

THE WIDER MACROECONOMIC AND POLICY CONTEXT



MACROECONOMIC INDICATORS



GROSS DOMESTIC PRODUCT (GDP)

Introduction

Gross Domestic Product (GDP) is defined as “the total market value of goods and services produced within a given period, after deducting the cost of goods utilised in the process of production” [2]. GDP is often used as a measure of the size of the economy, with nominal GDP being expressed in current dollar prices, and real GDP being expressed in constant dollar prices (i.e. the dollar value of a particular year, after adjustment for inflation).

Changes in real GDP are often used as a measure of economic growth, or the strength of the economy [2], with a recession typically being defined as two consecutive quarters of negative growth [3]. Recessions are often characterised by high unemployment, stagnant wages and a fall in retail sales, and though usually not lasting longer than a year [3], they may have significant implications for child wellbeing. New Zealand entered a recession at the end of June 2008 (after two consecutive quarters of negative growth), and left the recession at the end of September 2009 (when growth had increased to 0.3% [4]).

The following section briefly reviews changes in New Zealand's GDP since March 2006.

Data Source and Methods

Definition

Gross Domestic Product (GDP): Percent Change from Previous Quarter

GDP is the total market value of all final goods and services produced in a country in a given year, equal to total consumer, investment and government spending, plus the value of exports, minus the value of imports. A recession is defined as two consecutive quarters of negative growth (as measured by GDP).

Data Source

Statistics New Zealand: The New Zealand System of National Accounts. Produced Quarterly

Notes on Interpretation

Three approaches can be used to calculate GDP:

- *Production Approach:* This method calculates what each separate producer adds to the value of final output, by deducting intermediate consumption from gross output. Value added is summed for all producers.
- *Income Approach:* This approach measures the incomes received by the owners of the factors of production. These represent the returns to the labour and capital employed such as wages and salaries, and profits.
- *Expenditure Approach:* This method sums the values of all final demands, that is, final consumption expenditures (of households, government and private non-profit institutions serving households), changes in inventories, gross capital formation, and net exports.

Conceptually, both the production and expenditure approaches of measuring GDP are the same. However, as each series uses independent data and estimation techniques, some differences between the alternative measures arise. The expenditure approach series has historically shown more quarterly volatility and is more likely to be subject to timing and valuation problems. For these reasons, the production-based measure is the preferred measure for short-term quarter-on-quarter and annual changes [4]

New Zealand Trends

Production-based Measure of GDP

In New Zealand, GDP was either flat or decreased for six consecutive quarters from March 2008 to June 2009, before increasing again, for four consecutive quarters, from September 2009 to September 2010. GDP then briefly declined by 0.1% in the September quarter of 2010 and then remained static for a quarter, before increasing again, by 0.6% in the March quarter of 2011. Six consecutive quarters of growth were then seen, with GDP increasing by 0.6% in the June quarter of 2012 (**Figure 1**). Economic activity for the year ending June 2012 increased by 2.0%, when compared to the year ending June 2011 [4]

