

Taking action for equity from the start in Aotearoa New Zealand

Action in response to the WHO Commission on Social Determinants of Health

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EXECUTIVE SUMMARY

Inequities in early childhood limit the extent to which children, their families/whānau and society can reach their full potential and should have no place in 21st century New Zealand. Significant numbers of New Zealand's youngest citizens do not have a fair start to life. Many have poor living conditions and experience some of the highest rates of preventable disease and injury in the developed world. At its core the issues are inadequate prioritisation and focus on children, particularly vulnerable children, combined with wider patterns of societal disadvantage, particularly for Māori and Pacific people.

Two recent reports provide New Zealand with a good opportunity to refocus efforts to provide all children with a strong foundation for life-long health and well-being and to tackle the serious issue of inequalities. These are the World Health Organization's "Closing the gap in a generation" report (CSDH 2008) and the New Zealand Public Health Advisory Committee's report, "The Best Start in Life: Achieving effective action on child health and wellbeing" (PHAC, 2010).

Action to promote health equity must start early in life and must be multi-faceted – from within and outside the health sector. Ultimately, eliminating inequities in early life will require cohesive and sustained effort across the health system, and wider public sector and civil society. It will require work to empower communities and whānau, to improve social determinants of health, to reduce harmful exposures and boost protective factors, to remove socioeconomic and cultural barriers to services, and to ensure high quality and culturally appropriate services. Although this has clearly presented challenges in the past, it is necessary, it is a good investment, and what is more, it is achievable.

1 INTRODUCTION

“There can be no keener revelation of a society's soul than the way in which it treats its children.” President Nelson Mandela, Pretoria, 1995.

This paper explores the way in which New Zealand is currently treating its youngest children. For some time, New Zealand has been grappling with high levels of childhood hardship, preventable disease, and marked inequalities. Two recent reports provide New Zealand with a good opportunity to refocus on providing all children with a strong foundation for life-long health and well-being. It is in the interests of all New Zealanders, now and for the years ahead, for children to grow up in nurturing, safe and healthy conditions – children deserve no less.

This paper aims to provide the public health sector with information to support action within New Zealand on the “Equity from the start” section of the World Health Organization’s (WHO) “Closing the gap in a generation” report (CSDH 2008). More recently, the New Zealand Public Health Advisory Committee’s report, “The Best Start in Life: Achieving effective action on child health and wellbeing” (PHAC 2010), is also concerned with achieving equity from the start – both reports are mutually reinforcing catalysts for action.

Health inequities

In New Zealand health inequalities are present very early in life, well before children start school, and can be seen throughout life for most common causes of death or morbidity. Health inequalities are systematic differences in health between population groups. Health inequities are unfair and avoidable inequalities - both terms will be used interchangeably in this report. Health inequities primarily arise because of different patterns in the social determinants of health – the social conditions in which people live, which are in turn, shaped by wider societal factors. Social and health inequalities can fuel an ongoing cycle of disadvantage (CSDH 2008).

Ethnic inequalities are the most profound in New Zealand – particularly affecting Māori and Pacific children. Māori have special status and rights as indigenous people of New Zealand (rights enshrined in national and international treaties) yet statistics show that they experience disadvantage in society and consistently bear a great burden of ill-health. This concerning situation is a result of many factors, related to New Zealand’s history of colonisation through to the present, and is underpinned by an underlying unequal distribution of resources and opportunity. This has flow-on effects on living conditions, health behaviours, and access to quality services, affecting health and wellbeing from very early on in life (Robson et al 2007).

For example, Māori children are more than five times more likely to die of Sudden Infant Death Syndrome than non-Māori, and nearly three-and-a-half times more likely to die from unintentional injury (Ministry of Health 2010c). This unfair pattern of loss of life at such a young age shows that the need to focus on reducing inequalities early in life is very relevant for New Zealand. New Zealand is not yet adequately caring for and protecting some of its most vulnerable citizens and there is an ethical imperative for greater action.

Health inequalities also affect the whole population across the socioeconomic spectrum. The term “social gradient” refers to the commonly seen pattern of progressively better health with increasing socioeconomic position. Many different proximal causes of death are responsible for the socioeconomic inequalities in childhood mortality in New Zealand (Shaw et al 2005). Health inequalities may also be observed for children from a range of vulnerable

circumstances (such as those in the care and protection system, children with disabilities, and from refugee and migrant backgrounds).

