Giving children the best health care possible

SUBMISSION ON THE UPDATE OF THE NEW ZEALAND HEALTH STRATEGY

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Health care for children is not just an investment in their wellbeing.

It is a sound investment in the future of our nation.

The Children's Commissioner has a legislative mandate to advocate for children. All children have the right to the best health care possible. This submission endorses the direction of the proposed New Zealand Health Strategy, and provides advice on how it can be made more concrete and how a more child-centred focus can be applied to improve health outcomes for all.

SUMMARY

I endorse the general direction of the draft Health strategy. I am particularly pleased to see the emphasis on children and families in Action Area 6, on improving equity of outcomes, the investment approach, improved collaboration between primary and secondary care, and Health taking its role in supporting other Ministries to achieve their goals. I am pleased to see support for, or plans to grow, existing programmes and approaches, e.g. clinical networks, Well Child/ Tamariki Ora, Patient Portals and the integrated maternity record.

This submission suggests ways to strengthen the principles, in particular to improve outcomes for children. I suggest ways the Ministry of Health can support other Ministries to achieve their goals and patient groups that could be prioritised for investment.

I would particularly like to see more work done on Action 16a, developing a system-wide leadership and talent management programme, drawing on the experience of the United Kingdom's National Health Service Leadership Academy and Harvard School of Public Health. I believe this will be a critical investment, without which most initiatives will fail to achieve their potential.

BEST HEALTH CARE POSSIBLE FOR ALL CHILDREN – A GOOD START TO LIFE

The New Zealand Health Strategy goal – that all New Zealanders live well, stay well, get well –depends on a good start in life. A healthy start can be supported through pre-natal education and care, safe births, parenting skills, good nutrition and early child health and disability support.

Investing in children's health has benefits later in life and supports the preventative health care approach evident in this strategy. It is also important that children are prioritised as they do not make their own lifestyle decisions and are vulnerable to the situation into which they are born. A focus on children living in deprived areas and those with disabilities will contribute to more equitable outcomes.

Investing in children produces greater return on investment through positive long-term outcomes[1]. An investment approach focused on children and their carers will have substantial gains for the health system, children and society.

Make the principles more concrete

The principles broadly cover all the areas that a well-designed strategy would need to include. However, the strategy would benefit from a greater recognition of the centrality of children. We recommend principles 1 or 2 should explicitly include a child-centred principle. For example Principle 1 could read, "The best health and wellbeing for all New Zealanders from before conception, through childhood to old age."

[1] www.occ.org.nz/assets/Publications/Choose-Kids-Why-investing-in-children-benefits-all-New-Zealanders-OCC-2.pdf

I also recommend that principle 4 should have a clearer focus on the unique relationship between tangata whenua and the Crown under the Treaty of Waitangi. I suggest the focus of principle 4 should be greater than simply "acknowledging" this relationship, and focus on how it will demonstrate commitment to the Treaty.

Māori children (as well as Pacific children) are less likely to access health care early, and tend to have worse outcomes across all measures. The strategy could give effect to the Treaty by explicitly targeting more equitable health outcomes for Māori. This could be a specific Action, or a theme across all Actions, with a specific Maori and Pacific section for each, that would aim to address inequities shared by these groups. For example Action 3 could include greater cultural capability across service providers, or practical supports that help people make it to appointments. There needs to be a greater focus on making the health system more accessible to disadvantaged families.

Action 8 should specifically require services to dis-aggregate data by ethnicity and report on differences. We recommend their performance reporting should include their plans to reduce inequitable outcomes. Such actions would implement Principle 4 more tangibly.

Having a shared definition of 'at-risk children'

The strategy aims to improve the health and social outcomes for all children, particularly those 'at risk'. However there does not appear to be a definition of 'at risk' and this is an area that requires a shared understanding.

