CHILD POVERTY ACTION GROUP

CPAG 2023 Policy Brief on healthcare access

Ensure all children access the healthcare they need

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VISION

All tamariki will grow up surrounded by loving, thriving whānau within supportive communities where there are resources, opportunities and systems to enable them to live self-determined lives and futures.

CPAG acknowledges that tamariki Māori and whānau have unique rights as tangata whenua, affirmed within He Whakaputanga and Te Tiriti o Waitangi. The significant inequities in well-being outcomes and child poverty for tamariki Māori are the result of ongoing colonisation, systemic racism and neglect. Reducing child poverty in Aotearoa requires our country to address the inequitable distribution of power and resources that prevents Māori from flourishing.

ISSUES — THE CURRENT REALITY

Whānau who live with poverty are more commonly sick, with higher rates of physical and mental ill-health, than those who are not in poverty.[1]

Poverty does not affect children equally. Tamariki Māori and their whānau continue to experience ongoing colonisation with inequities in key determinants of health and wellbeing (such as having a home), have poorer access to healthcare, experience discrimination with higher rates of hospital admission, low rates of immunisation and high mental health impacts than Pākehā children. Other groups are disproportionately affected as well including Pacific children, children with disability and migrant children. (See CPAG 2023 Policy Briefs at www.cpag.org.nz/policybriefs.)

Hospital admissions. Children living in the 40% poorest neighbourhoods consistently experience inequitably higher rates of potentially avoidable hospitalisations than the better-off 60% (Figure 1); and Māori, Pacific and "MEELA"[ii] children also face inequitably high rates

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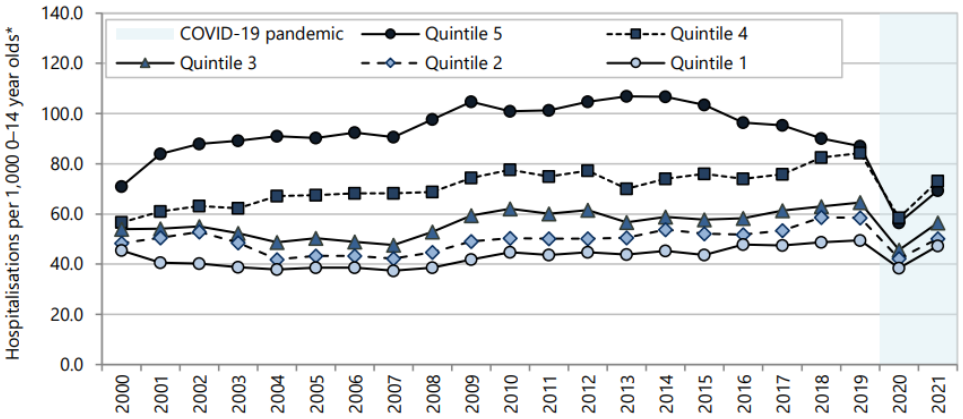
[ii] Middle Eastern, Latin American and African.

of such admissions.[2] The leading cause overall of such hospitalisations for children is respiratory illnesses – often "diseases of poverty" which are worsened by cold, damp, crowded homes.[3]

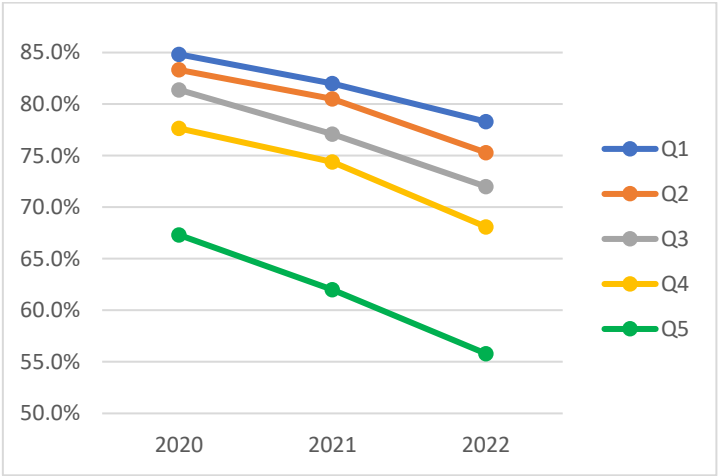
Figure 1: Potentially avoidable hospitalisations, 0–14 year olds, by deprivation quintile, 2000–2021



reproduced from the Child Poverty Monitor 2022[4]

