Summary of presentations given to the UNICEF forum, Wellington 15 February 2007

A review of economic and health issues in the Unicef Report Card 7 *Child Poverty in Perspective: An overview of child well-being in rich countries. Innocenti Research Centre, Unicef, Feb 2007*

E aku rangatira, he aha te mea nui o tenei ao? Maku e kii atu, he tamariki, he tamariki, a taatou, tamariki.
Leaders, where does our future lie? In our children.
Dame Anne Salmond

The new UNICEF Report Card on child well-being in the OECD countries tells an old story: NZ continues to perform poorly on many of our child well-being indicators when compared to other Western countries. This is a story of the effects of damage from decades of neglect of New Zealand's children.

International comparisons are useful contributions to debate about the status of New Zealand's children. The report card makes two crucial points:

- There is no obvious relationship between GDP per capita and child well-being. Poorer countries than us do better by their kids.
- Given levels of child well-being are not inevitable but policy-susceptible. The government can do a lot more to improve the quality of many children's lives.

Limitations:

While reports are useful, it is also important to acknowledge the limitations in this data. Most of the data is from 2000 to 2003, and New Zealand data is absent from many of the measured dimensions. No single dimension is a reliable proxy for child well-being as a whole. There are other important areas not included such as measures of mental health. However this is a significant advance on previous publications as it attempts to measure a range of broad child well-being indicators.

Structure:

Six different dimensions have been selected for comparison:

- Material well-being: NZ ranked 16/24
- Health and safety: 23/24!
- Education:17/24

- Peer and family relationships
- Behaviours and risks
- Young people's subjective sense of well-being

NZ ranks 16th out of 24 for material well-being, 17 out of 24 for education and an appalling 23 out of 24 for health and safety. We do not have a ranking for the other areas as they did not have complete data from NZ for many of their measures, which is disappointing and we hope NZ will contribute more fully to the next report.

1. Material Well-being

This dimension is divided into three components:

a. Relative income poverty: NZ is rated 18th out of 24

Can we hope that NZ has improved since 2001? The Ministry of Social Development 2005 does report that the proportion of NZ children living in poverty has altered from 16% of dependent children in 1987/88, to a staggering 27% in 2000/2001, subsequently reducing to 21% in 2003/4 – a figure which is estimated to represent approximately 210,000 children. This is using the measure of the proportion of children with net-of-housing incomes below the 60% line benchmarked to the 1998 median. Hence there appears to be some improvement, but child poverty rates still remain higher than in the 1980s.

It is worth noting that at the same time approximately 7% of people 65 years and over were in poverty on the same measure and income inequality was reported to have increased.

