

CHILD HEALTH IN TIMES OF SOCIAL AND ECONOMIC CHANGE

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NZ Med J 1997: 110:95-7

Global changes have affected all countries directly or indirectly participating in the international market. Transnational corporations, some owning more capital than individual countries, technology allowing instant financial transactions, and the loss of traditional boundaries have been some of the contributing factors. Restructuring demanded by these changes have seen the introduction of reforms based on the doctrine of monetarism in many industrialised countries, including New Zealand. Competitive individualism, a limitation of state responsibility, fiscal restraint in the public sector, and an increase in social inequity have been some of the results in this country. At the same time and together with other Western nations, New Zealand has experienced the effects of changing patterns of family structure, in particular those which are accompanied by risks of an inadequate income and social isolation. These interrelated, complex, and rapid changes have seen low income families additionally marginalised and joined by many others, with the requirements necessary for the health and well being of children at the centre of this crisis.

Social and economic indicators

With the exception of Statistics New Zealand,¹ there is little official documentation of the social, physical, intellectual, and emotional growth and wellbeing of children during the period of these reforms and these changes in family life. Information from UNICEF,^{2,3} and professionals working in health, law, economics, education, and sociology, have helped to fill the gaps.

Two key findings from the 1991 census relate to the rise in unemployment and sole parent households.¹ For children the implications of both are those of associated social and economic disadvantage. Twenty five percent of all children in 1991 had no parent in paid work compared to 10% in 1981. Twenty two percent of children in 1991 were living with a sole parent compared to 12% in 1981. A rate only exceeded by the USA. Overrepresented in this group were young children, Maori children (for whom the figure was 40 %), and Pacific Island children (28%).

With payment for work the most important source of a regular income for all families, there are obvious concerns for children whose parents are not employed. Sole parents, when viewed as a group, suffer multiple hardships in this and other ways. Seventy five percent of solo parents were not in paid work in 1991,¹ with the median annual income for sole parent families NZ\$15,900 compared to that of two parent families of NZ\$45,000.⁴ Other risks for children of lower income families documented were those of a lack of ready communication in the absence of a family car or telephone, living in rented accommodation, and sharing a home with people not part of the family.

Since 1991, further restructuring has continued to affect the family budget, particularly for those in the lowest socioeconomic bracket. Amongst these are the market geared housing reforms, lower wages, a trend changing full to part time employment, user charges in health and education, a continuity of high unemployment rates, reduced levels of, and access to benefits, and the lowest return of any group from the latest tax cuts.

Evidence of the reemergence of poverty has been demonstrated using several different methodologies.^{5,6} In 1993, one in six of New Zealand's population were estimated to be affected, with the largest group being children and their parents. Maori contributed disproportionately to this figure.

Child mortality and morbidity

Child mortality rates, recognised as a marker of the social and economic environment in which children live, are similarly concerning when international comparisons are made. Despite improvements in national annual figures, in 1994 New Zealand rated the third highest amongst 11 OECD nations for infant mortality and for girls aged 1 to 4.⁷ Ranking the highest death rate of the 11 was that of boys in this preschool age range, and school aged children of both sexes. Also at the highest rate was the death by suicide of boys, whether of school age, in adolescence or as young adults, with suicide in girls over this entire age range (5 to 24) ranking second. In comparison with 32 industrialised nations. New Zealand was also reported as having the highest rate of youth suicide in 1991, and for the years 1985-90 the sixth highest rate of infant death presumed due to abuse.—³ The influence of socioeconomic status is seen in the multiple causes of these deaths. Studies from overseas demonstrate that children of poor families have higher death rates from all causes.⁸⁻⁹ Two New Zealand surveys record this related influence in the sudden infant death syndrome,¹⁰ and in injuries and deaths due to pedestrian accidents.¹¹ The multiple, cumulative, and interrelated effects of poverty and disadvantage are also translated clearly in measures of morbidity.⁹ Failure to thrive, iron deficiency anaemia, preventable disability, glue ear, otitis media, deafness and chronic illness inadequately controlled are some of the results. Not only are there increased risks in their environment, but New Zealand studies show that these children are less likely to be presented for preventive health care,¹² to have low immunisation rates,¹³ and increased rates of infectious diseases, and higher rates of teenage pregnancy carrying significant risks of low birth weight and preterm delivery (Lennon D, personal communication). This is a double handicap for these babies, both in the chances of their intact survival, and the later consequences for their health stemming from their family environment.