I suggest the Ministry of Health uses the Children's Action Plan definition of vulnerable children; "Vulnerable children are children who are at significant risk of harm to their wellbeing now and into the future, as a consequence of the environment in which they are being raised, and in some cases, due to their own complex needs. Environmental factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in their wider community". (White Paper for Vulnerable Children, Vol 1, p6.)

For example, I recommend that children in care of the State be included in those 'at risk'. Many of these children have severe behavioural and learning difficulties, with conduct disorder, depression, post-traumatic stress disorder, alcohol and drug addiction and other mental illnesses. They also suffer poor dental health and other illnesses with a social gradient. Having children in 'care' of the State means the government is *responsible* for those children's health and education outcomes, as if it were a parent. Currently, children in care of the State do not get access to services they need because even if their carers recognise that they need help, they often miss out on therapeutic treatments, or remain on waiting lists without targeted or preferential treatment. However, parents of other children can choose providers, and get treatment through stronger advocacy or paying. Mental health services for children in State care, in particular, should be a priority of the Government.

Note this definition also requires the Ministry of Health to prioritise parents and caregivers of children, where their illness or disability impacts on children, for example children of parents with mental illness and addictions (COMPIA).

The work currently underway across government, including the Ministry of Social Development, to identify the numbers of children suffering material deprivation may also usefully contribute to the definitions of children 'at-risk'.

A more joined-up, prioritised set of actions

A great start for children, families and whānau (Action 6)

The initiatives listed in Action 6, while all valid and important areas of preventative health-care, seem somewhat dis-jointed. I recommend that this set of initiatives be prefaced with outcome statements about 'what a great start looks like', to help identify the most important initiatives more strategically. In Annex 1 I have suggested an 'example' list of such outcome statements that would support Action 6.

Parents need greater support to bring up healthy children

A key gap in the Well Child/ Tamariki Ora (WCTO) supports for new born babies and

All parents benefit from education on parenting skills.

Those at greater risk need more focused intervention.

their parents is parenting education and behavioural supports. Currently, the role of health in parent support is largely limited to WCTO visits and the B4School health and development check.

WCTO services need to be expanded to include universal parenting and behavioural education and supports, and they need to be delivered in culturally relevant ways to reach *all* babies and toddlers. All parents benefit from education on parenting skills, while more focused intervention is needed for those at greater risk. The Triple P Programme is an example.

Preventative health-care should begin at least from birth. Breast-fed babies have more resilient immune systems and metabolisms, supporting healthier bodies during childhood. However, there is no mention of breastfeeding in the strategy.

People with adequate understanding of childhood development and, critically, tools for managing child behaviour, are less likely to be controlling, abusive or neglectful. They are more likely to provide opportunities for children to learn about safety, to participate in sport, to control their eating, and to learn positive self-esteem and about healthy relationships.

Broaden the focus from children of offenders to those of all vulnerable families

There is a focus on connecting to health care services the 'children and families of offenders' [Action 6 (f)]. While this is certainly a key population group, it seems odd to prioritise this group over other vulnerable children or to not link it to the Government's other work on vulnerable children, e.g., children of parents with mental illness, addictions, family violence, low IQ, teen parents, those with low incomes, welfare dependency and poor family supports.

If the vision were to '*connect vulnerable families to health services*', then one initiative to start on could be the children and families of offenders. It may be an existing initiative that is ideal for implementation in the first five years of the strategy, simply because it is currently being progressed.

The Ministry may wish to consult with the Ministry of Social Development on how it could add value to the Children's Action Plan, which is not yet referenced in the Update of the New Zealand Health Strategy.

Support for the Ministry of Education's strategy for at-risk 15-24 year-olds (Action 6 e ii)

Now is a good time to prioritise access to health and social services for at-risk young people, improve the quality and accessibility of care to these young people and integration of mental, sexual and general health services, education and social services for this group. The literature suggests that integrated Youth One Stop Shops are a powerful way to achieve these goals.

