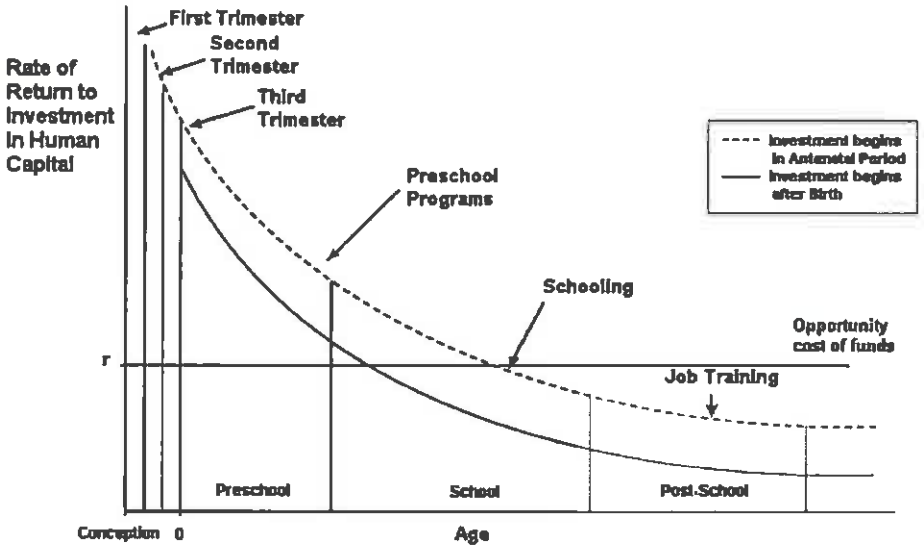
Rates of Return to Human Capital Investment Setting Investment to be Equal across all Ages



Rates of return to human capital investment setting investment to be equal across all ages

Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age Volume 2

REPORT OF THE HEALTH COMMITTEE

November 2013

NEW ZEALAND HOUSE OF REPRESENTATIVES

Inquiry into improving child health outcomes and preventing child abuse, with a focus from pre-conception to three years of age

Report of the Health Committee

Fiftieth Parliament
(Dr Paul Hutchison, Chairperson)
November 2013

Presented to the House of Representatives

Contents

1 Introduction

The major recommendations of this inquiry ask the Government to put more focus on and investment into the pre-conception period to three years of age, and take a **proactive, health-promotion, disease-prevention** approach (based on scientific evidence) to improving children's outcomes and diminishing child abuse.

Such policy is not only backed by science, equity, and ethics, but also makes sound economic sense. It will result in more children leading healthy lives and progressing to meaningful jobs. Productivity will be increased and money will be saved; an investment approach is a win for children and a win for New Zealand.

It has been estimated that well over half of Vote Health is spent on the last two years of life. This report advocates investing an equitable share in the very early years of life where there is clear evidence that it is most effective.

We initiated this inquiry in an attempt to find what practical health and social interventions can be made to promote children's wellbeing in New Zealand, prevent child abuse, and break cycles of disadvantage, particularly from pre-conception to three years of age. **The evidence is very strong; the first few years of life from pre-conception are fundamentally important for a broad range of child health outcomes, and for the achievements of children as adolescents and adults. The greatest gains and cost savings will come from effective evidence-based early intervention. Currently most New Zealand children enjoy good health, but there are significant and alarming differences in different parts of the country, which urgently need to be addressed.**

A long-term aim is that **parents should be as healthy as possible prior to conception**, so New Zealand's next cohort of children are given the best possible start in their first few years, and can achieve their full potential. For this ideal to become a reality New Zealand must have best-practice evidence-based policies and services

- prior to conception, in reproductive health, education, and nutrition
- in maternity and postnatal care, with rigorous on-going follow-up to allow the early detection of problems in the pre-school and school years
- in early childhood education, health, housing, and social services.

Such an approach requires commitment and accountability at all levels, with leadership from the top (the Prime Minister). Primary and secondary health services need to be well integrated into the community, and a whole-of-government approach taken to integrate health services with education, housing, social services, justice and so on. **Great effort must be made to ensure that Māori and Pasifika people have access to services that are culturally centred**.

We recognise the importance of the socioeconomic determinants of health, including the issue of addressing child poverty. We also note the importance of economic growth directed to benefit all sectors of society.

This volume two provides a summary of the main points of our inquiry report and lists all the recommendations we make to the Government.

Key recommendations of Inquiry

Following its inquiry, the Health Committee makes the following major recommendations to the Government. Detailed recommendations are set out in the chapters to which they pertain, and we also endorse the Ministry of Health's recommendations.

We strongly recommend that the Ministry of Health work with all relevant parties and other key ministries to establish a programme with timelines for implementing our recommendations, especially our key recommendations. We understand that the recommendations involving more investment in the very early lives of children may take time, but we wish to see the Government commit itself to optimal and equitable investment in this area in the medium to long term.

We make the following recommendations to the Government

Economics of early intervention

We recommend to the Government that it establish a New Zealand and international evidence base for the economic value and cost-effectiveness of very early intervention programmes (pre-conception to three years). The initial economic analysis should be completed within 12 months of this report being published, and once strong evidence is established, the Government should move quickly to reprioritise investment towards achieving

- best-practice reproductive health services and education
- optimal prenatal, natal, postnatal, and whole-of-life nutrition action plans
- best-practice maternity and postnatal care and monitoring
- best-practice health, early childhood education, and social service intervention programmes for the first three years of life (with particular focus on the vulnerable, the disadvantaged, and Māori and Pasifika children).

This should be completed within 12 months of this report being published.

Sexual and reproductive health

We recommend to the Government that it develop a co-ordinated cross-sectoral action plan with the objective of giving New Zealand world-leading, best-practice evidence-based sexuality and reproductive health education, contraception, sterilisation, termination, and sexual health services, distributed to cover the whole country. The plan should be developed within 12 to 18 months of this report being published, and be matched with appropriate, sustainable resourcing. The plan should also be monitored by trends in teenage pregnancy, sexually transmitted diseases, unplanned pregnancy, and terminations.

Leadership and integrated Children's Action Plan

We recommend to the Government

- That the Prime Minister accept the formal role of developing and implementing a whole-of-government, inter-agency action plan for improving outcomes for all children, including a specific early intervention action plan from pre-conception to three years of age.
- That the Prime Minister's responsibilities include defining the economic and general evidence base behind the action plan, monitoring outcomes, and reporting how the Government proposes to make improvements, in a transparent annual or biannual plan.
- That every attempt be made to secure cross-party agreement on key priorities related to children, to avoid electoral cycle disruption as much as possible.

Social and economic determinants of health and wellbeing

We recommend to the Government

- That it continue to progress policies to address disadvantage and promote opportunity for all children. This should include poverty, discrimination, healthy housing, optimal nutrition, access to health and education services, and safe home environments. The Government should publish an action plan setting out how it will address each area on a yearly basis, and employ a transparent monitoring system, with published results to demonstrate progress.
- That it continue to actively consider the recommendations in *Solutions to Child Poverty in New Zealand: evidence for action*, and at least establish an overall action plan for reducing child poverty or a Better Public Service target for child poverty.[1] The overall action plan or Better Public Service target should be established within two years of this report being published.

Nutrition, obesity, and related non-communicable diseases

We recommend to the Government that it develop a comprehensive, co-ordinated action plan, based on the best evidence available, involving government departments, non-governmental organisations, and the private sector (food and lifestyle industries), with a whole-of-life approach to improving nutrition, and reducing obesity and related non-communicable disease, with a special emphasis on working with Māori and Pasifika communities. The plan should begin to be implemented within 12 months of this report being published, and modifications made when new evidence-based information becomes available.

The plan will need

- A health promotion approach, directed through communities.
- A primary disease-prevention approach, (optimal nutrition, education and later exercise), starting before birth and carrying on through a child's early life.

[1] Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty. *Solutions to Child Poverty in New Zealand: evidence for action,* December 2012, www.occ.org.nz.

- A secondary prevention approach, dealing with those who have developed or are developing obesity/related non-communicable diseases, providing education, optimal exercise, nutrition, smoking cessation, and best-practice treatment services.
- Monitoring and evaluation, and final policy based on international scientific evidence is an essential part.
- At a high level, the plan should be about improving systems within which specific programmes, policies, or activities can be embedded, such as schools or antenatal services where systems need to be oriented to improve nutrition, and exercise.
- Equity focus and relevance to Māori and Pasifika.

The plan should be developed within 12 months of this report being published.

