

**CHILD
POVERTY
ACTION
GROUP**

**OUR CHILDREN:
The Priority for Policy
(2nd edition)**

Child Poverty Action Group

Child Poverty Action Group (Inc) is a non-profit group, formed in 1994 and made up of academics, activists, practitioners and supporters. CPAG, in partnership with Maori, advocates for more informed social policy to support children in Aotearoa/New Zealand, particularly the one-third of New Zealand children who presently live in relative, and occasionally, absolute poverty. CPAG believes this situation is not the result of economic necessity but due to policy neglect. Through research and advocacy, CPAG highlights the position of tens of thousands of New Zealand children, and promotes public policies that address the underlying causes of the poverty they live in.

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Kowhaiwhai pattern cover design: Derived from <http://www.maori.org.nz>
Koiri design – to flourish

ISBN 0-9582263-1-8
© March 2003
First edition published January 2001
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PART ONE

Preface to the Second Edition

The first official publication of the Child Poverty Action Group, *Our Children: The Priority for Policy*, was published in early 2001. This new edition updates *Our Children* and reflects on the events and progress of the past two years.

Since 2001, the official discourse has changed dramatically. There have been many small policy initiatives for families and children, and a willingness on the part of politicians, the media and public policy analysts to engage in debate over the rights and needs of children. Previously, individualism, free markets and self-responsibility were emphasised. Now, concepts such as social well-being, social capacity building and social development are freely discussed. For instance, the Ministry of Social Development has highlighted income disparity in various reports, observing that children are disproportionately among our poorest citizens, and Treasury has acknowledged the connection between economic and social policy with a raft of papers on social inclusion.

There has been new legislation on division of relationship property and paid parental leave; a review of early childhood education; a gaming review; and a tax review. Changes to primary health care have been proposed, and there have been improvements in resourcing schools, especially lower decile schools.

However, the May 2002 Budget failed to deliver significant improvements for children. There was no discussion of family assistance, and the projections out to 2006 did not include any inflation adjustments. Benefit levels were not reviewed, and there were no announcements for dealing with the anomalous Child Tax Credit. Moreover, work has continued to be promoted as the sole solution to low income. The Social Security (Personal Development and Employment) Amendment Act 2002 marginally improved the situation for working sole parents on the Domestic Purposes Benefit, but failed to put the interests of children at the centre. The "Closing the Gaps" approach to the high poverty rates among Maori was abandoned in favour of more general rhetoric.

In June 2002, the government released its *Agenda for Children* in which it was officially acknowledged, for the first time, that three out of every ten New Zealand children live in poverty. The heroic pledge was made to 'eliminate child poverty' but unfortunately there were no accompanying policies or a time frame.

Meantime the election intervened, with the initial possibility that child poverty would be one of the defining issues. Indeed, the Greens, New Zealand First, and the Alliance made it one of their major election platforms, but regrettably other issues became the focus and the major parties were not compelled to face up to this issue. Nevertheless, in her opening election speech on 30th June 2002, the Prime Minister promised:

In our next term Family Support and family tax credits will be reviewed so that our low-income families don't slip behind.

Although review of the whole family assistance area is long overdue, action is required immediately, not some time in the government's current term. Pending further reforms, the Child Tax Credit must be extended to all low-income children by amalgamating it with Family Support. As a primary way to consider children's needs first, all family assistance should be adjusted for past inflation and indexed.

Frustrated by the lack of progress following the release of the *Agenda for Children*, in October 2002, 14 organisations working in the children's movement released an action-based response document called *Making it Happen*. CPAG supported this initiative and urged the government to adopt its plan of action. The outcomes of *Making it Happen* are being monitored at <http://www.makingithappen.info>

A 2002 UNICEF report, *When the Invisible Hand Rocks the Cradle*, outlined how the impact on children and their parents of the economic reforms of the 1980s and 1990s was ignored. Also in 2002, an international study of 22 OECD countries described New Zealand as a "laggard" in financial support packages for families. Then *The Lancet* published the results of a University of Otago long-term health study showing that the health status of adults is conditioned by their socio-economic experiences in childhood, with much poorer health outcomes in adulthood for those who suffered socio-economic disadvantage as children.

This study has chilling implications for the workforce in 20 years time, given that child poverty today is clearly so much worse.

Since our last edition, the economy has grown strongly, unemployment has continued to fall and the prospects for New Zealand, despite a troubled international environment, look promising. Nevertheless, and worryingly, food banks continue to record increased demand, and children's hospitals see little let-up in serious disease caused by poverty and overcrowding. Food prices and rents continue their relentless rise. A booming property market, particularly in Auckland, has contributed to growing wealth among many families but has also fuelled a growing unaffordability problem in housing for low-income families. All have consequences that are prominent in low decile schools, which struggle to cope with the effects of poverty and social exclusion on their pupils.

Whereas wealthy countries (with the exclusion of the United States of America) have active and ongoing programs to assist families, a central issue in New Zealand is that there is no automatic mechanism that shares general prosperity with low-income children and their parents. The inadequacies for children of the current welfare state are likely to be further exposed should the economy stall in 2003.

Despite widespread acceptance of the presence and severity of poverty in the last two years, some people continue to dismiss the seriousness of the problems by "blaming" the victims, especially DPB beneficiaries. Personalisation of the issue of poverty encourages the community to ignore the structural features of poverty, which this report outlines. There are no quick fixes to the entrenched poverty we now see, only the hard work of deliberate and sustained commitment to change over many sectors, and a reversal of all too prevalent judgmental attitudes.

CPAG has commissioned detailed work in housing, to be published in 2003. This edition contains a preview of some of that work, along with updated sections in health, education, benefits and tax. Social indicators such as high rates of youth suicide, poor educational achievement, third world child diseases, and child abuse, are undoubtedly influenced by the proliferation of social hazards. This edition includes a new section on smoking, alcohol, cannabis and gambling and their impact on the young.

If New Zealand fails to grapple with the consequences of poor economic performance, rhetoric about the "knowledge economy" will be just that. It will also be much more difficult to address the poverty problem.

This edition also includes a section on the 2001 tax review and suggests that New Zealand should revisit the tax cuts of 1996 to bring about a substantial shift in resources to young families. While there are urgent measures that must take priority where funding is rationed, the case for a universal family benefit and access for all children to free healthcare are worthy medium term goals to strive for.

Our Children will accompany the Action for Children and Youth Aotearoa (Inc) report from non-governmental organisations to the United Nations Committee on the Rights of the Child, when they meet in June 2003.

CPAG New Zealand was inspired by CPAG United Kingdom. As noted in the preface to the first edition, the Labour government in the United Kingdom has adopted the vision of eliminating child poverty by 2020. CPAG New Zealand urges the Labour government to adopt that vision and make the elimination of child poverty in New Zealand their major priority.

Acknowledgements

CPAG acknowledges the contribution of the authors of the first edition, Susan St John, Alison Blaiklock, Claire Dale, Mike O'Brien and Sharon Milne.

Susan St John and Larissa Wakim co-ordinated this second edition. Specialised expertise has been sought in housing, benefits, tax reform, food banks, education, social services, social hazards and Maori and Pacific perspectives. Specific contributions and assistance have come from Innes Asher, Lorna Dyal, Brian Easton, Alan Johnson, Marianne Kayes, Susan St John, Janfrie Wakim, Larissa Wakim and Donna Wynd.

Caroline Dakin, Emma Davies, Ann Dunphy, Anne Else, Fiva Fa'alau, Kevin Hackwell, Kay Hawk, Bridie Henderson, Liz Gordon, Trish Gribben, Graham Howell, William O'Donnell, Dee Parks, Charmaine Pountney, Diane Robertson, Nikki Turner and Helen Yensen provided editing and content suggestions.

We would also like to thank all the members of CPAG throughout New Zealand who have provided valuable comments, interest and passion to this project. Although this monograph reflects a wide consensus among CPAG members, individuals will continue to debate policy details.

CPAG gratefully acknowledges support from the Hostel of the Holy Name Trust, the JR McKenzie Trust, and an anonymous donor, without which this project would not have been possible.

Executive Summary

Since the publication of the first edition of *Our Children*, there has been little improvement for children living in poverty in New Zealand. Despite the publication of a myriad of reports and Government statements that recognise the problem, little substantial action has been forthcoming.

By almost any measure of child poverty, New Zealand remains near the bottom of the league of comparable countries, at odds with its commitments under the Convention on the Rights of the Child. Although children of some ethnic groups and family types are over-represented in poverty statistics, a commitment to family-friendly policies, focused on ALL children, not just specific groups, is essential.

The Government's *Agenda for Children* provided a welcome opportunity for consultation with children about their views and opinions. It also contained the commitment to eradicate child poverty. However, it appears to have stalled, and without timeframes and deadlines, this is unlikely to change. NGO and sector groups have worked hard to push the Government into actioning the *Agenda for Children*, but with little success.

Developing good policy for children and families is undeniably difficult, but this cannot be used as an excuse for inaction. This publication, *Our Children*, contains recommendations at the end of each chapter, some specific and short-term, others medium or long-term, all reflecting the fundamental principle that the welfare of children be a key policy driver.

The task of eliminating child poverty requires coordination and cohesion among many sectors, including income, tax, housing, health, education, and social services. In the past, actions have been fragmented and ineffective, but a child-centred

approach to policy-making can bring about the cross-sectoral co-operation needed to eradicate the disgrace of child poverty by 2010.

Recommendations

CHAPTER ONE

New Zealand children and poverty

1. Eradicate child poverty in New Zealand by 2010.
2. Adopt an official measure of poverty and monitor regularly.
3. Focus policy development on the needs of *all* children, not just specific groups.

CHAPTER TWO

Why child poverty in New Zealand matters

1. Implement the *Agenda for Children*.
2. Ensure the rights and needs of children and young people are grounded in policy and law.
3. Eliminate food poverty by 2005.

CHAPTER THREE

Why are children poor?

1. Monitor whether economic policies improve living standards for all, especially children.
2. Balance the Fiscal Responsibility Act and the Reserve Bank Act by including the goal of fair social outcomes.
3. Continue high excise taxes on "social hazards" to protect and discourage use by young people.
4. Raise basic benefit levels to reduce reliance on supplementary benefits, and levels of debt amongst beneficiaries.
5. Adjust the bottom threshold for tax to \$13,000.
6. Redress the inequities of tax changes in the 1990s.

CHAPTER FOUR

Targeting versus universal support for children

1. Immediately extend the Child Tax Credit to ALL children of low-income families.
2. Abandon all discriminatory aspects of the Family Plus package of benefits.

3. Adjust all family assistance payments for past inflation, and index.
4. Place an obligation on the IRD to ensure families access their tax credits.
5. Implement a mixture of universal and targeted provisions, with a focus on children, to minimise the trap of high Effective Marginal Tax Rates (EMTRs).
6. Make a significant universal child benefit part of medium term policy.
7. Encourage public discussion about inter-generational issues and income distribution.

CHAPTER FIVE

Changing structures: families and work

1. Amend the Child Support Act to ensure that children receive some direct benefit from the liable parent contribution.
2. Increase support for the transition into paid work for beneficiaries and review the current punitive EMTR clawback regime.

CHAPTER SIX

Housing

1. Commit to build 1000 new state houses a year.
2. Soften the abatement of the Accommodation Supplement and income related rent subsidies.
3. Introduce assistance for home ownership including subsidised interest rates, reduced deposits, and sweat equity options.
4. Encourage and assist third sector housing initiatives for families on low incomes.

CHAPTER SEVEN

Health

1. Make health and dental care for under 18 year olds universal and free.
2. Inflation index all child health subsidies for children.
3. Extend Primary Health Organisation (PHO) development to all regions.

CHAPTER EIGHT

Education

1. Fund early childhood education to a level which ensures all young children are able to

- access quality, affordable programmes regardless of where they live, or their parents' income.
2. Increase funding for low and middle decile schools and eliminate subsidies for private schools.
3. Focus policy development on teacher quality to improve student achievement levels, especially in low decile schools.
4. Increase investment in schools to address student health problems and the effects of social exclusion.
5. Abolish fees for compulsory national qualification exams (NCEA, Bursary).
6. Computerise records of school attendance and provide well-resourced specialist programmes for chronic truants and other students in need.

CHAPTER NINE

Social services for children at risk

1. Investigate a *Sure Start* style of programme in New Zealand.
2. Enact legislation to ban the physical punishment of children, implement positive parenting programmes, and immediately repeal Section 59 of the Crimes Act.
3. Provide educational services for children with disabilities on the basis of the needs of the children, not solely on the basis of school rolls.

CHAPTER TEN

Social hazards

1. Encourage local initiatives to ban/eliminate pokie machines.
2. Increase contributions from gambling operators to cover social costs of problem gambling.
3. Campaign to make smoking tobacco and cannabis socially unacceptable in front of children.
4. Increase investment in smoking cessation programmes, especially those targeted at low-income families.
5. Continue with efforts to change prevailing attitudes towards excessive drinking patterns, and extend these efforts to other social hazards.
6. Raise the minimum legal age for the purchase of alcohol to 20 and ensure enforcement.

PART TWO

1. New Zealand children and poverty

Child poverty in rich nations

UNICEF has highlighted the persistence of child poverty in rich nations:

By the middle of the century that has just ended, the world's richest nations were confident that poverty would be overcome by a combination of economic growth and welfare spending. A prediction that poverty would still afflict a significant number of their children in the 21st century would not have been believed (UNICEF, 2000).

Poverty can be measured in two ways: absolute poverty, and relative poverty. Absolute poverty is the lack of resources for even a bare minimum existence:

Today, despite a doubling and redoubling of national incomes in most nations since 1950, a significant percentage of their children are still living in families so materially poor that normal health and growth are at risk (UNICEF, 2000).

But bare subsistence is insufficient for the development of human potential.

...a far larger proportion [of children] remain in the twilight world of relative poverty. Their physical needs may be minimally catered for but they are painfully excluded from the activities and advantages that are considered normal by their peers (UNICEF, 2000).

UNICEF points out that:

Accepting the notion of relative poverty means accepting that poverty may be worsening even if the absolute living standards of the poor are rising ...What constitutes an acceptable quality of life changes over time.... falling behind the average by more than a certain amount means effective exclusion from the normal life of society (UNICEF, 2000).

Measuring child poverty in rich nations

Many international studies consider that an income of less than 60% of median income constitutes poverty (Smeeding, O'Higgins, Rainwater, & Atkinson, 1990). UNICEF defines children in rich nations as relatively poor when they live in households with incomes lower than 50% of the national median household income. Using this definition, UNICEF found that child poverty rates in 23 rich nations varied from below 3% to over 25%.

Figure 1: Child poverty rates: relative poverty*

Low	3% -	8%
Sweden, Norway, Finland, Belgium, Luxembourg, Denmark, Czech Republic, Netherlands, France		
Medium	10%	- 13%
Hungary, Germany, Japan, Spain, Greece, Australia,		
High	15%	- 26%
Poland, Canada, Ireland, Turkey, UK, Italy, USA, Mexico		

* defined as households with income below 50% of the national median income (UNICEF, 2000).

Although New Zealand was not a part of the UNICEF study, in 1991 researchers compared New Zealand income distribution figures with Australian figures for 1981/2 and 1985/6 (Saunders, Stott, & Hobbes, 1991). The figures suggest that New Zealand would then have been in the group with medium child poverty rates. However, inequality increased more sharply in the late 1980s and early 1990s in New Zealand than in any other OECD country (O'Dea, 2000; Statistics New Zealand, 1999b), which suggests that New Zealand poverty rates have moved towards the higher end of UNICEF's child poverty rates.

Most countries use both absolute and relative measures of poverty. UNICEF warns against exaggerating the difference between relative and absolute poverty:

Most of the industrialised nations remain in approximately the same region of the child poverty league table whichever measure is used (UNICEF, 2000).

Both measures need to be monitored, and both need to be reduced. For example, Ireland is developing new measures of deprivation in areas such as health and housing to assist in the fight against poverty.

Child poverty in New Zealand

Around one in four New Zealanders - 23% - are under the age of 15 (Statistics New Zealand, 2001b). This is a higher proportion than the under-15 year old population in Australia, Canada, Hong Kong, Japan, Singapore, Sweden, the United Kingdom, and the United States (United Nations Population Division, 1997). Almost six out of every ten of the under-15s (59%) are of sole European descent. Almost one in four (24%) are full or part Maori. Around 10% are Pacific peoples, 7% are Asian, and 0.5% are from other ethnic groups (Ministry of Social Policy, 2000).

Reflecting the increase in those aged over 65, the total number of children is projected to fall (see Table 1). By the middle of this century the proportion of children in the total population will be around 16%. By 2050, children of full or part Maori and Pacific descent will make up 55% of all those under 15.

Table 1: Projected population of children by selected ethnic groups, 1996 and 2051

	1996		2051	
	Number	Percent	Number	Percent
Maori	202,400	23.9	256,400	33.5
Pacific	82,200	9.7	162,600	21.2
Other	561,500	66.4	346,700	45.3
Total	846,100	100	765,700	100

Source: Statistics New Zealand, 1999a

The existence of widespread child poverty in a country as affluent as New Zealand is difficult for many New Zealanders to accept. There are no official New Zealand poverty lines. However, various researchers have measured poverty here using criteria that reflect the living conditions of households.

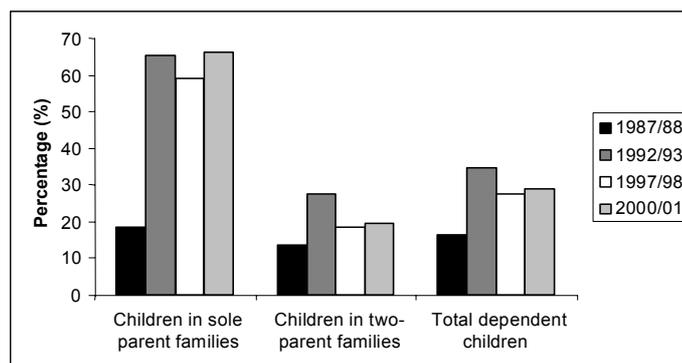
In 1972, the Royal Commission on Social Security (RCSS) set the social welfare benefit at a level designed to prevent poverty at that time. Economist Brian Easton adjusted the 1972 RCSS poverty line for changes in prices (since average incomes have not changed much over 25 years relative to prices). He showed that the overall numbers of New Zealanders in poverty had risen dramatically between the early 1980s and 1993, to about one in five of the population (Easton, 1999). By 1996, these numbers had fallen to about one in seven, reflecting the improved economy and increased rates of employment.

In another approach, giving similar poverty numbers, researchers set up focus groups around New Zealand to determine how much income was needed for a basic minimum lifestyle (Stephens, Frater, & Waldegrave, 2000). This income would be sufficient for a household to buy food and clothing, and pay for power and housing, without going into debt or using food banks. The study found that the 1991 poverty income level was about 60% of the median disposable income adjusted for household size.

Selection and interpretation of poverty lines is controversial. Neither Statistics New Zealand nor the government have endorsed the lines worked out for New Zealand. One problem is that people in different regions face very different housing costs. Another is that adjusting by the median income can be misleading if median incomes are falling (Easton, 1999, 2002a; Saunders & Smeeding, 2002). Nevertheless, recent government reports (Ministry of Social Policy, 2001; Mowbray, 2001; Treasury, 2001b) show a new willingness to recognise the profound changes that have taken place in income distribution and the rise of social exclusion in New Zealand.

The Ministry of Social Development has produced a poverty threshold of 60% equivalent net-of-housing costs median income. According to this measure, 29% of children are living in poverty (Ministry of Social Development, 2002c). As Figure 2 shows, there was a dramatic increase in the percentage of children in poverty between 1988 and 1993. While there had been some improvement by 1998, by 2002 that gain had slipped away. The proportion of children in sole parent families below the threshold rose from 18% in 1988, to a massive 66% in 2002 (Ministry of Social Development, 2002d).

Figure 2: Percentage of population with equivalent income net-of-housing costs below 60% median (1998 benchmark)



Source: Ministry of Social Development, 2002d

Statistics New Zealand ranks all households in order of their incomes, after an adjustment to allow for their different size and composition. Households are then placed in quintiles, or fifths, of this 'household equivalent' income, so that the bottom 20% of households fall into the bottom quintile, and so on. Each quintile of *households* may contain fewer or more than 20% of *individuals*. Because they are more likely to live in poor households, more than a fifth of all children are in the bottom quintile.

All the relative poverty levels suggest that about one fifth of all New Zealanders are living in relative poverty. Thus, by examining the characteristics of those who are found in the bottom quintile (or fifth) of the population, we can obtain some idea of the characteristics of those in poverty, on any reasonable poverty line.

In a 2002 report, Easton and Ballantyne show that the usual adjustment for household composition is biased against households with children. Using the Michelin Equivalence Scale and the RCSS poverty line, they conclude that 70% of the poor are children and their parents (the proportion does not include other adults also living in households with children). Adjusting for the fact that households with children generally live in more expensive housing, the figure becomes almost 80% (Easton & Ballantyne, 2002).

In 1996, 13% of all children of solely European descent were in the lowest income quintile, in contrast to 34% of full or part Maori children, 34% of Pacific children, and 28% of Asian children (Statistics New Zealand, 1999a). While the highest incidences of poverty were among ethnic minorities, because there are numerically many more Pakeha, Easton and Ballantyne (2002) found 58.5% of the poor were Pakeha, 19.9% were Maori, 11.8% were Pacific, and 9.8% were Asian and other ethnic minorities.

At the regional level, research into the Quality of Living in New Zealand's six largest cities confirmed that around 20% of families are 'poor' and found that:

With the exception of Manukau, the majority of families with children living 'in poverty' are European, reflecting the predominance of European ethnicities within the six largest cities. However, Maori, Pacific Islands and Asian families with children are over-represented.

In 1996, these ethnic groups made up around 29% of the population in the six cities, but comprised 42% of families with children living in hardship (Big Cities, 2001).

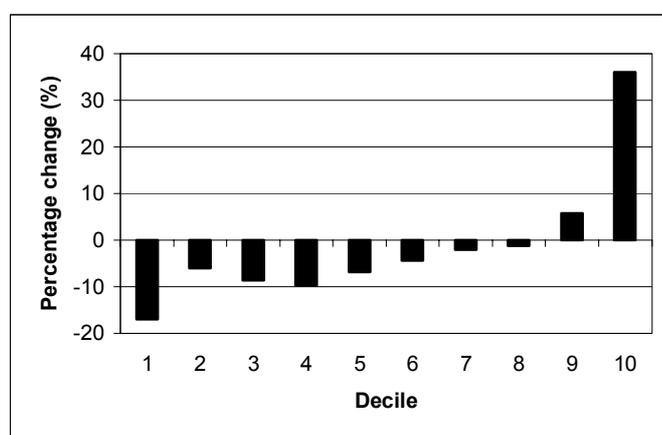
Similarly, while the incidence of poverty is higher in rental housing, a slight majority of the poor live in their own accommodation, typically owned with a mortgage. Easton and Ballantyne found the likelihood of a child being sick was about three times higher for those in the bottom household income quintile in comparison to the those children in the top quintile. Almost half of sick children were in the bottom quintile, and three quarters in the bottom 40% (Easton & Ballantyne, 2002).

One-parent households are disproportionately represented in the bottom two income quintiles: nearly 70% of all single parent households fall into this category. However, because overall there are more children in two parent families, there are more children from two parent families than from sole parent families in each of the bottom quintiles. This emphasises the important point that poverty is not just a sole parent family problem.

Increasing inequality affects children

Statistics New Zealand found that the overall increase in income inequality in New Zealand between 1982 and 1996 was as large as, or larger, than the increase in any comparable country (O'Dea, 2000; Statistics New Zealand, 1999b). Household income figures, adjusted for numbers of people, show there was a large shift of income from low and middle-income groups to the highest income group.

Figure 3: Change in median real equivalent disposable income 1982-1998



Source: Derived from Mowbray, 2001

By 1998, as shown in Figure 3, average real incomes had fallen for the bottom eight-tenths (deciles 1 - 8) of New Zealanders, while incomes for the top tenth (decile 10) had increased by 36%.

Since children are more likely to live in low-income households than adults, households with children are more likely to have experienced a fall in real incomes.

Cindy Kiro, reviewing the effects of the economic reforms on Maori, comments:

The picture of growing inequality is most worrying for Maori tamariki and rangatahi, along with Pacific Island families, as it is they who have experienced the greatest decline in incomes and overall well-being during the period of the reforms. Positive developments such as Kohanga Reo, Maori health providers, increased rates of secondary and tertiary participation and so forth, have almost invariably been the result of Maori efforts to bridge the gap created by the withdrawal of the state, or the provision of inappropriate state services (Kiro, 2000).

