

YOUNG PEOPLE NOT IN EMPLOYMENT, EDUCATION OR TRAINING (NEET)

Introduction

Young people are particularly vulnerable to the effects of economic downturns. Data from OECD countries indicated that, during the recession of 2008–9, in most OECD countries, youth unemployment rates rose more rapidly than adult unemployment rates [40]. Unemployment statistics do not fully capture the situation of young people as many are students and therefore not part of the full time workforce. When jobs are hard to get, young people’s participation in further education tends to increase. Policymakers developed the concept of NEET “not in employment, education or training” to facilitate comparisons between countries and to increase the visibility on the policy agenda of an especially vulnerable group of young people [41]. Young people who spend time NEET are at higher risk of becoming socially, economically and politically disengaged from the rest of society and of insecure and poor quality future employment, youth offending and mental and physical health problems [41].

Statistics New Zealand defines NEET as “people aged 15–24 years who are not in employment, education, or training” and states that NEET includes both those people who are unemployed and not in education and those who are not in the labour force and, at the same time, not in education or training [42]. The distinction between “unemployed” and “not in the labour force” is that those classified as unemployed are available for work and actively looking for work whereas those classified as “not in the labour force” are not. Some those who are not part of the labour force are engaged in unpaid caregiving.

The following section uses data from Statistics New Zealand’s Quarterly Household Labour Force Survey to review youth NEET rates since March 2004.

Data Source and Methods

Definition

The NEET Rate is calculated as [42]:

$$\left(\frac{\text{Number of unemployed youth + number of youth not in the labour force} - \text{number of unemployed youth and youth not in the labour force who are in education or training}}{\text{Total number of youth}} \right) \times 100$$

Data Source

Statistics New Zealand’s Household Labour Force Survey (n≈15,000 households). Available on the Infoshare page on Statistics New Zealand’s website <http://www.stats.govt.nz/infoshare/>.

Notes on Interpretation

Note 1: Unemployed refers to all people in the working-age population who during the reference week were without a paid job, were available for work and:

- (a) had actively sought work in the past four weeks ending with the reference week, or
- (b) had a new job to start within four weeks [36]

Those without a paid job who do not fulfil the above criteria are considered to be not in the labour force.

A person whose only job search method in the previous four weeks has been to look at job advertisements in the newspapers is not considered to be actively seeking work.

Note 2: Seasonal adjustment makes data for adjacent quarters more comparable by smoothing out the effects of any regular seasonal events. This ensures the underlying movements in time series are more visible. Each quarter, the seasonal adjustment process is applied to the latest and all previous quarters. This means that seasonally adjusted estimates for previously published quarters may change slightly [37].

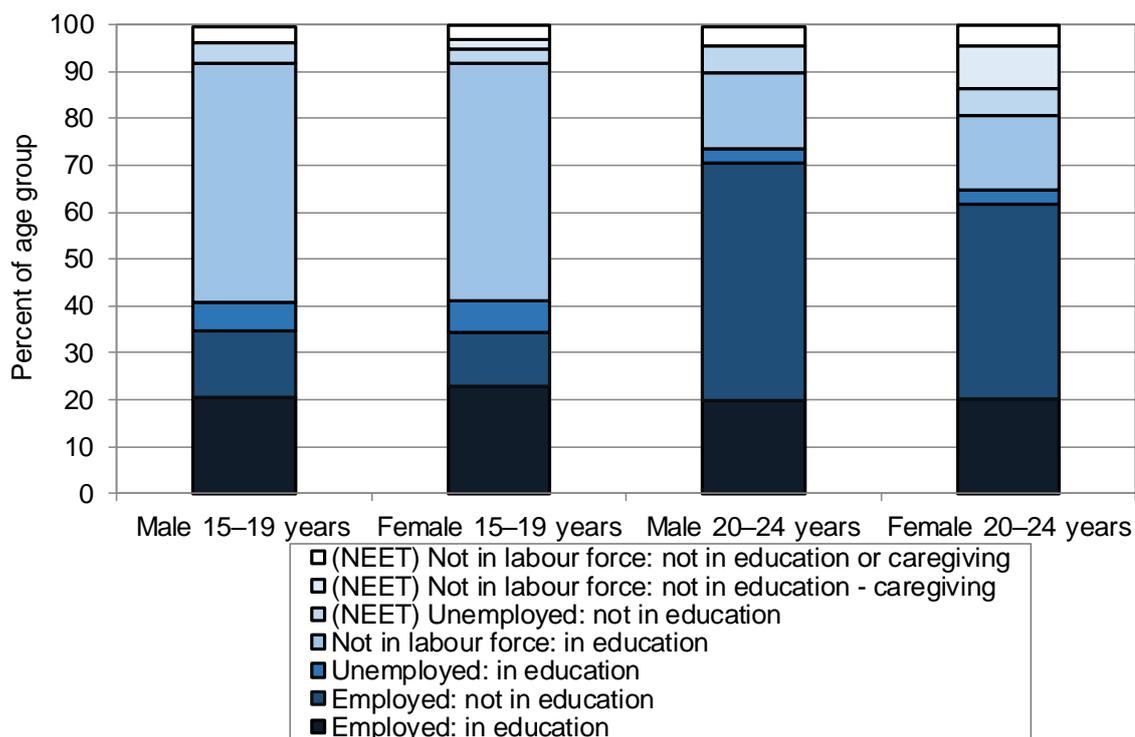


New Zealand Distribution and Trends

Labour Force Status by Age and Gender

In New Zealand during 2014, the majority of young people were in work, education or training, with the largest category for 15–19 year olds being *not in the labour force: in education* (51% of both males and females). In contrast, the largest category for 20–24 year olds was *employed: not in education* (50.5% of males and 41.8% of females). For those in the NEET category, gender differences in the proportions in the *unemployed: not in education* and *not in the labour force: not in education or caregiving* categories were not marked. However, a much higher proportion of females than males were in the *not in the labour force: not in education-caregiving* category, with gender differences being most marked in the 20–24 year age group (**Figure 1**).