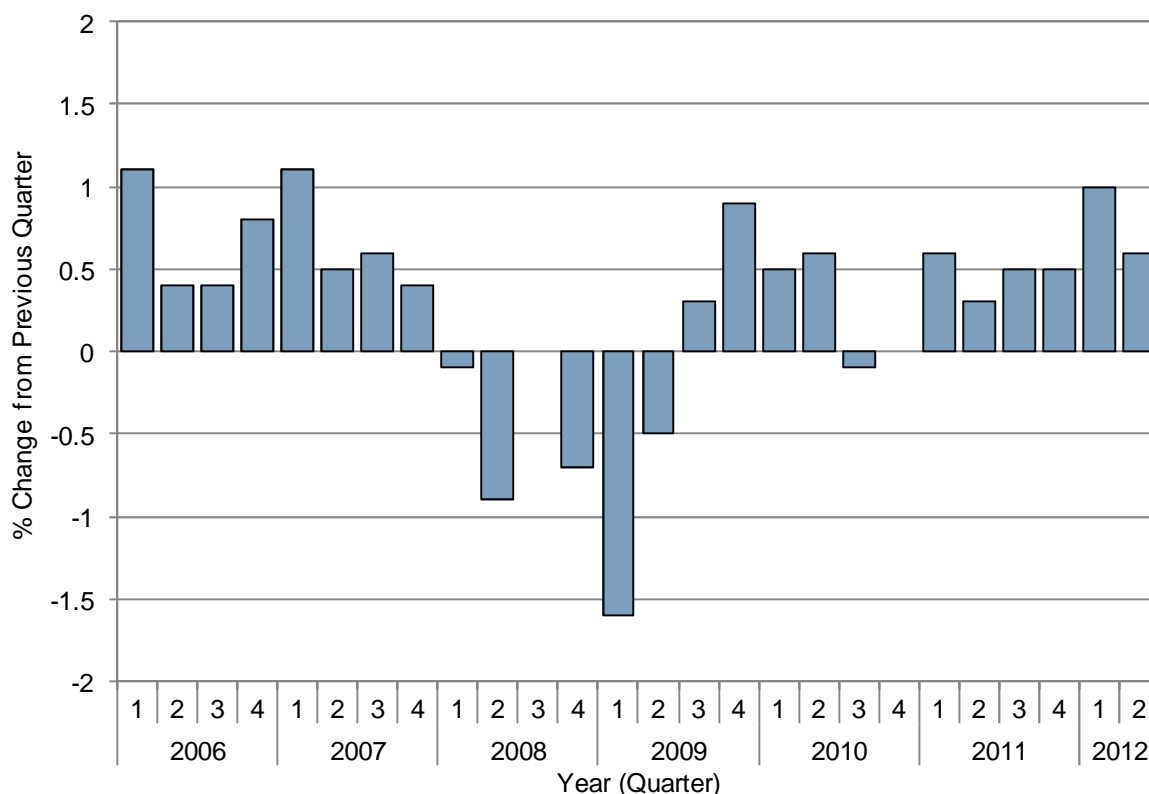
During the June 2012 quarter, agriculture (up 4.7%) was the largest contributor to economic growth, although construction (up 3.3%) and manufacturing (up 0.8%) also increased [4].



Expenditure-based Measure of GDP

The expenditure-based measure of GDP, released concurrently with the production-based measure, increased by 0.3% in the June quarter of 2012. During this period, household consumption expenditure increased by 0.2%, while export volumes were down 1.2% and imports were down 2.9%. On an annual basis, expenditure on GDP for the year ending June 2012 increased by 1.7%, when compared to the year ending June 2011 [4].

Figure 1. Gross Domestic Product (GDP): Percentage Change from Previous Quarter, New Zealand March Quarter 2006 to June Quarter 2012



Source: Statistics New Zealand; Seasonally adjusted chain volume series expressed in 1995/96 prices

Local Policy Documents and Evidence-Based Reviews Relevant to the Economic Environment for Children

Table 3 on **Page 62** considers local policy documents and evidence-based reviews which are relevant to the social policy environment and the socioeconomic determinants of child and youth health.

INCOME INEQUALITY

Introduction

There has been much debate regarding the influence of income inequality on population health. While it is widely acknowledged that poverty plays a crucial role in shaping health disparities, authors such as Wilkinson and Marmot [5] argue that income inequality itself also plays a role, via its links to psychosocial pathways associated with relative disadvantage. They cite the Whitehall studies of British civil servants, which found that mortality increased in a stepwise manner as relative socioeconomic status decreased, with social gradients being evident even amongst those who were not poor. In addition, they note that while health inequalities exist within societies, there is little association between average income (GDP per capita) and life expectancy across rich countries. Rather, there appears to be a strong correlation between income inequality and mortality. In Wilkinson and Marmot's view, such associations suggest that it is not absolute material deprivation which shapes health at the population level, but rather the effects such inequalities have on psychosocial outcomes such as the degree of control over work, anxiety, depression and social affiliations. In support of this argument, they cite a number of studies which demonstrate social gradients in the lack of control over work, low variety at work and a severe lack of social support, with animal experiments also suggesting that low social status, via its effects on neuroendocrine pathways, leads to atherosclerosis, unfavourable lipid profiles, central obesity, insulin resistance and raised basal cortisol [5].