Summary

Statistics relating to children are difficult to locate, and there are still many uncertainties in the poverty research of the last quarter of a century, but one result has persisted throughout. Children appear disproportionately among the poorest households, irrespective of the choice of the poverty line or the various transformations that are done to calculate the spending power of households.

It is true that children in sole parent homes, and those who are of Maori, Pacific and Asian descent are more likely to be poor. However, there are also a large number of children of European descent in two parent households who are poor. The needs of all children must be the focus for policy, rather than a subgroup based on, for example, ethnicity or marital status of parents. More useful data for determining policy emerges from focusing on all children.

Recommendations

1. Eradicate child poverty in New Zealand by 2010.
2. Adopt an official measure of poverty and monitor regularly.
3. Focus policy development on the needs of *all* children, not just specific groups.

2. Effects of poverty on children

In 2000, UNICEF commented on the consequences of child poverty in rich nations:

The persistence of child poverty in rich nations undermines both equality of opportunity and commonality of values. It therefore confronts the industrialised world with a test of both its ideals and of its capacity to resolve many of its most intractable social problems (UNICEF, 2000).

Internationally, rich nations are beginning to realise that many of the 'intractable social problems' they are facing have their origins in relative deprivation during childhood:

...while it is true that many poor families make sacrifices to give their children the best possible start in life, the broader picture shows that those who grow up in poverty are more likely to have learning difficulties, to drop out of school, to resort to drugs, to commit crimes and to be out of work, to become pregnant at too early an age and to live lives that perpetuate poverty and other disadvantage into succeeding generations. In other words many of the most serious problems facing today's advanced industrialized nations have their roots in denial and deprivation that mark the childhoods of so many of their future citizens (UNICEF, 2000).

Children's needs

What happens to children in their early years, and even before birth, significantly determines how well they develop and learn, and how much they will contribute to, or cost, society as adults. There is now a wide range of evidence about the ways in which poverty and economic stress impact on children's development:

Poverty during childhood (particularly early childhood) has impacts across the life span, setting off a developmental trajectory which is cumulative, affecting every conceivable kind of health outcome . . . as well as educational outcome (Smith, 1998).

While not true of all attempts at suicide and self harm, there can be no doubt that the desperation of poverty is an important consideration in the despair that leads to attempted suicide for some young people. The social and financial costs of failing to ensure children's healthy development are high.

Childhood occurs only once. If the experience of childhood is to be positive and productive for children, the best possible opportunities must be provided for them from birth.

Dr Robin Fancourt, leading medical authority on early cognitive development, explains:

The development and organization of the brain are directed by the day to day experiences of babies, infants and toddlers. Neglect of their needs is frequent in impoverished homes with this neglect seen in the failure of the brain to make vital connections and to form the pathways between the brain cells that are essential for communication. The myriad of disorders and disabilities seen later in adolescence and adulthood are already too expensive for the country to control or contain.

For the nation there is more than this, as research and studies from many disciplines have recently shown that the physical and mental health of a population, its well-being, coping and competency skills is accurately indicated by the slope of the line between the most wealthy and the poorest.

A very steep slope, as New Zealand has acquired over the past 16 years, means the social and economic advantages for all levels of the community are affected, although it is seen at its worst in the lowest socio-economic level.

The challenges and opportunities presented by the disastrous effects of poverty on children need to be understood by the public, and acted on by politicians and the powerful, if the measures of our continuing slip of indicators of child care amongst industrialized countries is to stop and if the health and the wealth of this nation are to return (Fancourt, 2000).

Children's Rights

It is interesting that New Zealand families have not been more assertive in their claims on the state...they have not argued a case for their needs in comparison with households without children, or that their contribution to the nation was as worthy of reward as the past working lives of the old...the state's commitment to these families remains an issue for the future ... (McClure, 1998).

In societies where there are sharp social and economic differences among individuals:

. . . the overall level of health and well-being is lower than in societies where these differences are less pronounced. . . This gradient effect [applies] not only for physical and mental health but also for a wide range of other developmental outcomes, from behavioural adjustment, to literacy, to mathematical achievement....

There is another cost that is much harder to estimate econometrically: the cost to a society in terms of its future potential to be economically innovative and thus to grow its economy. Under-investment in its human resources by failing to provide supportive contexts for human development, particularly for early childhood development, is likely to incur these "hidden costs" of lost opportunity for future economic growth. If the growing economies of the future rely heavily on human and intellectual capital, as many contemporary economic models suggest they will, then this under-investment may represent a major, though largely hidden, cost to society – the cost of talent lost (Keating & Hertzman, 1999).

From the moment of conception, children are dependent on the actions and inactions of those around them, especially their biological parents. This dependence does not negate the importance of regarding children as human beings and citizens in their own right, not just in terms of their relationship to adults. Without a focus on their rights, children are completely vulnerable to the actions of those on whom they are dependent.

Globally, children's rights are set out in the United Nations Convention on the Rights of the Child, UNCROC, ratified by New Zealand in 1993 (see box). The Convention incorporates general rights, rights requiring protective measures, rights concerning the civil status of children, rights concerned with development and welfare, and rights concerning children in special circumstances. It contains sections immediately relevant to the issues of child poverty.

In addition to the international rights conferred under the UNCROC, the Treaty of Waitangi provides a further structure of rights with important implications for Maori children. The Treaty requires the Government to work in partnership with Maori to protect and respond to the collective and individual interests of Maori wellbeing and development. Together, the Treaty and UNCROC work to reinforce Maori children's rights, for example, seeing Maori children in the context of their whanau, and shaping child policy to reflect Maori values, cultures and beliefs (Ministry of Social Development, 2002c)

Over a million New Zealand citizens (27% of the population) are aged under 18 years old. A focus on children as members of the society with certain rights carries with it crucial social responsibilities. In particular, there is a responsibility for ensuring that the resources, facilities and opportunities are available for those rights to be exercised. Three groups share this responsibility: parents or caregivers, the society or community, and the state or government.

The responsibilities of parents and caregivers are comparatively clear. Over the last two decades, parental responsibilities have been increasingly emphasised, while state and wider social responsibility and support for children have decreased. The extent to which parents in turn are supported by the state and the wider society has critical implications for children's current and future health and development.

Society is responsible for advocating and ensuring that the resources and opportunities required by children and their daily caregivers are available and that children do indeed come first. The state is responsible for ensuring that policy and law include and support children's needs, rights and interests.

The concept of treating children as members of society with rights is linked to their particular and unique position in society. Because children have no political voice and little financial power, their needs, rights and interests are easily overlooked or neglected by both society and the state.

United Nations Convention on the Rights of the Child (UNCROC)

Article 2: Non-discrimination: All Convention rights apply to all children, no matter who or where they are. The Government is responsible for protecting them from any type of discrimination and acting to promote their rights.

Article 3: Best interests of the child: All actions that involve children need to consider their best interests.

Article 4: Implementation of rights: The Government is obliged to do all it can to implement the rights in this Convention.

Article 6: Survival and development: Every child has the right to life, and the Government is obliged to make sure they survive and develop.

Article 12: The child's opinion: Children have the right to express their opinion freely and to have that opinion considered in anything that affects them.

Article 18: Parental responsibilities: Parents are jointly responsible for raising their children, and doing what is best for them. The Government must provide appropriate help to parents in bringing up their children.

Article 19: Protection from physical, mental or sexual violence, abuse or maltreatment: The child will be protected by the Government using all appropriate legislative, social and educational measures.

Article 26: Social security: Children have the right to social security, including benefits (depending on their circumstances).

Article 27: Standard of living: Children have the right to a standard of living that is adequate for their physical, mental, spiritual, moral and social development. Parents have the main responsibility for this – the Government has a duty to make sure they can, and do, provide it.

(Adapted from summary published by the Ministry of Youth Affairs, 2000)

Children are often treated as invisible, with the assumption that all that matters is the needs of adults. Alternatively, it is often assumed that their needs are important only to the extent that some clearly visible group of children is identified - for example, children and young people who come to public attention as a result of neglect, abuse or offending.

International opinion is increasingly shifting to viewing development of children's rights as crucial to society in two major ways. First, recognition of the rights of children leads to greater equality within the society. Second, children strengthen the links between the generations. As a result of strengthening the rights of children, everybody in the society has a greater commitment to all members of the society (Council of Europe, 1996).

How poverty affects children's living standards

A 1999 study surveyed 401 low-income New Zealand households. It looked particularly at households with children: 95% of the households surveyed contained children under 15 years of age. Nearly three-quarters of the households were paying more than 30% of their income on rent or mortgage payments, and a quarter were spending over half their income on rent or mortgage payments (Waldegrave, King, & Stuart, 1999).

Over half the households had experienced being unable to visit a doctor in the past year because of inability to pay, and for two-fifths of households, this had happened three times or more. Over half the households had been unable to afford to buy medicines or pay for prescriptions during the previous year.

Over half had been unable to afford to go to the dentist when they needed to in the previous year, and for a fifth this had happened on three or more occasions, or when they had ongoing toothache.

Four-fifths of households said it would be impossible or very difficult to raise \$2,000 in an emergency. Two-thirds of households were in debt, and a third were in debt for \$1,000 or more. Three-quarters had been unable to pay at least one regular household bill in the past year, and half had been unable to do this on three or more occasions. Two-fifths received support from their own family and a third grew their own vegetables. One-quarter used food banks or other community support. One-fifth did odd jobs or occasional housework for cash.

Food poverty

Enough healthy food is a basic need for growing children. The National Nutrition Survey found that "food often or sometimes runs out because of lack of money" for half of all Pacific people, a third of Maori, and a tenth of Pakeha (Ministry of Health, 1999b).

Waldegrave found that over 60% of households had been unable to buy what they identified as their top six most essential food items at least once in the last three months, because of a shortage of money. Half had been unable to provide a proper meal at least once in the last three months because they could not afford it. For over a quarter of households, this had happened at least four times in the last three months.

The report *Hidden hunger: Food and Low Income in New Zealand*, put together a wide range of evidence to show that food poverty is a reality and affects women and children most severely (New Zealand Network Against Food Poverty, 1999). It found:

- Low-income households do not have enough income to secure a basic healthy diet;
- Parents on low incomes go to great lengths to feed their children, and commonly miss meals themselves so that their children can eat better;
- When there is not enough money for basic food, there is likely to be too little money for other necessities such as health care;
- Low-income families rely more heavily on less healthy foods with high fat, salt and sugar. They know these foods are less healthy, but using them is a cheaper way of filling up hungry people;
- Better budgeting is not the answer - the basic problem is too little income.

Use of Foodbanks

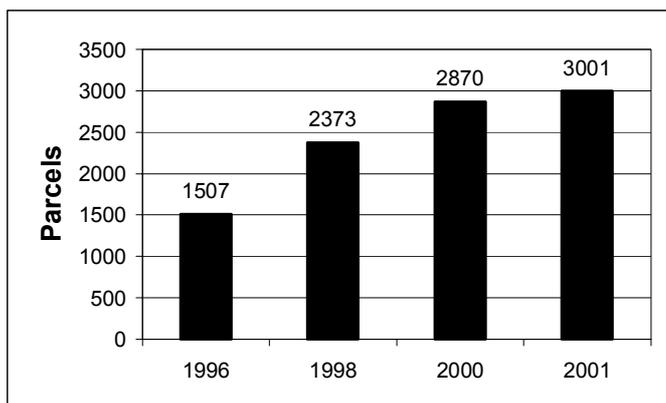
The Auckland City Mission distributes food to 70 food banks in the Auckland-Northland region. This food contributes to the 100,000 food parcels provided to people annually by these food banks. Their food parcels contain enough food for a family for at least four days. In the centre of the city, around 3000 food parcels are distributed annually. These provide for the urgent food needs of 7,000 adults and 12,000 children.

Since 1996, while the rate of increase in demand has slowed, the number needing food parcels has doubled, and continues to rise. Given current policies, a decline in the usage of food banks is not foreseeable.

The Auckland City Missioner, Diane Robertson, gives six major reasons for the increased workload seen in Auckland and Northland food banks since 1996:

- Families have exhausted all other benefit entitlements;
- High housing costs;
- Debt repayment;
- Medical costs;
- Higher food costs;
- Transport and moving costs.

Figure 4: Foodbank parcels distributed at Auckland City Mission 1996 – 2001



Source: Auckland City Mission statistics 1996 - 2001

Summary

Children's lack of political voice and their limited financial power easily leads to their interests being neglected, even though they are often most affected by the experiences of poverty. Child poverty is extremely damaging to children's lives and to their subsequent adult lives. Society also suffers because the potential contributions are not realised or, worse, there are substantial social and economic costs to be borne by everybody.

There is little evidence that the symptoms of poverty, for example, the use of food banks, child hunger at schools, and poor child health, have abated since the first edition of *Our Children* in 2001. The first term of the Labour-Alliance Coalition has undoubtedly seen some improvements in some services, but has provided no improvement in the financial benefits for children.

Recommendations

1. Implement the *Agenda for Children*.
2. Ensure the rights and needs of children and young people are grounded in policy and law.
3. Eliminate food poverty by 2005.

3. Why are children poor?

Getting economic decisions right . . . is especially important for children. Economic policies can be helpful to children or hostile. They can increase or reduce the number of children living in poverty. They can make it easier or more difficult for parents to combine work and family life. They can create or destroy young people's chance of finding their first job. They can help create a secure home environment for children or take it away. They can damage the lives of entire generations of children in 'declining' regions. Getting economic policies right is crucial for children (Save the Children, 2000).

For almost twenty years, most government policy in New Zealand has been made without reference to families and their children. The impact of economic reform has led to a marked deterioration in the position of children.

As a general pattern, ministries of finance set policies and targets designed to achieve overall economic goals while ministries of social affairs follow behind picking up the pieces. . . The injustices and inefficiencies of this economic priorities-first and social needs later approach have become evident at both the national and international stages. Social policy should not be an after thought. Attempts to reduce poverty, if they are to be even partially successful, demand integrated policymaking (UNICEF, 2000).

Macroeconomic policy, structural adjustment, and children

Poverty is not inevitable but is a structural problem to do with the unequal distribution of resources and opportunities... (UNICEF, 2000).

Children have been ignored in New Zealand's macroeconomic policymaking of the past twenty years, despite bearing the brunt of those policies.

Instead, the goals of economic and social policy have stressed achieving and maintaining low inflation, economic incentives, level playing fields and the growth of Gross Domestic Product (GDP). Yet even on narrow economic indicators, the New Zealand experiment has been far from successful (Dalziel, 1999b).

Rapid deregulation and privatisation, and the progressive withdrawal of the state from the economy were accompanied in the 1990s by lacklustre growth, high interest rates, a widening of income distribution, a ballooning current account deficit, and high overseas debt. To help achieve the goals of low inflation and fiscal surpluses, many public assets were sold and corporatised, and public services such as health and education were restructured under new public management principles. These changes emphasised user pays and profit, and introduced highly regressive pricing structures for basic goods and services such as water and education. Various commentators (Easton, 1997a, 1997b; Jesson 1999) have charted the negative impact of these reforms on society, as have numerous reports published by New Zealand and international non-government organisations, and government agencies.

In the early 2000s, overseas prices for exports and higher immigration have helped the economy. Interest rates and the current account deficit have fallen, and low inflation and lower levels of unemployment have been achieved. But the quality of much employment is low, with ongoing problems of low pay. While Government policy has regarded the achievement of goals such as low inflation and free trade as ends in themselves, there is a clear need to monitor whether policy directions achieve the social ends of improved living standards for all, especially children.

Since the Reserve Bank Act was passed in 1989, monetary policy has had a tight focus on keeping inflation between 0% and 3%. The Act does not require any monitoring of the social effects of monetary policy. Under the prevailing policy framework, the only policy tool available to achieve low inflation has been high interest rates. The high interest rates of the late 1980s and the mid-1990s were very damaging for families with mortgages and largely fixed or declining incomes.

In 1998, the Asian financial crisis triggered a rise in interest rates, which continued to rise as the Reserve Bank became aware of the inflationary consequences of the 1996 and 1998 tax cuts. Put very simply, tight monetary policy (high interest rates) was necessary to compensate for loose fiscal policy (low taxes). Low-income families were the losers.

In 2001, uncertainty in the United States and the events of September 11th saw New Zealand interest rates decline. While this decline was welcome, unrestrained speculation in housing, fuelled by a lack of capital gains and inheritances taxes, intensified the inequality of wealth distribution. Thus, while high interest rates can be damaging, lowering interest rates may have perverse effects by encouraging speculation in housing, thereby pushing up rents to the detriment of low-income families. The issues in the housing sector are complex and are discussed in a forthcoming CPAG publication (Johnson, 2003), and in Section 6.

The Fiscal Responsibility Act 1994 requires fiscal prudence. This has meant an emphasis on achieving operating surpluses and repaying public debt. The Act does not require these choices be evaluated. The choices between tax cuts, or spending on infrastructure such as schools and hospitals, or repaying debt, or buying shares, have a major distributional impact, yet there has been no serious consideration of the way in which families and children are affected by these political decisions on spending. The tangible and intangible costs of a failure to fund social expenditures are diffuse and difficult to quantify. The social benefits of poverty prevention are measurable only as 'prevented social costs' and are thus too easily ignored.

The 1990s emphasis on fiscal surpluses and reduced public spending has continued into the 2000s. Underfunding of social services has persisted, as have New Zealand's relatively high real interest rates. Taken together, these put our most vulnerable children at risk of falling even further behind. Policymakers must recognise that macroeconomic policy framework is too narrow and does not, on its own, ensure a better economic performance improves the position of children. There is a clear need to separate the tools or means (low inflation, budget surpluses, low unemployment, etc) from the ends. New Zealand must balance the framework with goals of social responsibility so that outcomes for people are included (Boston, St John, & Stephens, 1996).

Tax reform

Since the mid-1980s, economic policy has been dominated by the belief that the role of government in the economy is too large and that the tax take and government spending are too high. But there is clear evidence market incomes are unacceptably unequally distributed, and substantial government intervention is required.

New Zealand's tax system has been radically reformed over the last 17 years. First, the Labour Government brought in a Goods and Services Tax (GST) in 1986, a new tax on almost everything a household pays for except accommodation. Everyone pays this tax at the same rate, irrespective of the level of their income. Beneficiaries did get some compensation for GST when it began, but this did not cover all the price increases they faced. Since then, GST has risen from 10% to 12.5%, without any further compensation. Moreover, the benefit cuts in 1991 effectively undid the original compensation.

Roger Douglas, then Minister of Finance, also tried to bring in a 'flat tax' system, where everyone paid the same percentage of their income in tax, regardless of their income. While flat tax was never implemented as intended, taxes were substantially flattened. Combined with GST, this left more money in the hands of high-income groups and less in the hands of low-income groups.

In 1996 and 1998, taxes were cut substantially. The government claimed that these cuts, and concurrent increases in family tax credits, would benefit low and middle-income families, but in fact high-income earners gained the most. For every dollar of extra expenditure or forgone revenue in the programme, 40 cents went to non-family groups, 31 cents went to families in the top two income quintiles, and only 29 cents went to the 'target' group of low and middle-income families (Dalziel, 1999a). Single earner families gained far more than low-income two-earner families, with some low-income families gaining very little. Those on benefits missed out, and their gross benefits were simply adjusted to maintain the same value after tax.

The annual foregone revenue from the fully implemented tax cuts was \$2,335m (Birch, 1996). Family assistance increases cost a further \$345m, with substantial increases for older children over 16 years old. About \$160m of the new spending was for the controversial Child Tax Credit.

The benefits of the 1996 tax reductions are seriously questionable: the revenue foregone since their implementation has precluded much useful spending, including improving the income position of the worst-off families.

In 2003, the first \$9,500 of income is taxed at the relatively high rate of 15%. Despite inflation since 1986 of well over 60%, the threshold for this bottom rate has not been adjusted. The top threshold of \$30,875 was lifted to \$38,000 in 1996. If the bottom threshold had been similarly adjusted, it would now be about \$13,000.

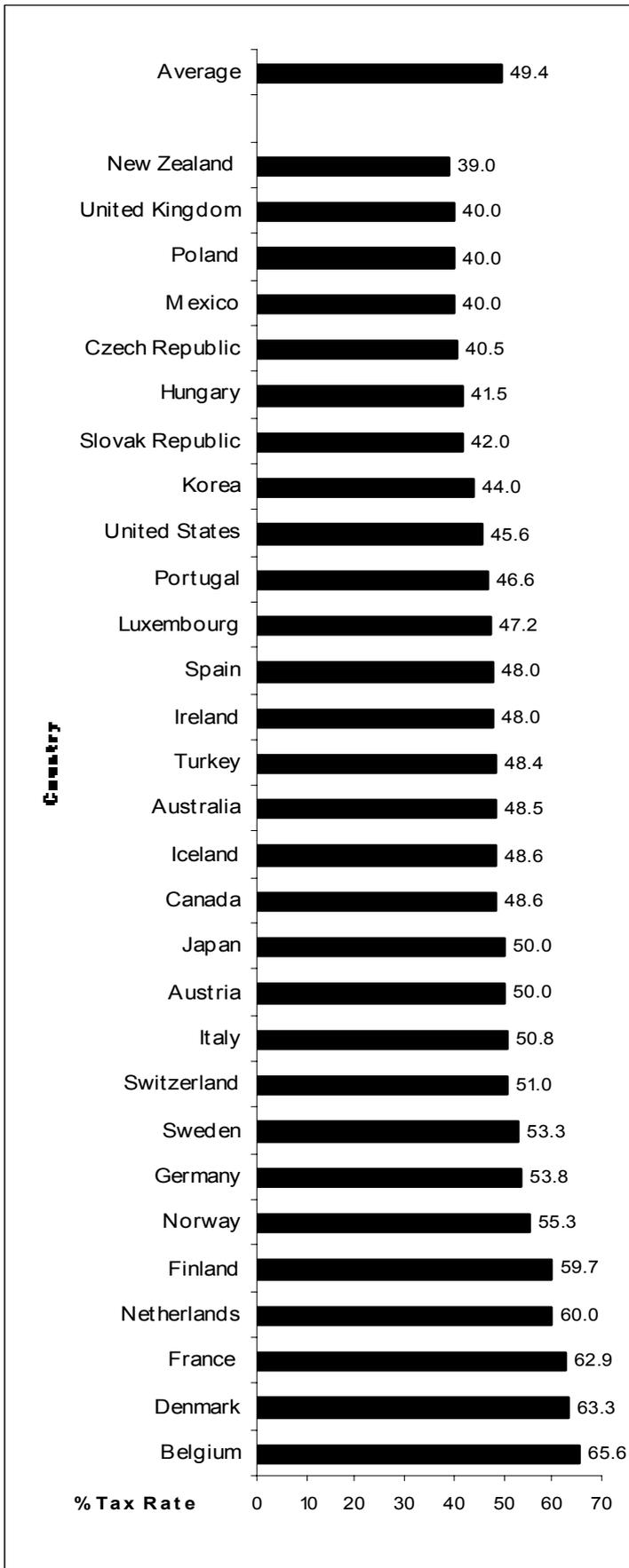
Are we overtaxed?

Presently, income of between \$9,501 and \$38,000 is taxed at 21%. On income over \$38,000 the rate is 33%, and 39% for those earning over \$60,000 per annum. ACC levies add another 1.2% to basic tax rates. New Zealand's highest rate of income tax of 39% is now the lowest in the OECD, and well below the average top rate of 49.4 % (see Figure 5 below).

While our tax levels are modest compared with other countries, many New Zealanders believe that they are overtaxed. In 1997, a study commissioned by the IRD suggested that the tax/GDP ratio for New Zealand should be only 20% (Caragata, 1997). In spite of the controversy this study generated, it is often cited as the evidence that New Zealand taxes are too high. But international comparisons do not support that conclusion.

On average, the contribution from GST in New Zealand approximates the percentage for similar indirect taxes in other countries. Personal income tax makes up 41.8% of total tax receipts in New Zealand. Other OECD countries average 26.3% but also collect social security payroll taxes of 16.1%. The higher personal income tax share of our tax receipts is explained by the New Zealand practice of paying benefits out of general tax revenue rather than via a separate social security tax.