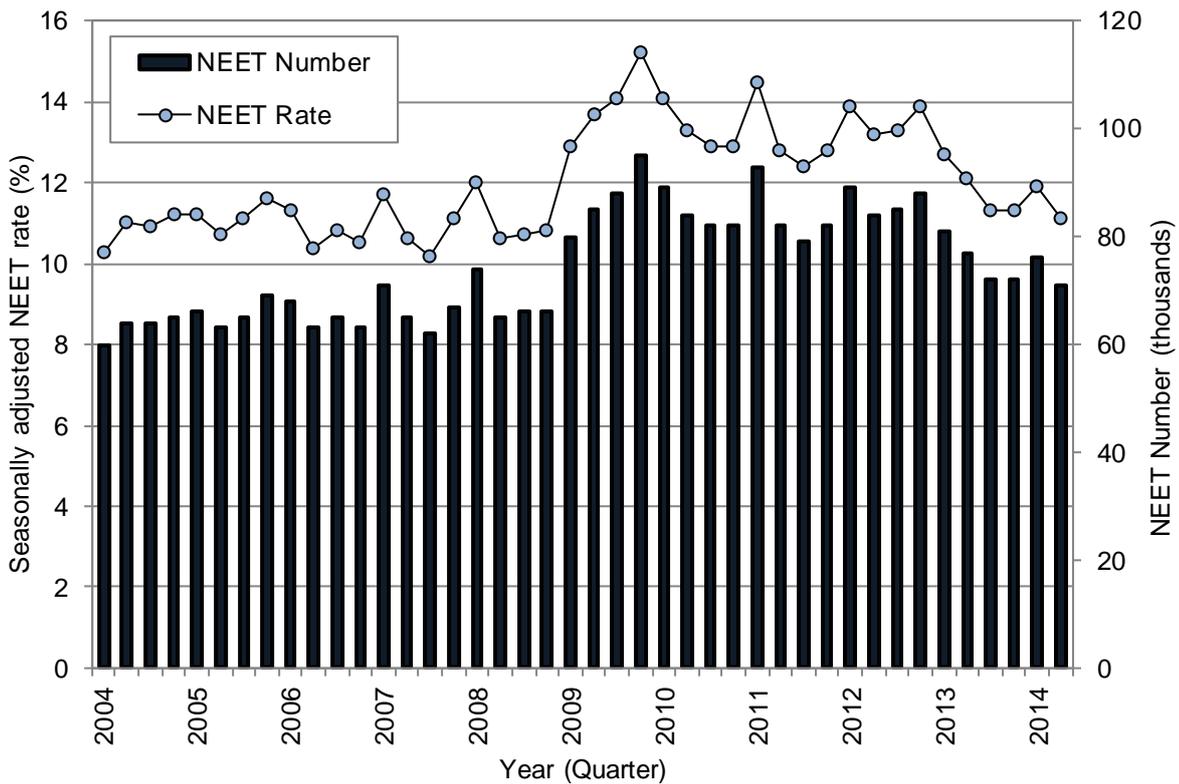
Figure 1. Labour force status of young people by age and gender, New Zealand 2014



