
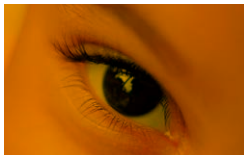

Our children, our choice: priorities for policy

A Child Poverty Action Group Policy Series
Part One

CHILD POVERTY ACTION GROUP

About Child Poverty Action Group

Child Poverty Action Group (CPAG) is an independent charity working to eliminate child poverty in New Zealand through research, education and advocacy. CPAG believes that New Zealand's high rate of child poverty is not the result of economic necessity, but is due to policy neglect and a flawed ideological emphasis on economic incentives. Through research, CPAG highlights the position of tens of thousands of New Zealand children, and promotes public policies that address the underlying causes of the poverty they live in.

If you would like to support CPAG's work, please visit our website: www.cpag.org.nz

About the authors

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Each topic-based part of the series is authored by experts in the field. The series would not be possible without their contributions and we thank them on behalf of Child Poverty Action Group.

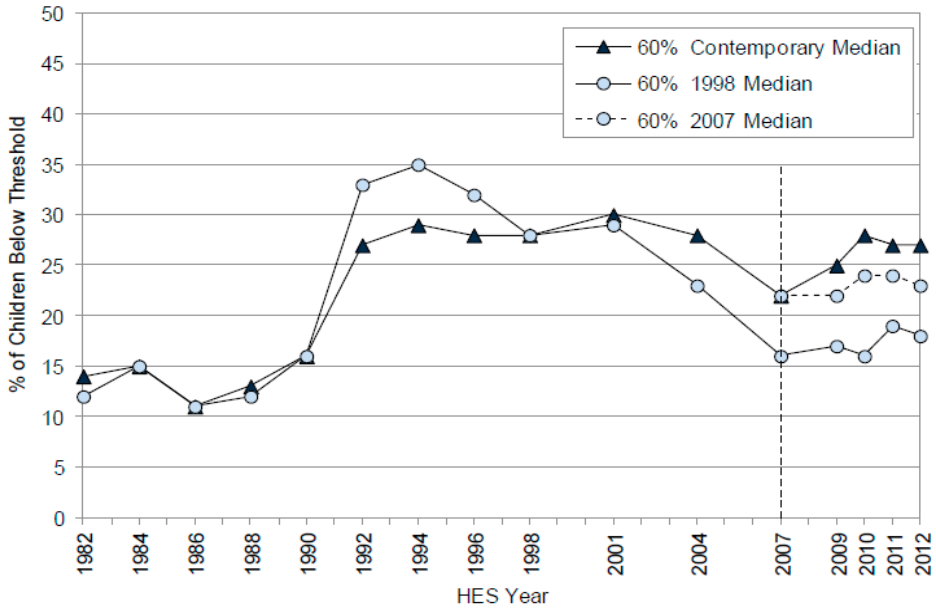
Our children, our choice: priorities for policy

Introduction to the series

In 2014, it is of grave concern that child poverty is now more entrenched and difficult to address than when Child Poverty Action Group published *Left Further Behind*, 2011.[1] The need for action is even more pressing. The full benefits of the 'Working for Families' (WFF) package are still only available to those families who meet a work-test and are not on any benefit, thus widening the gap between families 'in work' and others, between those seen as 'deserving' and the 'undeserving'. And since 2011, the situation for families in receipt of a benefit has worsened with the imposition of sanctions reducing benefit incomes by 50% or more if strict and often unreasonable requirements are not met.[2]

The evidence in New Zealand is overwhelming: around 285,000 of our children (27% of all children) are found under the poverty line used by the Ministry of Social Development. Many of these children have their lifelong health and education compromised. For three out of five of those children, poverty persists over at least seven years,[3] in other words for most of their early formative years. And, all the evidence shows that the longer the period on low income, the greater the harm.[4]

Figure 1. Proportion of Dependent Children Aged 0–17 Years Living Below the 60% Income Poverty Threshold After Housing Costs, New Zealand 1982–2012 HES Years (Source: Craig et al 2013, Figure 2)



Source: Perry 2014 [1] derived from Statistics NZ Household Economic Survey (HES) 1982–2012

Since the 1990s, the government's social policy has been driven by a focus on paid work. As important as good, secure, paid work is for families, this approach ignores the invaluable work of parenting. When parents can't meet norms of paid hours worked and require a state benefit, a discourse emerges of 'benefit dependency' in which parents are blamed for their poverty. Such a narrative generates support for the imposition of punitive sanctions and conditionality of benefit receipt, yet the vast majority of people who are currently poor, are poor in spite of their own best efforts. They are poor because welfare payments are low and limited, and the welfare system does not allow parents in paid employment to supplement their benefits in meaningful ways. They are poor because involuntary unemployment has eroded their assets and their capabilities. They may be poor because low-paid employment still keeps people in poverty: two in five poor children are in working families where at least one adult is in full-time employment or self-employed.[5] Policies, too, act to

keep poor families poor: the WFF tax credit package is discriminatory and badly designed.[6] The tax system remains punitive for low earners.

Unfortunately, conservative critics of welfare provision either deny that anyone in New Zealand is genuinely poor, or they insist, despite the evidence to the contrary, that most of those now in poverty are there because of poor life-style choices or an unwillingness to work. For such critics, the welfare net is too generous. They believe that any narrowing of the gap between welfare income and low pay would remove the pressure on the long-term unemployed to seek work. Poor children are disproportionately Māori and Pasifika, and can be dismissed too easily by conservatives who demonstrate an underlying racial bias.

On 11 October 2012, the Minister for Social Development released the *White Paper for Vulnerable Children*, to be implemented by the *Children's Action Plan*. The Action Plan's aim is: "Identifying, Supporting, and Protecting Vulnerable Children."[7] The narrow definition of 'vulnerable children' as those who are at risk of maltreatment by their caregivers ignores the social and economic conditions that create or exacerbate children's vulnerability and the report is silent on the fact that poverty is the single most obvious factor in family violence.[8] [9] [10]

In 2014, despite claims of economic recovery after the protracted recession, reports from frontline social services suggest child poverty has continued to worsen. These reports were corroborated by revised figures released on 27 February: "Children in poverty vastly underestimated". Queries from the OECD about the figures on child poverty led to the Treasury and Statistics New Zealand admitting a major error in calculations of household disposable income: they had overestimated incomes among poorer households by double-counting the Accommodation Supplement.

The Ministry of Social Development (MSD) emphasised that the mistake did not change the trend of inequality, but did increase it slightly, while Treasury's chief economist Girol Karacaoglu said: "[T] here are no 'real world' impacts on New Zealanders from the miscalculations". He was saying that the errors do not affect individual or household benefit payments, tax credits or the tax people pay. While no child was made poorer as a result of the mistake, the miscalculations *do* have real world implications for the poorest children. Not knowing that 30,000 more children than previously reported were living under the lowest 50% poverty line has meant that for 3 years no official alarm bells were raised. The depth of child poverty has been seriously unrecognised as it is not only the ones not seen to be below the poverty line but, even more critically, most of the 205,000 families below the 50% line have less income than previously thought.

