Child Poverty and Child Health

Failing our commitments to children in New Zealand in 2010

by
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on behalf of Child Poverty Action Group

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FAILING OUR COMMITMENTS TO CHILDREN: CHILD POVERTY AND CHILD HEALTH IN NEW ZEALAND IN 2010

M.Claire Dale, Susan St John, Innes Asher, & Olaf Adam.[1]

Executive Summary

This working paper is to form part of the report "Children and Youth in Aotearoa 2010" to the United Nations Committee on the Rights of the Child, prepared by Action for Children and Youth Aotearo Inc. (ACYA).

Child Poverty Action Group (CPAG) believes that Aotearoa New Zealand fails to meet its commitments under the convention in a number of areas, in particular income adequacy and health but also education and non-discrimination.

The underlying issue is increasing income inequality and a consequent high number of children living in poverty and severe hardship, in poor housing conditions, with limited access to primary health care. Our research found that children from low income households in New Zealand are multiple times more likely to suffer from large variety of diseases than their more affluent peers. These inequalities are most evident in hospital admissions for relatively common diseases such as Rheumatic fever (28 times), Bronchiectasis (15 times), serious skin infection (5 times) and Tuberculosis (5 times).

Whilst these facts are well established. our evidence suggests that health inequalities are increasing rather than decreasing, breaching **Article 6** of the United Nations Convention on the Rights of the Child (the convention), every child's inherent right to life. Such inequalities also breach **Article 24** of the convention which grants children the right to "...enjoyment of the highest attainable standard of health...", where health outcomes of least deprived children serve as benchmark.

Ethnic disparities are similarly evident, which breaches **Article 2**. States Parties agree to ensure children are protected against all forms of discrimination, yet Maori and Pasifika children disproportionately suffer higher hospitalisation rates than New Zealand European/Pakeha.

In 2005, 170,000 New Zealand children lived in families earning less than 50% of the median household income. New Zealand is outperformed by a number of countries with a much lower GDP per capita, i.e. Czech Republic, Slovak Republic, Hungary and Korea. Widespread child poverty undermines children's right to an "adequate standard of living" as per **Article 27** of the convention. In 2007 figures 50% of the median income equates to $355 per week for a single parent, an amount considered insufficient to cover essential living cost. As a direct result of poverty many children lack basics such as adequate nutrition or warm and dry housing.

New Zealand has the second worst child health and safety record amongst the 25 leading OECD countries as measured in child deaths caused by infant deaths, immunisation rates and accidental deaths (OECD). These measures, to a large extent related to poverty, result in a failure to meet **Article 5** of the convention.

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CPAG asserts that child poverty in New Zealand is a consequence of political choices and inaction, not an economic accident. As such, this breaches **Article 3** of the convention, and CPAG hold successive governments responsible for the continuing discrimination against children from low income families.

The current social welfare system is insufficient to provide for an "adequate standard of living" for many parents, who are unable to provide it themselves and as such New Zealand fails in its responsibilities under **Article 26** and **Article 27** of the convention.

Introduction

This working paper forms part of the report "Children and Youth in Aotearoa 2010" to the United Nations Committee on the Rights of the Child, prepared by Action for Children and Youth Aotearoa Inc. (ACYA).

Child Poverty Action Group (CPAG) is a non-governmental organisation formed in 1994 because of profound concern that poverty among families is endemic in Aotearoa-New Zealand and becoming increasingly intractable. The aim of our organisation is the development and promotion of better policies for children and young people. CPAG comprises a group of academics and workers in the fields dedicated to achieving better outcomes for children. We represent a wide network, and our backgrounders and monographs are widely read and distributed. Our recent reports *What Work Counts? Work incentives and sole parent families* (2010), and *Left behind: How social and income inequalities damage our children* (2008), can be found with other background material at our web site www.cpag.org.nz.