Source: Statistics New Zealand Household Labour Force Survey

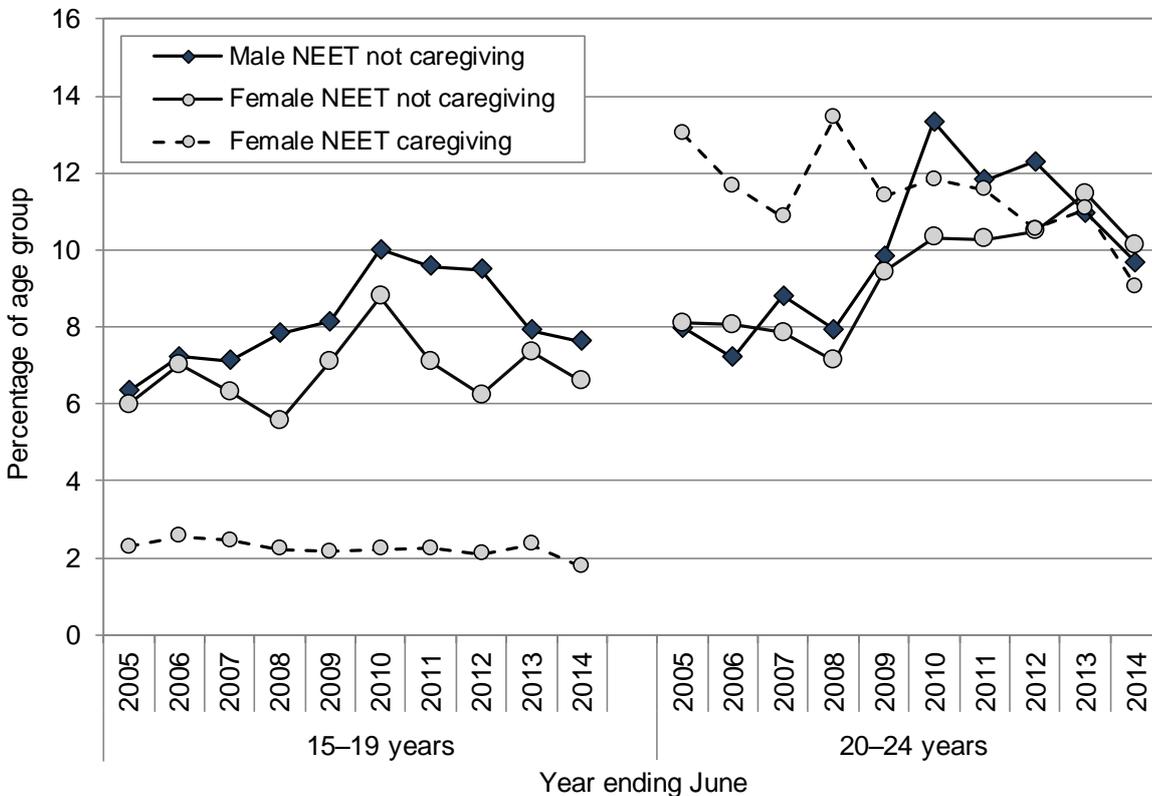


Figure 2. Seasonally adjusted quarterly NEET rates in young people aged 15–24 years, New Zealand March 2004–June 2014



Source: Statistics New Zealand Household Labour Force Survey; Note: Rates are seasonally adjusted

Figure 3. Young people not engaged in employment, education or training by age and caregiving status, New Zealand years ending June 2005–2014



Source: Statistics New Zealand Household Labour Force Survey; Note: Male NEET caregiving not included due to very small numbers



Seasonally adjusted NEET rates

In New Zealand, seasonally adjusted NEET rates were relatively static during 2004–2008 but began to rise thereafter, reaching their highest point, at 15.2% (n=95,000), in the fourth quarter of 2009. Since then, rates have exhibited a general downward trend, with rates in the June 2014 quarter being 11.1% (n=71,000) (**Figure 2**).

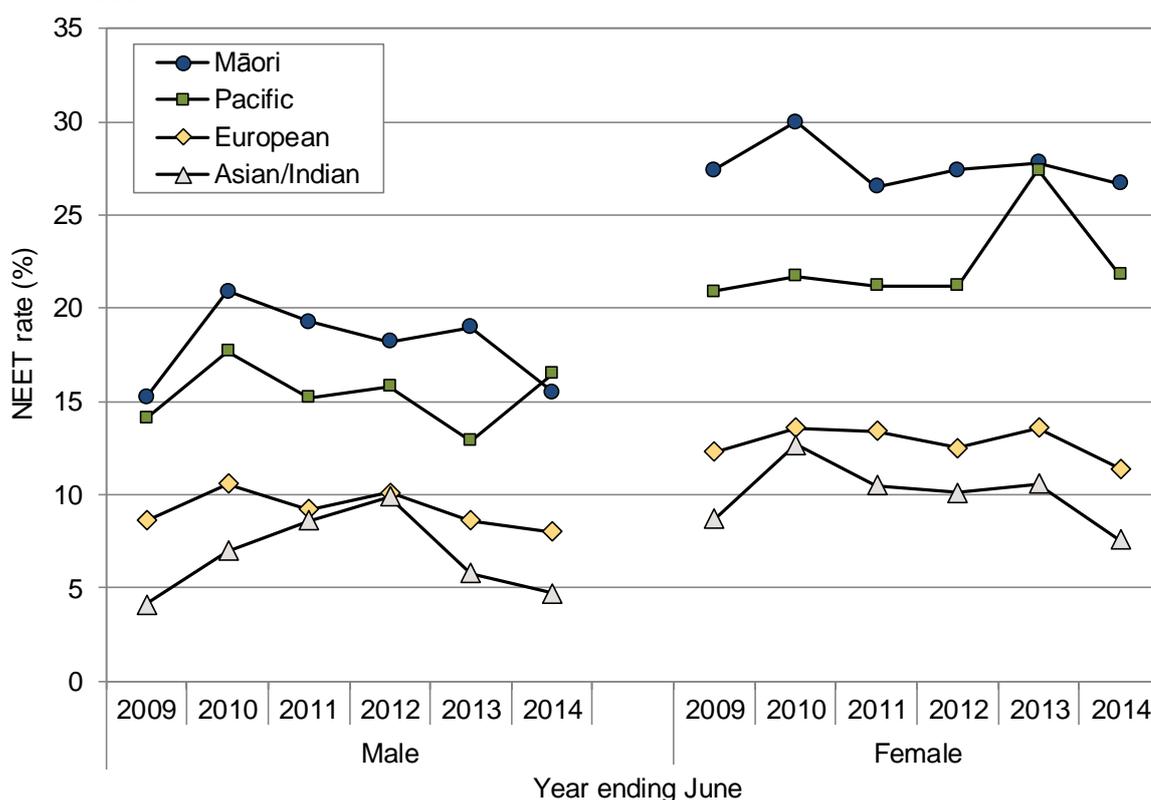
NEET rates by age and caregiving status

In New Zealand NEET rates in young people who were not engaged in caregiving roles increased between 2008 and 2010, and then (with the exception of females aged 20–24 years) gradually declined thereafter. In contrast, NEET rates in females aged 15–19 years engaged in caregiving roles were static during 2009–2014, while rates for females aged 20–24 years fluctuated during 2005–2011 and then declined (**Figure 3**).

