Maternal and Child Health Promotion Service Review

Submission to the Ministry of Health

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on Maternal and Child Health Promotion Service Review ('the Review').

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members the College of child and Youth Nurses, Women's Section, College of Primary Health Care, and our professional nursing, research and policy advisers.

3. In general, the Review was very well received by members, who found it comprehensive and useful. We welcome the proposal to use funding to establish a nationally-focussed maternal and child health promotion (MCHP) service and build health promotion capability within existing maternal and child health services.

4. We have included comments on the text in our responses to the consultation questions below, which we hope will be useful.

5. NZNO supports the Review and **recommends** that in reviewing the Maternal and Child Health Promotion (MCHP) Service you consider:

    - a bicultural service title that includes te Reo Māori;
    - the regulatory environment that is needed to support evidence-based health promotion services;

- encompassing preplanning for pregnancy;
- alternative and additional population health indicators;
- the limitations of SUDI and obesity as indicators of maternal and child health;
- community and workforce resourcing; and
- utilising the enabling framework of the HPCAA to drive the development of comprehensive, innovative and effective health promotion within existing maternal and child health services. consultation questions

Question 1

Are there any other issues with the current issues with the current MCHP services to consider?

6. While the name change/definition may seek to clarify that the service "is a health promotion service, not necessarily a service that promotes Well Child Tamariki Ora services", we are disappointed that the opportunity has not been taken to include **te Reo Māori** in the title, consistent with obligations under te Tiriti o Waitangi.

7. Moreover a distinct Māori MHCP focus is relevant given higher birth-rates and lower maternal age for Māori. We also note that of the 13 current providers listed on p24, all except one incorporate te Reo Māori or imply delivery of services to Pacifika fono.

8. We question whether they or their users will identify as strongly with the unremittingly generic and eurocentric title of Maternal and Child Health Promotion Services, for a service specifically directed towards mothers and children in Aotearoa New Zealand. We suggest a bicultural title would signal, at least nominally, that people could expect services to uphold and prioritise:

    - "a logistic view of health reflective of Māori and Pacific perspectives;
    - the Treaty principles of partnership protection and participation;
    - culturally tailored and responsive activities; and a
    - strengths-based approach to community engagement." (Review p11)

9. We agree that there is an issue with *Service Reach* and that geographic inequities are significant. Nurses working in Well Child

Tamariki Ora services in the South Island noted they were unaware of the purchase of specific Well Child Promotion services before reading the document, and were somewhat confused by the "rebranding of health promotion activity" and aspects of the review consultation which they assumed were already established.

10. Similarly that a comprehensive review of the evidence, outcomes and objectives of purchasing for child health promotion services is well overdue.

11. However, we suggest that there is no point reviewing or purchasing services to provide *evidence-based* health promotion messages if those messages are swamped and undermined by an environment promoting the opposite. Issues around **regulation** need to be considered.

12. Over the past few years the government has chosen not to regulate in critical areas where the evidence has been uncontested and overwhelming eg folate fortification of flour, sunbeds, alcohol reform, including advertising and promotion of alcohol, plain packaging of tobacco products, fluoridation, soft-drinks, paid parental leave to support WHO recommended guidelines for breastfeeding[1] etc.

13. The Review should identify key aspects of the current and potential regulatory environment necessary to underpin and reinforce evidence-based health promotion messages and ensure a healthy environment that enhances maternal and child health.

14. In terms of *strategic fit*, integration and consistency across government departments, as well as within the Ministry of Health need to be considered in terms of coherent action, not just high-level policy statements.

15. For example, while we recognise the development of an overarching maternal and child health strategy, we note that despite the plethora and promises of 'cross government' initiatives on child health, particularly those arising from the Vulnerable Children's Act 2014, the result of interagency collaboration and activity directed by the Children's Action Plan Directorate on nurses' work has largely been an

[1] See NZNO's submission on Parental Leave and Employment Protection (six months leave and work contact hours) Amendment Bill retrieved January 2016 http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2015-11%20PPL_Emplymt%20protectn%20(6%20mths%20contact%20hours)%20Amdmt%20Bill_NZNO%20.pdf

increase in work and compliance, with no increase in training or resourcing.