Figure 5: Top personal income tax rate % in OECD countries



Source: OECD, 2002

Table 2 shows data levels of revenue and expenditure for OECD countries. New Zealand's total tax receipts came to 35.6% of GDP, total government revenue was 40.5% and government spending, 36.4%. Both the tax and the spending ratios are below the average and the median for the OECD. Only 10 countries show lower spending than New Zealand

Table 2: Revenue and government expenditure as a % of GDP

	Current government revenue % GDP	Current government expenditure % GDP
Slovak Republic	53.8	56.3
Sweden	56.3	52.2
Denmark	53.1	51.1
France	47.5	47.5
Austria	47.1	46.9
Belgium	47.8	46.8
Germany	44.4	44.5
Italy	44.3	44.1
Finland	50.8	43.7
Greece	43.9	42.4
Canada	42.7	41.9
Netherlands	43.8	41.7
Poland	41.4	39.5
Norway	55.7	39.4
Portugal	38.6	39.0
Hungary	38.0	38.0
United Kingdom	39.8	37.7
Czech Republic	39.6	37.6
New Zealand	40.5	36.4
Luxembourg	44.3	35.7
Spain	37.3	35.3
Iceland	40.6	35.0
Switzerland	34.3	33.4
Australia	32.9	32.9
United States	32.8	32.7
Japan	29.4	31.9
Ireland	33.9	26.4
Mexico	19.7	17.7
Korea	26.3	17.2
Average	41.4	38.8
Median	41.4	39.0

Source: OECD, 2002

Tax reform - where are we now?

In 2001, the government established the McLeod Committee, charged with a fundamental re-examination of the basis of taxation in New Zealand. This was only the third such major review since the early 1980s.

CPAG made submissions on the preliminary document and requested that the issues for children be given a high priority. The interim report of the Committee was very discouraging. None of the fundamental issues raised by CPAG were addressed. The Committee simply reflected the well-known views of those such as the New Zealand Business Roundtable. These views include favouring a flatter and lower tax, a higher rate of GST, less income tax, and the abolition of excise taxation. No attempt was made to examine the role of tax credits for children.

CPAG noted with dismay in their second submission that the opportunity had been missed in the interim report to prioritise children as a matter of urgency in tax design (Child Poverty Action Group, 2001b). Many of the directions signalled in the interim report were adverse for families and children.

With respect to excise taxes, the McLeod review's claim that 'decisions to smoke, drink, gamble or drive all involve the acceptance of well publicised risks' (McLeod, 2001) failed to recognise the lack of choice children exercise in relation to each of these activities. Adults make the decisions, but the proposals suggested in the Report would only punish children (see also Chapter 10 on Social Hazards). While the Report advocated reduced excise taxes, with the fiscal shortfall to be made up by raising GST, CPAG argued that excise taxation must not be abandoned because:

- Excise taxes help prevent the young from initiating destructive behaviours;
- Excises can influence quantity consumed to favour moderation;
- Excise taxes discourage consumption of imported excise goods and thus favour the domestic economy.

The final McLeod report was a further disappointment. It continued with a very narrow focus, looking only at those things that the committee itself defined to be part of the tax system.

Tax credits for children were largely ignored as the Committee implicitly treated them as government spending and hence outside their brief. They did not grapple with issues of higher tax rates for former students as student loan repayments were not defined as a tax. Likewise, abatement of benefits and their interaction with the tax system were also considered outside the Committee's brief. There was little recognition of the impact of inflation on tax burdens over time when the system is not indexed. Nor was the issue of fairness in taxes paid between households on the same income but with different numbers of children addressed.

In fact New Zealand did not need a tax review. New Zealand needed a fiscal impact review. The review contained no discussion of the fact that in 1991 the government took one billion dollars from the lowest income groups in New Zealand but delivered almost none of this back through the \$2.7 billion tax and benefit packages of the mid to late 1990s. Problems in child health, education, and other pressing areas of government activity will continue to be intractable until we view taxes and government spending as a total package.

The CPAG response to the final McLeod report noted:

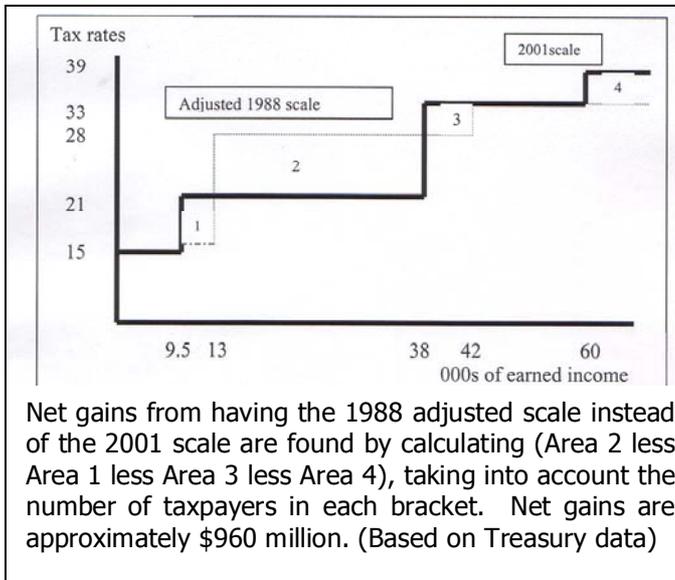
- Increasing GST to 16.5% while removing excise taxations would unambiguously intensify child poverty;
- The tax and benefit system must be viewed together as part of the whole redistributive system;
- The two-step tax scale proposed (18% to \$29,500 and 33% over that level) solves none of the problems identified by the review, and intensifies the poverty of the lowest paid (Child Poverty Action Group, 2001a).

CPAG argued that the 1988 tax scale properly adjusted for inflation should be taken as the starting point (see Figure 6). The saved revenue should be used to redistribute to families and provide free primary healthcare. There are many possible reform packages. For example, key tax changes to assist families might:

- Compensate families by adjusting family support thresholds and extending the Child Tax Credit of \$15 per week per child to all families, and indexing it to inflation. The cost would be approximately \$510 million;

- Count 1.5 percentage points of the 28% tax rate as a Medicare tax and introduce a 1.5% Medicare tax on incomes above \$42,000;
- Use extra revenue to make primary health care free.

Figure 6: Suggested tax structure changes – 2001 personal tax scale compared with inflation adjusted 1988 personal tax scale



Source: Child Poverty Action Group, 2001a

New possibilities for redistribution were emerging in 2002 as strong economic growth fuelled improved budget surpluses. There are strong grounds for a substantial redistribution to low-income families in the 2003 budget.

Benefits and household debt

In 1991 the government cut benefits severely. The multiplied effects of taking approximately one billion dollars out of local communities exacerbated the recession of the early 1990s. During that period, the "success" of government policies was gauged by benefit spending decreases and falling welfare numbers. The tools used to achieve this were a combination of restricting eligibility criteria, reducing entitlement, underpayment of benefits, a refusal to index abatement rates, and general harassment of beneficiaries.

Cutting government spending was not the primary reason given for these changes. Rather, it was claimed that welfare actually created poverty by encouraging dependency on the state.

However, during this time, the percentage of children whose parents received their main income from benefits actually rose from 25% in 1990 to 28% in 1998 (Department of Social Welfare, 1999). Presently over 300,000 children are still living in households supported by a benefit (WINZ, 2001).

Economic growth was, and still is, seen as the only way to solve the problem of poverty. However, the consequence of policy changes has been that economic benefits have been redistributed toward the highest deciles. In spite of the strong economic recovery in the early 2000s, poverty among families with children has remained a major social problem in New Zealand.

One clear indication of how economic policy has led to increased poverty is the rising level of debt in low-income families. Much of this is debt owed to Work and Income. It is impossible for families to clear these debts. They cannot improve their budgeting skills when there is simply not enough income to meet the weekly costs of living and servicing their debt. Moreover, research suggests increased income is more significant than better budgeting in improving the financial position of low-income families (Wilson, Lorgelly, & Houghton, 1997).

In 1999, the Downtown Community Ministry published a report on the debt situation of those on benefits - *Too poor to help: How Welfare Debt is Replacing Welfare*. It found:

- Since 1991, there had been a shift from benefits adequate to cover basic expenses, to an increased reliance on supplementary assistance;
- Increasingly, this assistance had been in the form of recoverable loans;
- As a result, WINZ has become a major money lender;
- Loans are required to be paid back out of already inadequate benefits;
- Recovery rates were increased sharply from 1994, with WINZ offices competing to reduce debt;
- Many people were having loan repayments of more than \$40 deducted from their benefit each week, creating further hardship (Downtown Community Ministry, 1999).

There are limits to the amounts that can be borrowed on these conditions. So the already poor become, literally, too poor to help.

One of the consequences of the 1991 benefits cuts has been an increased reliance on the second tier of means-tested supplements. The Downtown Community Ministry have shown that many individuals have missed out on their legitimate entitlements to the special benefit (Howell, Simmers, & Hackwell, 2000; Hackwell & Howell, 2002). Many families do not understand their rights to this extra assistance, and there are strong regional variations in the take-up rate of those entitled. A 20% increase in the numbers of special benefits awarded between August and September 2002 (Ministry of Social Development, 2002b) can be attributed to the hard work of beneficiary advocates.

While improved access to the special benefit may help poor families by providing an extra \$20-40 a week, the special benefit reflects the inadequacy of base benefits, and constitutes a complex addition to the welfare system.

International comparisons

Countries with low rates of child poverty also have high levels of taxation and of government spending, relative to GDP.

The extent to which state intervention can be said to reduce child poverty rates was calculated for 17 OECD nations by comparing the actual rate of child poverty with the rate that would theoretically prevail in the absence of tax and benefit policies (UNICEF, 2000). This provided an approximate measure of the extent to which different nations implement policies to protect their poorest children. New Zealand was not included in the study because we could not provide sufficient data.

The Nordic countries of Denmark, Finland, Norway and Sweden all have low rates of child poverty. These countries tend to have extensive public assistance, such as maternity leave and childcare to help women in the workplace, and high redistribution, with inclusive universal provisions rather than targeted provisions. This means high social expenditure, and high taxation to pay for it. Tax/GDP ratios are around 50% in these countries, well above New Zealand's modest levels (see Table 2). On the other hand, these high tax rates do not seem to have dented the continuing affluence that the Nordic countries enjoy:

Above all, it is clear that family focused social policy is deep-rooted in Nordic culture and that the principle of social entitlement is highly institutionalised, enjoying wide support among the electorate (UNICEF, 2000).

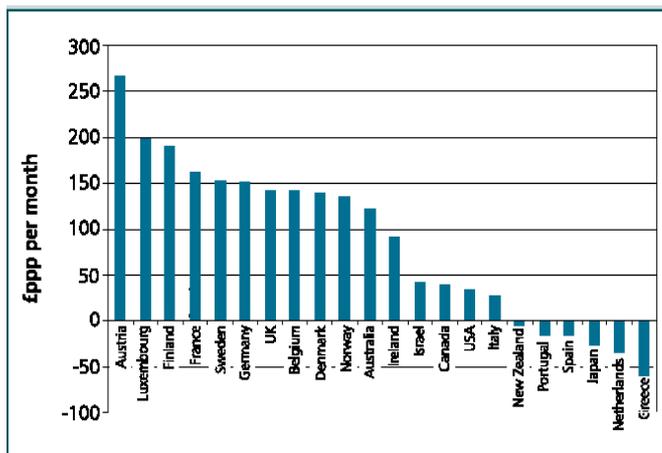
While of huge importance in the Nordic countries and in former communist countries such as Poland, state policies also reduce child poverty by 16 to 20 percentage points in France, Luxembourg, and the United Kingdom. In Italy and the United States, two rich countries with high rates of child poverty, state policies reduce child poverty by less than 5 percentage points:

In sum, it is clear that state provision for poor families is an important factor in all countries that have succeeded in reducing child poverty rates to low levels. Its broad significance is also made evident in the fact that most European nations have seen significant rises in unemployment in recent decades without correspondingly significant rises in child poverty - except in the case of the UK (UNICEF, 2000).

In a recent report from the United Kingdom, researchers compared the child benefit packages across 22 industrialised countries, looking at the tax allowances, cash benefits, exemptions from charges, subsidies and services in kind, which assist parents with the costs of raising children (Bradshaw & Finch, 2002). This followed a similar survey conducted in 1996.

As Figure 7 indicates, the results showed New Zealand consistently ranked in the lowest category, with the "laggards" Portugal, Spain, Japan, Greece and the Netherlands, with a meagre range of assistance available to parents, especially in comparison to our neighbour, Australia. We rank as having a negative child benefit package because housing costs and charges for services cancel out the value of tax and cash benefits for children.

Figure 7: Cash benefit package after housing and costs for services, paid to families with children



Source: Bradshaw & Finch, 2002

The report indicated that it is not New Zealand's relative lack of wealth that places us in this lowest bracket, but rather our overall social expenditure levels, and the proportion that is given to older persons and young families respectively.

Over the past decade, previous laggard countries such as the United Kingdom and Canada have substantially increased their financial commitment to assist families to offset the financial burden of children, with a clearly stated objective of reducing child poverty (Davies, Wood, & Stephens, 2002). New Zealand should be doing the same.

Recommendations

1. Monitor whether economic policies improve living standards for all, especially children.
2. Balance the Fiscal Responsibility Act and the Reserve Bank Act by including the goal of fair social outcomes.
3. Continue high excise taxes on "social hazards" to protect and discourage use by young people.
4. Raise basic benefit levels to reduce reliance on supplementary benefits, and levels of debt amongst beneficiaries.
5. Adjust the bottom threshold for tax to \$13,000.
6. Redress the inequities of tax changes in the 1990s.

4. Targeting versus universal support for children

One of the missing elements in protecting the economic position of children in New Zealand is the use of inclusive and universal programmes. Countries more successful than New Zealand in preventing child poverty tend to place far greater emphasis on these policies, which are designed for all children, not just those who are seen as disadvantaged. Most European countries have a family payment that is not means-tested. Even Australia has a quasi-universal family payment. These universal programmes are not regarded as a handout but as an entitlement.

Bradshaw's report on the comparison of child benefit packages found that the countries with the most generous overall child benefit package were not the countries that employed a substantial element of targeting, either through tax credits or income-related benefits. Rather, they were the countries that deliver most, if not all of their value as a non-income-related child benefit (Bradshaw & Finch, 2002).

Universal child benefit payments have many advantages. They:

- are inclusive, immediate and certain;
- allow for a register of all children to be kept;
- are not able to be taken away if either parent earns extra income;
- cope well with social change;
- put the needs of the child first.

New Zealand children have been the unwitting victims of a debate over targeting versus universal assistance that is often conducted at levels of high principle, removed from day-to-day reality. This section explores the issues, and contrasts New Zealand's approach with that of the United Kingdom and Australia. It is clear that universal payments for children do have an important role to play.

Family Assistance in New Zealand

In the early 20th century, state regulations attempted to ensure that wages paid to a full-time employed man were sufficient to support himself, a wife and three children. Over time, this method of helping families was seen as less appropriate.

Various special tax exemptions and rebates, and different kinds of cash supplements, as well as health and housing subsidies, were introduced instead. These could be tailored to individual family characteristics such as income and the number and ages of the children. However, this required the state to decide what constituted a family, and how family income should be measured.

Tax exemptions for the breadwinner's children and his dependent spouse were of much greater value to higher income taxpayers on high marginal tax rates. Therefore, these were not seen as an effective way to deliver adequate assistance to all families.

Direct financial assistance to families was at first highly selective and tended to focus on larger families, rather than all families with children. An income test took some account of assets.

The Family Benefit

The Social Security Act 1938 introduced new benefits, as well as free health care, education, and state funded maternity benefits. The Family Benefit paid four shillings a week for the third or subsequent child under 16, for those earning under £5 a week. Children born outside of marriage and migrant children, formerly ineligible, became eligible, as did those who remained at school for up to two years beyond the age of 16. The Family Benefit became payable for the second child in 1940 and for all children in 1941. The payment remained selective until 1946, when the means test was entirely removed.

One advantage of the Family Benefit was that it could be capitalised, and was frequently the means by which families funded the deposit for their own home. In contrast to the family tax credits that have replaced it, the universal Family Benefit was closely associated with the child, not the income position of the parents. Tax credits that are uncertain, and often not accessed until the end of the year, are more likely to be absorbed by the main earner's tax position.

Targeted family support

During the 1970s and 1980s there were many changes to the system of rebates for families. Between 1976 and 1982, the National Government introduced a series of tax rebates designed to help low-income families with children.

All were payable to the principal income earner. Because rebates are a fixed dollar amount, they are more progressive than tax exemptions, as they form a higher proportion of a low income than a high income. These rebates were generally targeted, so that they reduced in value as family income rose.

Until 1986, families on benefits such as the Sickness or Unemployment Benefits were not eligible for Family Care and the Family Rebate. They were paid a supplement for children of \$10 a week, in addition to the Family Benefit. Thus, the assistance low-income families received was based on the source of the low income (St John, 1994).

In 1986, a refundable tax credit called Family Support replaced the Family Rebate, Family Care and the Child Supplement. This tax credit treated all families the same. This egalitarianism was not to last. In 1989, the government proposed a new Guaranteed Minimum Family Income (GMFI) for low-income families in full-time work. The new GMFI openly abandoned the principle that children should be treated the same regardless of the source of low parental income. Families with children were to be rewarded if they were in the full-time work force, while other families would have a subsistence-level benefit only.

Problematically, when families on GMFI earned more, they faced effective marginal tax rates of 100%, disguised as a lagged income test (St John, 1994). With the ultimate rejection of flat tax, the GMFI proposal was also dropped and the Family Support/Family Benefit combination was reinstated.

Under the National Government, the Family Benefit was amalgamated with Family Support in April 1991. The entire amount was abated against joint family income, just as the old family support had been. By the mid-1990s both the major political parties had come to believe that targeted Family Support was *the* way to help low-income families.

Family Support and the Child Tax Credit

In 1996 the coalition government introduced free GP visits for all children under the age of six, and made some improvements to family support. However, the selective and discriminatory Independent Family Tax Credit, now called the Child Tax Credit (CTC), for 'working' families was also introduced. This was done instead of making adequate adjustments to Family Support.

Only a small percentage of children benefit from the CTC, and it neither provides meaningful assistance for working parents, nor helps to alleviate the plight of all poor children.

The CTC is available to families who are 'independent' from the state. Many families miss out because one or both parents are on a benefit, on ACC, or receive New Zealand Superannuation or a student allowance. The loss of the CTC punishes those children whose parents become ineligible by losing their job or getting sick, old or injured.

In October 2002, CPAG lodged a complaint with the Human Rights Commission, submitting that the CTC was a piece of legislation that unlawfully discriminated against beneficiaries, and the children of beneficiaries, and therefore breached the Human Rights Act. The complaint also argued that the CTC breached New Zealand's obligations under the Convention on the Rights of the Child. An outcome from that complaint is expected in 2003 (Child Poverty Action Group, 2002).

Family Support is now usually paid to the principal care-giver, but some families wait until the end of the year and claim it as an end of year rebate. If the end of year tax reconciliation shows that joint income was higher than anticipated, families have to pay back any 'overpayments' they received during the year. Many families rightly fear the subsequent burden of repayments, and do not apply for assistance because of this risk. IRD statistics show that about one in six families have money to repay at the end of the year. The average repayment amount is around \$1,000. About one in three families are entitled to a refund at the end of the year. This system, relying as it does on end of year reconciliations, means that the weekly income for many families is either unknown or insecure.

To receive the maximum Family Support (see Table 3), a family must have total gross parental income of less than \$20,000. For every extra dollar earned over \$20,000, the family has to pay back 18 cents of their Family Support. Once combined parental income exceeds \$27,000, the clawback rises to 30 cents for each extra dollar.

The \$20,000 threshold for abatement has remained unchanged since 1994, and the \$27,000 threshold since 1988. As wages have increased more of the Family Support has been clawed back.

The effect has been to substantially reduce the income support provided for middle-income families (Child Poverty Action Group, 2001a). Table 3 shows the rates of family support. There have been no adjustments since 1998, nor did the 2002 budget project any out to 2006.

Table 3: Weekly maximum rates of Family Support and the Child Tax Credit

	Prior to July 1996	From 1 July 1996 (Family Support)	From July 1998 (Family Support and Child Tax Credit)
For the eldest child:			
Aged 0 to 15 years	\$42.00	\$47.00	\$62.00
Aged 16 years or over	\$42.00	\$60.00	\$75.00
For each additional child:			
Aged 0 to 12 years	\$27.00	\$32.00	\$47.00
Aged 13 to 15 years	\$35.00	\$40.00	\$55.00
Aged 16 years or over	\$35.00	\$60.00	\$75.00

Source: Inland Revenue Department

Inflation adjusted Family Support

Example: A one-child family which does not qualify for the CTC receives a maximum of \$47 a week in Family Support. If this had been properly adjusted for inflation it would now be \$74.

Family Support and Child Tax Credit

Example: A family with one child under 13 years old has fully lost the entitlement of Family Support of \$2,444 per annum once their income reaches \$30,946. If they also qualify for the CTC, a maximum of \$15 per child per week (\$780 per annum) is abated after Family Support. All entitlement is lost at an income of \$33,546. Thus, a one-child family (with either one or two adults) on the average wage of around \$35,000 pays the same tax as a single person on their own and has the same disposable income.

Family Plus

The 1999 Budget brought in a new package called Family Plus. Family Plus extended the principle that working families are more 'deserving' than those on benefits. It included the Child Tax Credit (CTC) and a new parental tax credit of \$150 a week for eight weeks, following the birth of a child.

Currently all family assistance is tested against joint parental income. There is no special provision in the tax system for sole parents who work, nor is there any recognition of the work of child-rearing, regardless of parental income level. Unlike the Australian scheme (see following), there is no recognition of dependent children over 18.

Because the Family Plus package discriminates against children on the basis of their parents' ill-defined work status, it is against the spirit of the Human Rights Act 1993, as well as the United Nations Convention on the Rights of the Child. In uncertain social and economic times, families require maximum income protection, not further punishment. It is critical that the principle of the 'deserving poor', introduced in 1996, is abandoned immediately.

As well as difficulties defining who is and who is not independent of the state, this kind of targeted assistance is almost impossible to administer. Many families fall in and out of eligibility during the course of a year, as income earners move from work to benefits and back. Because of the complexities of the system there are substantial transaction costs involved for those claiming assistance. Therefore, many of those eligible do not claim their entitlements. In 2001, the IRD could supply no information about how many families were not accessing family tax credits to which they were entitled. The Ministry of Social Development however expressed concern that families were missing out:

. . . fewer families are claiming family assistance than we would expect. The system of tax-based family Assistance does not link well with the benefit system. Without help of this type, it is difficult for people to move in and out of work without falling into the poverty trap of benefit or tax debt, sometimes both (Ministry of Social Development, 2001).

Paid Parental Leave

A new scheme of paid parental leave was introduced in July 2002. Mothers who have been in paid employment with a single employer for 10 or more hours a week for a full year before the due birth receive \$325 gross per week, or 100 per cent of their previous weekly earnings, whichever is lower. About 20,000 women are expected to qualify, at a cost of \$42m. While CPAG welcomes the introduction of paid parental leave as a policy that supports the role of women in the workforce, its impact on child poverty is expected to be limited.

The loss of universal payments

In the 1990s, all universal payments aimed at relieving poverty were attacked as anachronistic, wasteful, and ineffective. Former Prime Minister Jim Bolger focused on the idea that universal assistance meant paying benefits to people who, strictly speaking, do not need them:

I am waiting for someone to provide moral justification, much less economic justification, to tax people on modest incomes so as to pay benefits to individuals or families who don't need them (Bolger, 1997).

It can be argued that universal payments involve mostly income 'churning' (where people pay taxes to receive benefits back). In a universal system, a given amount of money has to be spread thinly to give the same to everyone. The main argument against universal payments is that if that same amount of money was directed only to those that 'need' the payment, the poor will be better off, and the money would be spent more effectively (Boston & St John, 1999). Despite the apparent logic of focusing limited resources on the poor, there is strong evidence that child poverty has actually worsened under a targeted system. In the 1990s, it became clear that the targeting process was actually a means of saving money to fund the tax cuts, whose major benefit flowed to middle and upper income groups (Dalziel, 1999a). Poorer families received less so that better off families could keep more.

Why targeting does not work

Crudely targeted policies do not reflect the actual circumstances of individual children. Children in families who get nothing because parental income falls just outside the eligibility boundary, or receive little because income is close to the boundary, may have difficult circumstances and unmet needs. In many countries, the maintenance of some degree of universal payments for families with children is strongly supported. Universal, 'across the board' assistance recognises that: parents face extra costs at all income levels; that all children share basic rights; and all parents make a social contribution. Conversely, targeted assistance usually has a narrower goal of alleviating poverty. This in turn raises difficult questions about what constitutes poverty, and what level of child poverty deserves assistance.

