child & youth wellbeing

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Child and Youth Wellbeing Strategy – Submission

This document is intended for individuals or groups who wish to make a formal submission on the child and youth wellbeing strategy.

Please complete this template and email it to: childandyouthwellbeing@dpmc.govt.nz

A guide to making a submission is available on the DPMC website https://dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy

Submissions will close on **Wednesday 5 December**.

Please provide details for a contact person in case we have some follow up questions.

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Organisation Name:	New Zealand College of Public Health Medicine
Organisation description: (tell us about your organisation – i.e. who do you represent? How many members do you have? Are you a local or national organisation?)	The New Zealand College of Public Health Medicine (NZCPHM) is the professional body representing the medical specialty of public health medicine in Aotearoa New Zealand. We have 224 members, all of whom are medical doctors, including 187 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine. Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM strives to achieve health gain and equity for our population, reducing inequities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.

Executive Summary: (Please provide a short summary of the key points of your Submission - 200 words)	NZCPHM strongly agrees that children are our taonga and, as such, should be loved and cared for in ways that support them to reach their greatest potential. We submit that there is a need for monumental structural change to demonstrate a meaningful commitment to this kaupapa. We recommend a child wellbeing impact review of all current legislation and regulations, and a requirement for robust child wellbeing assessment before any proposed legislation is enacted. NZCPHM supports the seven underlying principles of the strategy. The Treaty of Waitangi should be given greater prominence within the principles. In addition to rights contained within the United Nations (UN) Convention on the Rights of the Child, rights contained in the UN Declaration of the Rights of Indigenous People and the UN Convention on the Rights of Persons with Disabilities should be included. The framing of the sixteen focus areas needs to move from placing the burden of responsibility on children and whānau to recognition of societal responsibility to improve the social determinants of health and wellbeing and create supportive environments that enable children to flourish. There are gaps within the current sixteen focus areas in relation to the right of children and young people to life and survival, and health care, and the importance of the physical environment.

Submission Content

The New Zealand College of Public Health Medicine (NZCPHM) welcomes the opportunity to make a submission on the Child and Youth Wellbeing Strategy.

You have sought advice on four areas in particular:

1. *The framing of wellbeing for the initial Strategy*

The NZCPHM supports the use of 'wellbeing' for the strategy. We note that 'wellbeing' can be assessed and measured both subjectively and objectively. Three of the strategy's proposed wellbeing domains could be described as subjective (1, 3 and 4) and two can be measured objectively (2 and 5). There are ways of measuring all five domains and the NZCPHM recommends that such measures are developed and agreed early on in the strategy development process. They should be reported on regularly.

We submit that there is a need for wellbeing domains and associated indicators that are relevant and meaningful for Māori. A recent example of innovative implementation of wellbeing measures in partnership with iwi Māori can be found in the Canterbury Wellbeing Index which has a set of indicators for Māori, He Tohu Ora, (Canterbury District Health Board, 2018) developed in collaboration with Ngāi Tahu.

2. *The proposed vision statement for the initial Strategy*

The NZCPHM agrees with the vision statement noting that it is aspirational. NZCPHM strongly agrees that children are our taonga and, as such, should be loved and cared for in ways that support them to reach their greatest potential. We submit that there is a need for monumental structural change to demonstrate a meaningful commitment to this kaupapa. The current legislative and policy environment in Aotearoa New Zealand is dominated by adult interests and there has been a systematic failure to prioritise children in public policy. (D'Souza, Signal, & Edwards, 2017) Children and young people have very little autonomy in our society, and no control over the actions of their parents, and other adults in their wider family, whānau and society. For this reason it is doubly important that their interests are placed front and centre of decision-making at every level.

3. *The proposed set of outcomes sought for all children and young people*

The NZCPHM supports the desired outcomes but notes that many of them currently have no associated measurement framework. Without a commitment to measuring outcomes it will be difficult to know whether they are on track to being achieved. The equitable achievement of these outcomes should also be given emphasis in the Strategy, (New Zealand College of Public Health Medicine, 2016) as this is currently lacking.