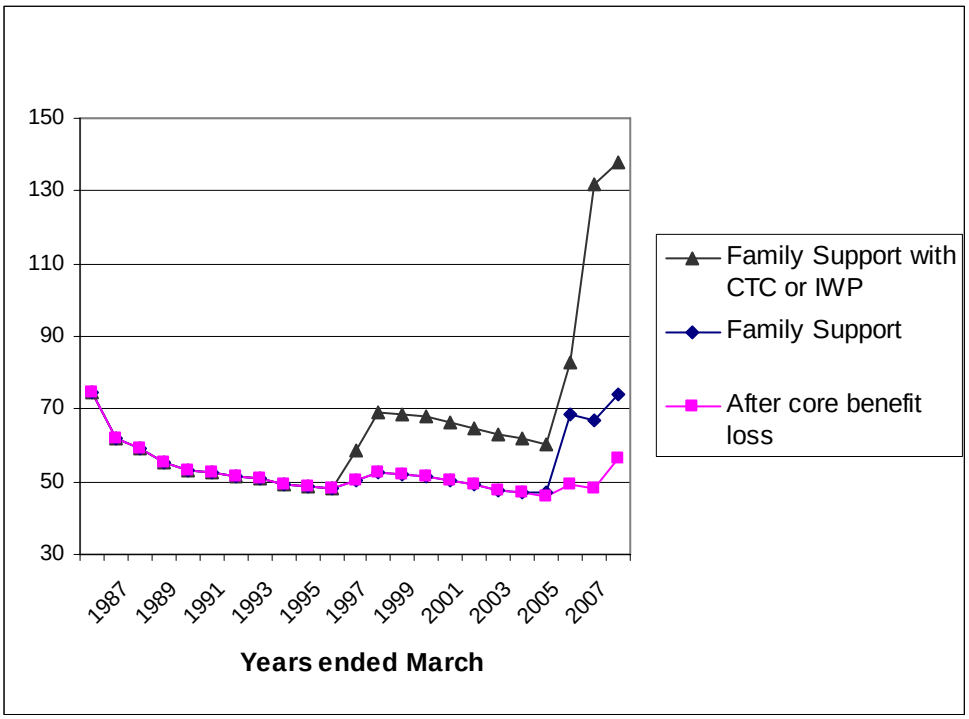
The 2004 budget introduced the new 'Working for Families' package which increased Family Support, and provided for inflation proofing it from 2008, and introduced a new 'In Work' Payment which replaced the Child Tax Credit from 2006 and goes to working families. However these income gains were simultaneously offset for the poorest by the loss of the child component of core benefits and reductions in Special Benefit hardship support (covering approximately 31,000 of the poorest families). Overall MSD projected an expected 30% reduction in the numbers of children in poverty following complete roll-out of the package, however some of the poorest families (particularly those with non-working parent/s) will be only "no worse off" under the package.

The increases in Family Support have amounted to $25 for the first child, $15 for extra children, and $10 more per child from 2007. The In Work Payment provides a minimum of $60 per (working) family with children, for those in the lowest income groups.

New Zealand made a significant commitment to child income in the 2004 budget, of that there is no doubt. The spending on the Working for Families package is very significant. However it needs to be seen in the context of years of neglect. Unfortunately because families' assets have been eroded over a long period, an increase in income alone is not going to cure the problem. Future security is however improved by the fact that finally all family payments and the levels of income to which they apply are going to be inflation-adjusted. This is a very significant factor, even if this measure only comes in after 2008.

It is of particular concern that those on benefits are not going to gain much and that the In-Work Payment drives a further wedge between families who access benefits and those that do not.

Graph showing **Maximum per week real family assistance**
1-child family 1986-2008 ($2004)
Dr S. St John 2004



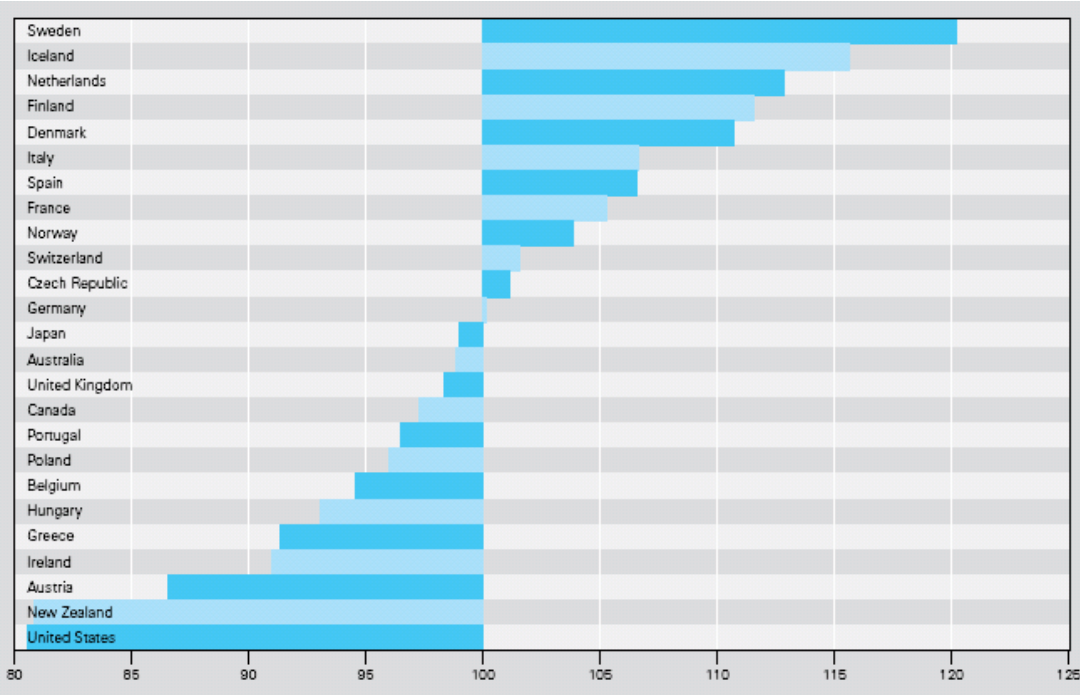
This graph from Dr Susan St John highlights that there are substantial real gains in income for working families from 2006, but with the loss of Special benefits some families may only be no worse off than in 2003, and still not back to the income levels of the 1980s.

