Human Rights Commission
Te Kāhui Tika Tangata

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Re: OHCHR Study on children's right to health – Human Rights Council resolution 19/37

1. The New Zealand Human Rights Commission (**Commission**) welcomes this opportunity to contribute to OHCHR's study on children's right to health (**Study**). The Commission is an independent national human rights institution (**NHRI**) with 'A' status accreditation. It derives its statutory mandate from the Human Rights Act 1993 (**HRA**). The HRA aims "to provide better protection of human rights in New Zealand in general accordance with United Nations Covenants or Conventions on Human Rights."

2. In preparing this response the Commission consulted with the Office of the Children's Commissioner (NZ) which, along with the Commission, has statutory responsibility to ensure that children's and young people's rights, interests and welfare are upheld.

Background

3. New Zealand's 1.05 million children (those aged 0-17 years) make up 26 per cent of the population.[1] Around 45 per cent of households have children. The diversity of children and young people continues to increase, with almost 20 per cent of those aged 15 years and under identifying with more than one ethnic group. The proportion of children currently identifying as European (72 per cent) has declined since 1996, while those identifying as Pacific (12 per cent), Asian (10 per cent) and other ethnic groups (1 per cent) has risen. The proportion of children identifying as Māori remains at approximately 24 per cent.

4. In 2006, 90,000 children aged under 15 years (10 per cent) were reported to have a disability.[2] The Disability Survey 2006 reported that an estimated five per cent of all children had "special education needs", which was the most common disability category used in that survey. Chronic conditions or health problems and psychiatric or psychological disabilities were the next most common disability types. More than half of disabled children (52 per cent) had a disability caused by a condition that existed at birth. Forty-eight per cent of disabled children had multiple disabilities.

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[1] Statistics New Zealand, *2006 Census*

[2] Statistics New Zealand (2007). *2006 Disability Survey: Hot off the press.*

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5. The *Children and Young People: Indicators of Well-being in New Zealand 2008* report shows improvements in health outcomes in a number of areas, such as infant mortality, immunisation and youth smoking rates.[3] In some areas, however, poor health outcomes remain a concern. New Zealand has high rates of injury morbidity and mortality, youth suicide, sudden unexplained death in infancy and communicable diseases compared to similar countries. New Zealand also has the highest rate of male youth suicide in the OECD.[4] Overall, child mortality is higher than the OECD average.

Main health challenges related to Children

Inequalities

6. International human rights treaty bodies have repeatedly expressed concern about inequalities in New Zealand. For example, in 2012 the United Nations Committee on Economic, Social and Cultural Rights (**CESCR**) noted that Māori, Pacific and disabled people continue to be disadvantaged in the enjoyment of economic, social and cultural rights.[5]

7. There are marked inequalities in outcomes for rich and poor children and young people. Of particular concern is the persistence of large disparities across a range of risk factors and health outcomes for Māori and Pacific children and young people. Infant mortality rates are higher for Māori and Pacific children and those living in the most deprived areas.[6] Disparities are also evident in risk factors such as obesity and smoking, and access to preventative measures such as immunisation.[7]

8. The United Nations Committee on the Rights of the Child (**CRC**) recently recommended to the New Zealand Government that urgent attention be given to disparities affecting tamariki Māori.[8]

9. There have been some progressive improvements in health outcomes for Māori and Pacific people. For example, between 2009 and 2011 the immunisation rates in Pacific and Māori children rose by 14 per cent, with 85 per cent of Māori and Pacific children now fully immunised by the age of two. However, Māori and Pacific people continue to generally experience poor outcomes. These groups have lower life

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[3] Ministry of Social Development (2008). *Children and Young People: Indicators of Well-being in New Zealand 2008*. Wellington: Ministry of Social Development.

[4] Supra, fn 38.

[5] Committee on Economic, Social and Cultural Rights (2012), *Concluding observations of the Committee on Economic, Social and Cultural Rights in relation to New Zealand's third periodic report on the implementation of the International Covenant on Economic, Social and Cultural Rights* (E/C.12/NZL/3). See also Committee on the Elimination of Discrimination against Women (2012), *Concluding observations of the Committee on the Elimination of Discrimination against Women in relation to New Zealand's seventh periodic report* (CEDAW/C/NZL/CO/7).

[6] *The Children's Health Social Monitor New Zealand* (2009). Accessed at http://www.nzchildren.co.nz/infant_mortality.php.

[7] Ibid. See also: Ministry of Social Development (2008). *Children and Young People: Indicators of Well-being in New Zealand 2008*. Wellington: Ministry of Social Development.