NEET rates by ethnicity

In New Zealand during 2009–2014, NEET rates were higher for Māori, then Pacific, then European and then Asian/Indian young people. NEET rates were also higher for females than for males in each ethnic group (**Figure 4**). In the year ending June 2014, NEET rates (both genders combined) were 21% for Māori, 19.2% for Pacific, 6.1% for Asian/Indian and 9.6% for European young people.

Figure 4. NEET rates in young people by gender and ethnicity, New Zealand years ending June 2009–2014



Source: Statistics New Zealand, Household Labour Force Survey; Ethnicity is total response

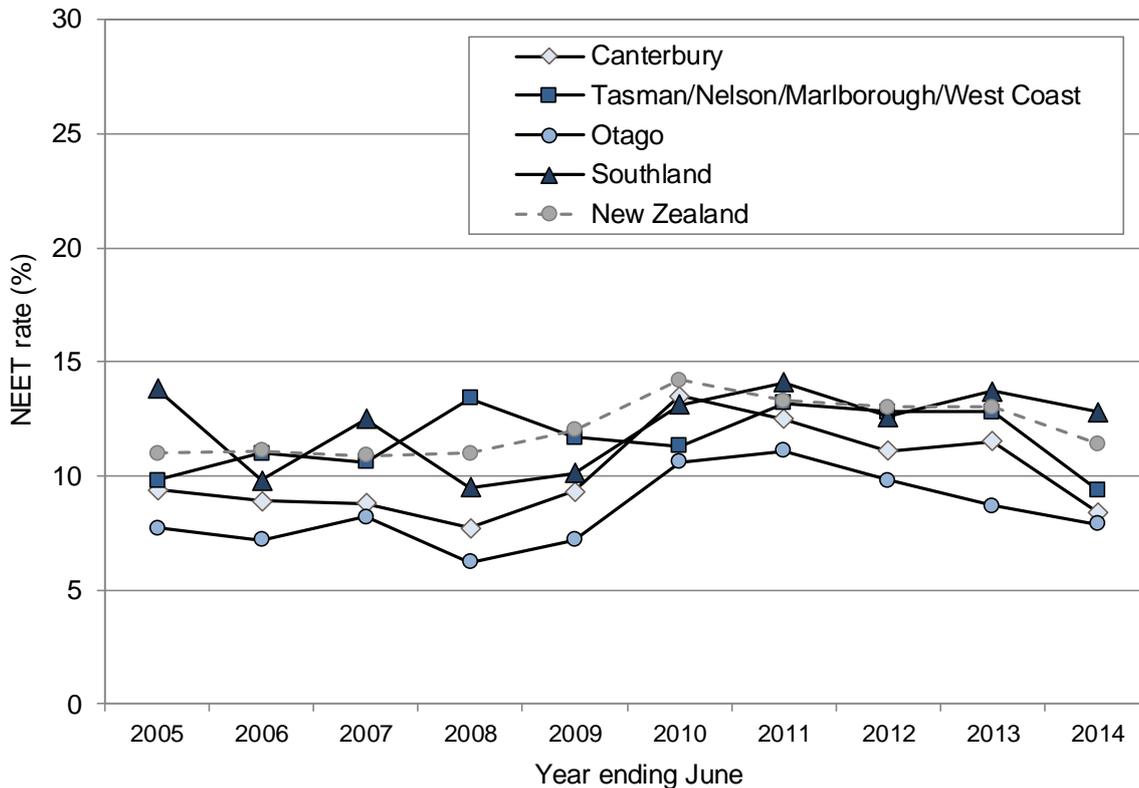


South Island DHBs Distribution and Trends

Distribution by Regional Council

In Tasman/Nelson/Marlborough/West Coast, and Southland during June 2007–2013, NEET rates were similar to the New Zealand rate, while in Canterbury, and Otago rates were consistently lower to the New Zealand rate. Large year to year variations made trends difficult to interpret (**Figure 5**).

Figure 5. NEET rates in young people aged 15–24 years by regional council, South Island regions vs. New Zealand years ending June 2005–2014



Source: Statistics New Zealand Household Labour Force Survey

Local Policy Documents and Evidence-based Reviews Relevant to the Social Determinants of Health

Table 1 (below) provides a brief overview of local policy documents and evidence-based reviews which consider policies to address the social determinants of health. In addition, Error! Reference source not found. on page **Error! Bookmark not defined.** reviews documents which consider the relationship between household crowding and health.



Table 1. Local policy documents and evidence-based reviews which consider policies to address the social determinants of child and youth health