In response to ongoing concern about health inequalities, WHO established the Commission on Social Determinants of Health (the Commission) in 2005 to support action to promote health equity. This work clearly frames social inequalities as a major health issue and aims to generate a renewed vigour with which this is addressed, within nations and globally.

The final report "Closing the gap in a generation" (CSDH 2008) contains three interrelated recommendations for civil society, governments and global institutions:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action.

Within the first recommendation, there are five broad areas for action, one of which is "Equity from the start" (see Box 1).

Box 1 "Equity from the start" section from "Closing the gap in a generation"

What must be done

A comprehensive approach to the early years in life requires policy coherence, commitment, and leadership at the international and national level. It also requires a comprehensive package of early child development (ECD) and education programmes and services for all children worldwide.

Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development.

Set up an interagency mechanism to ensure policy coherence for early child development such that, across agencies, a comprehensive approach to early child development is acted on.

Make sure that all children, mothers, and other caregivers are covered by a comprehensive package of quality early child development programmes and services, regardless of ability to pay.

Expand the provision and scope of education to include the principles of early child development (physical, social/emotional, and language/cognitive development).

Provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay. Identify and address the barriers to girls and boys enrolling and staying in school and abolish user fees for primary school.

Rationale for an increased focus on early childhood development (ECD)

Early childhood is a crucial part of human development where the foundations are laid for all aspects of life, including health. Living conditions, experiences and relationships early in life shape a wide range of later outcomes such as health, psychological well-being, educational achievement, criminal behaviour and future productivity.

The Commission recognises the importance of the early years as a key intervention point in improving health and reducing inequalities. Across the world many international agencies, professional bodies, governments, and non-governmental organisations are recognising the importance of ECD, and are adapting their priorities and work programmes (for example, the World Bank).

The rationale to increase the focus on and investment in early childhood is based on (Irwin et al 2007, NPHP 2005):

- Better understanding of human health and development – particularly early brain development.
- Evidence of a range of improved outcomes for children, families and society.
- Evidence of positive economic returns – from reduced costs of problems in health, education, justice and social welfare and increased future earnings and tax payments.
- Evidence for greater social equity.
- Moral and ethical obligations to care for and protect children.
- International obligations in children’s rights, including New Zealand’s responsibilities as a signatory to the United Nations Convention on the Rights of the Child.

A focus on early childhood should be viewed as a fundamental part of wider action to improve health and reduce inequalities for the whole population.

Objectives of this paper

The aim is to encourage a strong, cohesive approach to ECD in New Zealand, with a clear goal of achieving health equity. There are two main objectives:

1. To encourage people in public health to incorporate a focus on early child development as part of routine practice.
2. To encourage action on achieving equity from the start across the health sector and external to the health sector.

Early childhood refers to the period from antenatal development up to 8 years of age.

Note that in this report the term parent includes the role of primary caregivers and guardians.

2 BRINGING TOGETHER EARLY CHILD DEVELOPMENT AND PUBLIC HEALTH

Some of the key features of human development, outlined in Box 2, demonstrate why early childhood is so crucial for lifelong health and for reducing inequalities. It is easy to visualise how the social determinants of health can have such a profound effect so early in life.

Box 2 Key points on human development¹

- Human development is a complex, lifelong process shaped by many individual, whānau/family, community, and wider socioeconomic, cultural, and environmental factors.
- Both risk and protective factors are important.
- Influences on human development are especially powerful during the early years, the period of maximal plasticity and vulnerability of the developing brain.
- During the first years of life billions of sets of neural circuits are formed in the brain; at birth the brain is 25% of adult size and by age 3 is 90% of adult size.
- “Wiring” of the brain occurs under the influence of a mix of genetics and early environments and experiences.
- Simple neural circuits provide scaffolding for more complex circuits.
- Healthy relationships are the essential building blocks of healthy human development – nurturing, loving, secure and responsive care-giving relationships are key.
- Over time, unused neural circuits are “pruned” away.
- The different domains of development (social, emotional, cognitive, language and physical) are linked - disruption in one domain can affect others.
- Children are active participants in their own development – there is an inherent drive to achieve competence.
- Brain development can be seriously compromised by exposure to stress² – such as maltreatment and neglect, family violence, or serious mental illness/addiction affecting parents/caregivers.
- Early stress diverts brain development from learning to a persistently activated physiological stress response, the long-term impact of which depends on intensity, duration and the presence of protective factors such as supportive relationships.
- The brain has some capacity for repair and remodelling; children are vulnerable to risks and open to protective factors into adulthood.

