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Secretariat
Health Select Committee
Select Committee Office
Parliament Buildings
Wellington 6011
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To the Health Select Committee

Submission on the 'Inquiry into preventing child abuse and improving children's health outcomes'

Thank you for the opportunity to make a submission on the "Inquiry into preventing child abuse and improving children's health outcomes". This submission is made on behalf of the New Zealand College of Public Health Medicine.

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Yours sincerely

A handwritten signature in blue ink that reads "Julia Peters".

Dr Julia Peters
President

A handwritten signature in blue ink that reads "Richard Hoskins".

Dr Richard Hoskins
Council Member, Policy Committee Chair

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Submission on the “Inquiry into preventing child abuse and improving children’s health outcomes”

This submission is made on behalf of the New Zealand College of Public Health Medicine (NZCPHM). The NZCPHM is the professional body of doctors with specific expertise and interest in the practice of Public Health Medicine. Public Health Medicine is defined as the branch of medicine concerned with the epidemiological analysis of the health and health care of populations and population groups. It involves the assessment of health and of health care needs, the development of policy and strategy, the promotion of health, the control and prevention of disease and the organisation of services to best meet those needs. NZCPHM membership includes 181 fully qualified specialists and 32 registrars who are doctors in training in the speciality.

The NZCPHM notes that there have been a number of important consultations and inquiries focussed on child health in New Zealand in recent months including the Ministry of Social Development’s Green Paper for Vulnerable Children and the Māori Affairs Select Committee Inquiry into the Social Determinants of Health and Wellbeing for Māori Children. The NZCPHM considers it essential that the findings of these, and upcoming public consultation on poverty and welfare reforms, are integrated and considered in their totality in a cross-sectoral process.

The NZCPHM commends the Health Select Committee for the broad focus of this Inquiry and the consideration given to the broad range of factors that impact children, and appreciate the opportunity to submit.

Executive Summary

1. The NZCPHM is of the firm belief that the circumstances that a child is born into, and the opportunities and advantages they receive early in life, has a major role in determining their future health and wellbeing. A broad view incorporating these determinants of health¹ is essential when examining issues such as the prevention of child abuse.
2. Improving overall child wellbeing will result in significant public health gains, reduced inequalities in health and social wellbeing indicators including abuse and neglect, and reduced societal costs both in health and elsewhere.
3. The NZCPHM recommends that a public health approach is taken to reducing vulnerability to poor outcomes in New Zealand children and young people. A public health approach has:
 - A strong prevention focus
 - Is interdisciplinary and science-based
 - Draws upon knowledge from many disciplines, including medicine, epidemiology, sociology, psychology, criminology, education, economics
 - Emphasises collective action across diverse sectors (e.g. health, education, social services, housing, justice and policy)²

¹ Determinants of health include the conditions of daily living that impact on health and wellbeing (e.g. income, education, housing, access to healthcare) and the structural drivers (e.g. governance structures, legislation, policy, societal biases and norms) that influence their distribution within society. See http://www.who.int/social_determinants/en/

² World Health Organization (2002). *Chapter 1: Violence a Public Health Problem* in World Report on Violence and Health. World Health Organization. http://whqlibdoc.who.int/publications/2002/9241545615_chap1_eng.pdf

Summary of Key Recommendations

- The NZCPHM urges Government to lead the integration of submissions from the Green Paper on Vulnerable Children, the Māori Affairs Select Committee Inquiry into the Social Determinants of Health and Wellbeing for Māori Children, and this Health Select Committee Inquiry in order to inform a cohesive, cross-sectoral approach.

Term of Reference One: Factors that Influence Outcomes for Children

- The NZCPHM urges the Committee to consider recommendations made by the Public Health Advisory Committee regarding improving outcomes for New Zealand children.³
- The NZCPHM recommends that interventions that address risk factors and drivers of poor health outcomes in children be evaluated for their effectiveness for Māori and Pacific children.

Term of Reference Two: Pre-conception Period

- The NZCPHM recommends integration of reproductive planning and health promotion into women's primary care.
- The NZCPHM supports strategies for improving equity in access to long-term contraception options e.g. by removing cost constraints.

Term of Reference Three: Antenatal Period

- The NZCPHM supports implementation of the following evidence-based antenatal care strategies⁴ for improving pregnancy outcomes that also facilitate individual, provider, and population level monitoring:
 - A schedule of goal-oriented antenatal care visits
 - Early initiation of antenatal care by 10 weeks gestation
 - An early dating antenatal ultrasound scan at 10-13 weeks gestation
- The NZCPHM recommends that evidence based strategies for improving engagement with antenatal care be piloted and evaluated in New Zealand with particular reference to their effectiveness for Māori and Pacific.
- The NZCPHM recommends the development of a National Well Child Register to replace the National Immunisation Register as a centralised record of all Well Child services and that antenatal care monitoring come under the Well Child Tamariki Ora framework and be captured on this Register.

Term of Reference Four: Postnatal Period

- The NZCPHM recommends that postnatal care monitoring come under the Well Child Tamariki Ora framework and be captured on a National Well Child Register.

³ Public Health Advisory Committee. *The Best Start in Life: Achieving effective action on child health and wellbeing* .2010. Wellington: Ministry of Health. Available from: <http://www.nhc.health.govt.nz/sites/www.nhc.health.govt.nz/files/documents/publications/the-best-start-in-life-21may.pdf>

⁴ National Institute for Health and Clinical Excellence. *Antenatal care routine care for the healthy pregnant woman*. London: National Institute for Health and Clinical Excellence; 2008

Term of Reference Five: Well Child Services

- The NZCPHM supports the provision of universal Well Child services for all New Zealand children that include antenatal care, post-natal care, well-child checks (including B4 School), immunisation, oral health care, primary care (including after-hours care), and early childhood education.
- The NZCPHM recommends a number of national strategies for facilitating integrated cross-sectoral and multi-agency working for the purpose of improving child health at both individual and population levels. These include:
 - An Action Plan for Children supported by a Children's Act
 - Common core skills and knowledge for adults working with children
 - A common assessment framework
 - Adoption of the Scottish 'Named Person' model⁵
 - Development of the Lead Professional role
 - A National Well Child Register to replace the National Immunisation Register and to facilitate monitoring at an individual, population, and provider level
- The NZCPHM recommends that an Action Plan for Children be prevention-focussed and have actions across the life-course. In particular an increased focus on preparing children and young people for adulthood and parenting (primordial prevention), reducing the number of vulnerable children (primary prevention) and early identification of the need for additional support (secondary prevention) is warranted.

