Children's Health: Nation's Wealth

Speech at the launch of the

Charter on the Rights of Tamariki Children and Rangatahi Young People in Healthcare Services in Aotearoa

Wellington

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E nga mana
E nga reo
E nga hau e wha
Tena koutou, tena koutou
Tena tatou katoa

Greetings to you all.

Thank you for inviting me to speak at the launch of this important document, the *Charter on the Rights of Tamarki Children and Rangatahi Young People in Healthcare Services in Aotearoa.*

Can I start by acknowledging the hard work done by so many of you in the health sector in advocating for children and young people's health. I looked through the programme for the National DHB Child and Youth Health Workshop, and noted so many names that have become familiar to me as staunch advocates for children's health. I know that this advocacy is done as part of, but usually over and above, heavy workloads as managers, advisors and clinicians.

And now one of your own, as it were, Dr Russell Wills, is succeeding me as Children's Commissioner, an appointment that is an excellent one and I wish him well.

Given the acknowledgement I have just made, it might seem churlish to go on to be critical of the lack of priority given child health, and in particular the health of children and young people vulnerable to poor life outcomes. But that is what I want to do in this brief speech.

I will:

- make a couple of assertions about the importance of <u>increasing</u> the priority given children's health (making assumptions that I am talking to the converted)

- suggest some ways by which this might be achieved;

- make some points about how the new Charter can contribute to a greater emphasis on children and young people's health;

- and then get it launched.

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So first the assertions.

I do not need to tell you about the importance of good children's health as a foundation for good child and youth development. Nor that sound development pathways for children are fundamental to the nation's health and wealth. Let's take that as a given.

Second, there is ample evidence that for a significant number of children in New Zealand we are not providing conditions for their optimal development. This occurs in all sorts of ways: material hardship, poor access to quality pre-school education, risky family environments and variable access to health care. It includes an exposure to health risks that a nation like ours should find unacceptable. Yet the health of these children and addressing disparities in health outcomes is not a consistent priority. This is my second starting point. I hope you will take it as a given - at least for the purposes of this address.

It is surprising that children's health is not a consistent high priority given the links between children's health and the nation's wealth in the future. This failure is not, I think, because of a lack of knowledge. We know a great deal about the health status and health outcomes of young children in New Zealand. We also know an increasing amount about the link between the circumstances of young children and later health status - physical and psychological - enough in some cases to draw causal links.

We know something of the association between family and social circumstances and health outcomes - the social gradients of many common childhood illnesses for example.

Yet much of the knowledge has not translated into action. Let me give you some examples. We know more and more about the importance of infant mental health, yet when I ask about service and action plans I am referred to a few initiatives in places like Counties Manukau and mental health initiatives through primary care, still at the mostly aspirational stage. Perhaps we should be grateful for these small steps but I think the collateral damage done to infants' mental health through their parents' difficulties with alcohol, drugs, sometimes depression, and exacerbated by poverty is substantial. Addressing the risks of poor infant mental health deserves high priority within your sector but I don't see it yet.

A second example. The Public Health Advisory Committee put great emphasis on the early years in *The Best Start in Life.* The official response was muted. I sought the Ministry's advice to their Minister on the report. That advice was, with all due respect, generally dismissive and defensive. It identified one recommendation as a high priority (speeding up a Child Health Information system) two as medium (albeit substantial recommendations, a poverty measure and greater expenditure on early childhood), three as low and 15 as already underway. There is no ringing call to action there.

A third comparison, by way of example. When I look at health sector priorities and strategic plans, children and young person's health is not a strong common feature. The new Auckland City Council has just made children and young people the first priority in its social planning. I don't see a similar priority given by the Minister of Health, the Ministry or DHBs in their health planning.

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In the second part of this speech I want to suggest some ways in which child health might be given greater priority. I'll lead into this with the Public Health Advisory Committee's conclusions last year. They attributed New Zealand's comparably poor child health status to low investment by government, agency silos and differences,

haphazard “boom or bust” policies, stop/start programmes, inconsistent information and disjointed service delivery.

The Committee recommended:

- strengthened central government leadership including a senior cabinet minister with responsibility for children, a cross agency office for children and a cross party agreement

- child health as a priority in the Ministry of Health

- a set of cross-agency early childhood policies, child impact assessments, strategies to reduce child hardship, and specific public and primary health initiatives

- integrated service delivery

- monitoring using an agreed set of indicators

I think this is best described as a structural response: get the structures right and good health outcomes follow. There is much to commend and support in it. But in a sense, if some of these initiatives were in place the battle to give children’s health greater priority would already have been won. The question remains of how to get decision-makers to make such changes as prioritising child health in the Ministry or integrating service delivery.

