has the responsibilities and mechanisms to make *its decisions informed by Māori views*' [emphasis added].

We believe this policy objective fundamentally undermines the Crown's obligations under Te Tiriti o Waitangi for equal partnership and equal decision-making power. Instead, it reduces the obligations on Crown entities to simply 'consider Māori perspectives' and 'provide opportunities for Māori to contribute' rather than enabling Māori to have a meaningful role in the planning and design of services, including kaupapa Māori investment and innovation. This undermines tino rangatiratanga and Māori self-determination in health governance.

The MHF rejects the proposed repeals and amendments to section 6 of the Act, which seek to limit the Crown's responsibility to 'consider and provide for Māori interests'. In particular, we oppose the removal of:

- The provision for iwi-Māori partnership boards to enable Māori to have a meaningful role in the planning and design of local services, as this would diminish Māori influence over service priorities.
- The criteria for appointment to the board of Health New Zealand, meaning the board no longer has to collectively have knowledge, experience and expertise of Te Tiriti o Waitangi and tikanga Māori, which would weaken culturally informed governance.
- The requirement for the board of Health New Zealand to have systems and processes to ensure Health New Zealand has capacity and capability to understand Te Tiriti o Waitangi, kaupapa Māori services, cultural safety, mātauranga Māori, and Māori perspectives of services, which risks undermining cultural safety and responsiveness.
- The requirement for Health New Zealand to engage with iwi-Māori partnership boards and have systems for engaging with Māori and enabling responses from that engagement to inform its functions, which would reduce the role of Māori as partners in the health system.
- The accountability and transparency mechanism requiring Health New Zealand to demonstrate how its engagement with Māori has informed the performance of its functions, which will reduce oversight, trust, and the ability to track progress toward equitable Māori health outcomes.

The MHF opposes all corresponding clauses that give effect to the policy intent behind clause 8, including clause 12 (changing requirements for the Minister when appointing members to the board of Health New Zealand), clauses 14, 15 & 19 as it relates to the iwi-Māori partnership boards, clause 16 (changing the additional collective duties of the board of Health New Zealand) and clause 17 (removing requirements for Health New Zealand to engage with and report to Māori).

Health sector principles (clause 9)

The MHF opposes the wholesale repeal of the health sector principles (s7). While we accept legislative principles may not provide enough detail on their own, removing them without developing clear supports for how they ought to be applied in practice is not a sufficient solution. We urge the Committee to recognise the importance of retaining the fundamental concepts espoused by the principles and recommend alternative legally binding mechanisms to ensure health entities can prioritise, and be held accountable for, these necessary health system shifts and responsibilities. For most of these principles, no rationale is provided for their removal.

In particular, we strongly oppose the removal of principles that provide for:

- **Tino rangatiratanga and equitable outcomes for Māori** (s7(1)(a-d)). These principles are the primary way the legislation gives effect to Te Tiriti o Waitangi. They provide significant direction for health entities and the health system to 'engage with Māori...to develop and deliver services and programmes...', provide '...opportunity for Māori to exercise decision-making authority on matters of importance to Māori...', and 'provide choice of quality services to Māori'. Without this requirement, Māori health outcomes will not improve, and inequities will continue to widen, including higher rates of poor mental health and suicide. Currently, Māori face many barriers and harms when seeking or receiving health support, including experiences of systemic racism (Reid et al, 2019; Ellison-Loschmann & Pearce, 2006), clinicians' lack of cultural competence (Palmer et al, 2019), financial barriers (Graham & Masters-Awatere, 2020), disproportionately higher rates of coercive

practices[1], and lack of Māori representation in the health workforce.[2] Alongside the long-term impacts of colonisation, this perpetuates inequitable health outcomes, such as diagnostic inequity (Lee et al, 2017; Gurney, 2020) and disparities between avoidable hospitalisations and morbidity between Māori and non-Māori (Oben et al, 2022; Gurney et al, 2020).