Term of Reference Six: Optimising Child Health

- The NZCPHM recommends the development of principles for investment in initiatives for improving child health.
- The NZCPHM recommends that the Government takes a strong lead in addressing several of the key determinants of health for children at a population level, paying particular attention to equity for Māori children and their whānau, and to cross-sectoral collaboration. The NZCPHM supports action in the following areas: poverty, housing, early childhood education, smoking, high risk alcohol use, family violence, access to primary healthcare, overweight and obesity.

⁵ Scottish Government: *Getting It Right for Children Practice Briefings: Named Person* Available from: <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/publications/practice-briefings>

Factors that influence best childhood outcomes from before conception to three years and significant barriers

4. New Zealand compares poorly to other developed countries with respect to child health. For example New Zealand:⁶
 - is 21st for infant mortality out of thirty OECD countries
 - is fourth to bottom of all OECD countries for injury deaths among one to four year olds
 - has 14 times the average OECD rate of rheumatic fever
 - has rates of pertussis (whooping cough) and pneumonia five to ten times greater than the United Kingdom and United States
 - has a four to six times higher rate of child maltreatment death than OECD countries with the lowest incidence

5. Poor health among New Zealand infants and young children is unfairly distributed. Infants are subject to a birth lottery with their childhood outcomes strongly determined by the environment and circumstances into which they are born.
 - Babies conceived by women living in New Zealand's most deprived areas are significantly less likely to be born alive than those conceived by women living in the most affluent areas⁷
 - Māori and Pacific children are less likely to celebrate their first birthday than European children due to higher rates of premature birth, low birth weight, sudden unexpected death in infancy (SUDI), and death from injury⁸
 - Pacific infants are more likely to be admitted to hospital during their early years with a crowding related illness than European children^{9 10}
 - Around one in seventy Māori and Pacific children are admitted to hospital every year to have dental caries treated compared to one in two hundred European children¹¹
 - Children living in the most deprived areas in New Zealand are seven times more likely to be admitted to hospital with an injury resulting from abuse, maltreatment, or neglect than those living in the most affluent areas¹²

⁶ Public Health Advisory Committee. *The Best Start in Life: Achieving effective action on child health and wellbeing* .2010. Wellington: Ministry of Health. Available from: <http://www.nhc.health.govt.nz/sites/www.nhc.health.govt.nz/files/documents/publications/the-best-start-in-life-21may.pdf>

⁷ PMMRC. Perinatal and Maternal Mortality in New Zealand 2008: Fourth Report to the Minister of Health July 2009 - June 2010. Wellington: Ministry of Health; 2010

⁸ Craig E, Adams J, Oben G, et al (Draft 2011). The Health Status of Children and Young People in the Northern District Health Boards . New Zealand Child and Youth Epidemiology Service.

⁹ *ibid*

¹⁰ Jackson G, Thornley S, Woolston J, et al. Reduced acute hospitalisation with the healthy housing programme. *J Epidemiol Community Health* 2011;65:588e593

¹¹ Craig E, Adams J, Oben G, et al (Draft 2011). The Health Status of Children and Young People in the Northern District Health Boards . New Zealand Child and Youth Epidemiology Service.

¹² *Ibid*

6. The environments in which children live, learn, and play can have a greater impact on how long and well they live than medical care.¹³ Māori and Pacific have the poorest health of all children in New Zealand on average, in part due to inequitable access and exposure to the determinants of health and wellbeing.¹⁴
7. The NZCPHM welcomes the establishment of a Ministerial Committee on poverty and the Children's Commissioners expert group on child poverty. The impacts of poverty are far reaching and are evidenced by poor outcomes across the health, education, social, housing, and justice sectors.
8. One in five New Zealand children lives below the poverty line.¹⁵ Current State spending on children is not mitigating the impact poverty has on their health and wellbeing.
9. Children living in the most deprived areas of New Zealand are significantly more likely than children living in affluent areas to:^{16 17}
 - be admitted to hospital with a preventable illness
 - leave school early or to leave without a qualification
 - live in a crowded household, a household that is often or always cold, or is often or always damp
 - live in a sole parent household, to have a parent who is reliant on a benefit, and to witness or experience family violence
 - become a parent themselves at a young age
10. In addition to poverty, the Public Health Advisory Committee has identified factors that are driving continued poor outcomes for a significant proportion of New Zealand children.¹⁸ The NZCPHM supports the recommendations made by the Public Health Advisory Committee with respect to these drivers which are:
 - Increasing pressures on families/whānau
 - Widening socioeconomic disparities
 - Comparatively low government investment in early childhood
 - Uncoordinated services
 - Lack of good information for policy decisions and service delivery
11. In addition, a recent Australian economic analysis of the impact of modifiable risk factors on outcomes in adults highlighted the significant potential economic gains to be made by

¹³ Arkin, E et al. *Breaking Through on the Social Determinants of Health and Health Disparities*. Available from: <http://www.commissiononhealth.org/PDF/0d5f4bd9-2209-48a2-a6f3-6742c9a7cde9/Issue%20Brief%207%20Dec%2009%20-%20Message%20Translation.pdf>

¹⁴ Every Child Counts. He Ara Hou: The Pathway Forward. Getting it right for Aotearoa New Zealand's Māori and Pasifika children. <http://www.everychildcounts.org.nz/wp-content/uploads/2010/06/He-Ara-Hou-Report-20112.pdf>

¹⁵ Ibid

¹⁶ Craig E, Jackson C, Han D, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. CYF Notifications: p252-254

¹⁷ Morton S, Atatoa Carr P, Grant C, et al. (2012) Growing Up in New Zealand: a longitudinal study of New Zealand Children and their families. Report 2: Now we are born. Auckland: Growing Up in New Zealand

¹⁸ Public Health Advisory Committee. *The Best Start in Life: Achieving effective action on child health and wellbeing*. 2010. Wellington: Ministry of Health

addressing high risk alcohol use, tobacco smoking, intimate partner violence, and the drivers of obesity and overweight.¹⁹

12. A population prevention focus on these four risk factors areas will also contribute to significant gains for infants and young children, and a reduction in health disparities. The NZCPHM recommends that interventions that address these risk factors be evaluated for their effectiveness for Māori and Pacific children.