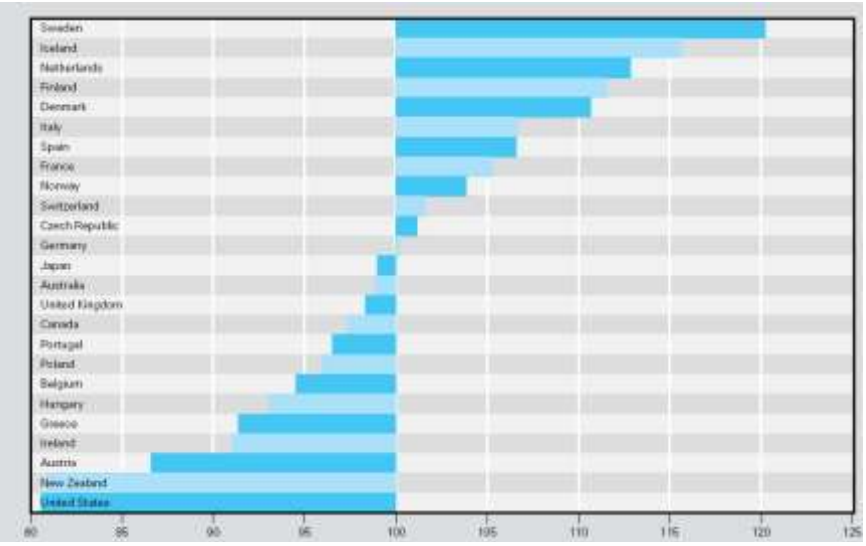
This working paper is based on presentations given in 2009 and 2010 by Professor Innes Asher, Associate Professor Susan St John, and Dr M.Claire Dale for CPAG to various audiences on child poverty, and the consequences for children's health and safety. Analysis of the state of children's health and safety provides evidence that health outcomes are interconnected with socio-economic status of children. We conclude that child poverty is the root cause for the poor health of children in Aotearoa New Zealand. There is evidence of substantial disparities between different ethnic groups, which breaches the provisions of non-discrimination, breaching **Article 2** of the United Nations Convention on the Rights of the Child (the convention). Further, **Article 24** recognises that the "highest attainable standard of health" is a right of every child.

CPAG strongly believes that child poverty in New Zealand is a consequence of political choices and inaction, not an economic accident. The OECD Report 2009 states: "New Zealand needs to take a stronger policy focus on child poverty and child health." It found that overall New Zealand spends less than the OECD average on young children, and needs to spend considerably more on younger, disadvantaged children.

As such we believe that New Zealand's government fails in its commitments under the convention, which in **Article 3** requires the interests of the child to be a primary consideration. **Article 4** requires that "...state parties shall undertake such measures to the maximum extent of their available resources ..." to implement the rights recognised in the convention.

International comparisons

Children's health and safety – % OECD average infant deaths, immunisation rates, deaths from injuries[2].



[2] UNICEF, 2007, *An overview of child well-being in rich countries.*

The OECD's 2009 report, *Doing better for children*, found that outcomes for New Zealand children are weak in several key areas.

New Zealand has the highest rates of suicide for those aged 15-19 year and child mortality is higher than the OECD average. Both breach **Article 6**, children's right to life.

Immunisation rates are poor especially for measles & pertussis. The immunisation rate against measles of 82% amongst 2 year olds is the second lowest of all OECD countries.

New Zealand's rates for serious bacterial infections and respiratory diseases compares poorly with other developed countries.

International comparisons of rates for serious bacterial infections and respiratory diseases[3]