Alcohol, drug harm, and tobacco

We recommend to the Government

- That it act on our specific recommendations on alcohol and tobacco, including alcohol guidelines regarding cessation during pregnancy and pre-conception, compulsory generic health warnings on alcoholic beverage containers, implementing further measures to reach the goal of a smoke-free New Zealand by 2025, increasing the target for advice to pregnant women to quit smoking to 95–100 percent, and exploring measures to combat smoking in cars with children.
- **That it develop an action plan to combat the harm caused by Foetal Alcohol Spectrum Disorder in New Zealand. The plan could be similar to that produced by the Australian Commonwealth Government in 2013 and should include the World Health Organisation (WHO) international prevalence study to establish reliable data for New Zealand. It should be whole-of-government, include the whole population but target those at risk, recognise that the disorder is preventable, provide access to services to those affected, and support the health and broader workforce to prevent it. This should be achieved within 18 months of this report being published.**

Maternity

We recommend to the Government

- **That the Ministry of Health require district health boards to set a key performance indicator for the majority of women to be booked in for antenatal assessment by 10 weeks gestation. Best practice clinical, social, and laboratory assessment should take place, and an ongoing plan for the pregnancy formulated. This should be introduced as a national health target within 12 months of this report being published. The target could start at 60 percent and over time be increased to 90 percent of all pregnancies.**
    - That the key recommendations of the *External Review of Maternity Care in the Counties Manukau District* be funded and adopted in the Counties Manukau District Health Board and relevant places elsewhere in New Zealand. Particular attention should be given to the following areas: early pregnancy assessment and planning (medical and social), ultrasound scanning, prioritisation of vulnerable and high-needs women,

family planning, Māori and Pasifika women, addressing gestational diabetes and obesity, outreach services, and integration of information services.

The recommendations of the Counties Manukau review should be fully implemented within *five years* of this report being published, both in Counties Manukau DHB and elsewhere in New Zealand, where relevant. We recognise this may require reprioritisation of funding.

Vulnerable children

We recommend to the Government that it progress the Vulnerable Children's Bill as a legislative priority, to give effect to the proposals on the Children's Action Plan.

Oral health

We recommend to the Government that it develop and implement an action plan to improve early childhood oral health. The plan should focus on identifying children at the greatest risk at the earliest stage possible, and targeting resources to them. The plan should include the recommendations listed in the oral health chapter, and be completed within 18 months of this report being published. This should include working with Local Government New Zealand to transfer responsibility for setting standards for the monitoring of fluoride additives to the Ministry of Health and District Health Boards.

Early childhood education

We recommend to the Government that it continue to strengthen and fund high-quality early childhood education (ECE) programmes, and ensure access to high-quality ECE for those who would benefit most, including exploring the delivery of ECE services within the public education system in the most disadvantaged communities and where provision is an issue. A clear target, aimed at zero-to-three-year-olds, with planned costing, should be set within one year of this report being published, and measures to achieve it implemented over the next two years.

Information sharing, collaboration, and service integration

We recommend to the Government that it continue to refine a system of information sharing, collaboration, and integration of services, taking appropriate steps to protect privacy, while allowing early identification of children at risk, and ensuring children do not fall through the cracks. This should be achieved within two years of this report being published.

Research on children

We recommend to the Government that research into human development and foetal and child health be strongly supported and sustained, with the inclusion of social science and economic research, and that funding be at least equivalent to international benchmarks, well-coordinated, and monitored for outcomes and value for money (see chapter 13). Funding to achieve international benchmarks should be budgeted within three years of this report being published.

Background

The principal focus of this inquiry is on health promotion and disease prevention to improve outcomes from pre-conception to three years of age and beyond. We acknowledge the fundamental importance of economic growth for improving health outcomes, provided the benefits are widely distributed throughout the population.

Research from the United Kingdom and elsewhere indicates that health status is influenced in large part (up to 75 percent in developed countries) by socioeconomic determinants such as housing, education, sanitation, transport, and social policy; and health services have a lesser influence. Success will require practical policy with a strong evidence base; childhood immunisation is a classic example. Optimal nutrition in a country such as New Zealand is becoming a huge health challenge, where so far there are no clear solutions with sufficient evidence of proven effectiveness.

The evidence is clear that loving committed parents or caregivers who exercise individual responsibility in providing a safe environment for their children are key to achieving positive outcomes, as is societal support and structure. The reality is that, through no fault of their own, a significant number of children in New Zealand miss out.

We acknowledge the Government is doing a great deal to reverse the unacceptably high rates of child abuse in this country. However finding an effective evidence-based programme is difficult and solutions complex. In the past many of New Zealand's services have been reactive, responding to abuse or poor treatment of a child that has already occurred. There is significant support for progressing the Government's White Paper and enacting legislation for a Children's Action Plan. We emphasise the need for a proactive, preventative approach that includes all children, with room for additional services where necessary. Our vision is to see every child from birth to three years of age in New Zealand getting the best start in life possible. To achieve this, a focus on early intervention is also crucial. Best-practice care must continue through adolescence and beyond.

For the purposes of this inquiry, pre-conception refers to the time preceding conception. The physical and mental wellbeing of parents, along with other important factors such as nutritional status, drug use, smoking, and other environmental conditions prior to conceiving can have a profound influence on the developing foetus.

Early Intervention: the next steps is an independent report commissioned by the United Kingdom Government and published in 2011. The principal author, Graham Allen, undertook the report at the request of Prime Minister David Cameron, as "part of a continuing cross-party effort to promote a culture of early, rather than late intervention". He says:

> Early Intervention is the answer: a range of well tested programmes, low in cost, high in results, can have a lasting impact on all children, especially the most vulnerable. In the past huge budgets were absorbed by remedial or palliative policies and few resources were spent on preventative policies.[2]

Allen recommended 19 such programmes.[3]

Despite increasing evidence, successive governments around the world have, with a few exceptions, failed to

[2] An Independent Report to Her Majesty's Government, Graham Allen MP. *Early Intervention: The Next Steps*. United Kingdom, HM Government, January 2011, p. ix.

[3] Shonkoff, JP, Phillips, DA, Committee on Integrating the Science of Early Childhood Development.*From Neurons to Neighbourhoods: The Science of Early Childhood Development*, Washington DC, USA, National Academies Press, 2000.

National Health Committee. *The Best Start in Life: Achieving effective action on child health and wellbeing*, Ministry of Health, June 2010.

- prioritise best-practice reproductive health and education services at primary and secondary schools, to enable students to make decisions based on knowledge and choice
- actively foster and create an environment for optimal nutrition before, during, and after pregnancy
- ensure maternity and postnatal follow-up services are gold standard, with early detection, follow-up, and prompt remediation of problems
- ensure cross-sector collaboration, integration, and information sharing, ideally from the first 10 weeks of gestation
- focus on investment in the first three years of a child's life, where evidence-based programmes demonstrate the maximum benefit.

For details behind our reasoning please see our inquiry report.

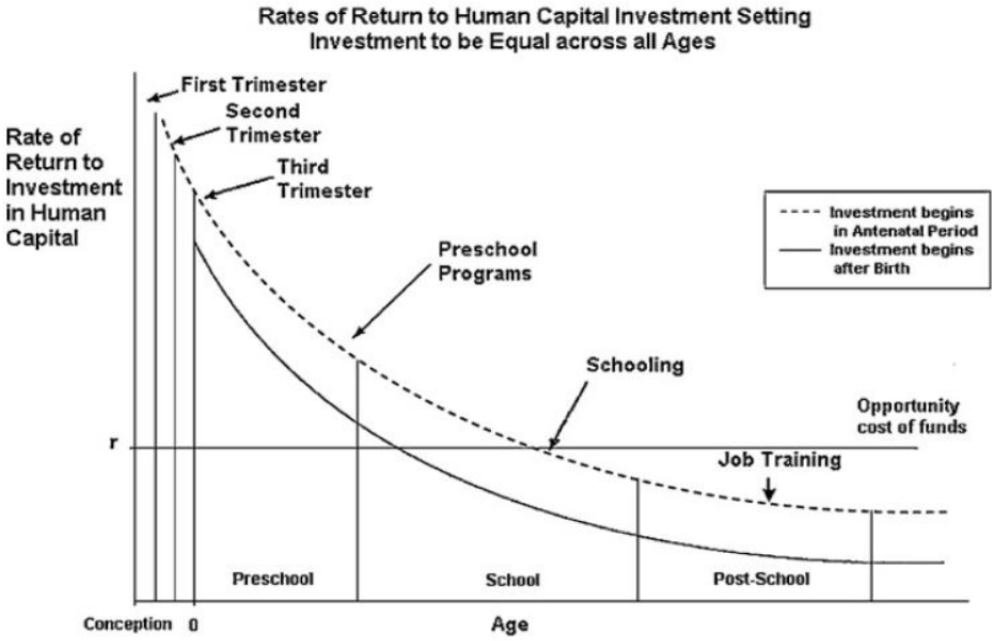
2 The economics of early intervention in children

The international literature, and in particular work by James Heckman, economist and Nobel Laureate, demonstrates that the longer society waits to intervene in the life of a disadvantaged child, the more costly it is to remediate the damage. Early investment generates returns over a longer time, and also raises the productivity of subsequent investment. Despite this evidence, the New Zealand health system invests proportionately far more in the last few years of life than the first. There are estimates that more than fifty percent of Vote Health is spent on the last two years of life.