On 10 March, the Prime Minister announced that 20 September would be the 2014 election date. Children are waiting for the election winners to provide a better future. The aim of the CPAG series, *Our Children, Our choice: Priorities for Policy*, published over the coming months, is to provide an overview of the situation for many children in New Zealand, and to support the immediate adoption by all political parties of child-focussed policies to reduce child poverty and mitigate its effects.

This series comes out three years after CPAG's report, *Left Further Behind (*2011), six years after CPAG's report: *Left Behind* (2008), and ten years after the New Zealand government announced the rollout of its flagship family assistance policy, WFF. The reports provided ample evidence that despite WFF and other family-related policies, the poorest children have continued to be left behind relative to their peers and likely to suffer harmful consequences.

The 2014 publications recommend changes to current policy around children's health; housing; early childhood education and care; provision of compulsory education; and family incomes. Each part is authored by experts in their field, and contains links to other resources including audio-visual material. This first part of the series focuses on the health of the poorest children in Aotearoa New Zealand. It closes with recommendations for better policies for our children.

Our children, our choice: priorities for policy. Part one:

Child poverty and health

Nikki Turner and Innes Asher

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Acknowledgements

Our thanks to the Children's Commissioner, Dr Russell Wills, for commissioning the Expert Advisory Group to produce *Solutions to Child Poverty* (2012),[11] and to the NZ Child and Youth Epidemiology Service and Dr Elizabeth Craig for permission to reproduce the selected graphs and tables from the *Child Poverty Monitor 2013 Technical Report*.[12] Also, our thanks to Associate Professor Simon Denny, Department of Paediatrics: Child and Youth Health, University of Auckland who contributed to the section on Youth Health; to Associate Professor Sally Merry, Department of Psychological Medicine, University of Auckland, who reviewed the recommendations; Dr Rhys Jones, Senior Lecturer, Te Kupenga Hauora Māori, University of Auckland and Dr Paula King, Public Health Physician, who contributed to the sections on Māori children; to Dr Katie Bach, Paediatric Dentist, who contributed to the section on oral health; and to Dr Stuti Misra, Post-Doctoral clinical research fellow, Department of Ophthalmology, University of Auckland, who contributed to the section on optometry.

Our children, our choice: priorities for policy series. Part 1: Child poverty and health
ISBN: 978-0-9922586-7-2

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>
> *New Zealand National Health Committee (1998) The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health.*[13]

The context of child poverty and health in New Zealand

The future health and wellbeing of any country is dependent on the well-being of its children. A much greater proportion of New Zealand children are affected by poverty now than 2-3 decades ago (see Figure 1 in the Introduction to the series), with accompanying ill health. Poverty is one of the leading factors contributing to childhood illness, disease, disability and deaths in New Zealand. In addition to those immediate consequences, many major health issues in adulthood have origins in childhood poverty, such as cardiovascular disease, mental illness, dental decay and lowered longevity. [14 15 16]

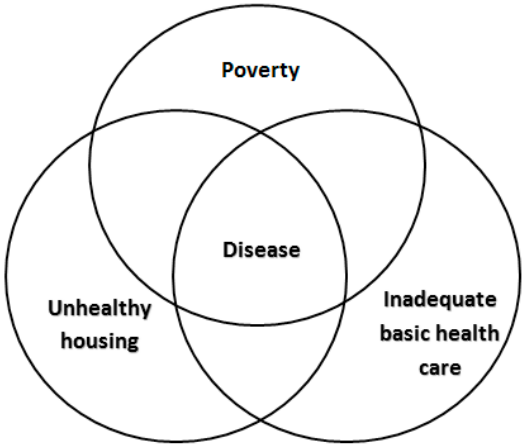
The long term impact of poverty on child health and wellbeing involves multiple causes and pathways. One important example as described by D'Souza et al[17] is the impact of 'enforced lacks', of families having to cut back on essentials because of money, such as children having to share a bed, or several to a bedroom; less fresh fruit and vegetables; difficulties heating the house in winter; exposure to damp or mouldy housing; and postponing doctors' visits and not collecting prescriptions because of costs. These 'economising behaviours' are a common experience for children living in poverty.

Sixteen years ago the National Health Committee[18] (quoted above) made strong evidence-based recommendations to improve the health of New Zealanders, including strong political leadership, and health, income, housing and intersectorial initiatives but many have yet to be implemented.

Most recently the Commissioner for Children, prioritising child poverty as the key issue in his first term, commissioned an Expert Advisory Group to report on Solutions to Child Poverty published in November 2012,[19] and referred to later in this chapter.

The basis of our high rates of preventable diseases lie in New Zealand's triple jeopardy for child health,[20] that is, a combination of problems in three critical areas at once: poverty, unhealthy housing and inadequate basic health care.

Figure 1. New Zealand's triple jeopardy for child health (Asher 2014)**.**



- ***Poverty:*** New Zealand rates of child poverty are very high, as are the proportion of children in significant poverty for long periods. Poverty has a deep impact on child health leading to more severe and recurrent illnesses in ways which are under recognised. This includes the ill-effects on growing children of a lack of regular nutritious food and the effects on the immune system functioning for children living with high levels of household stress and insecure living situations, all also creating further difficulties for learning and education.
- ***Unhealthy housing:*** Many of our houses are cold, damp and unheated or heated with unhealthy fuel. Fuel and rental accommodation are expensive and often lead to crowding, in an attempt to meet these expenses.
- ***Inadequate basic healthcare:*** Nationally there is no co-ordinated framework which effectively engages all children in healthcare from pregnancy to adulthood in ways that everyone can access.

When families experience problems in all these areas at once, some diseases may become almost inevitable for these children, as they did in the times of Dickens. All these factors affecting wellbeing can be changed, if we choose to.

RECOMMENDATION 1

Government to design a comprehensive plan to reduce child poverty that includes actions, targets, measurable outcomes and regular reporting requirements.

New Zealand compared with other OECD countries

New Zealand is seen as a world leader in child health and development research.[21] Despite our reputation, in 2009 New Zealand was ranked second to last in health and safety of 30 countries in an OECD report on child wellbeing, and did not score highly in any category.[22] While some of this data is now dated, the current New Zealand rates of hospitalisation for potentially preventable illness suggest that we have had little improvement in most areas.[23]

Other OECD countries do not have such high rates of serious skin or respiratory diseases, or rheumatic fever which is virtually unknown in countries like Sweden, the UK and the USA.

Of additional concern is New Zealand's low public financial investment in children by OECD standards, with investment in young children being less than half the OECD national average.[24]

The Marmot Review (2010) "Fair Society, Healthy Lives"[25] states:

> *Focusing solely on disadvantage will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, the principle of proportionate universalism must be applied.*

Currently this principle of 'proportionate universalism' (providing universal services and targeted extra services based on assessment of further need) is being applied in many aspects of health service delivery. We recommend that this funding principle become a national approach, applied consistently to redesign the funding of antenatal and postnatal health services and across all primary child and youth health services.

RECOMMENDATION 2

To improve the outcomes for children in poverty, healthcare should provide universal services and targeted extra services based on assessment of further need.

