BACKGROUNDER 16: POVERTY AND CHILD HEALTH

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IS THERE POVERTY IN NEW ZEALAND?

This decade has seen the relentless decline into poverty of more and more New Zealand children. Indices of poverty are debated, but those who work in health, education and social services consistently report that there are families unable to afford the basics of life: food, clothing and housing, and there are more of them now than 10 years ago. National statistics confirm these disturbing trends (1,2,3,4). Mean household income, after tax and adjusted for household size, has fallen over the last 2 decades, and those households with children have been the most severely affected. As well as low income, hardship is indicated by lack of access to a telephone or car, being a single parent family, or large numbers of people for the number of bedrooms in the house (5). The 1996 census found that a quarter of New Zealanders are children under 15 years, proportionately more children live in low income households than adults, and proportionately more preschool children are in the poorest group. One parent families with children had a median annual income of $17,000, and those with preschool children even less - $12,800 (4). Thus not only is poverty present in New Zealand, but it is increasing, and children are most commonly affected by it.

WHAT ARE THE CHILD HEALTH PROBLEMS IN NEW ZEALAND?

There are high rates of serious health problems for New Zealand children and young people: high infant mortality rates including cot death; low immunisation rates and epidemics of infectious diseases (whooping cough, measles, meningococcal disease); inadequately treated acute infections (gastroenteritis, glue ear, cellulitis); post-streptococcal diseases (rheumatic fever, glomerulonephritis); injuries (motor vehicles, child abuse, falls, drownings, poisonings, drug abuse); respiratory tract disease and allergy (pneumonia, bronchiolitis, bronchiectasis, asthma, allergic rhinitis, atopic eczema); teenage suicides, teenage pregnancies and teenage smoking; nutritional deficiencies (iron deficiency anaemia and rickets); and dental disease. All of these diseases and conditions occur more commonly in poor neighbourhoods.

I started clinical practice in paediatrics in the mid 1970's, when many of these conditions and diseases were reasons for admission to hospital. Some conditions, such as iron deficiency anaemia (which causes behaviour problems and impairs learning) and gastroenteritis lessened during the 1970's and the early 1980's as family incomes were more stable, housing costs for low income families were affordable, and child public health measures were reaching most children. However any small gains have been lost, and now iron deficiency anaemia, and some life threatening diseases, such as rheumatic fever, are as common as ever. Other diseases, such as meningococcal disease, are more frequent and severe. For these infectious diseases our rates in New Zealand are far higher than any other OECD country, and comparable to countries like Sri Lanka.

HOW DOES POVERTY AFFECT CHILD HEALTH?

Income is the single most important determinant of health (1). The financially worst off generally experience the highest rates of illness and death. The negative effects of poverty on child health have been extensively documented (6,7,8) and include all the problems some children continue to experience in New Zealand. These diseases are either aggravated or caused

by the effects of poverty. To many New Zealanders it seems unnecessary to articulate these simple observations, but the documentation of the ill-health effects of poverty will continue to be necessary until policy makers accept the evidence and implement changes to turn the tide.

Poverty affects child health firstly because of insufficient money for fundamental prerequisites of health such as adequate food, clothing and housing. The growing use of food-banks is testimony that inadequate food is a real phenomenon for some families. Lack of sufficient calories and a balanced diet leads to malnutrition such as iron deficiency anaemia, and poor resistance to infection, increasing the chance of a minor infection, such as a cold, becoming a serious one, such as pneumonia. With overcrowded homes, infections spread, and basic hygiene is more difficult to maintain. Damp, cold homes also aggravate infectious diseases and allergies.

Secondly, when families in poverty need medical care, some are in the anguishing position of having to choose between spending money on food and medical costs. With no access to a telephone there is a barrier to communicating with health professionals, and life threatening delays may occur with medical emergencies. With no car, access even to routine health care may be difficult. Medical care is relatively more costly now than in the previous decade. For the poorest families the gain of free visits for under 6 year olds is more than offset by the deterioration in their relative incomes. The costs of doctor visits for children and young people over six, and adults, remains high, and there are part charges on medications. The boundaries for high user cards have changed to exclude some previously eligible individuals. When a child is sick, others in their overcrowded homes are more likely to be sick. Sick parents struggling to provide food and shelter find it difficult to take children for immunisations and well child checks.