The scientific evidence is clear that the environment in which a child is conceived, develops in utero, and then is born, has profound effects on its subsequent life course, and specifically on the risk of developing heart disease, diabetes, and chronic lung disease in adulthood.

This chapter asserts the need for more detailed economic data specific to New Zealand, and much stronger action to implement investment in the early years (that is, pre-conception to age 3) in a systematic, evidence-based way. We consider the need to establish an economic and equity justification for investment of public funds at various stages of the life span.

Rates of return to human capital investment setting investment to be equal across all ages (Doyle, Harmon, Heckman, and Tremblay, 2009)



Rates of return to human capital investment setting investment to be equal across all ages

Recommendations

1 We recommend to the Government that it establish a New Zealand and international evidence base for the economic value and cost-effectiveness of very early intervention programmes (pre-conception to three years). The initial economic analysis should be completed within 12 months of this report being published, and once strong evidence is established, the Government should move quickly to reprioritise investment towards achieving

- best-practice reproductive health services and education
- optimal prenatal, natal, postnatal, and whole-of-life nutrition action plans
- best-practice maternity and postnatal care and monitoring
- best-practice health, early childhood education, and social service intervention programmes for the first three years of life (with particular focus on the vulnerable, disadvantaged, and Māori and Pasifika children.

This should be completed within 12 months of this report being published.

2 We recommend to the Government that it compile a New Zealand evidence base for the economic and equity justification of investment of public funds at various ages during the life span. **This should be completed within 12 months of this report being published.**

3 We recommend to the Government that it explore the cost-effectiveness of methods for funding programmes to achieve better outcomes for children; this might include measures such as social bonds.

4 We recommend to the Government that it conduct a review of the international literature pertaining to very early intervention, as a basis for on-going economic research in New Zealand. The review should include *Early intervention: the next steps* by Graham Allen, and be carried out within 12 months of this report being published.

5 We recommend to the Government that it continue to progress policies to address disadvantage and promote opportunity for all children. This should include poverty, discrimination, healthy housing, optimal nutrition, access to health and education services, and safe home environments. The Government should publish an action plan setting out how it will address each area on a yearly basis, and employ a transparent monitoring system, with published results to demonstrate progress.

3 Pre-conception care and sexual and reproductive health

New Zealand stands out among developed countries for its high rates of unplanned pregnancy (estimated at 40 to 60 percent of all pregnancies, compared with less than 20 percent in Sweden), sexually transmitted infections, and terminations. We heard that public health services are fragmented and unevenly distributed geographically.

While an unplanned pregnancy is not necessarily unwanted, if we want optimal conditions for the development of the next generation of children, it follows that their mothers should be as healthy as possible, physically and psychologically, before conceiving, and that they should have the knowledge, freedom and access to make wise choices on reproductive and sexual health matters.

There is a compelling need to develop a coordinated, multi-pronged action plan to improve pre-conception care and education, and sexual and reproductive health in New Zealand.

Recommendations

6 We recommend to the Government that it develop a co-ordinated cross-sectoral action plan with the objective of giving New Zealand world-leading, evidence-based sexuality and reproductive health education, contraception, sterilisation, termination and sexual health services, distributed to cover the whole country. The plan should be developed within 12 months of this report being published and be matched with appropriate, sustainable resourcing. The plan should also be monitored by tracking trends in teenage pregnancy, sexually transmitted diseases, unplanned pregnancy, and terminations.

7 We recommend to the Government that the Ministry of Health ensure that the patient co-payments being charged by Primary Health Organisations and the Community Services Card eligibility criteria for lower general practitioner fees present minimal or no obstacles for women seeking contraception advice and services. This should be achieved within two years of this report being published.

8 We recommend to the Government that it ensure that people have ready access to primary care reproductive and sexual health services, and that inexpensive or taxpayer-funded services be made available to those who cannot afford to pay. This should be achieved within three years of this report being published.

9 We recommend to the Government that it amend the National Education Guidelines to require all schools to deliver sexuality and reproductive health programmes that meet the criteria for success set out in the 2008 Ministry of Health review. This should be achieved within two years of this report being published.

10 We recommend to the Government that it require the Education Review Office to actively monitor and report on all schools' application of the best-practice criteria for sexuality and reproductive health education programmes, reporting specifically on their

efficacy for students of different cultures, ethnicities, genders, and sexual orientations. This should be achieved within three years of this report being published.

11 We recommend to the Government that the Ministry of Health coordinate the development of a whole-of-Government action plan to minimise teenage parenthood and to provide maximum support for teenage parents and their children. This should require DHBs to provide access to a teen parent unit where practicable. This plan should be completed within one year of this report being published.

12 We recommend to the Government that the Ministry of Health, through DHBs, be required to ensure that a choice of youth health services (including sexual and reproductive health) is available in urban centres wherever practicable. Services might include specific one-stop-shop youth health services, family planning, school-based services, and integrated general practice. A key performance indicator should be set requiring DHBs to make a choice of acceptable services available in their areas. This should be achieved within three years of this report being published.

13 We recommend to the Government that it ensure individual school-based and primary-care-based identification of and interventions for at-risk youth are available, along with treatment for sexual abuse, drug and alcohol use, and family distress. This requirement should be reflected in a DHB's KPIs. School-based facilities should have the competency and capability to provide up-to-date advice on contraception and reproductive health; they should encourage students but not require them to share this information with their general practitioner and their parents. This should be achieved within three years of this report being published.

14 We recommend to the Government that it provide funding for free or low-cost access to a wider range of long-acting reversible contraceptives, including the Mirena device or its equivalent, for all women of childbearing age, and ensure that health-workforce planning provides for delivery. Criteria for access should be related to ability to pay. This should be achieved within two years of this report being published.

15 We recommend to the Government that it ensure all DHBs provide ready access to male and female sterilisation, and that waiting times are kept under three months at all times. This should be achieved within two years of this report being published.

16 We recommend to the Government that it allow more specially trained primary care nurses the ability to prescribe contraception and fit intrauterine devices, and that the Nursing Council should appoint such nurses and provide training. This should be achieved within two years of this report being published.

17 We recommend to the Government that it ensure that all women are given the opportunity postnatally to access contraception or sterilisation before they go home or at the six-week check. This should be achieved within two years of this report being published.

4 Social Economic Determinants of Health and Wellbeing

Health outcomes are inextricably linked to education, housing, parenting, employment, welfare services, income, and many other factors that lie within and outside central and local government policy areas. Research from Britain suggests that health services per se account for only 15 to 25 percent of outcomes in developed countries, and that a vast range of factors such as those listed above are influential in determining the rest.

Evidence presented to us confirms that some New Zealand children and their families encounter significant social disadvantage. We were told that child poverty in Sweden was 5 percent, compared with over 20 percent in New Zealand.

This chapter reinforces the case for a whole-of-government, coordinated action plan, led from the top, to minimise inequalities and child poverty. Intervention needs to start before conception. The implementation of the plan needs to be monitored and evaluated, and regular reports of progress made to the public.

Recommendations

18 We recommend to the Government that it continue to actively consider the recommendations in *Solutions to Child Poverty in New Zealand: evidence for action*, and at least establish an overall action plan for reducing child poverty or a Better Public Service target for child poverty.[4] The overall action plan or Better Public Service target should be established within two years of this report being published.

19 We recommend to the Government that it construct a set of policy objectives focused on children, similar to those of the Marmot Review: to give every child the best possible start in life; to enable all children, young people, and adults to maximise their abilities and have control over their lives; to create a healthy standard of living for all; to create and develop healthy and sustainable homes and communities; and to strengthen the role and impact of ill-health prevention.

20 We recommend to the Government that it champion children's health and wellbeing, developing an effective whole-of-government approach to children, establishing an integrated approach to service delivery for children, and monitoring children's health and wellbeing using agreed indicators. . A specific action plan to improve children's health outcomes from pre-conception till three years of age should be established within 18 months of this report being published.