Child health outcomes in New Zealand affected by poverty

As noted in the Expert Advisory Group's (EAG) *Health Working Paper 17,*[26] New Zealand children in poverty are:

- At a 1.4 times higher risk of dying during childhood than children in higher-income households.[27]
- More likely to die of sudden unexpected death in infancy than their peers.[28] [29]
- Three times more likely to be sick.[30]
- At greater risk of contracting infectious diseases, as these spread more easily in overcrowded and difficult household conditions.[31]
- At least 1.5 times more likely to be hospitalised than their peers in other geographic areas.[32]
- Hospitalised at a 5.6 times higher rate than those in wealthier areas for injuries from assault, neglect or maltreatment.[33]
- Less likely to have fruit and vegetables than those in wealthier households.[34] [35]
- In adulthood, have higher risk of heart disease, alcohol and drug addiction, and worse oral health at age 26.[36]
- Children with disabilities are over-represented among poor children, with a disproportionate number living in beneficiary families.[37] [38]
- From 2007 - 2010 there has been an increase in children being admitted to hospital with medical conditions and rates are higher in children living in poverty with just under 5,000 extra admissions per year.[39]

Material deprivation for New Zealand children

The 2008 *Living Standards Survey*[40] showed that high proportions of children scored four or more issues on a composite deprivation index of 'enforced lack' (Table 1): 59% of children whose main source of family income was from a government benefit; over half (51%) of all Pasifika children; 39% of Māori children; and 15% of European children.

Importantly, a considerable proportion of poorer households at times postponed children's visits to the doctor, and at times were unable to collect prescriptions due to the cost. Children living in most significant poverty had a much higher incidence of serious health problems compared to those from wealthier backgrounds. Families in poverty were very likely to have to cut back on warming the house, buying fresh fruit and vegetables and visiting the doctor.

Table 1. Restrictions Experienced by Children, by the Deprivation Score of their Family, New Zealand Livings Standards Survey 2008 (Source: Perry 2009; Craig et al. 2013)[41 42]

	Percentage (%)					
	All	**0**	**1**	**2–3**	**4–5**	**6+**
Distribution of children across the DEP scores	**100**	**41**	**18**	**18**	**10**	**12**
Average number of children per family		2.2	2.3	2.5	2.7	2.7
Enforced lacks of children's items						
Friends to birthday party	6	-	-	5	9	31
Waterproof coat	8	-	2	8	11	39
Separate bed	5	-	-	3	13	20
Separate bedrooms for children of opposite sex (10+ yr)	8	2	3	6	14	24
All school uniform items required by the school	5	-	-	2	9	19
Economising 'a lot' on children's items to keep down costs to afford other basics						
Children continued to wear worn out shoes/clothes	8	-	-	5	15	39
Postponed child's visit to doctor	2	-	-	-	5	13
Did not pick up prescription for children	1	-	-	-	3	7
Unable to pay for school trip	3	-	-	-	6	17
Went without music, dance, kapa haka, art etc	9	2	4	8	18	37
Involvement in sport had to be limited	8	-	4	6	17	32
Multiple deprivation						
4+ of the 11 children's items above	6	-	-	2	11	35
5+ of the 11 children's items above	4	-	-	-	7	29
6+ of the 11 children's items above	3	-	-	-	2	24
Children's serious health problems reported by respondent						
Serious health problems for child in the last year	28	22	25	31	35	43
Enforced lacks reported by respondent in child's family						
Keep main rooms warm	9	-	3	8	18	37
Meal with meat/chicken/fish at least each second day	3	-	-	-	6	18
Cut back/did without fresh fruit and vegetables	14	-	-	15	32	63
Postponed visit to doctor	14	-	4	18	38	65

	Percentage (%)					
	All	**0**	**1**	**2–3**	**4–5**	**6+**
One week's holiday away from home in last year	33	14	28	42	52	73
Home computer	8	3	6	8	13	25
Internet access	9	-	7	9	18	28
Housing and local community conditions						
Physical condition of house (poor/very poor)	7	-	3	7	15	28
Major difficulty to keep house warm in winter	22	9	13	27	38	58
Dampness or mould (major problem)	17	5	13	18	37	49
Crime or vandalism in the area (major problem)	11	6	6	11	13	31

Note: Only those items mentioned in the Methods Box are included in the calculation of DEP Scores. This table includes a number of additional child specific items which were not included in the calculation of the DEP Index as they did not relate to all family types. These additional items have been included here in order to highlight the experiences of children living in households with differing experiences of material deprivation. This is why some of the percentages for individual items are >0 in the DEP 0 column i.e. a family may have scored 0 for the 14 items in the DEP Index, but did report an enforced lack for some of the other child specific measures.

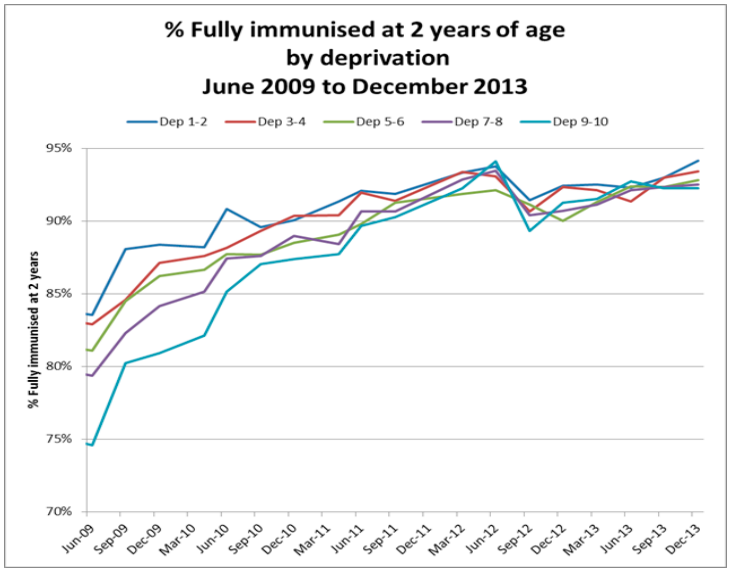
Some gains

Immunisation coverage

There has been improvement in some areas of health. One particularly positive example is with childhood immunisation coverage rates.

In 1992 the national coverage rate for 2 year olds was 56% with even lower rates for Māori and Pasifika children. In 2014, coverage is now just below the 95% target for all groups. Socioeconomic and ethnic gaps are closed almost completely at 2 years of age (Figure 2) and timeliness of delivery is much improved. This is a fantastic achievement, unique in the New Zealand child health environment which traditionally is dominated by inequalities in service delivery and outcomes.

Figure 2. Percentage fully immunised at 2 years of age by deprivation, June 2009 to December 2013
(Source: Data: NIR 2014; graph courtesy of Immunisation Advisory Centre, University of Auckland)



The achievements for immunisations have been attributed to strong leadership and community support, the effective use of target setting, appropriate infrastructure such as the national immunisation register, effective service delivery and feedback loops, and the use of specific evidence-based strategies.[43] This is clearly a successful example of where the government made a comprehensive plan with targets and measurable outcomes which are being achieved.

