CHILD POVERTY ACTION GROUP

A New Zealand where Children can flourish

Priorities for health

There are about 40,000 hospital admissions of children in New Zealand every year, with preventable illnesses that have links to poverty and unhealthy housing. The number of such admissions has increased since 2000.

If our systems were working well they would have reduced the numbers of children admitted to hospital with illnesses associated with poverty. It hasn't.

CPAG's health priority for the 2017 election is the introduction of measures to substantially reduce child hospital admissions for preventable illnesses.

These measures must address three key areas:

- Inadequate basic healthcare services and education,
- Income poverty and material hardship, and
- A lack of affordable, healthy housing

Triple jeopardy for children

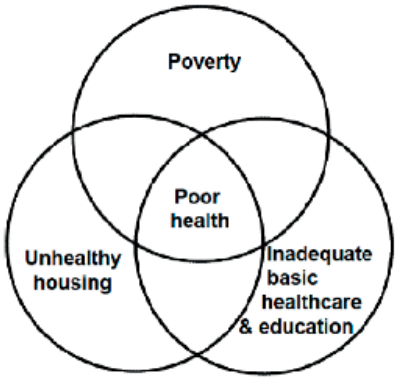


Figure 1. New Zealand's triple jeopardy for child health (adapted from Asher 2014)

The introduction of measures to ensure adequate healthcare, incomes and housing for families would result in a significant reduction in the number of potentially preventable admissions to hospital for children aged 0-14 years.

By 2022, such admissions could be reduced by half, from 40,000 per year to 20,000.

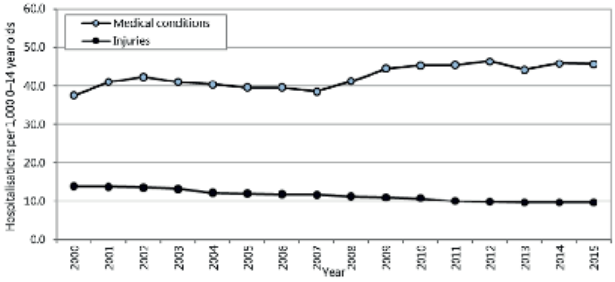
Poor health in childhood

The future health and wellbeing of any country is dependent on the well-being of its children. Currently, a raft of social inequities are severely affecting large numbers of children. High rates of preventable illness, particularly from diseases linked to poverty (conditions with a social gradient – see Figure 2), are reducing the likelihood of successful life outcomes for many children across New Zealand. Child health statistics are getting worse. A much greater proportion of New Zealand children are affected by poverty now than two to three decades ago. The latest Child Poverty Monitor report shows that more than one in four of our million children live in families where income is below the internationally recognised poverty line:
a household income of less than 60% of the national median, after housing costs. 155,000 children are

living in households that regularly experience material deprivation, while 85,000 endure severe poverty.

Poverty is one of the leading factors contributing to childhood illness, disease, disability and deaths in New Zealand. Children who are living in poverty are significantly more likely to end up hospitalised for many conditions. These particularly include respiratory conditions (including asthma, pneumonia, bronchiolitis, bronchiectasis), gastroenteritis, skin infections, road traffic crashes, drownings, falls, neglect and violence. Approximately 30% of all childhood hospital admissions are considered to be preventable (called ambulatory sensitive admissions)(1). Rates of these conditions in children have continued to rise from 2000 to 2015, and in particular Māori and Pasifika children suffer higher rates. For example a child living in poverty is nearly three times more likely to end up hospitalised than a child from a more affluent household, and over eight times more likely to be hospitalised for assault, neglect or maltreatment (2).

