



2021 Briefing to the Incoming Ministers: Health

To:	Hon. Andrew Little	Minister of Health
	Hon. Peeni Henare	Minister for Whānau Ora Associate Minister for Māori Health
	Hon. Dr Ayesha Verrall	Associate Minister of Health
	Hon. Aupito William Sio	Associate Minister for Health, Pacific Peoples
	Hon. Carmel Sepuloni	Minister for Disability Issues
	Rt Hon. Jacinda Ardern	Minister for Child Poverty Reduction

The vision of Child Poverty Action Group is

An Aotearoa where all children flourish free from poverty.

About Child Poverty Action Group

Child Poverty Action Group (CPAG) is an independent, registered charity founded in 1994 which works to eliminate child poverty in New Zealand through research, education and advocacy.

We envisage an Aotearoa where our society shows respect, generosity and care for *all* children.

We focus on eliminating poverty for *children* because:

- **Overall effects of poverty are worse for children:** Child development is adversely affected by poverty, & can lead to detrimental effects for an entire life. ([Appendix 1](#))
- **Children are more likely to experience poverty:** Children are over-represented among those in deprived households ([Appendix 2](#))
- **Children don't get a say:** Decisions affecting children are made without their input; democracy involves only adults.

Tēnā koutou Ministers,

Congratulations on your appointments to the important ministerial portfolios of Health, Whānau Ora, Disabilities and Child Poverty Reduction.

Through these responsibilities, you have key leadership roles to play in ensuring Aotearoa New Zealand is a good place to be a child; and in freeing children from the effects of the interaction between poverty and ill health, both of which can exacerbate the other.

In this briefing, we offer recommendations, many of which are based on our response to the recent Health and Disability System Review (H&DSR) (full response in [Appendix 4](#)), and we also offer information on child poverty to inform health policy (Appendices 1-3).

We hope you find this useful, and would be very happy to meet with you and/or your staff to discuss any of the points in further detail.

Nā mātou noa, nā

Child Poverty Action Group

www.cpag.org.nz

Current context – January 2021

- Since the onset of the COVID-19 pandemic, child poverty rates are likely increasing with material hardship rates expected to rise sharply (Treasury, 2020, p21; Ward, 2020, p.7). Many children and young people who were already in poverty are in increasingly dire situations (for example youth homelessness – see [Appendix 3](#)). Income support is still inadequate, despite 2018-2020 increases (CPAG, 2020).
- Given income is a significant determinant of health, inadequate income support is leading to worse health outcomes and will also be incurring expenses for the health and disability system. For example, hospitalisation rates for tooth decay, respiratory conditions and serious skin infections are all particularly high for children living in areas of high deprivation, with unconscious bias, discrimination, racism, inter-generational trauma and ongoing effects of colonisation (Waitangi Tribunal, 2019; RACP, 2020) contributing to especially high rates for Māori and Pacific children (Cure Kids, 2020).
- Reports indicate that some health services have become less accessible, particularly for low-income children, in the last few years. For example, 60 percent of Auckland children are reported as overdue for their regular dental appointments, and about 17,000 had not been seen at all in two years (Quinn, 2020a). Immunisation rates, particularly rates of timeliness of receiving vaccines for infants, have decreased since 2017; this trend is seen particularly for infants from low income families and tamariki Māori. The 2020 lockdowns exacerbated this decline and rates still have not fully recovered (Ministry of Health, 2020). Once NZ borders are open, further measles outbreaks remain a real concern if childhood immunisation rates continue to decline.
- Almost 12 percent of those under 20 are directly affected by disability; and they are more likely to live in materially-deprived households (H&DSR, 2020).

CPAG Policy Recommendations & Endorsements

Endorsements of current services

We recognise the current system has many positive aspects for children in low-income households, such as:

- the zero fees consultations and free prescriptions for those aged under 14 years
- the recent focus on improving and integrating well child/tamariki ora and immunisation services
- the recent increased funding and attention to mental health in the health sector.

Support for WAI 2575 Stage 1 report recommendations

1. We welcome and support the Waitangi Tribunal (2019) Stage 1 report for WAI 2575, including the recommendation that *“the Crown commit itself and the health sector to achieving equitable health outcomes for Māori.”* Systemic racism, discrimination and the ongoing effects of colonisation currently exacerbate poverty and poor health outcomes for Māori, including Māori children.