[4] Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty, *Solutions to Child Poverty in New Zealand: evidence for action,* December 2012, www.occ.org.nz

21 We recommend to the Government that it progress its work on rebuilding, strengthening, and growing the economy, supporting people into employment, and improving the delivery of public services that are responsive to the needs of New Zealanders, specifically where positive outcomes are demonstrated by evidence.

22 We recommend to the Government that it continue to develop and apply its policies, services, and programmes with a view to effective delivery for Māori children and their whānau, wherever possible considering Māori-for-Māori services and partnerships between Māori and mainstream providers for implementing access.

23 We recommend to the Government that it ensure that all policies are reviewed regularly and monitored to provide an evidence base for their efficacy.

24 We recommend to the Government that it continue its programme of upgrading public housing, ensuring it has adequate insulation and heat sources that meet the standards recommended by the World Health Organisation.

25 We recommend to the Government that it develop a legislative framework for private-sector landlords, to implement minimum quality standards, and introduce a "Warrant of Fitness" for all rental housing, with injury prevention among its objectives. This should be established within two years of this report being published.

26 We recommend to the Government that it ensure, through the building code and related legislation, that any new housing stock meets minimum quality standards regarding insulation and injury prevention.

27 We recommend to the Government that it progress its programme to prevent diseases often associated with poverty, such as rheumatic fever, and develop coordinated national public health preventive programmes to reduce the incidence of diseases such as cellulitis and skin and lung infections in children.

28 We recommend to the Government that it consider the possibility of providing more support for vulnerable women in the postnatal period to allow more opportunity for mothers to bond with their babies.

29 We recommend to the Government that it continue to progress policies to address disadvantage and promote opportunity for all children. They should cover poverty, discrimination, healthy housing, optimal nutrition, access to health and education services, and safe home environments. The Government should publish an action plan setting out how it will address each area on a yearly basis, and employ a transparent monitoring system, with published results to demonstrate progress.

5 Improving nutrition and reducing obesity and related non-communicable diseases

New Zealand has one of the highest rates of obesity in the Western world for all age groups, and childhood obesity continues to rise. This places a huge and growing burden of disease on New Zealand health services.

High obesity rates in pregnancy have profound implications, not just for the mothers but also the next generation, as the environment in-utero imprints on the foetus the tendency to develop diabetes and cardiovascular disease later in life. Nutritional status before conceiving is also very important. A whole-of-life approach is necessary.

There are no clear solutions, despite a plethora of initiatives, such as various programmes encouraging exercise, Health Promoting Schools, green prescriptions, the promising Project Energize in the Waikato, and guidelines on food and its marketing and labelling. Governments around the world are trying different approaches, all of which need monitoring and evaluation of their efficacy. The World Health Assembly has adopted a global action plan. Ultimately the Government needs to take an evidence-based approach.

Some current initiatives may prove to need replacing when they are eventually evaluated. Meanwhile we consider the situation so serious that the Government should develop a comprehensive, systematic, coordinated action plan based on the best evidence available, and be prepared to modify it as necessary.

Recommendations

30 We recommend to the Government that it develop a comprehensive, coordinated action plan, based on the best evidence available, and involving government departments, non-governmental organisations, and the private sector (food and lifestyle industries), with a whole-of-life approach to improving nutrition and reducing obesity and non-communicable diseases, and a special emphasis on working with Māori and Pasifika communities. **The plan should be in place within 12 to 18 months** of this report being published and modifications made when new evidence becomes available.

The plan will need:

- **A health promotion approach directed through communities.**
- **A primary disease prevention approach (optimal nutrition, education and later exercise) starting before birth and carrying on through a child's early life.**
- **A secondary prevention approach dealing with those who have developed or are developing obesity-related non-communicable diseases, through education, optimal exercise, nutrition, smoking cessation, and best-practice treatment services.**
- **Monitoring and evaluation, and final policy based on scientific international evidence is an essential part.**

- **At the high level the plan should be about improving systems within which specific programmes, policies, or activities can be embedded, such as schools or antenatal services where systems need to be oriented to improve nutrition, and exercise etc.**
- **An equity focus and relevance to Māori and Pasifika.**

This plan should include a requirement for cross-sectoral collaboration between relevant government agencies, such as the Ministries of Health, Education, Social Development, Consumer Affairs, Treasury, and Business, Innovation and Employment, and key performance indicators requiring chief executives to ensure their departments contribute to reducing obesity.

31 We recommend to the Government that it continue to support existing interventions and programmes where evaluation shows them to be effective. Coverage of effective programmes should be increased and ineffective programmes discontinued, which will require a review of all existing programmes.

32 We recommend to the Government that, given the urgency of problems associated with obesity-related non-communicable diseases, it should trial interventions that may not have been proven effective yet but have good prospects on the available evidence, provided that the trials are subject to proper evaluation and the interventions are only rolled out further if proven effective.

Breastfeeding and infant formula

33 We recommend to the Government:

- that it support the development of a strong research evidence base for the most effective methods to sustain the continuation and increase the duration of breastfeeding in New Zealand.
- that a coordinated public health action plan be developed to improve rates and duration of breastfeeding.
- that best-practice alternatives be recommended for those who cannot or do not wish to breastfeed.

This should be achieved within 12 months of this report being published.

34 We recommend to the Government that New Zealand remain clear on the message that "breast is best—provided you can" and that it continues to ensure manufacturing and marketing of infant formula is to the highest international standards.

35 We recommend to the Government that it revisit the issue of whether to add folic acid to bread on a mandatory basis, and take a scientific, evidence-based approach to implementing the option that would be most likely to reduce the incidence of neural tube defects. This should be achieved within 18 months of this report being published.

36 We recommend to the Government that it ensure the framework for the manufacturing, distribution, marketing, and supply of infant formula is of the highest standard possible, and aligned with international and New Zealand codes of compliance. We consider that a well-monitored, self-regulated approach (with conditions) should continue at present, but if the voluntary system is not working effectively within the next 18 to 24 months regulation should be implemented.

Childhood nutrition and schools

37 We recommend to the Government that it develop, evaluate, and implement nutrition and physical activity programmes for Māori, Pasifika, and low socio-demographic children and their families. Traditional Polynesian hospitality practices must be taken into account. This should be achieved within 18 months of this report being published.

38 We recommend to the Government that it urgently build a national community-based action plan for preventing childhood obesity, based on the best evidence from New Zealand and overseas. This should be developed within 18 months of this report being published.

39 We recommend to the Government that it develop best-practice guidelines for the delivery of nutrition and physical activity programmes in schools. The guidelines should specifically cover school canteens, vending machines, fundraising events, classroom rewards, and any other aspect of the school environment where food and beverages are supplied. The Ministers of Health and Education should provide a guidance pamphlet for parents and school board trustees regarding options for nutritious school lunches. This should be achieved within 18 months of this report being published.

40 We recommend to the Government that it continue to support and monitor the Waikato DHB's Project Energize, and that provided it can demonstrate a clear evidence base of efficacy, it be expanded to younger age groups and piloted in other DHBs.

41 We recommend to the Government that it ensure existing programmes like Health Promoting Schools and Project Energize are subject to mandatory evaluation and that national implementation is adjusted to reflect what is proven effective.

42 We recommend to the Government that it train school nurses to help implement best-practice guidelines on nutrition and physical activity, and to diagnose children who are overweight, or suffer from poor nutrition, and ensure they and their families receive appropriate follow-up care.

Economic instruments to improve nutrition

43 We recommend to the Government that it closely monitor options for using fiscal means to improve nutrition; if a policy is shown to be practical and effective in reducing obesity and improving nutrition, it should be implemented.

44 We recommend to the Government that it carry out research on the possibility of regulating the amount of sugar in beverages, or imposing a tax on beverages that contain unhealthy amounts of sugar. The options should be made public within 18 months of this report being published.

45 We recommend to the Government that it investigate regulatory and fiscal measures to improve healthy eating and activity that are supported by a sound evidence base. A report outlining the options should be published within 18 months of this report being published.

Food labelling

46 We recommend to the Government, regarding the Australian star system of food labelling, that it move to

- monitor progress and development with the Australian system

- trial and evaluate the system in New Zealand on a voluntary basis within two years (provided the Australian system is proven to be effective)
- mandate the system on a voluntary basis if it shows strong evidence of success
- if there is not wide compliance, move to a compulsory system (provided there is sufficient evidence) within three years of this report being published. It is important for New Zealand to remain flexible at this stage due to new knowledge and an incomplete evidence base.

Health target

47 We recommend to the Government that screening mechanisms including cardiovascular and diabetes checks are extended to ensure that people at high risk are identified and enrolled in prevention and management programmes.

