New Zealand: The urgent need to focus on child health?

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"E aku rangatira, he aha te mea nui o tenei ao? Maku e kii atu, he tamariki, he tamariki, a taatou, tamariki. Leaders, where does our future lie? In our children." – Dame Anne Salmond

The future health and well-being of any country is dependent on the well-being of its children. In New Zealand we have an image of children enjoying good health and young people growing to mature and responsible adulthood. Whether it is young people regularly making headlines in the international arts or sports arenas, or the thousands of young Kiwi kids regularly giving it their all on weekend sports' pitches, New Zealand punches above its weight in having future generations ready to take on the world. Moreover, with a superb natural environment, and a rich cultural diversity of child rearing practices to draw on, New Zealand should be a top tourist destination in which to raise children. While for a lot of families there is truth in this picture of ourselves, there is an alarming gap in the reality for many children.

Much of the recent health data about our children is poor. The 2007 UNICEF report[1] on child well-being in OECD countries infamously placed New Zealand 23rd out of 24 countries for health and safety outcomes for children (Figure 1). While this represents only part of the overall picture of child health, put together with many other gloomy reports, it provides an unenviable picture of the health and well-being of NZ children.

Causes for concern

Of the many causes for child health concern, the following have more particular relevance from a general practice perspective.

Infant mortality rates remain high, the main driver being ongoing high rates of SIDS, particularly for Maori children, and those from lower socioeconomic backgrounds. Despite considerable dedication and commitment by general practice and community health providers to immunisation, rates are still too low to prevent epidemics and to reach national targets; high background rates of diseases such as pertussis persist.

Infectious diseases including respiratory illnesses, gastroenteritis and skin infections are highly prevalent, producing levels of morbidity normally associated with countries outside the OECD. Although the rapidly rising hospitalisation rates for infectious diseases seen in the 1990s have levelled out, we have yet to see any significant falls in incidence.

In the UNICEF report, New Zealand came out worst of all the OECD countries in death rates from accidents and injuries in childhood. Outside the perinatal period, injuries are the leading cause of death, and falls the leading

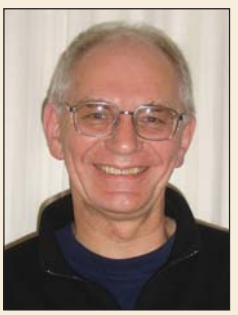

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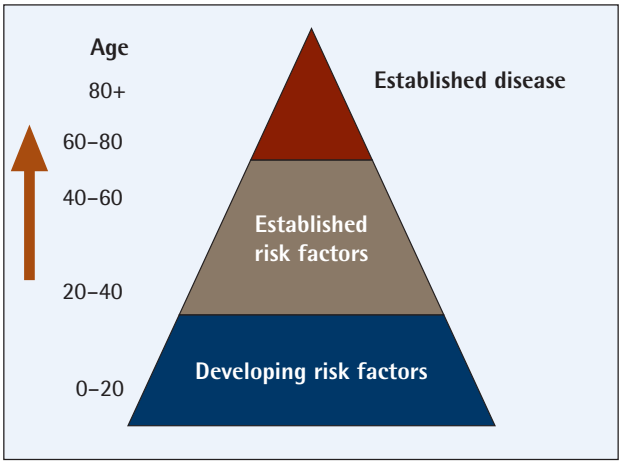
Figure 2. The potential to influence chronic conditions.



cause of hospital admissions. The most common causes of injury-related deaths in childhood are from transport accidents (45.3%), accidental threat to breathing (16.3%), drowning/submersion (14.1%) and assault (8.3%).

In youth and adolescence, high levels of psychological disorders, suicide, teenage pregnancy and substance abuse are creating a context in which many young people are unable to reach adult life with security and confidence.

Maternal health in pregnancy and early childhood health have considerable power to shape both short and long-term health and social outcomes for the individual. A graphic illustration of this is the University of Otago study which has followed 1000 children born between 1972 to 1973.[2] Children who grew up in low socioeconomic status families had poorer cardiovascular health, poor dental health and more substance abuse as adults, regardless of the adult socioeconomic conditions.

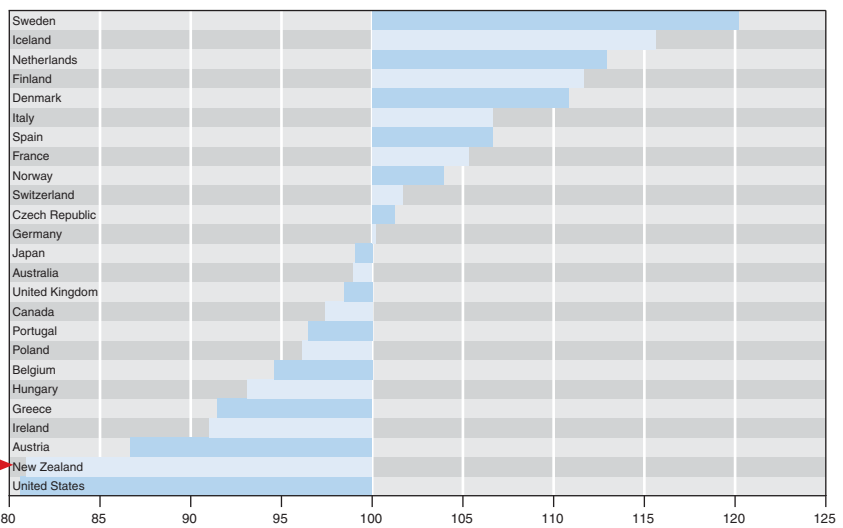
Furthermore, the effects of underlying issues such as poor nutrition and obesity in childhood are already beginning to be felt as a burgeoning tide of long-term conditions in those who are relatively young. Twenty-one per cent of New Zealand children are overweight and a further 10% are obese,[3] figures that are already starting to translate into teenage diabetes.