Declining rates of sudden unexpected infant death

Mortality from sudden unexpected death in infancy has declined dramatically in the past 20 years from 200 to around 60 per annum.[44] The improvement is attributed mostly to placing infants to sleep on their backs. However New Zealand still has one of the highest rates of sudden unexpected death in infancy among industrialised countries, with the risk being disproportionately high in the Māori community and those population groups that experience high deprivation.[45] [46] Unintentional suffocation is recognised increasingly as a significant contributor to the ongoing rates of sudden unexpected death in infancy, particularly with co-sleeping with adults.[47]

Increased attention and resourcing

There has been new health spending and particular attention has been given to rheumatic fever prevention, Whanau Ora, Gateway Assessments, Integrated Family Health Centres, and quality indicators in maternal and child health including a focus on timely newborn enrolment with primary care. There is generally, greater attention currently to child health concerns as seen with the Government's 2012 *Green paper on vulnerable children*[48] and *2012 White paper on vulnerable children*,[49] the Māori Affairs Select Committee *Inquiry into the Determinants of Wellbeing for Māori Children*[50] and the Health Select Committee *Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception under three years of age*.[51] However it is still accepted that action remains fragmented, insufficient and lacking a coordinated national framework across health and other sectors.[52]

Areas of concern

Recent trends in hospital admissions related to poverty

In 2013 the New Zealand Child Youth and Epidemiology Service (NZCYES) at the University of Otago working in partnership with the JR McKenzie Trust and the Office of the Children's Commissioner, produced a report designed to monitor child poverty using a range of measures to capture different aspects of poverty. The tables and figures are reproduced from their 2013 report health and wellbeing indicators.[53]

Table 2 below lists the most common reasons for hospital admissions for medical conditions and injuries with a social gradient in children. These conditions were selected for monitoring because they were shown to be at least 1.5 times higher for children living in poorer areas.

Craig et al's *Child Poverty Monitor Technical Report*, 2013,[54] showed that during 2008 – 2012 asthma and wheeze, bronchiolitis (a wheezy illness in babies) and gastroenteritis (infectious diarrhoea) were the leading reasons for children aged between 0 to 14 years being hospitalised for such medical conditions.

Craig et al's 2013 Report shows that falls were the leading cause of admission for injuries with a social gradient among children.

Table 2. Hospital Admissions for Conditions with a Social Gradient in Children Aged 0–14 Years (Excluding Neonates) by Primary Diagnosis, New Zealand 2008–2012 (Craig et al. 2013, Table 5)

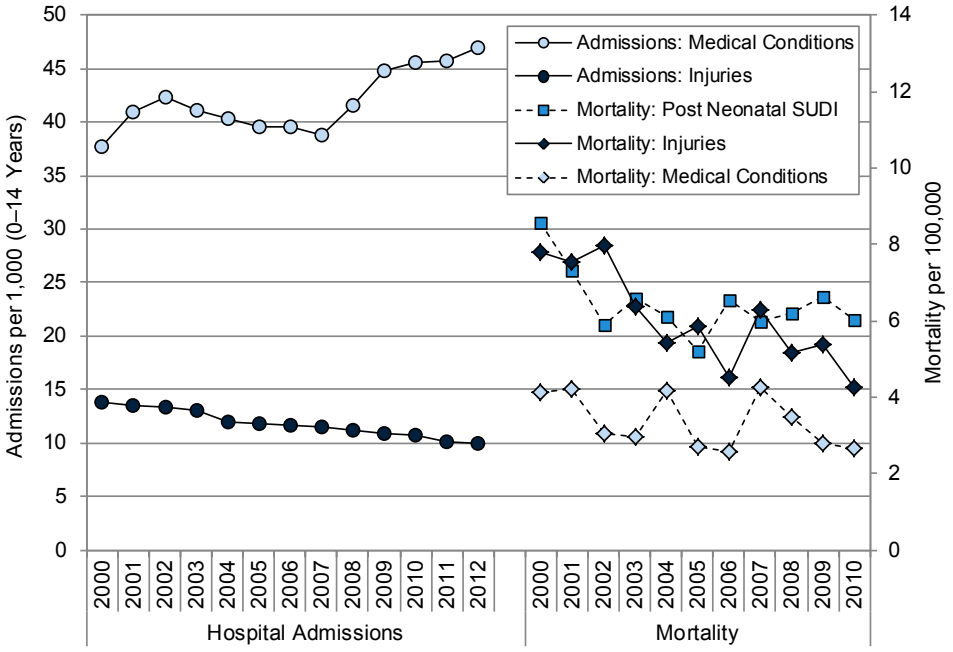
Primary Diagnosis	**Number: Total 2008−2012**	**Number: Annual Average**	**Rate per 1,000**	**% of Total**
Medical Conditions				
Asthma and Wheeze	30,224	6,044.8	6.78	15.1
Bronchiolitis	29,194	5,838.8	6.55	14.6
Gastroenteritis	26,985	5,397.0	6.05	13.5
Acute Upper Respiratory Infections	20,632	4,126.4	4.63	10.3
Viral Infection of Unspecified Site	19,987	3,997.4	4.48	10.0
Skin Infections	16,141	3,228.2	3.62	8.1
Pneumonia: Bacterial, Non-Viral, Unspecified	14,055	2,811.0	3.15	7.0
Urinary Tract Infection	7,145	1,429.0	1.60	3.6
Acute Lower Respiratory Infection Unspecified	6,736	1,347.2	1.51	3.4
Croup/Laryngitis/Tracheitis/Epiglottitis	6,054	1,210.8	1.36	3.0
Epilepsy/Status Epilepticus	4,302	860.4	0.96	2.1
Dermatitis and Eczema	3,511	702.2	0.79	1.8
Febrile Convulsions	3,409	681.8	0.76	1.7
Otitis Media	3,023	604.6	0.68	1.5
Pneumonia: Viral	2,216	443.2	0.50	1.1
Inguinal Hernia	1,270	254.0	0.28	0.6
Osteomyelitis	1,165	233.0	0.26	0.6

Table 2. Hospital Admissions for Conditions with a Social Gradient in Children Aged 0–14 Years (Excluding Neonates) by Primary Diagnosis, New Zealand 2008–2012 (Craig et al. 2013, Table 5)				
Primary Diagnosis	**Number: Total 2008−2012**	**Number: Annual Average**	**Rate per 1,000**	**% of Total**
Rheumatic Fever/Heart Disease	987	197.4	0.22	0.5
Vaccine Preventable Diseases	806	161.2	0.18	0.4
Meningitis: Viral/Other/NOS	765	153.0	0.17	0.4
Bronchiectasis	687	137.4	0.15	0.3
Meningococcal Disease	401	80.2	0.09	0.2
Nutritional Deficiencies/Anaemias	301	60.2	0.07	0.2
Meningitis: Bacterial	204	40.8	0.05	0.1
Tuberculosis	52	10.4	0.01	<0.1
New Zealand Total	200,252	40,050.4	44.90	100.0
Injury Admissions				
Falls	23,389	4,677.8	5.24	49.4
Mechanical Forces: Inanimate	12,422	2,484.4	2.79	26.3
Mechanical Forces: Animate	2,883	576.6	0.65	6.1
Transport: Cyclist	2,434	486.8	0.55	5.1
Accidental Poisoning	2,166	433.2	0.49	4.6
Electricity/Fire/Burns	2,035	407.0	0.46	4.3
Transport: Vehicle Occupant	975	195.0	0.22	2.1
Transport: Pedestrian	847	169.4	0.19	1.8
Drowning/Submersion	168	33.6	0.04	0.4
New Zealand Total	47,319	9,463.8	10.61	100.0

Source: Numerator: National Minimum Dataset (neonates removed); Denominator: Statistics NZ Estimated Resident Population (projected from 2007); Note: Medical Conditions: Acute and arranged admissions only; Injury Admissions: Emergency Department Cases Excluded.