16. Maternal and Child Health Promotion must be part of an overall strategy on health literacy and must be resourced accordingly.

17. We suggest that the population health/ ecological model which is somewhat isolated in the document, could be expanded on and used to underpin the theoretical model guiding the document. This concept is defined and more fully explored in the recently published Australasian text C*ommunity Health and Wellness: primary care in the community* (McMurray & Clendon, 2014) which we recommend to your attention, and by the World Health Organisation. NZNO's position statement on Interpersonal Violence[2] may also be of interest.

18. We agree that services need to be adaptable and responsive to change, and are confident that the enabling framework of the Health Practitioners Competence Assurance Act 2003 (HPCAA) provides the appropriate workforce to assure safe, flexible and high quality services, including the ability to promote maternal and child health.

19. Workforce *capacity,* however, is an issue in all health services and should be part of the Review's resourcing consideration.

Question 2

Do you agree with the list of priority issue areas? Are there any other issue areas?

20. Firstly, in terms of scope, we believe that a focus on **preconception**, the approach taken by the Health Committee in their 2013 Inquiry on child health outcomes, which you have referenced (Health Committee, 2013), is absolutely essential.

21. We strongly recommend that preplanning for pregnancy be an identified priority for maternal and child health promotion services. Indicators could include nationwide access to family planning and sexual health services; lowered abortion rates.

22. In general, the priority areas are clear and well supported.

23. In addition to the above recommendation on preconception, nurses suggested the need for family violence screening and for GP/Nurse

[2] NZNO Practice Guideline on Interpersonal violence (2015) retrieved January 2016 http://www.nzno.org.nz/Portals/0/publications/Interpersonal%20Violence,%202012.pdf

Practitioner enrolment to be prioritised. These could also be included as population indicators.

24. In general, the population indicators listed are only partial and sometimes not very accurate indicators of health, safety, and positive emotional and behavioural development; more robust and comprehensive measures will be needed to indicate the state of and improvement in priority areas of maternal and child health.

25. With regard to the *safety* of children, indicators other than physical injuries should be considered eg emotional abuse, sexual abuse, and neglect.

26. Sudden Unexpected Death in Infancy (SUDI) rates are one, "end-stage" measure of the lack of an optimal environment for infants; they are not comprehensive.

27. In relation to breastfeeding rates, we note that the public health indicators the Ministry uses for breastfeeding are neither consistent, nor compatible with the WHO recommendations for six months exclusive breastfeeding.

28. Exclusive breastfeeding is a Ministry indicator up to three months, but after that *any* breastfeeding qualifies as breastfeeding, which is neither accurate nor statistically robust, as such data may potentially be used to indicate the number of breastfed infants between three and six months, and/or to draw unsafe conclusions based on infant feeding patterns.

29. Given the WHO recommendations and the abundant evidence supporting lifelong health benefits of breastfeeding, we recommend prioritising breastfeeding indicators based on accurate and consistent data i.e. that they indicate exclusive breastfeeding up till six months or differentiate between partial and exclusive breastfeeding.

Question 3

What do you think of a determinants approach?

30. We strongly support a determinants of health approach that allows for the integration of providers' and government departments' policy and practice. This is consistent with NZNO's priorities for health which manifesto that advocates an overarching public health model of care, such as te whare tapa whā, which encompasses both individual and whānau empowerment and social responsibility for health (New Zealand Nurses Organisation, 2014, p 9).

31. A determinants approach recognises that health is impacted by many overlapping contributing factors, and allows a holistic approach to health issues and health promotion, which is not always possible with a

more narrowly focused issues-based approach. Prevention and treatment of rheumatic fever is a good example of a health issue that absolutely requires a determinants approach. However, we note that 'issues' can sometimes be the 'canary in the coal mine' signalling a wider failure, and can serve as a useful focus for health promotion messages.

32. Some of the factors used to determine deprivation are very broad eg income and employment, but do not capture subtleties such as access to phone/internet and transport. These needed to be as part of 'access to services/resources under the Physical Environment section in Figure 1, *Maternal and Child Health Issues and Determinants* (p6).