Healthy early child development

Early child development is influenced by many interrelated factors. Figure 1 is the model used by the Commission to illustrate the ecology of ECD. Put simply, children and whānau require the conditions supporting healthy development (and buffers to moderate the effects of stress) across time and at each level: household, community/neighbourhood, national and

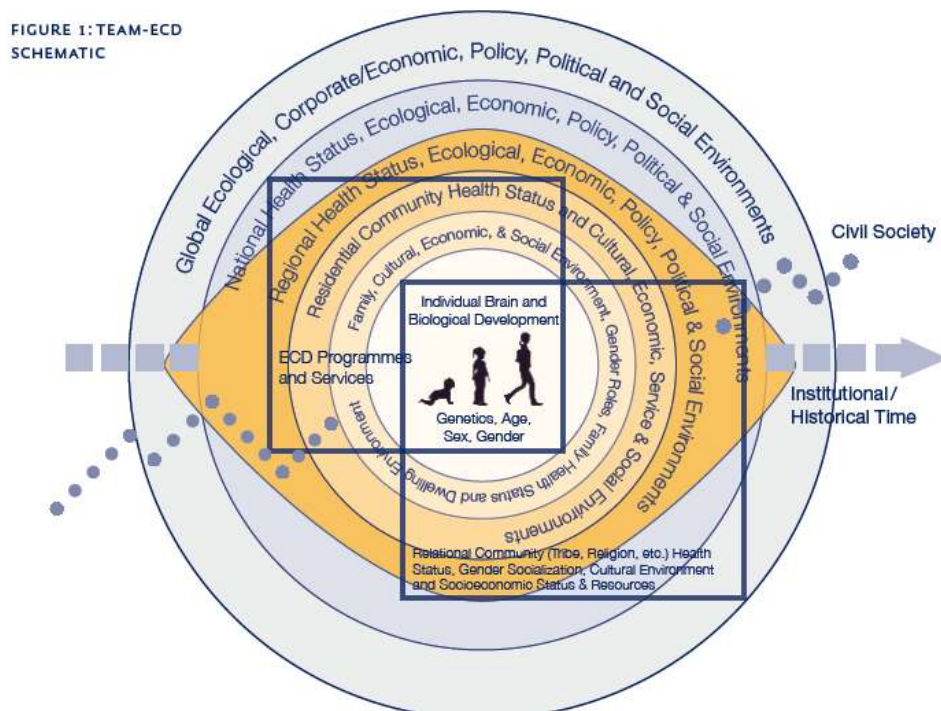
¹ Key points taken from Shonkoff and Phillips (2000) - see corresponding section in reference list.

² A “toxic” stress response can occur with strong, prolonged or frequent adversity without adequate adult support. A positive stress response is brief and a normal part of development; a tolerable stress response relates to more severe, longer-lasting adversity but is buffered by supportive relationships.

global. This ecological model of ECD acknowledges the central role of parents/whānau in providing appropriate care.³

There are many wider factors influencing ECD. These include the basic conditions and resources for health and Whānau Ora⁴, positive formal and informal social networks, accessible and quality services, and the wider societal context (for example, levels of discrimination/racism or violence, or norms relating to breastfeeding or alcohol, tobacco and drug use). Child/whānau-centred policy making is important across central and local government. Virtually every aspect of government and wider society has relevance to ECD – either by directly affecting children, or via effects on the wider social determinants on health or on the care-giving environment.

Figure 1 Influences on early child development (Irwin et al 2007)



The role of public health

A public health approach, collective action to protect and promote the health of populations, has much to offer the domain of early child development. Key features include:

- Understanding the patterns and underlying causes of ill-health and inequalities.
- Working in partnership with communities.
- Focusing on improving the health of populations.
- Addressing inequalities in health between population groups.
- An emphasis on prevention.
- A strategic and long-term perspective.
- Multifaceted action using an evidence-based approach.

³ Dimensions of care include providing a loving, responsive, and stable environment, protecting from harm, appropriate stimulation, guidance and boundary setting, and support for children to explore and understand their world.

⁴ Such as defined by the Ottawa Charter for Health Promotion 1996 - peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity (www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf). Also see www.beehive.govt.nz/sites/all/files/whanau-ora-taskforce-report.pdf.