As shown in Figure 3, medical admissions for childhood illness with a socioeconomic gradient (i.e. admissions which are known to be higher for children from poorer areas), showed an increase in the early 2000s, reached a peak in 2002 and then started to decline. However another upswing was seen in the years 2007 to 2012. In contrast, admissions for injury showed a slow decline through the period 2000 to 2012, although the exclusion of Emergency Department cases from the admissions for injury may have been partly responsible for this different trend from the medical admissions.

Figure 3 Hospital Admissions (2000–2012) and Mortality (2000–2010) from Conditions with a Social Gradient in New Zealand Children Aged 0–14 Years (Excluding Neonates) (Source: Craig et al. 2013)

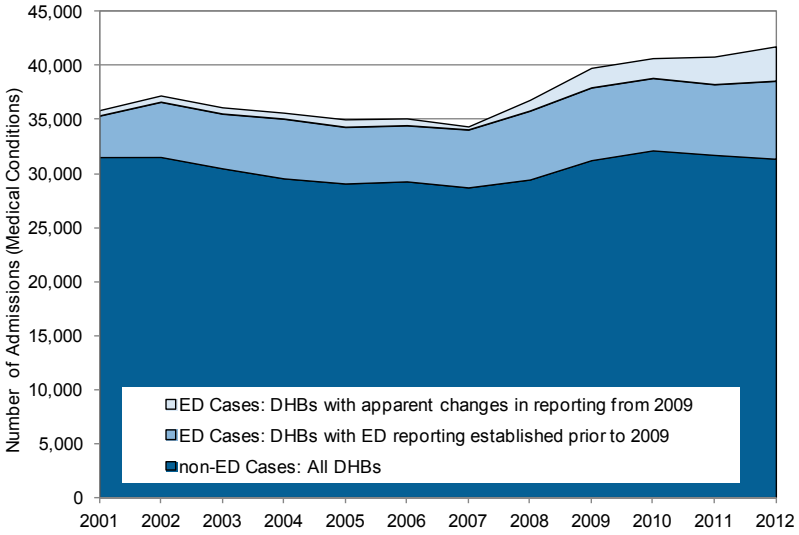


Source: Numerator Admissions: National Minimum Dataset; Numerator Mortality: National Mortality Collection. Denominator: Statistics NZ Estimated Resident Population (projected from 2007) Note: Medical Conditions Admissions: Acute and arranged admissions only; Injury Admissions: Emergency Department Cases Excluded.

Note on interpreting trends for medical admissions

The NZCYES's experience with using child health data shows that any analysis of children's hospital admissions for medical conditions must include Emergency Department (ED) cases, if hospitalisation rates are to be comparable across the country. Inconsistencies in the reporting of ED cases by DHBs, however, may affect hospital admissions rates. Many DHBs were reporting their ED cases from the early 2000s, but Figure 4 below shows the increase in admissions in the DHBs which changed their reporting practice from 2009 when the Ministry made reporting of ED day cases mandatory. The increase in numbers is modest, but some, not all, of the increase in medical admissions seen during this period may be due to these changes (for a more detailed review see the *Child Poverty Monitor Technical Report*).

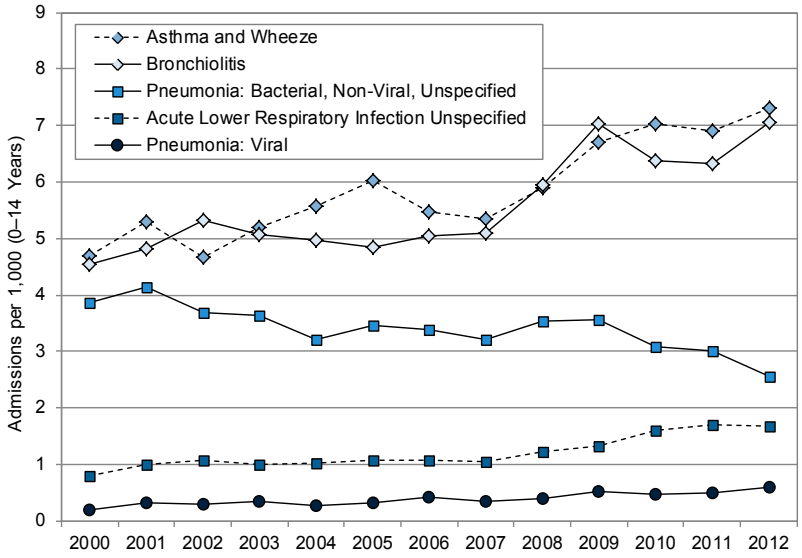
Figure 4. Hospital Admissions for Medical Conditions with a Social Gradient in Children Aged 0–14 Years by DHB Reporting Practice, New Zealand 2000–2012 (Source: Craig et al. 2013)



Source: National Minimum Dataset, Acute and Arranged Admissions only. **Note**: ED cases are those with a health speciality code on discharge of M05–M08.

Figure 5 provides a graphic example of the increase in hospital admissions for respiratory conditions that especially affect children who live in poverty. There has been ongoing rises in severe respiratory conditions particularly since 2007, which includes hospitalisations for asthma and other wheezy conditions, bronchiolitis and lower respiratory tract infections. The exception is the reduction in pneumonias since 2009. A possible contribution to this is the introduction of the pneumococcal vaccine for all children born since 2008.

Figure 5. Hospital Admissions for Lower Respiratory Conditions with a Social Gradient, Children Aged 0–14 Years, New Zealand 2000–2012 (Source: Craig et al. 2013)



Source: Numerator: National Minimum Dataset; Denominator: Statistics NZ Estimated Resident Population (projected from 2007); Note: Acute and arranged admissions only.

Māori children's high rates of disease

In addition to the attainment of health equity as a moral imperative, tamariki Māori as tangata whenua have the right to experience equitable health affirmed by Te Tiriti o Waitangi (1840), the United Nations Convention on the Rights of the Child,[57] the United Nation's Declaration on the Rights of Indigenous Peoples,[58] and within the broader frameworks of international human rights pertaining to indigenous peoples. However, such protection generally does not occur and Māori children disproportionately experience poor health outcomes. Recent data show that the very high rates of some preventable diseases such as acute rheumatic fever in Māori children are even more common now than a decade ago.[59] [60]

The adverse effects start from pregnancy onwards with Māori mothers more likely to have stillbirths, pre-term births and newborn deaths. Māori babies are more likely to be exposed to risk during the antenatal period. The proportion of Māori babies born to mothers without a Lead Maternity Carer (LMC) at the time of delivery, and the proportion of mothers of Māori babies smoking at time of first LMC contact are significantly higher than for non-Māori.[61]

Many potentially avoidable hospital admissions for poverty-related infectious diseases such as serious skin infections, respiratory infections such as bronchiectasis (chronic lung damage), influenza, pneumonia and gastroenteritis are higher for Māori children. The gaps have widened over the last 2 decades as Figure 5[62] clearly demonstrates. For Māori children, rates of admissions for these diseases remained fairly constant in the early 2000s, then increased during 2007 to 2009.[63] Compared with 2000, proportionately more Māori children were hospitalised in 2012 than European children (whose rates did not fall during those 12 years), i.e. the ethnicity gaps have widened.

