Inquiry into the Determinants of Wellbeing for Māori Children

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About NZMA
The New Zealand Medical Association (NZMA) is New Zealand's largest medical organisation and has a pan professional membership. We have around 5,000 members who come from all disciplines within the medical profession and include specialists, general practitioners, doctors-in-training and medical students.

The NZMA aims to provide leadership of the medical profession, and promote:

- professional unity and values, and
- the health of all New Zealanders.

The key roles of the NZMA are to:

- provide advocacy on behalf of doctors and their patients
- provide support and services to members and their practices
- publish and maintain the Code of Ethics for the profession
- publish the New Zealand Medical Journal.

Acknowledgements
The NZMA gives special thanks to Dr Julia Carr, public health physician, for her advice in regard to this submission.

Executive summary
The NZMA is pleased to be able to provide input into this inquiry. Doctors have a unique and trusted relationship with their patients and, because of that, are able to provide an unpartisan insight into the issues affecting the health of Māori children. When looking at ways to improve the system for Māori children, care must be taken to ensure that that relationship of trust and confidence remains.

The NZMA believes that there is a strong link between a society's health status and the social determinants of health. An example of that link can be seen in respect of cardiovascular disease where, although there has been a general reduction across the board, the reduction in is far less among those of lower socio economic means.

It is generally accepted today that many of the socially determined health inequities are strongly influenced, if not caused by, the environmental circumstances at the beginning of life. This includes the foetus' in-utero experience.

The New Zealand Government's investment in the early years is low by international standards, with "early childhood" spending being less than half that of the OECD average.

Māori children perform poorly across a range of economic and social measures, and are generally worse off than non Māori children in terms of education, health, nutrition, drug and alcohol abuse and life expectancy.

To address these inequities the NZMA believes that not only is further investment required but that the Government needs to be clever about the way it invests. The approach for improving the social determinants of health for Māori children needs to be a multi-sectorial, whānau-centred and support development that is by Māori, for Māori.

The Primary Health Advisory Committee (PHAC) in its report "*The Best Start in Life: Achieving Effective Action on Child Health and Wellbeing*[1]" made a number of recommendations to government including calls for the following:

- the need for all significant government policies to be assessed for their potential impact on children,
- an increase in investment in public health initiatives that target the determinants of child health, and
- a seamless transition from maternity services to health care services for infants and young children.

We support those recommendations as well as the need to recognise the significance of whānau in any programmes created to improve the wellbeing of Māori children. We also think that there is some merit in the Commissioner's call for the creation of a Children's Act.

However, we also note the need for individuals, families/whanau and communities to be proactive in looking after their children/tamariki.

The doctor patient relationship

1. Doctors are at the front line of the health of their community and of the health of children in particular. The first principle under the NZMA Code of Ethics requires doctors to consider the health and wellbeing of the patient as their first priority. The general practitioner's books are open to patients from all walks of life both rich and poor, privileged and vulnerable. Their relationship with the patient and the patient's family is one of trust and confidence, and the confidentiality of what is said by the patient to the doctor will not be disclosed barring certain exceptional circumstances. As such, while the social determinants of health may be determined by issues outside the domain of health (for example, housing, income, education etc) doctors bring a unique perspective to the issue of Māori children's health, and one that is not impacted by the political views of the day. If patients and their families are to continue to see doctors it is fundamental that the relationship of trust and confidence is not compromised.

The social determinants of health

2. The NZMA strongly believes that a society's health status is closely linked to various social determinants, but particularly the social gradient. In turn, these social determinants can define a social gradient for any given society. Those near the bottom of the gradient have poorer health status than those at the top and it has been proven that there is a causal relationship between the various social determinants that indicate the position on the slope and health status. Moreover the degree of difference in health status between those at the top and at the bottom of the slope is related to the slope's steepness. An easily studied surrogate for the social gradient is income and the degree to which income varies across societies will determine the breadth of

1 The Best Start in Life: Achieving effective action on child health and wellbeing". A report to the Minister of Health prepared by the Public Health Advisory Committee, June 2010; OECD 2009. Doing Better for children. Paris

difference in health status.[2] Other determinants include occupation[3], educational attainment, and housing.