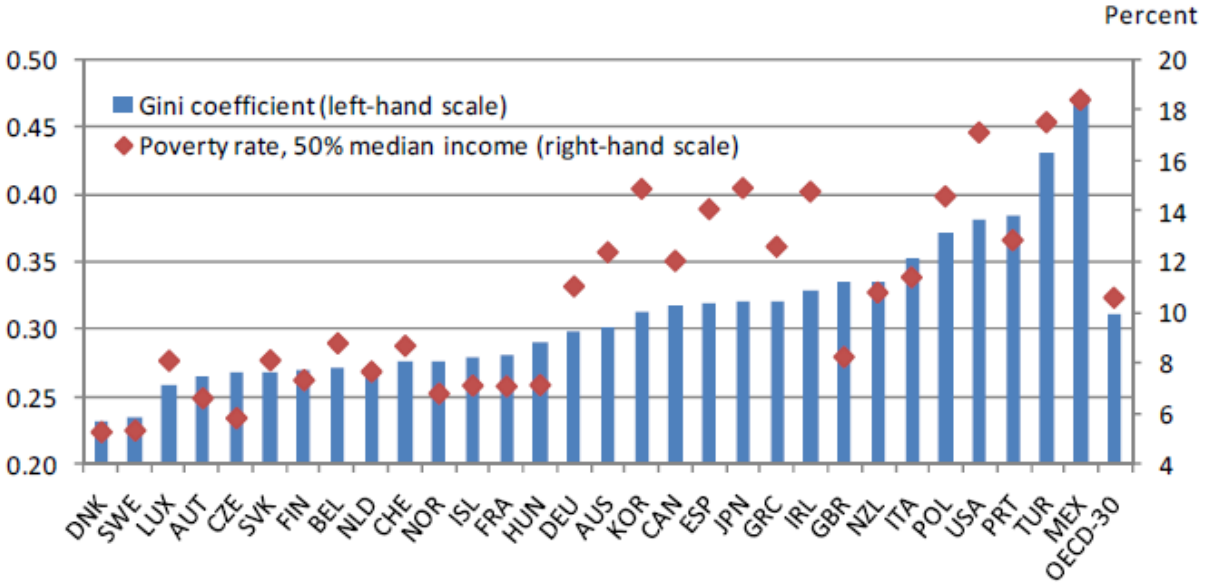
Disease	**Other OECD countries' relative rate**	**NZ relative rate**
Rheumatic fever	1 (OECD)	13.8
Serious skin infections	1 (USA, Australia)	2
Whooping cough	1 (UK, USA)	5-10
Pneumonia	1 (USA)	5-10
Bronchiectasis	1 (Finland)	8

CPAG sees a strong relation between these figures and child poverty, i.e. they result from inadequate and unaffordable housing and poor access to primary health services.

CPAG strongly believes that income inequality and poverty are the main causes for New Zealand children having worse health and safety standards than almost any other OECD, country, ranking 29th out of 30.[4]

Income inequality is measured by comparing the incomes of the top 20% of households with the incomes of the bottom 20%. In 2008 the Organisation of Economic Cooperation and Development published its report "Growing Unequal", in which it compared income inequality measured by the GINI coefficient and poverty rate. According to this report New Zealand ranks 7th worst on the GINI index amongst OECD countries.

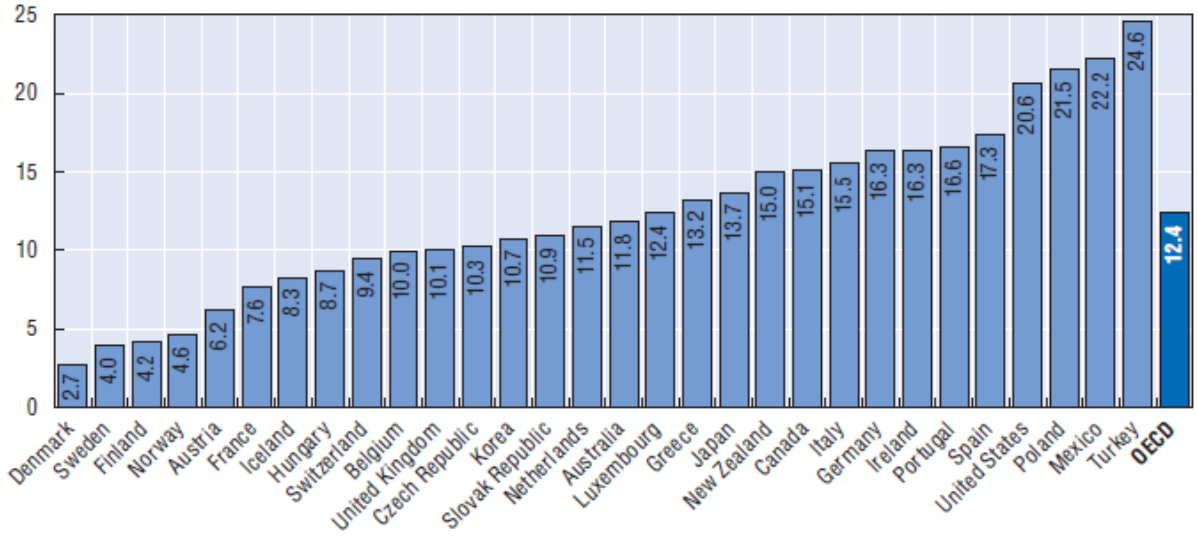
Levels of income inequality and poverty in the mid-2000s



[3] Craig E, et al., 2007. *NZCYES: Indicator Handbook.*
[4] OECD, 2009, *Doing Better For Children*, Table 2.1 p. 23.