Targeted family assistance relies on joint means testing. However, there are serious problems with this. Income is often inequitably shared within families. Children are often left dependent on the goodwill of parents to ensure that their allocation is signed over to the caregiver, or the assistance is used for their benefit. Families who fall outside the qualifying income range may also be poor, when housing and other essential costs are taken into account.

Most seriously, targeting necessitates onerous effective marginal tax rates (discussed below) that create a poverty trap that is difficult for families to escape from.

Effective marginal tax rates (EMTR)

As more social assistance is means-tested, there is more to 'claw back' as other income increases. To exclude those above the narrow entitlement range, targeting must be 'tight'.

This 'bleeding out', or abatement, of benefits occurs as other income increases pushes up the Effective Marginal Tax Rate (EMTR). When those receiving income assistance earn an extra dollar, it is taxed and levied for ACC. But it also causes them to lose eligibility for some of their family assistance. This means that the effective tax rate for those on benefits under a targeted regime quickly becomes extremely high - much higher than the current top income tax rate of 39%.

Effective Marginal Tax Rates

Example: A couple with children on an unemployment benefit receive \$327 per week. If they earn over \$80 from paid work, their main net benefit is abated at 70 cents, plus Family Support is abated at 18 cents in the dollar, because their combined income is over \$20,000 per annum. With a 21% tax rate, the loss for each dollar earned over a combined income of \$407 a week is 109 cents, giving a EMTR of 109%.

A couple with children not on a benefit with a combined income of more than \$27,000, including ACC levies, face EMTRs of 46.2% or 52.2%, depending on their individual income. For parents facing student loan repayments, the EMTR may become 62.2%, or even 74.2% for incomes over \$38,000.

Because all family assistance is targeted, high EMTRs apply over long income ranges, especially if there are several children (St John, 2001). There is a dilemma here: lower rates of abatement are expensive and would result in many more people being caught in abatement procedures. This runs counter to the intention of targeting, which is to help only the poorest and keep as many people as possible 'independent' of the state. On the other hand, high rates of abatement result in high EMTRs in a narrow income band, and these provide a strong disincentive to earn that extra dollar. It may also encourage work within the underground economy, which is unprotected by social or labour legislation, leaves workers vulnerable and open to exploitation, and reinforces the social exclusion of those on low incomes.

It is worth observing that a great deal of debate takes place around the disincentive effects associated with the top marginal income tax rate of 39 cents in the dollar, yet to date no political party has shown a willingness to deal with the disincentives inherent in the high EMTRs faced by a great many more, poorer, families.

There are no easy solutions to the targeting dilemma. The more assistance is targeted, the greater the problems. Where there are many non-coordinated abatement provisions, the result is high and arbitrary effective marginal tax rates over long income ranges. Technical solutions to prevent the cumulative impact of overlaps in income tests for different benefits have generally failed (St John & Rankin, 2002).

A universal child payment

The Royal Commission on Social Policy consulted throughout 1987 on the future of the welfare state. The Royal Commission favoured a Carers' Allowance for those doing unpaid caring activities, including caring for children, the disabled, and the elderly. It supported the retention of an increased, indexed, universal Family Benefit:

We strongly favour the continuation of the family benefit as an integral part of a flexible set of income support arrangements for families with children. Financial constraints must affect the amount of the benefit. But it should have more than symbolic significance, and we favour a modest increase in the benefit level together with indexing in line with other indexing proposals (Royal Commission on Social Policy, 1988).

None of the Commission's recommendations for children were adopted. Since that time, only a few voices, CPAG being among them, have been raised in support of the Family Benefit. In the meantime state support for children in low-income families has become increasingly mean-spirited. The restricted criteria for receiving Family Plus provide one example of this.

Bold moves are necessary to repair the damaging effects of targeting. Many advantages would flow from a universal child payment as a first step. CPAG supports every child's right to inclusion in society, secured by universalism in the economic and social treatment of children. The loss of the universal Family Benefit in favour of the targeted Family Support and the discriminatory Family Plus has not improved the situation of children in low-income families.

Universal provisions put the child at the centre of policy. Through the receipt of the benefit, a central register of children can be maintained, and it becomes possible to trace children who might otherwise disappear from the watchful eye of the Plunket nurse, or education system. Such a register may also improve the uptake of additional targeted assistance where it is necessary, by providing a means of contact with the family. Universal payments allow for regular income paid into the caregiver's account. They do not discriminate against children on the basis of a caregiver's income source, or family situation.

Universal benefits foster a sense of social cohesion, recognise social interdependence, are simple to administer, and fair. Under a policy of universal provision, everyone in the community has a stake in the welfare state and therefore an interest in protecting it. The price of universal provision is paying slightly higher tax rates on average and above-average incomes. Generally, the case for universal benefits is strongest when there is a genuinely progressive tax system, but it is a fairer alternative than the poverty traps and very high marginal tax rates created by policies of targeting.

Intergenerational issues

While the universal approach has been abandoned for the working age population and their children, it is in full force for the older population. Since the abolition of the surcharge in 1998, New Zealand pays a universal pension to everyone over 65 years old, regardless of wealth and income.

There is a large degree of redistribution towards the better-off in retirement. Although the pension is taxable, a single, well-off person over 65, taxed at the highest rate, receives a net weekly pension of about ten times the value of the child tax credit, and about three times the amount available to pay for the care and support of a child in the poorest family.

Moderately well-off and high wealth superannuitants gained a double advantage from the reduction in the middle rate of tax from 28% to 21% in 1996-98 and the removal of the surcharge. Few retired people earn income taxed at the highest rate of 39%, as it is easy to avoid. A couple over 65, who both have incomes of \$38,000, has gained a total of \$385 a week extra since 1996 (St John, 2001). This gain should be contrasted with the very modest CPAG suggestions for improved weekly assistance for children.

The establishment of the New Zealand Superannuation Fund is likely to make it extremely difficult to challenge the contrast between universal pensions for the old and highly income-tested payments for the young. The fund is being presented as the way to guarantee pensions for the future. Increasingly, the obligation to pay into the Superannuation fund will constrain the ability of government to increase either social welfare benefits or family payments. While there may be good arguments to support fiscal prudence, and the fund may prevent further damage done by tax cuts, intergenerational issues have been ignored. One outcome of the superfund may be the neglect of the increased numbers of children living in poverty.

Reducing the pension, or making payment of it conditional on means-testing, would not solve the problem. The pension is a success story, as it has removed most of the elderly from poverty. An attack on the old cannot help the young. However, we suggest it is unjust to apply the principle of universality so selectively.

International comparisons

United Kingdom

The Child Poverty Action Group in the United Kingdom was very influential in ensuring that the child benefit was not abolished, or amalgamated with other income-tested assistance, as it has been in New Zealand. In 1998, Prime Minister Blair said:

Giving a child the best start in life takes more than money, but it cannot be done without money. And I believe that the child benefit remains the fairest, the most efficient, and the most cost-effective way of recognising the extra costs and responsibilities borne by all parents. And raising it allows us to do more for mothers who choose to be at home, working at home to bring up children (HM Treasury, 1998).

The 2002 United Kingdom budget included a whole chapter devoted to creating a fairer society:

Since 1997, the Government has placed welfare reform at the heart of its strategy for promoting fairness and inclusion. A modern welfare state is the means to ensure that everyone in society has an equal chance to share in rising national prosperity. Tackling childhood disadvantage is particularly important because childhood experience lays the foundations for later life. Children growing up in low-income households are more likely than others to have poor health, perform badly at school, experience unemployment as adults or earn lower wages. The Government is therefore committed to halving child poverty by 2010 and abolishing it within a generation (HM Treasury, 2002).

In the United Kingdom, the child benefit is approximately £16 per week for the first child, and £10 for each subsequent child. The contrast to New Zealand can be readily seen. In New Zealand, a family with three children under 13 on the average household income of around \$45,000 gets no assistance at all from the state on account of their children, and even loses access to the health care subsidies provided by the community services card. In Britain, this family would have free visits to the doctor and £36 per week in universal child benefit.

The United Kingdom has also had substantial working family tax credits for families who spend at least 16 hours a week in work. Families with children on benefits get other assistance. The tax credit is set for six months ahead and does not disappear if income increases over this time.

The United Kingdom is currently introducing a new Child Tax Credit, but very different from New Zealand's. It treats all children the same and **does not differentiate on the work status of parents.**

There will be a common framework for assessment, so that all families are part of the same system and poorer families do not feel the stigma associated with the current forms of support.

With the universal Child Benefit, there will be £26.50 a week for the first child for the 85% of families with an income less than £50,000 a year; and £54.25 a week for the first child in families with an income of less than £13,000 a year.

The CPAG (United Kingdom) has strenuously argued that there are innumerable benefits associated with having a universal payment for all children. These include:

- a secure source of income that stays with the care giver of the child at times of family breakdown;
- certainty of payment, as the amount does not reduce with earned income;
- control of this amount by the caregiver, reducing problems of lack of sharing of family income;
- very high take-up rates, in contrast to income tested measures;
- the facility to maintain a national register of all children;
- eliminating the stigma associated with targeted state assistance.

While the government has indicated that it would like to tax the universal benefit for children, so far this has not happened. CPAG (United Kingdom) have mounted compelling arguments for leaving it untaxed, and it is likely to remain so (see <http://www.cpag.org.uk>).

Australia

In Australia, twelve complex assistance measures for families with children were replaced in 2000 by three major new payments. The new system retains the characteristics of the Australian system since 1997, when the fully universal family allowance was changed to eliminate its payment to high-income families. The effect of this change was small, removing payment for only about 6% of all children.

The ongoing reform in Australia has moved that country towards a more equitable system for children. There has been far less of the ideological overtones apparent in the New Zealand system. Family payments are adjusted each year for inflation, as are the thresholds from which abatement applies.

Thus, since the last edition of this report, payments and income levels for abatement have been raised significantly with the 2002 rates given below. In contrast, family tax credits in New Zealand have not been adjusted for more than six years and income levels have not been adjusted for over a decade.

Family Tax Benefit Part A

This part of the Australian tax credit pays a maximum amount of A\$61.50 per week for each child under 13 years old, and different rates for children over 13 and up to 24, if dependent. For income over A\$29,857, this tax credit reduces by 30 cents in the dollar until the basic rate of \$19.74 per child under 18, per week is reached. Only when family income reaches a high level, (A\$77,234 for a one child family, plus A\$3,139 for additional children) does this payment reduce gradually to nil.

Compared with the levels of family support and abatement in New Zealand, this is generous. Unlike New Zealand's tax credit arrangements, there is no attempt to differentiate between the 'deserving' and 'undeserving' poor. Moreover, the additional tax credit described next is more far-sighted than any changes New Zealand has introduced.

Family Tax Benefit Part B

This gives extra assistance to single income families, including sole parents, especially those with young children. The maximum weekly rate when the youngest child is under five years old is A\$52.78. If the youngest is aged between five and 18, it is A\$36.82. Only the caregiver's income is taken into account, so that a parent who stays home to look after their children, and has annual income under A\$1,679 qualifies for the maximum payment. It abates by 30 cents in the dollar for income above that level.

Parents will still receive partial payment until their income is A\$10,853 (for a youngest child under five, reducing to A\$8,079 for a youngest child aged between five and 18). Sole parents are entitled to the maximum amount of Family Tax Benefit Part B regardless of income.

Summary

The extreme emphasis on targeting since the early 1990s has been damaging for children and their parents. A better balance of universal and targeted provisions is needed. It is time for an appreciation of the advantages that would flow from a universal child benefit. An awareness of discrimination in policy design is less likely if a child focus is taken. Automatic CPI indexation of all child related payments is of paramount importance.

As in the United Kingdom, the goals for the eradication of child poverty should be stated explicitly. In light of the impending retirement (2010-2030) of the baby boom population, and the demands that will impose, it is not too ambitious to adopt the goal of eradication of child poverty in New Zealand by the year 2010. Indeed, it is in the best interests of the baby boom generation for this to happen, in order to ensure that the workforce of the years 2010 and beyond is healthy and productive.

Recommendations

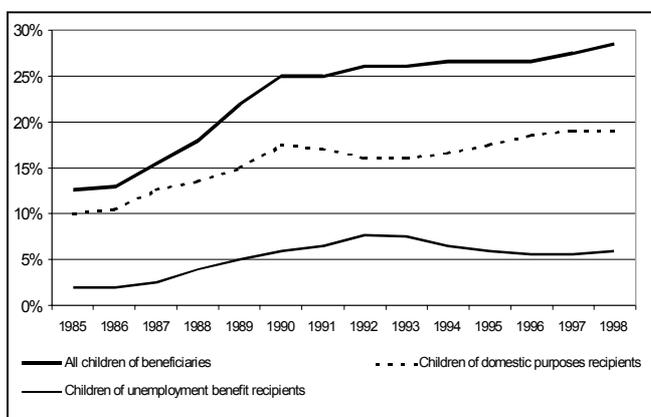
1. Immediately extend the Child Tax Credit to ALL children of low-income families.
2. Abandon all discriminatory aspects of the Family Plus package of benefits.
3. Adjust all family assistance payments for past inflation, and index.
4. Place an obligation on the IRD to ensure families access their tax credits.
5. Implement a mixture of universal and targeted provisions, with a focus on children, to minimise the trap of high EMTRs.
6. Make a significant universal child benefit part of medium term policy.
7. Encourage public discussion about inter-generational issues and income distribution.

5. Changing structures: families and work

Changing family structures are part of the picture of persistent child poverty in New Zealand. Over the past thirty years the traditional nuclear family, with children living their entire childhood with their two parents, has become less common. While almost 70% of all children continue to live in households with two parents, there are now more one-parent households, extended family households, families sharing accommodation, and more children living with at least one adult who is not their biological parent.

The percentage of children living with a sole parent increased from 26% in 1991, to 31% in 2001. Children in those one-parent families are significantly more likely to be living in low-income households - overall only 6% of two-parent families with child(ren) had an annual income of \$20,000 or less, compared with 61% of one-parent families with child(ren) (Statistics New Zealand, 2001a).

Figure 8: Children of benefit recipients as a proportion of children under 18 (1985-1998)



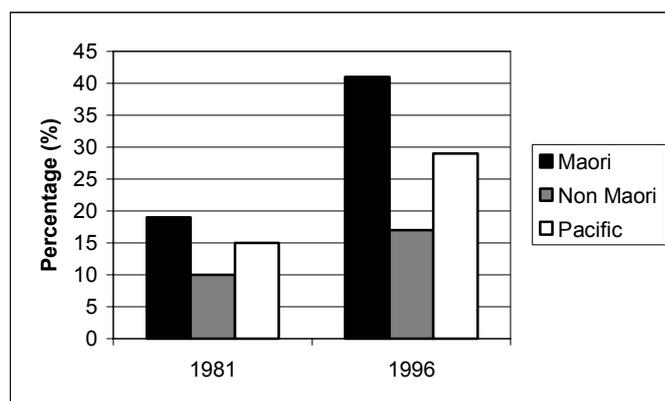
Source: Ministry of Social Policy, 2000

The numbers of children in households receiving their major income from a benefit has more than doubled since 1985. There are now over 300,000 children supported in households receiving a benefit, almost one-third of all children (WINZ, 2001). Around 80% of these children are children of DPB, Unemployment and Sickness Beneficiaries with those on the DPB by far the largest subgroup. (WINZ, 2001). The reforms of the 1980s and 1990s were designed to reduce the numbers of people on benefits, but in reality those policies failed dismally, and beneficiary numbers have soared.

Parenting alone

There has been a significant rise in the numbers of children being brought up in sole parent families (see Figure 9). A study of a group of Christchurch children born in 1977 showed that by the time they had reached 16 years old, over one third had experienced some time in a sole parent household. By far the most common reason (79%) was parental separation and divorce (Fergusson, 1998). One child in 20 in a sole parent household has a widowed parent. Widowed parents tend to be older than average, with 80% being 50 – 64 years old. The fastest growing group of children in sole parent families are those with a parent who has never legally married. This group made up 44.4% of all children in sole parent families in 1996 (Fergusson, 1998).

Figure 9: Proportion of children under 15 living in sole parent households



Source: Department of Social Welfare, 1999; Statistics New Zealand, 1999a

There is a common misconception that many sole parents are very young women – in fact, only 2.5% of sole parents are under twenty, and only 1.9% of sole parents began receiving their current benefit when they were under 20 years old. Over two-thirds of sole parents live apart from former partners, either married or de facto. Sole parents are predominantly female; one in 10 women (147,855) is a sole parent (Ministry of Women's Affairs, 2002); 10% of children with a sole parent live with a sole father (WINZ, 2001). In 2001, 74% of DPB recipients had been on the benefit for more than 12 months, and 23% for more than five years.

Children in sole parent families often live in households where there are other adults. Extended household arrangements are common for Maori and Pacific sole parent children, especially young children.

This was true for 49% of Maori babies under one year, 35% of Pacific Island babies and 14% for babies of Pakeha and other ethnic groups (Department of Social Welfare, 1999).

The Ministry for Social Development notes that the number of non-traditional and extended families will continue to grow, although at a slower rate than the last 30 years (Ministry of Social Development, 2002a). It is clear that greater numbers of sole parent families and diverse family structures are likely to be features of 21st century New Zealand.

The income gap between sole parent and two parent households has widened since 1988. This is confirmed by the findings of the *2000 Living Standard Survey*, which identified sole parents with dependent children, those on income-tested benefits, and Maori and Pacific Island families with children as being at-risk of low living standards. A number of factors have been important in this widening gap, as Work and Income New Zealand explained:

On 1 April 1989, the benefit rate for sole parents with one child (who made up 55 percent of sole parents on DPB at that date) was increased by less than the rise in price inflation. This was done to restore relativity with the rates for those who had two or more children. Secondly, there was a decline in the employment rates of sole parents between 1986 and 1991, and DPB numbers increased by 55 percent over that period. Thirdly, the real value of family assistance declined over the late 1980s and early 1990s (Department of Social Welfare, 1999).

The report goes on to note that while real incomes of two-parent households with children have risen above 1988 levels, this has not been true for sole parent households:

This is despite the rise in the employment of sole parents between 1991 and 1996...This suggests that in many cases, part-time work is [merely] making up the shortfall of income from benefits since the rate reductions in 1991 (Department of Social Welfare, 1999).

Child support: Liable parent contribution

Undoubtedly, the way income support is arranged for children after separation and divorce, as legislated in the Child Support Act 1991, has been

a significant contributor to family hardship. For families where no DPB is being received, these matters are usually resolved in the courts or by private arrangement.

For sole parents supported by the DPB, the state demands a contribution from the other parent, which is then used to offset the DPB cost to the government.

Except in some limited circumstances, mothers applying for the DPB are expected to name the father regardless of how difficult this may be for them, or how it may impact on their life and that of the child. Under the Social Security Act, the penalty for not naming the father is a \$20 per week reduction in the DPB payment. The number of women whose DPB payment is reduced because they could, or would, not name the father of their children has increased by nearly 1,000 per year since 1994. About 14,000 sole parents and their children are affected by this penalty. However, criticism in the media of the Child Support Act has ignored these children, focusing instead on the financial imposition avoidance by liable parents imposes on taxpayers.

Any money collected on behalf of children whose parent is on a benefit automatically goes to the state and does not enhance the welfare of the child at all. CPAG believes any contribution from the non-custodial parent should result in at least some increased income for the child, as happens in Australia.

The Child Poverty Action Group has drawn attention to the punitive nature of child support (Child Poverty Action Group, 1998, 2000). There is often no feeling of involvement by the non-custodial parent, usually the father, because their contributions, which may be a substantial amount, do not make the children any better-off. The contribution can be so impoverishing that direct gifts to the child are out of the question. It can also compromise the ability to provide accommodation for the child as part of access arrangements. As Keith Rankin notes:

Within New Zealand, households receiving remittances (classed as gifts) qualify for income-tested benefits/supplements that they would not get were the remittances classed as income. On the other hand, those who pay remittances get less income support - in some cases much less support - than is appropriate for their often very low levels of disposable income (Rankin, 2000).

Child Support

Three quarters of custodians (the person who has legal custody of the child/ren after a relationship breaks up) are Domestic Purposes Benefit recipients and have their child support paid to the Government to offset their benefit. The majority of child support-paying parents earn less than \$30,000 per year. *Approximately 25% of paying parents are beneficiaries.*

Child Support payments are based on taxable income, number of children and the circumstances of the liable parent. The maximum income considered (2002) is \$86,648. The formula used for child support payments is taxable income, less living allowance: 18% for one child, 24% for two, 27% for three, and 30% for four or more children. The living allowance varies from \$11,994 to \$30,248 depending on the family and marital circumstances of the paying parent.

While no other part of the welfare system that directly affects children is indexed, in 2001 the government decided to index the minimum child support paid to the Crown by liable parents:

The Child Support Amendment Bill increases the minimum rate from \$10 a week to \$12.75 a week or \$663 a year from 1 April 2002. The minimum rate has not been adjusted since it was set in October 1990. The increase reflects the actual and expected movement in the Consumer Price Index from March 1990 to March 2002. In the future the real value of the minimum payment will be automatically maintained. About 79,000 liable parents would be affected by this change (Treasury, 2001a).

This selective approach is inconsistent. If it is equitable for liable parents' contribution to be indexed it is also equitable for Family Support to be indexed (St John, 2001).

Children are innocent parties in sometimes bitter wrangles based on meeting the economic needs of adults. The true costs of adequately addressing the needs of the child, and how these are best met, are seldom debated. Research into the economic costs of children was encouraged as part of the Trapski report reviewing Child Support, yet these recommendations have never been implemented. Key points referred to a new formula and framework for the assessment of incomes, including anti-avoidance measures, and provisions for challenging decisions on a case-by-case basis (Trapski, 1994).

There are genuine problems with the Child Support Act. Improvements to the child support formula should be made, especially for those who are self-employed. While avoidance of parental responsibility cannot be condoned, at the very least changes are needed so that some of the child support paid to the government is used to directly improve children's lives.

Work and participation

In New Zealand, paid employment has become the key to citizenship. The high percentage of women in poverty and the exclusion of women from full-time paid employment, are major factors in the exclusion of women and their children from power in society. As the main caregivers, the economic position of women has a direct impact on children. Unpaid work is the unacknowledged and invisible other half of the world of women. It is this essential caring and domestic activity that enables the continuation of the paid work sector, and of society as a whole. The nurturing and education of children and young people is central to this unpaid work contribution. At the same time, unpaid work reduces the amount of income accessible to women and consequently accessible to children.

In recent years rising housing costs, tightened benefit eligibility, and a growing incidence of user-pays for education and health, have put more financial pressure on parents. For many, job flexibility has meant increased job insecurity, falling real wages and unfriendly family hours. In common with the United States and Great Britain, these conditions have been instrumental in the emergence of the "working poor" in New Zealand. Low wages, combined with high marginal tax rates on state assistance, and user-pays health and education diminish the ability of parents to provide a positive and healthy environment for children.

Child care

A New Zealand early childhood survey found that poor access to early child education (ECE) and out-of-school care was a barrier to participation in employment for 30% of sole parents and 12% of parents from two-parent families (Department of Labour, 1999). Particularly affected by access were those parents earning \$20,000 or less, and parents working part-time.

The main reason that early childhood education and care was not accessed by those who wanted to participate in employment, unpaid work, and training were the costs of arrangements, lack of informal care by someone known and trusted, lack of suitable or flexible hours of ECE and care, and lack of local services (Department of Labour, 1999).

In the survey, 60% of children under five had at least one ECE or care arrangement, and the proportion increased with the age of the child. Income and employment were associated variables, with 74% of children from higher income families using ECE and care, compared with 52% from lower income families.

Unpaid or informal care was used for nearly a third of all children under five years with care arrangements (45,000 children) and for 60% of school age children (Department of Labour, 1999). Children in major centres have some options of high quality, low cost holiday and after school programs – there is in fact a growing market in holiday programs from a range of providers, at a range of prices. Use of formal or paid school holiday care was highest (80%) among children from sole parent families where the parent was employed (Department of Labour, 1999). Other issues pertaining to early childhood education are discussed further in Chapter 8.