Figure 2. Hospitalisations for conditions with a social gradient[1] in 0–14 year olds (excluding neonates), New Zealand 2000–2015 (Accessed from Figure 31 Child Poverty Monitor Technical Report)



Poverty in childhood affects lifetime health and well being

In addition to those immediate consequences, many major health issues in adulthood have origins in childhood poverty, such as chronic lung damage, cardiovascular disease, mental illness, dental decay and shortened life expectancy. Mental health problems in pregnancy and early childhood are more common for those living in income poverty, and are more likely to lead to long-term social and emotional behavioural problems for the child. This significantly affects their life outcomes in all areas including education, work and stable emotional relationships. (3)

It is important to focus on getting the early years right to reduce the long-term consequences. This means taking a stronger focus on pregnancy and early childhood years, then improving access to appropriate healthcare support throughout childhood and adolescence. Currently New Zealand has no coordinated framework which effectively engages all children in healthcare from pregnancy to adulthood in ways that everyone can access. A coordinated framework is the platform necessary to identify those in greater need in order to offer more targeted services. Once need is systematically recognised, services in higher need areas, such as mental health, maternity, early years and teenage years could be provided.

The reality

Bronchiectasis, a life-threatening disease that is the result of prolonged lung damage due to repeated chest infections in early childhood, has strong links to poverty. Children who have bronchiectasis have lung damage for the rest of their lives, causing repeated infections, and reduced lung capacity, affecting their ability to work and exercise, and some may die in their youthful years. In New Zealand we have rates of bronchiectasis far higher than in other OECD countries, and our rates are continuing to increase. The Asthma and Respiratory Foundation reported that 99 new children under 15 were diagnosed with bronchiectasis in 2015. This is nearly three times higher than the rates back in 2001/2002 (10.8 per 100,000 in 2015 compared with 3.7 per 100,000 in 2001/2002).

Every past winter in New Zealand between 25,000 and 30,000 children have been hospitalised with respiratory infections and illnesses caused by living in cold, damp houses (4). As the numbers of tenancies increase, so will these numbers. For children, sub-standard, high-cost housing causes excess mobility: a CPAG survey of South Auckland schools reported accommodation as the most common reason behind

1 Conditions with a social gradient are defined as those were death or hospitalisation are more than one and a half times higher for children living in areas with the highest NZDep index of deprivations cores (deciles 9-10) compared with those of the lowest NZDep scores (deciles 1-2). Numerator: National Minimum Dataset; Denominator: Statistics NZ estimated population; Medical conditions acute and arranged hospitalisations; Injuries exclude ED cases.

high rates of transience (5). Sub-standard, high-cost housing contributes to overcrowding which affects more than 136,000 children in New Zealand, causes at least twice the risk of them being admitted to hospital for pneumonia (6), and has been identified as the most important risk factor for rheumatic fever (7) and meningococcal disease (8), illnesses that can compromise children's health with lifetime consequences.

Why does poverty make children sick?

Ivy is seven years old, she lives with her parents and brother. The parents are also looking after two extra children from the extended family. Her mother works evenings as a cleaner but is also chronically ill and her father works night shifts, but the work is not reliable and there are long periods when they are out of work. Her family has moved six times since she was born. They currently live in a three-bedroom house with her aunty's family. She sleeps in the same room as her family, in order to stay warm over winter. They all sleep on mattresses on the floor. Ivy has had eight admissions to hospital since birth – two for bronchiolitis (a wheezy chest infection) as a baby, two for pneumonia, one for asthma, one for a head injury, one for a skin infection and one for a tooth infection. Why has she ended up in hospital so many more times than other children have?

Firstly, infections spread more easily in a crowded environment, with close contact and limited ability to hand wash, maintain good hygiene and to keep a distance from others when sick. Secondly, Ivy's immune system is not responding to infections as well as other children. She will be very stressed by many factors including: a cold, mouldy house which makes fighting off infections harder; poor nutrition as the family income usually cannot afford consistently healthy food including fresh fruit and vegetables, resulting in deficiency; her family is chronically under stress with inadequate income, poor parental health, insecure housing and multiple house shifts. Thirdly, it can be difficult to get to the family GP early enough when she is unwell, with the parents working evening and night hours, and also often unwell themselves, creating difficulty for good care and supervision for her after school and in holidays. The family has a car but due to lack of income, it is often unwarranted or needing repairs.