In terms of child poverty – defined as percentage of children living in households with less than 50% of the median income – New Zealand ranks low at 20th amongst 30 OECD countries. Note that child poverty (15.0%) exceeds general poverty (11%) implying that more children are affected by poverty than the general population.

Percentage of children living in poor households (below 50% of median equivalised income, circa 2005[5]

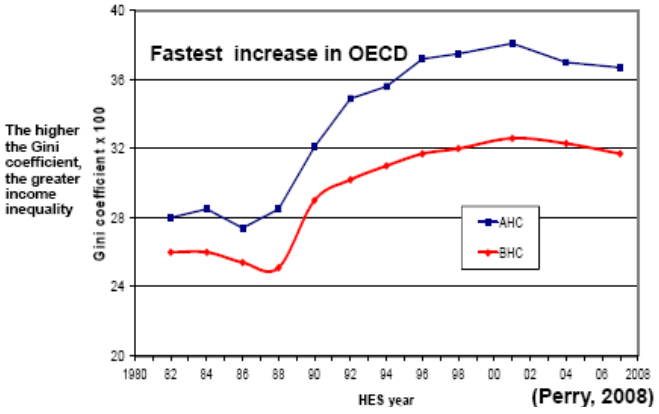


In 2007 figures 50% of the median income equates to $355 per week for a single parent or $475 for a couple.[6] Having regard for a modest family budget, these amounts cannot be considered sufficient to cover essential living costs. As such children living in poverty suffer severe hardship.

Inequalities within New Zealand - Income

High levels of inequality as measured by GINI index are associated with lower levels of social cohesion and personal wellbeing, even when people have adequate incomes to meet their basic needs. The proportion of the population with comparatively low incomes also provides information about how equitably resources are distributed and how many people are likely to be on incomes that do not allow them to participate fully in society.

Changes in income inequality in NZ, 1982-2007 (GINI)



[5] OECD, 2009, Doing Better For Children, Figure 2.2, p. 35.
[6] Children's Commissioner 2008, *A Fair Go For Children*, Michael Fletcher & Maire Dwyer.

As outlined earlier New Zealand's level of inequality exceeds OECD average. Children are disproportionately affected by poverty as demonstrated earlier. The definition of poverty most commonly applied (percentage of individuals with incomes below 50% of the median) relates closely to income inequality.

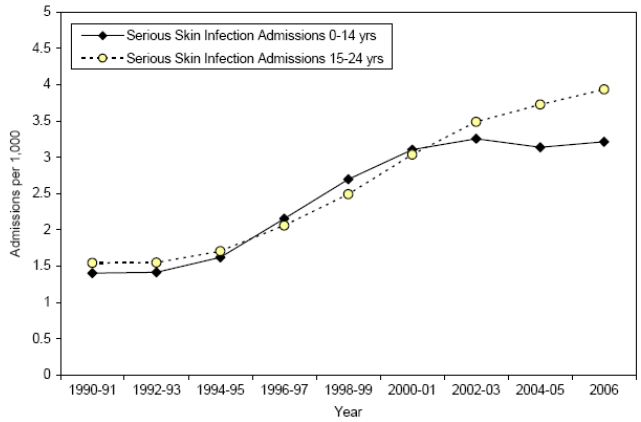
CPAG research and experience shows that people affected by poverty are unable to meet basic needs. As outlined earlier poverty in New Zealand means severe financial hardship for those effected as income levels are in most cases insufficient to meet basic needs in the areas of housing and nutrition. As a result children affected by poverty cannot enjoy a number of rights guaranteed in the convention. Particularly in the area of preventable diseases we have found considerable disparities between wealthy children and poor children.

Hospitalisation for serious bacterial infections and respiratory diseases risk by Deprivation 0-14 years, 2002-06[7]

Cause of hospital admission	Least deprived (NZDep1)	Most deprived (NZDep10)
Meningococcal disease#	1	4.93
Rheumatic fever	1	28.65*
Serious skin infection	1	5.16
Tuberculosis	1	5.06*
Gastroenteritis	1	2.00
Bronchiolitis##	1	6.18
Pertussis	1	3.70*
Pneumonia	1	4.47
Bronchiectasis	1	15.58
Asthma	1	3.35

There is evidence that disparities in health outcome are increasing in line with a widening of the wealth gap.