Endorsements of H&DSR recommendations

2. We endorse the development of a *“comprehensive indigenous commissioning framework.... which uses every enabler and lever, at every level, to ensure the system successfully delivers improved health and wellbeing outcomes for whānau. The commissioning framework should be Tiriti compliant and designed by, and with, Māori as an active expression of rangatiratanga and mana motuhake, in a way that is not possible within mainstream organisations, such as HNZ and DHBs, with broader population responsibilities. The time is right for action around a broader indigenous commissioning framework in Aotearoa/New Zealand, that could be world leading in addressing inequity at system and service levels”* (H&DSR, 2020). We note that this view is also held by others including the National Hauora Coalition, Te Kupenga Hauora Māori at the University of Auckland, Public Health Association and Royal Australasian College of Physicians.
3. We support the H&DSR recommendation to ring-fence funding for Tier 1 services and emphasise localities, as the great majority of child health services take place in primary care and community settings and it is here that one of the most important potential health sector contributions to alleviating the effects of child poverty can be achieved.
4. We endorse the H&DSR recommendation for a guaranteed annual adjustment to Vote: Health to ensure continuation of existing services.
5. We endorse the H&DSR proposal of *“increased ethnicity and socioeconomic deprivation weighting within the population-based funding formula”*.

Additional CPAG Recommendations – Sector Structure and Funding

6. That the government carefully identify the ongoing effects of the COVID-19 pandemic on the health sector and how the sector works, particularly in relation to how the pandemic exacerbates inequities in multiple ways for low income families; and that the government takes this into account when determining how to implement the H&DSR recommendations.
7. That the government ringfence funding for primary and population health services so that hospital deficits are not paid for through primary and population health services spending. We recommend the government gives serious thought as to how ring fencing Tier 1 services can be achieved practically and how ‘funding creep’ from secondary care would be prevented.
8. That the government significantly increase funding for Tier 1 services (primary care and population health), using an equity lens in order to address unmet need and existing inequities and realise the potential to improve population health.
9. That the government take direction from people with disabilities (including children with disabilities), families and support groups about how best to ensure disability services achieve the greater consistency, coordination and funding they require.
10. That the government specifically identify the health system needs of refugees and migrant groups, including children from refugee and migrant backgrounds, and addresses their needs appropriately in making improvements in the Health and Disability System.
11. That the government develop and implement policies to better support and integrate general practice, maternity services, wellchild/tamariki ora and other primary care services, including addressing the following issues, which were not addressed by H&DSR:
 - 11a. access problems for children in low-income families – barriers include transport, opening hours, long waiting times, costs and locations of practices. Solutions need to address the following:
 - inadequate numbers of general practices in some high-needs areas. This leads to closed lists, and families not being able to register with practices in close proximity, as well as over-busy practices without the capacity to see patients in a timely fashion. All children need a registered general practice “home” from birth with no delays, and to be able to access general practice services urgently without any delay.
 - lack of extended after hours services in many areas; and/or high costs to access some after hours services, leading to increased demand for ED services in some areas as a result.
 - practices having minimal or no ability to offer outreach services for those in high needs areas. There is a need for outreach services to further integrate with each other rather than remain as piecemeal services.
 - high co-payments for low income parents living in high income areas. Addressing this issue requires a full review of the current funding models in primary care.
 - delayed presentation of children due to a practice family debt.