3. Being Maori, in New Zealand's current social context, can also be considered a social determinant – implying that in a different, more equitable social context this need not be the case. Māori have poorer health than non-Māori across many measures including heart disease, cancer and mortality.[4] This persists after controlling for other factors such as socioeconomic status and smoking.[5]. Explanations for this are multi-factorial.[6]

4. Sir Michael Marmot in his ground breaking research into the social determinants of health, for example, noted that a boy in the deprived area of Calton, Glasgow had an average life expectancy of 54 years compared with a boy from affluent Lenzie, 12 km away in East Dunbartonshire, who could expect to live to 82[7].

5. Minimising the impact these social determinants have on health is now a focus of concern for many high income nations including New Zealand. Apart from the obvious societal gains from a more healthy and equitable nation, there is the potential for addressing the ever increasing cost of healthcare.[8]

6. New Zealand has a very high level of understanding of its own particular set of social determinants and through the efforts of the Ministry of Health and the wider sector, has already made some progress in converting this knowledge into action.[9]

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[2] Wilkinson R, Pickett K. The Spirit Level: why greater equality makes societies stronger. New York: Bloomsbury Press; 2009.

[3] Health inequalities among British civil servants: the Whitehall II study
M.G. Marmot, S. Stansfeld, C. Patel, F. North, J. Head, I. White, E. Brunner, A. Feeney, G.Davey Smith, The Lancet, Volume 337, Issue 8754, 8 June 1991, Pages 1387-1393

[4] Ministry of Health. A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey. Public Health Intelligence Occasional Bulletin No 21. Wellington: Ministry of Health; 2004. Ministry of Health. Decades of Disparity: ethnic mortality trends in New Zealand 1980-99. Wellington: Ministry of Health; 2003.

[5] Reid P, Robson B, Jones C. Disparities in health: common myths and uncommon truths. Pacific Health Dialog 2000;7(1):38-47.

[6] Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Effects of self-reported racial discrimination and deprivation on Maori health and inequalities in New Zealand: cross-sectional study. Lancet 2006;367(9257):2005-9.. Reid P, Robson B. Understanding health inequities. In: Robson B, Harris R, eds. Hauora: Maori Standards of Health IV A study of the years 2000-2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare; 2007. Secretariat of the Permanent Forum on Indigenous Issues. State of the World's Indigenous Peoples. New York: United Nations; 2009 ST/ESA/328.

[7] Bulletin of the World Health Organisation, Vol 89 No. 10, Geneva October 2011.
http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862011001000005&lng=en&nrm=iso

[8] Marmot M. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010, London: The Marmot Review; 2010; Marmot M. The Status Syndrome. New York: Times Books; 2004; Wilkinson R, Pickett K. The Spirit Level: why greater equality makes societies stronger. New York: Bloomsbury Press; 2009.

[9] Blakely T, Tobias M, Atkinson J, Yeh L-C, Huang K. Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981-2004. Wellington: Ministry of Health; 2007; Robson B, Purdie G, Cormack D. Unequal Impact II: Māori and Non-Māori Cancer Statistics by Deprivation and Rural-Urban Status, 2002-2006. Wellington: Ministry of Health; 2010; Joshy G, Simmons D. Epidemiology of diabetes in New Zealand: revisit to a changing landscape. New Zealand Medical Journal 2006 Jun 2;119(1235); Chan W, Wright C, Riddell T, et al. Ethnic and socioeconomic disparities in the prevalence of cardiovascular disease in New Zealand. New Zealand Medical Journal 2008 Nov 7;121(1285).

7. By many health indicators however, New Zealand continues to perform poorly when compared to other high income countries and this poor performance has direct links to our own particular set of social determinants[10].