The evidence on early childhood interventions

There is an extensive and growing evidence-base on effective early childhood interventions. Most early childhood evidence relates to targeted individual or community-based programmes, rather than wider action on the determinants of health. There remain some gaps in knowledge. In some cases there is a good understanding of risk or protective factors, but insufficient evidence on the (cost-)effectiveness of interventions, or evidence may not be generalisable to different populations. The evidence does show that care is required to ensure that interventions reach those most at need.

Current knowledge supports the following approaches, programmes or policies (see corresponding section in reference list):

- Accessible, high quality maternity, primary care and well child services for all pregnant women and young children.
- Multi-level interventions to reduce harm from factors such as tobacco, alcohol, illicit drugs or violence – for pregnant women and young children.
- Quality early childhood centre-based education/development programmes for vulnerable young children.
- Quality intensive home visiting programmes. These have the potential to be effective, particularly for disadvantaged children, but need to be evidence-based and carefully designed and implemented, particularly when scaling up model programmes.
- Quality two-generation programmes. These can be beneficial for parents and children at risk of poor developmental outcomes but they need to be carefully designed, implemented, and evaluated, particularly if being introduced in a large-scale manner. There is insufficient evidence to identify whether a combined programme for parents and children is more effective than separate programmes.
- Some specific parent training and education programmes.
- A range of multi-level or specific interventions in domains such as injury prevention, housing, infant mental health, maternal nutrition and breastfeeding, infectious disease, and oral health.

It is important that the planning and implementation of interventions is as evidence-based as possible. In areas where there are promising interventions but insufficient evidence, there should be clear evidence-based intervention logic and programme design should include evaluation. Interventions should be designed, implemented and evaluated in partnership with communities, with the reduction of inequalities as a fundamental objective.

3 A PICTURE OF EARLY CHILDHOOD DEVELOPMENT IN NEW ZEALAND

For some time, across many childhood indicators, New Zealand has performed poorly compared to other developed nations. For example, although rates of injury and infant mortality have been declining, the rate of decline has been less than in other nations, and inequalities have persisted or even widened (CYMRC 2008). The most recent international comparative study to rate New Zealand poorly in child well-being, *Doing Better for Children* (OECD 2009), found that New Zealand did not score highly in any category and was second to last in health and safety. New Zealand had the fifth lowest levels of social spending on early childhood in the OECD.

The significant socioeconomic and public sector changes in New Zealand over the past three decades have had a major impact on young children. Many policy changes during the 1980s and 1990s have been detrimental to children because of their effects on the social determinants of health. Over the 2000s there have been patchy areas of improvement, such as in primary health care, housing and early childhood education. Poverty remains a concern - the Working for Families package has increased incomes for many families, but not the poorest (St John et al 2008). The effects of the recent recession and the subsequent policy responses are still unfolding⁵ – past experience shows that children are especially vulnerable, and their needs easily overlooked, during times of significant social change (Blaiklock, Kiro et al. 2002).

Overview of current early childhood policy and services

Early childhood policy and services in New Zealand are complex and fragmented. Currently, there is not an active overarching ECD policy. At a high level, the health sector has several relevant strategic documents,⁶ many emphasising the need for a population-based approach, a reduction in inequalities, and greater preventive efforts. There are some legislative and bureaucratic instruments to encourage the reduction of inequalities, and there are some resources for service-planners and policy-makers (for example, the Health Equity Assessment Tool (Signal, Martin et al. 2007)).

The three key planks of early childhood health care services are primary maternity services, the Well Child Tamariki Ora schedule, and primary health care services.⁷ All have national specifications in place, however the exact configuration can vary. All three services are expected to promote a holistic approach, recognising the physical, social, and emotional needs of the mother, child and whānau.

Primary maternity and Well Child Tamariki Ora services are free for women and children. The Ministry of Health, through the Primary Maternity Services Notice 2007, funds Lead Maternity Carers (LMCs, usually midwives, some obstetricians or family doctors) to provide care throughout pregnancy, labour and the postnatal period. DHBs are funded to provide a small proportion of primary maternity services.

The Well Child Tamariki Ora schedule (revised July 2010) is based on the notion of universal provision of services for all, with additional services according to need. The schedule outlines five health contacts during the postnatal period (provided by LMCs or primary health

⁵ The NZCYES is monitoring the effect on child health. See the Children's Social Health Monitor at nzchildren.co.nz.