- the direct cost of general practitioner visits for children 14-17 years old.
 - lack of integration with other services and a lack of adequate wrap around services, allied health services and support for high needs, maternity, wellchild/tamariki ora and behavioural health.
 - Ongoing shortages of maternal and child health services in mental health
 - Lack of systemic identification of high-needs families in pregnancy, so they can be given integrated support packages matching their needs.
- 11b. The need for integration, including on digital platforms, for all health services and health professionals undertaking pregnancy and well child/ tamariki ora checks: <https://www.wellchild.org.nz/who-does-well-child-checks>
- 11c. The role and place of PHOs and their interactions with DHBs.
- 11d. Workforce needs
- sustainable work force (given the aging general practitioner and primary care workforce)
 - culturally appropriate practices (there are inadequate numbers of Māori, Pacific and other diverse ethnic groups across the primary care workforce)
 - increased rural practices (current numbers are inadequate)
 - increased continuity
12. That the government fully engage with the sector to ensure more sustainable and equitable models of general practice and primary care funding. Current practice across all existing business models has the potential to amplify negative impacts of child poverty.
13. That the government carefully considers all consequences of disestablishing Te Hiringa Hauora (Health Promotion Agency) before deciding whether or not to do so per the H&DSR recommendation; and if it does decide to do so, that it ensures a smooth continuation of the current critical health promotion work that is being carried out by Te Hiringa Hauora to address maternal smoking cessation and alcohol use, and promotion of childhood immunisations.
14. That, as DHBs merge, the government take its lead from iwi, hapū and whānau to ensure the voice and the needs of Māori communities are heard and have some agency over DHB strategic planning, functioning and resourcing. Merging of DHBs increases the risk that largely Māori communities in localities such as Northland and Tairāwhiti will be (further) overlooked if merged with localities with largely non-Māori communities.
15. That, if the funding and accountability is to sit at the DHB level as the H&DSR committee recommends, the government offer DHBs clear guidance and accountability as to how to ring-fence and prioritise the competing needs of their populations. Given that DHBs are currently in significant deficit, direction and oversight will be required to ensure that urgent infrastructure and secondary service needs are not inappropriately prioritised over the needs of primary care and disability sectors, and over longer term approaches to improving population health and resolving equity issues.

16. That the government carefully design locality organisations of maternal and child health services to ensure enhancement of community agency, integration and local innovation, without further fragmentation and losing out to competing demands.
17. That the government extends policies to reduce the availability and accessibility of alcohol (as recommended by the Government Inquiry into Mental Health and Addiction – Patterson et al, 2018), gambling and unhealthy food as these directly or indirectly harm children, especially those living in disadvantage (RACP, 2020)

Additional CPAG Recommendations – Service Provision

18. Make universal free healthcare, including prescriptions, primary care and all vision and hearing care, available to all pregnant people, and children and young people up to 18 years.
19. Make proactive dental and oral health services free and accessible for pregnant people, and children and adolescents up until the age of 18, prioritised within public health and primary care preventive checks.
20. Increase mental health and drug and alcohol addiction support during pregnancy and postnatal periods.
21. Make extra resources and wrap-around services available for all children with identified high needs everywhere in the country, starting with systematic antenatal screening and identification.
22. Provide ACC-equivalent health care for children with health conditions or disabilities not due to an accident, and for those parents with health conditions or disabilities not due to an accident, who are caregivers of dependent children.
23. Collect quality data about children affected directly or indirectly by disabilities in Aotearoa. This includes data from outpatient healthcare settings, preschools and schools, and regularly-collected data on the socio-economic status of households with disabled children and/or disabled parents. These data need to be reliably disaggregated by ethnicity, age and source of income support.
24. Increase focus and resourcing on public health measures to improve the health of poorer children and reduce health inequities. Examples that we recommend include:
 - Supporting increased services to improve vaccination coverage further and eliminating all equity gaps
 - Extending school approaches to improving diet and physical activity (eg: banning soft drinks, providing healthy school lunches, selling only healthy food in schools)
 - Taxing sugar-sweetened beverages
 - Providing schools-based health checks every two years for each child, including vision, hearing and dental checks
 - Evidence-based interventions to prevent uptake of smoking, vaping, alcohol, other drugs and gambling
 - Increase the number of primary and secondary schools offering school-based health and social welfare services, including social workers, and mental health services specific to early detection, appropriate for the age of the children, noting that the approach to healthcare for adolescents is different for younger children.