There has been a paucity of any concerted or comprehensive response to this new morbidity. Payment for medical consultation and pharmaceuticals, and the loss of a significant proportion of community nursing services are barriers to children of low income families and their high health needs. The limitation of the state through fragmentation of delivery and resourcing has also ended any chance of providing national coordinated programmes in

preventive health care, and often, of addressing the site of ultimate responsibility and expected action. Current attempts by each of the regional health authorities and other community endeavours to target a select number of high risk families using different methods, demonstrate these problems.

Educational opportunities

Success in learning is an important indicator of a child's wellbeing. Major influences are those of the economic and social circumstances of a child's family, with these expressed through both the provision of relevant opportunities in the home and the building of a strong foundation on which the required abilities and a desire to learn are based.

Ironically both children of lower income families and schools in poor communities have been disproportionately disadvantaged by reforms ostensibly designed to help. Restricted funding - based on pupil numbers, not need - and the demands of meeting the costs of mainstreaming and deinstitutionalisation, have eroded the chances of these children whose collective problems in learning are high. Diminishing resources and the additional stress of these children's social needs have also eroded the chances of their schools in attracting and securing good teachers with additional funding allocated to schools in poorer areas unable to meet the range of assistance required.^{14,15}

United States studies have demonstrated significant differences for poor children when compared to those raised in higher income groups, in school days missed through ill health, and attention affected by hunger, abuse, and family stress.⁸ Some of the results are measured in increased rates of learning disabilities, severe emotional and behavioral problems, and lower IQ and achievement scores. Impressively, other studies have shown that given the right educational environment these children learn and do well,⁸ as has been demonstrated in the American Head Start¹⁶ and the Israeli HIPPIY programmes.¹⁷

In New Zealand there is growing evidence of the escalation of concern over the same problems of destructive and aggressive behavior, developmental and learning problems, suspension and soaring rates of truancy amongst children suffering from the multiple effects of financial hardship and family dysfunction.¹⁵ malnutrition⁸ and a lack of pre-school education¹² are other identified problems in this sector.

In spite of these trends, the reforms in education allow concerning numbers of children to escape school and roam the streets with these children unable to be tracked. Limited resources continue to restrict the ability of principals and parents to meet even basic educational needs. Special education services have been severely pruned, and for the majority of poorer children any dream of tertiary education can be abandon

Care and protection

The care and protection of children requires parental competence and commitment, and a secure and supportive environment. When these fail the state has a role to play. As in other sectors the resources and responses required all levels for child protection are being eroded. At the same time social changes have also encroached on the wider care and protection of

children. Urbanisation, family isolation, restriction in the role of the family and its size, women needing to work outside the home, and the loss of neighborhood cohesiveness all contribute. So too does the emphasis on competitive individualism and individual self interest fostered by current changes in policies and public attitude.

This comes in parallel with the risks to children seen in New Zealand now with the increase in violence and violent crime, evidence of an increase in children joining these activities and becoming offenders (an 83% rise apprehended adult offenders and an 86% rise in apprehended juveniles from 1992 to 1995), and children left abandoned and unattended (a 283% rise of reports from 1993 to 1995).¹⁹ Hidden and more common in low income and sole parent families are the very real dangers of mobile families, mobile children, changing names, changing addresses, and for some the risks of frequently changing father figures. Exposure to abuse, neglect, and adult violence and a lack of early education and health care, are common results. As for schools, the chances of finding these lost children and ensuring their oversight and access to services has been substantially eroded with the one remaining source available through the New Zealand Children Young Persons and Their Families Service (NZCYPFS) now withdrawn.

The multiple effects of poverty are risk factors for abuse and particularly for neglect,²⁰ while the other markers of societal disintegration speak of the indirect maltreatment of large and increasing numbers of New Zealand children, Child abuse and neglect are significant and poorly addressed problems in this country. So too, for children, are the consequences of family violence, whether as a victim or a witness.²¹ Early support and intervention for stressed and needy families is uncommon, and accurate measured outcomes for children in need of care and protection, or who are recipients of abuse or neglect have never been recorded.

On a larger scale is the lack of any but anecdotal evidence of the benefits or pitfalls for children of The Children, Young Persons and Their Families Act (1989) which, despite being widely promoted overseas, has never been monitored or reviewed. Accumulating media reports point to the increasing inability of the NZCYPFS to respond to the required demands, despite multiple restructuring in order to cope with the need for improved competency, and technological advances. These reforms, at the same time, kept within a narrow resource base with a budget decrease of 8% for all services between fiscal years 1992-96²² despite reported increases in case loads and the seriousness of many cases during this time.²³

Despite these escalating requirements in intervention, prevention programs, psychoeducation at the time of a crisis, and the preventive benefits of supporting skilled therapy for children who suffer the associated psychological trauma of any form of maltreatment, these have never been seen as paramount concerns. Similarly, their need of access to long term review in light of the known chances of the later emergence of related problems in adolescence, has been persistently ignored.