There is an urgent need to fill the gap between all learning disabilities and mental health care. The action relating to a better response to children and families living with foetal alcohol spectrum disorders (FASD) is very important and overdue. We recommend that the work on FASD proceed urgently with adequate supports.

Issues faced by FASD children also affect children with other spectrum disorders, such as Learning Disability, Autism Spectrum Disorder and Attachment Disorders, which carry higher risks of mental illness and lifelong disability. Investing in early diagnosis and post-diagnosis support can reduce the risk of poor educational outcomes, mental illness, welfare dependency and crime in these children. Currently access to diagnosis and post-diagnosis support for children with these conditions is highly variable.

'People-power' does not work for children without adequate parental support

I agree that the system should understand people's needs, help them in making healthy choices, and involve them in designing health services that meet their needs. Patient-centred booking of appointments and Patient Portals are good examples.

However these initiatives are rarely relevant to children. Children do not understand their own needs, or make their own health choices, and are often side-lined in consultations on service design. Children rarely have the capacity to take power over their access to the healthcare they need, and younger children are unlikely to participate directly in the

proposed technological access to health records (e.g. through mobile devices).

A way to empower children through the health system would be to actively seek their views on how they want to receive services, how they would like to navigate the system and make complaints, or what they need for their advocacy. We have developed advice on how to consult with children on our website: Listening2Kids[2]. This can support *Action 2 – Promoting people-led service design*.

I recommend a specific action in Action 2 to require DHBs to consult with children in the design and evaluation of health services. Improvements that work for children (such as use of plain English) will make the system more accessible to children, young people and for other disadvantaged people too.

A people-focused system will be beneficial for New Zealanders but there are trade-offs

The strategy discusses the need to apply an investment approach and help people to make their own healthy decisions. A preventative health care approach is seen as the only affordable way to a healthier future.

This may be true, but the public needs to adjust to this strategic shift. How will the Ministry of Health manage the public conversation on the trade-offs?

Funding, treatments, therapies and medicines are currently applied to those who are most ill, even if patients are less likely to respond well due to advanced illness. Such prioritisation is inconsistent with an investment approach. In contrast, investing earlier in the life of a problem may enable patients to respond more fully to treatment, become well and productive again.

Investment to enable a better start in life – through a greater focus on early childhood – can be afforded more easily when investment is directed where it can have the most impact. This will require a conversation about what constitutes appropriate and timely health care and how those investment decisions are determined.

[2] www.occ.org.nz/listening2kids

BUILD LEADERSHIP, TALENT AND WORKFORCE (ACTION 16)

Quality of care, patient outcomes and success in implementing new initiatives are strongly correlated with the depth of leadership and management ability within health services. I believe the success of the Strategy will largely depend on the effectiveness of implementing this Action, in particular 16a, developing a system-wide leadership and talent management programme.

The international experience is that leadership development in Health requires specific training in health service leadership and management. Health leadership and management training is delivered in different ways internationally, e.g., the NHS Leadership Academy and Harvard School of Public Health. Both are partnerships between health services, academics in health, leadership and management and private enterprise.

I recommend Ministry staff be sent to review these programmes and report back.

WILL THE STRATEGY BE ENOUGH TO DELIVER BETTER HEALTH OUTCOMES FOR ALL?

The Ministry's role in addressing the determinants of health is largely unaddressed in the draft Strategy. The Ministry has a fundamental role to engage with other Ministries and Ministers to explain the impact of determinants of health and social outcomes such as income inequality and poverty, crowding and low-quality housing, family violence, easy access to very low-priced alcohol, sugary soft drinks and poor urban planning. There is a significant social gradient to most health outcomes for children (see the Child Poverty Monitor Technical Report, www.nzchildren.co.nz). These issues will persist in the health sector unless child poverty is also addressed.

Similarly, the initiatives in the Obesity Plan are likely to have limited impact until consumption of calorie-dense, low nutritional value food and drinks is significantly reduced

There is a significant social gradient to most health outcomes.