Appendix 1: The effects of poverty on children: Poorer wellbeing is more likely in all areas for an entire life

- **Poverty causes poor outcomes.** Poor outcomes for children are not only correlated to lack of family income, they are caused by them. The [Rapid Evidence Review \(RER\) on the impact of poverty on life course outcomes for children](#) prepared by the Ministry of Social Development (2018) for the Welfare Expert Advisory Group is a good introduction to the large body of evidence that supports this.
- **All aspects of life are affected by deprivation**, from physical development and physiological functions to social inclusion and educational attainment. Deprivation can have detrimental effects on the physical, mental and social wellbeing of children. For example, in Aotearoa, high school students in most deprived areas (NZDep1-3) have four times the suicide rate of those in least deprived areas (NZDep8-10) ([Youth19 survey, 2020](#)).
- **Effects can be long-term, lasting (and shortening) a child's entire life.** For example, the longitudinal University of Otago study found that children born 1972-1973 who grew up in low socioeconomic status families had poorer cardiovascular health, poor dental health and more substance abuse as adults, regardless of adult socioeconomic conditions (Poulton et al., 2002).
- **Dealing with deprivation, and with the stigmatisation of deprivation, creates toxic stress and disempowerment.** Inadequate income prevents children from accessing goods, services and opportunities that support their positive development; and, in addition, poverty also increasing parental/caregiver stress, depression and shame (exacerbated by stigmatisation, including by government agencies), and places greater demands on adult decision-making, all of which may affect children as well as adults. ([Orchard, 2018](#)).

*When you're in a low socio sort of environment, your head's not looking up and looking at what the future looks like for you next year. **Or what your dreams and aspirations are looking over there or "what I wanna do"**. Your head's looking down and it's looking around in that pool of just trying to survive day by day.*

Tahu, Te Whakaruruhau Service Worker & whānau advocate, quoted in [Rua et al \(2019\)](#)

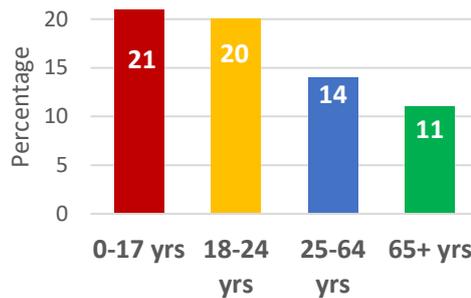
- **Poor outcomes for the few affect the many.** Depriving children of essential resources to actively participate in society, and disempowering their whānau and families, generates poor outcomes for individuals, whānau, and ultimately whole communities, who cannot reap the benefits of people reaching their full potential.

To enable our children to flourish, and to empower them to contribute to their communities over their lives, we need families to have guaranteed adequate incomes & **healthy appropriate homes**

Appendix 2: Children are the **most likely** age group to live in poverty; Most affected include **Māori & Pacific** children, & children with **disabilities**.

- **Children are almost twice as likely as those aged over 65 to live in poverty** and 1.5 times more likely than those aged 25-64, when housing costs are taken into account. Children with disability in NZ are 1.5 times more likely than other children to live with caregivers who report not having enough. This is not the case elsewhere, for example, in the UK ([Neuwelt-Kearns, Murray, Russell & Lee, 2020](#)).

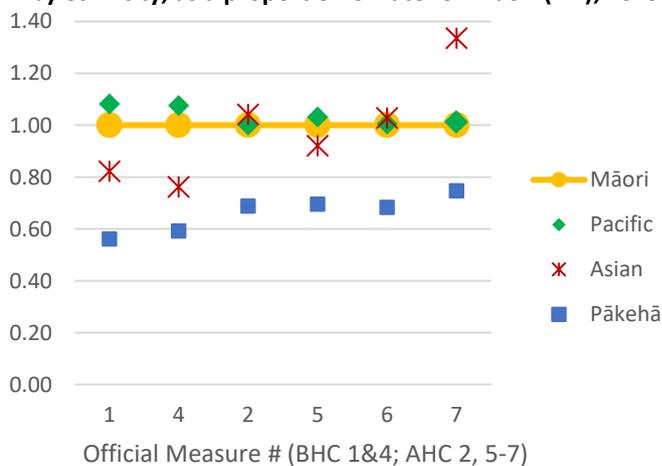
Fig 1: % of all individuals in low-income households by age (AHC 50, moving line, relative) 2018