Discussion

While this information allows only suggestive correlation rather than direct causality there are wider markers of concern. The disproportionate loss of finance for children in times of economic decline has been demonstrated in the USA and there are no indications that New Zealand's recent policies have not done the same. The dangers of a tolerance of an increase in inequity within structures designed to enhance economic recovery have been detailed both for this country,^{6,25} and in others following the same model of monetarist reform which comes accompanied by the simultaneous reduction in assistance for those inevitably disadvantaged.² More specifically the cumulative effects of social disadvantage and deprivation on children's vulnerability to a wide range of childhood problems, has been documented in longitudinal research in this country.²⁶ This was at a time when New Zealand was considered to have a commitment to an egalitarian social structure. The consequences of the abandonment of this commitment evident in New Zealand's economic restructuring and the related disregard of the necessity to incorporate, not ignore, current social changes, are likely to be carried by children. While not all children adversely affected will suffer, the measured outcomes in child health, welfare, and education are already considerable.

Beyond the more obvious parameters there are others. One is the potential source of a corruption of values and attitudes to work and a learned dependency, that these early experiences can bring. Another cost of this abandonment is the loss of the essential right to belong which allows children to achieve a place in their culture and community.²⁷ For some this carries additional dangers, in fostering a sense of alienation and with it the risks of anti-social behavior and violence.

While economic change has been inevitable, a renewed focus on children is essential. Investment in children is cost effective. The provision of their needs is the only way to ensure the competency of future parents, the appropriate education and skill of future employees, and the protection of safety and security in any future social structure. A national policy for children, child impact assessment as a primary requirement in proposed legislation and cross sectorial coordination in the determination and funding of children's needs, are all ways to protect this investment. So too is research and the collection of information that allows accurate review and monitoring of important aspects of children's lives are all ways to protect this investment.

The incorporation of the profound contribution of socioeconomic disadvantage and related family dysfunction on children's health and outcomes seen in adolescence and adulthood, a component lacking in current strategies, is another form of expected financial saving and success. Present attempts to solve the hard end of many expensive high health risk behaviours - smoking, alcohol and drug use, and teenage pregnancy amongst them, and of seemingly individual health problems - a lack of immunisation, poor nutrition, glue ear and deafness, and sudden infant death syndrome - will never be effective unless addressed from this perspective and collectively resourced. These families require a comprehensive

assessment, and personal, early, and long term support. Pamphlets, posters, and media campaigns may inform but cannot change their lives.

The long term cost savings in ensuring the well being of children by removing any barriers of payment for the health care for preschool children, and incorporating a system that ensures universal and voluntary access for such preventive review and early education, with government protection for poor families, is another potential source of value, both to children and the country as a whole. Models of such systems are already in place in many European countries and demonstrably successful in association with monetarist reforms.^{2,28}

In parallel the influence of the social and economic background on educational opportunities must be appreciated with resources tailored to these needs if children's chances are to improve. For those who have no interest in any investment in children a response should be seen as necessary in order to avoid the inevitable decline in the productive potential of this country, if the importance of the asset represented by this significant proportion of the future workforce continues to be disregarded. In addition, the interpretation of policies that place the family or the community as the source of redress for all the needs and problems of children must be countered for those families and communities who have neither the abilities nor the resources to respond.

Conclusion

Economic policies introduced over the last ten years in hand with changing patterns of family life are contributing to the loss of the one irretrievable chance of normal development for an increasing number of New Zealand children. The multiple effects of a disadvantaged start in life together with a lack of ready access to health care, education, and social support are already apparent. With evidence of the powerful influence of the social environment in which a child is raised and the indelible imprint of early life experiences on the brain development and brain function, this risk to children cannot continue to be ignored.²⁹ The costs, financial and in terms of the loss of human potential, health, and competency, as well as the destructive effects of the alienation of a large sector of the community, can be expected to be considerable. They will also be irreversible. Most are costs of choice, not chance, and are the result of the failure to make the one most effective investment of any for this nation — that of providing for and carefully protecting the physical and the psychological well being of children.

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