[8] Committee on the Rights of the Child. Fifty-sixth session concluding observations: New Zealand. Geneva: Committee on the Rights of the Child; 2011.

expectancy than other ethnic groups and have more than twice the risk of needing hospital care for infectious disease.[9]

10. The gap in life expectancy between Māori and non-Māori was specifically cited by the UN Permanent Forum on Indigenous Issues in its report on the State of Indigenous Peoples. The report cited research showing that from the 1980s to the end of the century, "a slowing or stalling of indigenous health improvements measured by life expectancy meant that the gap failed to close significantly (Canada) or even widened (New Zealand and the United States)". The Permanent Forum poignantly emphasises that indigenous children have the right to live long lives.

11. People with an intellectual disability experience a lower life expectancy and greater prevalence of health problems compared to the general population. They also do not have access to the same levels of preventative health care and health promotion programmes as others. No significant change has occurred since the National Health Committee identified "systemic abuse" that required the urgent attention of Ministers in 2003.[10]

12. In 2012 the CESCR expressed concern at the continuing difficulties faced by persons with intellectual disabilities in accessing some health services and recommended that New Zealand "ensure that its primary health system is adequately equipped to provide care to persons with intellectual disabilities."[11]

Poverty

13. Socio-economic factors are widely acknowledged as important determinants of health and other social outcomes.[12] Children are consistently the age group most likely to be affected by poverty and material hardship.

14. In 2009, the OECD's first ever report on outcomes for children concluded that "New Zealand needs to take a stronger policy position on child poverty and child health, especially during the early years when it is easier to make a long-term difference."[13]

15. The 2012 Household Incomes Report provides showed that 21 per cent of children were living in poverty in 2011, "poverty" established as below 60 per cent of the median income after housing costs.[14] In June 2011 there were 234,000 children in beneficiary families (22% of all dependent children). Around 25% of children live in households in which there is no adult in full-time employment.

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[9] Supra note 26.

[10] National Health Committee (2003), *To Have an Ordinary Life: Kia Whai Oranga Noa,* (Wellington: National Advisory Committee on Health and Disability).

[11] Supra note 5.

[12] See for example: Macintyre, S. (1997) "The Black Report and beyond: What are the issues?" *Social Science and Medicine*, 44: 723-745; Ministry of Health (2000) *Reducing Inequalities in Health*, Ministry of Health, Wellington.

[13] Organisation for Economic Cooperation and Development (2009), *Doing Better for Children* (Paris: OECD).

[14] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/household-incomes/index.html

Violence, abuse and bullying

16. Violence and child maltreatment are prevalent in New Zealand. The Ministry of Justice's *New Zealand Crime and Safety Survey 2009* (**NZCASS 2009**) provides an estimate of the level of crime experienced by New Zealanders aged over 15 years. NZCASS 2009 estimates that there were 699,000 incidences of assault and 137,000 incidences of sexual offending in 2008. There is no measure of assaults on under 15 year olds.

17. In 2009, the Ministry of Social Development (**MSD**) reported that 2855 children were physically abused, 1126 were sexually abused and 15,615 suffered emotional abuse and neglect.[15] In 2010/11 the MSD found there were 55,194 recorded incidences of family violence, up from 46,937 in 2009/2010.[16]

18. The Commission believes that reported "child abuse" significantly under represents the reality of violence and abuse toward children and young people in New Zealand. Only 10 per cent of assaults of people over the age of 15 are ever reported and if data were available it would be surprising if there was not a high level of assault of under 15 year olds.

19. Neglect is a particularly important sub-type of maltreatment. Neglect is the second most frequent finding in Child, Youth and Family investigations and is at least as damaging as physical or sexual abuse in the long term.

20. Violence is pervasive in New Zealand schools and in the wider community, and has serious and often life-long effects. Effects on victims can include living with anxiety and fear, lowered self-esteem, engagement in risk-taking behaviours such as substance abuse, self-harming, truanting and dropping-out from school, all with associated long term adverse impacts. Victims may suffer mental health issues including suicidal ideation, relationship difficulties and impeded emotional, behavioural and cognitive development.[17]

21. In response to recommendations made during New Zealand's UPR the Government confirmed its objective to make the community safer for children, and to protect children and young people from abuse and neglect.[18] However, the prevalence of peer- to- peer violence and abuse in schools shows that the current legislative and regulatory framework fails to provide enough protection for children and young people. Statistics New Zealand figures show the number of recorded offences of "acts intended to cause injury" at schools or education institutes increased 23 per cent from 2004 to last year.[19]

22. In 2012 the CESCR recommended that New Zealand "(a) systematically collect data on violence and bullying in schools; (b) monitor the impact of the student mental health and well-being initiatives recently introduced in schools on the reduction of the