Source: Perry (2019) Table G3, p151

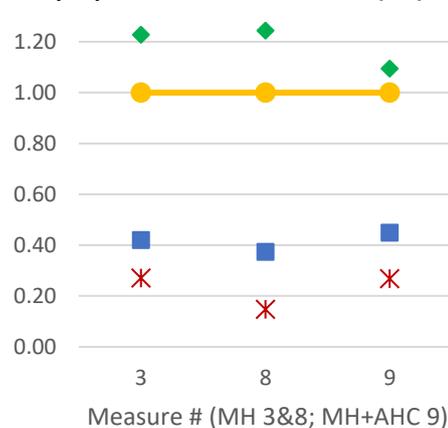
- **Māori children, and other children of non-Pākehā ethnicity, are even more likely than Pākehā children to experience income poverty** (Fig 2; rates for MELAA & “other” ethnicities are likely highest but not shown, as sampling error is very high). For Māori, this is an effect of multiple, ongoing breaches of Te Tiriti o Waitangi. For others as well as Māori, it is an issue of systemic discrimination and has effects on equity: entire communities will bear the burden of the potential lost due to poverty-impacted health and educational outcomes.
- **Proportionally far more Pacific and Māori children suffer material hardship** than Asian and Pākehā children (Fig 3; MELAA rates are unclear). Pacific children suffer severe hardship (as defined by StatsNZ) at 4 times the rate of the national average.

Fig 2: The six official income poverty measures for children, by ethnicity, as a proportion of rate for Māori (= 1), 2019



Source: StatsNZ (2020)

Fig 3: The three official material hardship measures for children, by ethnicity, as a proportion of rate for Māori (= 1), 2019



Appendix 3: Since **COVID-19** hit, rates of child poverty will have **increased**; Reports indicate many already in poverty are in dire situations

- **Material hardship** rates are expected to have increased sharply for children (Treasury, 2020, p21; Ward, 2020, p.7), and income poverty rates (AHC, 50%, fixed line measure) will also have increased since the onset of the COVID-19 pandemic, although it is unclear how much they've increased by: while the unemployment rate is lower than expected, the number of children in households receiving benefits increased by 23,767 (12.6%) in the year to December 2020 to 211,165, and is now the highest since records began in September 2013 (MSD, 2020; 2018b). It is also a concern that Māori and Pacific unemployment rates have increased (from 8.4% to 9% for Māori, and from 7.2% to 9.6% for Pacific people – an increase of 20%) (Harris, 2021), particularly as Māori and Pacific communities are already more likely to be disadvantaged than others.

*The most severe negative effects [of the COVID-19 pandemic on child wellbeing] are likely to be felt by those who are **already disadvantaged**.*

- Briefing to the incoming Minister for Child Poverty Reduction (Ward, 2020)

- **Youth homelessness** appears to have increased dramatically; services are not currently designed to address this problem. For example, Lifewise youth housing reported nearly 120 people requesting support over winter, of which they could only house four, having to turn 89 away due to lack of resourcing, and monitor the rest. Lifewise also reports 16 and 17 year olds living on the streets after being turned away from Work and Income ([Corlett, 2020](#); see also [Manaaki Rangatahi, 2020](#)).
- **Educational inequity** – already high – is likely to have been increased by COVID-related poverty, according to anecdotal reports: more young people may be having to leave school to work ([1news, 2020](#)) – a pathway that can lead to lifelong precarious work and further intergenerational poverty ([Rua et al, 2019](#)) – and others may be working longer hours while struggling to keep up at school, including during lockdowns (supermarket workers are 'essential' workers for example). Digital exclusion remains a deep and ongoing concern ([Biddle, 2020](#)).
- **Food insecurity** and **rheumatic fever** – a childhood disease of deprivation – have also increased dramatically in 2020 ([Martin, 2020](#); [TVNZ, 2020](#); [Quinn, 2020b](#)).

Appendix 4: CPAG Initial Response to the Health & Disability System Review

1 September 2020

Hon Chris Hipkins

Minister of Health

Re: Child Poverty Action Group (CPAG) response to Health and Disability System Review Final Report March 2020

We are writing to you as our new Minister of Health looking at this Report through the eyes of children living in poverty – we do not believe that there is enough in the Report to improve their health and disability outcomes. In fact there is barely any reference at all to issues around child poverty and inadequate attention to the multiple challenges for families with disability.