The potential to ameliorate or prevent the impact of the most significant long-term health problems begins in childhood, when risk factors are developing, rather than in adult life when they are established (Figure 2). This is as true of ischaemic heart disease as it is of chronic obstructive lung disease, depression or diabetes. Paradoxically there is an inverse funding law where the least money is spent on prevention of these conditions in the younger age groups.

Underlying causality

All complex health issues have complex and multifactorial underlying aetiology and child health is no exception. Most child health issues, however, are directly related or significantly affected by poverty and disparity. There is a clear association between greater income inequality and higher child mortality rates in OECD countries.[4] The current generation of children in New Zealand are the victims of a growing equity gap between rich and poor, accelerated by economic policies such as the erosion of child welfare benefits. Children are overwhelmingly more likely to live in poverty than any other age group. According to the Ministry of Social Development's Living Standards Report in 2004, 26% of children live in severe or significant hardship. This is

Figure 1. The Health and Safety of Children – an OECD overview (UNICEF Innocenti report card 7 Feb 2007)[1]



significantly worse than in 2000, and much worse than any adult group. In contrast to the 26% of children, 15% of 25–44-year-olds, 10% of 45–64-year-olds and only 4% of those 65 years and older lived in severe or significant hardship in 2004.

The impact of poverty, and particularly intergenerational poverty, is now embedded in many communities and this is having a broad impact on children and young people. As an example, evidence-based road safety measures such as speed bumps and 'walking-to-school buses' are more likely to be concentrated in higher socioeconomic areas, in contrast to the poor housing conditions and fewer recreational facilities in lower socioeconomic areas.

Many of the child health issues faced daily in general practice have significant underlying socioeconomic determinants at their core.

It has been estimated that exposure to second-hand cigarette smoke results in 500 hospital admissions each year for chest infections in children under two years of age, 15 000 episodes of childhood asthma, 27 000 GP consultations for asthma and respiratory problems and 1 500 surgical interventions for OME.[5]

While our child health statistics are a cause for concern, there is perhaps a more fundamental issue about a potentially deeper malaise in New Zealand society; how we, as individuals and society, view children. There continues to be a mythology that New Zealand is a child-focused and 'child friendly' society. The reality is that for many children it is a harsh and brutal environment with high levels of stress, illness, anger and violence.

We may feel that we live in a society that still has the school gala and play centre as paramount, and indeed there are many thousands of individuals who commit time and energy to child focused activities. Many New Zealand institutions, however, are tolerant of children rather than engaging directly with them. The great New Zealand barbecue may be a case in point; in mythology a happy gathering of families, often in reality an opportunity for adults to consume large amounts of alcohol, while children play by themselves. We must confront the paradox of New Zealand as an enviable environment that increasingly provides ready opportunities for unsupervised and often ill-considered activity, and few indications of a truly positive child-centred society.

Our public and political reaction to child health problems is often confused and defensive. The extreme reactions to Section 59, and the violent language in parliament, indicate a society which has not just a general lack of 'manners and being nice', but high levels of anger, poor impulse control and poor role modelling for children and young people. It is exacerbated by excessive political correctness and outrage at each accidental or non-accidental death – and then often a sadly minimal response.

Responses

A first step in responding to some of these challenges would be honest and no doubt painful debate at societal level as to how child-focused we are as a society. The 2007 UNICEF report made two crucial points:

- There is no obvious relationship between GDP per capita and child well-being; poorer countries than us do better by their children.
- Given levels of child well-being are not inevitable but policy-susceptible.

At a policy level children are left wanting, and restoration of a universal child benefit could be the greatest single preventive health measure we could devise.

Also some of our health policies, such as our attitude to alcohol consumption and tolerance of appalling morbidity and mortality caused by immature road users, are increasingly out of step with other OECD countries.

The role of general practice

While the greater economic and policy issues continue to need debate and action, there may be a number of opportunities for general practice to enhance our present ways of working. Child and youth health

The kids are doing all right; well some of them anyway.

is an area where public health campaigns are unlikely to achieve significant change without the engagement of personal health services.

There are already many examples where new and creative models are in place and providing effective targeting, particularly for youth, and complementing existing models of general practice care, e.g. PHOs providing ready for school checks, school clinics, youth health services and sexual health services. Reducing cost barriers for children to attend general practice has helped to reduce disparities of access.