I want to talk about three possible approaches that might have children’s health interests given higher priority:

- structural changes in central government leadership - as recommended by Public Health Advisory Committee - to build child health into the agenda

- investment based arguments - drawing on research and appeals to the utilitarian arguments of economists - to get greater resources

- an emphasis on children’s rights - an appeal to international obligations, human right doctrines and essentially normative approaches to public policy (because it is the right thing to do) - to get children’s interests and voices heard.

First the structural approach. The Public Health Advisory Committee laid great store by changing central government structures to provide greater leadership. For much of my term I have been thinking about how the interests and voice of children might be brought more centrally into the central government policy environment: how they might be heard and their interests given more weight. It is, of course, one of the functions of my Office, and I will leave others to judge how successful we have been.

Some of the discourse about a greater priority for children’s interests has focused on having a Minister for Children around the Cabinet table, or an Office for Children or a Ministry within the policy making laager in Wellington. Others advocate for assessments of the likely impact on children of policy or operational proposals to be built into advice to ministers. These structural arrangements do not have a great track record where they have been tried. The effectiveness of a Minister for Children depends on his or her ability to influence peers. And child impact assessment processes have struggled to demonstrate effectiveness in achieving changes in policy decisions. One common conclusion of studies of such structures and processes is how important it is to have a receptive audience amongst decision-makers and their top advisors for such advocacy and advice. This may require legislative change.

Some current proposals have merit. The New Zealand Labour Party commitment to designate a senior minister with the responsibility to put the interests of children forward in Cabinet discussions has more potential than adding a Minister for Children to an already long list of Ministers in and out of Cabinet. A second promising proposal is to require bills that impact on children to be assessed for their impact on children and consistency with UNCROC, and to require that assessment to be reported to Parliament. This would be akin to the assessment of bills against human rights provisions under Section 7 of the Human Rights Act, something already required and done for the Attorney General by a group in the Ministry of Justice.

Another change that I think has merit is to increase the involvement of children's advocacy groups early in policy processes. I am thinking of the work done by the Public Health Association and the Paediatric Society, and more widely ACYA and the Every Child Counts coalition. Policy processes in Wellington are often very closed. There is merit in more inclusive processes, and we should commend Paula Bennett and her colleagues for adopting such an approach to a national child action plan. I suspect that making decision-makers more receptive will require political leadership for momentum and legislative change for sustainability. Officials will follow.

The second approach is to argue for expenditure on child health as an investment that will have a good payoff. It seems self evident that better health in childhood will save costs to government later, and there is evidence for it. But such arguments have failed to gain much traction.

There would seem to be two reasons for this:

- proponents have not always been robust enough in their arguments or they have been seen by decision-makers as advocates rather than evidence-based advisors

- the audience of decision-makers has not seen advantages in paying much more than lip service to the investment approach, with few real shifts in funding

Several reasons are postulated for the latter :

- decision-makers' short term frame of reference, and the political pressures to assuage voters (witness money for elective surgery)

- the pressure to fund treatment rather than prevention

- difficulties in getting robust evidence of what works in achieving the behavioural, family and social changes that are often necessary for better health outcomes

- the unpalatability to government of opening up expectations about change in deep seated economic and social patterns, for example changes to patterns of income inequality.

On the other hand, there is an increasing body of evidence (Heckman, Hertzman and others), and we should look forward to the upcoming report of Sir Peter Gluckman.

A third approach to having children's interests given more weight in health policy is to argue on the basis of rights, to appeal to justice and equity. The starting point for a rights approach is UNCROC. Article 3 enjoins governments to "in all actions concerning children [have] the best interests of the child [as] a primary consideration". Article 24 contains clear expressions of rights to "the enjoyment of the highest attainable standard of health" and to access to facilities for treatment and rehabilitation. Article 23 addresses the rights of children with disabilities.

A discussion of rights to health services does not proceed far before issues of access and resource commitments arise. Issues of access are important. The New Zealand public health system is driven by rationing by likely benefit from service as a fundamental paradigm, not rights. There is no legislative entitlement to services. The Code of Health and Disability Consumer Rights explicitly excludes issues of a "right" to access treatment, an exclusion that was challenged by some in the 2009 review, but retained.