This is a complex review and commentators have given a range of responses. The suggested high level structural changes make sense, but will have little impact on children without more substantive constructive changes at lower levels. As Associate Professor Tim Tenbensen in Health Systems at the University of Auckland notes, the devil is in the detail
<https://www.policycommons.ac.nz/2020/06/23/health-system-changes-no-small-task/>.

After introducing some interesting broad ideas that may have benefit (a focus on equity particularly for Māori, creation of Health NZ, increasing digital capacity), the report is then short on detail about how any of the proposed changes will actually be implemented and operationalised and what the cost equations for change will be.

Given the decline in real dollars for health under the National government, we applaud the recommendation for a guaranteed annual adjustment to Vote: Health to ensure continuation of existing services. While there is a stated focus on communities and population health, it is very unclear how this is going to be actioned and how. The funding and accountability level is to be at the DHB level, but funding tensions between primary, secondary and tertiary level needs to be solved.

The Report does not give appropriate recognition of the many positive aspects of the current system such as the zero fees for under 14 year consultations, the increasingly integrated nature of well child and immunisation services, and the recent attention to mental health in the health sector with potential impact on families in poverty.

New innovations and opportunities should take time, be based on evidence and evaluated, but this is not made clear. There are risks that change and change processes can actually lose some of the positive gains and create more roadblocks and hardship. This needs careful consideration. There is an even more pressing need for incremental innovation rather than radical restructuring in the light of the COVID-19 pandemic. While the work of the review took place prior to this event, it is important that Government recognises its very significant impact on health sector working.

Will this Report help children in poverty?**Child rights**

We opened our submission on the Review in May 2019 with a statement on child rights, but these are not mentioned in the Report:

Under the United Nations Convention on the Rights of the Child, New Zealand must recognise:

- the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health (Article 24);
- the right of the disabled child to enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community (Article 23); and
- the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development (Article 27). "

Clare Breen of University of Waikato's view is that *"The Health and Disability System Review a partial path to recovery. However, the prescription for change neglects to include a key element for the sustained good health of Aotearoa New Zealand's health care system, and that is its failure to make any mention of the right to health."* Law Professor

https://www.nzherald.co.nz/opinion/news/article.cfm?c_id=466&objectid=12340630

Disability

CPAG notes with concern that although disabled people make up 24 percent of New Zealand's population, and that Māori are far more likely to have a disability than any other ethnicity, there was no representation of disabled people or Māori disabled people on the steering committee or review panel, nor even an advisory group for disability for the Report. Almost 12 percent of all children and young people under 20 are directly affected by disability and the number of children indirectly affected is even greater if we consider those who are raised by parents with disabilities.

The Report states: "Disabled New Zealanders report lower life satisfaction on average, being more likely to live in low-income households, and having poorer outcomes across health, economic and social indicators. Disabled people aged 15-64 years are half as likely to be employed compared to non-disabled people of the same age. Disabled children are more likely to be in households that have low incomes and that report having just enough or not enough money."

Given the lack of involvement of disabled people in the report, it is not surprising that the report's recommendations for disability are weak and have been poorly received by the Disability Sector. While the current disability services require greater consistency, coordination and funding, there is no clear strategic direction proposed to achieve this and little indication of what level of increased funding might be required to produce any improvement in current service levels. We strongly support the need for the disability support system to include thought and action beyond the health system and recognize the impact of broader social determinants.

"Disabled people, families and support groups alike say it is time for the disability support system to move away from the health system to include things like housing, education, employment and transport. They want to abandon what they say is a two-tiered system which arbitrarily discriminates on funding depending on the cause of disability."

<https://www.rnz.co.nz/news/national/419956/disability-sector-calls-for-separate-ministry-support-unshackled-from-health-system>

Māori health

CPAG notes that Māori views have been under-represented in the Report. Although the Report recommends greater recognition of Te Tiriti and equity as a priority for Māori, and states “there is evidence that inadequate access to services, poorer quality of care, and a failure of health services to improve outcomes for Māori can and do lead to inequities in health outcomes”, there is insufficient in the Report to address these issues. Rates of acute rheumatic fever in Māori children are 25 times higher and bronchiectasis (serious lung scarring) 6 times greater than European/Pākehā children. There is no section of the Report which addresses their needs.