Others such as Lynch [6] however, would argue that it is not the psychological effects of income inequality which play the greatest role, but rather the lack of material resources (e.g. differentials in access to adequate nutrition, housing and healthcare), coupled with a systematic underinvestment in human, physical, health and social infrastructure (e.g. the types and quality of education, health services, transportation, recreational facilities and public housing available). In Lynch's view, the combination of these negative exposures is particularly important for the health of the most disadvantaged (who have the fewest individual resources), and that in this context, the associations between income inequality and health are not inevitable, but rather are contingent on the level of public infrastructure and resources available. While debate on the precise pathways continues, both sides of the income inequality argument agree, that reducing income inequality by raising incomes for the most disadvantaged, will improve population health [7].

The following section explores income inequalities in New Zealand since 1982 using two different measures, the P80/P20 Ratio and the Gini Coefficient.

Definition

1. *Income Inequality as measured by the P80/P20 Ratio*
2. *Income Inequality as measured by the Gini Coefficient*

Data Source

Statistics New Zealand Household Economic Surveys (NZHES n=2,800–3,500 households per survey) via Perry 2012 [8].

Note: The P80/P20 Ratio and Gini coefficient are monitored by the Ministry of Social Development using NZHES data which was available 2-yearly from 1982 to 1998, and 3-yearly thereafter. Since 2007, income data has become available annually through the new NZHES Incomes Survey. The full NZHES (including expenditure data) however remains 3-yearly. For more detail on methodology used see Perry 2012 [8].

Notes on Interpretation

P80/P20Ratio: When individuals are ranked by equivalised household income and then divided into 100 equal groups, each group is called a percentile. If the ranking starts with the lowest income, then the income at the top of the 20th percentile is denoted P20 and the income at the top of the 80th percentile is called P80. The ratio of the value at the top of the 80th percentile to the value at the top of the 20th percentile is called the P80/20 ratio and is often used as a measure of income inequality (e.g. a P80/20 ratio of 3.0 indicates that those at the top of the 80th percentile have incomes 3.0x higher than those at the top of the 20th percentile). In general, the higher the ratio, the greater is the level of inequality [8].



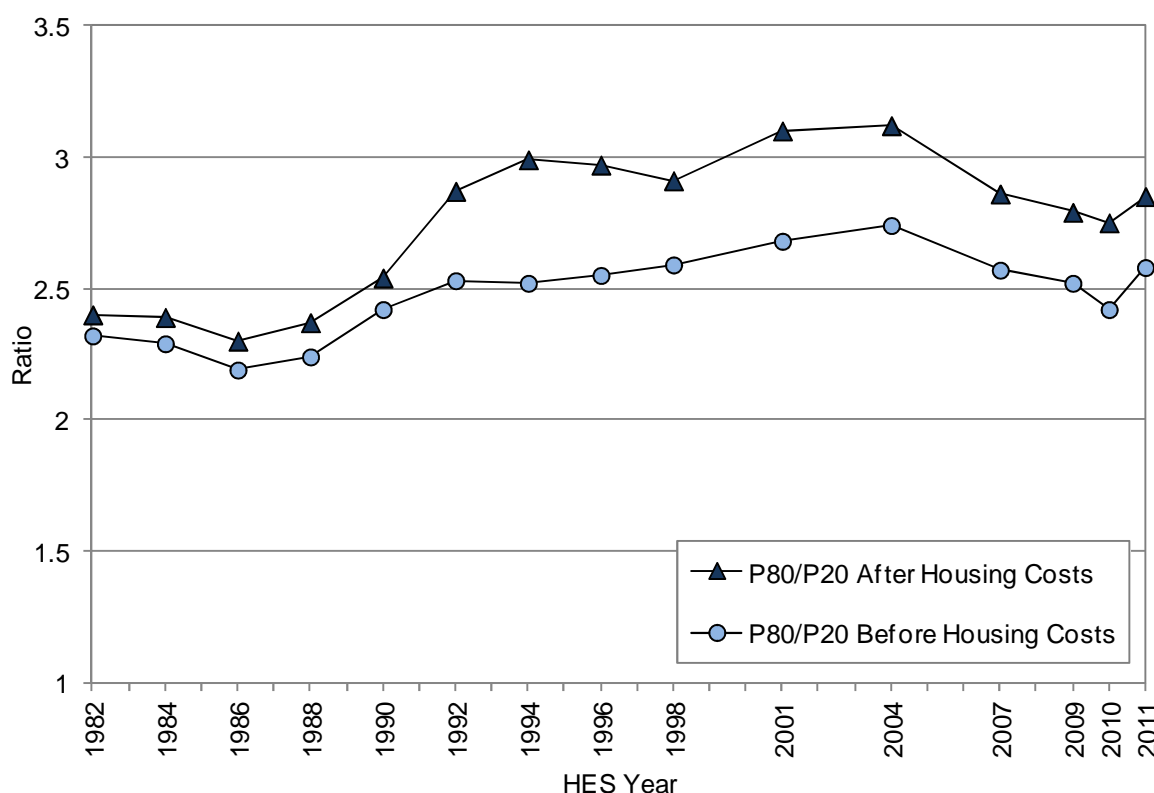
Gini Coefficient: The Lorenz curve is a graph with the horizontal axis showing the cumulative % of people in a population ranked by their income. The vertical axis shows the corresponding cumulative % of equivalised disposable household income (i.e. the graph shows the income share of any selected cumulative proportion of the population). The diagonal line represents a situation of perfect equality (i.e. all people having the same income). The Gini coefficient is derived from the Lorenz curve and is the ratio of the area between the actual Lorenz curve and the diagonal (or line of equality), compared to the total area under the diagonal. When the Gini coefficient = 0 all people have the same level of income. When it approaches 1, one person receives all the income (i.e. it is an overall measure of income inequality: the higher the number, the greater the level of inequality) [9]. When comparing changes in income distributions over time, the Gini coefficient is more sensitive to changes in the more dense low to middle parts of the distribution, than it is to changes towards the ends of the distribution [10].