Marketing to children and advertising

48 We recommend to the Government that a substantial evidence-based social marketing programme be developed, evaluated, and implemented to support parents, caregivers, and families in the promotion of healthy diets and physical activity. This should be implemented within 18 months of this report being published.

49 We recommend to the Government that clear, measureable, timely targets be established in consultation with stakeholders for the labelling, manufacturing, and advertising of healthy food and drinks. This should be particularly directed at children and specifically the zero-to-five age group.

50 We recommend to the Government that it seriously consider developing the necessary legislative framework and regulations to effectively protect children from all forms of marketing of unhealthy foods and beverages.

6 Alcohol, tobacco, and drug harm

Alcohol is the most commonly used recreational drug in New Zealand. Adults' alcohol consumption can significantly and permanently affect young children starting before they are born. We await the impact of recent alcohol reform legislation, but consider that gaps remain in the legislation pertaining to women and children.

New Zealand data regarding foetal alcohol spectrum disorder (FASD) is unreliable, and estimates of the number of affected babies born each year have varied from 173 to 600 and even 3,000.[5] While the full-blown disorder is easily recognisable, it is not obvious at the lesser end of the spectrum; and it is considered likely that thousands of young New Zealanders born each year will struggle with reading, writing, and mathematics because of unrecognised FASD. This is entirely preventable.

Health harm attributable to tobacco exposure anywhere from the in utero environment to adulthood is well proven. The effects on children, including low birth-weight, stunting, sudden unexpected infant death, and respiratory problems, are significant. There is no doubt that second-hand smoke affects children adversely.

We strongly support the aspirational goal of making Aotearoa smoke-free by 2025, and we make additional recommendations specifically to protect children.

Recommendations

Alcohol

51 We recommend to the Government that the Ministry of Health formulate evidence-based guidelines for low-risk alcohol consumption, to be promoted widely, with particular emphasis on alcohol cessation during pregnancy and pre-conception. We recommend that they be formulated within 18 months of this report being published. This could be done by contracting experts in the disciplines of addiction and maternal healthcare.

52 We recommend to the Government that the Ministry of Health progressively increase screening for alcohol misuse, and follow-up intervention, ensuring that

- it is carried out in all emergency departments
- it is a key performance indicator for all initial antenatal assessments
- best-practice guidelines are issued for primary care/general practice with emphasis for women of child-bearing age
- primary care/general practice auditing require alcohol screening and follow-up.

This should be achieved within two years of this report being published.

53 We recommend to the Government that it require DHBs to follow up all alcohol-related emergency department presentations with an alcohol assessment by an alcoholism

[5] Sellman, D, Conner, T. "In vitro brain damage from alcohol: a preventative tragedy", New Zealand Medical Journal, 2009, 122 (1306:6-8).

treatment professional. This should be achieved within three years of this report being published.

54 We recommend to the Government that it analyse the findings of the Alcohol Advertising Forum on alcohol marketing and sponsorship when they become available, and implement any recommendations with a strong base of evidence.

55 We recommend unequivocal health warnings that include, at minimum, "alcohol causes brain damage to the unborn child". This should be achieved within two years of this report being published.

56 We recommend to the Government that it develop an action plan to combat the harm caused by foetal alcohol spectrum disorder in New Zealand. The plan could be similar to that produced by the Australian Commonwealth Government in 2013, and should include the WHO international prevalence study to establish reliable data for New Zealand. It should be a whole-of-government plan, and include the whole population but target those at risk, recognise that the disorder is preventable, provide access to services for those affected, and support prevention measures by the health and broader workforce. This should be achieved within 18 months of this report being published.

57 We recommend to the Government that it carry out a comprehensive analysis of alcohol sales and pricing data, particularly in relation to teenage binge drinking. If the evidence is clear that it would be effective, the Government should consider introducing a minimum price regime, focusing on the cheapest products available.

58 We recommend to the Government that it consider further raising the alcohol excise tax, in a strategic manner to minimise harm.

Tobacco

59 We recommend to the Government that it continue to pursue the aspirational aim of New Zealand becoming smokefree by 2025.

60 We recommend to the Government that it ensure that the maternity indicator of the health target requiring that 90 percent of pregnant women who identify themselves as smokers receive advice and support to quit is achieved and eventually increased to 95 percent.

61 We recommend to the Government that it require DHBs to prioritise the prevention of sudden unexpected death in infancy by utilising the Health Quality and Safety Commission's guidelines, and consider using this as a KPI for DHBs.

62 We recommend to the Government that it continue with the planned progressive increase in tobacco excise tax, and consider increasing its rate.

63 We recommend to the Government that it consider introducing legislation to introduce additional smokefree areas.

64 We recommend to the Government that it reduce or remove the current personal duty free tax concession(s) for tobacco products, provided that the trade agreement implications can be accommodated.

7 Maternity care and post birth monitoring

Given that the vast majority of pregnant New Zealand women formally make contact with public health services for antenatal services and delivery, this provides an ideal opportunity to take steps to achieve optimal outcomes for mothers and babies.

We were concerned to hear that the services available vary around New Zealand, and that in some areas such as Counties Manukau District Health Board less than 16.8 percent of pregnant women accessed maternity care before ten weeks' gestation. This is despite the local population's known high risk for gestational diabetes. Early booking provides a unique opportunity for clinical and social scrutiny, early detection of problems, and timely treatment.

We strongly endorse the view of the Ministry of Health that "improving safety and quality in maternity services and engaging with vulnerable pregnant women and their children" are key priorities for the maternity system. We make a number of recommendations, including the creation of a national health target, to be achieved gradually, of having 90 percent of pregnant women booked for assessment and on-going care by 10 weeks' gestation.

Rationale behind the early booking target to become a national health target

The rationale behind this recommendation is that the earlier in pregnancy that assessment medically and socially can take place, the sooner appropriate intervention can occur if it is necessary.

We were told that only 16.8 percent of all women living in the Counties Manukau region accessed maternity care before 10 weeks' gestation. We also heard that 86 percent of pregnant Pasifika women were overweight or obese. High rates of gestational diabetes are picked up in the region, especially in Māori, Pasifika, and Indian women.

There are many other medical and social conditions that can have profound detrimental effects on both the mother and foetus, and if they are picked up early subsequent intervention can markedly improve the outcomes.

Early identification of vulnerable mothers, as early as possible during pregnancy, followed by appropriate intensive wrap-around services, in line with the government's action plan for children, should prove to diminish later childhood dysfunction and abuse.

Given the increasing level of obesity, diabetes, and other non-communicable diseases in New Zealand, the case for early booking, best-practice testing, and appropriate follow-up care and intervention is overwhelming.

We were told that the criteria for setting a national health target are practicality and measurability, and that the target must start at an achievable rate, as in the case of immunisation, then be incrementally increased. We consider that a target of early enrolment in pregnancy fulfils these criteria.

Implementation will require maternity services to be accessible in the community as well as at base hospitals.

We were told in Sweden, it is estimated that over 90 percent of women are booked in by eight weeks gestation.

Recommendations

National health target: 90 percent of pregnant women booked in by 10 weeks gestation

65 We recommend to the Government that the key recommendations of the *External Review of Maternity Care in the Counties Manukau District* be funded and adopted in the Counties Manukau District Health Board and relevant places elsewhere in New Zealand. Particular attention should be given to the following areas: early pregnancy assessment and planning (medical and social), ultrasound scanning, prioritisation of vulnerable and high-needs women, family planning, Māori and Pasifika women, addressing gestational diabetes and obesity, outreach services, and integration of information services.

The recommendations of the Counties Manukau review should be fully implemented within three to five years of this report being published, both in Counties Manukau DHB and elsewhere in New Zealand, where relevant. We recognise this may require reprioritisation of funding.

66 We recommend to the Government that it ensure that the maternity system provides mothers and fathers with support in a sensitive, positive, and practical way, as much as possible, in the antenatal and postnatal periods and beyond.

67 We recommend to the Government that the Ministry of Health require DHBs to set a key performance indicator for the majority of women to be booked in for antenatal assessment by 10 weeks gestation. Best-practice clinical, social, and laboratory assessment should take place, and an ongoing plan for the pregnancy formulated. This should be introduced as a national health target within 12 months of this report being published. The target could start at 60 percent and over time be increased to 90 percent of all pregnancies.

Pre-conception planning

68 We recommend to the Government that it develop an ongoing media campaign via the Ministries of Health and Education, urging prospective parents to plan and get healthy before conception, and focus on the welfare of their future babies. This should be achieved within 18 months of this report being published. See Chapters on nutrition, reproductive health, and research regarding pregnancy preparation.

Parenting education

69 We recommend to the Government that the current service specification for pregnancy and parenting education be completed, and that it be evidence-based and culturally appropriate, and put into practice within one year of this report being published.

