

The State of the Nation's Children- Child Poverty in NZ 2014

Opening Address at the Paediatric Society of New Zealand's Annual Scientific Meeting
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Innes Asher

I would like to acknowledge everyone who has contributed to the information and the perspectives in this essay, especially: the children; Dr Liz Craig of New Zealand Child and Youth Epidemiology Service¹; Child Poverty Action Group² particularly the economic expertise of Associate Professor Susan St John; and Dr Russell Wills, Children's Commissioner,³ who has made Child Poverty his priority for his first term.

A beautiful young Māori woman I know died this year from bronchiectasis. Three months before she died she said:

"Poverty is our reality – it doesn't have to be our reality."

Bronchiectasis is our reality – it doesn't have to be our reality"

She was right. This essay is dedicated to her.

In this short essay I will touch on three topics: New Zealand child poverty statistics, so that we know the parameters of the problem we're talking about; some consequences of child poverty including the high rates of preventable diseases; and reasons why child poverty has increased. This third section will focus on two aspects: (i) the impact of government policies, and (ii) consideration of how colonisation compounds the issues of poverty for Māori who have worse health outcomes than Pākehā.

Many of my figures are grim, but there is a lot we can do. The Prime Minister has prioritised child poverty, so New Zealand should be well placed to make the right changes.

Child Poverty – The state of the nation's children

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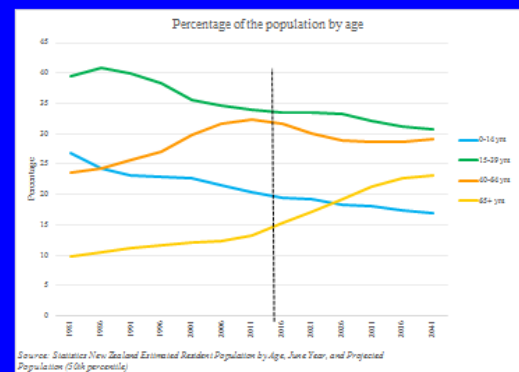


In This Essay

- **Child poverty statistics**
- **Some consequences of child poverty**
- **Why has child poverty increased?**

This slide shows how important each child will be in New Zealand's future, projected forward to 2041. The proportion of children (the blue line) is steadily declining while those >65 years (the yellow line) is increasing, and these proportions will be crossing in about 10 years.⁴

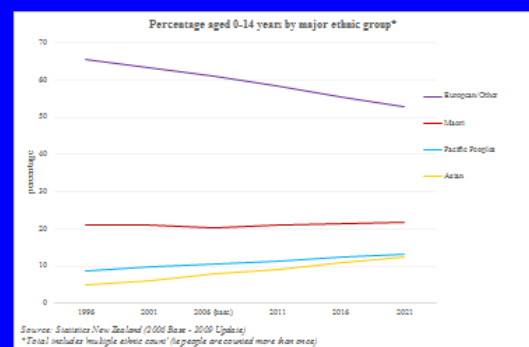
Percentage of the population by age 1981-2041



Statistics New Zealand, 2014

European children (the purple line) will eventually become a minority, because an increasing proportion of children are Māori, Pasifika and Asian.⁵

% aged 0-14 yrs by major ethnic group 1996-2021

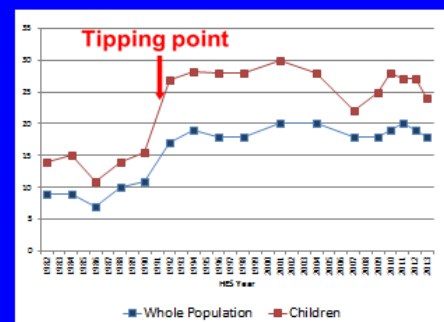


Jackson N, 2014

Each year the Ministry of Social Development publishes the Household Incomes Report which is the source of my statistics.⁶

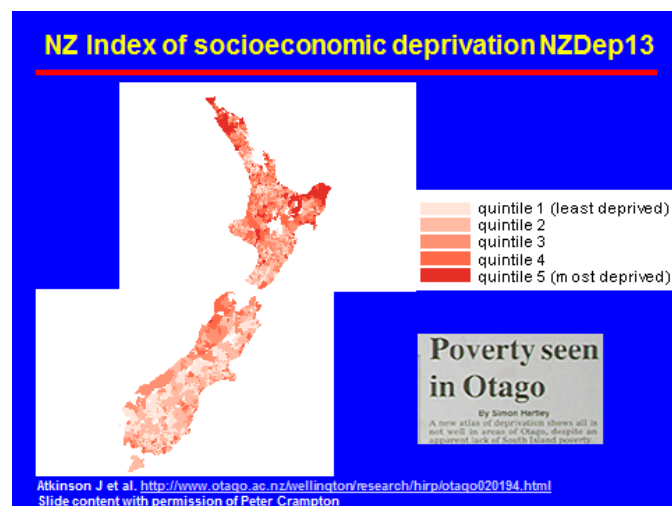
This slide uses the common income measure of poverty as defined in the subtitle. I will be using this measure in most of my figures. About twice as many New Zealand children are in poverty now than in the 1980s, and children are more likely than adults to be living in poverty. There was a tipping point for poverty levels in 1991 following policy changes by the Government, especially reduction in the level of benefits for families.

