Key Points Emerging from the New Zealand Children's Social Health Monitor 2011 Update

(website http://www.nzchildren.co.nz/)

General Comments: Because of the anonymous nature of the data used, it is impossible to prove direct causal links between rising unemployment, increases in the number of children reliant on benefit recipients, and increasing hospital admissions for socioeconomically sensitive medical conditions in children. Despite this, the overall picture painted by the 2011 Childrenôs Social Health Monitor remains concerning, with one in five (20%) New Zealand children being reliant on Government Benefits as the main source of their familyôs income, and the 2008 Living Standards Survey suggesting that these benefits may inadequately protect them from exposure to material hardship (e.g. having to wear worn out shoes or clothing, sharing a bed, cutting back on fresh fruit and vegetables, and postponing doctors visits because of cost). Further, while the increases in hospital admissions for medical conditions with a social gradient seen during 2007ï 2009 were less steep in 2009ï 2010 (and for Pacific children may be beginning to taper off), large social gradients persist for many conditions (e.g. hospital admission for injuries arising from the assault, neglect or maltreatment of children are 5.6 times higher for those living in the most deprived (NZDep Index decile 9ï 10) areas, and mortality from sudden unexpected death in infancy is 7.4 times higher).

Changes in Individual Economic Indicators

1. **GDP**: New Zealand entered a recession at the end of June 2008 (after two consecutive quarters of negative growth), and left the recession at the end of June 2009 (although growth at that time (+0.1%) was extremely close to zero). Since then GDP growth has been variable (range -0.1% to +0.9%), with GDP growth in the most recent (March 2011) quarter being +0.8%. Economic activity for the year ending March 2011 increased by 1.5%, when compared to the year ending March 2010.
2. **Seasonally Adjusted Unemployment**: After sitting below 4.0% for the majority of 2005ï 2007, seasonally adjusted unemployment rates rose during 2008ï 2009, to reach a peak of 7.0%, in the December quarter of 2009. Since then unemployment rates have fluctuated in the mid-to-high 6% range, with rates in the most recent (June 2011) quarter being 6.5%.
3. **Youth Unemployment**: While young people 15ï 19 years are not the primary focus of the Monitor, it is concerning to note that on an annual basis, unemployment rates for those aged 15-19 years rose extremely rapidly during (the years ending) June 2008ï 2010, with unemployment in this age group reaching 26.0% in the year ending June 2011.
4. **Ethnic Differences in Unemployment**: When broken down by ethnicity, both overall unemployment rates and absolute increases in unemployment were highest for MŪori and Pacific peoples during 2008ï 2009, although rates for these two ethnic groups were more static during 2010ï June 2011. In the June quarter of 2011, unemployment rates were 12.6% for MŪori, 13.7% for Pacific, 6.5% for Asian and 5.3% for European people.
5. **Children Reliant on a Benefit Recipient**: Even during 2007ï 2008, when New Zealandôs unemployment rates were at their lowest, nearly one in five (å18%) of New Zealandôs children were reliant on a benefit recipient for their familyôs income. During April 2008ï April 2010, the number of children reliant on benefit recipients increased further, with the number of children reliant on DPB recipients increasing from 158,173 in April 2008 to 177,226 in April 2010, and the number reliant on unemployment benefits increasing from 5,289 in April 2008 to 16,380 in April 2010. Between April 2010 and 2011 the number of children reliant on DPB recipients increased still further (to 180,845 or 15.8% of all NZ children), while the number of children reliant on unemployment benefit recipients declined slightly (to 15,711 or 1.4% of all NZ children). When all benefit types were taken into account, the total number of children reliant on a benefit recipient

increased from 201,083 in April 2008 to 234,572 in April 2011, with 20.4% of all NZ children being reliant on a benefit recipient in April 2011.

6. **Living Standards**: In the 2008 Living Standards Survey, 51% of Pacific children, 39% of MŪori children, 23% of ñOtherò children, 15% of European children, and 59% of children whose familyôs income source was a benefit, scored four or more on a composite deprivation index, which measured a range of ñenforced lacksò Children (aged 0ï 17 years) scoring four or more on the composite deprivation index had much higher exposures to household economising behaviours such as having to wear worn out shoes or clothing, sharing a bed or bedroom, cutting back on fresh fruit and vegetables and postponing doctors visits because of cost.

Changes in Individual Health Status Indicators

7. **Hospital Admissions for Socioeconomically Sensitive Conditions**: In the Monitor, conditions are considered socioeconomically sensitive if they exhibit a socioeconomic gradient (i.e. hospital admission rates at least 1.5 times higher for those living in the most deprived areas). In New Zealand, hospital admissions for medical conditions (mainly infectious and respiratory diseases) with a social gradient in children increased during the early 2000s, reached peak in 2002 and then declined. An upswing in rates was again evident in 2008ï 2009, and while rates rose further in 2010, the rate of increase was much less marked than between 2007 and 2009. When compared to 2007, these increases equated to approximately 4,890 extra admissions per year by 2010*. In contrast, injury admissions with a social gradient declined throughout 2000ï 2010.

   When broken down by ethnicity, hospitalisations for medical conditions with a social gradient were consistently higher for Pacific > MŪori > European and Asian children. For Pacific children, admissions increased during the early 2000s, reached a peak in 2003 and then declined. An upswing in rates was again evident during 2007ï 2009, with rates then declining during 2010. For MŪori children, rates were static during the mid-2000s, but then increased during 2007ï 2009, while for Asian and European children rates were static during the mid-2000s but increased after 2007. Injury admissions with a social gradient were also higher for Pacific and MŪori > European > Asian children. Admissions for European and MŪori children declined during 2000ï 2010, while rates for Pacific and Asian children were more static.

   *Note: The figures presented here differ from those reported previously due to an ICD-10-AM code mapping change which resulted in a number of (presumed infectious) gastroenteritis cases being diverted to a non-infectious gastroenteritis code in the National Minimum (hospital admission) Dataset from 2008. This yearôs figures include corrections for this mapping change, which previously resulted in an underestimation in the number of gastroenteritis (a socioeconomically sensitive medical condition) admissions in children from 2008 onwards.

8. **Injuries Arising from the Assault, Neglect or Maltreatment of Children**: In New Zealand during 2000ï 2010, hospital admissions for injuries arising from the assault, neglect or maltreatment of children declined very gradually, while mortality during 2000ï 2008 fluctuated from year to year. On average during 2000ï 2008, seven children per year died as the result of injuries arising from assault, neglect or maltreatment, with the highest mortality being seen in infants under one year of age. Marked socioeconomic gradients were also evident, with hospital admissions being 5.6 times higher for those living in the most deprived (NZDep Index decile 9ï 10) areas, when compared to those living in the least deprived (NZDep Index decile 1ï 2) areas.

9. **Infant Mortality:** In New Zealand during 1990ï 2008, neonatal and post neonatal mortality both declined, with neonatal mortality exceeding post neonatal mortality during 1996ï 2008. During 2004ï 2008, neonatal and post neonatal mortality were higher for Pacific and MŪori infants, males, those in average / more deprived areas, preterm infants and those with younger mothers. Similarly mortality from Sudden Unexpected Death in Infancy (SUDI) was higher for MŪori > Pacific > European > Asian infants, those in average / more deprived areas, preterm infants, and those with mothers under 30 years of age. Of all three outcomes, SUDI had the largest social gradients, with mortality rates being 7.4 times higher for babies in the most deprived (NZDep decile 9ï 10) areas when compared to those in the least deprived (NZDep decile 1ï 2) areas.