Thirdly, lack of money for food, clothing, housing and medical care leads to stress among family members, stress related symptoms, lack of self esteem and a feeling of alienation from the rest of society. This can lead to family breakdown, risk taking behaviours, antisocial behaviour against family members or society at large, or suicide.

Fourthly, inequalities in socioeconomic circumstances of the whole population affect the health of people, especially those who are poorest, and the greater the inequality, the greater this effect (1,2). Disintegration of social networks are more likely in poorer areas. A feeling of not belonging to and not participating in society is associated with poorer health.

Those most affected have the least resource to deal with these problems and diseases. Not only have incomes dropped, but user pays has affected everyone in New Zealand, despite the theoretical safety nets for the most deprived. When financial top ups are received, these are often inadequate to meet the basic needs, and accumulated debt may rise. Many who are eligible do not get their full entitlements. Reasons for this include lack of knowledge that they are eligible, they don't know where to go or what to ask for, lack of transport to the offices, lack of reading and writing skills, shame, embarrassment, or their desire for self reliance. Educational opportunities for those in poverty are more limited than for those who are well off, yet the challenges of living in poverty, and moving out of it require much more skill than living in affluence. The adverse effects of poverty on child health are not only at the personal and social level, but also lead to increasing pressure on health services, and ultimately to an increase in health and social spending.

WHY HAS POVERTY AND CHILD HEALTH WORSENED IN NEW ZEALAND?

Changes in Government policies since 1984 have made more New Zealand families poorer and driven wages lower. A new tax (GST) on staples such as food and clothing has been added. Income support benefits have been reduced. User pays affects health services (such as direct cost to patients of a larger number of medications and hospital parking) and education.

Housing costs have increased for low income families, through the reduction in availability of State Housing and increase in rentals to market rates. This is a most serious factor because

housing is such a large proportion of household expenditure. Those most affected are families with children. The poorest families have experienced the greatest income reductions of any New Zealanders in the last decade.

New helpful strategies, recommended by experts have been ignored. The most recent example is the Health Funding Authority's decision not to support a national population based strategy to monitor the immunisation status of all children.

WHAT IS TO BE DONE?

During the latter part of the 1980's all these problems, and many of the solutions, had been identified by families and those working with them. However little has been done to improve the wellbeing of children in poverty, and much has happened to worsen it. So there are now more children in poverty and the health consequences are worse.

There needs to be free access to children's health prevention and treatment, close to home. New Zealand needs a national child health scheme reaching all children, which ensures that children's health problems are prevented, treated and monitored.

Measures that would have immediate financial impact include reducing the cost of housing for low income families. Other measures, which have been the focus of other Child Poverty Action Backgrounders, include a thorough overhaul of the use of family tax credits. These are often difficult to access and understand. Worse still, a substantial portion of these payments on behalf of children are denied to the poorest families because they fail to be "independent from the state".

There is strong evidence that children's health is better in countries with stronger preventative health policies and social policies which provide more support for families than the level of support currently provided by countries with policies similar to those in New Zealand (9).

It is time to take stock again and ask ourselves and our politicians to recognise how current policies have failed children, and to make a commitment to reverse the drive into poverty of our children, with constructive new policies. In June 1998 the National Health Committee reported on "The social, cultural and economic determinants of health in New Zealand: action to improve health", and advised the Minister of Health that there are immediate health gains to be made by applying information and knowledge that is already available (1). The Committee urged the Minister to act on their comprehensive recommendations, but no policy changes have happened. This November is the 10th Anniversary of the United Nations Convention on the Rights of the Child, but New Zealand's record is deteriorating rather than improving. This trend must be reversed.

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