So overall Dr St John estimates that the WFF package will offer significant gains for 125,000 poor children. They are predominantlyhose whose parents are in work and the figure assumes 100% uptake. However 175,000 equally poor or poorer children will largely miss out because, for no fault of the child, their parent/s are on income support benefits.

b. Children in households without an employed adult: NZ is rated 18th
c. Other, direct measures of deprivation included growing up in a household with unemployed parents (18th out of 24), and a compilation measure of material deprivation including children reporting low family affluence, few educational possessions and less than 10 books in the house. NZ rated better on these measures (6th out of 24 overall), although we did not contribute to the first aspect of the compilation measure.

2. Health and Safety of our children

Overall NZ is rated 23rd out of 24, with the only country doing worse than us being the USA. This is a shameful position to be in.



There are 3 health indicators that were used in this report:

a. Health at 0 – 1 years.

This is an amalgamation of infant mortality rates and birth weight.
Overall the neonatal mortality in NZ (children in the first 28 days of life) is a relatively stable figure. However NZ's bad statistics lie in the post-neonatal infant mortality which is dominated by SIDS (cot death) rates. SIDS accounts for 36.7% of all causes of post-neonatal mortality (NZCYES 1988 – 2002).

SIDS rates had been declining in the past 15 years but the rate of decline has begun to taper off. For a child the risk of dying of SIDS is much higher if you are born in poverty with the New Zealand Child and Youth Epidemiology Service (NZCYES) calculating that children born into the poorest socioeconomic quintile group have a 6.58 increased risk of dying from SIDS than children from wealthy families. A Maori child has a 4.87 increased risk over NZ European children. It is amongst the children in these groups that we are not seeing significant reductions in mortality rates.

b. Preventative health services

As a measure for the country's focus on their child health prevention services the report measured immunisation rates. When measuring the percentage of children aged 1 – 2years immunized, NZ ranks 23 out of 25 with only Ireland and Austria worse than us. This was on 2003 data, so have we been doing better recently. NZ has improved in its immunisation rates – in 1991 only 56% of our children were fully immunized at the age of 2 years (National Immunisation Survey 1991/2). A repeat survey in the Northern region in 1995 showed improvement to 72% (North Health Survey 1995/6), and a further survey in 1995 showed rates up to 77.5%. While it is good to see improvement these rates are still well below the national targets of 95% of children fully immunized, and as a result we continue to have high rates of vaccine-preventable diseases such as whooping cough. Further to this story the data shows a significant equity gap with Maori children still 8.5% less likely to be fully immunized that NZ European. We have a long way to go in improving immunisation rates to our children, and we are unlikely to be any higher up the OECD ranking scale currently.

c. Safety (deaths from accidents, murder, suicide, violence)

NZ comes last in all the OECD for our measures on child safety.