Immunisation is one of the most cost-effective medical interventions to prevent disease. Immunisation is also a marker for the effectiveness of a functioning health system. Worryingly, inequities have dramatically increased particularly since 2020 for those in greatest disadvantage, and for tamariki Māori and for Pacific children, at the same time as immunisation rates have fallen overall. For example, for immunisation coverage at six months, the equity gap between least and most deprived deciles increased from 17.5 percentage points in 2020 to 22.5 percentage points in 2022 (Figure 2).[5]

Figure 2: Immunisation coverage at six months, by deprivation quintile (Q5 – most deprived)

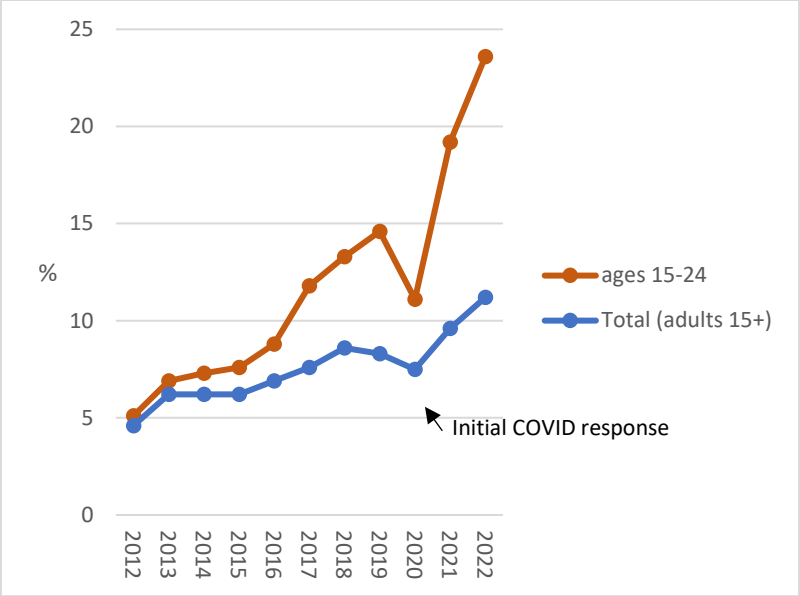


source: NIR data[6]

The current system of enrolment in primary care significantly disadvantages children living in poverty. Those who haven't been enrolled have much lower immunisation rates; for example, non-enrolled infants at 8 months of age have more than 30% lower immunisation rates than those enrolled.[7]

Mental health. Rates of mental distress are increasing, more rapidly for young people than for adults (Figure 3).[8] Mental health burdens disproportionately affect Māori,[9] Pacific, disabled,[10] care-experienced,[11] and LGBTQI+[12] youth more frequently.[13] Most of these populations face inequitably high rates of deprivation, and they are all less likely to be able to access healthcare when they need it,[14] get poorer quality healthcare and get fewer referrals for mental health support.[15] The burden for young people is worsened by socioeconomic disadvantages: in a nationwide 2021 youth survey, respondents in low-income areas (21%) were around twice as likely as respondents from middle (11%) and high income (9%) areas to report having attempted suicide in the last 12 months.[16]

Figure 3: Percentage of people reporting high or very high psychological distress in last 4 weeks, Youth (15–24), and Total (for all aged 15 and over)



source: NZ Health Survey[17]

Parental mental health is also affected by socioeconomic deprivation: perinatal distress (including ante- and post-natal anxiety, depression and psychosis) is strongly associated with poor housing, low income, and food insecurity, as well as domestic abuse.[18] Ongoing perinatal distress can lead to poorer outcomes for the parent and their children.

In particular, Māori mothers experience "persistent and significant inequities" in stressful life events during pregnancy and while their pēpi is very small. Many of these events are due to socioeconomic deprivation, and lack of support and social structures, which are legacies of colonialism and racism.[19]

BARRIERS REQUIRING POLICY ACTIONS: INACCESSIBILITY AND UNAFFORDABILITY

Many systemic barriers to achieving good health are strongly correlated with deprivation, material hardship and income poverty. They include lack of transport, crowding, homelessness, damp cold houses, inadequate food and nutrition, disability, poor education, toxic stress, ill-health itself (mental or physical), and racism and other forms of discrimination (such as ableism, homophobia and transphobia). Many of these issues are

addressed in other CPAG Policy Briefs (see www.cpag.org.nz/policybriefs). Here, we discuss pressing health system issues: costs of and lack of access to primary, preventative and diagnostic healthcare and systemic racism.