33. With regard to finalising planning the service design "with the selected provider(s) of this service", we note the model of health promotion being integrated within the Well Child Tamariki Ora service. This capitalises on existing engagement and assessment of need based on a comprehensive review of health determinants, and the ability to tailor opportunities for the caregivers of the child to engage in activities that may "change the distribution and influence of the range of determinants".

34. Many children are being brought up by other people, often grandparents, rather than being in maternal care; a determinants approach should also encompass these caregivers.

Question 4

What other maternal and/or child health population indicators would be good population indicators for the new MCHP service?

35. In "measuring success" it is essential to distinguish between what outcomes the provider is able to influence/be accountable for, and what outcomes they contribute to, as there will be many confounding factors at play. This is a critical aspect overlooked in the new wave of contracted services based on "social investment", which are not supported by evidence. NZNO has discussed this extensively in responses to the Productivity Commission's draft and final reports on More Effective Social Services[3], and elsewhere. Indicators and

[3] http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/1_2014-12%20More%20Effective%20social%20Services_NZNO.pdf

http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2015-06%20More%20Effective%20social%20services%20response.pdf

performance measurements are meaningless unless there are equally robust measure of the context.

36. While the overall outcome is aspirational, we suggest that the statements in the boxes could do with some refining. Eg "All mokopuna/children have improved outcomes" is meaningless without identified comparators i.e. 'Improved' compared with what? As one nurse commented: "*What does "getting ready for the rest of my life" look like? Even if the "I know who I am" statement is generally accepted as being best understood by the child, some children will have had more opportunity than others to explore this*."

37. We see no reason to limit the population health indicators to two or three given the ubiquity of digital information and communication technologies and the extraordinary potential to use diverse data to extract highly relevant information to inform policy choices.

38. Otago University's Burden of Disease Epidemiology, Equity & Cost-Effectiveness Programme (BODE^3), for example, has extracted information from the 'dark data' of diverse, historic Aotearoa New Zealand health datasets to provide estimations of disease burden, cost-effectiveness and equity impacts of proposed interventions, and undertake a range of such assessments.

39. Similarly, the significant data collected by Plunket would surely provide a sound basis to inform decisions around health promotion. Eg Staff are required to record coded health promotion recommendations given in response to identified strengths/actual or potential risks to health needs.

40. The opportunity to process diverse data in innovative ways to identify, clarify and address problems in a timely way should be embraced and extended not limited. For example, it took twenty years to realise that health messaging around SUDI was not well targeted to Māori parents, and the situation was similar with smoking. If several, diverse indicators had been used that inequity would have been apparent and addressed, much earlier.

41. Otitis media; smoking, breast feeding, immunisation, nutrition, stress, parenting – prop feeding and nose-blowing, dental extractions, access to affordable health services (GP, NP, Ear Nurse, family planning and sexual health); access to therapeutic products (medicines, medical devices etc.); suggested as useful indicators, particularly those for which there are long-standing, reliable datasets which enable meaningful international and national comparisons.

42. Otitis media, for instance, has been an issue for a considerable period and is a well-established indicator of health disparities since its incidence should mirror the population makeup and distribution, but does not. It leads to preventable hospital admissions, exposure to

general anaesthetic risk, poor school attendance due to illness or attending doctor or hospital appointments, poor learning and determines life course potential in academic, employment, and other outcomes. Eg a significant proportion of the prison population had otitis media as a child.

43. We have concerns with both the given examples of population health indicators – SUDI and obesity.

44. Sudden Unexpected Death in Infancy (SUDI) rates are possibly an "end-stage" measure of the lack of an optimal environment for infants. Historically SUDI records are incomplete in terms of information they contain eg about sleeping environments, bedding, temperature, alcohol, smoking, breastfeeding etc. and there have been issues with advice given to parents on the basis of incomplete and misleading information eg recommendations for the infant sleeping prone which were later reversed.

45. Based on feedback from members with experience in Child and Youth Mortality Review Group reviews of SUDI deaths, we recommend that health literacy is included as both a maternal factor and a whānau determinant with regard to DUDI rates.

46. Obesity is a relatively new 'indicator' and there is considerable contention around measurements such as BMI and their interpretation, particularly in relation to different ethnicities. We would suggest a very cautious approach to adopting obesity as an indicator of maternal and child health in preference to established indicators, if a choice needs to be made.

