Child health and child poverty in New Zealand – a medical student's experience

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I spent the first decade of my life in South Africa. There, for all the country's great beauty, poverty cannot escape one's notice – it stares out at every street corner, intersection and doorway. Shanty towns, beggars, burglar bars become part of everyday life. New Zealand, by comparison, seemed a land of milk and honey, with free access to healthcare and education; and housing for all. Until my medical student placements in the Counties Manukau District Health Board catchment, ideas of inequities, health disparities and poverty in Aotearoa were abstract; almost absurd. What I have discovered, on community visits and hearing the stories of patients and their families, has entirely changed my understanding of life for many Kiwi families. My community visits have revealed the way in which the social, cultural and economic factors affecting child health relate to barriers to healthcare access and demonstrated the importance of community agencies in overcoming these.

"As income decreases, rates of poor health increase" (Public Health Advisory Committee, 2004). A visit to a decile one school with the Public Health Nurses demonstrated how this might be the case. The children playing outside were clearly inadequately attired – shoeless and wearing shorts and t-shirts on an icy day. We dressed a number of infected wounds because, according to the school nurse, families were unable to afford plasters or sterile bandages. The school itself had already exceeded its annual "health" budget only halfway through the second term. While we were standing at the school reception, a mother dropped in, wanting to thank the school for providing her children lunch the week before, admitting that she had been unable to afford the food. The school supplies both breakfast and lunch to the majority of its students – some children arrive at school having not eaten since their school lunch the day before. Poor nutrition and insufficient clothing are associated with adverse health outcomes, in both the short- and long-term.

Inadequate housing has significant impacts on health. The disproportionately high numbers of children with respiratory disease on the paediatric ward is testament to this. I was fortunate to make a number of home visits with the community team, during which I was struck by the poor quality of the housing. Most of the houses were damp with mouldy carpets and peeling walls, and often as cold indoors as out. Unfortunately, despite the Warm Up New Zealand programme, many houses are uninsulated – either because the residents do not meet the criteria, or simply because these families cannot afford even the subsidised costs. Furthermore, there were a number of homes that were clearly overcrowded. One residence had twelve people living in a three-bedroom house. Close-contact infectious diseases account for more than one quarter of hospital admissions in NZ. The child we visited had suffered severe bronchiolitis (a serious chest infection) and at the same time scabies infection, both spread by human contact.

The underlying drivers of health are complex and are in some ways inextricably linked to economic factors. A background of deprivation often complicates whānau dynamics. One boy regularly missed doctors' appointments because he was living with ailing grandparents, his father in prison and mother an itinerant substance abuser. Another two-year-old girl, seen on a Plunket visit, had not received any of her immunisations as

her care had repeatedly been passed from family member to family member, staying with each for only a short period of time. It felt like the system failing its children.

Education plays a critical role in children's health. It was clear that many parents simply did not have an understanding of the importance of immunisations, nor what constituted a healthy diet. A young mother proudly told us of her overweight 18-month-old's "good" diet – a full-sized can of tinned "spaghetti" at each meal! Many parents also do not understand the significance of sore throats, perhaps explaining the high numbers of children with rheumatic fever on the children's wards. I am beginning to understand that education is not simply a matter of increasing the number of public health advertisements on television or brochures distributed. My time in the community has revealed the barriers to education for the socioeconomically deprived. How can one expect a child to learn at school when she had no dinner the night before, then slept on the floor in a cold, damp house and now are inadequately clothed on a wintery day?

I have been taken aback by the breadth and tireless dedication of the community agencies that act to improve the community's health. I have also been appalled by the inequities and poor standard of living experienced by so many families. What struck me as particularly tragic was the fact that, likely for complex social, educational or economic reasons, so many families do not receive the proffered input because they were not home for their scheduled appointments. This rate was up to 50% with some agencies. I believe that this highlights the importance for opportunistic health education and thus our role as doctors in providing it – be it in a primary care or hospital setting.

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