⁶ Such as the Primary Health Care Strategy, He Korowai Oranga - the Māori Health Strategy, the Child Health Strategy, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014 and strategies for mental health, disability and alcohol and other drugs (see www.moh.govt.nz).

⁷ See www.moh.govt.nz for more detail.

providers) and eight contacts for children from 4-6 weeks of age to 5 years. Currently, the Royal Plunket Society is funded to deliver these services to around 85% of children with DHBs responsible for the remainder (with over 50 providers, many Māori or Pacific providers). Additional Well Child contacts are available for all first-time parents or families with additional needs (if they live in moderate to high deprivation areas). A range of needed improvements to these services will be phased in over the next two years.

For primary health care, all children are encouraged to be enrolled with a primary health organisation (PHO). However, significant co-payments can be required, particularly for after-hours care. The “Zero-fees for under sixes” initiative for standard consultations, introduced in 2008, is voluntary and has been taken up by many, but not all, PHOs. Children from birth to 17 years of age are entitled to free basic oral health services.

There are also many preventive/early intervention programmes⁸ provided throughout the health system, as well as specialist health services, including child development and child and adolescent mental health services.

In the education sector, the key ECD components are early childhood education services (ECEs) and primary schools, with specialist services available when there is an identified need. There is a holistic, bicultural early childhood curriculum (Te Whāriki), and initiatives are in place to increase the quality of ECEs. The universal 20-hours-free ECE policy has been a major policy development. There are also targeted programmes to promote ECE participation, for example, for disadvantaged children, or for Pacific communities.⁹

The social sector is complex. There is a complicated and flawed system of targeted income support and family assistance (St John et al 2008). There is a large array of early intervention, violence prevention, and positive parenting programmes/resources¹⁰ funded by the Ministry of Social Development (MSD). Child Youth and Family (CYF) have a statutory role to protect children from maltreatment. CYF are working towards improving their response for infants (“Vulnerable infants” programme) and to have a more flexible response, addressing the broader needs of families (“Differential response model”).

Across sectors there are some interagency initiatives such as Strengthening Families, the Campaign for Action on Family Violence, the Inter-agency Plan for Conduct Disorder/Severe Antisocial Behaviour, and health and education assessments for children coming into care.

Current status of early childhood development in New Zealand

Although there are several sources of information (see reference section), ECD in New Zealand is not regularly reported or summarised cohesively or in a way to monitor inequalities. Obtaining information in the right format, for the purposes of focusing on early childhood and inequalities is not simple. Reporting on inequalities can be variable.¹¹ Population measures of ECD are being used in Canada and Australia with the Early Development Index (EDI), administered by teachers at school entry, but have yet to be introduced here.

⁸ In topics such as immunisation, Well Child promotion, communicable disease, injury, mental health, tobacco control, family violence, breastfeeding, nutrition, oral health, alcohol and other drugs, sexual health, healthy housing, screening (e.g. antenatal, newborn hearing and metabolic screening), and Health-Promoting Schools.

⁹ See www.minedu.govt.nz.

¹⁰ See www.familyservices.govt.nz.

¹¹ For example, inequalities are particularly pronounced in child injury yet “A Chartbook of the New Zealand Injury Prevention Strategy - Serious Injury Outcome Indicators for Children 1994-2005. A report by the Injury Prevention Research Unit for ACC” does not present information by ethnicity.

Information on child health has greatly improved over recent years, particularly from the New Zealand Child and Youth Epidemiology Service (NZCYES) and the Ministry of Health data and statistics programme. The health sector has improved data collection and use, including ethnicity data, and is looking at increasing the use outpatient and mental health service data.

Table 1 shows some of the most recent, readily available indicators of ECD. Population-based information is not easily available for some, such as coverage of the Well Child Tamariki Ora programme and antenatal care. Many important indicators do not have information presented for young children or is not provided by ethnicity or deprivation.

The picture is of much preventable ill-health, with a pervasive pattern of inequalities. Poverty and hardship are heavily weighted towards families with young children, particularly for Māori and Pacific, and families reliant on benefits. Māori and Pacific children experience the greatest risk of poor outcomes. Exposure to tobacco smoke, infant mortality, injury and child maltreatment are indicators with particularly marked inequalities. The groups with the greatest burden of disease have had poor immunisation coverage, although this is beginning to improve and inequalities are starting to narrow.