NZ Poverty: child vs whole population 1982-2013 (<60% median disposable household income after housing costs)



Perry B. Ministry of Social Development, 2014, p133 Table F.4, p137 Table F.7.

The latest Socioeconomic Deprivation Index figures show that the distribution of poverty is very uneven around New Zealand.⁷ Children in poverty are found in all District Health Board areas, but in those with lower rates such children may be overlooked. For example this year the *Otago Daily Times* was surprised to find poverty in Otago.



This slide shows the numbers and percentages of New Zealand children in poverty.⁶ All children are vulnerable. Children in poverty are especially vulnerable.

Poverty is measured by income and by material hardship. We have two income measures of poverty – less than 60% and less than 50% of the median disposable household income after housing costs. The second measure includes more than 200,000 of our million children. Theoretically it is possible that no-one would be below these thresholds.⁸ Material hardship is the other measure we use - 180,000 children. The most extreme poverty is the two combined – 95,400 children. Most New Zealanders underestimate the numbers of children in poverty.⁸

Child poverty figures, under 18 yr (2013)

Child poverty figures in NZ	No. of children	% of children
Total number of children 0-17 yrs	1,060,000	100%
Income-poverty (<60% median after housing costs)	260,000	24%
Severe income poverty (<50% median after housing costs)	205,000	19%
Material hardship (Material Wellbeing Index)	180,000	17%
Severe income poverty AND material hardship	95,400	9%

Perry B. Ministry of Social Development, 2014, pp33-34, p135 Table F.5, p137 Table F.7, p217 Table L.3

Material Hardship is defined as the deprivation of essentials in the four areas shown here.⁶

Families report that they do not have these essential items because of cost, or because money is needed for other essentials.

Material Hardship Deprivation of essentials

- Enforced lack of essentials
eg meals with meat
- Cut back or delayed purchases a lot
eg visits to doctor
- In arrears more than once in last 12 months
eg electricity
- Financial stress and vulnerability
eg could not pay unexpected bill

Perry B. Ministry of Social Development, 2014, Section L

It is often stated by our political leaders that paid work is the way out of poverty. Of course it is if the work is well paid and secure. But it isn't for many families. Although only 12% of children supported by paid work are in poverty, 37% of children in poverty are supported by paid work.⁶ This proportion is commonly underestimated. In September this year the Prime Minister quoted it as 11% when he should have said 37%.¹⁰ Some paid work these days may be casual, poorly paid, at family-unfriendly hours, or insecure.

Most children in poverty are supported by a benefit, which is clearly inadequate for most of them (75% in poverty). Income support benefits for parents should be at an adequate level for families where parents are caring for children, of any age, and unable to work, or unable to find suitable, adequately-paid work. There are not enough jobs out there for everyone so job-seeking may be stressful, time-consuming, demoralising, and unsuccessful.

The current Government policy of sanctions - cutting the benefit for parents who do not meet strict social or job-seeking criteria - will make poverty in this group much worse.

Child poverty figures – supported by 'paid work' or a benefit

Child poverty figures in NZ	% children in this category who are in poverty	% of children in poverty who are in this category
Parent in paid work	12%	37%
Parent on benefit	75%	63%

Perry B. Ministry of Social Development, 2014, p159 Table H.5

This slide shows poverty by ethnicity.⁶ The lowest rates of child poverty are among European/Pākehā children (17%). Māori and Pasifika children have twice that rate (34%), and children in the "Other" category have an intermediate rate. Are these inequities something we accept as inevitable or do we think they are an outrage?

Child poverty figures – ethnicity

Child poverty figures in NZ	% children in this category who are in poverty	% of children in poverty who are in this category
European/Pakeha	17%	38%
Maori	34%	34%
Pasifika	34%	13%
Other	27%	14%

Perry B. Ministry of Social Development, 2014, p159 Table H.5

This slide shows how children in four family types are affected by poverty.⁶ Of the children in poverty, about equal numbers are in one- and two-parent families, and in small and large families.

Child poverty figures – family type

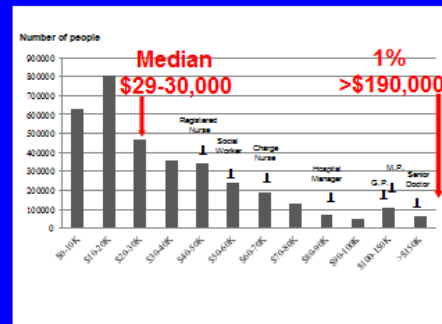
Child poverty figures in NZ	% children in this category who are in poverty	% of children in poverty who are in this category
Sole parent family	53%	53%
Two parent family	15%	47%
In families with 1 or 2 children	21%	55%
In families with ≥3 children	29%	45%

Perry B. Ministry of Social Development, 2014, p159 Table H.5

Many in New Zealand do not realise how low incomes are for some of the population – the median income is about \$29-30,000, so half earn less than that.¹¹ At the same time, many of us earn more, some much more, and some older senior doctors like me are in the top 1%. Most people making policy about family incomes and child poverty are themselves earning very high incomes and thus may have difficulty understanding how low incomes actually are¹² and the pressures and stresses of life on very low income.