Investment in children can mitigate the effects of poverty and result in a healthier, more productive population over time

by addressing access, pricing and direct marketing of these products to children.

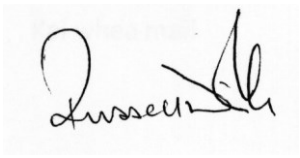
Investment in children can mitigate the effects of poverty and result in a healthier, more productive population over time. Preventative health – particularly lifestyle and dietary health messages – have their greatest impact on receptive children who are most at-risk of poor health outcomes. This includes those with disabilities, and those in low income families, poor housing, and deprived areas.

In conjunction with parenting supports, improving vulnerable children's health and cognitive development will also improve the return on investment in education. Better education outcomes lead to higher incomes – an important route to raising families out of poverty and improving health in the next generation.

Children deserve health and wellbeing in their own right, not just because they are potentially productive 'adults-in-waiting.'

New Zealand is a signatory to the United Nations Convention on the Rights of the Child, which states that all children have the right to the best health care possible (Article 24) and may not be discriminated against (Article 2). The Government therefore has a global responsibility to fulfil its promise on page 38 of the Update of the New Zealand Health Strategy: "to improve and make more equitable the health and social outcomes for all children, families and whānau, particularly those at risk."

I appreciate the opportunity to make this submission to promote the best health care possible for *all* the children of New Zealand.



Dr Russell Wills
Children's Commissioner

ANNEX 1 EXAMPLE OUTCOME STATEMENTS FOR ACTION 6

Action 6 A great start for children, families and whānau

What 'a great start' looks like	*Initial initiatives in roadmap*
Seamless and collaborative Government policy results in more equitable health and social outcomes of all people.	The Ministry of Health will continue to collaborate across government agencies, using social investment and life-course approaches, to improve and make more equitable the health and social outcomes for all children, families and whānau, particularly those at risk.
All women have healthy pregnancies and good postnatal health, including support for mental health issues.	a. Increase support to pregnant and postnatal women experiencing mental health and alcohol and other drug conditions.
All women have healthy pregnancies and good postnatal health including support to make healthy choices.	b. Promote healthy nutrition and activity for pregnant women and children to reduce the prevalence of childhood and adult obesity.
All women have healthy pregnancies and good postnatal health, focusing on babies growing up in positive environments.	c. Support families, especially those with new born babies, to have healthy housing (warm, dry and smoke-free) and address crowding issues, to reduce transmission of infectious diseases and family stress.
Health and Education collaborate to ensure healthy pre-school development.	d. Improve collaboration between early childhood services and health services for pre-schoolers to improve early childhood education attendance and better address unmet health and development needs.
Health and Education collaborate to ensure healthy school-age development of children and young people.	e. Be a strong participant in the Government's programme of work to improve social outcomes for children and young people, with initial focus on:
	i. leading the Government's programme of work to ensure all children, at the age of six, turn up to school regularly, are ready to learn, are well fed and healthy, and live in a safe and nurturing environment
	ii. supporting Ministry of Education's lead on the Government's strategy for at-risk 15- to 24-year-olds, which includes working towards improved health outcomes for these young people.
Vulnerable families access health services in a timely manner.	f. Connect children and families of offenders to health services.
Family and sexual violence is avoided through positive programmes across society and support for young people to have healthy relationships.	g. Work with the Accident Compensation Corporation and other partners to build on a range of programmes that support young people to make healthy relationship choices with the aim of reducing the incidence of sexual and family violence in the future.
All children with learning disabilities and behavioural problems on a spectrum receive the support needed*	h. Lead the development of a plan to improve the health system's response to children and families who are living with foetal alcohol spectrum disorders.

* Needed, for example, to i) reduce the risk of mental illness in the children or their families, and ii) enable children to develop to their full potential.