Table 1 A selection of current indicators of early childhood and inequalities in New Zealand (see abbreviations and references for more information)

Level 1: Social Determinants of Health	
<p>Poverty Living in households earning < 60% of the median income <i>2008 Household Economic Survey data in Social Report, MSD 2009</i></p>	<ul style="list-style-type: none"> • 20% of all children aged 0-17 years (compared to 14% of total population and 9% of 65+ years). • Māori 22%, Pacific 29%, European 12%, 38% other ethnicity (figures for total population). • Two-parent families 13%, one-parent families 39%.
<p>Living Standards Experiencing hardship <i>2008 Living Standards Survey, MSD in Perry 2009</i></p>	<ul style="list-style-type: none"> • 19% of all children aged 0-17 years (13% for total population and 4% of 65+ years). • Māori and Pacific people have hardship rates 2 to 3 times that of European/other. • One-parent families 39%, two parent families 11%. • Beneficiary families with children 51%, working families with children 11%.
<p>Household crowding Living in crowded households - needing ≥1 more bedroom. <i>2006 census data in Social Report 2009, MSD</i></p>	<ul style="list-style-type: none"> • 17% of children aged 0-9 years (10% of total population and 9% of >15 yr olds). • Māori 23 %, Pacific peoples 43%, Asian 20%, European 4%, other 23% (figures for total population).
<p>Early childhood education Year 1 school entrants participated in ECE services <i>2009 data, MoE 2010</i></p>	<ul style="list-style-type: none"> • 95.1% of all new school entrants. • Māori 91.4%, Pacific peoples 85.4%, European 98.5%, Asian 95.6%. • Gradient present: 82% in the lowest school decile to 99% in the highest decile.
<p>Primary health care Children unable to see a GP when they needed to in the previous 12 months. <i>NZ Health Survey 2006/7, MoH 2008</i></p>	<ul style="list-style-type: none"> • 5.7% of children aged 0-4 years, 4.0% of children aged 0-14 years. • 6.7% of Māori, 4.0% Pacific, 4.3% Asian, 3.8% European/other (figures for children aged 0-14 years). • No significant differences by neighbourhood deprivation.
Antenatal care	Insufficient population-based data readily available.
Well child services	Insufficient population-based data readily available.
<p>Self-reported racial discrimination Self-reported experience of racial discrimination <i>NZ Health Survey 2002/3 in Harris et al 2006</i></p>	<p>No data available for children. Adult experience of racial discrimination:</p> <ul style="list-style-type: none"> • Unfair treatment in health setting: Māori 4.5%, non-Māori 1.5%. • Housing-related unfair treatment: Māori 9.5%, non-Māori 0.7%.
Level 2: Intermediary risk or protective factors	
<p>Exposure to tobacco smoke Living with at least one parent who was a regular smoker <i>2006 census data in NZCYES report, Craig et al 2007</i></p>	<ul style="list-style-type: none"> • 35.3% of children aged 0-14 years (compared to 40.2% in 1996). • NZ European 27.5%, Māori 59.3%, Pacific 48.1%, Asian 18.5%. • Steep gradient present: 15.8% for least deprived quintile to 56.6% for most deprived quintile. • Varies by family type for infants - 52% of infants (under 1 year) living in one-parent families; 28% in two-parent families (<i>in Child & youth indicator report, MSD 2008</i>).
<p>Drinking while pregnant Consumed alcohol while pregnant <i>NZ Alcohol and Drug Use Survey 2006/8, MoH 2009</i></p>	<ul style="list-style-type: none"> • 28.7% of women who had been pregnant in the previous 3 years reported that they had consumed alcohol while pregnant. • European/other 31.6%, Māori 31.8%, Pacific 20.2%, Asian 4.0%. • No significant differences by neighbourhood deprivation.
<p>Childhood exposure to harmful drinking Experienced harmful effects on home life due to own alcohol use. <i>NZ Alcohol and Drug Use Survey 2006/7, MoH 2009</i></p>	<ul style="list-style-type: none"> • 5.4% of adults aged 16-64 years experienced harmful effects on their home life in the previous 12 months due to their own alcohol use; 14.2% lifetime prevalence. • Māori women and Pacific men about 80% more likely to have experienced harmful effect compared to total population (Asian people and Pacific women less likely). • Social gradient for men (3.4% for least deprived quintile to 10.3% for most deprived quintile), nil significant gradient for women.