Practical improvements to health, education, social and other services, targeted at the pre-conception period to improve infant and child health outcomes

13. The preconception period provides opportunities for improving the health and wellbeing of women prior to conception. Although a specific preconception assessment is appropriate for women with complex medical problems, it is an inadequate population strategy as it will miss opportunities for health promotion and prevention for women who become pregnant by chance rather than deliberate choice.²⁰
14. Growing Up in New Zealand recently reported that 40% of pregnancies are unplanned, with the prevalence increasing with decreasing maternal education.²¹
15. The NZCPHM recommends integrating reproductive planning and health promotion into women's primary care. The aim of this approach is to decrease the chances of women experiencing unintended pregnancies, and increase the odds of women entering pregnancy with high levels of preconception wellness, thereby increasing the odds of a healthy pregnancy and infant.
16. An approach has been recommended in the United States by the Centres for Disease Control and Prevention and others that includes a focus on:^{22 23 24}
 - Family planning counselling and the use of a reproductive life plan²⁵
 - Physical activity, nutrition and weight
 - Specific nutrient intake e.g. folate, Vitamin D, calcium, iron
 - Immunisation/immune status e.g. rubella, hepatitis B, pertussis
 - Tobacco

¹⁹ Cadilhac D, Magnus A, Cumming T, Sheppard L, Pearce D and Carter R (2009) The health and economic benefits of reducing disease risk factors, Victorian Health Promotion Foundation, accessible at <http://www.deakin.edu.au/dro/eserv/DU:30020085/magnus-reducingdiseaserisk-2009.pdf>

²⁰ Moos M, Dunlop A, Jack BW, et al. *Healthier women, healthier reproductive outcomes: recommendations for the routine care of all women of reproductive age*. American Journal of Obstetrics and Gynaecology. 2008;199(6):S280-S289.

²¹ Morton S, Atatoa Carr P, Grant C, et al. (2012) Growing Up in New Zealand: a longitudinal study of New Zealand Children and their families. Report 2: Now we are born. Auckland: Growing Up in New Zealand

²² Ibid

²³ Johnson K, Posner SF, Biermann J, et al. Recommendations to improve preconception health and health care: United States: a report of the CDC/ATSDR Preconception Care work group and the Select Panel on Preconception Care. MMWR Morb Mortal Weekly Rep 2006;55:1-23.

²⁴ Lu MC, Tache V, Alexander GR, Kotelchuck M, Halfon N. Preventing low birth weight: is prenatal care the answer? *J Matern Fetal Neonatal Med*. Jun 2003;13(6):362-380.

²⁵ A reproductive life plan is a tool that facilitates the discussion of a woman's reproductive plans, enabling appropriate contraception options to be discussed in the context of these plans

- Alcohol
 - Other drug use, including prescription medicines
 - Sexually transmitted infection
 - Consideration of referral for specialist pre-conception care e.g. women with diabetes, women on anticoagulants, women with a complex medical history or a history of previous obstetric complication
17. The NZCPHM supports the development of universal approaches for increasing the opportunities for women to make informed reproductive choices. Such an approach is supported by the literature and includes a focus on:
- Increasing reproductive health literacy and empowering women to make deliberate reproductive choices:
 - A US study has demonstrated that the receipt of preconception health promotion interventions that included an assessment of reproductive plans in low-income women attending family planning clinics reduced the proportion of subsequent pregnancies that were unplanned in the intervention compared to the control group²⁶
 - A computer assisted motivational intervention provided in quarterly sessions in conjunction with a home visit for two years post-delivery in a teenage population reduced the odds of a subsequent birth within two years by 55% compared to usual management²⁷
 - Improving equity in access to long-term contraception options by removing cost constraints:²⁸
 - Offering free intrauterine contraceptive device (IUCD) placement increased the uptake from 25% to 49% in all women, and from 10% to 42% in women aged <19 years, post-termination of pregnancy in one Auckland clinic. Women who chose to have an IUD placed were 70% less likely to return for a repeat termination over a three year follow-up period than women who chose a contraceptive pill prescription²⁹
 - In an Australian study the use of a long-acting contraceptives in teenage mothers reduced the odds of a subsequent pregnancy within two years by 73% compared to those who chose barrier or oral contraception³⁰

²⁶ Moos MK, Bangdiwala SI, Meibohm AR, Cefalo RC. The impact of a preconceptional health promotion program on intendedness of pregnancy. *Am J Perinatol*. Feb 1996;13(2):103-108

²⁷ Barnett B, Liu J, DeVoe M, Duggan AK, Gold MA, Pecukonis E. *Motivational intervention to reduce rapid subsequent births to adolescent mothers: a community-based randomized trial*. *Ann Fam Med*. Sep-Oct 2009;7(5):436-445.

²⁸ Similar recommendations were made by the Welfare Working Group. See: Welfare Working Group, 2011. *Reducing Longterm Benefit Dependency*. p 77. Available from: <http://ips.ac.nz/WelfareWorkingGroup/Downloads/Final%20Report/WWG-Final-Recommendations-Report-22-February-2011.pdf>

²⁹ Roberts H. *Post-abortion contraception and its effect on repeat abortions in New Zealand*. 2011. ADHB Healthcare Excellence Awards. Auckland.

³⁰ Lewis LN, Doherty DA, Hickey M, Skinner SR. *Predictors of sexual intercourse and rapid-repeat pregnancy among teenage mothers: an Australian prospective longitudinal study*. *Med J Aust*. Sep 20 2010;193(6):338-342.