47. To invite participation in relevant Health Promotion activities, accurate knowledge of specific health determinants is required for the child's caregiving in that whānau. Otherwise such activities risk being implemented as a blunt-edged instrument for groups that people may choose not to identify with, or won't see as relevant to them.

48. While it is commendable that the outcomes in Tier 1 of the Pop Health Outcomes Framework are framed in terms of what is optimal for each child, children have limited agency in determining their circumstances to health. Promotion outcomes need to prioritise engagement with parents/caregivers, to influence how they meet the needs of children.

49. **Question 5**

*What do you think of the evidence-based principles for the new MCHP service ie a life course approach; systems focus; determinants of health; proportionate universalism, health literacy; settings approaches; community empowerment; working across health social local government, philanthropic and business sectors***.**

50. The principles are generally very sound. They appear to require providers to work not only with 'service users' but with other health and social organisations, as consistent with the principles in the Ottawa Charter.

51. Principle 6 introduces the idea of 'settings approaches', for which the WHO definition – "where we live, work and play" appears on p26. However, the examples given of settings are limited to those outside the home ("work places, school communities, alternative educational settings, churches, marae, public areas and events"). It isn't clear why home should be omitted as a setting. Is it to exclude services that are funded on the basis of personal health as seems evident in Figure 3 on page 15 where there are no arrows from the Service Ottawa Charter 'box' up to the inner semi-circle containing 'child and family/whānau' (Bronfenbrenner)?

52. We support Principle 7 community empowerment and involvement, but note the need for investment in community capability and capacity.

53. Principle 8 calls for better integration of individual clinical services with public health approaches. We support this principle and agree that it will require both workforce development and community and services changes to support health promotion in practice. This cannot be done in a vacuum.

54. Additional resourcing will be needed if MCHP providers are to be tasked with equipping health professionals regulated under the HPCAA, to have an 'increased role' in delivering health promotion approaches to families and communities. Ie they will need time to participate in workforce development, and time to engage in strategies to promote health with families and communities (e.g. motivational interviewing, or attendance/participation in events).

55. In this respect we draw your attention to the fact that DHBs have generally not released nurses to attend health promotion/public health programmes and that this is a systemic barrier that will need to be addressed.

56. We also note there is considerable concern around the CAP directorate's current development of generic and, for professional workforces, duplicative and unnecessary Children's Workforce Competencies. Our understanding is professional workforce feedback on children's workforce competencies (ie concise guidelines for employers) has gone unheeded and that comprehensive new children's workforce competencies are being developed that are superfluous and inferior to the mandatory competencies regulated health practitioners are subject to.

57. We strongly recommend that the Review of MCHP services does not impose additional competency requirements on the health workforce.

Question 6

What do you think of the proposed role for the new MCHP service and direction for Public Health Group (PHG) HF purchasing? Do you see any barriers to implementation of the proposed new MCHP service?

58. We warmly welcome the clear expression of a practical and integrated approach to health promotion which is nationally focussed and supporting existing maternal and child health services by building health promotion capability *throughout the system* (i.e. not just "in other parts" of the system) (p15). This is both practical and holistic.

59. We believe health promotion is intrinsic to the comprehensive primary health care approach across all health settings that we have long advocated.

60. Empowering all New Zealanders to reach their health potential requires a fundamental shift in focus and funding to service models that support health and well-being. Such models must include access to good health information and the promotion of health literacy and self-management at all levels of care, including screening and health promotion programmes.

CONCLUSION

61. In conclusion NZNO welcomes and **supports** the review and reiterates the recommendations above that the Review considers:

    - a bicultural service title that includes te Reo Māori;
    - the regulatory environment that is needed to support evidence-based health promotion services;
    - encompassing preplanning for pregnancy in the MCHP service;
    - alternative and additional population health indicators to those indicated;
    - the limitations of SUDI and obesity as indicators of maternal and child health;
    - resourcing requirements for the development of community and workforce capability; and
    - utilising the enabling framework of the HPCAA to drive the development of comprehensive, innovative and effective health promotion within existing maternal and child health services.

62. NZNO would be happy to discuss any aspect of the above.

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