As Margaret Chan, Director-General of the World Health Organisation said this year “*Wealth does not trickle down*”.¹³

Distribution of taxable personal income 2012



www.ird.govt.nz/about/external/stats/revenue-refunds/inc-dist-of-ind/

The consequences of poverty include ill health – physical and mental illness and injury. Poverty also causes stress, loss of hope, poor self-worth, loss of educational potential, lack of sport and music, and participation in the other normal things expected for New Zealand children.

Some consequences of child poverty for health

We have high rates of preventable diseases. The slide to the right illustrates the incidence of bronchiectasis, which is well known internationally to be linked to poverty.

Our incidence of bronchiectasis¹⁴ is much higher than that of Finland¹⁵ and the UK¹⁶ – the only other OECD countries to report such figures.

Incidence of Bronchiectasis* in children: International Comparisons

Country	Age	Incidence	Year of data
UK ¹	0-15yrs	0.2/100,000	2006-7
Finland ²	0-14 yr	0.5/100,000	1998
NZ ³	0-14 yrs	3.7/100,000	2001-2

*Not due to cystic fibrosis

¹Lavery A et al. *Pediatr Pulmonol*. 2009; 44:626-627.

²Saynajakangas O et al. *Centr Eur J Pub Health*1998;6: 235-237.

³Twiss J et al. *Arch Dis Child*. 2005; 90: 737-740.

We have large health inequities in New Zealand, as illustrated here by hospital admissions for five diseases in children and young people averaged over 2006-2010.¹⁷ European children are standardised to a rate of 1. Māori have at least double the rate, with shockingly higher rates for bronchiectasis and acute rheumatic fever highlighted in yellow. All the rates are even worse for Pacific children, with the worst highlighted in green. The Asian/Indian rates are similar to European rates or even lower.

Hospitalisation for five diseases in children & young people. Risk by Ethnicity 2006-2010

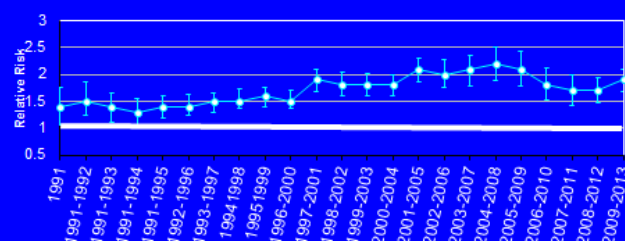
Cause of Hospital Admission	European	Māori	Pacific	Asian/Indian
Serious skin infection+	1	2.97	4.42	1.00
Pertussis#	1	2.29	3.11	0.47
Pneumonia+	1	2.08	4.46	1.16
Bronchiectasis*	1	7.51	11.2	1.30
Acute Rheumatic fever*	1	25.3	44.2	0.46

0-24 years; + 0-14 yr; * <1 year

Craig E, et al. NZCYES Report 2011.

The data on the slide to the right demonstrates that the national excess of hospital admissions for pertussis in Māori has been occurring at least since 1991 – the relative risk is consistently greater than 1.¹⁸

Ethnic differences in Pertussis 5 year average annual relative risk of discharge for Māori vs non-Māori



Sinclair O. Ethnic disparities: The long view. Starship Grand Rounds August 2014

There are longer term health consequences of child poverty which extend into adult life. The Dunedin Longitudinal Study enrolled babies in 1972-3. They found that children who were disadvantaged in preschool years had poorer health as adults at 26 years: poorer cardiovascular health, increased periodontal disease, caries and substance abuse. These were not mitigated or reversed by moving into better socioeconomic positions in later childhood or adulthood.^{19,20}

Child disadvantage and adult health

Dunedin Longitudinal Study enrolled 1972-3

At age 26, people who were disadvantaged in preschool years have:

- Poorer cardiovascular health
- Increased periodontal disease
- Caries
- Substance abuse

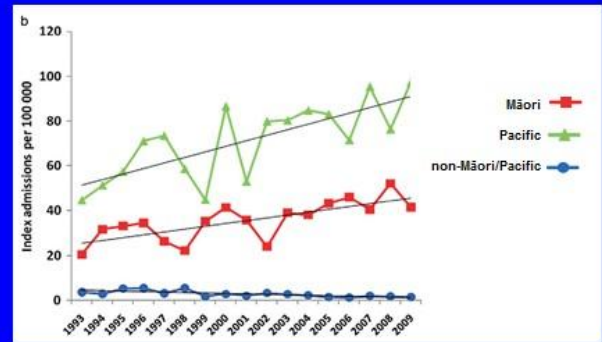
Not mitigated or reversed by later 'upward mobility'

Poulton R et al. Lancet 2002; 1640-1645.
Melchior M et al. Am J Epidemiol 2007; 166: 966-74.

Some health inequities are increasing.

This is data for rheumatic fever from 1993-2009.²¹ In 1993 there were marked ethnic differences, with Māori rates many times European rates, and Pacific rates double Māori rates. The shocking inequities seen in 1993 have increased to a horrendous extent over this 16 year period: the European rate fell by 71%, while the rates increased 79% for Māori and 73% for Pacific children.