Parenting alone and employment

New Zealand has low rates of participation of sole parents in full-time paid work. In 2001, the part- or full-time labour-force participation rate for sole parents was 48%, up from 36% in 1996 (Statistics New Zealand, 1999a). Although partially explained by the benefit cuts of 1991 and the introduction of 'workfare' and the 'Community Wage' concept in 1998, this increase in participation was probably due to the improved jobs market. In 2002, the Labour-led Government, in recognition of the shortage of suitable employment opportunities, and the negative effects of 'workfare' on children and families, made improvements to the regime. To assist sole parents to return to the workforce, the 2002 Budget allocated approximately \$36.6 million for extra childcare (OSCAR) funding *over four years*. The Social Security (Personal Development and Employment) Amendment Act 2002 removed formal work-testing and reduced the anomalous treatment of work-tested sole parents in the abatement regime.

However, the Act did little other than to re-emphasise work as the answer to poverty. A child focus is missing from this legislation; in fact the benefit cuts that apply in the event that a sole parent refuses to comply with the provisions of the Act have the potential to impact negatively on children, even though they have no control over the situation.

All DPBs and widows now have an improved abatement regime for income earned between \$80 and \$180 a week, but even this creates high Effective Marginal Tax Rates. The first \$80 gross earned per week incurs no abatement of the benefit. However, any special benefit entitlement is reviewed, and the accommodation supplement falls by \$20. After \$80 a week, a DPB recipient can earn a further \$100 with abatement of their benefit set at 30 cents per dollar earned (instead of the 70 cents abatement applied prior to the change in 1996).

After tax, benefit abatement, and the ACC levy, income between \$80 and \$180 per week is reduced at a total rate of 52.2%. With the abatement of Family support, this EMTR rises to 70.2%. Above income of \$180 a week, the EMTR becomes a punitive 92.2% or 110.2% with abatement of Family Support. Repayment of a student loan (a further 10%) will also be required, once gross income exceeds \$15,496. This abatement regime represents a significant barrier to sole parents taking up paid work.

The abatement regime also explains why sole mothers in employment are more likely than partnered mothers work more than 30 hours per week. Working part-time while receiving a benefit incurs harsh penalties, which, combined with childcare costs, make this option unattractive. Either full-time employment, or earning a maximum of \$80 per week, is the real choice. Moreover, if any income-tested benefit is being received, the children of sole parents are ineligible for the Child Tax Credit – a particularly harsh and punitive arrangement. Given the way in which child care subsidies, the Community Services Card and the new income-related rent subsidy are abated, the low employment rates of sole parents, and the associated economic hardship, can be expected to continue.

Training

Government training schemes provide no guarantee of work. An example of appropriate assistance is that given to Domestic Purposes

Beneficiaries whose educational entitlements under the Training Incentive Allowance (TIA) include Universities and Technical Institutes, not just employment schemes. Importantly, fees, texts and some childcare costs are included in the coverage. This has enabled many trained women to move off the benefit once children are more independent, into either part-time or full-time employment.

A report by the Department of Social Welfare showed that 74% of women acknowledged that knowing about the TIA helped them decide to do a course, and 44% said they would not be doing the courses without the allowance (Department of Social Welfare, 1996). Significant training support, such as training for a profession, has the most positive outcomes:

. . . educational upgrading for an unemployed person is increasingly recognised as the best investment in a world of rapidly changing skill needs (Lerner, 1997).

Similar results have emerged from research on vocational training in the United States confirming that job-specific training is an effective way of assisting sole parents and the unemployed back into the workforce. Despite these findings, the costs of training still outweigh the funding provided and, together with childcare and transport, form a barrier preventing some parents from beginning or completing training. Fear of debt, and of repayments associated with student loans are further disincentives. Parents who receive a student allowance receive much less in total, including supplementary assistance, such as the Accommodation Supplement, than parents on major benefits.

Given the Government's commitment to a knowledge economy, and its stated concern with child poverty, it seems obvious that any funding that assists parents to train for worthwhile, well-paid employment in order to better support their children, can only be viewed as money well spent.

Recommendations

1. Amend the Child Support Act to ensure that children receive some direct benefit from the liable parent contribution.
2. Increase support for the transition into paid work for beneficiaries and review the current punitive EMTR clawback regime.

PART THREE

6. Housing

Housing plays a critical role in the health and wellbeing of children. The home is where children spend the most formative period of their lives.

In 1991, there was a sharp shift in housing policy, from a long history of benign, highly regulated, state support to a market-based approach. More recently, the Government has sought to temper the market approach to housing policy, but many aspects remain.

Housing policy in the 1990s was driven by ideology rather than a careful appraisal of what is best for children. The outcome has been increasing housing problems for one in five families, with those on the lowest incomes, and especially families with children, bearing the heaviest load.

The state housing sector since 1990

When the Housing Corporation of New Zealand was restructured in 1992, the company owned nearly 70,000 rental units (Housing Corporation of New Zealand, 1990). By 1999, this stock of rental housing had been reduced to less than 59,000 units (Housing New Zealand, 1999).

In the 2002 Budget, \$262 million was committed for the building and/or acquisition of 1,500 new state houses over the next three years (Treasury, 2002). At the same time, the waiting list for families needing or wanting a state house stood at over 11,000, with 4,000 of these families being judged to have a high or urgent need. At this level of commitment it will take over 20 years to replace the 10,000 houses sold by Housing New Zealand.

The Accommodation Supplement was introduced in 1993. Predictably, this subsidy fuelled rapid increases in rents and left many tenants materially worse off than they had been under the old system (Friendship House, 1997). It has also become increasingly expensive for taxpayers. In 1993 the Government spent \$352 million on the Accommodation Supplement. By 2000 this had risen to \$868 million (Treasury, 2000). This figure has fallen since the Government introduced income-based rentals for state houses.

Not only have the housing reforms of the 1990s been fiscally expensive, they are associated with deteriorating housing conditions for the poorest New Zealanders. In addition, during the 1990s, homeownership levels dropped for the first time since the 1940s, as housing costs rose faster than incomes.

Inevitably, problems of overcrowding have arisen. Research indicates that the most severely affected have been Maori and Pacific children (Maori Women's Housing Project, 1991; Murphy & Cloher, 1996; Paparoa, 1994; Te Puni Kokiri, 2000a). There is now evidence that problems of overcrowding and affordability have led to the increasing transience of families, and with this, diminished educational opportunities for children already at risk of failure within the education system. The social impact of overcrowded housing has been evidenced in the increasing incidence of diseases such as meningococcal disease and tuberculosis in South Auckland. Inadequate housing has been directly responsible for the death of children through fires in makeshift shacks in rural areas. A widespread cycle of social disadvantage, reinforced by housing poverty, has reappeared into New Zealand society for the first time since the 1930s.

Declining home ownership

Home ownership is still most New Zealanders' preferred option. A report by Te Puni Kokiri found that Maori believe home ownership gives them 'a turanga-waewae or a place which establishes where a person belongs' and 'satisfies a desire for roots, security and stability for themselves and their whanau' (Te Puni Kokiri, 1998). Despite this, Maori home ownership rates are well below that of non-Maori. The desire for one's own home is understandable when ownership traditionally offers benefits not available from rental accommodation, including in some instances, lower costs.

However, the removal of state mortgage assistance, and dramatically increased house prices in areas such as Auckland, means that home ownership is no more than a dream for many families.

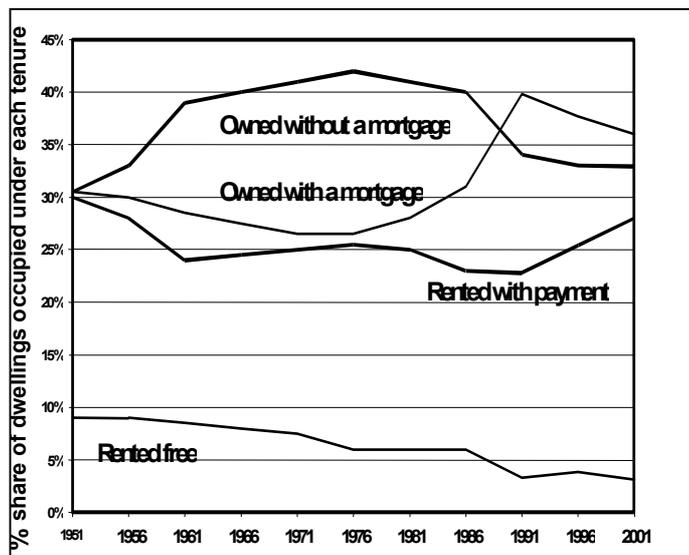
For those on low incomes or reliant on benefits, high rents make saving for a deposit impossible. This situation is exacerbated by other factors such as job insecurity, financial uncertainty and extended family obligations.

High interest rates, and substantial deposit requirements also put home ownership beyond the reach of many New Zealanders. Sweat equity options, where the future owners' labour is recognised as a deposit, are rarely available.

Between 1986 and 1996, children became less likely to live in a home owned by the occupants. The proportion of children in sole parent families living in homes owned (with or without a mortgage) by their parent fell from 52% in 1986 to 44% in 1996 (Statistics New Zealand, 1999a). The proportion of children in two parent families living in homes owned by their parents also fell, from 78% in 1986 to 75% in 1996. These figures emphasise the widening gap between sole and two parent households. There are also considerable ethnic differences. Over half of Pacific children, just under half of Maori children, over a quarter of Asian children, and a fifth of Pakeha children lived in rented homes (Statistics New Zealand, 1999a).

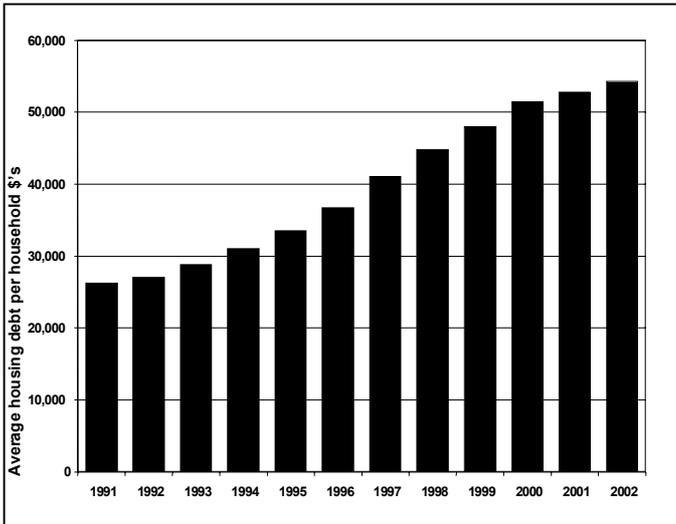
Figure 10 shows the changing tenure patterns in New Zealand's housing sector for the 50 years to 2001. The rapid increase in mortgaged homeownership between 1986 and 1991 coincided with the liberalisation of financial markets. The offsetting decline in debt free homeownership over the same period may have been a portent of rising household debt, which is shown in Figure 11. From 1991, declining levels of home ownership have been matched by an increase in the number of households renting.

Figure 10: Changing tenure in New Zealand's housing sector 1951-2001



Source: Royal Commission on Social Policy, 1988; Statistics New Zealand.

Figure 11: Housing related debt per household 1991-2002

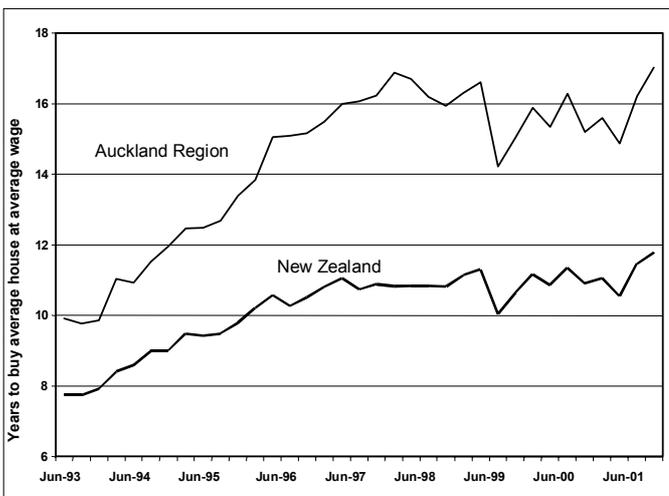


Source: Reserve Bank of New Zealand, 2002

The household debt figures in Figure 11 indicate a doubling of inflation-adjusted household debt over the past 10 years. This increase may in part be due to more flexible financing structures, which have allowed households to secure consumer debt against the equity in their home. However, it is more likely to be due to increasingly expensive houses (fuelled in part by immigration), and the willingness of households to take on higher levels of debt to finance them.

Figure 12 below shows the increased time it now takes someone earning the average wage to buy an average house.

Figure 12: Years to purchase an average house at the average wage 1993-2001

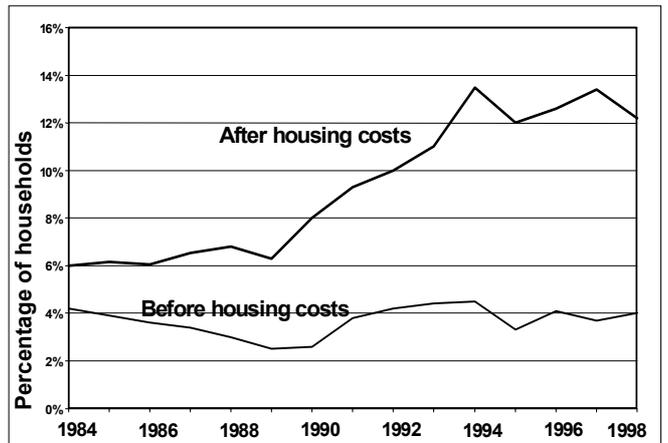


Source: Data sourced from Valuation New Zealand, Quotable Value; Statistics New Zealand

Housing related poverty

The spread of housing related poverty is shown in Figure 13, as measured against a poverty line set at 50% of the median household income. It indicates how the incidence of poverty is directly affected by housing costs, and how this incidence rose sharply during the early 1990s. Contributing factors included the 1991 benefit cuts, the introduction of market rentals for state houses, and rent rises in the private sector following the introduction of the Accommodation Supplement.

Figure 13: Incidence of poverty at 50% of median income threshold 1984-1998



Source: Mowbray, 2001

While many low-income families are spending more than half their income on housing costs, the percentage is significantly less for those who own their homes (Milne, 1998; Murphy, 1999; Stephens et al., 2000). To pay for housing, many families cut back spending on other essential items such as food, health and clothing.

The Labour-Alliance Government introduced income related rents for low-income, state house tenants in December 2000. Although this assisted more than 50,000 families living in state houses, more than 150,000 low-income families, and over 200,000 children renting in the private sector and facing similar financial hardship, did not benefit. The Accommodation Supplement remains the sole mechanism for the delivery of housing assistance to them. As discussed below, aspects of the new policy reinforce rather than diminish the poverty trap, and discourage, rather than encourage, self-help.

Overcrowding

The “market response” of families and households faced with expensive housing is to “economise” by crowding in or making use of informal housing, such as sheds, garages and caravans.

Such responses shift the housing problem out of sight, and give the illusion that market based policies are effectively dealing with housing demand.

Research by Solomon estimated that almost 9% of children in the Auckland area live in overcrowded accommodation. His research identified the concentration of this problem in South Auckland, where over 10,000 children live in overcrowded housing. Pacific families and, in particular Pacific children, were worst affected; an estimated one in three Pacific children living in Auckland lives in an overcrowded house. Further, his research showed that the level of overcrowding appears to be getting worse for Pacific children, while it is improving for other children (Solomon, 2002).

Health Effects from overcrowding

The effects of overcrowding on a child’s health are difficult to isolate from other contributing factors such as inadequate nutrition and limited access to primary health care. However, it is clear that overcrowding makes children more susceptible to communicable diseases and is a major factor in poor health outcomes.

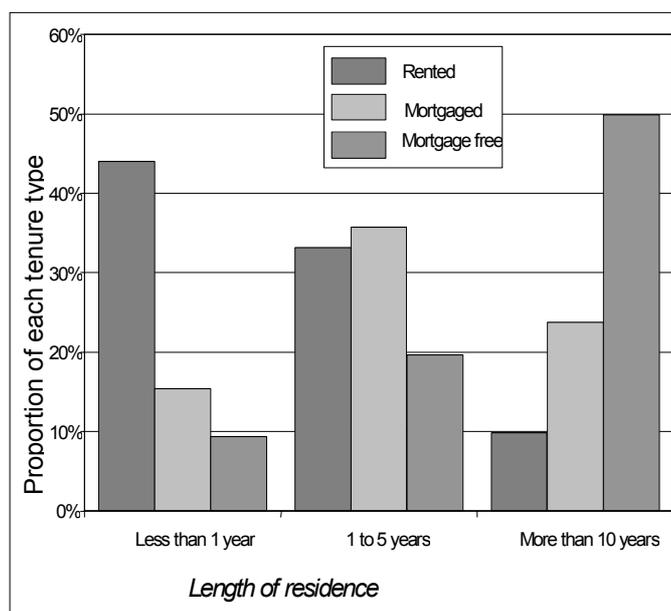
This is particularly apparent in South Auckland and Northland where rates of meningococcal disease are the highest in the industrialised world. The Counties-Manukau rate was twice the national average for children under one year old, and two and half times the national rate for children aged between one and 14 years. Other diseases such as cellulitis, rheumatic fever, and tuberculosis were also more prevalent in areas with severe overcrowding (Counties Manukau District Health Board, 2001).

A major study looking at the health risks associated with overcrowding identified six factors related to an increased risk of developing meningococcal disease, regardless of ethnicity. The single most important factor was the number of adolescents and adults per room living in the child’s house. The report found a child living in a six-roomed house with three adolescents or adults had a 50% greater risk than a child living in the same house with two adolescents or adults (Public Health Advice, 2000).

Transience

During the 1990s, there was a noticeable increase in the mobility of households, consistent with the increased number of families renting. As Figure 14 shows, tenant households are more mobile than owner-occupier households. In turn, private sector tenants move more frequently than state tenants (Statistics New Zealand, 2001b). This suggests that housing policies that provide stability are lacking.

Figure 14: Residential mobility by housing tenure 2001



Source: Statistics New Zealand, 2001b

Transience is a major barrier to children’s educational achievement. Children take time to settle into a new school, and it takes time for teachers to identify and address the new child’s learning needs. Because of these delays, children who shift houses and schools frequently quickly fall behind their peers at school, and this creates ongoing problems in their learning.

Transience Research

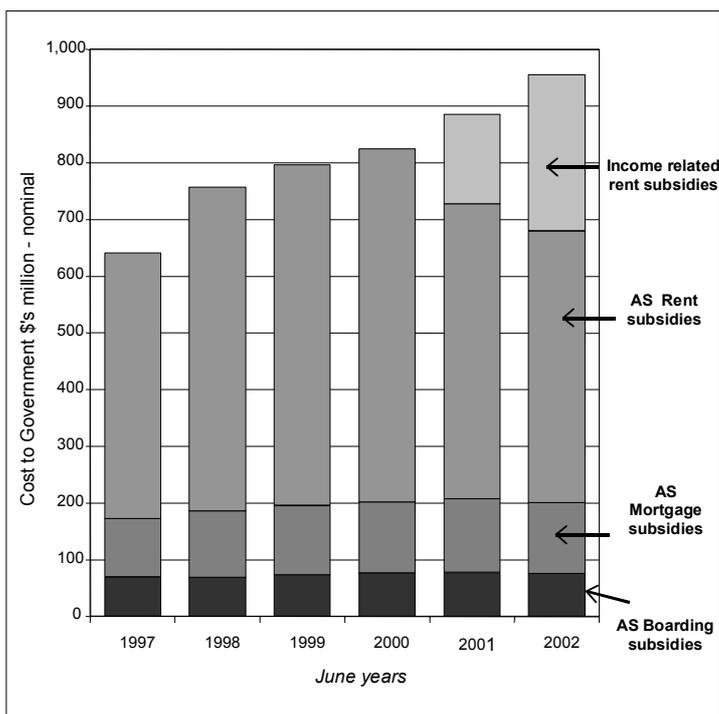
In 2002, a CPAG research survey of 59 South Auckland primary schools found that nearly one third of children in decile one schools (the poorest schools) were likely to change schools in any given year. This was twice the rate of transience in schools which are decile three or higher, and is correlated to the tenure of their housing (Johnson, 2002).

The costs of housing assistance

The Accommodation Supplement is now factored into property values and into both landlords' and tenants' expectations. Accommodation Supplement subsidies (rent, mortgage and boarding) cost taxpayers around \$680 million a year, in addition to the \$275 million for income related rents (Treasury, 2002). The costs of these housing subsidies are shown in Figure 15.

Given present policy settings, and current population growth, it is likely that the cost of the Accommodation Supplement will continue to rise. Under modest growth rate assumptions, the cost of Accommodation Supplement rent subsidies is likely to grow from to \$480 million in 2002 to \$750 million per year by 2010. The bulk of this growth will be in Auckland.

Figure 15: The cost of housing assistance, 1997-2002



Source: Department of Work and Income New Zealand and Housing New Zealand Corporation

The formula used to calculate eligibility for the Accommodation Supplement includes household income and assets, level of rent, location, and composition of household. If a beneficiary earns up to \$80 a week, they lose up to \$20 of the Accommodation Supplement. With tax and ACC levies, they pay an effective marginal tax rate of 47.2%. After that, there is no further abatement of the Accommodation Supplement.

However, for low-income, non-benefit recipients, abatement of 25 cents in the dollar applies from a low-income level until the whole of the Accommodation Supplement disappears. Other penalties may also apply, such as the loss of entitlement to the Community Services Card, loss of childcare subsidies, loss of Family Support, incurring possible child support payments, and student loan repayments. High levels of abatement, plus tax, ACC levies on earned income, and other abated measures create a very effective poverty trap for low-income working families.

This trap is intensified by the asset test on the Accommodation Supplement. Household savings may be insufficient as a deposit on a home-purchase, and be held as capital. This may reduce eligibility for the Supplement. For example a sole parent/married couple can hold just over \$5,000 in cash savings before the Accommodation Supplement is reduced by 25 cents for each extra \$100 held. This effectively penalises efforts to become independent and achieve home ownership.

For families in state houses paying income-related rents and earning over \$27,000, every extra \$1 earned will cost 38.9 cents in reduced rental subsidy, 30 cents in reduced family support and 22.2 cents in tax and accident compensation levies - a total of 91.1 cents. If the earner has a student loan, a further 10 cents in every dollar is deducted. It is hard to imagine how such a family could ever save for a deposit on their own home.

Options for the future

The Government now faces a stark choice. It may continue with its minimal state house building programme and accept the rising cost of market based rent subsidies through the Accommodation Supplement, or recognise the need to make significant investments in new housing, particularly in Auckland.

Estimates based on Statistics New Zealand's household projections, and an assumption that dependency rates will remain constant, suggest that an extra 3,000 households each year will require state assistance with their housing. Of these, 2000 will live in Auckland.

It will cost the Government \$150-200 million a year to meet just half of the Auckland demand. \$200 million for new housing for poor families seems a modest outlay compared with the \$1,200 million the Government plans to put aside in the 2002/2003 financial year into the New Zealand Superannuation Fund, or the budgeted Government surplus of \$2,600 million.

It is not simply a matter of more money, but of more houses as well. The recent purchase by Government of Auckland City Council's rental housing stock for \$83 million did not increase the housing available to low-income families and households, it merely changed the landlord. This is also true of much of Housing New Zealand's modest stock acquisition programme. For example, in 2002/03, Housing New Zealand is intending to purchase 350 existing houses and 180 new houses through its planned state house acquisition programme. In Auckland, the company will buy 139 new and 206 existing units in a region where the shortage of affordable housing is already severe. The purchase of existing housing for state rentals actually reduces the housing opportunities for poor families not eligible for a state house.

Third sector housing

The provision of a wider range of housing opportunities for low-income families and households should become a Government priority. While some initial work has been done on planning for low-income home ownership lending programmes and community-state housing partnerships, little has eventuated to date. There is considerable value in supporting home-ownership for low-income families, especially those who may be described as the "working poor" - families who earn little more than a benefit but who face high levels of abatement on state assistance. Low-income home-ownership programmes would build more stable communities and provide more stable homes for children.

Such programmes directed at state tenants may also be a way of radically reshaping the purpose and public image of state housing. The present system, with its aggressive abatement of rent subsidies as people move off benefits actually acts as a disincentive for state tenants to move into paid employment, where this is available. This results in state housing being portrayed as "welfare housing", and makes political support for a public housing programmes unfashionable.

Public housing should be seen as key component in moving families out of housing related poverty into a stable family environment, and towards a future that is outside of the direction and control of the state. This can be done by offering home-ownership opportunities to long-term state tenants and by then offering the vacated state houses to families with urgent housing needs.