The Report proposes that: “The health and disability system needs a clear accountability framework with stronger leadership at all levels, more distinct focus and a better reflection of Te Tiriti principles.” However, its recommendations are not sufficient to address the findings of the Māori Health Trends Report (Wai 2575). The findings of Wai 2575 highlight the fact that there is systemic bias not only in our health system but also amongst those who determine health priorities and funding matters.

There are conflicting views in the sector as to whether a Māori Health Authority will improve this situation. CPAG believes that, if the decision is to proceed with a Māori Health Authority, strong consideration should be given to the Authority having commissioning capacity.

The Health and Disability System Review Final Report shows extraordinary racial bias that the majority view on the role of the Māori Health Authority – i.e. that it should fund and commission services -- is presented as an “alternate view” when it is signed by the majority (four) of the seven panel members and the entire six-person Māori Expert Advisory Group <https://www.racp.edu.au/news-and-events/media-releases/health-and-disability-system-review-m%C4%81ori-health-authority-proposal-rings-hollow/>. It is in fact the view of the other three members that is the alternate or “minority view” (the term used by the Tax Working Group for a view of three of the eight members).

CPAG supports the development of a “comprehensive indigenous commissioning framework.... which uses every enabler and lever, at every level, to ensure the system successfully delivers improved health and wellbeing outcomes for whānau. The commissioning framework should be Tiriti compliant and designed by, and with, Māori as an active expression of rangatiratanga and mana motuhake, in a way that is not possible within mainstream organisations, such as HNZ and DHBs, with broader population responsibilities. The time is right for action around a broader indigenous commissioning framework in Aotearoa/New Zealand, that could be world leading in addressing inequity at system and service levels”. We note that this view is also held by others including the Public Health Association, Royal Australasian College of Physicians, National Hauora Coalition, Te Kupenga Hauora Māori at the University of Auckland.

Pacific people

The Report states: “There are long-standing inequities in health outcomes between Pacific and non-Māori non-Pacific people in New Zealand. Inequities include shorter life expectancy, a higher amenable mortality rate, multimorbidity, and a higher rate of death from cancer compared with non-Māori non-Pacific people. Pacific peoples are disproportionately affected by intergenerational poverty, and are more likely to reside in high deprivation areas, live in crowded households, be unemployed, and have a lower median income than non-Māori non Pacific people. Pacific peoples live six years less than non-Māori non Pacific people, of which 3.3 years for females and 3.4 years for

males was potentially avoidable.” Rates of acute rheumatic fever in Pacific children are 50 times higher and bronchiectasis (serious lung scarring) 13 times greater than European/Pākehā children. In spite of these glaring inequities, there is no section of the Report which addresses the needs of Pacific families.

Other marginalised groups

Refugee and migrant groups appear to be overlooked, in the Report, despite the language around the importance of equity. Specific pieces of work need to be done to include them and address their needs appropriately in making improvements in the Health and Disability System.

Population health and poverty

CPAG welcomes the emphasis in the Report on population health such as:

“The health and disability system is not the main factor in determining health outcomes. If New Zealand does not significantly reduce intergenerational poverty and act on the social determinants of health, little that happens in the health and disability system would have a lasting impact.”

“Inherent in a population health approach is an explicit focus on equity. Working to eliminate systematic inequities in health outcomes requires:

- looking at which groups are most impacted
- understanding how and where inequities are evident
- recognising the upstream factors (the social, economic and commercial determinants that underpin health inequity)
- implementing comprehensive strategies to eliminate or ameliorate upstream factors
- an intelligent, equity driven and data informed health and disability system.”

How these will be enacted is not clear. If DHBs are to get the funding for regional population health programmes, this funding really does need to be ring fenced, otherwise the problem of hospital-dominated DHBs not giving greater priority to population health will continue.

Child poverty could be improved if real actions occurred across each of these sectors as proposed: "Comprehensive and sustained action is required across multiple levels and multiple sectors, including health, transport, local government, housing, education and the natural environment, as well as commercial sectors such as the food and beverage industries". But it seems unlikely that the DHBs, Health NZ and/or the Ministry will have the power to influence these sectors in any substantive way.