Annual Index Cases and Incidence Rates for Rheumatic Fever 5-14 years, 1993-2009

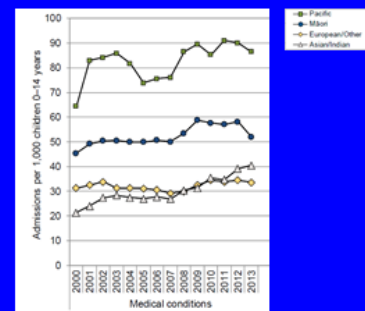


Milne R, et al. J Paediatr Child Health 2012; 48: 685-91.

The slide on the right shows medical admissions for childhood illnesses with a socioeconomic gradient from 2000-2013.²²

Over this 13 year period the admission rates for European/Other remained consistently lower than for Māori and Pacific children. Asian/ Indian rates have been increasing to about the European level. Māori rates have been much higher than European, and Pacific even higher still, with widened gaps since 2000 – another horrifying picture.

Hospital Admissions for Medical Conditions with a Social Gradient, Children Aged 0–14 Years, New Zealand 2000–2013

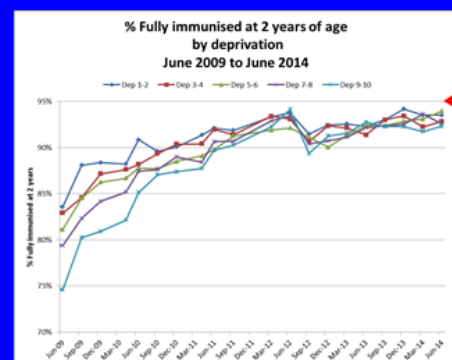


Craig E et al. Child Poverty Monitor, 2014

However, there is some good news!

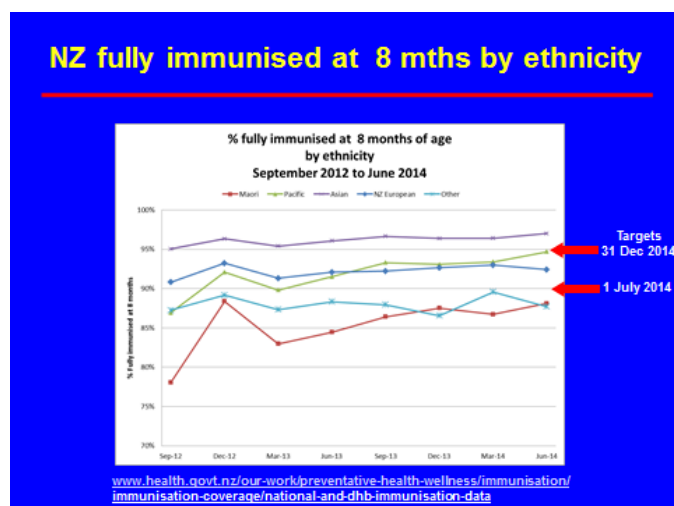
With immunisations, rates of “fully immunised at 2 years” have dramatically increased over the last 5 years, and now nearly 95% of children are immunised in all ethnic groups,²³ illustrating that we can improve child health and achieve equity if we choose to.²⁴

NZ fully immunised at 2 yrs by deprivation

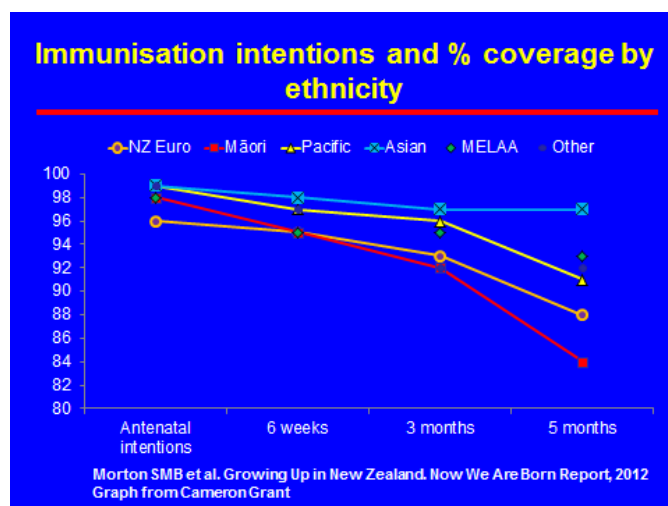


<http://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data>

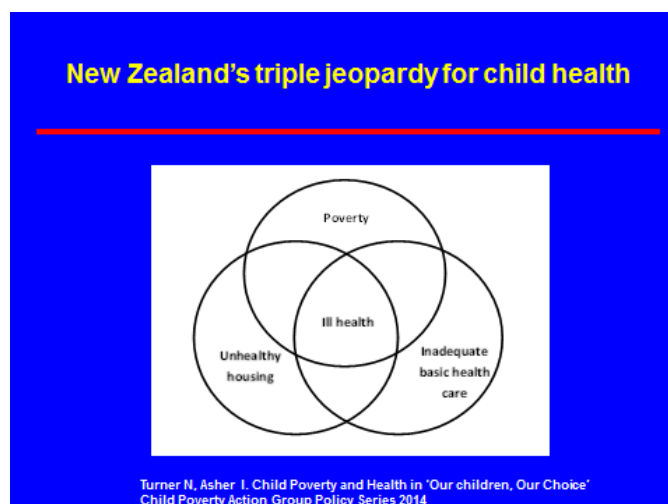
The slide on the right shows the more challenging target of “fully immunised at 8 months” for the last 2 years.²³ While great progress has been made in all ethnic groups, there is an ethnic gradient, with Māori and “other” sitting at a sub-optimal level.