Ministry of Health publications
<p>Ministry of Health. 2002. Reducing Inequalities in Health. Wellington: Ministry of Health. http://www.health.govt.nz/publication/reducing-inequalities-health</p> <p>This report considers socioeconomic gradients and ethnic disparities in health in New Zealand. The report finds that addressing these inequalities in health requires a population health approach that takes into account all the influences on health and how they can be tackled. This approach requires both intersectoral action that addresses the social and economic determinants of health and action within health and disability services. The report proposes principles that should be applied to ensure that health sector activities help to overcome health inequalities. The proposed framework for intervention entails developing and implementing comprehensive strategies at four levels: structural (targeting the social, economic, cultural and historical determinants of health inequalities; intermediary pathways (targeting the material, psychosocial and behavioural factors that mediate health effects; health and disability services (undertaking specific actions within health and disability services); and impact (minimising the impact of disability and illness on socioeconomic position). The framework can be used to review current practice and ensure that actions contribute to improving the health of individuals and populations and to reducing inequalities in health.</p>
Other government publications
<p>New Zealand Treasury. 2011. Working Towards Higher Living Standards for New Zealanders. New Zealand Treasury Paper 11/02. Wellington: New Zealand Treasury. http://www.treasury.govt.nz/publications/research-policy/tp/higherlivingstandards</p> <p>This paper discusses the Treasury's understanding of living standards, which are defined as incorporating a broad range of material and non-material factors such as trust, education, health and environmental quality. The Treasury has developed a "Living Standards Framework" centred on four main capital stocks: financial/physical, human, social, and natural; from which flows of material and non-material goods and services which enhance living standards are derived. The importance of the way living standards are distributed across society, and consideration of the distributional impacts of policy choices are highlighted as core aspects of policy advice.</p>
Systematic reviews
<p>Ndumbe-Eyoh S, Moffatt H. 2013. Intersectoral action for health equity: a rapid systematic review. BMC Public Health, 13, 1056. http://www.biomedcentral.com/content/pdf/1471-2458-13-1056.pdf</p> <p>Most of the social determinants of health are outside the realm of the health sector therefore those working in the health sector need to collaborate with governmental and non-governmental agencies to develop policies and programs to reduce health inequalities. Intersectoral relationships can involve information sharing, cooperation, coordination and integration. This review aimed to assess the impact and effectiveness of intersectoral action in public health on the social determinants of health and health equity. The review authors identified 17 articles of varying methodological quality meeting their inclusion criteria: one systematic review, 14 quantitative studies, and two qualitative studies. The findings of the systematic review (Smith et al. 2009) are discussed below. Only two of the primary studies examined interventions directed at upstream (system-level) determinants of health, one housing and the other, employment. Eight studies reported on interventions addressing a variety of midstream (community-level) determinants: employment and working conditions (2 studies), early childhood literacy development, housing (NZ's Healthy Housing Programme), social and physical environments (3 studies), and social and physical environments and food security. The studies of upstream and midstream interventions found mixed effects. Seven studies evaluated downstream interventions, all focused on access to health care. The studies of downstream interventions found that interventions generally had positive effects, increasing the availability and use of services by disadvantaged communities. None of studies set out to examine the effectiveness of intersectoral action on health equity specifically, and most of the outcome evaluations were not methodologically strong, therefore the review authors found it difficult to tell whether the effectiveness or otherwise of interventions was due to intersectoral action. They stated that the lack of evidence should not be interpreted to mean that intersectoral action on health determinants is ineffective and that "rigorous evaluations of intersectoral action are needed to strengthen the evidence base for this public health practice".</p>
<p>Loirenc T, Petticrew M, Welch V, et al. 2013. What types of interventions generate inequalities? Evidence from systematic reviews. Journal of Epidemiology and Community Health, 67(2), 190–93. http://jech.bmj.com/content/67/2/190.abstract</p> <p>A public health intervention may increase inequalities if it is of greater benefit to advantaged (low-risk) groups than to disadvantaged (high-risk) groups. This review involved a rapid review of systematic reviews to identify evidence on intervention-generated inequalities (IGIs) by socio-economic status (SES). The authors included any review of non-healthcare interventions in developed countries that presented data on differential effects of an intervention on health status or health behaviour outcome(s). They found that there was some evidence that media campaigns and workplace smoking bans increase inequalities between different SES groups, but that for many intervention types data on potential IGIs was lacking. There was some evidence that structural workplace interventions, provision of resources, and fiscal interventions, such as tobacco pricing, reduce health inequalities. The review authors stated that their findings were consistent with the belief that "downstream" preventive interventions are more likely to increase inequalities than "upstream" interventions. They also stated that, to increase the evidence base regarding IGIs, more consistent reporting of differential intervention effectiveness is needed.</p>

Bambra C, et al. 2010. **Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews.** *Journal of Epidemiology and Community Health*, 64(4), 284–91.
<http://www.ncbi.nlm.nih.gov/pubmed/19692738>

This systematic review of systematic reviews (from developed countries, published from 2000 to 2007) assessed the health effects of any intervention based on the wider determinants of health (water and sanitation, agriculture and food, access to health and social care services, unemployment and welfare, working conditions, housing and living environment, education, and transport). Thirty reviews were identified. Only reviews with adult participants (16 years and over) were included. Generally, the effects of interventions on health inequalities were unclear. However, there was evidence to suggest that certain categories of intervention, particularly in housing and the work environment may have a positive impact on inequalities, or on the health of specific disadvantaged groups.

Smith KE, Bambra C, Joyce KE, et al. 2009. **Partners in health? A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008.** *J Public Health (Oxf)*, 31(2), 210–21. <http://jpubhealth.oxfordjournals.org/content/31/2/210.long>

The authors of this review defined public health partnerships as “organizational partnerships (of two or more organizational bodies), which aim to improve public health outcomes (through population health improvement and/or a reduction in health inequalities)”. To be included in this systematic review studies had to involve partnerships in England between 1997 and 2008, explicitly describe the public health partnership being evaluated (or assess a known public health partnership), and contain data on the impact of the partnership on public health outcomes (health improvement and/or reduction in health inequalities), either directly or indirectly.

The review authors identified fifteen studies, relating to six different interventions, meeting their criteria. Most of the included studies were not designed specifically to assess the impact of partnerships on public health outcomes. There were only four quantitative studies and these found mixed results on the impact of partnership working. The qualitative studies suggested that some partnerships raised the profile of health inequalities on local policy agendas. Due to the design of both the partnership interventions and the studies evaluating them, the review authors found it difficult to determine the extent to which the success or otherwise of interventions was due to partnership working. They concluded that there was not yet any clear evidence for the effects of public health organisational partnerships on health outcomes and that better-designed evaluation studies were needed.