8. Cardiovascular disease is a good illustration of social equity on health. Over recent decades there has been a reduction in both the incidence and mortality from cardiovascular disease. This reduction has occurred right across the social gradient. However, the *relative* reduction in incidence is far less among those at the lower end of the gradient.[9] Most studies agree that this phenomenon is predominantly due to those at the lower end of the gradient continuing to have relatively higher rates of tobacco use and central abdominal obesity. But most researchers agree there is still a 20% difference not accounted for by traditional risk factors, and this difference appears to be due to the effects of social determinants. Therefore, addressing tobacco use and obesity in low gradient groups will require some intervention at the social determinant level in addition to simply promoting smoking cessation and diet modification.[11]

9. Likewise the high rates of rheumatic fever among Māori children is a strong indicator of social inequity as Māori children suffer rates of rheumatic fever more in line with third world countries than the first world country New Zealand prides itself as[12]. In this regard we acknowledge the recent government announcement of increased funding to fight this disease.[13]

10. There is universal agreement that many of the socially determined health inequities are strongly influenced, if not caused by, the environmental circumstances at the beginning of life, including the foetus' in-utero experience.[14]

11. A child's early life experiences, including whether they are brought up in a nurturing environment, have good exposure to language development, and develop social skills also have a critical effect. Conversely a child's exposure to overwhelming stress, emotional neglect, violence – whether witnessed or endured – or even environmental uncertainty has a profound influence on the incidence of a number of diseases in later life and future mental health problems. Substantial international evidence shows that

[10] Above n 2.
[11] Kawachi I, Subramanian SV, Almeida-Filho N. A glossary for health inequalities. Journal of Epidemiology and Community Health 2002;56(9):647-52; Kivimäki M, Shipley M, Ferrie J, et al. Best-practice interventions to reduce socioeconomic inequalities of coronary heart disease mortality in UK: a prospective occupational cohort study. The Lancet 2008;372(9650):1648-54
[12] An article in BPAC$^{NZ'}$'s magazine Best Practice noted the following: "Pacific peoples have the highest rate of rheumatic fever in New Zealand and one of the highest rates in the world. In 2009, there were 53 notified cases of rheumatic fever among Pacific peoples in New Zealand, a rate of 23 per 100 000. This is over six times the overall rate for all New Zealanders of 3.5 per 100 000 (a total of 140 cases).New Zealand stands out from most other developed countries in continuing to have high rates of acute rheumatic fever (ARF) and rheumatic heart disease (RHD). It is estimated that 97% of cases of RHD worldwide occur in developing countries and in the indigenous populations of countries such as New Zealand and Australia."
http://www.bpac.org.nz/magazine/2010/november/infectious.asp?section=2
[13] http://www.nzdoctor.co.nz/news/2011/december-2011/12/maori-party-doubles-rheumatic-fever-spend.aspx
[14] Above n 2.

adult unemployment, welfare dependence, violence and ill health are largely the results of negative factors experienced in the early years[15].

12. Finally if through their life course, people are exposed to an unacceptably high number of negative environmental and social circumstances, these negative experiences accumulate and eventually affect health status.

New Zealand children

13. Before comparing relevant statistics for Māori and non-Māori children it is important to first have an appreciation of where New Zealand children sit in relation to other OECD countries.

14. At the start of this century the New Zealand Government's investment in the early years was low by international standards, with "early childhood" spending less than half the OECD average. This has been rectified to a degree. The OECD has reported that although the overall spending per child fell between 2003 and 2007, there had been a welcome increase in early-childhood spending and childcare provision. The increase in spending on children aged 0-5 years as a share of spending on all children was one of the largest in the OECD[16].

15. New Zealand also compares poorly internationally for other measures. Out of 30 OECD countries New Zealand is ranked:[17]

    - 21st for infant mortality (5.1/1,000 live births)
    - 29th for measles and immunisation rates (82% vaccinated by age two)
    - 20th for the percentage of children living in poor households (15% of all children)
    - 17th for children in overcrowded houses (31% of all children).