The slide on the right shows longitudinal data from the Growing Up In New Zealand Study.²⁵ It demonstrates that Māori parents (in red) have high aspirations antenatally to have their children immunised. There is a falling off of immunisation coverage in all ethnic groups, but most of all for Māori children. Why could that be? Why isn't our system acting in a way that recognises and values the aspirations of Māori parents in particular, and provides for them?



The basis of our high rates of preventable ill health lie in New Zealand's triple jeopardy for child health; that is, a combination of problems in three critical areas at once: poverty, unhealthy housing and inadequate basic health care.²⁶ In New Zealand, poverty itself is a root cause for both unhealthy housing and inadequate basic health care, and the three combined can make poor mental and physical health almost inevitable.



New Zealand has high rates of preventable diseases associated with poor housing. The key housing issues are crowding,²⁷ poor quality situations including cold and damp housing, and unaffordable or unhealthy fuel. Several research studies in New Zealand have demonstrated that addressing these issues leads to improved health, and is cost effective.²⁸⁻³³ Inadequate money in families is a key factor in children living in unhealthy homes. Other adverse systemic factors which could also be changed by policy include insufficient houses, very high rents in private rentals, lack of regulation of the quality of rental homes, and the high cost of electricity.³⁴⁻³⁵

A fall off in the availability of social housing has been another major factor. Numbers in the priority list rocketed up from 425 in June 2012 to 3188 in June 2014. Despite this, the Government now wants to sell off most state houses, and has no explicit plan to meet all social housing needs.³⁶ Normal shelter for some children in New Zealand now appears to be garages³⁷ and vehicles,³⁸ rather than proper housing. This appalling change seems to cause little outrage and woeful official response. Is this our new norm?

The parents in both the families shown in the slide on the right reported sickness in their children which they believed to be due to their poor accommodation.

Many children are receiving inadequate basic health care.²⁶ Some of the factors listed here are due to inadequate money in the household, and some are due to inadequacy in our systems.³⁹⁻⁴¹

A good education also underpins health, and it is vital that inequities which affect early childhood care and education⁴² and compulsory schooling⁴³ are addressed.

Unhealthy housing



Key health issues

- Crowding
- Poor quality – cold and damp
- Fuel – unaffordable or unhealthy

Families living in garages, then cars.....



Western Leader 3 Oct 2013, www.stuff.co.nz/business/money/9238710/Garage-life-for-two-years
NZ Herald 4 Oct 2014, www.nzherald.co.nz/nz/news/article.cfm?_id=11336725

Inadequate basic health care

Includes lacking any of these:

- Basic hygiene in the home
- Health literacy – systemic and family levels
- Access to primary health care, including doctor visits and medicines
- Enrolment with health providers from pregnancy, regular assessment and coordination
- Dental care
- Optometry care

Is poverty impacting on youth? Repeated cross-sectional data on young people attending secondary schools have shown that over the 12 year period 2001-2012 there have been some pleasing, positive trends for young people.^{44,45}

However, disturbingly, there have been increases in teenagers reporting parents' worries about money for food, a lack of part-time jobs and reduced access to general practice.

Resources for families with teenagers are just as important as for younger children. For a start, their food⁴⁵ and clothing costs a lot more.

Why has child poverty increased? Factors which impact on child poverty rates are shown in the slide on the right.⁶ Policies are highly influential and arguably the easiest to change.

The slide on the right shows changes in policy adversely affecting incomes of all low income households with children.

Trends in Youth Health 2001 – 2012



Positive

- Fewer risk taking activities
- Better school experiences

Negative

- Parents worry about money for food increased
- Part time job decreased
- GP access decreased

Clark TC et al. J Paed Child Health 2013; 49: 925-934.

Why has child poverty increased?

Factors which impact on child poverty rates:

- Policy changes
- Society's structural and cultural norms
- The economy and labour market
- Demographic shifts

Changes in Policy Adversely Affecting Incomes of All Low Income Households With Children

- Low wages and relatively high taxes for the low paid
- Family income support inadequate for low income families:
 - No indexing of family income support for 20 years (1989-2008)
 - 1991: The universal family benefit abolished

The slide on the right shows further changes in policy, additionally adversely affecting incomes of 'beneficiary' households with children.⁴⁷⁻⁵¹

In my next slide I will illustrate some key changes in income policy over the last two decades which have had consequences for child poverty, good and bad.⁵²

Changes in Policy Additionally Adversely Affecting Incomes of 'Beneficiary' Households With Children

- Beneficiary families treated very harshly:
 - 1991: Benefits cut by 21%, not restored relatively
 - 1996: Child Tax Credit introduced excluding parents on benefits from \$15 per child/wk
 - 2006 In Work Tax Credit replaces Child Tax Credit and worth at least \$60 per week – discrimination (Human Rights Tribunal & Court of Appeal)
 - 2010: Sanctions if parents do not meet *strict* criteria ie benefit halved for a defined period

Look at the green columns. Following the benefit cuts in 1991 the percentage of children in poverty in 'beneficiary' families increased from 25% to 75% and has remained at that level since. A bad policy.