For breastfeeding see Chapter on nutrition, recommendations see 33, 34, and 35.

Better information and integration of information technology

70 We recommend to the Government that it create a comprehensive integrated maternity information system (a maternity shared care record), with a means of communicating effectively with self-employed lead maternity carers. This should be set up and functioning within three years of this report being published.

71 We recommend to the Government that a system of "quadruple enrolment" of all newborns be developed into an integrated national online information system recording

- registration with primary care (general practice)
- registration on the National Immunisation Register
- registration with an oral health provider
- registration with Well Child Tamariki Ora.

This should be completed within three to four years of this report being published.

Antenatal services

72 We recommend to the Government that it ensure that when children are identified antenatally as vulnerable or at risk, appropriate expert wrap-around services are provided, as proposed in the Children's Action Plan, with co-ordination of all service providers postnatally and rigorous ongoing follow-up.

Most of this work, including the refining of the referral guidelines, should be completed within two years of this report being published.

73 We recommend to the Government that it establish best-practice auditing for children who have received treatment for physical problems or social vulnerability to ensure that treatment is completed or ongoing. This should be in place within four years of this report being published.

Maternity Quality and Safety Initiative

74 We recommend to the Government that the Maternity Quality and Safety Initiative be progressed, monitored, and improved by

- continued refining of the national quality and safety programme
- regularly updating maternity referral guidelines to evidence-based gold standard
- developing nationally-standardised maternity records to allow the electronic transfer of information between health professionals
- improving the collection of maternal and newborn information so the quality and safety of maternity services can be monitored more effectively.

Postnatal handover

75 We recommend to the Government that it update section 88 of the Primary Maternity Services Notice 2007 to include a requirement for the formal electronic transfer of relevant information from the lead maternity carer to the general practitioner or primary care provider before the six-week postnatal handover. We also recommend that the general practitioner be required to confirm receipt of the information and take on accountability for further professional and clinical care of the mother and child. This should be achieved within 18 months of this report being published and 100 percent of newborns should be accounted for.

Well Child Tamariki Ora

76 We recommend to the Government that it set key performance indicators for DHBs to record the coverage of WCTO checks and B4 School Checks, and that a completion target of 95 percent be established, with special emphasis on vulnerable and hard-to-reach children. Physical problems or social vulnerability must be audited and treated where possible. A tracking arrangement should be established so that all referrals, particularly for serious conditions, are followed up and accepted to confirm that remedial action has been completed. A B4 School Check is needed at school for children who have not already been checked. This check should initially be targeted at decile 1 to 3 schools. This should be in place within three years of this report being published.

77 We recommend to the Government that it complete and put into action the WCTO quality framework, with the support of an expert advisory committee. This should be in place within three years of this report being published.

78 We recommend to the Government that it combine WCTO and B4 School Check reporting with the national information technology record. This should be in place within three years of this report being published.

79 We recommend to the Government that it put progressively more resourcing into WCTO visits to high-needs, hard-to-reach mothers and babies, and that multi-sector

services be made available to plan and action remedies. This should be in place within three years of this report being published.

Integrated collaborative model of maternity care

80 We recommend to the Government that key providers, midwives, obstetricians, paediatricians, general practitioners, anaesthetists, and consumers continue to develop a collaborative integrated model of maternity care for New Zealand according to guidelines based on research, evidence, and best practice. This should be completed within three to five years of this report being published, and include consideration of primary and lead maternity carers working with Primary Health Organisations.

8 Leadership, whole-of-government approach, and vulnerable children

We support and endorse the work of the Government on vulnerable children. We would like to see this work taken further as we are convinced that in order to solve the challenges facing our children, especially the most vulnerable, we need to start intervention before their conception or at least during the early antenatal period.

A theme running through submissions to our inquiry was the crucial need for leadership at all levels of New Zealand society, with calls for a whole-of-government inter-agency approach. At the top there needs to be leadership from the Prime Minister and the relevant ministers, (of Health, Education, Social Development, Housing, Justice, and Finance) committed to improving children's outcomes.

Cross-party agreement is needed on key priorities relating to children, and an action plan setting out priorities for allocation of resources and service delivery. Leadership should place positive outcomes for children at the centre of decision-making by Government, and on the role of the wider community in meeting the needs of and investing in children.

Recommendations

81 We recommend to the Government that it ensure that all new programmes for child abuse treatment and prevention are thoroughly evaluated for efficacy and cost-effectiveness before being widely disseminated.

82 We recommend to the Government that the Ministry of Health require all WCTO providers to report comprehensive enrolment and service delivery data every 12 months to ensure that contracting for services is adequate.

83 We recommend to the Government that when resources are available, it institute comprehensive health checks on all children before they leave primary school and again before they leave secondary school.

84 We recommend to the Government that the Prime Minister accept the formal role for developing and implementing a whole-of-government, inter-agency action plan for improving outcomes for all children, including a specific early intervention action plan covering pre-conception to three years of age. The Prime Minister's responsibilities should include defining the economic and general evidence base behind the action plan, monitoring outcomes, and reporting how the Government proposes to make improvements in a transparent annual or biannual plan.

85 We recommend to the Government that every attempt be made to secure cross-party agreement on key priorities relating to children to avoid electoral cycle disruption as much as possible.

86 We recommend to the Government that it refine and progress plans to change the way information is shared between professionals to enable them to recognise and act on signs of concern more readily.

87 We recommend to the Government that it progress the Vulnerable Children's Bill as a legislative priority to give effect to the proposals in the Children's Action Plan.

88 We recommend to the Government that it continue to develop strong inter-agency collaboration and leadership initiatives.

89 We recommend to the Government that it continue efforts to develop predictive tools to systematically alert professionals to vulnerable children and families, and that it specifically develop predictive modelling tools to help identify at-risk women (pregnant or of child-bearing age), and thus at-risk children and families, as early as possible.

90 We recommend to the Government that it evaluate the case for further investment in the development of multi-disciplinary teams including paediatricians, social workers, behavioural psychologists, and family support workers, to provide an integrated system of assessment and evidence-based services for families with a high risk or history of child abuse. It is important that any such service changes are subject to thorough evaluation, randomised trials, or similar methodologies, to evaluate their success.

91 We recommend to the Government that it continue to support, fund, and strengthen early intervention programmes for vulnerable children, which are evidence based, agreed on and jointly designed by the agencies involved, and monitored and audited for efficacy. Any intervention programmes not found to be effective should be stopped, and replaced by programmes that work.

92 We recommend to the Government that it ensure adequate intensive home-based support is available for the most vulnerable, particularly in the first two years of life, and that there is a choice of centre-based early interventions where appropriate, from birth to five years. There must be special provision for children with disabilities.

93 We recommend to the Government that it develop key performance indicator's to be published annually in all sectors, to demonstrate that vulnerable children from birth to five years are receiving optimal evidence-based services, and are monitored as a cohort to ascertain outcomes.

9 Immunisation

Immunisation against infections is the most effective evidence-based way to prevent infectious diseases that previously caused severe morbidity and mortality.

We have already undertaken considerable work in this area: see *Inquiry into how to improve completion rates of childhood immunisation, Report of the Health Committee, 2011.* It has been very satisfying to see immunisation completion rates for New Zealand children increase from a totally unacceptable 67 percent of 2-year-olds in 2007 to over 93 percent in 2013.

Twelve district health boards have reported that Māori completion rates are higher than those of non-Māori—an historic achievement. This can be attributed partially to the immunisation health target, and also the teams of professional and community workers who used innovative methods to access hard-to-reach children.

While the new target of 90 percent of eight-month-olds completing their primary course of immunisation on time by 2014 is on track, there are still many older children who are not immunised. To achieve the new target, New Zealand needs to make an unrelenting commitment to children's immunisation.

Recommendations

94 We recommend to the Government that it require enrolment of children in general practitioner health services before discharge from the postnatal ward or from the lead maternity carer's care, to ensure continuing engagement with primary care and Well Child services and timely newborn enrolment. This should be achieved within two years of this report being published.

95 We recommend to the Government that it continue to implement the Ministry of Health's action plan to Enrol, Engage, Promote and Monitor, to achieve immunisation targets.

96 We recommend to the Government that it provide transparent, consistent delivery of immunisation services, by improving local monitoring and engagement among health professionals, developing local immunisation plans, and integration of services.

97 We recommend to the Government that it offer choice for young people, by allowing youth health services to advise on and manage vaccinations, especially those for rubella and human papilloma virus.

98 We recommend to the Government that it continue to implement the recommendations from the Health Committee's 2011 inquiry, and that it report on outstanding recommendations not yet implemented. This should be reported on within 12 months of this report being published.

