ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

TOI MATA HAUORA

Submission to the Social Services and Community Select Committee on the Child Poverty Reduction Bill

4 April 2018

Introduction

The ASMS is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent nearly 4,800 members, most of whom are employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians.

Over 90% of all DHB permanently-employed senior doctors and dentists eligible to join the ASMS are in fact members. Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members, mainly general practitioners, are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

Key points

The ASMS strongly supports the stated purposes of this Bill to:

- encourage a focus by successive governments and society on child poverty reduction
- facilitate political accountability against published targets
- require transparent reporting on levels of child poverty
- create a greater commitment to action on the part of Government to address the wellbeing of all children, and the particular needs of children in poverty and those at greater risk.

Owing to time and resource limitations our submission is confined to child health issues associated with poverty.

Reports on child poverty in New Zealand over the years have consistently shown a lack of commitment by governments to properly address the issue, along with a lack of reporting and lack of accountability for their neglect.

We recognise that significantly reducing poverty is not a simple task. It requires action across government sectors and on many levels. It requires setting poverty reduction targets that are bold and at the same time doable. Given the depth of child poverty in this country, the suffering it is causing, and the long-term social, economic and financial costs (not least to the public health system), we believe the emphasis must be on **bold**, matched by the necessary government support to ensure the targets are achieved.

We question whether the targets announced by the Government earlier this year (eg, reducing the number of children in material hardship from 150,000 to 80,000 over 10 years) are bold enough.

Significant funding – genuine social investment – will be needed across multiple sectors to lift children and their families out of poverty. This includes not only funding support to improve the incomes for families in poverty but also to improve access to services to address their immediate and ongoing needs. In the health sector, the most urgent need is to remove the barriers to timely access to health care when it is needed, including access to primary health care (including strengthening school health services) and access to hospital specialist care.

The benefits of this funding investment can be illustrated in one very specific but substantial scenario, concerning the rate of ambulatory sensitive hospitalisations (ASH) for children under 5, which increases progressively from deciles 1 through to decile 10. Data supplied to the Ministry of Health shows that if all these potentially avoidable hospitalisations (including emergency department cases) were at the same rate as those in deciles 1 and 2, hospitalisations for young children would be more than halved overall. The greatest decrease would be for those children in deciles 9 and 10, with hospitalisations reduce by more than 70%.1

Background

ASMS members see the effects of child poverty every day in their hospital departments. The scourge of poverty is reflected in New Zealand's shameful ranking in UNICEF's annual reports on child wellbeing, which track the progress of goals such as reducing child poverty, inequality and deprivation and improving the lives of children in areas such as health and education.

In an overall measure of child wellbeing, the last report, published in 2017, placed New Zealand 34th out of 41 developed countries (Table 1). New Zealand's worst results are in the category of 'health and wellbeing' which includes indicators such as neonatal mortality, suicide, mental health, and nutrition. New Zealand may have been placed lower still but for the fact that our high child obesity

rates (32% of 2-14-year-olds are overweight or obese) were not included in the UNICEF measurement because specific data requirements could not be met.

Nor do the UNICEF health indicators drill down to the incidence of diseases often associated with poverty, such as meningococcal disease, rheumatic fever, whooping cough, pneumonia, bronchiectasis or serious skin infections. International comparisons are not easy to come by but as far as we are aware the last time an attempt was made (2007) to shed light on how New Zealand fared on such measurements we compared badly.[2]

Table 1: New Zealand rankings in child wellbeing goals

Goal	Ranking out of 41 countries
End hunger - 18th	18
Ensure health and wellbeing	38
Ensure quality education	15
Promote decent work and economic growth	34
Reduce inequalities	26
Make cities safe and sustainable	9
Ensure sustainable production and consumption	35
Promote peace, justice and strong institutions	33
End poverty	Insufficient data for a ranking
Overall ranking	34

Source: UNICEF 2017

A separate comparison of child health indicators across 15 countries,[1] including New Zealand, found:

- New Zealand's mortality rates per 1,000 live births for children aged 1-4 years was the second highest (behind the United States).
- New Zealand's mortality rates for all cancers in children aged under 5 was second highest (behind Greece).
- New Zealand's death rate due to external causes of injury and poisoning for children under 5 was second highest (behind the United States). Public health campaigns including home safety and road safety were credited with the relatively positive results in other countries, nine of which had rates less than half that of New Zealand's.
- New Zealand's under-18 obesity rates were the third highest behind Greece and the United States. 3

New Zealand ranked well in just two indicators, where we were third-lowest in stillbirth and low birth-weight rates.