Now look at the yellow columns. In the 1993 rents on state houses were increased to market rents (the level of private rentals), subsequently increasing child poverty in 'beneficiary' families by 2001 to 88%. A bad policy.

This policy was changed back in 2001, with a small fall in the percentage of children in poverty in 'beneficiary' families from 88% to 73%. A good policy.

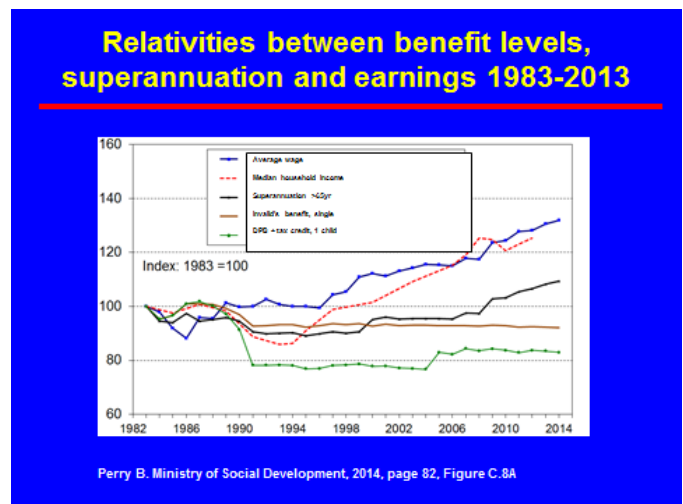
Now look at the lilac columns. In 2004 the Working for Families package was introduced, helping children in families supported by paid work – the percentage of those children in poverty halved from 21% to 11%. A good policy for that group. 'Beneficiary' families do not get a key child-related tax credit of Working for Families, and thus their poverty rates have not changed. In 2013 the Courts found children of beneficiaries were discriminated against by this policy.⁵³ A bad policy for them.

Child income poverty following income policy changes

Main source of parent's income	Before 1991 benefit cuts	After 1991 benefit cuts (1994)*	Before income-related rents HNZZ (2001)	After income-related rents HNZZ (2004)	Before Working For Families (2004)	After Working For Families (2009)
Parent in paid work						
Income poverty	18-20%	18-20%	18-20%	18-20%	21%	11%
Parent on benefit						
Income poverty	25%	75%	88%	73%	75%	75%

Perry B. Ministry of Social Development, 2010 p105, Table H.3
 *Perry B. Ministry of Social Development, 2014 p 26

This graph summarises the effects on incomes for 'beneficiary' families with children compared with other New Zealanders over the last 30 years.⁶ The green line is Domestic Purposes Benefit (now named Sole Parent Support) with one child, which fell dramatically in 1991 and has hardly changed since. The brown line is invalid benefit with no children. The black line is NZ Superannuation which is the income support benefit for the elderly. The red line is median household income and the blue line is the average wage. You can see that incomes of those in paid employment have steadily risen. So has NZ Superannuation. By law this cannot fall less than 60 % below the average wage.



However other income support benefits are NOT linked to wages, and we see how they have remained static and, in real terms, have fallen. We can see here that raising incomes for 'beneficiary' families and linking benefits to wages have to be part of the solution to child poverty.

Pleasingly the Ministry of Social Development, in November this year, have indicated they will undertake a review of benefits to tackle child poverty.

Children in poverty are often stereotyped as Māori or Pasifika, and stigmatised, with others assuming they must have parents who are stupid or irresponsible. These prejudiced images are fuelled by the media, and reinforced by the words of government leaders. Dismissive statements like "don't throw more money at the poor" are not helpful.

I want to reflect for a minute on poverty and Māori children. Our society accepts and has expectations that Māori will have poor outcomes, even though in pre-European times Māori were healthy and well looked after, as documented by Anne Salmond: *"to both Cook and Banks...these people were healthy in the highest degree.....compared with Europe [of the time] children were rarely hit..."*.⁵⁴

Colonisation, racism and child poverty

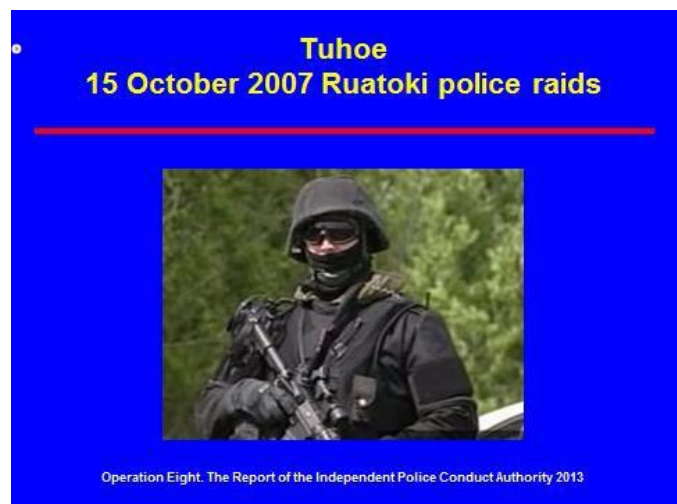
Colonisation leads to behaviour based on erroneous assumptions of coloniser superiority and has caused much harm to Māori. In the last two centuries this harm included stealing large tracts of fertile land which resulted in famine, disease and impoverishment for many.⁵⁵