Primary Care

The great majority of child health services take place in primary care and community settings and it is here that a potential health sector contribution to alleviating child poverty can be best achieved. The report is again very light on detail about how the organisation of areas of care relevant to child health and poverty such as better coordination of maternity care can be achieved, where general practice and primary care networks plays a crucial role.

We support the recommendation to ring-fence Tier 1 services and emphasize localities. But practical recommendations are required as to how this would be achieved and how ‘funding creep’ from secondary care would be prevented. It is important that there is sufficient negotiation and

discussion is achieved between the different members of the proposed Tier 1 grouping in relation to their activities that impact on child poverty and that current positive activities from different groups are not lost in any new grouping.

General Practice remains at the core of Tier 1 services. However, General Practice itself received little mention, with no comment about the problems it currently faces, and how to solve them. These include:

- access problems for children in low-income families – financial, transport, opening hours and location barriers:
 - not enough general practices in some high needs areas, including closed lists
 - lack of extended after hours services
 - minimal or no ability to offer outreach services for those in high needs
 - high costs for access to some after hours services,
 - Inappropriate overuse of ED services in some areas as a result
 - practices too far from families without no transport
 - long waiting times
 - high co-payments for poor parents living in high income areas
 - family debt to the practice may delay presentation of children
 - lack of integration with other maternity services and wellchild/tamariki ora services
- workforce needs
 - sustainable work force
 - An aging general practitioner workforce
 - culturally appropriate practices
 - inadequate number of Māori, Pacific and other diverse ethnic groups across the primary care workforce
 - inadequate numbers of rural practices
 - lack of continuity
 -
- Practices with business models which tend to amplify the above issues
- The role and place of PHOs and their interactions with DHBs.

Organisation

The report suggests that there is a lot to be reorganised – three instead of one peak health body, and there is no clear implementation pathway.

The issue of national versus devolved services is complex, and may not work well if it is not set up appropriately. There is support for commissioning and delivering a range of integrated services on a locality basis, but funding needs to be ring fenced so that hospital deficits are not paid for through primary and population health services spending.

There are also concerns at a local community level what the role of existing organisations such as PHOs will be and also what, if any, would be the role or continuation of organisations with an existing national role that may be devolved eg Plunket.

We are disappointed in the recommendation to disestablish the Te Hiringa Hauora (Health Promotion Agency) as this could lead to further fragmentation of health promotion across the Ministry of Health, Māori Health Authority, HealthNZ, DHBs, primary care, and NGOs. Critical health promotion work that is being carried out by Te Hiringa Hauora to address maternal smoking cessation and alcohol use, and promotion of childhood immunisations could also be disrupted.

Reduction in the number of DHBs has merit, but localities such as Northland and Tai Rawhiti have their own unique communities and populations; if DHBs are going to merge, it is important to ensure

the voice and the needs of these largely Māori communities are heard and have some agency over their strategic planning, functioning and resourcing.

If the funding and accountability is to sit at the DHB level, which is what this report is advocating, DHBs will need clear guidance and accountability as to how prioritise the competing needs of their populations. Given that DHBs are currently in significant deficit, direction and oversight will be required to ensure that urgent infrastructure and secondary service needs are not inappropriately prioritised over the needs of the disability sector, and longer term approaches to improving population health and resolving equity issues.

Child poverty and child health

There is some commentary in the Report about how health is adversely affected by poverty/socioeconomic deprivation/determinants of health (although little focus on poverty mentioned only seven times). It is pleasing that the Review proposes “increased ethnicity and socioeconomic deprivation weighting within the population-based funding formula”.

Intergenerational poverty is mentioned, but child poverty is not directly mentioned anywhere in the report, even though children are disproportionately affected by poverty compared with other age groups, with high health and disability consequences.

While the Report states that “the first 1,000 days of a child’s life is a crucial time for development that sets the stage for physical and mental wellbeing throughout life” there is little in the Report that would focus on this concern to address the shortcomings in the current system. While locality organisation of maternal and child health services has the potential to enhance community agency and local innovation, there are dangers of further fragmentation and losing out in locality-competing demands unless carefully designed.

We believe that fully addressing the issues we have raised here will help to improve the poor health and disability outcomes for children living in poverty.

Yours faithfully

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on behalf of Child Poverty Action Group

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