- **Working to improve mental and physical health and diagnose and treat mental and physical health problems equitably** (s7(1)(e)(iii)). Parity of esteem is a principle by which mental health must be given equal priority to physical health. The inclusion of this principle in health legislation has been long argued for by mental health advocates in Aotearoa, and follows a similar recognition given in the UK through the *Health and Social Care Act 2012*. In Aotearoa New Zealand, 1 in 5 people experience mental distress or illness every year (Health and Disability Commission, 2018) and it is estimated that mental illness costs us about 5 percent of gross domestic product annually. In 2023, this meant more than $20 billion (Office of the Auditor General, 2024). People who access secondary mental health services are twice as likely to die before the age of 65, including from preventable and treatable health issues (Lockett et al, 2018). The MHF's view is that mental health has been significantly underfunded by successive governments (and certainly not funded commensurate with mental health need) and progress remains limited by pervasive prejudice, discrimination and a narrow biomedical view of mental illness.

- **Protect and promote health and wellbeing** (s7(1)(e)). The removal of principles to ensure the health system and decision-makers protect and promote people's health and wellbeing will reorient the system towards a default downstream disease management approach that is not in keeping with modern understandings of health and wellbeing, and nor is it effective or cost efficient in the long term. As we note below, there is minimal literacy in and support for public health approaches in the current health sector,

[1] When accessing specialist services, Māori experience higher rates of coercive practices that are restrictive and can cause harm – including community treatment orders and solitary confinement (seclusion) (Te Hiringa Mahara, 2022).
[2] 2021 data shows that Māori are noticeably under-represented compared to their proportion of the population. Māori make up 16.5% of the population, but only 4.3% of doctors (Medical Council of New Zealand, 2022).

especially those related to mental wellbeing that sit outside of traditional mental health services.

- **Harness lived experience to continuously improve services, access to services and outcomes** (s7(1)(d)(iv)). It is a well-established approach in modern health care that people with lived experience (such as lived experience of mental distress) of the health system and services, and those most impacted by health inequities, must have an integral role in the governance and delivery of the system and services that are designed to meet their needs. Doing so ensures systems and services are inclusive, equitable, relevant, accessible and responsive. Specifically in mental health care, evidence shows that organisations working in partnership with people with lived experience achieve more effective service delivery (RANZCP, 2021).

Functions of Hauora Māori Advisory Committee and iwi-Māori partnership boards (clause 14, 15 & 19)

As stated above, the **MHF opposes the narrowing of functions of iwi-Māori partnership boards from strategic priority-setting, support of hauora Māori stewardship, and monitoring and accountability functions to that of an information-gathering role**. While the MHF supports the expanded role of the Hauora Māori Advisory Committee in principle, such a change in the context of a narrower iwi-Māori partnership board role risks channelling Māori voices through a Ministry-appointed committee, which may in turn risk neutrality and genuine focus on the wide variety of local Māori perspectives. This shift could weaken the influence of Māori at the local level and undermine meaningful partnership and tino rangatiratanga.

Expert advisory committee on public health (clause 32)

The MHF opposes no longer requiring the expert advisory committee on public health to collectively hold a broad range of knowledge, experience and expertise including health promotion and preventative health. The MHF has long advocated for strong public health expertise within the health system and health entities, noting that public health literacy is lacking nationally and even within the health sector itself. It is our observation that public health is often viewed narrowly

within the context of communicable disease surveillance and management to the detriment of health promotion and other preventative, upstream approaches. Within public health itself, there is an even poorer understanding of population-level approaches to mental health and wellbeing.