From 2000 to 2012 admissions for injuries from assault, neglect or maltreatment of children aged 0 to 14 years were higher for Māori children. Poverty plays a key role in child abuse and preventable diseases, and we can change this too if we choose to.[64]

The racism, which underpins the lack of progress in many areas in the determinants of health and the health care system, perpetuates this profound disadvantage. The association between racism and poverty too can be altered if we have the will to make the necessary changes in ourselves and our systems.[65]

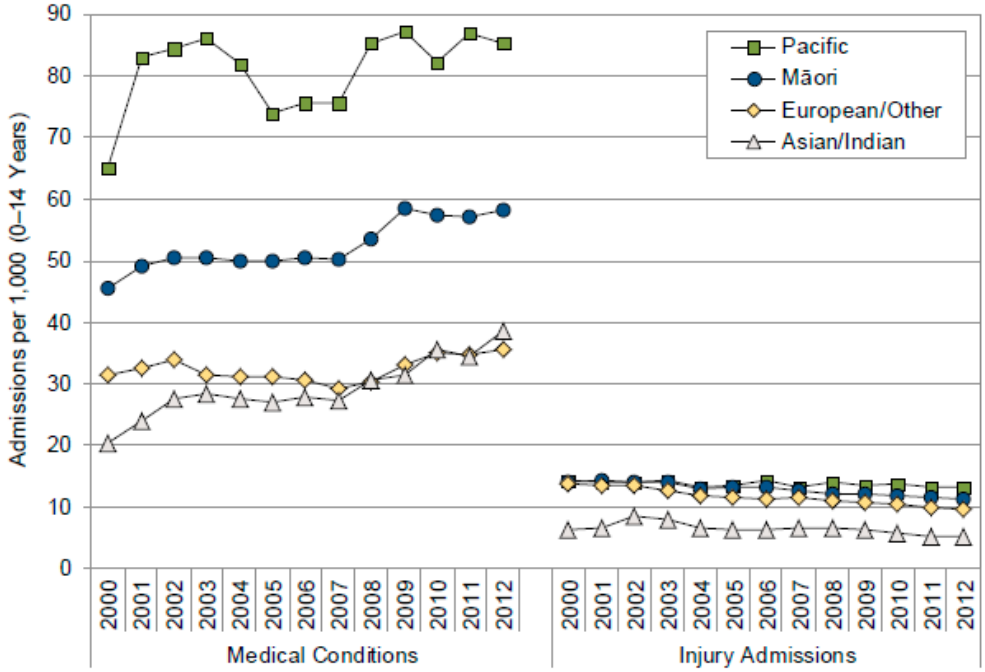
Pasifika children's high rates of disease

New Zealand is a signatory to the United Nations Convention on the Rights of the Child, and as such is compelled to protect all children from poor health outcomes.[66] Yet Pasifika children are more at risk than children from other ethnic groups for many of the same diseases and poor health outcomes as is shown in Figure 6. It is of particular concern that Pasifika children and young adults are nearly 50 times more likely that New Zealand European children, and twice as likely as Māori children, to be admitted to hospital with acute rheumatic fever.[67] [68]

The combination of preventable poverty, unhealthy housing and inadequate basic health care underpin these shocking figures.

That Asian and Indian children are relatively protected from these preventable diseases (Figure 6) illustrates that high rates of disease are not inevitable for non-European children in New Zealand.

Figure 6. Hospital Admissions for Conditions with a Social Gradient in Children Aged 0–14 Years (Excluding Neonates) by Ethnicity, New Zealand 2000–2012 (Source: Craig et al. 2013)



Source: Numerator: National Minimum Dataset (neonates removed); Denominator: Statistics NZ Estimated Resident Population (projected from 2007); Note: Medical Conditions: Acute and arranged admissions only; Injury Admissions: Emergency Department Cases Excluded; Ethnicity is Level 1 Prioritised .

RECOMMENDATION 3

Increase health funding for children to a level that achieves equal child health outcomes for all ethnic groups.

Antenatal care

Early engagement in pregnancy with health providers is likely to lead to better maternal and child health outcomes.[69] Early engagement can enable providers to offer regular antenatal care as well as informing and supporting pregnant women with important issues such as better antenatal nutrition, discontinuation of smoking and alcohol use and identify important health and social needs such as mental health concerns, poor housing, family violence and other social concerns.

Currently pregnant women from backgrounds of poverty, and particularly Pasifika women, often present late in pregnancy and receive limited antenatal care. Data from 2010 indicated that more than one third of Pasifika women and nearly one sixth of Māori women were not attended at all by a Lead Maternity Carer (midwife, general practitioner or obstetrician) during their pregnancy.[70] Early engagement with maternity services can be a greater challenge for women living in disadvantaged neighbourhoods, and greater resourcing is required. Effective engagement strategies have been documented in the international literature and with a range of New Zealand local services[71] and need to be applied so that all women in New Zealand are engaged early in pregnancy.

RECOMMENDATION 4

Effective and universal antenatal care/maternity services to be provided that include national targets and ensure all pregnant women are enrolled with maternity services as early as possible in their pregnancy.

National coordination

Nationally there is no co-ordinated framework which effectively engages all children in accessible healthcare from the pregnancy to adulthood. Current health and social services are often very fragmented which leads to inefficiencies particularly for children in poverty whose families face greater challenges to navigate and access services. Many of these challenges can be reduced by developing and sustaining engaged relationships with health care providers and between providers, starting antenatally and continuing throughout the early childhood years.

Currently families express having to repeat their stories often to multiple professionals from different disciplines.[72] Taking a common assessment approach to service planning and delivery for all children from the antenatal period has the potential to identify needs and respond more systematically, reduce fragmentation in services, improve communication and trust with families and target extra resources more effectively when needed.

RECOMMENDATION 5

Develop and share across all health service providers a universal common assessment plan and pathway for all children starting antenatally; including universal enrolment at birth with primary care, national immunisation register, well child/tamariki ora providers and dental provider.

Financial barriers to accessing health care

In July 2012 the government implemented free after hours primary care visits for children from birth to age 6 years. All DHBs are required to have a minimum of 60% coverage, with 100% to be achieved 'as soon as practicable'. Good progress has been made in achieving this. Although not complete, it is estimated that approximately 80% of practices currently offer free visits for this age group during regular hours.[73] In February 2013 a survey undertaken by CPAG found that the average fee for under sixes visiting a general practitioner was $1.30 (range $0-45) in office hours and $3.60 (range $0-60) out of hours for children under six. However the cost for children 6-17 years was much steeper with an average of $24 (range $0-60) in hours and $44 ($0-89) out of hours.[74] [75]

In 2011 there was an increase in prescription charges for people six years and older from $3 an item to $5 per item. It was predicted that those who have the most health problems would be the ones most adversely affected.[76] The 2008 Livings Standards Survey showed that 10% of poorer households at times were unable to collect prescriptions due to the cost.[77] This proportion is expected to be higher now since the charges have almost doubled. Medication costs often have to be weighed against more immediate household needs such as food and rent for low income families.