In New Zealand, where policy preference has alternated between state and market provision, third sector housing has been largely ignored. Housing trusts, housing associations and cooperatives play an almost insignificant role in New Zealand's social housing sector because they have never had a supportive policy environment, such as exists in Canada, Britain and north-western Europe. Building up a credible third sector housing movement in New Zealand is consistent with the aspirations of many iwi and hapu organisations. Such a shift may be the only protection low-income families have from future Governments which are indifferent or hostile to the ideal of decent housing for low-income families.

Recommendations

1. Commit to build 1000 new state houses a year.
2. Soften the abatement of the Accommodation Supplement and income related rent subsidies.
3. Introduce assistance for home ownership including subsidised interest rates, reduced deposits, and sweat equity options.
4. Encourage and assist third sector housing initiatives for families on low incomes.

7. Health

Poor children and adolescents, excluded from the prosperity and good health of better-off children, are disadvantaged from the start. Poverty and inadequate health systems compound their vulnerability to sickness, and possible death, despite our collective knowledge of effective and affordable actions that can protect children from ill health, and restore health to sick children (World Health Organisation, 2002).

The health of New Zealand children

The health of New Zealand children and young people now ranks among the poorest in the industrialised world. The deterioration in many indicators of health for children since the early 1990s reflects a high incidence of diseases aggravated by low household income, overcrowding, and poor access to primary health care. These issues must be urgently addressed through government policy changes (Asher, Parks, & Dakin, 2002).

Recently published research from the University of Otago showed that socio-economic disadvantage in childhood has long-lasting negative effects on adult health. The study assessed 1000 children born in 1972-1973 in a large variety of health outcomes. It found that children who grew up in low socio-economic status families had poorer cardiovascular health, poorer dental health measures, and more substance abuse resulting in clinical dependence than children from wealthier backgrounds. The authors of the report found:

Protecting children against the effects of socio-economic adversity could reduce the burden of disease experienced by adults. These findings provide strong impetus for policy makers, practitioners, and researchers to direct energy and resources towards childhood as a way of improving population health (Poulton et al., 2002).

New Zealand has seen a resurgence of childhood diseases usually associated with poor countries, including meningococcal disease, measles, whooping cough and tuberculosis. New Zealand children also suffer from inadequately treated acute infections (gastroenteritis, cellulitis, glue ear);

diseases that can follow streptococcal infections, usually seen only in developing countries including glomerulonephritis and rheumatic fever; respiratory tract diseases and allergies (pneumonia, bronchiolitis, bronchiectasis, asthma, allergic rhinitis, atopic eczema); nutritional deficiencies (iron deficiency anaemia and rickets); and dental disease. New Zealand children also have high rates of motor vehicle and pedestrian injuries, falls, poisonings and child abuse.

Hospital admission rates (excluding injuries) for children and young people (under 24 years old) are significantly higher in low-income areas. Admission rates (as a percentage of the population) in 1999 for low income South Auckland and rural Waikato were 12.1 and 13.2 respectively, compared with a nationwide rate of 10.1, and a rate in high income North Auckland of just 7.2 (Graham, Leversha, & Vogel, 2001).

Immunisation coverage is a marker of the accessibility and acceptability of primary health care services for children. New Zealand still has one of the lowest immunisation rate of any Pacific nation, and consequent high rates of vaccine-preventable disease (Bellamy, 2000). Lower respiratory tract infections in infants (pneumonia and bronchiolitis) are increasing, and our rates of pneumonia are the highest in the industrialised world. Poor housing, lack of access to health care, poor health knowledge and poor nutritional status of children are all contributing factors (Grant, 1999).

Birth rates to teenage mothers are third highest in the industrialised world (28 OECD nations), with only the United States and the United Kingdom rating higher (UNICEF, 2000). In 2000, there were 1,175 births to females aged under 18 years old (8.8 births per 1,000 females aged 13-17) (Ministry of Social Development, 2002c). In addition, rates of the sexually transmitted diseases chlamydia and gonorrhoea are ahead of those recorded in many other industrialised nations (Ministry of Health, 2000). There is now a substantial body of literature linking high teenage birth rates with poverty and poor future prospects (Paton, 2002).

Suicide is the second most common cause of death for people aged 15-24 in New Zealand, following motor vehicle crashes (Ministry of Health, 1999a).

Further, about 25% of children are likely to experience some kind of mental health problem before the age of 15 years (Ministry of Health, 1998b).

New Zealand has been suffering an epidemic of meningococcal B disease of a magnitude that has no equivalent elsewhere in the world today. Meningococcal disease causes blood infections and meningitis resulting in death for 5% of children infected, and serious disability, such as loss of limbs, brain damage and deafness, for about 20%. The worst affected are children under one year of age, with rates for Maori children over two times higher than Pakeha. Rates for Pacific children are over four times higher. As one researcher explains:

New Zealand is in its eleventh year of an epidemic of meningococcal diseases, with the highest incidence in Maori and Pacific children under five. Household crowding is the most important risk factor (Baker et al., 2000).

The Ministry of Health is currently working on the provision of a vaccine against meningococcal B. While this vaccine is potentially of considerable benefit, the underlying issue of poor housing conditions, outlined in Section 6 of this report, needs to be addressed urgently.

Of further concern is New Zealand's low immunisation coverage for Maori and Pacific children. The major issue behind poor immunisation rates for these children is difficulty accessing primary health care services. Access issues are strongly linked with poverty.

Inequality and poverty

The *Top 10 Report*, conducted in the Auckland and Waikato regions, was the first significant overview of the most important indicators of child and youth health (Graham et al., 2001). The report covered more than 550,000 children and young people under the age of 25, approximately 40% of all young people within the area. The coverage area included the most deprived (South Auckland) and least deprived (North Shore to Wellsford) regions of New Zealand. Not surprisingly, its findings generally confirmed the well-established relationship between poor health outcomes, poverty and inequality (Graham et al., 2001).

Children and young people in rural Waikato and South Auckland lived in the areas of greatest deprivation and suffered the poorest health of the groups studied. However, their disease-specific hospital discharge rates were lower, suggesting poorer access to hospital and health services. Children and young people from the North Shore and Wellsford regions were the least deprived and enjoyed the best health.

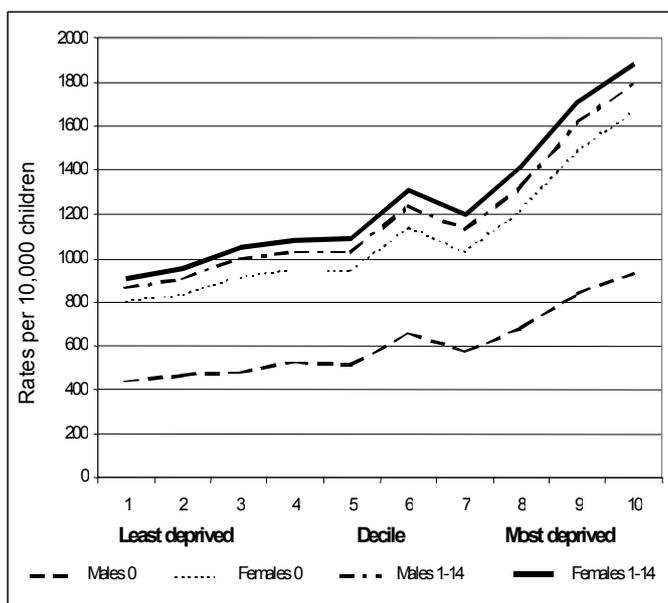
The report prioritised ten issues that need to be addressed if the health of children and young New Zealanders is to improve. Those ten issues emphasize New Zealand's failings when comparing health outcomes with similar countries, and include youth mortality, avoidable hospitalisations, and infectious disease rates.

The effects of inequality are vividly seen in differences in life expectancy at birth. Maori life expectancy at birth is consistently shorter than Pakeha in all areas. This is one demonstration of the effects of long standing marginalisation. A Maori baby boy living in the most deprived areas of New Zealand can expect to live 63 years, whereas a Pakeha baby girl in the least deprived areas can expect to live 78 years – a difference of 15 years (Howden-Chapman, Blakely, Blaiklock, & Kiro, 2000). For males, there is an eight-year difference in life expectancy at birth between those living in the most and the least deprived areas, for females a nine-year difference.

Furthermore, Maori children are more likely to experience health problems. For example, Maori infant mortality rates remain higher than those for non-Maori. While infant mortality and the overall mortality rate in the 0 to 14 years age group dropped over the past decades, the higher rate among Maori children, fell by less (Ministry of Health, 1998a). The reduction in the gap between Maori and Non-Maori infant mortality between 1996 and 1999 is due mainly to the decline in the number of babies dying from Sudden Infant Death Syndrome (Te Puni Kokiri, 2000a). While there is limited information on the health of Pacific and Asian children, there is evidence of serious inequality for Pacific children as well (Percival, 1998). Despite these ethnic differences, the common factor is socio-economic status:

Levels of socio-economic status underpin patterns of risk taking, which affect health status, health outcomes and levels of health service utilisation. Improvements in health outcomes for Maori will only emanate if effort is focused on improving the socio-economic position of this population (Te Puni Kokiri, 2000b).

Figure 16: Rates of hospital admission for children by areas of residence



Source: Statistics New Zealand, 1999a

Researchers have ranked New Zealand neighbourhoods by degrees of deprivation, **decile one being the least deprived, decile ten, the most deprived.** (Note that these deciles are ranked opposite to decile rankings used in other sections of this report). Figure 16 demonstrates that the rates of disease and other health problems, measured by rates of hospital admissions, all increase correspondingly with economic deprivation. Children living in the most deprived areas are more than twice as likely to be admitted to hospital as those living in less deprived areas. Pacific children are particularly affected, as nearly half live in decile ten areas.

Health service delivery to children

Targeted policy: the Community Services Card (CSC)

In the early 1990s, user-pays policies in health were introduced. Concurrently, there were no increases in subsidies for general practice visits, making primary health care even less affordable for families on the lowest incomes. To redress this problem, the Community Services Card was introduced in 1992.

The card entitles those on low incomes to subsidised general practice visits and prescription medicines, but a significant residual cost remains. The visit cost is typically \$35 for adults, \$20 for older children, \$10 or less for younger children, and usually free for under-sixes (although more for all after-hours services). The subsidies for children six and over and their parents have remained unchanged since 1992.

Serious problems have been identified with the CSC. Of those eligible, more than one in four do not hold a CSC, and many others who have it do not use it. Pakeha New Zealanders are the group most likely to have a card, Pacific people are the group least likely. Two thirds of card holders still have difficulty affording doctor fees, and 27% of card holders, including 57% of beneficiaries, could not afford to fill prescriptions in the previous 12 months (Parks, 1996). This has been ameliorated to some extent by the introduction of increased subsidies for the under-sixes (see below) but does not address the health of older children.

Income eligibility for the card is set at an unrealistically low level, despite some adjustments. For example, a sole parent with one child loses the card when his or her income reaches \$29,398. This may cost the parent many hundreds of dollars in lost subsidies and be another disincentive to earning extra income. Many low-income families just above the eligibility threshold find paying for primary health care very difficult, and this often means choosing between paying for health care or paying for food, housing, clothing and education.

Table 4: Income Levels for the Community Services Card (gross income) (2002)

Family Circumstances	Income Threshold
Single (sharing)	\$18,924
Single (alone)	\$20,047
2 members	\$29,933
3 members	\$34,866
4 members	\$39,800
5 members	\$44,735
6 members*	\$49,670

*For each additional person, the income limit increases by \$4,480.

Source: WINZ

Increased subsidy for GP visits and medicines for the under-sixes

Increased subsidies for visits to the GP and prescriptions were introduced in 1997 for all children under six years old, with the aim of making these free of charge. The cost of the scheme was estimated to be around \$60m per annum, after allowing for an increase in consultations of about 15%. However, the subsidy does not meet the extra costs for after-hours services, which may be up to \$40 a visit.

In 1999, research was conducted to evaluate the success of the "free under-sixes" policy, firstly in terms of equity and improved access to services, and secondly in reducing disparities in health status (O'Dea & Penrose, 1999). The scheme had been operating for too short a time to measure the second objective, as many of the health benefits of early treatment could be expected to occur in the long term. Nevertheless, the perception of many GPs was that the scheme was having a worthwhile impact.

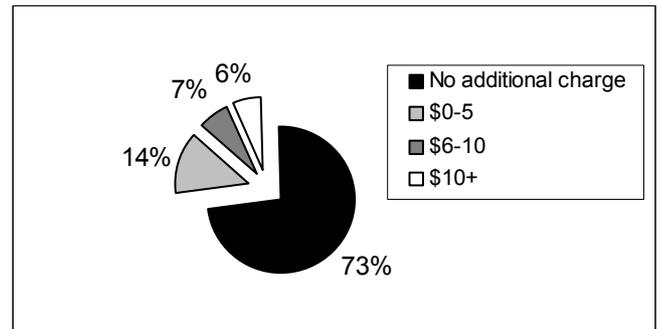
The equity gains from this universal policy – as compared with the targeted Community Services Card – come about because of three factors. Universal access for those under six assists:

- Families with the card who find the part charges a significant barrier;
- Families who qualify for a card but do not have it;
- Families who just miss out on the eligibility criteria for the card.

O'Dea and Penrose concluded that the largest share of the financial benefit of this policy accrues to those in the lowest 40% of the income range. This is due to the concentration of families with young children in that part of the income range, plus the higher average use by children from families with a card.

While the introduction of increased subsidies for GP visits the under-sixes was a welcome move, the subsidy is not sufficient to make this universally free, particularly after hours – a time many young children need health care. In 2002, a survey conducted by CPAG of almost 200 doctors in the Auckland region showed that 27% charged extra for under-sixes - between \$5 and \$17 a visit.

Figure 17: Surveyed health clinics in Auckland and charges for under-sixes



Source: Child Poverty Action Group

Many children over six are missing out. Children need to be allocated health benefits on an individual level that is independent of family income. All children under 18 need free health and dental care. Prevention, early recognition and treatment of problems are essential for all children and adolescents.

Primary Health Organisations (PHOs)

The Primary Health Care Strategy is a new government initiative aimed at improving access to primary health care services (Ministry of Health, 2001d). The strategy involves working with local communities and enrolled populations, removing health inequalities, offering comprehensive services, co-ordinating care across services, developing the primary health care workforce, and improving quality of services. Implementation of these aims has the potential to offer significant gain for children; however, thus far, implementation has been slow and patchy.

Primary Health Organisations (PHOs) are multi disciplinary healthcare providers, funded by District Health Boards (DHBs), and committed to improving the health of a defined population. They will have community representation in governance structures, and take a population-based focus to improve equity of access and service delivery, including delivery provided by Maori and other ethnic groups. Some new funding is specifically targeted to high needs populations. The key indices in the formula are age, gender, socio-economic basis and ethnicity (Maori, Pacific, other) with initial focus on areas with the lowest decile rankings (nine and ten), and Maori and Pacific communities.

The intention is to introduce PHO-type organisations throughout the country. Some of the long-term aims are to reduce the cost of all child visits to the GP so that no child pays more than \$10 per visit anywhere in the country, and the phasing out of Community Services Cards.

This new focus on primary health care integration, improving access to health care services, and reducing inequities, is to be highly lauded. However there are concerns with its implementation, specifically the staggered process of introducing PHOs, and the lack of geographical coverage. These factors will lead to inequities in healthcare access between those with and those without PHOs if the process stops, or is not adequately funded for full implementation.

It is important that the pace of the introduction of the scheme does not slow. This would create further friction from the inequities in the change process.

Finally, there is concern that the success of the PHO scheme rests to a large extent on the relationships between 21 individual DHBs and the primary health care providers in their areas. Together, they must be able to sustain reasonable working conditions and salaries that are inflation adjusted to enable quality delivery of health care.

Reaching all children and adolescents

There is a need for improved access to, and acceptability of, services for those children who are currently missing out – Maori tamariki and rangatahi, Pacific children and young people, children from poor families, children with disabilities, refugees and asylum seekers, and those who are not legally resident and therefore not legally entitled to publicly provided services. By depriving non-residents of access to these services, New Zealand is failing to meet its obligations under the United Nations Convention on the Rights of the Child. New Zealand made a reservation to the Convention concerning this matter, which the Committee on the Rights of the Child has asked the Government to withdraw (United Nations Committee on the Rights of the Child, 1997).

Innovative Examples of Health Service Delivery

There are now many innovative examples of health service delivery throughout the country. Examples include Whai Oranga o te Iwi, a new community based service set up in Wainuiomata, Lower Hutt, as a joint venture between local Wainuiomata people, the Hutt Union and Community Health Service. The Kokiri marae in Seaview now has two clinics providing low cost, culturally appropriate primary health care to low-income people including many Pacific and Maori people, and combines clinical services with health education and health promotion. It is part of a consortium looking to be the first PHO in the Hutt Valley DHB.

In Auckland, Health Star Pacific serves the needs of Pacific communities. It provides primary health services in local languages, and outreach and education campaigns using Pacific media outlets, and in areas where communities gather – churches, flea markets, local shopping areas and language groups.

However, more services are needed. There are wide gaps in access to primary medical care, well-child care, immunisation, child and youth mental health services, services for children with disabilities, comprehensive ambulatory paediatric services, therapeutic services for those who have been abused, youth health services, oral health services for young people, and public health strategies designed to prevent problems.

The New Zealand Child Health Strategy

There have been many official reports and a plethora of health strategies, including strategies outlining what should be done to improve the situation for children, but most have not been implemented or only implemented in part. The 1998 New Zealand Child Health Strategy, which was widely supported, identified four priority populations: tamariki Maori, Pacific children, children with high health and disability support needs, and children from families with multiple social and economic disadvantage (Ministry of Health, 1998a). However, action on the strategy seems to have been buried under the weight of further health sector restructuring.

Discussion papers on primary health care and the New Zealand Health Strategy (King, 2000a, 2000b) make little reference to children and young people. However, the Child Health Strategy includes many recommendations, which if implemented, can be expected to improve the health of children, as does the Youth Health Strategy.

The interests of children and young people must be represented at all levels, including child and youth health committees on the District Health Boards, representation on all committee structures set up by the new DHBs, and a Directorate of Child Health within the Ministry of Health. There must also be effective mechanisms for better co-ordination for children and young people within the health sector.

Although the New Zealand Health Strategy called for more research, there is now a substantial body of evidence linking child poverty with poor health outcomes. It is not more research that is needed but strategy implementation, evaluation, leading to improved service delivery for all children.

Recommendations

1. Make health and dental care for under 18 year olds universal and free.
2. Inflation index all child health subsidies for children.
3. Extend Primary Health Organisation (PHO) development to all regions.

8. Education

Most teachers don't care whether the causes of poverty are globalisation, mean employers, stingy government benefits, market rentals for state houses, greedy church pastors, or disorganised, spend-thrift parents. The effects on children are the same. No child can learn properly if he or she comes to school hungry, malnourished from insufficient or inappropriate food, sick with diseases spread by overcrowding or inadequate medical care, tired from chronic noise or late night videos (Pountney, 2001).

Introduction

The Labour-led Government has declared New Zealand should become a 'knowledge society'. In reality, pursuit of such a goal can mean adding value to those who already receive a high quality education, while ignoring the problems of non-achievement. CPAG believes that a knowledge society can be realised only with due attention and adequate value given to the needs and rights of children, as set down in Articles 28 and 29 of the United Nations Convention on the Rights of the Child (UNCROC) (see box below).

Each child should be viewed as a citizen, an active participant and a co-constructor of community, society and family. They should be valued as much for 'being' as 'becoming', and education services need to foster "the visibility, inclusion, and active participation of all children in society" (Durie, 2001; Moss & Petrie, 1997). *Te Whariki*, the early childhood curriculum, accurately reflects this approach:

...to grow up as competent and confident learners and communicators, healthy in mind, body and spirit, secure in their sense of belonging and in the knowledge that they make a valued contribution to society (Ministry of Education, 1996).

Educational attainment acts as a proxy indicator for competency in learning civic responsibilities, social skills, work ethics and life skills. Qualifications, as representations of attainment, are important factors in determining economic outcomes and quality of life for individuals and society as a whole (Hawk & Hill, 1996). Poverty and other factors such as cultural, social and resource issues, limit educational achievement. Therefore, the provision of adequate and appropriate education is a vital condition for reducing disparities between citizens.

Policies that address the issues affecting educational achievement are needed to enable children from low-income families to attain their full potential in New Zealand.

This section discusses early childhood education, compulsory education and factors that influence educational achievement. Because the focus of this monograph is children, the tertiary sector is not discussed in depth.

Public education in New Zealand

The early colonial government instituted universal, free, and compulsory education from age five. It was based on the notion of enabling access to education was a public good that benefited not only individuals, but the whole community. Peter Fraser as Prime Minister, and Clarence Beeby as Director General of Education, further developed this ideal in the 1930s:

The government's objective, broadly expressed, is that every person, whatever [her or] his level of academic ability, whether [she or] he be rich or poor, whether [she or] he live in town or country, has a right as a citizen, to a free education of the kind for which [she or] he is best fitted and to the fullest extent of [her or] his powers (Easton, 2001).

This statement has stood the test of time. Prior to 1989, a sound primary education was available to most children, and students were generally able to achieve well in secondary schools, although Maori and lower socio-economic groups remained disadvantaged. Initiatives such as Kohanga Reo and Kura Kaupapa, established in the early and mid 1980s, enabled increasing numbers of Maori children to be educated in their own language and culture.

Major reforms of state schools, consistent with the neo-liberal philosophies of the time, began during the 1980s. Following the *Tomorrow's Schools* report, the government stated their intention that "at all levels of education, the early childhood sector will have equal status with other education sectors" (Lange, 1988). Funding and administration were integrated under the Ministry of Education, in acknowledgement that "care" and "education" of young children could not be separated. Significant funding for the early childhood sector was committed by the Labour Government, but withdrawn in the early 1990s.

United Nations Convention on the Rights of the Child

Article 28

1. States Parties recognize the right of the child to education and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:
 - (a) Make primary education compulsory and available and free to all;
 - (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;
 - (c) Make higher education accessible to all on the basis of capacity by every appropriate means;
 - (d) Make educational and vocational information and guidance available and accessible to all children;
 - (e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.
2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention
3. States Parties shall promote and encourage international co-operation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States Parties agree that the education of the child shall be directed to:
 - (a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;
 - (b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;
 - (c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilisations different from his or her own;
 - (d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;
 - (e) The development of respect for the natural environment.
2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Early childhood education

Quality early childhood education services have never enjoyed full state funding, despite being central to the wellbeing of families with young children. There is convincing evidence that attendance at early childhood education programmes has a significant and lasting effect on children's later development, both in educational success, and more widely. Participation also appears to be a more important influence in the lives of low-income children than it is for children of middle-income families (Smith et al., 2000).

In New Zealand, rates of participation in early childhood education in New Zealand are generally high by international standards, although the data are somewhat unreliable, as children who attend two or more services are counted in each. However, increased government funding is required to achieve access to quality early childhood services for all children whose parents would like them to attend. There continue to be ongoing problems with funding formulae that are unresponsive to differing types of provision. Access and affordability for families, and the quality of some programmes remain major issues, with significant discrepancies in participation continuing between socio-economic groups. Some component of free entitlement to high quality early childhood education is crucial.

In 1996, a bicultural early childhood curriculum, *Te Whariki*, was introduced with widespread support from the early childhood community. In 2002, the release of the Government's 10-year strategic plan for early childhood education was welcomed. The plan aims to achieve three broad goals, being: increased participation; improved quality; and the promotion of collaborative relationships (Ministry of Education, 2002b). However, a number of important questions remain unanswered, including the level of funding which will be forthcoming, and how new systems will be implemented.

For low-income families, there are many barriers to early childhood education. The cost of early childhood services is an obstacle to participation (Mitchell, 2002). A childcare subsidy is available to some, but this may not cover the cost of full day care. If the caregiver is a non-working sole parent, or the non-working partner in a two-parent family, the number of subsidised hours is limited to nine per week. Thus, children in families with the most need may not be eligible.

Further barriers include the lack of early childhood providers who are fluent in Te Reo Maori and Pacific languages. As many prospective trainees with the relevant language background themselves come from low-income families, additional targeted training funding is needed to overcome this deficiency.

Other groups, such as migrant and refugee families, may not access early childhood education because of communication difficulties or lack of information and support. Moreover, early childhood services may not be located in the areas where they are most needed. For-profit services are not likely to be established in areas where families cannot afford the fees, and 'free' or not-for-profit childcare centres require significant state funding.