4. *The 16 potential focus areas proposed for the initial Strategy*

Aotearoa New Zealand has high rates of child abuse and neglect. In addition to the aspirational goals of safety and nurture (focus area 1), there must be a reorientation of services to address family violence where it does occur. Children who are in the care of Oranga Tamariki have higher health needs than other children. (Duncanson, 2017) Health and social services have an important role to play in prioritising and addressing the broad

range of needs that affect these children, and in providing appropriate care for them and their families and whānau.

The physical environment has minimal attention within the sixteen focus areas (hinted at in the 'have what they need' heading but not included in any focus area). Basic requirements like clean water and adequate sanitation are essential for wellbeing. The NZCPHM recognises climate change as a serious risk to global public health that poses significant threat to child and youth wellbeing.

Focus area 2 mentions protection during travel and recreation. A very high proportion of childhood injuries occur in the home. Protective environmental factors such as safe water temperature and functioning smoke alarms, robust and enforced pool fencing legislation, and safe packaging of medications and poisons are examples of environmental contributors to child wellbeing.

Within the sixteen focus areas the NZCPHM supports inclusion of a focus on the first 1000 days and the early years (age 2–6) in focus areas 14 and 15. There is a strong evidence base for the importance of support for children, parents and communities in the antenatal period and earliest year. (New Zealand College of Public Health Medicine, 2017) However, resilience in the Strategy is framed solely as an individual characteristic of children and not of their family and whānau or the community around them – the development of resilience in children should not be used as an excuse not to prioritise their needs.

The framing of the sixteen focus areas needs to move from placing the burden of responsibility on children and whānau to recognition of the social determinants of health and wellbeing and societal responsibility to create supportive environments. Personal empowerment is a key component of the Ottawa Charter for Health Promotion (World Health Organization, 1986). However the environment needs to be conducive to that empowerment. Empowerment is only possible when individuals and whānau are in a position to make the type of decisions described in focus areas 10, 12 and 13 (as examples). Structural barriers to empowerment include racism, discrimination, income poverty, material hardship and gender-based violence.

Physical and social environments also impact on autonomy – weak regulation around advertising and harmful product availability, lack of choice in transport options, and purchasing environments dominated by industry interests all constitute barriers to healthy lifestyle decisions.

Services for children and young people need reorientation to enable the sixteen focus areas to be realised. Education, health and other social services need to review how services are provided, and develop more diverse workforces, if children and young people are to engage with them to thrive. These services should provide more intensive interventions as the need increases, with a strong emphasis on collaborative practice that is child-centred and trauma-informed. These services need to include children's participation in decision-making about their care.

There is a gap within the current sixteen focus areas in relation to the right of children and young people to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health (UNCROC Article 24). This includes the obligation on the government to diminish infant and child mortality. Māori and Pacific communities, and households living in the most challenging and deprived living situations, bear the heaviest

burden of sudden unexpected deaths in infancy (Child and Youth Mortality Committee Te Ropu Arotake Auau Mate o te Hunga Tamariki Taiohi, 2017). There is an urgent need for a whole of government approach to ensure that all services better serve these communities (Child and Youth Mortality Committee Te Ropu Arotake Auau Mate o te Hunga Tamariki Taiohi, 2017). Suicide is the leading cause of death for adolescents aged over 14 years in Aotearoa New Zealand, and in recent years the number of deaths by suicide in under-15 year olds has increased. (McDonald, et al., 2018)

The right of children to highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health is also a gap in the sixteen focus areas. As well as making healthy decisions (about food, exercise, sleep, alcohol, drugs and sexual relationships), support and services for disability, and having support for mental health (Focus areas 10, 11, 12 and 13), children need to live in environments that protect, promote and improve their physical health. The NZCPHM notes that poverty is a key barrier to the enjoyment of health, as reflected in high rates of diseases such as rheumatic fever, pertussis (whooping cough) and pneumonia compared with other rich countries. (New Zealand College of Public Health Medicine, 2017) When children are unwell, they need to be able to access appropriate, affordable health services. The current configuration of child health services in Aotearoa New Zealand leads to inconsistent availability of services depending on geography, on household and community health literacy, and on the knowledge, confidence and cultural competency of health professionals responsible for their care. The goal of consistently good and accessible health services that meet the needs of the communities they serve is important to include in the strategy.