The law of scarcity of resources applies in the health sector as elsewhere, and issues of demand and supply are acute and complex. It is easy for children's interests to be lost in the clamour of adult voices. Attention to children's interests by those with power and influence is vital and appeals to children's rights have their place.

I suspect that the way ahead lies in some combination of the investment and rights approaches. The arguments need to be around what is wise and what is fair. If they are well made, and gain some purchase, the listeners will emerge, political leadership will emerge, structures will be put in place and children's interests will be seen and heard.

Let me finish this part of my speech on a note of cautious optimism. It is true that there are some fundamental threats to children's health being given more priority. They include:

- government's fiscal position
- the pressure of an ageing population on services
- the political imperatives of taking an ageing population along with major policies
- the seeming public acceptance of wide disparities - between and within ethnic groups
- ongoing structural changes within the policy and strategic levels of the sector, such as in the Ministry of Heath

But I think there are many opportunities:

- at an operational level there are strengths in the child health primary care sector and examples of how it can be used, (in Midlands for example off the back of a well managed database) And there are strengths in the commitment of many child health professionals, as being realised in the clinical network
- there are footholds in the multi-faceted ediface that is service delivery - including the violence and child abuse programmes across DHBs, and the services many of you manage
- at a political level, children are on the agenda of major players in a way I have not seen for 15 years. There are opportunities in the government's Green Paper/White Paper process; the Labour Party's rejig of its social policy that has a good start in life as its centre piece and in the Green's social policy
- the focus of the Chief Science Adviser, Sir Peter Gluckman on child development provides another opportunity

So I think we should be optimistic, albeit in a difficult context, about children's interests being given more weight at strategic and policy levels of health. I urge you to seize these opportunities over the next year.

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Let me turn to the third part of this speech. The role this charter might play. I firmly believe that "on the ground" actions, guided by commitments to children such as this Charter can play a part in giving weight to children's interests. There is a tendency, easily bought into in Wellington, to see change as a top-down process driven by policies and strategies. I was struck when looking at the literature on child impact assessments as a way to increase the weight given children's interests how much the focus was on policy decisions rather than the wide range of operational decisions that impact on children and where much progress could be made.

Of course policies and resource allocations are important, but so are decisions about when, where and how services are available. And the literature on health and social services pays good attention to how important the culture of individual wards, departments and clinics is to the health outcomes of their patients.

This is where this Charter can have a powerful effect. If we are to give greater priority to child health, then we need some changes in the hearts and minds of adults with power and authority. We should not underestimate the impact of listening to children and young people on the hardest-headed of managers and the most flint-like of budgeters.

This Charter enjoins all of those in the health sector to treat children as individuals in their own right; to listen to their views; to have them participate in decisions. It commits those who adopt it to give weight to children's rights in respect of both individual matters, and matters to do with children as a group. This might include decisions about individual treatment, plans for facilities, or the way in which primary health services for young people are delivered. So I think it has the potential to increase the priority for children's health in ways that are real, sustainable, and potentially far-reaching.

Can I thank the organisations who have prepared the Charter for the quality of their work: Children's Hospitals Australasia and Paediatric Society New Zealand. Can I commend you, Anne Morgan, Rosie Marks and your colleagues for the way in which this Charter has been developed.

- its rights-based foundation on UNCROC

- the work of the Experts Reference Group and the consultations they did

- the attention paid to tamariki, rangatahi and whanau - making it truly representative of New Zealand

- the development of a children's version and a young person's version in consultation with children and young people - can I acknowledge Paul Watson and Judith Duncan's work

- and finally, the way in which the document embodies a kaupapa of respect for children and for their families - recognising that gestalt between the individual child and their family that is at the centre of children's lives - well all our lives really.

I encourage all of you to use this Charter all the time - clinicians, managers, advisors. I hope its use will be rigorously monitored and reported on. I expect to see: indicators of take-up and impact on practice developed; targets set; and comparative reports on achievement across DHBs published. And somewhere down the track a gold standard randomised trial of its use, subject of course to research ethics committee approval.

Seriously, it is a great resource. You should all commit to it and use it, and get your DHBs to commit to it. It will serve well as a tool for the sort of reflective practice that will improve services for children. I think it has the potential, in ways that are incremental, sustainable and practical, to increase the priority given children's health.

It will improve children's health and the nation's wealth. I declare the *Charter on the Rights of Tamariki Children and Rangatahi Young People in Healthcare Services in Aotearoa* well and truly launched.