New Zealand now takes Te Tiriti o Waitangi⁵⁶ seriously and has ratified the UN Convention on the Rights of the Child,⁵⁷ and endorsed the UN Declaration on the Rights of Indigenous People.⁵⁸

In the case of Tuhoe, in July this year the Crown apologised for the first time for its *“unjust and excessive behaviour and the burden carried by generations of Tuhoe who suffer greatly and carry the pain of their ancestors.”*⁵⁹

Yet as recently as 2007 the Crown’s police raids on Tuhoe demonstrated that profound racism is present in sections of our society. The police behaviour towards some families was illegal.⁶⁰

The psychological trauma experienced by some Māori children because of behaviour of police dressed like the man above has largely been hidden from public view.⁶¹



Difficulties for some Māori children in everyday life experiences have their origins in our history and society structures, and the ways in which the dominant culture can make it difficult for them to reach their potential. For Pākehā children it can be “like biking with the wind behind them”; for Māori children it can be “like biking into the wind”.⁶²

Life experiences towards reaching their potential



Pakeha children

“like biking with the wind behind them”




Māori children

“like biking into the wind”

Fiona Cram 2012 www.katoa.net.nz
Duluth unfaircampaign.org/resources/see-it/

The childhood experience of Parekura Horomia illustrates this.⁶³

The adverse outcomes for Māori compared with Pākehā in health and wellbeing are well documented and obvious. Their roots in poverty were clear in the 2013 report of the Māori Affairs Select Committee.⁶⁴



Parekura Horomia
(9 Nov 1950 – 29 Apr 2013)
Cabinet Minister 2000

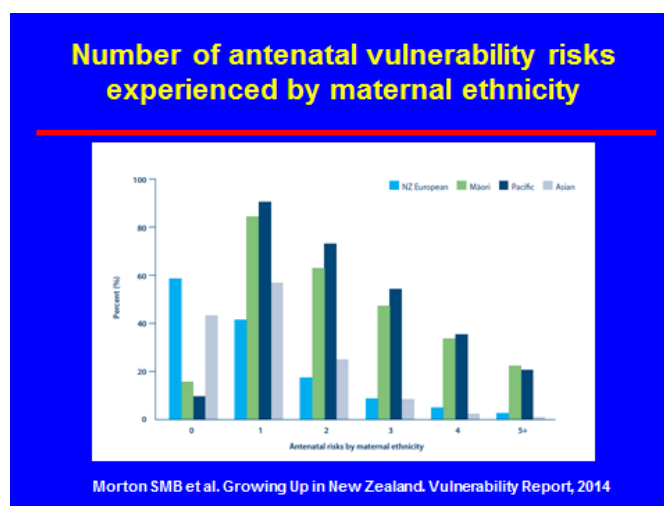
“When I was a schoolboy I vividly recall walking to school ... five kilometres to school and back ...

Everyday we would watch the empty school bus drive past us and other whanau to collect the pakeha kids that lived a half a kilometre from our school...

I used to dream of being picked up by that school bus...

I relate that story now because Maori are often told we’ve missed the bus. And many cases Maori have not even had the opportunity to get on the bus.”

The Growing Up in New Zealand study has looked at antenatal vulnerability risk factors, illustrated here by ethnicity.⁶⁵ Numbers of risks increase towards the right. Māori and Pasifika children (green and navy bars) have disproportionate exposure to these vulnerabilities even before they are born, illustrating how early in life inequities are having effect. Some of these vulnerability risks are directly related to income poverty, whereas others include poverty of experience.



Are Māori children accessing health care enough? Well no. The cost of Māori child health inequities has been examined recently by Clair Mills and others.⁶⁶ This table shows the great disparities in the extent to which the health care system engages with Māori children.

Column A shows that more Māori children have avoidable hospital admissions than non-Māori. Column A also shows fewer Māori children than non-Māori are attending primary care, outpatient clinics, getting medicines, laboratory tests and ACC support. Column B shows the level of contact that would occur if Māori children accessed health care equally to non-Māori. The right hand column shows the dollar amounts per year. The increased admissions for Māori children cost \$5.62 million.

**Health care for Māori children:
We should be spending \$24.74m per year more on them**

	A Māori/non-Māori rate ratios	B If Māori = non-Māori rates then over one year there would be	Annual cost/'saving' of difference between columns A and B
Avoidable hospital admissions	1.27	3075 fewer admissions	Cost \$5.62 million
Consultations in primary care and outpatients	0.86-0.92	63,414 more consultations	Total 'savings' for consultations and claims categories \$30.81 million
Claims for pharmaceuticals, Laboratory, ACC	0.45-0.85	305,770 more claims	

