New Zealand Nurses Organisation

Submission to the Health Select Committee

On the

Inquiry into Preventing Child Abuse and Improving Child Health Outcomes

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Inquiries to: Marilyn Head
Policy Analyst
NZNO
PO Box 2128, Wellington
Phone: 04 4999 533 DDI: 494 6372
Email: policyanalysts@nzno.org.nz

ABOUT NZNO

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 46 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to contribute to the inquiry into preventing child abuse and improving child health outcomes.

2. NZNO has drawn on the extensive consultation we undertook with all member groups and our professional nursing, research, policy, legal and industrial advisers in response to the government's *Green Paper on Vulnerable Children* and the Māori Affairs Committee *Inquiry into the Determinants of Wellbeing for Māori Children,* both of which cover similar territory.

3. NZNO's submissions on both are publicly available from our website and we refer you to them for the evidence and rationale for recommendations summarised in this document.

4. We also refer you to our 2011 Election Manifesto, particularly the chapters on *Universal Primary Health Care*, and *Social and Health Equity*, which similarly present compelling evidence for addressing the social determinants of health and ensuring access to primary health care (PHC) as the most cost effective means of improving child health.

DISCUSSION

5. NZNO commends the Committee for seeking practical advice in addressing the needs of tamariki[1], in order to reverse child health statistics which are among the worst, and most inequitable in the OECD (Ministry of Health, 2012).
6. We support a particular focus on the formative first three years of life, and note that that requires strengthening families and ensuring the wellbeing of parents, whānau and communities.
7. Reducing opportunities for Adult Continuing Education and Early Childhood Education, and not considering the extension of paid parental leave are contrary to what is needed to engage and enable people to develop resilient families and cohesive communities.
8. Programmes such as the recently piloted Plunket Well Child Programme for Young Parents, the evaluation of which is imminent, which are aimed at engaging not only parents and children, but also health and other professionals and the wider community, generally have a high degree of success and should be supported.

[1] As is consistent with the Treaty of Waitangi and the equal status of Māori and English as official languages for Aotearoa New Zealand, this document uses tamariki and children, and Aotearoa and New Zealand interchangeably.

9. Similarly ensuring regular free*, accessible and culturally appropriate* opportunities for contact and consultation with health, social and other agencies is a cost effective way of preventing abuse and enhancing health.
10. NZNO has repeatedly drawn the Committee's attention to the under utilisation of the nursing workforce in ensuring all New Zealanders have access to primary health care, currently denied to many because it is mediated through private GP practice which is unaffordable, inaccessible, and occasionally culturally appropriate to some.
11. The evidence is unequivocal - universal access to PHC is the most cost effective and humane way to manage health demand. While improved access to after hours care and GP visits have been useful, the sole focus on the medical model is inappropriate in today's environment where the requirement is for better management of health as well as addressing disease.
12. This is the province of nursing whose focus is on optimising health within a holistic framework that encompasses *'te whare tapa whā'* concept of health - physical, mental, spiritual and whānau/community - and who are also trained and educated refer appropriately. Effective utilisation of nurses, especially nurse practitioners (NPs) and experienced and skilled specialist nurses with those with approved expanded scopes of practices, would enable a more flexible workforce able to respond to the needs of New Zealand children and families.
13. We strongly recommend more nurse -led and mobile clinics in areas, and at times, that are convenient to the communities they serve. This will require changing some funding pathways.

Preventing Child Abuse

14. NZNO takes this opportunity to validate the Crimes (Substituted Section 59) Amendment Act 2007 which removed the legal defence of "reasonable force" for parents prosecuted for assault on their children. We believe this was the

first practical step towards preventing child abuse, sending, as it does, the unambiguous message that "children are unbeatable".

15. While mandatory reporting and shared information are current foci of proposals to prevent child abuse, and though there is room for better linkages between maternity and child health services, NZNO believes that in general, the problem is not lack of information, individual and/or systemic failure or inability to act, primarily because of lack of resources.

16. Child abuse is not limited by culture, ethnicity, education, or financial resources, nor is it attributable to one cause. Solutions must therefore be holistic and aimed at improving the 'soil' in which children grow.

17. Overflowing prisons testify to the repeated failure not just of parents, but of whānau, communities, and government and other agencies including health agencies. It is abusive to allow children to grow up without their physical, intellectual, emotional and health needs being met.

18. Child poverty is unacceptable.

Public health

19. Alcohol and tobacco continue to be the most pernicious causes of abuse and ill health, respectively, with children the innocent victims. More stringent measures to prevent/address alcohol abuse - particularly fetal alcohol spectrum disorder (FASD) - and to deter smoking would effect significant improvements in health.

20. Similarly, well proven cost-effective public health measures such as statutory regulation for fluoridated water supplies (Wright, 1999) and folate-enriched flour are essential: children do not have a 'choice' about tooth decay or neural tube defects. In this context, we note the excellent result from the mandatory fortification of bread through replacement of plain salt with iodised salt that appears to have addressed the prevalence of mild to moderate iodine deficiency in the 2002 National Children's Nutrition Survey (Edmonds, 2012). Iodine deficiency, irreversible at the developmental stage of health, can lead

to detrimental health outcomes throughout all life stages and include impaired mental development, congenital abnormalities, hypothyroidism, cretinism and goiter. It is impossible to quantify the effect that this decisive intervention action has had, and will continue to have, on the health of New Zealanders.

Housing

21. There are many factors determining the health status of New Zealanders, but we would particularly like to draw the Committee's attention to the dominant effect of housing, noted in our submission on the Productivity Commission's Housing Affordability Issues paper (NZNO, 2011).