16. New Zealand fares poorly in other international comparisons. New Zealand:

    - is fourth to bottom of all OECD countries for injury deaths among one to four year olds[18]
    - has 14 times the average OECD rate of rheumatic fever[19]
    - has rates of whooping cough and pneumonia five – ten times greater than that for the United Kingdom and the United States[20]
    - has a four - six times higher rate of child maltreatment and death than OECD countries with the lowest incidence[21].

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[15] Above n 1
[16] OECD Better Life Index. http://oecdbetterlifeindex.org/countries/new-zealand/
[17] Above n 1
[18] Above n 1; UNICEF 2001 A League table of child deaths by injury in rich nations. Innocenti Report Card No 5. Florence UNICEF Inocenti Research Centre
[19] Above n 13:E Craig et al NZYCES Steering Committee 2007 "Monitoring the Health of New Zealand Children and Young People; Indicator Handbook." Auckland: Paediatric Society of New Zealand and the New Zealand youth and Child Epidemiology Service.
[20] Above n 1
[21] Above n 1: UNICEF 2003 "A League Table of Child Maltreatment Deaths in Rich Nations". Innocenti Report Card No 5. Florence UNICEF Inocenti Research Centre

Māori children and social determinants – how they compare

17. As the Select Committee will be well aware, New Zealand's indigenous population performs poorly across a range of economic and social measures.

18. Looking first at the socio-economic determinants of health; the government's Māori Health website[22] provided the following data showing that non-Maori were more advantaged than Māori in terms of schooling, employment, income and housing.

Socioeconomic indicators: percentage of each ethnic group, 2006[23]

Indicator	Māori			non-Māori		
	Males	Females	Total	Males	Females	Total
School completion (Level 2 Certificate or higher), 15+ years, 2006, percent	40.7	45.7	43.4	65.0	62.5	63.7
Unemployed, 15+ years, 2006, percent	7.1	8.2	7.6	2.8	3.0	2.9
Total personal income less than $10,000, 15+ years, 2006, percent	22.8	27.9	25.5	16.1	25.6	21.0
Receiving means-tested benefit , 15+ years, 2006, percent	19.9	32.6	26.7	8.8	12.1	10.5
Living in household without telephone access, 15+ years, 2006, percent	5.6	5.3	5.5	1.5	1.0	1.2

[22] http://www.maorihealth.govt.nz/
[23] http://www.maorihealth.govt.nz/moh.nsf/indexma/socioeconomic-indicators

Living in household without motor vehicle access, 15+ years, 2006, percent	7.8	10.2	9.1	3.8	6.2	5.0
Not living in own home, 15+ years, 2006, percent	69.6	70.1	69.9	44.9	42.6	43.7
Household crowding, [2] all age groups, 2006, percent	22.2	23.3	22.8	7.9	7.9	7.9

Source: *Statistics New Zealand*

19. In terms of health specifically the statistics show that compared with non-Māori, Māori have:

    - poorer levels of health literacy[24]
    - higher rates of smoking[25]
    - higher rates of drug and alcohol abuse[26]
    - poorer nutrition[27]
    - poorer health[28]
    - a shorter life expectancy[29]
    - have higher rates of obesity[30].

20. Alarmingly, a recent article in the Lancet indicates that rates of infectious diseases have risen over the last ten years but with a greater increase in the rate for Māori than for Pakeha.[31]

[24] http://www.maorihealth.govt.nz/moh.nsf/indexma/socioeconomic-determinants-of-health
[25] http://www.maorihealth.govt.nz/moh.nsf/indexma/risk-and-protective-factors
[26] http://www.maorihealth.govt.nz/moh.nsf/indexma/risk-and-protective-factors
[27] http://www.maorihealth.govt.nz/moh.nsf/indexma/risk-and-protective-factors
[28] http://www.maorihealth.govt.nz/moh.nsf/indexma/health-status-indicators In particular ,Māori have higher rates of cancer, cardiovascular disease, diabetes, asthma, Arthritis, infectious disease, spinal disorders and osteoporosis They also have higher rates of suicide and self harm
[29] http://www.maorihealth.govt.nz/moh.nsf/indexma/health-status-indicators
[30] *Monitoring the health of New Zealand children and young people*. Indicator Handbook 2007 Auckland Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service
[31] Baker, MG et al, "*Increasing incidence of serious infectious diseases and inequalities in New Zealand: a national epidemiological study"* The Lancet, 20 February 2012. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61780-7/fulltext?_eventId=login