Lucas P, et al. 2008. **Financial benefits for child health and well-being in low income or socially disadvantaged families in developed world countries.** *Cochrane Database of Systematic Reviews*
doi:10.1002/14651858.CD006358.pub2 <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006358.pub2/abstract>

This review assessed the effectiveness of direct financial benefits to socially or economically disadvantaged families in improving children's health, wellbeing and educational attainment. Nine RCTs, including over 25,000 participants, were included in the review. Eight studies assessed the effects of welfare reforms (changes to welfare payments including cash incentives such as negative taxation or income supplements combined with work support or requirement to work) and one study assessed a teenage pregnancy reduction programme. No effect was observed on child health, or on measures of child mental health or emotional state. Non-significant effects favouring the intervention group were seen for child cognitive development and educational achievement, and a non-significant effect favouring controls in rates of teenage pregnancy. While the authors did not find evidence to support the use of financial benefits as an intervention to improve child health, the conclusions were limited by the fact that most of the interventions had small effects on overall household income and were accompanied by strict conditions for receipt of payment. Gaps in the research evidence remain in the evaluation of unconditional payments of higher value, with high quality child outcome measures.

Oliver S, et al. 2008. **Health promotion, inequalities and young people's health: a systematic review of research.** London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
<http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=2412>

This systematic review examined whether, and how, health promotion and public health research among young people has addressed inequalities in health. The researchers sought to identify how much research activity has addressed health inequalities among young people, what types of research have looked at gaps or gradients in health status, how much of this research specifically relates to socially disadvantaged young people, and how much of the research addresses the impact of structural interventions. The review identified 191 mostly observational studies. Most were conducted in the USA, examined physical health (inequalities research) or health behaviours (intervention research) and sampled broad populations rather than defined disadvantaged groups. Most studies did not explicitly aim to measure or reduce inequalities. Recommendations for researching interventions intended to reduce inequalities are made including: to investigate appropriate research methods; to conduct high quality outcome evaluations of interventions which compare outcomes between different groups, especially SES comparisons; to conduct such evaluations with vulnerable groups; rigorous evaluations of the effects of structural and social support interventions which earlier reviews have highlighted as having potential for reducing inequalities; and evaluations which can provide information on the implementation of interventions and their acceptability to young people and their families.

Other relevant publications

Pons-Vigues M, Diez E, Morrison J, et al. 2014. **Social and health policies or interventions to tackle health inequalities in European cities: a scoping review**. BMC Public Health, 14, 198. http://www.biomedcentral.com/1471-2458/14/198?utm_source=rss&utm_medium=rss&utm_campaign=social-and-health-policies-or-interventions-to-tackle-health-inequalities-in-european-cities-a-scoping-review

This review is based on a search in “PubMed” and “Sociological Abstracts” for articles published in scientific journals between 1995 and 2011 reporting on social or health policies or interventions in European cities where the interventions had reducing health inequalities as one of their objectives. The review authors identified 54 studies meeting their criteria. Forty were conducted in the UK, five in Spain, four in the Netherlands, two in Germany, one in France and two in multiple centres. The studies were of various designs and took place in various settings. The majority (46 interventions, 79%) were evaluated and 29 of them (53.7% of the total) had positive effects. The review authors noted that, although almost half of the interventions promoted healthy behaviours, health behaviours are not the main determinants of health inequalities.

Currie C et al., eds. 2012. **Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey**. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/_data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf?ua=1

This is the fifth report from the Health Behaviour of School-aged Children (HBSC) study. It reports on a survey of 200,000 young people aged 11–15 years in 43 countries across Europe and North America in 2009/10. This survey focused on the social and demographic determinants of young people’s health. The results for health and social indicators are presented by age and gender for each country and bar charts illustrate the relationships between family affluence and the various health and social indicators for each country by gender. In general, higher family affluence was associated with better health outcomes, health behaviours and positive social contexts in regard to family, peers and school. There was no clear pattern of health inequalities in risk behaviours such as alcohol use.

Mackenbach JP. 2011. **Can we reduce health inequalities? An analysis of the English strategy (1997–2010)**. J Epidemiol Community Health, 65(7), 568–75. http://hal.archives-ouvertes.fr/docs/00/62/82/75/PDF/PEER_stage2_10.1136%252Fjech.2010.128280.pdf

England was the first country in Europe to institute a systematic policy to reduce socio-economic inequalities in health. This paper offers an assessment of how well the strategy worked, and discusses what lessons can be learnt. In 2001 the Secretary of State for Health announced two inequalities targets: to lower the gap in gap in life expectancy between areas and the difference in infant mortality across social classes by 10% by 2010. The 2003 Department of Health strategy ‘Tackling health inequalities: a Program for Action’ set out the Government’s plans to achieve these targets. The author of this paper reviewed key documents, and analysed the entry points for policy (i.e. health determinants targeted), the specific policies chosen, policy implementation, changes in intermediate health outcomes and changes in final health outcomes. He concluded that despite some partial successes, the strategy failed to reach its targets because it did not address the most relevant entry points, did not employ effective policies and was not delivered on a large enough scale to achieve population-wide impacts. He stated that substantial reductions in health inequalities can only occur if governments have a democratic mandate to make the necessary policy changes, if policies that are demonstrably effective can be developed, and if such policies are implemented on a sufficiently large scale.