What are our children dying of? Breaking down injury-related deaths for NZ children aged 0 – 14 years for 2000 – 2002 (NZCYES) the report shows:.

- Transport accident 45.3%
- Accidental threat to breathing 16.3%
- Drowning/submersion 14.1%
- Assault: 8.3%
- Electricity/fire/burns 7.3%
- Other 8.6%

Every one of these categories is strongly poverty linked.

Outside of the perinatal period, injury is the leading cause of mortality for NZ children. Road traffic accidents are the leading cause of death and falls are the leading cause of hospital admissions.

Are we improving? There has been a marked fall in mortality from transport injuries in young people aged 15 – 24 years, but the injury rates among children aged 0 – 14 years have changed little. We have a very long way to go!

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Once again these rates are strongly related to poverty. A child from a low-income household has a 1.87 times higher risk of dying from a non RTA injury than from a high income family. Overall a child from a low-income household has a 1.44 times higher overall risk of dying than a child from a wealthy household (Shaw C, et al NZMJ 16 Dec 2005).

So why is our children's health so bad? Perhaps the easiest way to explain is to illustrate with stories from the children.

Lily:

'Lily' is an 8 month old girl who was admitted to hospital with pneumonia. Her story is her mum is a solo parent, 19 years of age, and Lily is the second child. Mum has a sexually and emotionally abusive background. Lily's dad is violent and a drug dealer. The family has moved house 3 times since her birth. They are currently living in her Auntie's house. There are 16 people in this house. It is damp and cold.

From her story there are many reasons why Lily is getting sick.
Firstly, environmental exposure to the bug: She lives in a crowded house and has lots of exposure to other people.
Secondly the state of Lily's immune system: in an environment like this she is likely to be stressed and have poor nutrition, both of which lead to reduced immune responses to illness. And finally her access to health care services is likely to be less than many other children.
We know that poor children get sick a lot more often. I see this endlessly in general practice compared to my own very robust children. The likelihood of a child being sick is 3 times higher for those in the bottom household income quintile *(Easton and Ballantyne, 2002).*
Hospital admission rates for children are also significantly higher in low income areas (*Graham, Leversha and Vogel 2001).*

Access to healthcare services is also a significant problem for children like Lily. Lily will turn up in my general practice on a Monday morning because her Mum cannot afford the after-hours services when she gets sick in the middle of the night. I have repeatedly seen poorly controlled asthma and chest infections in children who should have been seen earlier by a doctor but had the misfortune to get sick out of hours.

A 2005 random survey looked at the cost of after hours services by reviewing 44 primary health care services nation-wide. It showed a wide range of charges for consultation for children under 6 years of age ranging from free to $25, and for children over 6 years of age from free to $47 for a consultation.

Jack:

My next story is 'Jack' whose story has a very similar pattern to Lily's, just a few more damaging years further on. Jack is a 9 year old, his Dad is in jail, he has 2 siblings, and another brother who drowned aged 3 years. His Mum is 29 years old, she has a chronic medical condition, and has been unable to sustain a job though has been trying, and has been going in and out of jobs for years.

Jack is overweight, he has learning difficulties at school, and has been bullying in the playground.
His medical history when written down is dramatic: He has had multiple visits to the GP and A+M clinics, he has asthma, eczema, recurrent chest infections, skin infections and many minor injuries. Furthermore he has had 10 hospital admissions – twice for bronchiolitis as a baby, three times for asthma, a broken leg, a head injury, two admissions for skin infections and one for a dental abscess.

Jack's future is all too predictable. He is likely to suffer from poor health in a range of lifelong issues: obesity, drug and alcohol abuse, school failure, limited occupational options, criminality, broken relationships and overall shorter life expectancy. Already at such a young age he doesn't have much chance of a happy, fulfilling life.