> *Housing tenure and quality is inextricably linked to health. Health determines the capacity and timeframe of workforce participation, and is thus a fundamental factor of productivity as well as health and wellbeing. Rented housing is associated with lower incomes and poorer health (Blane, 2000; Mitchell, 2002), while poor quality housing is a key contributor to health inequalities (Howden Chapman, 2011).*
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> *There is abundant evidence linking poor quality housing with asthma and other respiratory diseases (Howden Chapman, 2008); serious communicable diseases such as meningitis (Baker, 2000); and increased diastolic and systolic blood pressure (Mitchell, 2002). Aotearoa's unprecedented levels of rheumatic fever, particularly for Māori and Pacific peoples (Jaine, 2008), are just one indication of the overcrowded, cold and unsanitary conditions that many families are living in. This easily preventable third world disease which carries a lifetime sentence of impaired health is a disease not of poverty but, in this country, of willful neglect of fit and proper building and housing regulations and inspection.*
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> *Preventable hospital admissions were estimated at over 31% of all admissions costing $97 million in 2003, and the latest Ministry of Health figures indicate that level has risen by 3.4%.*

22. Government spending of $24 million to combat rheumatic fever in children could be rendered ineffectual, unless the housing issues which cause it are addressed.

RECOMMENDATIONS

23. Accordingly, NZNO offers the following **recommendations** which include those made in response to the government's *Green Paper on Vulnerable Children* and the Māori Affairs Committee *Inquiry into the Determinants of Wellbeing for Māori Children* and suggests that you:

- **agree** that any child policy must be inclusive of all children;
- **agree** to undertake a stock take of existing programmes and services, how these have been evaluated and their effectiveness in different communities;
- **agree** that solutions require a multi-agency/service/professional/ community approach;
- **agree** that approaches to working with vulnerable children be based around a Whānau Ora model;
- **agree** to reach cross party agreement from all political parties on approaches to child health and well-being including levels of funding and commitment to long-term outcomes;
- **agree** to appoint a full time nurse in every New Zealand school and early childhood centre;
- **agree** that the government has a fundamental responsibility to provide a baseline social system and structure to support all tamariki to grow and develop safely, and to demonstrate leadership in the support of children;
- **agree** to ensure that all services are culturally and clinically appropriate, accessible and available to all tamariki;
- **agree** to make children central to decision making for all ministers so any decision has to pass the "is it good for children test";

- **agree** to appoint a minister with the mandate to ensure implementation of a children's action plan;
- **agree** to lead change in societal attitudes and behaviour toward marginalised groups and populations;
- **agree** to improve funding and support to existing and demonstrably effective well child tamariki ora providers including Plunket, Iwi and Pacific providers;
- **agree** to provide ongoing and sustainable funding to support evidence-based and demonstrably effective programmes that support tamariki and their families whānau, for example the Victory Community Health Centre;
- **agree** to address the social determinants of health such as poor housing and low incomes as this will have the greatest impact of any intervention on improving outcomes for children;
- **note** our support for a children's action plan, associated legislative change and the establishment of a working group to develop this;
- **agree** to develop a national database of all children to keep track of all interventions and outcomes;
- **note** our support for an evidence-based approach to piloting and independent evaluating of those programmes and services that have been proven to be effective overseas for their suitability in New Zealand;
- **note** our support for independent evaluation of programmes and services that are home-grown and show promise;
- **note** our support for the Public Health Advisory Committee report that leadership for whānau ora should run throughout all services, not just Māori specific services;
- **agree** that funding for new programmes should not be at the expense of effective existing child programmes;
- **note** our support for increased funding for evidence-based early intervention programmes;
- **note** our support for a 'child first' policy;

- **agree** that all children being placed in care receive a timely health check with a registered health professional and are enrolled with a local health provider;
- **agree** that the government must take responsibility for failing to keep tamariki in care safe;
- **note** our support for mandatory information sharing between social, health and education agencies;
- **note** our support for the development and implementation of a set of common principles and standards to guide those working with tamariki;
- **agree** to implement multi-disciplinary training and education for all practitioners working with children across sectors;
- **agree** that bicultural training be made mandatory for all overseas registered health professionals who wish to practice in New Zealand health sector;
- **agree** to ensure education of frontline staff on the delivery of culturally and clinically appropriate service delivery for tamariki – in particular cultural safety training for all frontline staff in all government agencies;
- **agree** that all professionals working with children should hold mandatory registration and take part in government funded professional/clinical supervision;
- **note** our support for the co-location of nursing services within frontline social service facilities;
- **agree** that the pay parity campaign for Māori and Iwi providers working in primary health care – Te Rau Kōkiri – be urgently addressed;
- **note** that we strongly agree Tamariki ora service delivery is not just the responsibility of Māori health providers, but the responsibility of all health providers, including Plunket, GP services and every other primary health care service and who should be able to reach 'those that are deemed hardest to reach';

- **note** that we strongly recommend that bicultural training be made mandatory for all overseas registered health professional who wish to practice in New Zealand health sector;
- **agree** to address the pay parity campaign Te Rau Kōkiri that continues for Māori and Iwi providers working in Primary Health Care ;
- **note** the specific examples of other structural or systems barriers that have impede the care that they have delivered to tamariki and their whānau which include: greater importance placed on smoking health targets, than focused on the health needs of client or whānau; inability to access key agency services for at risk clients afterhours, people related services need to be available 24/7 not just Monday to Friday 9-5pm; inappropriate resourcing of services for pregnant mothers, with mental health issues; no proactive services to support mother and baby, having to wait for 'crisis' to intervene in welfare of mother and baby; and role confusion, losing trusting relationships with patient when they see you not as the nurse but as 'the policeman', when reporting becomes a priority over practical solutions.

Marilyn Head

Policy Analyst

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