<p>Immunisation Fully immunised by 24 months <i>Year to July 2010 NIR data, MoH 2010b</i></p>	<ul style="list-style-type: none"> • 86% of children fully immunised at 24 months of age. • NZ European 86%, Māori 80%, Pacific 87%, Asian 92%, Other 82%. • Gradient present: From 83% for most deprived quintile to 89% for least deprived quintile.
<p>Breastfeeding Exclusive breastfeeding <i>NZ Health Survey 2006/7, MoH 2008</i></p>	<ul style="list-style-type: none"> • 72.9% at 6 weeks, 55.8% at 3 months, 25.2% at 5 months. • No significant differences by ethnicity at 6 weeks and 3 months, at 6 months European/other infants less likely to be exclusively breastfed. • Minimal or no social gradient for 6 weeks and 6 months. Gradient at 3 months from 46.2% for most deprived quintile to 64% for least deprived quintile.
<p>Family cohesion Parents of children aged 0-14 years rating their family's ability to get along as poor or fair. <i>NZ Health Survey 2006/7, MoH 2008</i></p>	<ul style="list-style-type: none"> • 4.3% of parents of children aged 0-14 years. • By ethnicity of child: NZ European/other 4.1%, Māori 7.1%, Pacific 3.8%, Asian 3.2%. • Gradient present: 2.5% for least deprived quintile to 6.8% for most deprived quintile.
<p>Obesity Body Mass Index classified as obese <i>NZ Health Survey 2006/7, MoH 2008</i></p>	<ul style="list-style-type: none"> • 8.3% of children aged 2-14 years. • European/other 5.5%, Māori 11.8%, Pacific 23.3%, Asian 5.9%. • Gradient present: 5.2% and 5.7% for least deprived quintile to 13.9% and 16.4% for most deprived quintile for boys and girls respectively.
<p>Physical punishment Experienced physical punishment by primary caregiver in previous 4 weeks <i>NZ Health Survey 2006/7, MoH 2008</i></p>	<ul style="list-style-type: none"> • 10.4% of children aged 0-14 years; 19.4% of children aged 2-4 years. • By ethnicity Māori 14.0%, Pacific peoples 16.9%, European 9.6%, Asian 6.0% (children aged 0-14 years). • Boys living in the most deprived areas have the highest risk. No gradient present for girls or boys.
<p>Level 3: Health indicators</p>	
<p>Infant mortality Death rate per 1,000 live births <i>Fetal and Infant Deaths 2006, Ministry of Health 2010a</i></p>	<ul style="list-style-type: none"> • 5.1 per 1,000 live births. • Māori 7.2, Pacific 6.4, other 3.8 per 1,000 live births. • Gradient present: 3.1 per 1,000 for least deprived quintile to 7.8 per 1,000 for most deprived quintile.
<p>Sudden Unexpected Death in Infancy Death rate per 1,000 live births <i>CYMRC data for the period 2003 to 2007, CYMRC 2009</i></p>	<ul style="list-style-type: none"> • 1.10 per 1,000 live births. • Māori infants make up 61.6% of SUDI deaths. • Māori rate 2.34 per 1,000 live births, Pacific 1.31, Asian 0.14, and other 0.52. • Gradient present: 0.3 per 1,000 for least deprived quintile to 1.4 per 1,000 for most deprived quintile (SIDS 3-year moving average, 2004 to 2006 in <i>Fetal and Infant Deaths 2006, MoH 2010a</i>).
<p>Unintentional Injury mortality Death rate per 100,000 children <i>NZCYES report, Craig et al 2007. Tatau Kahuhua, MoH 2010c.</i></p>	<ul style="list-style-type: none"> • 11.5 per 100,000 children aged 0-14 years (2000-2004 data, NZCYES 2007). • Māori children 18.6 per 100,000 children aged 0-14 years, non-Māori 5.4 (2004-2006 data, MoH 2010c). • Strong gradient present: Children from poorest quintile have 1.91 times the risk of non-transport-related death (NZCYES 2007).
<p>Child Maltreatment Mortality and hospitalisation rate for children per 100,000 <i>NZCYES report, Craig et al 2007 Child & youth indicator report, MSD 2008</i></p>	<p>Child maltreatment mortality rate (2001-2005 data, MSD 2008)</p> <ul style="list-style-type: none"> • 1.6 per 100,000 children 0-4 yrs (5 yr average), 0.8 per 100,000 children 0-14 yrs. • Māori 1.5, Non-Māori 0.6 per 100,000 (children 0-14 years 5-yr average). <p>Child Maltreatment hospitalisation rate (2002-06 data NZCYES 2007)</p> <ul style="list-style-type: none"> • Māori 35.8 per 100,000, Pacific 35.8 per 100,000, European 12.4, Asian 9.6. • Strong gradient present: 6.9 per 100,000 for least deprived quintile to 37.5 per 100,000 for most deprived quintile.
<p>Oral Health ≥1 teeth removed due to decay, abscess, infection or gum disease. <i>NZ Health Survey 2006/7, MoH 2008</i></p>	<ul style="list-style-type: none"> • 11.3% of children aged 2-14 yrs. • European/other 10.1%, Māori 14.5%, Pacific 16.1%, Asian 10.9. • Gradient present: 10.7% and 5.2% for least deprived quintile to 16.7% and 15.4% for most deprived quintile for boys and girls respectively.