A combination of all these factors means Ivy will repeatedly get sick and need hospitalisation much more frequently than other children her age.

CPAG recommends the following health provision to support the reduction in children's hospital admissions

1. Universal and adequate health care for children up to the age of 18 yrs (0-17 years) for ALL their health needs – GP visits, prescriptions, oral health, vision and hearing care. Add full funding for GP visits and prescriptions for 13-17 year olds, and from 0-17 year olds for oral health, vision and hearing care.

2. 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 GP, National Immunisation Register, Well Child / Tamariki Ora providers and dental provider. Develop a new national target that 90% of children are comprehensively enrolled. This plan should include a comprehensive health literacy programme made available to all low-income families and increased support for maternal and child mental health services to respond to identified need.

3. Add to the new National Enrolment Service enrolment which includes GP, National Immunisation Register, Well Child / Tamariki Ora providers and oral health provider new targets to achieve 90% registration and enrolment by 6 weeks and 98% by three months for all these health care providers.

4. Increase the number of primary and secondary schools with school-based health services, including mental

health services specific to early detection, appropriate for the age of the children, noting that the approach to healthcare for adolescents is different for younger children. Develop a new national target that 90% of all schools have healthcare appropriate for the age of the pupils, and their health needs.

5. Extend the food in schools programme to reach all hungry children. Develop a new national target of less than 5% of children arriving hungry at school.

6. Effective and universal antenatal care/maternity services to be provided and accessible to all. Develop a new national target that 90% of all pregnant women are fully booked with a lead maternity carer by ten weeks.

7. Add a fully funded visit with the General Practitioner (GP) for pregnant women in the third trimester. The purpose is to renew engagement of the mother–to-be with the GP, assessment of psychosocial issues, discussion regarding family planning, provision of whooping cough vaccination, and provision of vitamin D in the winter months, and pre-enrolment of the infant-to-be. Develop a new national target that 90% of all pregnant women are seen by their GP in the last three months of pregnancy.

8. Improved access to and supply of maternal mental health services. Poverty is stressful, and it acts as a barrier to accessing help. Develop a new national target so that 90% of affected women can access the services and do not have delay in being seen.

CPAG's recommended health priority for the 2017 election is to introduce measures to substantially reduce child hospital admissions for preventable illnesses. These measures require improvements in housing and basic income.

References

1. Health Quality and Safety Commission. 2015. Childhood ambulatory sensitive hospitalisations. http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcarevariation/childhood-ambulatory-sensitive-hospitalisations/

2. Child poverty monitor technical report NZCYES 2106 http://www.nzchildren.co.nz/

3. Wickham, S., Whitehead, M., Taylor-Robinson, D., & Barr, B., 2017, The effect of a transition into poverty on child and maternal mental health: a longitudinal analysis of the UK Millennium Cohort Study. The Lancet Public Health, 2(3), e141-e148.)

4. Health and cold damp houses' Environmental Health Indicators NZ, at: http://www.ehinz.ac.nz/indicators/indoor-environment/health-conditions-related-to-cold-and-damp-houses/.

5. Wynd D. The revolving door – student transcience in Auckland schools 2014 http://www.cpag.org.nz/news/new-report-student-transience-in-auckland/.

6. Grant CC, Emery D, Milne T, Coster G, Forrest CB, Wall CR, Scragg R, Aickin R, Crengle S, Leversha A, Tukuitonga C, Robinson EM. Journal of Paediatrics and Child Health (2011) Journal of Paediatrics and Child Health 2011;1-11. doi:10.1111/j.1440-1754.2011.02244.x

7. Jaine R., Baker, M., Venugopal, K., Acute Rheumatic Fever Associated with Household Crowding in a Developed Country, Pediatric Infectious Diseases Journal, 2011: 30: 315-319.

8. Baker M, Martin, D., Kieft, C., Lennon, D., A 10-year serogroup B meningococcal disease epidemic in New Zealand: Descriptive epidemiology, 1991–2000, Journal of Paediatrics and Child Health, 2001: 13-19.