Research indicates that the quality of children's early childhood education is not independent of family background:

Families with low risk backgrounds tend to use higher quality care and families with high risk backgrounds tend to use lower quality care. . . a combination of low quality care both within and outside the family produces the most negative outcomes (Smith et al., 2000).

Family income levels influence the type of service chosen as well as the quality of the care. High quality programmes are the most effective, but may not be affordable for low-income families, and are not yet ensured by state provision.

One of the positive measures that has been recently implemented is the introduction of "equity funding". This is an additional subsidy for centres serving low-income areas, isolated communities, or those supporting high numbers of students with special or other needs, such as English as a second language. However, the subsidy is not available to all services that have high needs children, and it should not be regarded as a substitute for adequate base funding for all services.

In making access to free early childhood education a statutory right, New Zealand would remove significant cost and access barriers, be consistent with 'rights' conventions and join leading OECD countries . . . in placing priority on children's educational interests (Mitchell, 2002).

Compulsory education

In the compulsory sector, feedback from principals, trustees, parents and teachers has revealed that while the reforms of the 1980s and 1990s brought some positive gains, they came at a cost, and the gains were unequally spread. Differences between schools were exaggerated and huge disparities never before seen in the New Zealand state system were created. The combined effects of under-funding and de-zoning (introduced in the mid 1990s) impacted most severely on schools that served communities with low incomes (Wylie, 1999).

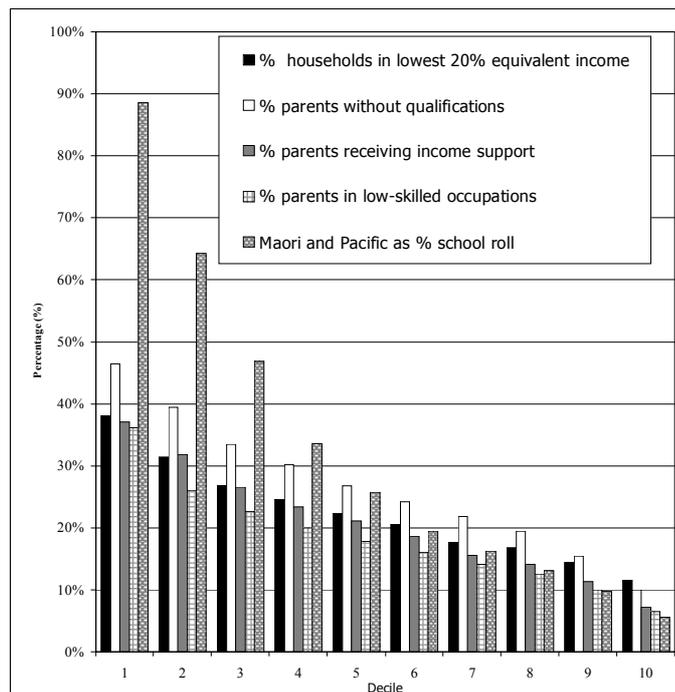
Based on the socio-economic catchment of their local communities, schools are ranked from 1 to 10 (note these are different measures to the deprivation deciles used in chapter 7 of this report). Decile 1 schools have communities with very low incomes; decile 10 schools are in wealthy neighbourhoods. However, schools are not spread evenly across the 10 deciles.

In 1995, faced with undeniable disparities between schools, the National government introduced Targeted Funding for Educational Attainment (TFEA), a subsidy program assisting low decile schools. Despite this, only 4% of Government funding of schools in New Zealand is decile-related (Middleton, 2002). Perversely, during this period, subsidies to private schools were increased. CPAG advocates an increase in decile related funding for schools and the gradual elimination of government subsidies to private schools.

As shown in Figure 18, on average, almost 50% of parents in decile 1 communities are without educational qualifications, and 36% are employed in unskilled manual work. This compares with just 10% of parents in decile 10 who are without educational qualifications and 6% who are employed in unskilled manual work.

Operational funding for schools declined in real terms in the 1990s, even though they faced increased operating and compliance costs, and additional new costs associated with Information and Communications Technology (ICT). Local communities must pick up shortfalls in state provision, or necessary items are simply done without. High decile schools are much better equipped than low decile schools to raise funds locally. As well, parents in high decile areas are more likely to have home computers, phones, books and reliable transport.

Figure 18: Characteristics of parents; and percentage of Maori and Pacific by school roll, in schools ranked by decile.



Source: Ministry of Education, 2001b

Latimer estimated that parents are now paying schools about \$30 million a year in donations for the "free" state education of their children (Latimer, 2002) because the Government is not funding schools adequately. Wylie's research reported estimates of parents' spending on their children's primary education which showed a 163% increase over five years (1991–1996) when the CPI increase over the same period was just 11.5%. The percentage of schools raising over \$15,000 by fundraising increased from 28% in 1996 to 38% in 1999 (Wylie, 1999).

Excluding teacher salaries, fundraising paid for 33% of services in high-decile primary schools in 1999, and 48% in high-decile secondary schools. In many secondary schools, most of that additional money came from fee-paying overseas students, rather than "donations" or high-effort, low-return events such as galas and raffles (Latimer, 2002). Low decile schools are usually unable to access overseas students as a source of additional funds.

In 1991, the National Government abolished school enrolment zones to ensure school choice for all parents:

Enrolment patterns in New Zealand. . . became increasingly stratified. . . in the five years following the introduction of parental choice in 1991, New Zealand students sorted themselves out by ethnic group and to a lesser extent by socio-economic status, to a degree that cannot be explained by changes in ethnic and demographic residential patterns. . . one set of schools for the (mostly Pakeha) middle classes, and another set for the (mostly Maori and Pacific) poorer classes. [This system] advantages those who can afford to live near 'good' schools or pay for transport to distant schools - or fund their offspring into the private sector (Harker, 2000).

This goal of parental choice was only selectively attained. Wylie's longitudinal research found that parental choice in primary, intermediate and secondary schools led to increased ethnic and socio-economic polarisation (Wylie, 1999). Maori and Pacific students became concentrated overwhelmingly in decile 1-5 schools, with the largest percentages in the lowest two deciles. Between 1991 and 1998, median rolls shrank in decile 1-5 schools: the lower the decile, the larger the shrinkage. However, median rolls grew in decile 6-10 schools, very few of which now have more than 20% Maori and Pacific students (see Figure 18). Roll changes between 1994 and 1998 indicated that 'Pakeha students have moved from high decile schools with more Maori pupils to high decile schools with fewer Maori pupils' (Harker, 2000).

Generally, schools in low socio-economic areas and with high Maori enrolments were likely to have gained least from the reforms. Problems included falling rolls (when primary school rolls were generally rising), additional administrative costs, and fewer voluntary resources to draw on. Maori parents were less likely than Pakeha parents to get their first choice of school for their children (Wylie, 1999).

Student Achievement

Patterns of student achievement reflect these disparities. Educational achievement statistics reveal that in 2001, 47% of students from decile 1-3 schools left with 6th or 7th form qualifications, compared with 79% of students from deciles 8-10. Conversely, 30% of students from decile 1-3 schools left school with no formal qualifications, compared with only 7% of students from deciles 8-10 (Ministry of Education, 2001a).

It is vital that Government policy should focus on improving the educational achievement outcomes of students at low decile schools, so they can access ongoing, high level, tertiary education.

From the mid 1990s, concerns about increasing inequities in the educational sector and their effects prompted monitoring of attainment levels and led to several Government initiatives: ascertaining what strengthens education in schools in low socio-economic areas - Strengthening Education in Mangere & Otarā (SEMO); what barriers to achievement exist in low decile schools - Achievement in Multicultural High Schools (AIMHI) (Hawk & Hill, 1996); and what factors are involved in sustaining school improvement (Mitchell, Cameron, & Wylie, 2002). Such information, enhanced by material such as the Durie framework for considering Maori educational advancement (Durie, 2001) offer positive ways of developing educational directions in the immediate and long-term future.

In 1999 the Labour-Alliance Government reintroduced school zoning, which resulted in a less competitive environment between schools. A stated priority of the 2002 Labour Coalition Government is to raise participation and achievement of underachieving students, the majority of whom, are most severely affected by the multiple effects of poverty and social exclusion. It will require considerable political will to address the significant disparities in core literacies, school participation, attainment of qualifications, and progress on to tertiary education presently evident in New Zealand schools.

Factors influencing educational achievement

Research consistently shows that poverty and low socio-economic status are linked to poor educational attainment (Department for Education and Employment, 1999). However, there are factors, both internal and external to the school, that can positively affect student learning.

If Maori children do not do as well as Pakeha children at preschool and primary school, this is much more likely to be because of what has happened in the children's lives outside school, such as their family income. . . We believe that some of the main problems are outside the education system. But this does not mean that solutions cannot be found within the education system.

It is possible that problems caused outside the school can be dealt with inside the school. . . (Else, 1997).

There is growing understanding of how improvements to student achievement can be made and sustained within schools. Hawk and Hill's report (1996) details a number of factors that impact on student achievement and participation in school life. They are interdependent and require a "whole student" approach. Unless students arrive at school in a "teachable state", or schools are equipped to assist students who do not, then efforts within the classroom will be limited.

All factors can be influenced positively by appropriate policy development by government. Some, which CPAG wishes to emphasise, can be defined as anti-poverty measures, but all will require funding. Research shows that additional resources matter most for minority and disadvantaged students, and may matter much less for students from more advantaged families (Annesley, 2001).

- **Teacher quality**

Research indicates that teacher quality, measured by teacher ability, teacher education and teacher experience, is strongly related to student achievement. A large US study found that teacher quality accounted for about 40% of the variance in students' reading and mathematics achievement - more than any other single factor (Verstegen and King in Annesley, 2001). Research conducted in New Zealand is consistent with those findings. Hattie's research on what factors influence achievement levels concluded that, after individual student ability, teachers were the most important influence (Hattie, 1997).

Haberman maintains that successful teachers of children in poverty create an extended family within their classrooms, and a caring world that extends beyond their classrooms (Haberman, 1995).

In the contemporary New Zealand educational context, a report that examined the beliefs and attitudes which inform highly successful teachers in Auckland's low decile schools concluded that such teachers: have a strong belief in children taking responsibility for their own learning; have a personal and public passion for learning;

establish a strong sense of connectedness with children and their worlds; and have dispositions which enable them to teach effectively 'across habitus' (Carpenter, McMurchy-Pilkington, & Sutherland, 2001).

Realistic financial incentives must be introduced to recruit and retain competent teachers in "hard to staff" schools. Increased levels of support staff in low decile schools would also allow teachers to focus on their core responsibilities. A stronger focus on professional development opportunities should also be implemented.

- **Student health and welfare**

The association between low educational attainment and poor health is well demonstrated. Many students arrive at school manifesting complex physical, emotional and social problems that require attention by comprehensive, co-ordinated, well-integrated and well-resourced forms of support.

From the mid-decile schools down, there are increasing numbers of children suffering from preventable conditions of poverty, including glue ear and dietary deficiencies.

Government initiatives should include establishing health profiles for all students upon entry to school; annual screening for vision, hearing, iron levels, immunisations and general health; comprehensive on-site health, guidance, careers and transition (between levels of school and beyond) facilities and programmes; programmes reinforcing healthy eating choices; substantial and secure funding for a Social Workers in Schools programme; and investment in community-driven links with schools.

- **Attendance**

Many complex and interrelated factors combine to result in intermittent or prolonged absences from school. These have a direct bearing on the achievement levels of students. Absences are also an important marker of students being possibly 'at risk'.

Truancy is a huge issue in lower decile schools. The CPAG survey of truancy in South Auckland primary schools was discussed in Chapter 6.

Its results reinforce data from Census 2001, including that families with the lowest 10% of incomes shift twice as often as children from wealthier families (Johnson, 2002). The costs of transience include the fragmentation of learning patterns of students, and high administrative costs for schools.

To address the issue of poor attendance, computerised records are needed, with appropriate follow-up to identify accurately the source of the difficulty and liaise effectively with students, their families and their teachers.

There is also a need for the provision of alternative education programmes for chronic truants staffed by specialist teachers, and the application of effective programmes to enhance such students' learning, and facilitate positive relationships between their families and teachers (Lee, 2000).

- ***Family support, links with community***

Local experience of individual low-decile schools achieving very strong results show that the connection between socio-economic status and low achievement can be broken (Ministry of Education, 2002a).

Successful partnerships between schools, families/whanau and communities are essential for supporting positive social and academic outcomes. But parents/caregivers' ability to facilitate full participation of their children in the life of their schools is severely limited by financial, educational and social constraints.

Iwi education partnerships, such as that with Te Runanga o Ngati Porou, have led to a strengthening of community capability to guide useful, local education initiatives. Kura Kaupapa schools have been successful at involving Maori parents, because both teachers and parents viewed education as a home-school partnership (McKinley, 2002).

- ***Quality learning programmes***

The determination of the Labour-led government in 1999 to implement the National Certificate of Educational Achievement (NCEA) has presented increased opportunities for students to succeed within a national qualifications framework.

Now, a more diverse curriculum base, with quality, innovative programmes that have been shown to respond effectively to disadvantaged groups, should be a Government priority. These should include schemes based around youth mentoring, alternative education programmes for at-risk youth, and programmes that reward and foster achievement.

The financial barriers to undertaking assessments, such as the high fees required for NCEA exams, must be eliminated as soon as possible, as they are proving a significant disincentive for students from poorer areas (Hawk & Hawk, 2003).

- ***Facilities and equipment***

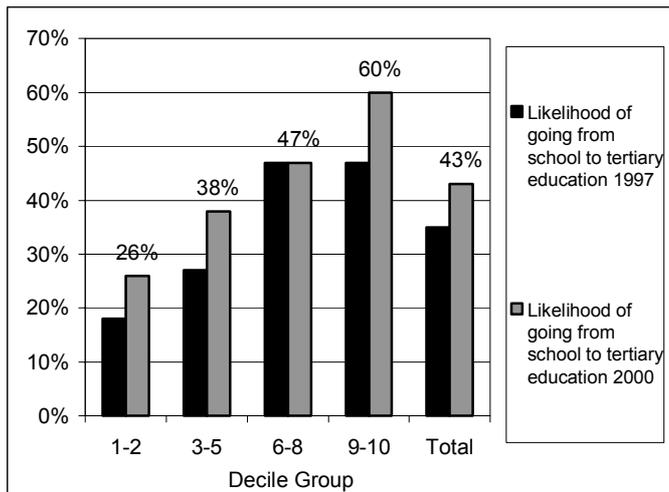
The Education Review Office has reported on the poor state of facilities and buildings in some low decile schools in contrast to schools with high quality learning programmes. The physical environment of every school should be conducive to good learning, and maintained and enhanced appropriately. Maintenance of many schools was deferred during the 1990s, and generally, only schools with increasing rolls, usually high decile, were funded to improve facilities. CPAG recommends that funding for maintenance should be related to need, not growth in roll numbers.

Information Technology requires heavy investment, often provided or assisted by the school community. Provision of up-to date equipment, audited regularly to ensure equity of opportunity in programme delivery, is required in low decile schools to prevent increasing the disparity between students who can access computers in their homes and those who cannot.

Tertiary participation

The likelihood of school leavers from low decile schools continuing on to tertiary education is significantly lower than for students leaving higher decile schools. Particularly pronounced are low rates of participation at university by school leavers from low decile schools. This is important because higher-level tertiary qualification lead to increased employment opportunities and other social benefits. Figure 19 shows that in 2000, only 26% of school leavers from decile 1-2 schools went on to tertiary education, compared with 60% of students from decile 9-10 schools.

Figure 19: Likelihood of tertiary participation by decile group, 1997 and 2000



Source: Matthews, 2001

These outcomes perpetuate the cycle of disadvantage. It is critically important that tertiary education is made more accessible.

Summary

Evidence on the effects of the educational reforms of the late 1980s and 1990s reveals increased inequalities at all levels of the education sector. The key indicators of participation, achievement and retention in education demonstrate continuing disadvantage experienced by children in Maori, Pacific and low-income families. Financial barriers to participation have been exacerbated by the governmental policies of the past decade. The provision of successful educational experiences for all children and young people in New Zealand requires investment in communities and homes, as well as direct investment in schools and other learning institutions.

Social and structural inequalities in childhood which impact most severely on the children of low income families, can be addressed more explicitly if schools are regarded as pivotal community institutions involved in the business of developing whole people, and not simply and narrowly as places where academic excellence alone is valued.

What the best and wisest parent wants for his own child, that must the community want for all its children. Any other ideal for our schools is narrow and unlovely: acted upon, it destroys our democracy (Dewey, 1959).

Recommendations

1. Fund early childhood education to a level which ensures all young children are able to access quality, affordable programmes regardless of where they live, or their parents' income.
2. Increase funding for low and middle decile schools and eliminate subsidies for private schools.
3. Focus policy development on teacher quality to improve student achievement levels, especially in low decile schools.
4. Increase investment in schools to address student health problems and the effects of social exclusion.
5. Abolish fees for compulsory national qualification exams (NCEA, Bursary).
6. Computerise records of school attendance and provide well-resourced specialist programmes for chronic truants and other students in need.

9. Social services for children at risk

The linkages between poverty and social service needs were well captured by Judge Mick Brown when he noted the destructive effects on children living in "a perpetual cycle of poverty" in his review of the Department of Child Youth and Family Services (Brown, 2000). While New Zealand has strong legislation to ensure the care and protection of children, there is a paucity of research on the effectiveness of this legislation and how it affects particular groups of children and families. There is an urgent need for a thorough evaluation of the Children, Young Persons and their Families Act, as well as the implementation of community development strategies for the prevention of child abuse and neglect. Moreover, agencies charged with the protection of children must be given sufficient resources to fulfil their statutory duties.

Care and Protection

Poverty in its various forms is a significant risk factor in child abuse and neglect. While it is difficult to establish conclusive causal links, poverty is a thread that runs through most social pathologies, and one that policy can address successfully, given the political will.

The Department of Child, Youth and Family Services (CYFS) is the statutory body charged with ensuring the care and protection of children in New Zealand. For the year ended June 2002, the Department received 27,572 notifications of possible neglect or abuse, up 3% from 2001. This figure includes notifications for children at risk of physical, sexual or emotional abuse, neglect, self-harm or behavioural difficulties. During the same period, the proportion of notifications requiring further action rose more than 4%, indicating a trend of increasingly serious notifications (Department of Child Youth and Family Services, 2002). Social workers report that cases are becoming more demanding, requiring increased levels of resourcing to deal effectively with families who present with complex and multiple issues.

Despite these alarming figures, the overall rate of child abuse and neglect in New Zealand fell in 2001. Based on the 5,432 cases of **substantiated** abuse or neglect CYFS assessed in 2000, of those children under 17 years old, 6.9 children (12 Maori children) in every 1,000 were abused or neglected. By 2001, this had dropped to 5.5 children overall and 7.2 Maori children (Ministry of Social Development, 2002c). The reasons for the fall are not clear, nor the extent to which it reflects a real decrease in levels of violence towards children (Ministry of Social Development, 2002c).

Drawing on data from the Christchurch Health and Development study, the Ministry of Health's 1998 report on children's health states that, when interviewed at age 18, 17% of females and 6% of males reported sexual abuse before the age of 16 (Ministry of Health, 1998b). These figures represent the tip of a much more substantial iceberg, as they are the cases that were formally notified, and do not include:

- children whose needs for intervention and assistance were met within the non-statutory sector; or
- children who were not accepted for referral either because their needs were considered inappropriate or because they did not meet the threshold level for intervention.

CYFS assesses all new notifications as critical, very urgent, urgent or low-urgent. The response time for a critical notification is the same day, for a low-urgent case, 30 days.

In 2002, most of the critical and very urgent cases were seen within those recommended time periods, a very positive outcome. However, there was a significant failure in attending urgent and low-urgency cases within the acceptable time period (seven and 30 days respectively) (Department of Child Youth and Family Services, 2002).

Front line social workers report increased difficulty in securing funds for social work interventions beyond the initial crisis period because social work practice has become focused on investigation and assessment of child abuse, and time-focused interventions. In addition, much of the equally important roles of preventative and supportive social work have been transferred to communities and the voluntary sector, which are often ill-equipped and/or under-resourced to deal with the responsibility.

Similarly, the Department is severely constrained in its ability to provide the necessary funding for services such as family counselling and therapy, and otherwise effectively meet the needs of children and families. The result is that families have their immediate crisis dealt with, but the long-term issues remain unresolved. Many of these families return to CYFS several months later, when a new crisis develops. As summarised in a UNICEF research report released in 2002:

Much of the preventative and empowering aspects of child protection policy have remained inoperable due to a lack of resources, and there has not been a full evaluation of the effects of the legislation. There has been an emphasis on dealing with children at high risk of abuse, with support often unavailable because of financial constraints. The state has transferred responsibility to families, but not the resources required to allow families to exercise these responsibilities. The emphasis on high risk has not worked sufficiently to prevent the deaths of a number of children for whom the agency had responsibility (Blaiklock et al., 2002).

While continuous involvement from CYFS in families is undesirable, leaving families lurching from crisis to crisis, with intervention only in emergencies is also unsatisfactory. The right intervention at the right time, for the right amount of time, can maximise the chances of improvements in family functioning. Given the consequences of not providing the appropriate assistance when necessary, cost should not be the driver of social work interventions.

Some success has been achieved with targeted policies, such as *Strengthening Families* and *Family Start*, however they are largely reactive programmes for existing problems. A fundamental problem with such programmes is the stigma associated with being involved. The family may incur a loss of respect of self and others by being classed as 'at risk'. Improving the availability of resources such as quality, affordable housing, adequate income levels, and access to health services to all families and communities would be more effective than targeted intervention on the basis of generalised 'risk factors'.

A programme such as the English *Sure Start*, (see box), is an effective way of ensuring that the needs of vulnerable families and children are met. This programme is a mixture of universal and targeted options, and encompasses a cross sector approach, including health, education, welfare, and income levels.

Physical punishment of children

Te Puni Kokiri, the Ministry of Pacific Island Affairs, the Commissioner for Children, and Women's Refuge are among a growing number of groups calling for action in relation to levels of violence against children, especially in the home. CPAG joins with those voices. A ban on the physical punishment of children is urgently required, combined with programmes that focus on positive parenting, behaviour management, and guidance and help to parents experiencing stress.

Sweden banned physical punishment of children in 1979. Combined with widespread education campaigns on alternatives to hitting, this approach dramatically reduced risk to children (Durrant, 1999). With a population of 8.5 million, compared with New Zealand's 3.8 million, there were 4 recorded deaths in Sweden from child abuse in the 20 years from 1975 to 1995. New Zealand recorded approximately 160 over the same period.

In a 1999 evaluation of the success of the corporal punishment ban, 70% of the Swedish population disapproved of physical punishment of children. In contrast, a survey conducted in 2001 found 80% of New Zealanders believe it is acceptable, at least in some circumstances (Ministry of Justice, 2001). This confirms the urgent need for changes in the law, and improved parenting skills models and support programmes for parents.

Sure Start – a possible programme for New Zealand?

The United Kingdom is currently implementing and evaluating a new programme aimed at improving the outcomes for children living in poverty. The *Sure Start* programme consists of universal and targeted programmes within deprived neighbourhoods. It is designed to prevent young children in low-income, high-risk communities from experiencing poor developmental outcomes, which then require expensive health, education and social services. *Sure Start* utilises a "whole child" methodology and is based on a collaborative approach between Government, volunteer agencies, communities and families to break the intergenerational cycle of disadvantage.

Sure Start involves evidence-based interventions, with high quality, well paid, and well-trained staff and significant government funding – £500 million. It focuses on communities, not individual families. Children are therefore born into the programme by virtue of their geographical location, rather than referred or enrolled. Families are automatic members. Because local services (transport, libraries, housing, sport and leisure services) are involved, local interventions are accessible, non-stigmatising and therefore more acceptable to families.

New Zealand has a range of social services that provide assistance and support for families experiencing difficulties. However, their availability is patchy and they largely reactive, accessible only once a family is in trouble. Anecdotal reports indicate that mainstream well-child services and parent education programmes are as not well utilised by families from socio-economically disadvantaged backgrounds, as they are by more affluent families.

While not suggesting that the *Sure Start* programme could be lifted wholesale into a New Zealand context, there is evidence to suggest that such a collaborative, community based programme could prove effective. The Government would need to commit significantly more funding than it has currently earmarked for such interventions. Treasury should take a significant role, offering an integrated and co-ordinated package of assistance involving District Health Boards, the Ministry of Education, CYFS, NGOs, and Maori social services. The Ministry of Social Development should also take a lead role in developing and co-ordinating such a programme.