[1] Australia, Belgium, Canada, France, Germany, Greece, Ireland, Italy, Netherlands, New Zealand, Portugal, Spain, Sweden, United Kingdom, United States.

More distressing is the fact that New Zealand's policy-makers have known about the poor state of our children's health and wellbeing for many years and have known what is needed to be done to address it. A 380-page report on child health prepared for the Ministry of Health and DHBs in 2016 found hospitalisation rates on a range of poverty-related diseases has actually got worse since at least 2000. [4]

The lack of commitment to addressing child poverty is reflected in comments from UNICEF about the New Zealand Government's apparent indifference to reporting child poverty rates. The report's authors, noting New Zealand was not ranked against the goal of ending poverty, commented, "New Zealand is clearly capable of reporting against [UNICEF's] measures for multidimensional poverty, but hasn't."

UNICEF New Zealand spokesperson Dr Prudence Stone called for greater government action. "The more we've focused on New Zealand's economic wellbeing, the more we've lost sight of our children's."[5]

The introduction of this Bill signals a welcome change of attitude, which we believe most New Zealanders expect from our Government, and a more responsible approach to addressing child poverty.

Access to health care

While reducing poverty – along with complementary measures such as improving housing – will ease at least some of the pressures on our health system, there is an immediate and ongoing need to improve access to services which would benefit those in the poorer decile groups in particular, given their poorer health status, as discussed above. New Zealand ranks poorly against other comparable countries on access to health care. Long-term nursing and medical staff shortages are a major factor.

According to the New Zealand Health Survey 2016/17, over 20% of children experience one or more access barriers for primary health. The main barrier is not being able to get an appointment at their usual medical centre within 24 hours when their parents wanted them to. This was also a major issue for adults and adolescents.

Timely access to hospital specialist services is also an issue in many areas. A Commonwealth Fund study on the performance of the health systems of 11 comparable countries[2] found New Zealand ranked among the worst for waiting times for elective surgery, waiting times to see a specialist, and waiting times for treatment after diagnosis. New Zealand ranked second-to-bottom on a measure of health equity, and bottom for access to diagnostic tests.[6]

In the key specialty area for children – paediatrics – the number of specialists per head of child population in New Zealand is broadly similar to England's (where there are wide variations across the regions), though recent reports from the UK indicate severe strain in child health services amid calls for significant increases in the paediatrician workforce.[7] Access to specialist paediatric services is further complicated by 'no shows' once appointments have been made. Anecdotally, this can be a particular issue for Maori families and points to a need for work to be done to better understand the barriers to accessing services, with a follow-up response as necessary.

Unmet health need in mental health is well acknowledged, with staff shortages across the board cited as a critical problem.[8] [9]

[2] Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, United States.

The much needed strengthening of commitment to reducing child poverty, signaled in this Bill, needs to go hand in hand with a commitment to invest in the public health service to ensure the present barriers to care are addressed.

References

[1] J Simpson, M Duncanson, et al. The Health Status of Children and Young People in New Zealand 2015, New Zealand Child and Youth Epidemiology Service, Otago University, June 2016.

[2] I Asher. The Porritt Lecture, Whanganui, 3 November 2010.

[3] R Cheung. *International comparisons of health and wellbeing in early childhood*: Research Report, March 2018. Nuffield Trust In association with the Royal College of Paediatrics and Child Health, England.

[4] (Simpson, et al 2016).

[55] I Ewing. New Zealand lagging behind in child wellbeing report, Newshub, 15 June 2017.

[6] K Davis, S Stremikis, et al. Mirror, Mirror on the Wall: How the performance of the US health care system compares internationally, Commonwealth Fund, June 2014

[77] Royal College of Paediatrics and Child Health. Facing the Future: A Review of Paediatric Services, April 2011.

[8] Ibid.

[9] Royal College of Paediatrics and Child Health. The State of Child Health. Short report series: The Paediatric Workforce, 2017.