The practice environment: While many waiting rooms and surgeries contain a toy box, little of the imagery and messages we have available is aimed at children or young people, and there are often few positive images of children and young people offered.

Our present focus on disease management, while having made great progress for chronic adult issues, has had little focus on the major issues for children's physical and mental health. Except for immunisations, population health approaches for children have not been well developed or resourced in GP settings. There are existing and future opportunities for screening and identification of at risk children at birth, the six-week check, or later childhood well child checks. The new Ministry of Health initiative of the four-year-old 'ready for school' well child check could be an excellent opportunity for primary care to enhance childhood screening.

Much work remains to be done to develop tools and pathways to optimise screening, tracking and identification of children's health needs in the GP setting. Effective coordination and integration of the work of general practice, schools, Plunket and social services is a case in point. General practice is now in a good position to engage in these issues. Positive system features include enrolled populations, increasingly effective teamwork, a high degree of computerisation and familiarity with the use of practice management systems for screening and tracking. There is also extensive experience of disease state management in adults, which uses very similar principles.

There are a number of specific clinical areas where additional resources and reflection on current practice could produce health gain.

New Zealand general practitioners are aware of the rapid onset of significant skin and soft tissue infections and, by international standards, tend to be aggressive in their treatment. Despite this, cellulitis and other skin infections continue to cause significant morbidity. Recent PHO initiatives providing patient education packs encouraging wound care and hand washing could be extended and maintained, and there is potential to use 'public health' money in this way at PHO level to achieve effective personal health interventions.

New Zealand general practice is remarkable by international standards in routinely offering long consultation times and, through this, delivering high quality practice. It is easy, however, for many paediatric consultations to be taken over by the acute and presenting complaints, and for underlying developmental, psychological or preventive care issues to lose out in the competing demand for consultation time. We have identified some things we wish we did more of in our clinical work and 'never seem to get round to' in a systematic way (Box 1).

Some of the existing models of consultation, used successfully in adult care, may have increasingly widespread application in childhood and adolescence. Given the increasing prevalence of 'lifestyle health problems' such as obesity, lack of exercise and poor nutrition in childhood, the adoption of consultation models, which include preventive care and discussion about health seeking behaviours, seems increasingly relevant. There are considerable challenges in this, not least the acquisition of research evidence of effective and practical interventions to produce lifestyle change in children and adolescents.

Box 1. Consultation options we wish we could get round to doing more often.

- Talking about hand washing to prevent infection.
- Recording the smoking status of households in kids' notes.
- Monitoring weight at all four-year-old immunisation visits.
- Reviewing records of children who have multiple visits to A&M Departments (likely to be more 'at risk' children).
- Structuring adolescent consultations (HEADDSS) or similar.
- Contraceptive advice and chlamydia screening for adolescents.

There is, for example, a good case to be made for routine enquiry about psychological problems in adolescent consultations, due to the high prevalence of disorder, associated serious morbidity, such as attempted and completed suicide, and evidence about the effectiveness of 'screening'. Students report high levels of suicidal thoughts (males 16.9%, females 29.2%), suicide attempts (males 4.7%, females 10.6%), and depressive symptoms (males 8.9%, females 18.3%).[6] 12.4% of young drinkers consume large amounts of alcohol at least once a week[7] and more than one quarter of students (males 27.2%, females 27.6%) report riding in a car driven by a potentially intoxicated driver within the last four weeks. Two-thirds of those suffering from depression also have further mental health morbidity.[8] The use of a structured 'teenage consultation' using the HEADDSS mnemonic (Home/Education/Employment/Alcohol/Drugs/Depression/Smoking/Sex) or something similar can be challenging within a busy surgery, but may yield significant results.

There are evidenced-based case finding tools that could help to further discussion about mental health problems with children, adolescents and caregivers following initial cues within the consultation. The use of these tools such as the Strengths and

Difficulties Questionnaire (SDQ)[9] may be appropriate for paediatric use in the same way that scales such as the Kessler K10 or PHQ can be used in adult practice.

The development of better screening processes and identification tools for children at the primary health care level will gain little if there are not also appropriate care pathways available for referral and management. Currently secondary service responses, particularly for child mental health and child/family attachment disorder problems, are extremely limited in many parts of NZ. Better screening and identification will come to very little without response and action.

Conclusion

New Zealand remains a country that has much to be envied, with a range of healthy outdoor environments, a tradition of child-focused sporting activities and the commitment of families, whanau and communities. Despite this we are performing very poorly in child health. General practice cannot solve many of the underlying socioeconomic disparities and poverty that disproportionately affect children in our society. With sufficient resourcing, however, it is in a position to enhance existing high quality care for children and young people. This can be achieved by developing appropriate systems and resources at DHB and PHO level, and by considering the structure and content of paediatric consultations, classifications and screening. In the process we may all have to question some of New Zealand's fundamental belief systems about how well we support children and young people.

Competing interests

None declared.

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