Improvements to antenatal maternity services so children 'at risk' of adverse outcomes are identified early, monitored appropriately, and followed through to achieve best outcomes

18. Antenatal care is comprised of a combination of health promotion, screening, risk assessment, and intervention. It is the vehicle via which effective interventions for improving pregnancy outcomes for women and their infants are delivered. Systematic reviews of the antenatal care literature reiterate that the benefits of alternative models of care in high income settings are likely to be modest.³¹
19. Every year in New Zealand, women give birth who received little or no antenatal care. In a 2007 survey of maternity service consumers 1.6% reported having no antenatal care³² while 2-3% of women in the Growing Up in New Zealand longitudinal study reported having no antenatal care,³³ with variation by District Health Board (DHB). In a review of maternity service utilisation in women living in Counties Manukau DHB, being Māori or Pacific, having a high parity (3+ previous children), and being aged <25 years, were independently associated with having higher odds of having no antenatal care.³⁴
20. International research³⁵ suggests that the most important independent barriers to accessing timely and adequate antenatal care are:³⁶
 - Beliefs that care in pregnancy is unnecessary
 - Unintended pregnancy (mistimed or unwanted)
 - Perceptions of barriers e.g. cost, can't take other children to appointments
 - Financial constraints e.g. cost of pregnancy test, child care costs, transport
 - Substance use
21. Evidence suggests that family and community attitudes towards antenatal care influence engagement. Facilitators for timely and adequate antenatal care include:³⁷
 - Pregnancy and the early years as eligibility criteria for participation in a Food Stamp Programme (supplying cheques/debit cards for purchasing specified nutritional foods e.g. milk, fruit and vegetables, tinned fish)
 - Being encouraged by a family member
 - Receipt of information about antenatal care

³¹ Hollowell J, Oakley L, Kurinczuk JJ, Brocklehurst P, Gray R. The effectiveness of antenatal care programmes to reduce infant mortality and preterm birth in socially disadvantaged and vulnerable women in high-income countries: a systematic review. *BMC Pregnancy Childbirth*. 2011;11:13.

³² Health Services Consumer Research. *Maternity Services Consumer Satisfaction Survey Report 2007*. Auckland: Ministry of Health; 2008

³³ Bartholomew K. *The Realities of Choice and Access in the Lead Maternity Care System: Operationalising choice policy in the New Zealand maternity reforms*. Auckland, The University of Auckland; 2010.

³⁴ Jackson C. *Antenatal Care in Counties Manukau DHB: A focus on primary antenatal care*. Auckland: Counties Manukau District Health Board; 2011.

³⁵ Although local New Zealand research on barriers and facilitators for accessing antenatal care is scarce, results of two recent New Zealand studies are awaited Counties Manukau DHB research project (lead by Sarah Corbett) and a study of barriers in Pacific women (led by Ausaga Faasalele Tanuvasa, Victoria University).

³⁶ Jackson C. *Antenatal Care in Counties Manukau DHB: A focus on primary antenatal care*. Auckland: Counties Manukau District Health Board; 2011.

³⁷ Ibid

22. A 2009 systematic review evaluating the effectiveness of interventions aimed at increasing early initiation of antenatal care in socially disadvantaged and vulnerable women concluded that there was insufficient evidence to make a firm recommendation.³⁸ Only one intervention was considered promising:³⁹
- **Resource Mothers Program** (South Carolina, USA): This programme uses trained lay workers to deliver social support, structured goal-oriented health promotion/education, and other assistance to pregnancy teenagers in the home during pregnancy and for one year after delivery. This was thought to have adequate evidence of effectiveness.
23. A recent systematic review found insufficient evidence to conclude that alternative models of organising or delivering antenatal care are effective in reducing infant mortality in socially disadvantaged or vulnerable women when compared with standard models of care.⁴⁰ Although a small number of interventions were considered promising for reducing preterm birth, the effects, if any, are likely to be modest. These were:
- **Group Antenatal Care:** Groups of eight to ten women with similar due dates receive antenatal care in a group setting meeting for approximately two hours every two weeks or so. Sessions typically involve self-directed care (e.g. weight, BP, self-recording), a health check with a midwife, and a facilitated discussion/education session covering issues related to pregnancy, childbirth, and parenting with an emphasis on skills building and empowerment run by an educator.
 - **Comprehensive Multidisciplinary Antenatal Care with Outreach:** Pregnant women are actively sought and supported using a range of outreach nurses and social workers, home visiting, support with transportation and child care during appointments, and follow-up of missed appointments.
 - **Patient Coordinators/Navigators:** The North Carolina Baby Love Program targets pregnant and post-partum Medicaid recipients and has a number of elements including antenatal care, assessment (psychosocial, nutritional, medical, education, financial), service planning, coordination and referral, follow-up and monitoring, education, and counselling. The maternity care coordinator acts as an advocate, assisting navigation of the complex service system, and ensuring access to services for which women were eligible for in addition to their antenatal care, e.g. job training, social work, transportation, food stamps, and housing assistance.
 - **Nutritional Programmes:** The Higgins Nutrition Intervention Program in Montreal adolescents consisted of an assessment of each pregnant adolescent's risk profile for adverse pregnancy outcomes and an individualised nutritional programme based on that profile.

³⁸ Oakley L, Gray R, Kurinczuk J, Brocklehurst P, Hollowell J. *A systematic review of the effectiveness of interventions to increase early initiation of antenatal care in socially disadvantaged and vulnerable women*. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2009.

³⁹ Three additional strategies were identified as plausibly able to affect the timing of antenatal care although effectiveness was unproven: mobile health clinics, link-workers located in GP clinics, and culturally based community clinics.

⁴⁰ Hollowell J, Oakley L, Kurinczuk JJ, Brocklehurst P, Gray R. The effectiveness of antenatal care programmes to reduce infant mortality and preterm birth in socially disadvantaged and vulnerable women in high-income countries: a systematic review. *BMC Pregnancy Childbirth*. 2011;11:13.