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[15] Ministry of Social Development (2009), *Protecting our most vulnerable infants.* Media release, 3 September. http://www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2009/pr-2009-09-03.html
[16] Ibid.
[17] Office of the Children's Commissioner (2009) *School Safety: An Inquiry into the safety of students at school.*
[18] Supra note 1.
[19] Supra note 23.

incidence of violence and bullying; and (c) assess the effectiveness of measures, legislative or otherwise, in countering violence and bullying."[20]

Mental health services

23. In recent years, concerns have been raised regarding gaps in provision of essential mental health services for children and young people.[21] These gaps include:
    - a lack of forensic, residential placements[22]
    - a shortage of mental health professionals who specialise in working with children and young people (although there have been attempts to address it. The workforce having more than doubled over the last decade)[23]
    - addiction services for young people and those with parenting responsibilities
    - adequate coordination among the multiple agencies involved in the care and treatment of young people with very high needs (although this is being addressed through a variety of programmes with other government agencies).[24]

24. Recent research notes improvements in funding, staffing and access to mental health services. Despite progress, there is a continued need to broaden the range of services and support available, and to improve access to services for Māori and Pacific peoples.[25]

25. While adult-focused Mental Health and Addiction Services may be aware that their clients have children, they often do not have the tools, skills or interests in assessing the impact of their clients' issues on their children.

Examples of good practice

Immunisation rates

26. Between 2009 and 2011 the immunisation rates in Pacific and Māori children rose by 14 per cent, with 85 per cent of Māori and Pacific children now fully immunised by the age of two.

27. This was achieved by setting targets and thresholds that could only be met if health agencies addressed inequalities in Māori and Pacific health outcomes. In short what gets measured gets managed.

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[20] Supra note 5.
[21] Supra, fn 7.
[22] The Ministry has prepared a youth forensic guidance document for DHBs in preparation for further development when funding is available
[23] The shortage of trained professionals in this area is not limited to New Zealand but presents as an international problem
[24] For example, the Ministry of Health is working with the Ministries of Social Development and Education on health and education assessments for children coming into the care of CYFs and improving information sharing mechanisms between agencies working with children and their families.
[25] The Werry Centre. (2009). *The 2008 Stocktake of Child and Adolescent Mental Health Services in New Zealand.* Auckland: The Werry Centre for Child & Adolescent Mental Health Workforce Development, The University of Auckland.

28. The adoption of a National Immunisation Register (**NIR**) ensured that hard-to-reach children received their vaccinations on time. The NIR was rolled out throughout New Zealand in 2005.The NIR enables authorised health professionals to quickly and easily find out what vaccines a child has been given. This helps to make sure immunisations are given at the appropriate time.

29. The NIR also provides a more accurate record of immunisation coverage rates – regionally and nationally. This enables better programme planning to target populations with the lowest immunisation rates.

Better Public Service

30. The Better Public Services (BPS) programme, was announced by Prime Minister John Key on 15 March 2012. BPS outlines outcomes that the Government expects to see over the next 3 to 5 years. These include a commitment to supporting vulnerable children, reducing the level of violent crime, and the level of abuse and assault of children and young people.[26]

31. Government departments and agencies are developing action plans across these areas and are setting targets and thresholds that are said to only be able to be met if enduring inequalities are addressed. For example, the Government has committed to reducing the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by June 2017.

Well Child Tamariki Ora

32. The introduction of B4 School Checks and strengthening of the Well Child Programme have been positive developments. The Well Child Services are based on a universal platform, with additional Well Child contacts available for all first-time parents or families with additional needs if they live in moderate to high deprivation areas.

33. Well Child / Tamariki Ora services are offered free to all New Zealand children from birth to five years. A child is entitled to 11 free health visits under the service. These visits, along with other Well Child / Tamariki Ora services, aim to protect against illness, detecting problems early and providing support to you.

34. The Royal Plunket Society is funded to deliver these services to around 85 percent to 90 percent of children with District Health Boards responsible for the remainder. There are over 50 provides, many of whom are Māori or Pacific providers.

Cot Death

35. The National Cot Death Campaign during the 1990s was successful in reducing death rates for the total population. This campaign comprised widespread and intensive media publicity of the main modifiable risk factors.

[26] Rt Hon John Key (15 March 2012), Speech to Auckland Chamber of Commerce. https:/johnkey.co.nz/categories/4-Speech

36. However, it was less effective for Māori, who experience the greatest burden of SUDI.[27] This led to the development of kaupapa Māori approaches. The Māori Prevention Programme has raised the profile of SUDI as an important public health issue and worked in a manner consistent with the expectations of the Māori community.