99 We recommend to the Government that it improve the functionality of the National Immunisation Register, and ensure the implementation of quadruple enrolment by improving the National Health Information Strategy. This should be completed within three years of this report being published.

100 We recommend to the Government that it continue to implement the advice of the Immunisation Advisory Centre regarding "hard to reach" children and Māori, who often have low completed immunisation rates.

10 Oral health

Oral diseases are among the most prevalent chronic diseases in New Zealand and among the most preventable in all age groups. Dental caries can affect children's development, school performance and behaviour, and their families and society in general.

In 2012, 59 per cent of children had caries-free first teeth when they started school. For Māori children the proportion was lower at 42 percent, and for Pasifika children 37 percent. Risk factors and indicators for dental caries include socioeconomic deprivation, suboptimal fluoride exposure, ethnicity, poor oral hygiene, prolonged infant bottle feeding, poor family dental health, enamel defects, and irregular dental care.

We were advised that the scientific evidence is clear; when fluoride is added to the water supply in appropriate monitored doses there is a reduction of dental caries in children, particularly children living in low socioeconomic families.[6]

The recommendations below aim to significantly reduce the risk factors associated with children's dental caries and improve oral health.

Recommendations

101 We recommend to the Government that it invest in a nationwide public oral health campaign, aimed at increasing parental awareness of the importance of enrolling preschoolers with the Oral Health Service and attending scheduled appointments. The campaign should include good teeth-brushing practices, and the importance of drinking water or milk rather than soft drinks, fruit juice, and other sweetened drinks. This should be implemented within 18 months of this report being published.

102 We recommend to the Government that it work with the Ministry of Health to ensure that the addition of fluoride to the drinking water supply is backed by strong scientific evidence and that ongoing monitoring of the scientific evidence is undertaken by, or for, the Ministry of Health, and that the Director-General of Health is required to report periodically to the Minister of Health on the status of the evidence and coverage of community water fluoridation.

103 We recommend to the Government that it work with Local Government New Zealand and the Ministry of Health to make district health boards responsible for setting standards around water-quality monitoring and adjustments to meet World Health Organisation standards (or their equivalent), including the optimal level of fluoridation of water supplies. Part of the work programme would be to ensure that costs imposed on councils relating to standards and monitoring, are realistic and affordable. This should be implemented within two years of this report being published.

104 We recommend to the Government that it develop and implement an action plan to improve early childhood oral health. The plan should focus on identifying the children at the greatest risk, at the earliest stage possible, and targeting resources to them. The plan should include the recommendations listed in this chapter and be completed within 18 months of this report being published.

[6] Ministry of Health. "Advice to the Chair of the Health Committee regarding water fluoridation", August 2010.

105 We recommend to the Government that the category of children classified in ethnicity reporting by the Ministry of Health as "other" be further defined and reported on to identify any at-risk ethnic groups within it.

106 We recommend to the Government that it closely monitor children who miss scheduled oral health appointments and take corrective action when a pattern emerges. This might include topical fluoride applications and a delegated health worker to encourage their developing a healthy diet and a healthy home care regime.

107 We recommend to the Government that it expand taxpayer-funded oral health care, as resources allow, to include one course of basic oral health care, including oral hygiene instruction, cleaning and scaling, and management of untreated dental caries for pregnant women who hold community service cards. This service could utilise the skills of new oral health graduates with therapy and hygiene scopes of practice, and would focus limited additional health care resources on oral health improvements for a group of adults whose oral health is most associated with oral health outcomes in early childhood.

108 We recommend to the Government that the Ministry of Health maintain a single NHI-linked health record for each child enrolled in a primary care practice. Oral health should form part of an integrated health record. All Well Child practices should have targets for the achievement of oral health checks and follow-up care. (Quadruple reporting)

109 We recommend to the Government that "dental neglect" be defined as an important category of child neglect and recognised and managed accordingly. Systems must be established for following up children who do not attend scheduled appointments, and therefore risk pain from dental abscesses and untreated decay.

110 We recommend to the Government that it ensure that parents of pre-school-aged children can access an online health record for their children, including oral health information.

111 We recommend to the Government that it encourage healthy food policies and dental hygiene programmes in early childhood centres and schools.

All of the above recommendations should be implemented within one to two years of the publishing of this report.

11 Early childhood education

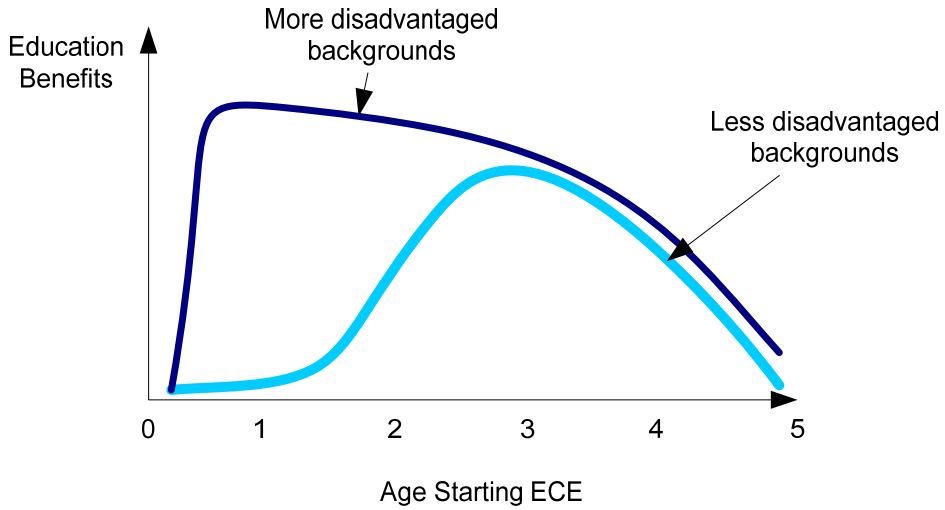
A basic thesis of this inquiry is that what children experience and learn in the first three years of life has the most profound impact on whether or not they achieve their full potential. The research evidence is overwhelming regarding the benefit of good-quality education (formal or informal) from the earliest age.

Conditions that are fundamental for a baby to thrive include a secure, safe, stable, relaxed home environment, with loving parents or caregivers dedicated to the welfare of the child, and where breastfeeding can extend for as long as 12 months, and the parents can bond with the child and act as first teachers.

In New Zealand there is a wide spectrum of choice in early childhood education. The 2012 ECE Taskforce reported that the benefits of an early start in ECE are particularly strong for children's learning of new languages, for children with disabilities, and for children from low-income families, but all children can benefit. During these early years, children are not only influenced positively by rich learning environments, but they are extremely vulnerable to impoverished learning environments. This is particularly true for children during the first two years of life, and for children from disadvantaged backgrounds.

Currently the New Zealand government is forecast to spend $1.5 billion dollars on early childhood education in the 2013/14 financial year, with children aged up to two years accounting for $255 million of this. The total spending is high by OECD standards.

Effects of ECE on disadvantaged children (Ministry of Education)



Recommendations

112 We recommend to the Government that it focus on achieving high participation rates in early childhood education (up to 98 percent by 2016) for vulnerable/disadvantaged children aged up to three years, where the literature suggests most benefits are obtained.

The aim is to have children attending 15 to 20 hours where this is possible and benefits can be demonstrated.

113 We recommend to the Government that it continue to research and develop an evidence base for optimal provision arrangements for ECE in New Zealand, especially for children aged up to three years.

114 We recommend to the Government that it continue with its programme on vulnerable children, and make special provision to ensure they have the opportunity to benefit from high-quality, best-practice ECE and care in the first years of life.

115 We recommend to the Government that it continue to ensure all early childhood education is of a standard where it can be demonstrated to be effective and positive, and that appropriate auditing and monitoring is strictly maintained.

116 We recommend to the Government that it continue to strengthen and fund its programme of early childhood education for the zero to three-year age group, particularly where evidence shows it is improving outcomes.

117 We recommend to the Government that it explore the provision of ECE services, including associating or co-locating ECE services with public schools, where analysis shows gaps in the education system.

The recommendations in this chapter should be achieved within one to two years of this report being published.

12 Collaboration, information sharing, and service integration

The need for a collaborative, multidisciplinary, integrated approach to the provision of services, including information sharing by professionals, was a key theme of submissions. We believe it is fundamental that the health system be underpinned by a modern, secure information system. We advocate "quadruple reporting", whereby a newborn is enrolled in the National Immunisation Register, and with a Well Child Tamariki Ora provider, a primary care provider, and an oral health provider. We are very supportive of the Vulnerable Kids Information System and the reform of privacy law to allow effective sharing of health information.