The 2012 health report of the Office of the Commissioner for Children report on *Solutions to Child Poverty*[78] [79] commented that Emergency Department visits and hospitalisations of young children for infectious diseases could be reduced if children were able to receive free primary care services and free after hours services at any time of the day or night. Supporting this is the published data from Capital and Coast DHB that showed a link between increased investment in primary healthcare and increased access to primary care among low income and high needs groups, which would be expected to lead to reductions in preventable ED visits and hospitalisations.[80]

Dental caries remains the most common chronic disease of childhood and one of the most common reasons for hospital admissions for children in New Zealand. The most vulnerable children are shouldering the burden of the disease with Māori and Pacific children experiencing greater prevalence and severity of dental caries. Early childhood caries has deleterious effects on a child's oral and general health and significant numbers of preschool aged children experience pain and infection. There is enormous scope to reduce these inequalities, as most dental disease is preventable.[81]

Children require access to dental services to prevent problems and to avoid carrying serious problems into adulthood. For example, oral health status at age 5 years predicts oral health at 26 years of age.[82] While dental services for children are free, there is maldistribution of these services and lack of resourcing in some areas, usually where the need is greatest. There is also a lack of monitoring to establish whether children most in need are actually receiving adequate services.[83]

An often overlooked problem in children is the need for spectacles to correct refractive errors. The visits to an optometrist, the eye tests, and the spectacles (which are easily broken by children), all cost money which has to be balanced against other needs in low income families. Thus many children who need spectacles miss out, impairing their intellectual, psychological and social development.

RECOMMENDATION 6

Primary health care services are free for all children from maternity through to age 18, including general practice services, prescriptions, dental and optometry care.

Housing

About 300,000 older New Zealand homes are un-insulated, damp and cold. It was only in 1978 that insulation for new housing became compulsory. Cold, damp homes cost a lot to heat, which is unaffordable for many low income families; for those who cannot afford to heat their homes, many choose expedient non-flued gas heating which is unhealthy and worsens asthma.[84] Houses become crowded because of the high cost of rental and buying. Māori and Pasifika children are more likely than others to be living in overcrowded homes, even within the same neighbourhood deprivation decile.[85] Cold and damp homes with mould can cause ill health such as cough or asthma.[86] All of these unhealthy housing factors individually and collectively combine to cause disease.

New Zealand-based research has shown that improving housing quality improved self-rated health, self-reported wheezing, days off school and work, fewer visits to general practitioners, and fewer hospital admissions for respiratory conditions; and children with asthma significantly reduced their symptoms, days off school and healthcare visits.[87] [88] While there are a range of governmental and

non-governmental initiatives to improve insulation, these have reached only a minority of homes needing them. The government's own state housing stock is not yet reliably healthy; and the number of houses in New Zealand is insufficient for the population's needs, especially in Auckland and Christchurch.[89]

A cross-party accord is needed to comprehensively address these issues (see *Child Poverty and Housing* in this series).

RECOMMENDATION 7

Develop and fund programmes to ensure all homes are adequately insulated over the next decade; and develop a ten year national plan to overcome the shortage of affordable housing.

Nutrition

Inadequate and nutritionally poor food during pregnancy and childhood is linked to poor health outcomes. These include more frequent and more severe acute illnesses, but also poor long term outcomes such as high cholesterol and obesity,[90] which is an increasing problem in New Zealand.[91]

A Ministry of Health survey in 2003 revealed that around 20% of households with school-age children experienced food insecurity, with rates significantly higher among Pasifika, Māori, large families, and families from the lowest socio-economic groups.[92]

There have been a range of efforts to raise awareness of healthy eating and to improve the eating habits of New Zealanders. Positive examples of public health programmes include the national Healthy Eating Healthy Action[93] initiatives and Project Energise Waikato.[94] However these valuable programmes have not resulted in any overall consistent government strategy on nutrition and no particular focus on the challenges of nutrition for children living in poverty. The high cost of providing nutritious food for children is beyond the budget of some low income families, with teenagers' meals being especially expensive.[95]

Hungry children going to school has been a topic for public discussion in the past few years, stimulated by CPAG's own research.[96] Breakfast is an important meal for improving uptake of nutrients including iron, and regular breakfasts can reduce children's likelihood of being overweight or obese. Hunger impairs children's learning, and thus their life chances. While families have the responsibility to feed their children, when income is very low this may not be feasible at times (see section on material deprivation). Children need to be fed regardless of their parents' income.

To this end, CPAG has recommended that nutritional breakfasts should be made available universally to children in decile 1 and 2 primary, intermediate and primary/intermediate combined schools. Breakfast programmes need to be resourced properly through regular and secure partial funding from central government to cover most of the costs, and schools need to develop partnerships with local businesses, parents and suitable non-governmental organisations to assist with the provision of nutritional food.[97]

RECOMMENDATION 8

Develop a national child nutrition strategy, including a 'food in schools' programme.

Youth health

The New Zealand Youth 2000 studies have studied teenagers in schools in 2000, 2007 and 2012.[98] The 2012 study[99] shows a more healthy generation of teenagers, with a marked reduction in tobacco, alcohol consumption, binge drinking and illegal drug use as well as lower rates of dangerous driving and small positive shifts in school life. The significant overall reduction in risk-taking behaviours among adolescents is a cause for optimism.

However, this 'more healthy generation of teenagers' are the young people with access to education and more likely to be non-Māori: the results of the survey demonstrated that Māori leave school at an earlier age, In addition there will be a number of young people excluded from school whose voices will not be heard. The report clearly identifies divisions between the 'haves' and 'have nots' in regards to healthcare access and nutrition, and in the outlook for future education and training.

Young people in low income families are aware of the challenges their parents face living in surroundings that are less than ideal. The survey showed 43% of youth indicated that their parents worry about not having enough money for food. Living rooms used as bedrooms was a reality for 22% of survey participants and 10% said the garage was used as a bedroom.

There is increasing evidence that the school environment can positively influence outcomes for teenagers.

> *In addition to access to education functioning as a structural determinant, there is strong evidence from high-income countries that stronger connection of young people and their parents with their school, together with aspects of school environment such as leadership and safety, positively affect many health outcomes directly. There is also emerging evidence that connections within school protects against a wide range of health risk behaviours in middle-income and low-income countries. Programmes that improve secondary school environment and connectedness are the most promising large-scale interventions for improving health outcomes in adolescence.*[100]

RECOMMENDATION 9

Establish youth-friendly health and social services in all low decile secondary schools, with sustained Government funding.

Recent reports and recommendations

In the last 2 years there have been several national reports on child poverty and child health. CPAG has developed our recommendations based on evidence, including evidence in these reports. We have summarised the recommendations in these recent reports relevant to child poverty and child health in relation to CPAG's recommendations below and in Table 3.