Currie J, Goodman J. 2010. **Parental Socioeconomic Status, Child Health, and Human Capital**. In Peterson P, Baker E, McGaw B (Eds.), International Encyclopedia of Education (3rd edition): Elsevier. <http://scholar.harvard.edu/files/joshuagoodman/files/parentalses.pdf>

This essay considers the evidence from developed countries for the effects of parental socioeconomic status (SES) on child health and for the effect of child health on future outcomes such as education. It cites evidence that differences in health between high and low SES children are apparent from birth and continue through early childhood and beyond. Low SES babies are more likely to have low birthweight and low SES children are more likely to have chronic health conditions and more likely to experience limitations as a result of their chronic conditions. Persistent poverty is likely to have worse health effects than temporary poverty and several studies have provided evidence for the greater effects of persistent (as opposed to current) poverty on child mental health, particularly aggressive behaviour. The authors discuss the evidence that low SES causes poor health and that interventions to improve parental SES improve child health. They report that there is very limited evidence for either proposition possibly because of the difficulty of finding interventions that affect parental SES but do not directly affect child health. They state that improving maternal education does seem to have a positive effect on child health possibly because better educated mothers receive better antenatal care, drink and smoke less and are more likely to be married. The authors concluded that there is strong evidence for the association between parental SES and both child health and educational outcomes but causality is difficult to prove.

Other relevant New Zealand publications

Hancock John. 2014. **Legislating to Reduce Child Poverty: considering the UK Child Poverty Act 2010 and its application to New Zealand. Report for Winston Churchill Memorial Trust Board.**

[http://www.communitymatters.govt.nz/vwluResources/WCMT-John-Hancock-report/\\$file/WCMT-John-Hancock-report.pdf](http://www.communitymatters.govt.nz/vwluResources/WCMT-John-Hancock-report/$file/WCMT-John-Hancock-report.pdf)

The principal function of the UK Child Poverty Act 2010 (CPA) is to reduce the numbers of UK children experiencing material deprivation, income poverty, “absolute” poverty and persistent poverty. For each of these poverty indicators, the CPA prescribes both a measure to be used and a target to be reached by 2020. In 2010, John Hancock travelled to the UK on a Churchill Fellowship to research the CPA. His research paper’s primary aim is to consider the impact the CPA has had on reducing child poverty in the UK. The first two sections consider the structure of the CPA and its impact while the third provides a summary of the New Zealand legislative context and considers ways of measuring child poverty. The final section assesses the lessons the CPA provides for New Zealand policy makers and offers some broad conclusions. The author found that the CPA had not been effective in reducing child poverty but it had resulted in the formal establishment of a policy framework sitting across the tiers of government and the establishment of the Social Mobility and Child Poverty Commission, thus adding to the infrastructure for monitoring child poverty and developing policy. Austerity measures introduced by the UK government in response to the financial crisis had a fundamental impact on the effectiveness of the CPA since these measures disproportionately affected low income households with children. The author considered that achieving a political consensus regarding the need for central government to implement a systematic policy approach to reducing child poverty may be the most challenging aspect of any initiative to develop legislation to reduce child poverty in New Zealand.

The Office of the Children’s Commissioner has published a research brief based on this research paper. This can be found here: <http://www.occ.org.nz/assets/Publications/OCC-Summary-Sheet-Legislating-to-Reduce-Child-Poverty.pdf> .

Office of the Children's Commissioner. 2013. **A framework for food in schools programmes in New Zealand**

Wellington: Office of the Children’s Commissioner. <http://www.occ.org.nz/assets/Uploads/Reports/Poverty/A-framework-for-food-in-schools.pdf>

This working paper addresses the design and implementation of a collaborative food in schools programme, one of the 78 recommendations in the *Solutions to Child Poverty* report (see below). It discusses the evidence for a Government-supported framework and how the Government might partner with families, whānau, schools, communities and business. The paper concludes with a worked example of a possible policy framework for food programmes in New Zealand schools and early childhood education (ECE) services, based on the principles of partnership, best practice and proportional universalism.

Smith C, Parnell WR, Brown RC, et al. 2013. **Providing additional money to food-insecure households and its effect on food expenditure: a randomized controlled trial.** Public Health Nutrition, 16(08), 1507–15.

This paper reports on a RCT involving 214 low income households with children in Dunedin. Participants were recruited via newspaper advertising, flyers distributed at supermarkets, posters in schools and via invitations issued to participants in a previous study. It aimed to examine the effect of extra money (in the form of supermarket vouchers) on food expenditure in food-insecure households with children (≤18 years). The trial used a parallel design with a four week baseline phase followed by a four week intervention phase during which households were randomised to receive (or not) supermarket vouchers. The vouchers had a mean monetary value of \$17.00 per week. In the intervention phase the voucher group spent \$15.20 (95% CI 1.46–28.94, $p=0.030$) more per week on food than the control group. There was no difference between the intervention and control groups in spending on ‘fruit and vegetables’, ‘meat and poultry’ and ‘dairy’. All differences were non-significant and <\$1. The study authors concluded that providing money via supermarket vouchers to food-insecure households led to increased spending on food.

The Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty. 2012. **Solutions to Child Poverty in New Zealand: Evidence for Action.** Wellington: Office of the Children's Commissioner.