The NZCPHM further comments on:

5. The seven principles underlying the strategy

Overall the NZCPHM supports the seven underlying principles of the strategy. The Treaty of Waitangi should be given greater prominence within the principles. The NZCPHM recognises that Māori have distinctive indigenous rights as Tangata Whenua in Aotearoa New Zealand. The United Nations (UN) Declaration of the Rights of Indigenous People includes the right to self-determination (article 3); the right to be free from discrimination (article 2); and the right for indigenous peoples to be respected as distinct peoples (article 5); with collective, as well as individual rights (article 1). The inequities in health outcomes experienced by Māori children and young people in Aotearoa New Zealand are a stark illustration of the need to establish kaupapa Māori health services as well as to reorient mainstream services to meet the needs of whānau and tamariki within them. (New Zealand College of Public Health Medicine, 2015)

The inclusion of the rights contained within the United Nations Convention on the Rights of the Child (UNCROC) within the principles of the strategy is important. To ensure the degree of structural change required to realise the aspirations of the Strategy, UNCROC must be embedded within public law and institutional policies and practices. (D'Souza, Signal, & Edwards, 2017) In addition to rights contained within the UNCROC, the rights contained in the UN Declaration of the Rights of Indigenous People and the UN Convention on the Rights of Persons with Disabilities (UNCRDP) should be included as principles. UNCRDP requires States Parties to “take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms

on an equal basis with other children" which goes beyond the current statements within focus area 11.

6. The Child Impact Assessment (CIA) tool

The NZCPHM supports the development of the CIA tool. In our day-to-day work as public health physicians we see the negative impact on children and young people as a result of policies in relation to alcohol, sugar-sweetened drinks, and minimum wage and welfare entitlements. We recommend a child wellbeing impact review of all current legislation and regulations, and a requirement for robust child wellbeing assessment before any proposed legislation is enacted. As one example, reduction of the alcohol purchasing age to 18 years, allowing supermarket sales of alcohol, and long-standing refusal to have on-bottle warnings about alcohol in pregnancy have contributed to alcohol-related harm and to fetal alcohol spectrum disorder. (Wall, Casswell, & Yeh, 2017) (Lange, et al., 2017)

We would like to see the CIA tool and accompanying impact assessment tools such as the Health Impact Assessment guide, the Whānau Ora Health Impact Assessment guide[1] and the Health Equity Assessment Tool[2] more widely publicised and utilised in Aotearoa New Zealand. The last three tools have been developed to ensure that the determinants of health are considered in policy and to ensure that policy does not perpetuate or further exacerbate existing inequities.

Finally the NZCPHM believes that to truly create 'the best place in the world to be a child' there will need to be long-term investment in children and whānau for at least two generations. Implementation of long-term (30 year) budgetary and financial forecasting would help to put this in perspective. At a purely financial level Aotearoa New Zealand cannot afford to not make this investment: the ageing population structure means that there will be fewer working age adults to support an increasing number of older citizens and so we need to achieve the best outcome for each child and young person today.

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[1] The Ministry of Health has several tools available on this site designed to ensure that the wider determinants of health and wellbeing are adequately addressed in policy making. https://www.health.govt.nz/our-work/health-impact-assessment/resources-health-impact-assessment

[2] https://www.health.govt.nz/publication/health-equity-assessment-tool-users-guide

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