It is now time to take a long-term strategic approach in defining social and economic priorities, and putting resources behind thoughtful policies and practices to promote the well-being of children (Davies et al., 2002).

When parents are under pressure, what begins as a smack can lead to a beating. Parents have the right and the responsibility to discipline their children, but they should not have legal protection for assaulting them. Further, teaching children that violence is unacceptable in schools and communities is seen as hypocritical if parents then have the right to hit children. There is an epidemic of child abuse in New Zealand, and changing public attitudes towards physical punishment of children is one step in reversing this trend.

It is time to pass legislation that sets a standard for violence-free discipline of children. The first step towards this is the urgent repeal of Section 59 of the Crimes Act, which provides a defence to a parent or caregiver charged with assaulting their child. While the same assault on an adult would allow no defence, Section 59 allows a caregiver to justify the use of force by way of correction against a child, if the force used was reasonable in the circumstances. The Government conducted a review of Section 59 during 2001, but announced there would be no alternations to the law, thus reinforcing the acceptability of using physical punishment to discipline children. The Government instead may define a "reasonable" level of punishment to be included in this Section. CPAG rejects this approach - it is unacceptable to allow persons who assault children a defence that would not be available if they had assaulted an adult.

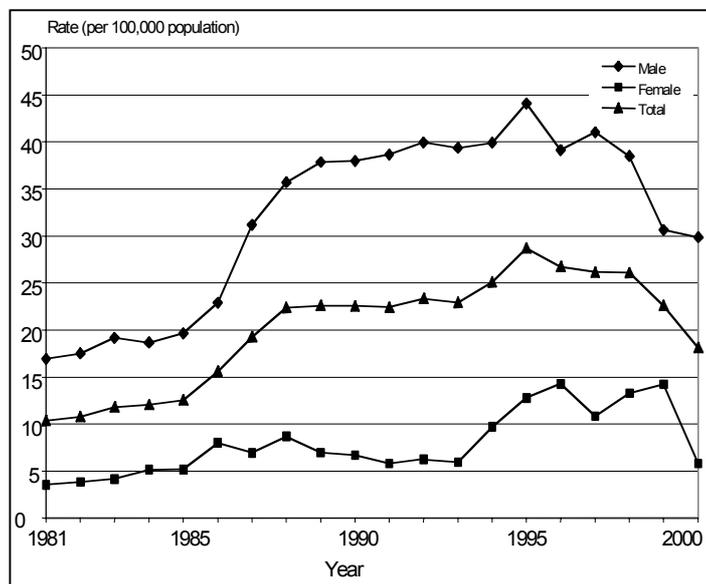
The repeal of Section 59, followed by the introduction of legislation that bans all forms of physical punishment of children, would act as a guide for our society and provide a direction for change. Proactive positive parenting and alternatives to smacking campaigns would accompany this. Unfortunately, there is a marked reluctance on the part of legislators to support banning corporal punishment, despite its importance in contributing to lowering levels of violence towards children.

Youth suicide

New Zealand continues to have a youth suicide rate amongst the highest in the OECD, despite a significant decline in recent years (Ministry of Health, 2002b). In 2000, there were 96 suicides of 15-24 year olds, (a rate of 18.1 per 100,000) down from 120 in 1999 and 140 in 1998.

Despite this declining trend, rates of suicide amongst young males remained high at 29.9 per 100,000, and very high for young Maori men at 43.5 per 100,000 (up from 42.4 in 1999).

Figure 20: Youth suicide rates (aged 15–24 years), 1981 – 2000



Source: Ministry of Health, 2002b

According to the report *In Our Hands*, the highest female suicide rate is for those aged between 15 and 19 years (Ministry of Youth Affairs, Ministry of Health, & Te Puni Kokori, 1998). The rates for both young males and females increased significantly over the 1980s and 1990s, with the male suicide rate for 15-24 year olds increasing from 19.6 per 100,000 to 39.5 per 100,000 between 1985 and 1996. The female rate for the same age group increased from 5.1 per 100,000 to 14.3 per 100,000 in the same period. However, as Figure 20 shows, there has been a marked decrease in the youth suicide rate, both male and female during the late 1990s.

It is not clear if these recent declines are due to the effects of community, health service and government intervention; changing social circumstances (such as the improvement of youth employment rates); or a cohort effect as the youth of the 1980s entered an older age group (Blaklock et al., 2002).

Hospitalisation rates for attempted suicides have also decreased over recent years, falling from 198.5 per 100,000 (1054 hospitalisations) in 1999/2000 from 195.2 per 100,000 in 1998/1999 (1047) and 238.4 per 100,000 (1172) in 1995/1996 (Ministry of Health, 2002b).

Between 1993 and 1999, 983 children aged under 15 were hospitalised as a result of attempted suicide or self inflicted harm (Ministry of Health, 2001e).

On-going government and community-led programmes to address the causes of youth suicide are necessary if these high rates are to continue to decline.

Children and Mental Health

Child abuse and neglect is only one of a number of factors that detrimentally affects children's mental health. Others include genetic predisposition; socio-economic status; and family, peer and school relationships.

It appears that mental illness in young people has been increasing over the past 50 years. Recent statistics show that 5% of children and young people have a "serious, ongoing and disabling mental illness" requiring specialist intervention, and that 15% of the youth and child population have chronic mental health problems of a less serious nature (Mental Health Commission, 1998).

The importance of addressing mental disorders that are apparent in early childhood is reflected in an analysis of the Dunedin Child Development Study data. It found that 74% of 21 year olds with a mental health problem had also had mental health problems in childhood or adolescence (Newman, Moffitt, & Caspi, 1996). Such problems include anxiety conduct disorders, depression, conduct disorders, and alcohol and substance use disorders (Ministry of Health, 2002a). Alcohol and drug abuse are also frequently associated with mental illness in young people. Those who present with both mental illness and alcohol and drug abuse are at very high risk of a range of poor health and social outcomes.

Current developments in provision of mental health services for children and youth, and the strengthening of the workforce in this area remain essential priorities. It is clear that quality services, available when needed, are vital.

Children and disability

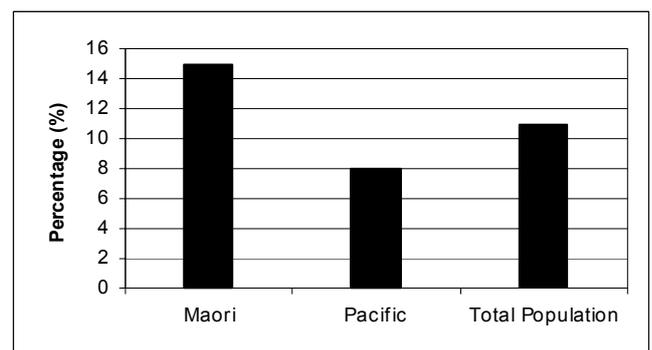
The New Zealand Disability Survey 2001 reported that 11% of all children (90,000 children) under the age of 15 had a disability, a rate that remains stable from previous years. 58% of those children

had speaking limitations, learning and developmental difficulties and/or required special education due to their disability. 17% of children with disabilities reported they had needs for some type of health service that were unmet (Statistics New Zealand, 2002).

Male children (13%) were more likely to have a disability than female children (9%), and, as Figure 21 shows, Maori children were more likely than all children to have a disability (15% compared with 11%). The significant factors shaping the impact of the experience of disability were summarised by the Overview Report on Disability:

Among children, after adjusting for other socio-demographic variables, having a disability was significantly related to age, being Maori, being male, living in an urban area and living in households with lower income (Ministry of Health, 1998b).

Figure 21: Disability rates for children by ethnic group



Source: Statistics New Zealand, 2002

The significance of the experience of disability in shaping the lives and experiences of children is reflected in their educational needs and experiences. In 1996, 92% of children (aged 5-14 years old) with a disability attended a mainstream school. However, many of those children required assistance within the classroom.

Nearly one third needed a teacher aide, a note taker, computer access, talking books and/or other specialist equipment or services because of their condition (Statistics New Zealand, 1999a). The 2001 Disability Survey found 7% of all disabled children aged five or over were unable to attend the school of their choice (Statistics New Zealand, 2002).

The Government's disability strategy report, published in 2001, includes access to local education as one of the most important actions to implement for disabled children (Ministry of Health, 2001c). However, funding for disabled students is thorough the Special Education Grant, a bulk funded grant based on the size of the general school roll that bears no relation to the numbers of children at the school with special needs, or the needs of those children. This disadvantages low decile schools, because children with moderate special education needs are seven times more prevalent in decile 1 schools compared with decile 10 schools (Quality Public Education Coalition, 2002). Funding formulas based on school rolls take no account of this.

Summary

The position of vulnerable children, and their families in the areas reviewed here – care and protection, suicide and self-harm, mental health, and disability - require an active and close working relationship between the state and the voluntary sector in order to ensure that the strengths of each are utilised in the interests of children. In the social services, as in the other sectors discussed in this publication, the most significant impact on the lives of children will come from active attempts to eliminate child poverty.

Recommendations

1. Investigate a *Sure Start* style of programme in New Zealand.
2. Enact legislation to ban the physical punishment of children, implement positive parenting programmes, and immediately repeal Section 59 of the Crimes Act.
3. Provide educational services for children with disabilities on the basis of the needs of the children, not solely on the basis of school rolls.

10. Social hazards

Family poverty is often associated with various social hazards including smoking, gambling, cannabis, and alcohol use. Talk of a "knowledge society" is just that, while social hazards damage the health and learning potential of children and drain the meagre resources of low-income families.

It is important to note that stereotypic notions of low-income householders as heavy drinkers and gamblers are not accurate. A study of 400 low-income households found that although 54% smoke cigarettes, confirming the strong correlation between smoking and low socio-economic status in both New Zealand and international studies, less than 12% gamble (outside of buying a lotto ticket) and 75% had not had a glass of alcohol in the previous week (Waldegrave et al., 1999).

Many other non-governmental organizations provide valuable statistics on the alarming increase in hazards for the health and well-being of our children, and while this area of policy is somewhat outside CPAG's main activities, we believe that these issues are in need of more focused policy debate.

The interests of children must be protected against the power and influence that the gambling, alcohol and cigarette industries wield in New Zealand, and internationally. Industry self-regulation is not adequate - the Government must make substantial efforts to ensure the most vulnerable members of society are protected from, and prepared for, the effects of such hazards. Advertising polices concerning smoking, gambling and alcohol is one area that should be more heavily regulated.

Three aspects of social hazards must be considered when designing policy for their use/restriction: Firstly, the **individual** who is involved (utilise policies of harm minimisation); secondly, the **agent/hazard** (utilise policies that make that agent less attractive or accessible); and finally the **environment** in which the use of social hazards takes place (policies must take account of the wider costs/benefits of social hazards).

CPAG believes that restriction of access to social hazards by age; venue; price or time of day are all important policy tools. Further, a "hands on" approach from Government to the regulation of these industries is essential, as are government led education campaigns on the dangers of social hazards. Finally, policy must recognise that social hazards impact most seriously on the lives of people whose financial situation limits the choices they can make to avoid or escape them. Leadership from Government encouraging a responsible and careful approach/environment to such hazards is essential.

Gambling

Gambling in New Zealand is increasing, and public concerns are growing too. Gambling raises two main issues of public policy concern. The first concern the wider negative social and economic impacts that gambling has on society as a whole, and on specific low-income communities who are disproportionately affected by the social costs of gambling. The second issue is the public health concerns surrounding pathological or problem gamblers.

Wider Community Impact

With 86% of New Zealanders partaking in some kind of gambling each year (Australian Institute for Gambling Research, 2001), and an annual national gambling expenditure figure of \$1.46 billion in 2001, gambling can now be said to touch most New Zealanders' lives in some way (Department of Internal Affairs, 2002).

Gambling policy was not immune to the neo-liberal economic reforms of the 1980s and 1990s. Government controlled gambling bodies (such as the Lotteries Commission) adopted a more commercial approach, marketing themselves, and attempting to overcome the perception that gambling is a "vice". Deregulation saw an explosion of casinos, gaming machines (pokies), Lotto, Instant Kiwi, and sports betting. Pokies have grown at a phenomenal rate – there are now more than 25,000 machines in New Zealand, the second highest rate per head of population in the world (New Zealand Herald, 2002).

At the same time, the cut back of welfare provisions, the adoption of 'low tax' policies, technological developments, and the increasing consumption of leisure and recreation, all contributed to gambling's popularity and profits. The overwhelming emphasis on economic objectives led to a gradual devaluation of social policy imperatives with respect to gambling (Australian Institute for Gambling Research, 2001).

The economic contribution of gambling is uncertain. Some commentators believe that a move to a more liberal gaming environment leads to an increase in gambling turnover and in the industry's contribution to GDP. Others argue that gambling simply transfers money from other areas of expenditure and does not contribute to GDP on its own.

This view is supported by Easton who believes that gambling is essentially a mechanism that transfers wealth into the hands of a few, and is therefore economically regressive (Easton, 2002b).

Some proceeds of gambling contribute to worthy community groups, schools, sports clubs and other organisations, however many commentators see this, too, as a "transfer", and not an economic benefit per se. It is also difficult for community groups to access funds in the event of declining contributions. An recent example of this was the application by Sky City and Sky Alpine Casino, whom despite posting profits for 2002 of over \$85 million, wished to reduce their contribution to the Community Benefit Fund from \$100,000 per annum to \$30,000 for the first 18 months of operation and \$45,000 per annum thereafter (Gambling Watch, 2002). This is tantamount to expecting the community to subsidise their profit shortfall.

Further, it is inappropriate for social and community services to become dependent on the proceeds of gambling. Recently, some community groups (including Wellington's Downtown Community Ministry) have indicated they will not seek grants derived from the proceeds of gambling (Radio New Zealand News, 2002) because of the social costs gambling has on the wider community.

To counter these wider social costs, more responsibility must be taken by Government and the industry over acceptable levels of activity in our communities. Harm minimisation policies - higher age limits for youth, and stricter opening hours should be utilised, as should other policies, such as increased community involvement in the establishment and size of gaming businesses. In addition, more resources must be made available for vulnerable groups. There is also a clear need for more research on the impacts that gambling has on communities and low-income families. Most importantly, gambling must be seen in its wider context. Questions about the level to which gambling should be encouraged in communities; the dangers of such encouragement; and the risks involved in having research and sport institutions dependent on income derived from gambling must be addressed by Government and the community at large.

Problem Gambling

Gambling can become a public health issue when it develops into problem gambling, or a pattern of 'gambling behaviour that [can] compromise, disrupt or damage health, personal, family or vocational pursuits'. (Abbott in Australian Institute for Gambling Research, 2001). Australian research on problem gambling takes less of a medicalised approach, defining problem gambling as a social and public health issue subject to a broad range of environmental, socio-cultural, political and economic factors (Australian Institute for Gambling Research, 2001). CPAG endorses this wider view and is encouraged to see the New Zealand Government moving towards this more comprehensive definition.

In New Zealand, 1.3% of the total population are thought to be problem or pathological gamblers (Abbott in Australian Institute for Gambling Research, 2001). In 2001, the Gambling Problem Helpline received more than 14,000 calls, double the number of three years earlier (Gambling Problem Helpline, 2001). In 2000, 48% of new callers seeking help through the helpline were women – the adults most likely to be the primary caregivers of children. Problem gambling is destructive of individuals, whanau and communities. It is sadly ironic that Maori, as a unique indigenous population, which prior to contact with non-Maori, had no history or traditional concepts relating to gambling, are now some of the worst affected (Dyall, 2003). A recent study showed that Maori were three times more at risk of gambling problems, and spent more on gambling than Pakeha, even though on average, Maori household incomes were significantly lower (Abbott & Volberg, 1999).

Risk factors for problem gambling include low educational achievement, unemployment, youth, and a history of anti social behaviour or psychiatric problems. Coming from a low socio-economic background was also found to be a possible risk factor (Australian Institute for Gambling Research, 2001). The growth of gaming machines is thought to be a specific concern for problem gamblers, and more research into their effect is urgently needed.

The costs of problem gambling spread beyond interpersonal networks and into the public domain. Specific examples include job losses which lead to benefit qualification, related ill-health placing demands on public health resources and

counselling services, and related financial difficulties occasionally involving the services of charities. With respect to gambling-related crime, costs borne by the public legal system include demands on police services, the courts and penal institutions (Productivity Commission in Australian Institute for Gambling Research, 2001).

Responsible Gaming Bill

The Responsible Gaming Bill was introduced into Parliament in 2002 and is expected to become law in 2003. CPAG welcomes the Bill and its aim to coordinate regulation of all sectors of the gambling industry into one Act. It is positive to see recognition of the public harm that gambling causes, the efforts in the Bill to increase "harm minimisation" measures, and involve the Ministry of Health in assisting with problem gambling. CPAG also welcomes the increased community involvement regarding the availability of more "risky" forms of gambling.

However, the Bill needs to be strengthened to further tighten controls on the number of gaming machines in existing buildings, and to apply stricter procedures for gambling licence applications. In addition, a stronger public health perspective should govern the proposed Gambling Commission.

Smoking

Parents and other household members smoking tobacco is one of the primary causes of ill health in children (Ministry of Health, 1999c; Waldegrave et al., 1999). Each year in New Zealand, second hand smoke causes more than 500 children under two years old to be admitted to hospital with chest infections; about 15,000 episodes of asthma in children; glue ear which requires operation in 15,000 children; and 50 children to be afflicted by meningococcal disease. Second hand smoke also doubles the rate of cot death in babies (Ministry of Health, 2001b).

Recent research from the University of Otago shows that more than 10% of children in New Zealand are likely to be at risk from household spending on tobacco, as cigarette expenditure can compromise other areas critical to child health. This disproportionately affects children from low-income families. The report notes that smoking cannot be seen merely as a matter of parental choice, given the addictive nature of nicotine and the substantial efforts by the tobacco industry to recruit smokers.

Smoking is highly addictive, and directly damages health. A 2001 ASH survey conducted amongst Year 10 students showed that 15.2% of girls and 13.5% of boys were smoking daily. Although the rate for girls has declined, the rate for boys remains unchanged. Both levels are still unacceptably high (Action on Smoking and Health (ASH), 2001).

Maori are over-represented in statistics on smoking – while only 23% of non Maori smoke, 46% of Maori do (Ministry of Health, 1999c). Within Maori, those with low incomes are even more likely to smoke. Of families with an income of less than \$10,000 a year, 63% smoked, compared with 39% of those families with an income of \$50,000 or over (Te Puni Kokiri, 2000b).

Although the Government collects more than \$1 billion from tobacco taxes each year, only a fraction of that is spent on tobacco control programs. There is an urgent need for a substantial increase in funding smoking cessation programs, especially amongst low-income parents (Thomson, Wilson, O’Dea, Reid, & Howden-Chapman, 2002).

A further concerning aspect about tobacco is the extent to which it acts as a “gateway” drug to other drugs. Children and adolescents who have learned to cope with the initial unpleasantness of cigarette smoke are better able to handle the harshness of marijuana smoke. Surveys conducted in Britain showed that 50% of tobacco smokers had also tried an illegal drug, compared with only two percent of non-smokers (Scott & Grice, 1996).

While New Zealand has made good progress in advancing a smoke-free environment and anti-cigarette culture, there must be continued and sustained government intervention to promote anti-smoking messages.

Cannabis

Cannabis is the third most widely used recreational drug in New Zealand, after alcohol and tobacco, despite its illegal status. Prolonged and heavy use of cannabis can have serious health consequences including respiratory diseases, psychotic symptoms (such as schizophrenia) and can impair the educational performance of adolescents (Ministry of Health, 2002a). Like tobacco smoke, marijuana can damage the unborn child, effecting foetal development with associated low birth weight.

There is also an increased risk of birth abnormalities, or childhood abnormalities. Cannabis can adversely affect parenting skills and the socio-economic potential of affected families.

Cannabis is usually used for the first time by young people aged between 15 and 18. By age 21, 9% of the population are expected to be addicted to cannabis (Ministry of Health, 2001a). The National Drug Survey found that 48% of those who tried cannabis had done so by the age of 16. Almost everyone (97%) who ever tried it had done so by the age of 25 (Ministry of Health, 2002a).

A recent study from the University of Otago showed that adolescents who started smoking cannabis had a substantially greater likelihood of suffering from adult schizophrenia by the age of 26 (Arseneault et al., 2002). This confirmed a 1997 report which found that young people who began using cannabis before the age of 16 were more likely to have problems such as juvenile offending, mental health disorders, low scholastic achievement, and unemployment in later adolescence. The report recommended policies that delayed the onset of first cannabis use.

There is a lack of appropriate treatment facilities in Auckland and support for recovering addicts, especially young people, whose rehabilitation can be costly and frustrating.

The tragedy of drug use with children and adolescents is that they absorb these substances much faster than adults, the blood level of these drugs will consequently be higher and their effect on the body greater. Their livers metabolise them...less efficiently and their livers excrete them...more slowly. At the same time, their personality, intellect and body systems are undergoing profound changes, thus rendering them vastly more susceptible to harm than adults, who, in theory anyway, are fully formed and mature (Scott & Grice, 1996).

Alcohol

Alcohol is New Zealand’s most widely used drug. Its negative health effects are well documented. Low-income families with children suffer disproportionately more because, as with smoking families, income spent on alcohol is money not available for other necessities.

Some research has shown that for young heavy drinkers (14 years old), coming from a disadvantaged background was a noticeable risk factor (Fergusson et al in Ministry of Health, 2002a).

Teenage drinking increased throughout the 1990s (Casswell & Bhatta, 2001). Between 1995 and 2000 drinking consumption changed markedly among the younger age groups. Among 14 to 15 year olds, there was an increase in amount consumed on a typical drinking occasion, as well as an increase in frequency of drinking. As well, 16- to 17-year-olds were drinking alcohol more often and consuming more (Ministry of Health, 2002a).

Reasons for this increase are not clear, but could include the normalisation of alcohol within New Zealand society, illustrated by the removal of the prohibition on alcohol advertising and the increased availability of alcohol; and the effect that international youth culture is having on teenagers in New Zealand (Easton, 2002c).

The most recent Youth and Alcohol Drinking Monitor found that 50% of young heavy drinkers were under the age of 15 years when they began drinking. The same study found that 7% of 14-17 year olds purchased their own alcohol for consumption (Kalafatelis and Fryer in Ministry of Health, 2002a). This indicates an urgent need for increased enforcement of the laws covering the sale of alcohol.

The level of drinking amongst Maori is also a concern as they make up a large percentage of low-income families. Young Maori are more susceptible to becoming "hazardous" drinkers. Of 15-24 year olds, 32% of non-Maori were likely to fall into this category, compared with 43% of Maori (Te Puni Kokiri, 2000b).

New Zealand lowered the legal minimum age of purchase from 20 to 18 years old in December 1999. There is substantial international research that shows a direct causal link between a lowered minimum purchase age and increased motor vehicle-related fatalities and injuries, and deaths by suicide. Most studies also indicate that the younger the age a person starts drinking, the more likely longer-term adverse outcomes are, such as alcohol dependence and abuse, and alcohol-related medical conditions (Ministry of Health, 2002a).

Some evidence of the effects of the lowering of the purchase age are found in a report that analysed admissions to an Auckland hospital emergency department. This reported a significant increase in the proportion of intoxicated 18 and 19 year olds presenting to the department, as well as a similar trend among 15 to 17 year olds. The study found no corresponding increase among those aged over 19 years (Ministry of Health, 2002a).

The minimum legal age of purchase should return to 20, and strict enforcement of this age limit should be a priority.

Summary

The extent of the impact of social hazards on children and young people is deeply concerning. Each year in New Zealand through second hand smoke, and drug and alcohol use and abuse, thousands of children and young people die, or suffer poor health outcomes, at huge cost to their families and society. Gambling seriously undermines family income and may adversely affect the behaviour of family members. These hazards have greater impact on poor families, because a lack of resources limits the choices they can make. Reducing the prevalence of these social hazards requires appropriate legislation and education, combined with government policies that reduce poverty and its effects.

Recommendations

1. Encourage local initiatives to ban/eliminate pokie machines.
2. Increase contributions from gambling operators to cover social costs of problem gambling.
3. Campaign to make smoking tobacco and cannabis socially unacceptable in front of children.
4. Increase investment in smoking cessation programmes, especially those targeted at low-income families.
5. Continue with efforts to change prevailing attitudes towards excessive drinking patterns, and extend these efforts to other social hazards.
6. Raise the minimum legal age for the purchase of alcohol to 20 and ensure enforcement.

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