Serious skin infections hospital admissions 1990-2006 (Craig E, et al., 2007. *NZCYES: Indicator Handbook*).



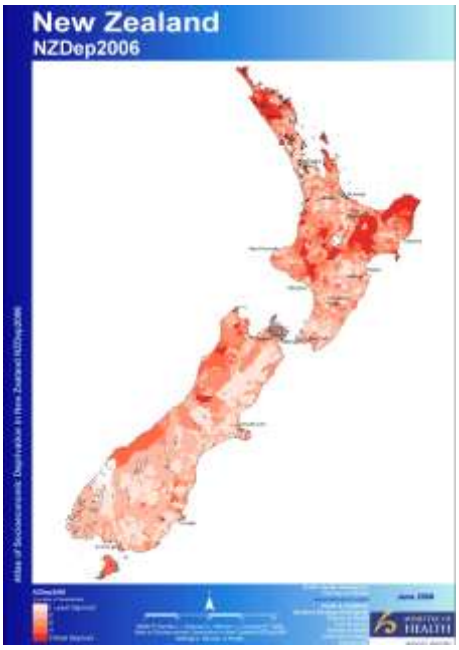
Professor Sir Geoffrey Rose, 1992. *The strategy of preventive medicine*: "The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart."

The incidence of serious skin infection hospital admissions 0-14 Years by District Health Board (DHB) 2002-2006 (Craig E, et al., 2007. *NZCYES: Indicator Handbook*), reflects regional differences in hardship and poverty, which are also visible in DHB's 2008 *Atlas of Socio-economic Deprivation,*[8] as illustrated below.

[7] Craig E, et al. 2007. *NZCYES: Indicator Handbook.*

[8] See: *http://www.moh.govt.nz/moh.nsf/indexmh/dhb-Maps-and-background-information-atlasof-Socioeconomic-deprivation-in-nz.nzdep2006*.

In 2007, new entrants at school with prior participation in early childhood education (ECE) was highest in Canterbury and Otago regions where there is little poverty (99% and 98% respectively); and lowest in Northland (91%), Auckland and Gisborne (both 92%) where there is widespread poverty. The lasting positive effects of early childhood education are now well-known, yet in 2007, only 83% of new entrants in decile 1 schools (most socio-economic disadvantage) had previously attended ECE services, compared with 97% in decile 6 and 99% in decile 10 schools (MSD, *The Social Report,* 2008).



Despite government funding, the ECE service is not always available: rural areas have few children, high costs of transport, less access to services, and high levels of poverty.

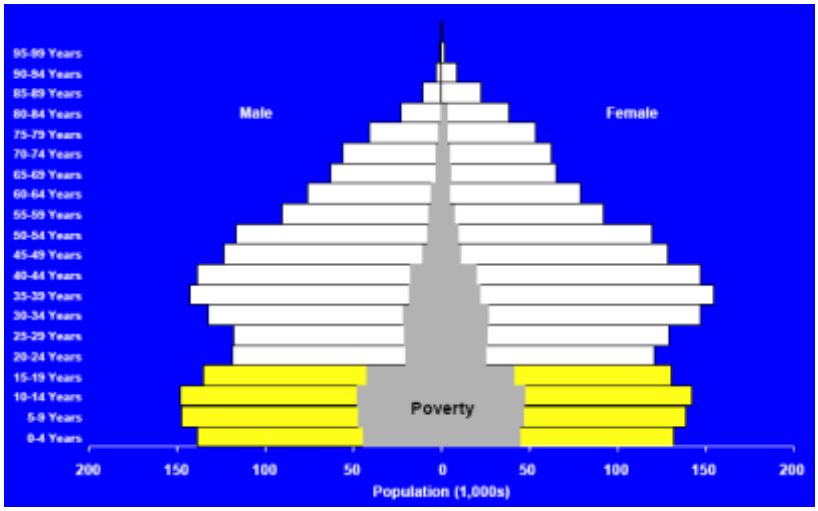
Applying health outcomes of least deprived children as a benchmark for "the highest attainable standard of health", the above statistic implies that **Article 24** of the UN convention is being breached. In simple terms, poor children in New Zealand *do not* enjoy the same standard of health as their more affluent peers.