Expert Advisory Group on Solutions to Child Poverty commissioned by the Office of the Commissioner for Children

The most specific recent report on child poverty was the November 2012 report from the Expert Advisory Group (EAG) on Solutions to Child Poverty commissioned by the Office of the Commissioner for Children.[101] This has 78 recommendations to government on wide ranging areas, including on many of the issues covered in this chapter. Of the nine recommendations of CPAG in this chapter, eight are mirrored in their report (see Table 3).

Health Committee Report on improving child health outcomes and preventing child abuse

The Health Committee Report to Parliament *Inquiry into improving child health outcomes and preventing child abuse, with a focus on pre-conception until three years of age*[102] was released in November 2013. It is a comprehensive and broad-reaching health report with three key areas of focus:

- Early intervention and the social and economic determinants of health and wellbeing
- Coordinated action across the government sector
- Improving specific services

Many key recommendations related to child poverty and health, and all of them are supported by CPAG. Those mirrored by CPAG are summarised in Table 3 below.

Māori Affairs Committee on determinants of wellbeing for tamariki Māori

Report of the Māori Affairs Committee *Inquiry into the determinants of wellbeing for tamariki Māori* was released in December 2013.[103] This Committee agreed with the basic principles of the Health Committee's Report (above). Poverty was highlighted throughout the report. The introduction states:

> *Around 22% of our 1.07 million children live in poverty. One in six of these children are Pakeha and one in three is Māori. There is evidence that the incidence of poverty is getting worse. The Children's Commissioner told us that before 1988, income poverty rates were similar for Māori and Pakeha, but by 1994 the income poverty rate (after housing costs) for tamariki Māori jumped from somewhere under 10% to 50%. While the child poverty rate in the 1980s was around 11%, in 2012 it was between 25% and 27% in real terms. This trend appears to be disproportionately affecting Māori.*

The conclusion of the report states:

> *Poverty is a major barrier to the wellbeing of tamariki Māori, and often has a domino effect in all areas of a tamaiti's life. We believe that moving whanau out of poverty will benefit tamariki and allow whanau to build a strong foundation for a positive future.*[104]

Among the 48 far-reaching recommendations, 40% were directly on health. All of those recommendations are supported by CPAG. Those mirrored by CPAG are summarised in Table 3.

Child Well-being Network

There are common themes for action in all these reports, which are well expressed in the New Zealand Medical Association equity statement.[105] This advocated for strong nationwide leadership with a voice for children at the highest level of Cabinet. All policies and strategies need child and equity impact assessments; healthy children's policy requires measures for, and monitoring of, progress on child hardship; greater co-ordination and integration is required across all policy and service delivery domains; and enhanced effort and integrated approaches are required particularly in the early childhood years with adequate investment and time to develop and be reviewed.

A group of child health experts have made more specific recommendations.[106]

- *The approach needs to be based on a universal platform to enable identification of need*
- *Build on existing quality improvement and integrating frameworks for children's services*
- *Resource effective community-led development initiatives to improve child wellbeing and reduce inequities*
- *Introduce evidence-based measures to protect children from harmful exposures*
- *Implement or broaden specific evidence-based measures in important child health areas – particularly for child nutrition, infant and child mental health, respiratory and infectious diseases, injury prevention, oral health and sudden unexpected death in infancy prevention*
- *Continue and broaden the programmes which improve home heating and insulation*
- *Ensure the momentum towards all children having free access to primary care services continues and that the additional services that they and their parents need are available at no cost and in a timely fashion.*

The White Paper for Vulnerable Children

The Government's White Paper for Vulnerable Children October 2012[107] followed the Green Paper 2011 which held promise because of its title: *Every child thrives, belongs, achieves. Ka whai oranga, ka whai wahi, ka whai taumata ia tamaiti*.[108]

However there was scant analysis in these papers of the role of poverty in child health and wellbeing. The higher rates of child ill health and abuse among Māori were inadequately considered, as illustrated by the mention of the Treaty of Waitangi only once in the Green paper written earlier and not at all in the White Paper. This is disappointing given New Zealand's obligations to the Treaty of Waitangi and as a signatory to the United Nations Convention on the Rights of the Child and the large disparities between ethnicities evident in children's health and child abuse. The extraordinary efforts required to rectify these disparities seem to be overlooked by these governmental reports.[109]

Table 3 compares CPAG recommendations with the reports referenced above, and illustrates the lack of attention of the White Paper on critical issues.

Table 3. Summary of recommendations from recent reports on child health and wellbeing compared with CPAG's recommendations

	Children's Commissioner (EAG)	Health Committee	Māori Affairs Committee	Child Wellbeing Network	White paper on vulnerable children	CPAG recommends
A govt* plan to reduce child poverty	**yes**	**yes**				**yes**
Increased health funding for children						**yes**
Proportionate universalism for resourcing child health	**yes**			**yes**		**yes**
Free doctor's visits	**yes**		**yes**	**yes**		**yes**
Maternity care early and full enrolment	**yes**	**yes**				**yes**
All children enrolled at birth with health providers	**yes**	**yes**	**yes**			**yes**
Youth health services in all low decile secondary schools	**yes**					**yes**
A govt nutrition strategy	**yes**	**yes**				**yes**
A govt housing strategy	**yes**	**yes**		**yes**		**yes**

Note: * govt = government

The way forward

The four non-governmental reports have outlined a range of clear, sensible recommendations for improving the health outcomes of children in poverty. All the issues leading to poor child health could be dramatically reduced, if we choose to do so. We need leadership and collective responsibility. A cross-party accord is urgently needed to comprehensively address all the factors. Examples of effective child health policies which have been successfully championed by the Minister of Health in recent times include immunisation coverage and free doctor's visits for under sixes. Other contributions to the large burden of preventable ill health in our children could be lessened if New Zealand chose to follow these nine health-related recommendations:

CPAG recommendations

1. Government to design a comprehensive plan to reduce child poverty that includes actions, targets, measurable outcomes and regular reporting requirements.
2. To improve the outcomes for children in poverty healthcare should provide universal services and targeted extra services based on assessment of further need.
3. Increase health funding for children to a level that achieves equal child health outcomes for all ethnic groups.
4. Effective and universal antenatal care/maternity services to be provided that include national targets and ensure all pregnant women are enrolled with maternity services as early as possible in their pregnancy.
5. Develop and share across all health service providers a universal common assessment plan and pathway for all children starting antenatally; including universal enrolment at birth with primary care, national immunisation register, well child /tamariki ora providers and dental provider.
6. Primary health care services are free for all children from maternity through to age 18, including general practice services, prescriptions, dental and optometry care.
7. Develop and fund programmes to ensure all homes are adequately insulated over the next decade; and develop a ten year national plan to overcome the shortage of affordable housing.
8. Develop a national child nutrition strategy, including a ‘food in schools’ programme.
9. Establish youth-friendly health and social services in all low decile secondary schools, with sustained Government funding.

Audio-visual resources

Bryan Bruce (2013) *Inside Child Poverty: a special report*: http://www.tv3.co.nz/Shows/InsideNZ/InsideChildPovertyASpecialReport.aspx.

Dr Rhys Jones (2014) *Child health inequities: How do we become part of the solution?* Starship Children's Health, Paediatric Update: https://www.starship.org.nz/for-health-professionals/paediatric-update/2014-archive/child-health-inequities-how-do-we-become-part-of-the-solution/.

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