Mills C et al. BMC Public Health 2012; 12: 384

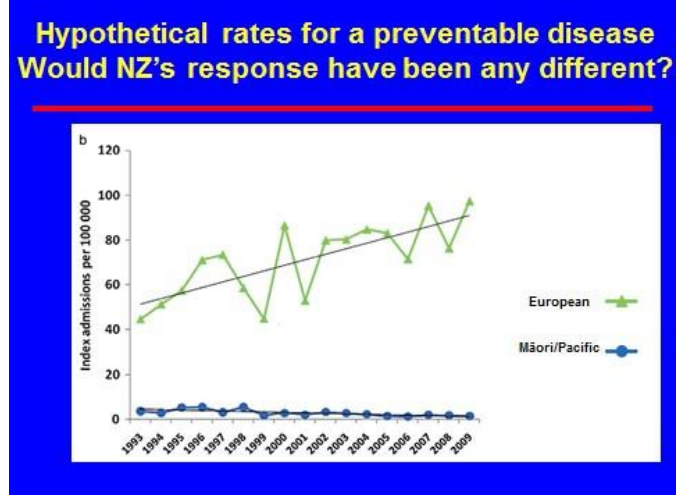
However through reduced contacts of Māori children the country spends \$30.81 million less than it should. Thus there is a net underspend of \$24.74 million per year for Māori children.

These perverse figures result in the perpetuation of inequities of health for Māori children and generate other costs to the children and their families, and society in the short, medium and long term. We have not adequately wrestled with this.

Similar calculations for Pasifika children have not been done.

To reflect further on whether child poverty is imbedded in our society's racist structures, let us consider this graph of hypothetical rates by ethnicity for a preventable disease. This graph is based on the figures for rheumatic fever admissions I showed earlier, but I have deliberately changed the ethnicity labels.

I ask myself if this was our real data would New Zealand's response have been any different in addressing a preventable disease? Would it have been more urgent, more comprehensive?



I recommend to you the Starship Paediatric Update lecture this year by Dr Rhys Jones, Public Health Physician and Senior Lecturer, Te Kupenga Hauora Māori at the University of Auckland, entitled: "Child health inequities: How do we become part of the solution?" He touched on how our society, our health systems, and ourselves are part of the problem. Like him, I believe that we can be part of the solution through transformative individual change. This includes reducing the effects of colonisation on ourselves.⁶⁷

The Ministry of Health has just produced a valuable framework for Equity of Health Care for Māori, pointing to how we need to act. We need Leadership, Knowledge, Commitment in the Health System, Health Organisations, and Health Practitioners.⁶⁸

As Treaty Negotiations Minister Chris Finlayson said when he apologised for past Crown behaviour against Tuhoe "*Let these words guide our way to a greenstone door – Te tatau pounamu – which looks back on the past and closes it, which looks forward to the future and opens it.*"⁵⁹

Child health inequities: How do we become part of the solution?

Our society, our health systems, ourselves
are part of the problem

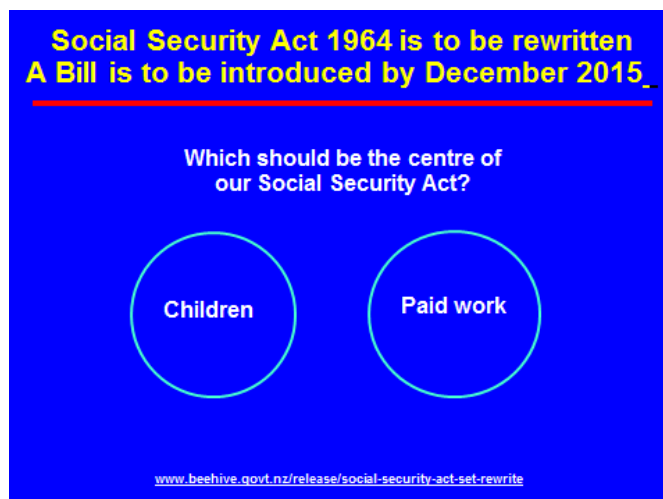
We can be part of the solution through transformative change
including reducing the effects of colonisation on ourselves.

Need Leadership, Knowledge, Commitment
in the
Health System, Health Organisations, and Health Practitioners

Jones R. www.starship.org.nz/for-health-professionals/paediatric-update/2014-archive/child-health-inequities-how-do-we-become-part-of-the-solution/
Ministry of Health. Equity of Health Care for Māori: A framework. June 2014

Professor Linda Tuhiwai Smith in her essay "The Future is Now" says "The future is what we choose to develop as well as what we choose to ignore. It is in our decisions and actions, our values and relationships, our language and mind-sets. There is no accidental future for our society."⁶⁹

The next chapter for the future of children in poverty is the changes to the Social Security Act 1964. It is to be rewritten over the next 12 months, and a bill is to be introduced by December 2015.⁷⁰



A fundamental question which needs to be asked is *"Which should be the centre of our Social Security Act - children or paid work?"*

As parenting is vital to children's wellbeing, the State should support rather than harass parents. How is the unpaid work of parenting valued in the welfare state?

I hope you have appreciated that paid work is not a feasible way out of poverty for most families currently in poverty. Children supported by benefits must be lifted out of poverty too, by increasing incomes in their families as well as the incomes of those in low paid work.⁷¹

As motivational speaker Rita Davenport once said: *"Money isn't everything,..... but it's right up there with oxygen."*

I suggest that a major piece of work, for experts and advocates for children, is to influence the rewriting of this Act, looking through the eyes of children, through the eyes of Māori and Pasifika children and, especially, through the eyes of children in poverty.

Let our outrage at their lost chances fuel our courage to continue to try and change things.

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