Recommendations

118 We recommend to the Government that it continue to refine a system of information sharing, collaboration, and integration of services, taking appropriate steps to protect privacy, while allowing early identification of children at risk, and ensuring children do not fall through the cracks. This should be achieved within two years of this report being published.

119 We recommend to the Government that it introduce a key performance indicator for DHBs requiring the efficient enrolment of newborn babies with primary health services (that newborns be enrolled with a general practice and Primary Health Organisation before six weeks, and that immunisations and Well Child checks are on time, and a general practitioner chosen antenatally). This should be achieved within two years of this report being published.

120 We recommend to the Government that it ensure that the system facilitates identification of at-risk women and babies as early as possible in pregnancy, to allow home visiting programmes such as Family Start and Early Start to begin at an appropriate time. This should be achieved within two years of this report being published.

121 We recommend to the Government that it implement quadruple enrolment of infants (on the National Immunisation Register, in WCTO, with a primary caregiver or general practitioner, and an oral health provider), within two years of this report being published.

122 We recommend to the Government that under the Children's Action Plan, a single lead professional for each child be assigned overall responsibility for ensuring that appropriate interventions are carried out and followed through (along the lines of the Scottish model of a "named person" for every child).

123 We recommend to the Government that it continue to develop service hubs tailored to the needs of particular communities (particularly for Māori and Pasifika people) and focused on delivering high-quality appropriate services.

124 We recommend to the Government that it continue to develop information-sharing support and integrated working, such as the national shared maternity record of care and

the clinical health record, and ensure they are fully available throughout New Zealand within three years of this report being published.

125 We recommend to the Government that it implement the vulnerable kids information system as soon as issues regarding information sharing and privacy law reform are resolved by legislation. We strongly support the Government in this work and consider it to be a crucial instrument for preventing child abuse.

13 Research on children

Good children's policy must be underpinned by a strong base of research evidence. In June 2011, the Health Committee made a major recommendation to the Government, asking that it establish a long-term objective of bringing New Zealand public and private records up to international benchmarks.[7] We see it as critical that New Zealand continue to build a strong research base and that research on children feature predominantly in it. This applies to basic developmental, and operational research.

Sustaining research efforts such as the Christchurch and Dunedin longitudinal studies and *Growing up in New Zealand* is very important to understand and define our successes and failures. The strength of the Perinatal and Maternal Mortality Review Committee, the Child and Youth Mortality Review Committee, the Family Violence Death Review Committee, and the Social Report are immensely important.

A better start to life—improving the potential of young New Zealanders to have a healthy and successful life, is one of the National Science Challenges announced by the Government as part of Budget 2013, which committed funding of $316.5 million over 10 years. We strongly endorse this research programme which includes maternal health, pregnancy, and early childhood, successful transition into healthy adulthood, and education for living in the digital world.

New Zealand's research reputation has been enhanced by the stellar work of the Liggins Institute and more recently Gravida, the National Centre for Growth and Development.

Sustained high-quality investment in children's research, development, and innovation is hugely important for our children's health and New Zealand's economic growth.

We are supportive of the Social Policy Evaluation and Research Unit (SuPERU), which was established to help ensure that services for vulnerable children and their families are based on evidence of effectiveness.

Recommendations

126 We recommend to the Government that it ensure all programmes related to child services are carefully monitored and evaluated using best-practice, evidence-based techniques, wherever possible.

127 We recommend to the Government that it ensure reports on child health and wellbeing outcomes, including the Social Report published by the Ministry of Social Development, are of the highest quality and give an accurate picture of the data that can be used for evaluation and research.

128 We recommend to the Government that it ensure the Social Policy Evaluation and Research Unit is well resourced, and audited for the quality of its evaluation of programmes; and that it cultivate a readiness to add or drop programmes in response to evidence of effectiveness.

[7] Report of the Health Committee, *Inquiry into improving New Zealand environment to support innovation through clinical trials* , June 2011.

129 We recommend to the Government that Whānau Ora "action research" be evaluated to ensure it produces high-quality evaluation of programmes, and there is a readiness to add programmes or drop them if they are shown to be ineffective.

130 We recommend to the Government that research into human development and foetal and child health be strongly supported and sustained, with the inclusion of social science and economic research, and that funding be at least equivalent to international benchmarks, well-coordinated, and monitored for outcomes and value for money. Funding to achieve international benchmarks should be budgeted within three years of this report being published.

Appendix A

Committee procedure

The committee called for public submissions on the inquiry. The closing date for submissions was 4 May 2012. The committee received 95 submissions from the organisations and individuals listed in Appendix B and heard 48 of the submissions in person.

Committee members

Dr Paul Hutchison (Chairperson)
Shane Ardern
Paul Foster-Bell
Kevin Hague
Hon Annette King
Iain Lees-Galloway
Moana Mackey
Scott Simpson
Barbara Stewart
Dr Jian Yang

Appendix B

List of submitters

Alcohol Advisory Council of New Zealand
Alcohol Healthwatch
Andrew Sheldon Crooks
Anita Thomas
Anthony Pitt and Dr Brian Stillwell
Aotearoa New Zealand Association of Social Workers
Associate Professor Julie Tolmie
Auckland Breastfeeding Network
Auckland Regional Public Health Service
Barnardos New Zealand
Benjamin Wiseman
Brainwave Trust Aotearoa
Bridget Wilson
Bronwyn Drysdale
Carol Bartle
Catholic Diocese of Auckland Justice and Peace Commission – Social Welfare Anti-Poverty Committee
CCS Disability Action
Child Matters
Child Poverty Action Group
Children's Commissioner
Counties Manukau District Health Board
David Ironside
Donna Hourigan-Johnston
Dr David Small
Dr Denise Guy and Incredible Families Charitable Trust
Dr Jan Raymond
Dr Nick Baker
Dunedin Community Law Centre
ECPAT Child Alert
Every Child Counts
Families Commission
Family First New Zealand
Family Planning
Federation of Women's Health Councils Aotearoa
Fetal Alcohol Network NZ
Footsteps Education
GE Free NZ in Food and Environment
Great Fathers Trust
Great Potentials
Hawke's Bay District Health Board
Health Rotorua

Hilary Stace
Hutt Valley Study Group of Wellington Federation of Graduate Women
International Association of Infant Massage
Jeanette Clarkin-Phillips
Jennifer Goldsack
Jigsaw Family Services
Joanna Hill
Katherine Smith
Kati Knuutila
Maternity Services Consumer Council
Mother-Well Holistic Health Centre
National Council of Women
New Zealand College of Midwives
New Zealand College of Public Health Medicine
New Zealand Federation of Business and Professional Women
New Zealand Journal of Natural Medicine
New Zealand Kindergartens
New Zealand Medical Association
New Zealand Nurses Organisation
New Zealand Playhouse Federation
No Forced Vaccines
Paediatric Society of New Zealand
Patients' Rights Advocacy Waikato
Paul Waddell and Dr John Gardner
Peter Zohrab
Professor Boyd Swinburn
Professor Cindy Farquhar
Professor David Fergusson
Professor Doug Sellman, Professor Jennie Connor, Professor Geoff Robinson, Emeritus
Professor John Werry
Professor Sir Peter Gluckman
Public Health Association of New Zealand
Regional Public Health
Relationships Aotearoa
Rotorua District Council, Community Policy and Resources Department
Royal New Zealand Plunket Society
Safekids New Zealand
Save the Children New Zealand
Shine – Safer Homes in New Zealand Everyday
Smokefree Coalition
Social Service Providers Aotearoa
Sue Grey
Te Tari Puna Ora o Aotearoa New Zealand Childcare Association
Te Whānau o Waipareira Trust
The Methodist Mission
The Royal Australasian College of Physicians - New Zealand
The Royal Australasian College of General Practitioners
The Social Policy and Parliamentary Unit, The Salvation Army

Tom Reardon
Tony Baird
Unicef New Zealand
Vaccination Information Network
Waves Trust
Women's Health Action Trust
Wrigley Street Health
Youth Justice Independent Advisory Group

Appendix C

List of those who assisted the committee in its consideration

Andrew Little
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Christine Rogan
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Donna Provoost
Dr Cam Calder
Dr Gareth Morgan
Dr Jackie Blue
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Dr Robert Beaglehole
Dr Robin Whyman
Dr Russell Wills
Hon Maryan Street
Dr Gill Greer
Louisa Wall
Ministry of Education
Ministry of Social Development
Professor Boyd Swinburn
Professor Cindy Kiro
Professor David Fergusson
Professor Doug Sellman
Sir Peter Gluckman
Susan Guthrie