There is a lot of literature now on the effect of childhood poverty on life outcomes. Socio-economic disadvantage in childhood has long-lasting negative effects on adult health. The University of Otago cohort study that followed 1000 children born in 1972-1973 showed that children who grew up in low socioeconomic status families had poorer cardiovascular health, poor dental health and more substance abuse as adults, regardless of their adult socioeconomic conditions (Poulton R, et al Lancet 2002;360:1640-45).

One health angle that many are unaware of is the link between poverty and obesity in Western countries. It is clear that ppeople on low incomes tend to purchase energy-dense food when money is available, and, for those on limited incomes, proper nutrition is a secondary consideration to paying rent and utilities bills (Scheier, 2005). The highest rates of obesity in developed countries occur in where income differentials are the greatest (Wilkinson, 2005). This is most graphically summed up by a NZ teacher in 2005 who stated "*If you have five bucks left to feed the family with at the end of the week, you'll go and get $4 worth of chips and a loaf of Rivermill bread, not fruit and vegetables."*

NZ has a problem with poorly nourished, underfed children going to school hungry. Recent figures from the Auckland City Mission of numbers of food parcels given out shows a steadily increasing rate since 1996.

Another graphic example of our inability to keep our children healthy is the meningococcal B epidemic which started in poor overcrowded houses in South Auckland and then spread across the country. This is another disease which is much more likely to attack children from poor families than those from richer families, and is vividly illustrated in nightmare stories and visual pictures of children losing their limbs and damaging their brains.

While we can wring our hands at the endless lousy statistics that keep coming out there is really an urgency to act.

"Many things we need can wait. The child cannot. Now is the time his bones are being formed; his blood is being made; his mind is being developed. To him we cannot say tomorrow. His name is today."

Gabriela Mistral

Or as Dame Anne Salmond put it so eloquently at the Knowledge Wave conference in 2003, *"If we want a prosperous knowledge economy, where is the human capital going to come from? …The fate of the bottom 20% of our children should be at the top of our list of national priorities…… "*

The most outstanding feature of how we in NZ choose to run our economic base is that children are the members of our community that are most likely to be in poverty. Knowing the damage this does both short and long term this is an incredibly short-sighted policy approach.

The table below summarises data from Fig 44 of The Living Standards Report, from the Ministry of Social Development (2004) which looks at the number of people in the country who are living in severe and significant hardship according to a scale that has been developed specifically for reporting.

	% in severe/ significant hardship 2000	% in severe/ significant hardship 2004
CHILDREN	18%	26%
Adults 25-44 yrs	12%	15%
Adults 45 – 64 yrs	8%	10%
ADULTS 45 – 64 yrs	2%	4%

While NZ has been pretty successful at keeping our elderly out of poverty and hardship we have failed a large group of our children.

Summary:

NZ child indicators have a mixture of the best in the world and the worst in the world. There has been considerable improvement in many areas since the depths of the 1990s however while the Working for Families Package will take many children out of poverty, it leaves the poorest and most vulnerable children behind. Growing inequities are creating a widely divergent society, with divergent outcomes.

There are many positive new initiatives such as childcare subsidies and the primary health care strategy, but many health and education outcomes are still lagging behind such improvements in access to free health care.

Children as a group suffer much more poverty and hardship in NZ than any other age group. Children are very vulnerable to the effects of poverty both in short and long term outcomes. We are leaving the most vulnerable children behind – the consequences of our actions will live on for many generations.

It is a great NZ myth that we care for our children!

Recommendations:

Do not subsume child issues into other issues.

- Focus on the child first: reduce the inequities
- Do not leave out our most vulnerable children
- All government policy needs to be reviewed for its effect on children
- Restore the family benefit as a benefit **for the child** (historically subsumed into CTC, then into In-Work Payment)
- Tax cuts for the poor
- Free health care for all children
- More resourcing for support for child needs in a range of areas – health, education, early childhood intervention.

This article is an abridged version of a talk given at the UNICEF forum in Wellington February 19th 2007 by Dr. Nikki Turner

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