CPAG has identified three main causes for above disparities;

- One: Poverty;
- Two: Limited access to primary health care; and
- Three: Cold, damp, overcrowded housing.

One: Poverty

Estimates of New Zealanders in real term poverty include 28% of our children. "Using the 60% 'moving line' measures (After Housing Costs) the child poverty rate fell from 30% to 22% from 2001 to 2007, but rose to 28% in 2008, consistent with the rise in housing costs relative to income" (MSD, 2009, p. 19).[9]



Five indicators are used in the Ministry of Social Development's *Social Report* to provide information on different aspects of economic standards of living: market income per person, income inequality, the population with low incomes, housing affordability and household crowding. These objective measures of economic living standards provide information on the adequacy of people's incomes and their ability to participate in society and make choices. They also provide information about overall trends in living standards, levels of hardship and how equitably resources are distributed.

Market income per person gives an indication of the average level of income and therefore the overall material quality of life available to New Zealanders. This internationally-recognised measure allows comparisons between New Zealand and other countries. As demonstrated previously, young people from low socio-economic communities are less likely than other young people to attain higher school qualifications, and are thus less likely to earn higher incomes through their adult lives.

[9] Ministry of Social Development (2009) *Household incomes in New Zealand: trends in indicators of inequality and hardship 1982 to 2008.*

A practical definition of poverty is that people have insufficient income for:

- Health care (transport, doctors fees, prescription costs, hospital parking);
- Nutritious food;
- Adequate housing (not crowded, damp, cold or too costly);
- Clothing, shoes, bedding, washing facilities;
- Education (stationery, school donations, exam fees, school trips);
- Recreation and social participation.

In 2007, only 49% of school leavers from deciles 1–3 schools (in the most disadvantaged communities) attained qualifications at NCEA Level 2[10] or above, compared with 62% of those leaving deciles 4–7 schools and 79% of those leaving deciles 8–10 schools. Those achievements are reflected in adult incomes. While a causal relationship is not implied, there is an apparent correlation.

Despite its limitations as a poverty measure, income impacts on education, and is one of the most important determinants of health. Insufficient disposable income, substandard housing, inadequate nutritious food and unequal access to health care all contribute to the risk of poor health.

CPAG calculates that in 2010, 150,000 children in New Zealand are in severe or significant hardship. Compared with almost any other OECD country, our children have higher rates of infant mortality, preventable illness, and deaths from injuries.

Two: Access to primary health care

"Immunisation rates are a measure of national commitment to primary health care for all children." (Ministry of Health (MoH), 2007. *The National Childhood Immunisation Coverage Survey 2005)*

Fully immunised at 2 years:

	NZ average	**MOH plan**
1991/2	56%	• 85% full immunisation by 1997, Māori equalling non-Māori • then 95% by 2000
1999	63.1%	90% by 2003
2005	77.4%	95% but no date for goal given
June 2008	78%	
March 2010	85%	

Direct cost of GP visits for children: comparative figures:

	NZ	**UK, Europe***	**Canada**	**Australia**
In hours: 25% of the week	$0 - $33	$0	$0	$0 - 7.50 for a $50 visit
Out of hours: 75% of the week	$0 - $120	$0	$0	$0 - 7.50 for a $50 visit

* Excluding Ireland

MoH (NZ), 2005. *After Hours Working Party*: "High fees create access barriers, patients may delay seeking urgent primary health care treatment."

MSF, 2008. *No cash No care. How user fees damage health*: "The people most excluded from primary health care are the poor."

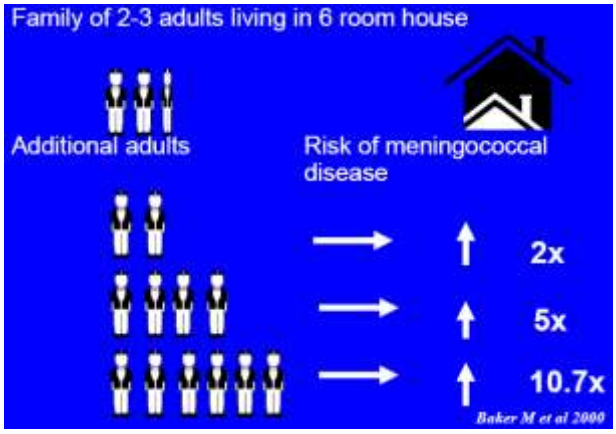
UN, 2009. *Great leap forward on free healthcare*: "User fees punish the most vulnerable members of society, especially women and children."