24. The UK National Institute for Health and Clinical Excellence has published evidence based guidelines for antenatal care⁴¹ that include recommendations for the provision and organisation of antenatal care that, for the most part, are in line with the Section 88 Primary Maternity Service Notice. Notable exceptions that should be considered for New Zealand women are:
 - A schedule of goal oriented antenatal care visits⁴²
 - Early initiation of antenatal care by 10 weeks gestation⁴³
 - An early dating antenatal ultrasound scan at 10-13 weeks gestation⁴⁴
25. These recommendations could be implemented without delay and have readily measurable indicators of success that are amenable to social marketing messaging, population level monitoring, and DHB level target setting.
26. To facilitate the delivery and monitoring of antenatal care to New Zealand women and their infants, the NZCPHM recommends that antenatal care monitoring come under the Well Child Tamariki Ora framework. The NZCPHM suggests that unborn infants be assigned a NHI number and entered on a National Well Child Register by the Lead Maternity Carer (LMC) once 20 weeks gestation have passed,⁴⁵ and that participation in a goal-oriented schedule of care be captured in this dataset (see paragraphs 32-43 for additional discussion).

Practical improvements can be made to post-natal services to ensure best outcomes for children

27. There is currently no complete national record of publically funded post-natal care provided to New Zealand infants, including care provided by LMCs under Section 88 of the *New Zealand Public Health and Disability Act 2000* or as part of the Well Child Tamariki Ora schedule.
28. Women and infants frequently receive care from more than one provider during the post-natal period (0-6 weeks).⁴⁶ The roles and responsibilities of each provider are not always clear.
29. The NZCPHM recommends that publically funded postnatal care monitoring come under the Well Child Tamariki Ora framework, and that data be captured during the post-natal period to support the appropriate provision of Well Child Tamariki Ora care on a National Well Child Register at birth (see paragraphs 32-43 for additional discussion).

⁴¹ National Institute for Health and Clinical Excellence. *Antenatal care routine care for the healthy pregnant woman*. London: National Institute for Health and Clinical Excellence; 2008

⁴² A goal-oriented schedule specifies the purpose of each antenatal visit and what should be addressed at each, with an increased number of visits for first time mothers. The aim is to provide increased consistency of care, to ensure time-sensitive evaluations are undertaken appropriately, and to provide certainty for mothers.

⁴³ Supported by the Perinatal and Maternal Mortality Review Committee. PMMRC. *Perinatal and Maternal Mortality in New Zealand 2008: Fourth Report to the Minister of Health July 2009 - June 2010*. Wellington: Ministry of Health; 2010.

⁴⁴ Early dating scans are more accurate predictor of gestational age than the last menstrual period particularly in women with diabetes, who are multiparous, have a small stature, or who are overweight or obese. They improve the accuracy of later assessment of fetal growth and reduce induction for post term deliveries. It does not replace the 18 week anatomy scan.

⁴⁵ The *Births, Deaths, Marriages, and Relationships Registration Act 1995* requires registration of all live and stillborn infants that weigh 400g or more at birth or that were born after 20 weeks of pregnancy

⁴⁶ Morton S, Atatoa Carr P, Grant C, et al. (2012) *Growing Up in New Zealand: a longitudinal study of New Zealand Children and their families. Report 2: Now we are born*. Auckland: Growing Up in New Zealand

Improvements to the 'Well Child' services

30. The NZCPHM supports the provision of free universal Well Child services for all New Zealand children that include antenatal care, post-natal care, well-child checks (including B4 School Check), immunisation, oral health care, primary care (including after-hours care), and early childhood education.
31. There is substantial evidence that access to these services is inequitable. For example:
 - Early antenatal care engagement is least likely in younger mothers (<25 years) and those living in rural areas⁴⁷
 - Māori, Pacific, and children living in deprivation are least likely to receive any early childhood education⁴⁸
 - On time immunisation occurs less frequently for Māori and Pacific infants⁴⁹
 - Young children (<5 years) are two to three times more likely to be admitted to hospital with an ambulatory sensitive condition⁵⁰ if they live in an area with high deprivation⁵¹
 - Delivery of B4 School Checks varies significantly by DHB (from 35%-92%)⁵²
32. The NZCPHM is of the opinion that the provision of these services can be strengthened via adoption of the following strategies:

National Action Plan for Children

33. New Zealand infants and young children would be well served by the development of a **National Action Plan for Children** with clear and shared cross-sectoral goals, actions for achieving these, clear accountabilities, and a monitoring framework.
34. The NZCPHM recommends that an Action Plan for Children be prevention focussed and have actions across the life-course (see Figure 1).
35. The prevention of child abuse and neglect is especially important as mitigation of associated long-term outcomes is costly, and difficult to achieve.⁵³ The NZCPHM recommends an increased focus on preparing children and young people for adulthood and parenting (primordial prevention), reducing the number of vulnerable children (primary prevention) and early identification of the need for additional support (secondary prevention).

⁴⁷ Jackson C. Antenatal Care in Counties Manukau DHB: A focus on primary antenatal care. Auckland: Counties Manukau District Health Board; 2011.

⁴⁸ Craig E, McDonald G, Reddington A, and A Wicken. 2009. *The Determinants of Health for Children and Young People in Auckland DHB*. New Zealand Child and Youth Epidemiology Service.

⁴⁹ Ministry Of Health. National And DHB Immunisation Data 12 Month Reporting Period To 1 October 2011. Available From <http://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data>

⁵⁰ Ambulatory sensitive hospital admissions are potentially preventable via early intervention in primary care

⁵¹ Craig E, Adams J, Oben G, et al. *The Health Status of Children and Young People in the Northern District Health Boards*. Draft 2011. New Zealand Child and Youth Epidemiology Service

⁵² Ministry of Health. B4 School Check information for the health sector 2010/11. Available from: <http://www.health.govt.nz/our-work/life-stages/child-health/b4-school-check/b4-school-check-information-health-sector>

⁵³ Macmillan HL, Wathen CN, Barlow J, et al. *Interventions to prevent child maltreatment and associated impairment*. Lancet. 2009. Jan 17;373(9659):250-66.