Positive Behaviour School Wide

37. Positive Behaviour School Wide (**PBSW**) is a universal approach to tackling problem behaviour in schools. It focuses on teaching positive behaviour, communicating clear behaviour expectations and creating a school culture that supports responsibility for behaviour.

38. PBSW is based on an American programme, Positive Behavioural Interventions and Supports which has been running in the United States for 16 years. It is also being implemented in Australia, Norway, Canada and Iceland. Studies of this approach have shown a sustained drop in suspensions, increased instructional time, and a positive increase in wellbeing.

Barriers

Targets and monitoring

39. Prior to 2012 the majority of government initiatives have generally failed to address entrenched inequalities because assistance has not been specifically targeted to the small proportion of people within vulnerable groups who experience the highest level or most complex forms of disadvantage. As identified by the CESCR Maori, Pacific and disabled people are disproportionately represented in this group.[28]

40. While action plans and strategies have been set in some areas until recently they have not been accompanied by specific targets and thresholds. The CESCR has repeatedly noted the lack of monitoring and data collection and has recommended better target setting and monitoring across all key indicators.[29]

Appropriate funding

41. An issue repeatedly raised by the CRC is the lack of available data on budgetary allocations for children. In 2003 the CRC recommended the collection of disaggregated data on budget allocations for children and the systemic assessment of the impact of economic policy on children.[30]

42. In 2009, the OECD reported that in recent years New Zealand spent less than the OECD average on young children in particular, despite the fact that spending more on young children is more likely to generate positive changes and make a difference in

[27] Child and Youth Mortality Review Committee, Fifth Report to the Minister of Health: Report on mortality 2002-2008. Wellington: Child and Youth Mortality Review Committee; 2009.
[28] Supra note 5.
[29] Ibid.
[30] United Nations Committee on the Rights of the Child (2003) *Concluding Observations: New Zealand,* paras 14-15 and (2011) *Concluding observations: New Zealand,* paras 16-17.

the long term.[31] Based on international evidence, the OECD concluded that New Zealand should spend considerably more on younger, disadvantaged children, and ensure that current rates of spending on older children are more effective in meeting the needs of the disadvantaged amongst them.

Lack of coordination

43. At a national level, there are a range of policies and strategies aimed at ensuring that children's rights are protected.[32] However, in the absence of a comprehensive strategy or mechanism for incorporating children's rights into policy and legislation, the level of recognition and protection of children's rights can be ad hoc and inconsistent. Lack of coordination and of a clearly defined focal point for responsibility within central government for children's rights has been an issue.

44. Despite some of the foundations being in place, early childhood policy and services in New Zealand are complex and fragmented. For example, in the social sector alone, there is a complex array of early intervention, violence prevention, community action and positive parenting programmes/resources.[33] Currently there is no overarching children's legislation, leadership or children's policy across Government.

45. In the health sector, while the cornerstones of early childhood health services are in place they have not yet reached their full potential and there is substantial variation across the country. Recent research by the Public Health Advisory Committee (PHAC) identifies factors in the poor health status of New Zealand children, including:[34]
    - increasing pressures on families/whānau (including financial and time pressures);
    - widening socio-economic disparities;
    - comparatively low government investment in early childhood; and
    - lack of coordination of services and of information collection and sharing.

46. The PHAC report highlights the particular vulnerability of children and the crucial importance of the early years, "as the positive and negative effects of young children's health can last a lifetime". The committee stresses the need for a holistic, comprehensive approach to improving child health, requiring a whole-of-government commitment, effective coordination and sustained investment.

Accessing services

47. There remain substantial barriers to accessing health care for children in New Zealand, despite the Ministry of Health's policy of primary health care during office hours being free for children under six. Substantial co-payments can be required, particularly for after-hours care. So-called hard to reach families and whanau often

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[31] Organisation for Economic Cooperation and Development (2009).

[32] These include the *Agenda for Children* and the *Youth Development Strategy Aotearoa*. The Ministry of Youth Development coordinated a five year UNCROC work programme for implementing the CRC's recommendations, reported online at http://www.msd.govt.nz/what-we-can-do/children-young-people/uncroc/how-uncroc-is-improving-the-rights-of-children-and-young-people-in-nz.html.

[33] See www.familyservices.govt.nz

[34] Public Health Advisory Committee, (2010). *The Best Start in Life: Achieving effective action on child health and well-being.* Wellington: Ministry of Health.

share characteristics including extreme poverty, low health literacy, poor connections to family, whanau and community and sometimes active distrust of services.

48. A further barrier is the lack of information for early childhood policy and service planning.

49. If you require any further information please contact the Chief Human Rights Commissioner or Michael White, Legal and Policy Analyst at michaelw@hrc.co.nz.

Yours sincerely

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