The first 1000 days: barriers to primary care access and engagement

In Aotearoa, over 60,000 babies are born each year. The first 1000 days (pregnancy to 2 years) are the most important part of life's trajectory,[20] as acknowledged by the state's useful "Best Start" payments for our youngest children introduced in 2018.

Well Child Tamariki Ora is New Zealand's key programme for supporting the health, development and wellbeing of tamariki from birth to five years, yet not all children receive enough of this essential programme. There are significant equity gaps to access, with infants from quintile 5 (the 20% most deprived areas) significantly less likely to be enrolled in these services than other infants.[21]

The developmental importance of the first 1000 days means that affordable access at all times to primary care is vital for pregnant people and children, including for prevention, ongoing care and after-hours care. Yet such access has worsened since the COVID-19 pandemic started.

Issues of availability

- There is a shortage of Lead Maternity Carers.[22]
- Enrolment with a general practice – a key enabler – is lower for families living in poverty, for whānau Māori[23], for Pacific families and for children cared for by Oranga Tamariki, only 53% of whom are enrolled with a GP.[24]
- A major obstacle to enrolment with a GP is the lack of general practice services in many areas, and many general practices currently have closed books.
- The current under-resourcing of primary care with resultant shortages of GPs and nurses[25] also results in difficulties accessing timely appointments.[26]
- Low-income families in unstable housing, having to move around a lot, have greater challenges in being enrolled with a stable, supportive local general practice, increasing the obstacles to receiving healthcare.

Issues of unaffordability

- During pregnancy, GP non-pregnancy-specific visits are not free, nor are dental visits (particularly necessary due to pregnancy effects on teeth).
- Many after-hours services charge for children, while free-of-charge hospital emergency departments usually have significantly long wait times sometimes to the point of compromising healthcare.[27]

Issue of being inappropriate for whānau and communities

- The Well Child Tamariki Ora checks are not reaching all children, especially those most in need.[28] The nature of the checks and/or the way they are conducted may not

meet the cultural needs of whānau Māori and Pacific families, and adequate intervention does not always follow from referral. Dr Teuila Percival summarises (about Pacific children): "so most of these kids aren't getting any help at all".[29]

These cultural barriers also apply to all healthcare services across primary care and other areas. Pacific families reporting experiences of healthcare for rheumatic fever (linked to overcrowding and poverty), wanted greater involvement during consultations, and saw this as central to their rights and responsibilities as parents or caregivers. In addition, families were the targets of inappropriate and unacceptable judgements from healthcare professionals, experienced for example as "where's all the fathers at?"[30]

Adolescence: barriers of primary care and mental healthcare cost and engagement

Adolescence is a crucial and sensitive period of psychological and biological change and rapid brain maturation, second only to early childhood in the rate and breadth of developmental change.[31] Adolescent health needs are high, including mental distress, serious skin infections, pneumonia, asthma, bronchiectasis, rheumatic fever and reproductive health.

Yet, unaffordable healthcare remains a barrier for secondary school students.[32] For children aged 14 and over, families have to pay for their GP visits as free doctors' visits are only offered to children aged 13 and under. (The prescription co-payment barrier – $5 to $15 per item up to 20 items per year per family – has also impacted the ability of parents and caregivers to care for children in low-income families; we welcome the removal of this barrier from 1 July 2023.)[33]

Barriers to access mental healthcare contribute to youth mental distress. Yet specialist child and adolescent mental health services are "overwhelmed" by increasing numbers of patients, and they receive only 62% of the funding per patient of adult services.[34]

Community and culturally focused national and local responses

To address the persistent inequities for tamariki Māori, a range of solutions are required. At the policy level, Te Aka Whai Ora has prioritised funding to support the delivery of Māori- led solutions for perinatal parental and early years services. Te Whatu Ora and Te Aka Whai Ora have a joint approach, Kahu Taurima, to provide extra support for the first 2000 days of life. However, given that many parents experience racism, discrimination and ableism in service delivery,[35] more needs to be done to ensure that mainstream services are welcoming and culturally safe for whānau Māori, Pacific and ethnic minority families, families with a person with disability and those led by young parents.[36]