Figure 1: Example of a Prevention Framework and Life-course Framework

Focus	Intervention Level			
	Primordial	Primary	Secondary	Tertiary
Pregnancy and infancy	Parenting education	Screening for risk and referral to prevention programmes	Home visiting programmes e.g Early Start	Programmes to improve infant–mother attachment
Pre-school	Universal early childhood education	Universal early childhood education	Strengthening families programmes	Cognitive behavioural therapy
Primary school	School meals Life skills e.g. gardening, cooking, budgeting	Personal safety programmes	Assertiveness training for “at risk” children	Cognitive behavioural therapy
Secondary school	Preparation for entering the workforce Life skills Free long-acting contraception	Personal safety programmes	Targeted programmes for “at risk” youth to increase individual resiliency	Cognitive behavioural therapy
Parents and whānau	Free long-acting contraception Paid parental leave	Well Child Tamariki Ora services	Parent education programmes	Child protection service referrals e.g. Anger management programmes
Community / Society	Education/employment programmes for young adults and sole-parents	Media awareness campaigns e.g. It’s not ok, Never shake a baby	Targeted media campaigns in “at risk” communities	Intensive community interventions e.g. zero alcohol tolerance zones

Adapted from Hunter⁵⁴ and Macmillan⁵⁵

Legalisation

36. Legislation (**Children’s Act**) that supports information sharing, integrated cross-sectoral working, and monitoring for all New Zealand children for the purposes of ensuring children’s rights under the United Nations Convention on the Rights of the Child and Te Tiriti O Waitangi will support actions for improving child health in New Zealand.

Common core skills and knowledge

37. Integrated working will be improved by the development and implementation of **common core skills and knowledge** across the workforce for children that includes training, resources, and assessment on:
 - Effective communication and engagement with children, young people and families
 - Child and young person development

⁵⁴ Hunter, C Defining the public health model for the child welfare services context. 2011. <http://www.aifs.gov.au/nch/pubs/sheets/rs11/index.html>

⁵⁵ Macmillan HL, Wathen CN, Barlow J, et al. *Interventions to prevent child maltreatment and associated impairment*. Lancet. 2009. 373:250-66.

- Common assessment framework
- Safeguarding and promoting the welfare of the child or young person
- Supporting transitions
- Multi-agency and integrated working
- Information sharing
- Cultural competence

Common Assessment Framework

38. The development and implementation of a **common assessment framework** (CAF) has been shown to improve outcomes for children and their families, information sharing and integrated multi-agency working.⁵⁶ A CAF is a shared assessment and planning tool designed for use across all children's services enabling a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met. The UK developed CAF was adapted for use in New Zealand by the Ministry of Social Development⁵⁷ but not implemented across all sectors (health, education, justice, welfare and so on).

Named Person Model

39. The NZCPHM supports adoption of the Scottish Named Person⁵⁸ strategy whereby each child born has an identified professional from the children's workforce who is responsible for early identification of the need for additional support and referral as required. This could be their LMC during pregnancy until two weeks of age, a Well Child provider from two weeks until five years, an educator from five years to school leaving, and a youth worker from school leaving until 18 years.⁵⁹

Lead Professional Role

40. The NZCPHM supports the further development of a Lead Professional role, supported by additional training, and referral of children with complex additional needs to an agency that provides a Lead Professional role. The role of the Lead Professional is to act as a single point of contact for the child, young person or family, co-ordinate the delivery of the actions agreed, and reduce overlap and inconsistency in the services received.⁶⁰

⁵⁶ The UK common assessment framework facilitates holistic assessment of an unborn baby, child, or young person across several dimensions including development, parents and carers, family, and environments. It has been implemented and evaluated in a number of settings. See: Children's Workforce Development Council. *The Common Assessment Framework for children and young people: Early identification, assessment of needs and intervention*. <http://www.nfer.ac.uk/nfer/publications/LGMX01/LGMX01.pdf> and Easton, C., Morris, M. and Gee, G. *LARC2: Integrated Children's Services and the CAF Process*. 2010. Slough: NFER. <http://www.nfer.ac.uk/nfer/publications/LAQ01/LAQ01.pdf>

⁵⁷ Child Youth and Family. *Differential Response*. Information for Community Service Providers. 2009. <http://www.cyf.govt.nz/documents/working-with-others/dr-information-for-community-providers.pdf>

⁵⁸ While every child has a Named Person, who play an important role in to determining which children have additional needs and require additional support, only children with complex needs necessitating the involvement of several agencies have a Lead Professional.

⁵⁹ Scottish Government: *Getting It Right for Children Practice Briefings: Named Person* Available from: <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/publications/practice-briefings>

⁶⁰ Easton, C., Morris, M. and Gee, G. *LARC2: Integrated Children's Services and the CAF Process*. 2010. Slough: NFER. <http://www.nfer.ac.uk/nfer/publications/LAQ01/LAQ01.pdf>

National Well Child Register

41. The NZCPHM recommends the creation of a National Well Child Register to replace the National Immunisation Register (NIR), and that records well child information that is currently captured in different databases either nationally or locally. This register could collate:
 - Contact information for child and parents / caregivers
 - Name and contact details for the child's workforce providers i.e. LMC, well child provider, GP, Early Childhood Education Centre, school, oral health provider, Named Person, Lead Professional
 - Well child data – antenatal and post-natal care, antenatal and newborn screening, immunisations, well child visits, B4 School Check, oral health records, etc
42. The NZCPHM recommends that a National Well Child Register be opt-off as the NIR currently is. There should be provision for parents to opt-off via the submission of a written request. There are several benefits to children and their families to the approach the NIR has taken:
 - It makes is easy for all children and families to participate
 - Parents can access their child's information in order to check immunisation status
 - Parents have certainty regarding who has a responsibility to provide services to their children
43. A National Well Child Register will facilitate improved monitoring at an individual child, provider, DHB, and national level and could contribute to significant improvements in delivery of services for children as was seen after the implementation of the NIR, and therefore outcomes.