<http://www.occ.org.nz/assets/Uploads/EAG/Final-report/Final-report-Solutions-to-child-poverty-evidence-for-action.pdf>

This report contains the recommendations from the Children’s Commissioner’s Expert Advisory Group (EAG) on solutions to child poverty. It also provides a picture of child poverty in New Zealand, reports on the feedback the EAG received on their Issues and Options paper (see below), and outlines the approach the EAG used to develop their recommendations. The 78 recommendations are intended to: address the causes and consequences of child poverty, be sensitive to the issues around children in sole parent families, and be informed by the best available evidence. They are grouped under the following headings: strategy and accountability; tax credits, benefits and income support; child support; employment, skills and training; housing; Māori children; Pasifika children; problem debt; health and disability; education; local communities and family; the justice system; research and evaluation and areas for further consideration.

Expert Advisory Group on Solutions to Child Poverty. 2012. **Solutions to Child Poverty in New Zealand: Issues and Options Paper for Consultation**. Wellington: Office of the Children's Commissioner.

<http://www.occ.org.nz/assets/Uploads/EAG/Options-paper/Issues-and-options-paper-for-consultation.pdf>

This report presents the initial package of proposals to reduce child poverty and mitigate its effects, developed by the Expert Advisory Group on Solutions to Child Poverty, established in March 2012 by the Children's Commissioner. The group examined international and New Zealand evidence on child poverty and its solutions, which is summarised in this document and available in a series of working papers on the website (the health policy working paper is available at: <http://www.occ.org.nz/assets/Uploads/EAG/Working-papers/No-17-Health-policy.pdf>). Proposals include: developing a standard approach to measuring child poverty; increased household incomes through changes to the child support and Family Tax Credit systems, a universal Child Payment and increasing parents' employment earnings; improvements in housing quality and affordability; and health and education system recommendations. Proposals for the health system include: improvements to maternity care to increase the uptake and early engagement of women from low socioeconomic backgrounds, especially teenagers, Māori and Pasifika, and integrated continuity of service from antenatal to age five; improved integration of health and social services for pre-school children; improved access to primary care; and youth health care through secondary schools.

Rowe Davies Research for Every Child Counts. 2012. **The Netherlands Study: Learning from the Netherlands to improve outcomes for New Zealand's children**. Wellington: Every Child Counts.

<http://www.everychildcounts.org.nz/news/the-netherlands-study-2/>

The Netherlands achieves high OECD rankings in child wellbeing outcomes, at relatively low cost compared to countries with similar outcomes. This report considers whether there are specific policies that contribute to these outcomes and have the potential to inform New Zealand's efforts to improve child wellbeing and status. The report found that a culture of respect for children and of the caring responsibilities of parents, combined with a universal approach to supporting parents, makes it easier for parents and children to access support when they need to and contributes to child wellbeing. Systematic, nationwide programmes appeared to be more widespread in the Netherlands. Differences in parental leave entitlement and work patterns, out-of-school rather than pre-school care, parent education and parent involvement in schools, generous housing assistance, rates of sole parenthood and teen parenthood, and historical difference in terms of colonisation were identified. The report makes a number of recommendations for New Zealand, including: expanding the reach of effective parent support and education programmes; expanding Plunket and well-child services to include access to practical help with childcare; developing effective services for mothers with post natal depression to improve their sensitivity to their infants; expanding the availability of out-of-school care; increasing statutory parental leave; and improving the effective provision of state-funded housing for parents.

Couchman J & Baker K. 2012. **One step at a time: Supporting families and whānau in financial hardship. A Families Commission research report**. Wellington: Families Commission.

<http://www.familiescommission.org.nz/publications/research-reports/one-step-at-a-time>

This report aims to assist the Families Commission in supporting families and whānau in financial hardship, by examining practices that community organisations use when working with families/whānau, and investigating how existing services can provide more effective support, to identify practical strategies for working with families/whānau. Five case studies of community organisations that have worked in partnership with the Families Commission were undertaken. These included interviews with family/whānau, staff, and other supportive organisations, hui, and focus groups. Findings included: building life skills and self-worth, and creating a less oppressive environment (through reducing the presence of fringe lenders, takeaways and alcohol outlets, and gambling machines) to improve health and reduce addictions, may be more effective than teaching 'financial education'; support is most effective when it is 'inside out' (driven from within a group or community), 'early intervention' may be seen as 'outside in' and the research suggested identifying 'opportunities for engagement', and to focus on building relationship networks from within a community, which can identify problems early would be helpful. Success factors included high-trust relationships, advocacy, promoting access to cultural, social, economic and environmental resources and the development of mana or self-esteem. A number of policy directions are identified.

Public Health Advisory Committee. 2010. **The Best Start in Life: Achieving effective action on child health and wellbeing**. Wellington: Ministry of Health. <http://nhc.health.govt.nz/resources/publications/best-start-life-achieving-effective-action-child-health-and-wellbeing>

This Public Health Advisory Committee report to the Minister of Health highlights that New Zealand ranks low in child health outcomes compared with other OECD countries, and there are wide disparities in the health outcomes of New Zealand children. It identifies four major improvements that are necessary across government and the health and disability sector to improve outcomes: strengthen leadership to champion child health and wellbeing; develop an effective whole-of-government approach for children; establish an integrated approach to service delivery for children; and monitor child health and wellbeing using an agreed set of indicators. Health sector recommendations include: prioritisation of, and increased spending on child health; development of DHB child health implementation plans with measurable outcomes and accountabilities; improved access to primary care; and ensuring a seamless transition from maternity services to health care services for infants.

Note: The publications listed above were identified using the search methodology outlines in **Error! Reference source not found.**