21. Finally, in respect of Māori children, Brian Perry's report on *"Household Incomes in New Zealand"*[32] shows that in 2010 there were 1.07 million children and young people aged 18 and under in that year. Of those, 22 % were living in poverty[33]. More specifically one in six Pakeha children and one in three Māori children. The report notes that the higher poverty rate for Māori children reflects the high proportion of Māori children living in sole parent beneficiary households. Around 42% of current Domestic Purposes Benefit (DPB) recipients are Māori.[34]

Poverty and children

22. High rates of poverty are a cause for concern as low family income is associated with a range of negative outcomes including low birth weight, infant mortality, poorer mental health and cognitive development, and hospital admissions from a variety of causes. Further, the Christchurch Health and Development Study suggests that exposure to low family income during childhood and early adolescence may increase the risk of leaving school without qualifications, economic inactivity, early parenthood and criminal activity."[35] It is still too often the case that, for the most deprived Māori children, poor educational engagement and traumatic experiences result, not in additional support but relegation into the justice system.

23. A report prepared by J Pearce in August 2011 on "*An Estimate of the National Costs of Child Poverty in New Zealand*" suggested that the annual cost was between $6 and $16 billion annually with the best estimate in the region of $8 billion. This is between 3.5 % to 9% of GDP, with the best estimate being about 4.5%.

Where to from here?

24. While New Zealand has endeavoured to address these inequities in the past with funding this clearly has not worked as well as we would wish. Sometimes this has been due to adopting a traditional Western medical based health settings approach to implementation that was inappropriate (for example requiring attendance at hospital based clinics when a community or marae based programme would have been both more convenient and acceptable). Further, the length of time that Māori have lagged behind non-Māori in terms of the social determinants of health has led to the creation of intergenerational problems, as children born into poverty and with one or more parents on a benefit are increasingly found to have followed in the same cycle. While further funding is necessary the funding needs to be a combination of general base funding for all and better targeting of funding to those with higher needs (i.e proportionate universalism). One thing is certain; the status quo is not the answer.

25. We need to identify those programmes that are working well and fund these, while looking at new and better ways to address the socio-economic imbalance. We also need to recognise the significance of whānau (referred to by Mason Durie as one of

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[32] Bryan Perry *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2010*, Ministry of Social Development Wellington July 2011

[33] Above n 32. Poverty defined as an income below 50 – 60% of median household incomes p 75

[34] Graph of sole parents receiving the DPB, Prepared by Welfare Working Group, Ministry of Social Development, April 2010. http://ips.ac.nz/WelfareWorkingGroup/Downloads/Working%20papers/MSD-Overviews-of-DPB-SB-IB.pdf

[35] The Children's Social Health Monitor New Zealand - Child Poverty and Living Standards: http://www.nzchildren.co.nz/documents/child_poverty.pdf

the four pillars of health[36]) in any programmes created to improve the wellbeing of Māori children.

26. Doctors also have a role as they are the health advocates for their patients and therefore can expect part of their advocacy to cover the particular needs of Māori children. In its statement on the Role of the Doctor – a statement written by the profession for the profession and either endorsed or supported by all New Zealand doctors, the NZMA said

> Doctors uphold the primacy of the individual patient:doctor relationship, with the requirement to advocate for the patient and advise about all treatment options. Doctors also appreciate the needs of their patients in the context of the wider health needs of the population. Where the capacity to treat is growing but resources are finite, doctors, as critical decision makers with responsibility for allocation of significant health resources, have a duty to use those resources wisely, and to engage in constructive debate about such use. As significant resources themselves, they are committed to ensuring their own and others' skills and knowledge are deployed to best effect. When appropriate, doctors use their influence to advocate for increased resources to improve health outcomes for their patients and populations.
>
> Doctors have a role in the promotion of population health, including ongoing efforts to achieve health equity. Some doctors will take an increased focus on the health of the population through formal roles in health education or promotion, service improvement, public health and/or health advocacy. This commitment is to the health of all New Zealanders, but it exists alongside a professional responsibility for the health of individuals and communities throughout the world[37].