Improvements or interventions for optimising outcomes from six weeks to three years, including health services, education, social, housing, justice and other determinants of life

44. The NZCPHM has recommended several strategies for strengthening the way that services are provided for New Zealand children (see paragraphs 32-43).
45. In considering new and existing interventions, the NZCPHM recommends the development of principles for investment that could include the following:
 - High-quality evidence, ideally from randomised controlled trials, that a service/intervention is effective in improving outcomes
 - That the service/intervention has clearly defined and measurable indicators of success to enable on going evaluation
 - That the service/intervention will reduce inequalities in outcomes or their determinants
 - That the service/intervention is acceptable
 - That the service/intervention does not cause harm
 - That there is capacity to provide the service/intervention within the existing workforce or evidence that this can be developed
 - That systems exist to ensure fidelity to the evidence base and robust performance monitoring
 - That the cost-benefit of the service/intervention has been considered

- That services/interventions with screening elements (e.g. antenatal care, Well Child Tamariki Ora services, B4 School) meet the New Zealand criteria for a screening programme⁶¹
46. In situations where evidence is lacking, but there is a plausible programme logic indicating likely success, investment is appropriate if made in conjunction with a robust and funded evaluation, preferable undertaken by an independent third party. A guide for how this can be achieved has been proposed by the Prime Minister's Chief Science Advisor, Sir Peter Gluckman.⁶²
47. The NZCPHM recommends that Government take a strong lead in addressing several of the key determinants of health for children at a population level, paying particular attention to equity for Māori children and their whānau. The NZCPHM supports action in the following areas:
- **Poverty:** Around 200,000 New Zealand children live below the poverty line, just over half of whom are Māori or Pacific.⁶³ Living in poverty increases the odds of exposure to household crowding, poor quality housing, tobacco smoke, high-alcohol use, family violence, and poor nutrition and reduces access to primary healthcare and early childhood education.⁶⁴ These are all key determinants of health and wellbeing for children. The cycle of intergenerational poverty and benefit dependence needs to be urgently addressed if the children born into these circumstances are to reach their potential.
 - **Housing:** Improving the quality and affordability of housing in New Zealand will contribute to significant health gains for children. Investing resources in housing will result in reduced costs incurred by the health and welfare sectors and also money saved by families through less GP visits and prescriptions, and less days off work and school.^{65 66 67}
 - **Smoking:** Exposure to cigarette smoke during pregnancy and in the early years is a continuing problem for New Zealand children and is contributing to death during pregnancy and infancy, hospital admissions with respiratory illnesses, and numerous other childhood illnesses;^{68 69} the burden is disproportionately borne by Māori infants.

⁶¹ National Health Committee. *Screening to Improve Health in New Zealand: Criteria to assess screening programmes*. 2003. http://www.nsu.govt.nz/files/NSU/Screening_to_improve_health.pdf

⁶² Gluckman, P *Improving the Transition Reducing Social and Psychological Morbidity During Adolescence: A report from the Prime Minister's Chief Science Advisor*. 2011. Office of the Prime Minister's Science Advisory Committee. <http://www.pmcsa.org.nz/wp-content/uploads/2011/06/Improving-the-Transition-report.pdf>

⁶³ Every Child Counts. *He Ara Hou: The Pathway Forward. Getting it right for Aotearoa New Zealand's Māori and Pasifika children*. <http://www.everychildcounts.org.nz/wp-content/uploads/2010/06/He-Ara-Hou-Report-20112.pdf>

⁶⁴ Craig E, McDonald G, Reddington A, and A Wicken. 2009. *The Determinants of Health for Children and Young People in Auckland DHB*. New Zealand Child and Youth Epidemiology Service.

⁶⁵ Howden-Chapman P. Effect of insulating existing houses on health inequality: cluster randomised study in the community. *BMJ*, doi:10.1136/bmj.39070.573032.80

⁶⁶ Jackson G, Thornley S, Woolston J, Papa D, Bernacchi A, Moore T. Reduced acute hospitalisation with the healthy housing programme. *J Epidemiol Community Health* 2011;65:588-593.

⁶⁷ Howden-Chapman P. Effects of improved home heating on asthma in community dwelling children: randomised controlled trial. *BMJ* 2008; 337:a1411 doi: 10.1136/bmj.a1411

⁶⁸ Jackson C. *Perinatal Mortality in Counties Manukau DHB*. Manukau City: Counties Manukau District Health Board; 2011.

The NZCPHM recommends that all smoking cessation and prevention initiatives be reviewed for their effectiveness for Māori.

- **High-Risk Alcohol Use:** Heavy alcohol use in parents is associated with an increased risk of child abuse and neglect, childhood experience of intimate partner violence, behavioural, emotional and learning problems, and heavy alcohol use in adolescents.^{70 71 72} Access to alcohol is higher in local areas that are socio-economically deprived compared with more affluent ones.⁷³ The NZCPHM supports local alcohol policies.⁷⁴
- **Family Violence:** Children who live with family violence are at increased risk of being exposed to traumatic events, being neglected or abused, losing one or both of their parents, behavioural, social, and emotional problems, poor school performance, limited problem solving skills, pro-violence attitudes, and reduced odds of receiving appropriate well-child and primary health care.^{75 76 77} A survey of New Zealand secondary school students suggests that experience of violence within the home is increasing.⁷⁸
- **Overweight and Obesity:** Obesity is associated with a wide range of poor health outcomes including heart disease, stroke, diabetes, and stillbirth.^{79 80} Obesity in childhood is strongly linked to the risk of obesity during a child's adult years.⁸¹ The drivers of overweight and obesity in children are complex and are related to eating behaviours, dietary intake, access to food options, levels of physical activity, and family, school, and

⁶⁹ Craig E, McDonald G, Reddington A, and A Wicken. 2009. *The Determinants of Health for Children and Young People in Auckland DHB*. New Zealand Child and Youth Epidemiology Service.

⁷⁰ CASA. (1999) No Safe Haven: Children of Substance-Abusing Parents. A report from the National Center on Addiction and Substance Abuse, (CASA) Columbia University.