4 THE WAY FORWARD

In the developed world as infectious disease and injury rates have been declining, paediatricians have talked about the “new morbidities” of behavioural and developmental problems, poor mental health and social problems such as abuse (CPACFH 2001). New Zealand must face the challenges posed by effectively responding to these “new” morbidities yet is still struggling with “old” morbidities.

Significant numbers of New Zealand’s youngest citizens do not have a fair start to life. Many have very poor living conditions and experience some of the highest rates of preventable disease and injury in the developed world. This is severely curtailing optimal development, particularly for Māori and Pacific children, and reflects poorly on the nation. The pattern of increasing socioeconomic deprivation being associated with progressively poorer health means that less than optimal health is an issue across the population. These patterns are observed in many health determinants, risk and protective factors, and health outcomes.

The reasons for New Zealand’s poor performance in early childhood are likely to be a result of many factors at different levels. At its core the issues are inadequate prioritisation and focus on children, particularly vulnerable children, combined with wider patterns of societal disadvantage, particularly for Māori and Pacific people. In part, there may be insufficient knowledge of the importance of early childhood and health inequalities, and a lack of clarity on how to act. The Public Health Advisory Committee have identified the following key issues:

- Increasing pressure on families/whānau.
- Widening socioeconomic disparities.
- Comparatively low government investment in early childhood.
- Uncoordinated services.
- A lack of information for policy decisions and service delivery.

The Commission’s report and now the National Health Committee’s “The Best Start in Life” report, present a good opportunity for New Zealand to refocus on achieving equity from the start. Ultimately this will require cohesive and sustained effort across the health system, and wider public sector and civil society. It will require work to empower communities and whānau, to improve social determinants of health, to remove socioeconomic and cultural barriers to services, to ensure high quality and culturally appropriate services, to reduce harmful exposures (e.g. from alcohol, tobacco, violence, discrimination) and boost protective factors (e.g. social support, immunisation, cultural development).

Success will require working in partnership with parents/whānau and communities, knowledge of evidence, and the use of adequate data to plan and monitor progress. For the health system, a key part of action is to ensure the accessibility and quality of existing maternity, Well Child Tamariki Ora and primary health care services, particularly for those with the greatest need – many of these services are already funded, quality is expected, and there is a clear mandate to reduce inequalities and for a holistic and preventive approach. These services have not reached their full potential - a stronger population focus is necessary to complement the current focus on individual children and families and to reduce inequalities.

Although a major re-focus is necessary, significant improvements could be made relatively quickly, without major reorganisation. However, given the size of the task, it is hard to see how a system-wide focus on equity from the start can be achieved without a higher profile and high-level leadership, support and coordination.

Inequities in early childhood have no place in 21st century New Zealand. The country has a good foundation on which to build a strong and equitable approach to early childhood – but there is much more work to be done.

LIST OF ABBREVIATIONS

CYF	Child Youth and Family
CYMRC	Child Youth Mortality Review Committee
DHB	District Health Board
ECD	Early Child Development
ECE	Early Childhood Education
CSDH	Commission on Social Determinants of Health
LMC	Lead Maternity Carer
MoE	Ministry of Education
MoH	Ministry of Health
MSD	Ministry of Social Development
NIR	National Immunisation Register
NZCYES	New Zealand Child Youth Epidemiology Service
OECD	Organisation for Economic Co-operation and Development
PHO	Primary Health Organisation
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy
WHO	The World Health Organization

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