27. When working with Māori children and their whānau, doctors need to understand that the western medical approach to advocacy may not be effective when trying to get their health message across to Māori and may need to explore ways that are more culturally appropriate.

28. In addition we note that the Children's Commissioner is calling for the creation of a Children's Act in order to provide greater and continuing focus on the needs of children. The same view has been taken by Primary Health Care Advisory Committee. The NZMA believes that the idea has merit, although care must be taken in that whatever action is taken does not lead to unintended consequences.

29. PHAC in its report "*The Best Start in Life: Achieving Effective Action on Child Health and Wellbeing*"[38] said that improving child health outcomes would require more than fixing any one health problem and that changes needed to be made to the overall investment in and structure of policies and services for children. The report goes on to make a number of recommendations including the following.

    a) The establishment of government structures and processes to strengthen leadership for children, including the consideration of:

[36] Above n 1
[37] NZMA Statement on the Role of the Doctor, 2011. http://www.nzma.org.nz/sites/all/files/ps_roleofdoctor.pdf
[38] MOH June 2010.

- a cross-agency Office for Children to implement the strategic direction and oversee sector contributions to early childhood development

- a cross-party agreement that provides strategic direction and outlines shared principles and goals.

b) The Ministry of Health makes child health a priority and increases the proportion of health sector spending on services for children aged up to six years.

c) District Health Boards develop child health implementation plans with measurable outcomes and accountabilities.

d) The health and disability sector continues to strengthen leadership on tamariki ora and work with iwi leadership to improve service design and delivery.

e) The health and disability sector strengthens child health networks in each region, which are supported by the Ministry of Health.

f) All significant government policies are assessed for their potential impact on children.

g) Longitudinal studies of childhood development are continued as well as the need to research and monitor the effectiveness of early childhood interventions.

h) The Government continues to assess the access to, and quality of, health care and disability support services for children and finds ways to increase timely access to these services by vulnerable groups of children.

i) An increase in investment in public health initiatives that target the determinants of child health.

j) The continued development and expansion of funding and contracting models that support whānau ora and other integrated approaches to service delivery in early childhood.

k) A seamless transition from maternity services to health care services for infants and young children.

l) The development of a set of universally agreed high-level indicators for child health and wellbeing that includes a subset of health indicators[39].

30. The NZMA agrees with the recommendations made in the PHAC report. We would further add that the approach to improving the social determinants of health for Māori children needs to be multi-sectorial, whānau-centred and by Māori for Māori. In

[39] Above n 1

particular, we need to look at ways of increasing Māori community involvement in dealing with health and wellbeing issues for Māori as well as increasing the number of Māori working in health.

Conclusion

31. In summary there is a considerable amount of data already available showing that Māori have less favourable health determinants then non Māori. Obesity and smoking rates are particularly significant as New Zealand children and adolescents are a significant public health concern and unless sound policies and strategies are put in place to address this issue, the socioeconomic and ethnic disparities in obesity and smoking will lead to disparities in chronic disease burden, as this generation reaches maturity.

32. It seems to us that New Zealand has spent considerable time analysing the problems facing Māori children and while action has been taken, that action has only been partially successful, perhaps in part due to our not fully taking into account cultural differences that exist between Māori and non Māori. If New Zealand as a country is to make a significant difference the approach has to be one that understands these cultural differences and responds accordingly. The approach must be inter-sectorial and as far as possible be undertaken by Māori for Māori. In particular we need to encourage more Māori to enter the health workforce.

33. We trust the Committee finds our submission helpful in its deliberations. The NZMA would be pleased to appear before Select Committee to further discuss our submission.