⁷¹ Kumpfer K. (1999) Outcome Measures of Interventions in the Study of Children of Substance-Abusing Parents. *Pediatrics*. Supplement. 103(5):1128-1144

⁷² Lay W and Rutherford D. (2003) Alcohol Problems in the Family. A joint EU report from EURO CARE and COFACE. www.eurocare.org/content/download/1902/9677/.../1/.../familyen.pdf

⁷³ ARPHS Auckland (Local Board and Ward) Council Data (2010). Accessible at: <http://www.arphs.govt.nz/downloads/Auckland%20Council%20Demog%20and%20Access.doc>

⁷⁴ Assuming the Alcohol Reform Bill is enacted in its current form.

⁷⁵ US Department of Health and Human Services. Domestic Violence and the Child Welfare System. Available from: <http://www.childwelfare.gov/pubs/factsheets/domesticviolence.cfm>

⁷⁶ Carlson E. Children Exposed to Intimate Partner Violence : Research Findings and Implications for Intervention. *Trauma Violence Abuse* 2000 1: 321

⁷⁷ Bair-Merritt M, Crowne S, Burrell L, et al. Impact of Intimate Partner Violence on Children's Well-Child Care and Medical Home. *Pediatrics* 2008;121:e473

⁷⁸ The proportion of students who reported witnessing adults physically hitting or hurting each other in the home almost doubled from 5.6% in 2001 to 10.4% in 2007. See: Clark TC, Robinson E, Crengle S, et al (2009). *Youth'07: The Health and Wellbeing of Secondary School Students in New Zealand. Findings on Young People and Violence*. Auckland, New Zealand: The University of Auckland, Adolescent Health Research Group.

⁷⁹ Ministry of Health and the University of Auckland, *Nutrition and the Burden of Disease: New Zealand 1997-2011*. 2003, Ministry of Health: Wellington.

⁸⁰ Flenady V, Koopmans L, Middleton P, et al. Major risk factors for stillbirth in high-income countries: a systematic review and meta-analysis. *Lancet*. Apr 16 2011;377(9774):1331-1340.

⁸¹ Whitaker, R., et al., Predicting Obesity in Young Adulthood from Childhood and Parental Obesity. *New England Journal of Medicine*, 1997. 337(13): p. 869-873.

community environments.⁸² The NZCPHM urges particular attention to be paid to equity for Māori children and their whānau and to the security of healthy and affordable foods. Evidence based initiatives supported by the NZCPHM include pricing strategies to promote the purchase of fruit, vegetables and low-fat snacks in schools and low income communities,^{83 84 85} the reduction in TV advertising of high fat and/or high sugar foods and drinks to children,⁸⁶ and the development and implementation of multi-faceted school-based programmes with an active physical education component.⁸⁷

- **Early Childhood Education:** Early childhood education has been shown to contribute to prevention of maltreatment⁸⁸ in addition to improved achievement at school, increased economic wellbeing in adulthood, including reduced reliance on the State, and to be cost-effective.⁸⁹ The NZCPHM supports the provision of universal early childhood education.
- **Access to Primary Health Care:** The NZCPHM supports the provision of free primary care during pregnancy and early childhood including free prescriptions. In 2011, 13% of children less than six years old did not have access to free GP services during the daytime.⁹⁰ The parents of 3.5% of babies in the Growing Up in New Zealand study (equivalent to 2,300 babies nationally) reported difficulties paying for medical care and 3.3% could not afford to pick up medicines that had been prescribed.⁹¹

⁸² Craig E, McDonald G, Reddington A, et al. (2010) The Health of Children and Young People with Chronic Conditions and Disabilities in Auckland DHB. New Zealand Child and Youth Epidemiology Service.

⁸³ French S, Jeffrey R, Story M, et al. 1997. A pricing strategy to promote low fat snack choices through vending machines. *American Journal of Public Health* 87: 849–51

⁸⁴ French S, Story M, Jeffrey R, et al. 1997. Pricing strategy to promote fruit and vegetable purchase in high school cafeterias. *Journal of the American Dietetic Association* 97: 1008–10

⁸⁵ Jeffrey R, French S, Raether C, et al. 1994. An environmental intervention to increase fruit and salad purchases in a cafeteria. *Preventative Medicine* 23: 788–92.

⁸⁶ Haby MM et al. A new approach to assessing the health benefit from obesity interventions in children and adolescents: The assessing cost-effectiveness in obesity project. *International Journal of Obesity (London)*, 2006,30(10):1463–1475.

⁸⁷ Ibid

⁸⁸ C Mikton, A Butchart. *Child maltreatment prevention: a systematic review of reviews*. Bull World Health Organ, 87. 2009. pp. 353–361

⁸⁹ Schweinhart, L. J. *The High/Scope Perry Preschool study through age 40: Summary conclusions and frequently asked questions*. 2004. Ypsilanti, MI: High/Scope Educational Research Foundation.
<http://www.peelearlyyears.com/pdf/Research/INTERNATIONAL%20Early%20Years/Perry%20Project.pdf>

⁹⁰ Tony Ryall. Free after-hours care for under six-year-olds. Media Release. <http://www.beehive.govt.nz/release/free-after-hours-care-under-six-year-olds> Retrieved 27 October 2011

⁹¹ Morton S, Atatoa Carr P, Grant C, et al. (2012) Growing Up in New Zealand: a longitudinal study of New Zealand Children and their families. Report 2: Now we are born. Auckland: Growing Up in New Zealand

Conclusions

48. The NZCPHM welcomes the Inquiry and thanks the Committee for the opportunity to comment.
49. Society should ensure that children have access to enough food, clothing, adequate shelter, health care and the learning experiences and opportunities to develop their full potential. While parents and caregivers have a primary responsibility, they need financial and other support to equip them to provide these essentials for their children.⁹²
50. The NZCPHM considers New Zealand's children to be precious taonga and the most important economic resource for building a better future. The high number of children that continue to be impacted by poverty, deprivation, abuse, and neglect show that as a society we are collectively failing those who most need our protection and care. In New Zealand, these children are more likely to be Māori or Pacific. Children do not choose the circumstance of birth, and the significant advantage some children receive purely as a consequence of the birth lottery is inequitable. All children have a right to thrive, achieve and belong, and to reach their potential. We could and must do better.

⁹² Fletcher M and Dwyer M (2008) A fair go for all children. Actions to address child poverty in New Zealand. Children's Commissioner and Barnardos.