In New Zealand there have been some reductions in cost barriers to primary care for children under six years, but the goal of universal free care remains unmet. Reducing cost barriers to primary care access for young children should remain an important target as one component of reducing preventable diseases.

[10] NCEA is the national education qualification.

Three: Housing

As the figure demonstrates, the risk of contracting meningococcal disease is increased by household crowding.



Housing affordability measures the proportion of the population spending more than 30% of their disposable income on housing. Housing costs have a major impact on overall material living standards. The final indicator measures the number of people living in overcrowded houses. Housing is a basic need, and this indicator provides a direct measure of the adequacy of housing people can afford.

Housing quality in New Zealand is variable: 300,000 older New Zealand homes are wooden, un-insulated, damp and cold. In 1978 insulation for new housing became compulsory, but in 2008, less than half of all old state (public) houses have been retrofitted with insulation, despite the government's commitment to do all by 2013.

Also, energy to heat homes is unaffordable for many families. Since 2001 some healthy housing programmes have been in place and evaluated (eg *Healthy Housing, Healthy Homes*). New Zealand research studies show clear health benefits from healthy housing.

Inequalities within New Zealand - Ethnicity

Ethnic inequalities are evident in New Zealand's health statistics. Closely correlated to poverty it is evident that Maori and Pacifika in particular fail to reach the same standards as their European peers.

Hospitalisation for serious bacterial infections and respiratory diseases risk by ethnicity 0-14 years, 2002-2006[11]

Cause of hospital admission	European	Māori	Pacific	Asian/Indian
Meningococcal disease#	1	2.13	4.05	0.31
Rheumatic fever	1	22.97	48.62	0.99
Serious skin infections	1	2.77	4.77	0.88
Tuberculosis	1	11.10	45.18	54.98
Gastroenteritis	1	0.88	1.45	1.10
Bronchiolitis	1	2.95	4.34	0.45
Pneumonia	1	2.04	5.07	1.05
Whooping cough	1	2.25	2.77	0.29
Bronchiectasis	1	4.03	10.63	0.7
Asthma	1	2.19	3.14	1.14

The statistics above demonstrates the breach of **Article 2** of the convention which demands that the rights are ensured for each child without any ethnic discrimination. However, it is not the disparities in themselves but the continuous lack of effective targeted action by the government that has caused the breach.

Dr Papaarangi Reid & Dr Bridget Robson, 2007. *Hauora. Maori standards of health. A study of the years, 2000-2005:* "…consistent, comprehensive and compelling disparities in health outcomes and exposure to the determinants of ill-health. …despite the strength of these longstanding heath inequalities, they do not create dismay, disbelief or horror. They have become expected. This acceptance and normalisation of inequalities provides an excuse for government inaction."

[11] Craig E, et al., 2007. *NZCYES: Indicator Handbook*

In terms of educational achievement Maori and Pacifika also lag behind New Zealand Europeans / Pakeha. The table below draws on data from MoEd 2007, and Statistics New Zealand's Household Labour Force Survey, to show ethnic differences in ECE attendance, and secondary and tertiary qualifications.

Education level	**Year**	**European %**	**Maori %**	**Pacific %**
ECE	2007	98.2	90.6	84.0
Upper secondary	2007	80.1	62.9	49.7
Tertiary	2007	21.6	9.4	8.4

Intense focus is on early childhood because that experience of education, nutrition, and physical, intellectual and emotional learning flows through into adolescent and adult potential.

Professor Sir Michael Marmot et al., WHO, 2008. *Closing the gap in a generation: Health Equity through Action on the Social Determinants of Health:* "Social injustice is killing people on a grand scale."