New Zealand Trends

Income Inequality: P80/P20 Ratio

In New Zealand during 1982–2011 income inequality, as measured by the P80/P20 ratio, was higher after adjusting for housing costs (as housing costs generally make up a greater proportion of household income for lower income than for higher income households). The most rapid rises in income inequality occurred during 1988–1992. While income inequality also rose during 1994–2004, the rate of increase was slower. During 2004–2007, income inequality fell, a decline which Perry attributes to the Working for Families package. During 2009–2011 however, the impact of the economic downturn and global financial crisis led to volatility in the index, with Perry noting that it may take one or two further surveys before the post-crisis inequality level becomes clear [8] (**Figure 2**).

Figure 2. Income Inequality in New Zealand as Assessed by the P80/P20 Ratio for the 1982–2011 HES Years

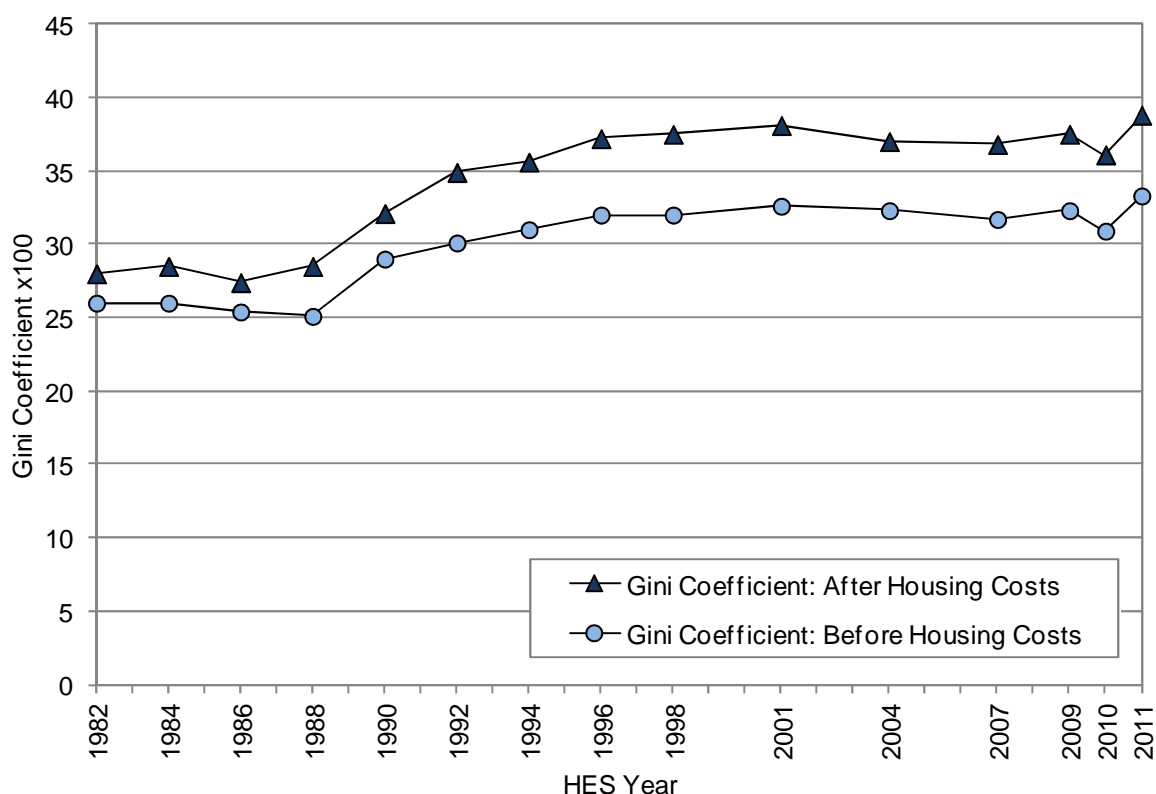


Source: Perry 2012 [8] derived from Statistics NZ Household Economic Survey (HES) 1982–2011

Income Inequality: Gini Coefficient

In New Zealand during 1982–2011, income inequality as measured by the Gini coefficient, was also higher after adjusting for housing costs. The most rapid rises in income inequality also occurred between the late 1980s and early 1990s. Using both the before and after housing cost measures, the Gini Coefficient declined between 2001 and 2007, a decline which Perry attributes to improving employment and the impact of the Working for Families package. During 2009–2011 however, there was considerable volatility in the Gini coefficient, which Perry attributes to the differing size and timing of the impact of the global financial crisis and associated economic downturn on different parts of the income distribution. Again Perry notes it will take one or two more surveys to see where the inequality trend will settle after the impacts associated with the global financial crisis [8] (Figure 3).

Figure 3. Income Inequality in New Zealand as Assessed by the Gini Coefficient for the 1982–2011 HES Years