There are grassroots innovations in delivering healthcare for tamariki in communities by NGOs, youth services and hapu/Iwi providers that are making a difference, but are under-resourced and overwhelmed. Community, hapu and Iwi initiated programmes and services must be better resourced to self-determine the wellbeing of whānau. Finally, designing services that meet the unique localised needs of tamariki and their whānau requires collaboration, resourcing and deliberate equity planning.

RECOMMENDED POLICY ACTIONS

The first 1000 days are the most important part of life's trajectory, and must be prioritised more.

Serious pregnancy and childhood health conditions can potentially be avoided by: actions in the community (timely perinatal care and primary care); public health activities that improve and promote health of the population (eg immunisation, injury prevention); and social policy actions that address factors such as adequate incomes, healthy housing and underlying racism. (See CPAG 2023 Policy Briefs at www.cpag.org.nz/policybriefs.)

Adolescence (also developmentally important) should attract appropriate care, attention and resourcing.

Recommended Action 1: Ensure every child can access healthcare to meet their needs, at all times

- Ensure every infant is enrolled with an accessible general practice where the whānau feel welcomed, comfortable and supported, ideally with Lead Maternity Carers checking and supporting the enrolment of the pregnant parent pre-birth or, at the latest, at birth.
- For families who move between areas, ensure that ease of shifting general practice enrolment is enabled for all children and whānau, using system navigators where necessary.
- Address the shortage of midwives to enable ease of access for all low-income parents-to-be as early as possible in pregnancy by ameliorating their conditions and recruitment.
- Ensure all Well Child Tamariki Ora checks and immunisations are made accessible and their approach is fit-for-purpose for every whānau wherever they live; if issues are found, ensure that appropriate follow-up of the child occurs using system navigators where necessary.
- Increase resourcing to support primary care, after-hours and emergency department services to deliver safe, effective and timely services, particularly for children.
- Increase resourcing in schools to support School Based Health Services under Te Whatu Ora,[37] involving students in the design and ensuring all healthcare occurs in a safe comfortable environment with practitioners whom students trust.[38]

  We note that rangatahi contributing to the Taitamariki Youth Declaration call for "educational programmes on how to recognise symptoms and support those with mental health issues" including via seminars in schools.[39]
- Te Whatu Ora and Te Aka Whai Ora need effective strategies to address racism and discrimination in the healthcare system. Develop, resource and implement strategies to address these issues, and in particular, support the development of Kahu Taurima to address the following issues identified: 1. Service delivery racism, discrimination and ableism; 2. Barriers to appropriate perinatal education; 3. Support for distress

and bereavement during the first 2000 days; and 4. Better rural access to primary and specialist perinatal parental and early years care.[40]

- Substantively increase resourcing to child and youth mental health so that, at minimum, it has resourcing parity with adult mental health services per person in need.

Recommended Action 2: Make all healthcare free for all children from pre-birth to 18 years at all times

- Make all General Practice visits (not just pregnancy-related GP visits) free during pregnancy, including for mental health.
- Make dental care free for all pregnant people up until 6 weeks after birth.
- Extend current free General Practice visits to all children up to 18 years; and to all people with Community Services Cards (in order to cover caregivers in low-income families).
- Make all after-hours healthcare services free for all children up until 18 years in all parts of the country.
- Introduce fees-free visits to primary mental health support and perinatal parental mental healthcare.

IMPACTS AND INDICATORS

If implemented, these actions would be steps towards moving Aotearoa to be a nation where all children and families flourish free from poverty.

Meeting the health needs of every child will assist the Crown in addressing Te Tiriti o Waitangi obligations, including health equity,[41] and assist New Zealand to meet:

- Targets for UN Sustainable Development Goal 3: "Ensure to ensure healthy lives and promote well-being for all at all ages".[42] This includes "3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."
- Obligations under the UN Convention on the Rights of the Child, **Article 24: "**recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services."

And meeting the health needs of every child will help us all realise the national vision "that New Zealand be the best place in the world for children and young people".[43]

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