In 2007, the Labour government implemented a support package targeted at working families. While it addressed some of the issues for children of low income parents, the package discriminated against children in households reliant on state support.[12]

Increase in beneficiary numbers, March 2008 – June 2010[13]

	Unemployment		Domestic Purpose		Sick Benefits		Invalid Benefits		All Main Bene
End Quarter	Beneficiaries	Change	Beneficiaries	Change	Beneficiaries	Change	Beneficiaries	Change	Beneficiaries
Mar-08	19,034		95,861		45,676		81,130		241,701
Mar-09	37,147	95.2%	102,003	6.4%	51,041	11.7%	83,961	3.5%	274,152
Sep-09	60,660	63.3%	107,658	5.5%	56,384	10.5%	85,051	1.3%	309,753
Jun-10	62,085	2.3%	111,689	3.7%	58,465	3.7%	84,877	-0.2%	317,116

CPAG has argued that the In Work Tax Credit (IWTC) part of Working for Families, discriminates against the children of beneficiaries, and has taken a case to the Human Rights Tribunal on these grounds. The child-relatedness of this payment has been made visible by the National government continuing to pay it via the "ReStart" package to workers who are parents who have been made redundant during this recession. In 2008, the Human Rights Tribunal found that the IWTC does indeed discriminate, and causes significant harm, but such discrimination is the prerogative of a democratically elected government. CPAG is appealing the decision.

The above outlined discrimination between workers and recipients benefits has been increased further by proposed changes to the benefits recently announced by the National led government. The introduction of work testing will force "able" beneficiaries to seek at least part time employment. This will in particular impact on domestic purposes beneficiaries, who may lose their entitlements if they are unable (or unwilling) to demonstrate initiative to find part time work. "When sanctions are enforced, children are effectively punished because of the rules applied to the behaviour of adult beneficiaries." (Associate Professor Mike O'Brien, 2005) This is in direct conflict to the provisions of **Article 26** of the convention, which grants "... every child the right to benefit from social security".

Article 27 of the convention grants all children the "right to a standard of living for the child's physical, spiritual, moral and social development." The reality of child poverty in New Zealand – as evident in health outcomes, poor housing and nutrition – contradicts this provision. Whilst the convention acknowledges the parents primary responsibility to secure such living conditions, it also commits state parties to "assist parents ... to implement this right and shall in case of need provide material assistance and support programmes,

[12] See Dale, Wynd, St John, O'Brien, 2010, *What Work Counts*, www.cpag.org.nz.
[13] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/benefit/2010-national-benefit-factsheets.html.

particularly in regard of nutrition, clothing and housing." If parents are unable to provide adequately for their children, regardless of the cause, the state is required to cover the shortfalls.

In a developed nation such as New Zealand there is no justification for children to go without a daily breakfast, for them to walk to school barefoot during winter, or to get sick because of living in un-insulated and damp houses.

Actions to improve child health and reduce the damage of poverty:

Visionary leadership is needed to address the state neglect of our children, which fundamentally breaches the United Nations Convention on the Rights of the Child. To rectify the identified breaches of the convention the following key policies need timely implementation:

***Nutrition*:** Free healthy breakfasts for children in Decile 1 & 2 schools.

Primary health care: Increase funding for prevention; and make immunisation delivery 'watertight' for all NZ children by increasing resources for providers, infrastructure for locating children, accessibility and acceptability. Provide free health care for children under 18 years, 24 hrs a day, 7 days a week. To achieve this, we need new resources and funding models.

Housing: Extend healthy housing programmes to all low income households. For landlords whose tenants get the accommodation allowance, offer an adequate government subsidy to retrofit these homes with insulation. Introduce a Warrant Of Fitness for insulation for all rental homes.

Education: Improve access to education and educational resources for the most disadvantaged children.

Incomes: Extend payment of what is now called "In Work Tax Credit" and is part of "ReStart" to all children, beyond those whose parents meet the work text, or who have been made redundant.

Benefits*:* Ensure that benefits are available to all caregivers of children at a level which ensures an adequate standard of living.

CPAG firmly believes that New Zealand has the economic ability to implement these policies. Furthermore we believe that the wider social and economic benefits will outweigh the initial cost of these policies in the long term.

Immediate benefits and savings resulting from improvements in child health would include reduced hospital admissions, and less time off work for parents and caregivers of sick children. More importantly, children's health and well-being will be improved, and some children's lives would be saved.

Long term benefits and savings as a result of improvements in child health would include less child abuse; fewer young people on invalids benefits; better adult health outcomes; breaking the cycle of intergenerational poverty; a better educated, more productive work force; stronger communities; better long term economic prosperity for the nation; and once again, in the long term, lives would be saved.