Inadequate consultation and stress-testing of policy options

We note that 'only limited consultation has been undertaken and engagement with Māori representatives has been limited to the Hauora Māori Advisory Committee' in the development of the Bill (RIS, p.3), which would appear **insufficient to fully understand the impacts of the proposed changes on Māori and Māori health outcomes.** It appears the RIS is referring to an earlier version of the Bill, and its analysis does not therefore assess the full suite of changes before the Committee. In addition, 'there has been negligible engagement with the Ministry of Health or Health New Zealand'. This is a major concern given the conclusion that 'any improvement will likely be marginal and will depend on how changes are given effect by Health New Zealand' (RIS, p.2). We suspect the lack of consultation has also **resulted in unintended consequences**, such as the delay in delivery of the Mental Health and Wellbeing Strategy, which was due to come into force in October 2025 as a requirement under the Act.

Summary

Thank you for considering our submission and overarching recommendation to reject the Bill or at least significantly amended the Bill to retain much of the status quo of the Act as it relates to hauora Māori, equity, parity of esteem (giving mental health equal priority to physical health) and lived experience-informed health settings and services.

Mauri tū, mauri ora,

Shaun Robinson
Chief Executive

References

Ellison-Loschmann, L. and Pearce, N. (2006). Improving Access to Health Care Among New Zealand's Maori Population. Am J Public Health 94(4), 612-617. https://doi.org/10.2105/AJPH.2005.070680

Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. Australian and New Zealand Journal of Public Health, 44(3). https://doi.org/10.1111/1753-6405.12971

Gurney, J., Stanley, J., McLeod, M., Koea, J., Jackson, C., & Sarfati, D. (2020). Disparities in cancer-specific survival between Māori and non-Māori New Zealanders, 2007-2016. JCO Global Oncology, 6(6). https://doi.org/10.1200/GO.20.00028

Gurney, J., Stanley, J., & Sarfati, D. (2020). The inequity of morbidity: Disparities in the prevalence of morbidity between ethnic groups in New Zealand. Journal of comorbidity, 10, 2235042X20971168. https://doi.org/10.1177/2235042X20971168

Health and Disability Commissioner. 2018. *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. https://www.hdc.org.nz/media/m2wfw5vk/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf

Lee, C. H. J., Duck, I., & Sibley, C. (2017). Ethnic inequality in diagnosis with depression and anxiety disorders. New Zealand Medical Journal, 130(1454), 10–20.

Lockett, H., Jury, A., Tuason, C., Lai, J., & Fergusson, D. (2018). Comorbidities between internalising disorders and long-term physical health conditions: An analysis of the New Zealand Health Survey data. *New Zealand Journal of Psychology,* 47(3), 5-11.

Mental Health Foundation of New Zealand. 2024. *Tino rangatiratanga and wellbeing*. Position statement on tino rangatiratanga and wellbeing | Mental Health Foundation

Oben, G., Crengle, S., Kokaua, J., & Duncanson, M. (2022). Trends in deprivation in hospitalisations of Indigenous children and young people in Aotearoa New Zealand. Journal of paediatrics and child health, 58(8), 1345–1351. https://doi.org/10.1111/jpc.15979.

Office of the Auditor General New Zealand. 2024. *Meeting the mental health needs of young New Zealanders.* Meeting the mental health needs of young New Zealanders

Palmer, S., Gray, H., Huria, T. et al. (2019). Reported Māori consumer experiences of health systems and programs in qualitative research: a systematic review with meta-synthesis. International Journal for Equity in Health 18(163). https://doi.org/10.1186/s12939-019-1057-4

Royal Australia and New Zealand College of Psychiatry. 2021. *Partnering with people with lived experience*. Partnering with people with lived experience | RANZCP

Reid, P., Cormack, D., & Paine, S. J. (2019). Colonial histories, racism and health—The experience of Māori and Indigenous peoples. Public Health, 172(172), 119–124. https://doi.org/10.1016/j.puhe.2019.03.027

Russell, L. 2018. *Te Oranga Hinengaro: Report on Māori Mental Wellbeing Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey.* Health Promotion Agency/Te Hiringa Hauora. https://healthnz.figshare.com/articles/report/Te_Oranga_Hinengaro_Maori_Mental_Wellbeing_Results_from_the_New_Zealand_Mental_Health_Monitor_Health_and_Lifestyles_Survey/26636671