Source: Perry 2012 [8] derived from Statistics NZ Household Economic Survey (HES) 1982–2011

Local Policy Documents and Evidence-Based Reviews Relevant to the Economic Environment for Children

Table 3 on Page 62 considers local policy documents and evidence-based reviews which are relevant to the social policy environment and the socioeconomic determinants of child and youth health.



CHILD POVERTY AND LIVING STANDARDS

Introduction

High rates of child poverty are a cause for concern, as low family income has been 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 [11]. Further, longitudinal studies suggest 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 contact with the justice system. While adjusting for potentially mediating factors (e.g. parental education, maternal age, and sole parent status) reduces the magnitude of these associations somewhat, they do not disappear completely. This suggests that the pathways linking low family income to long term outcomes are complex, and in part may be mediated by other socioeconomic factors [12]. While there is much debate about the precise pathways involved, there is a general consensus that the relationship between poverty and adverse outcomes is non-linear, with the effects increasing most rapidly across the range from partial to severe deprivation [13].

In New Zealand, the Ministry of Social Development has periodically reviewed the socioeconomic wellbeing of families with children using information from two data sources:

1. The NZ Household Economic Survey, which can be used to assess the proportion of families with children who live below the income poverty line [8].
2. The NZ Living Standards Surveys, which use the Economic Living Standards Index (NZELSI) to assess the proportion of families with children who live in severe or significant hardship [14].

The following section uses information from these two data sources to assess the proportion of New Zealand children living below the 60% poverty threshold, or in families exposed to very reduced living standards.

Children Living in Households Below the Poverty Line

The Ministry of Social Development publishes an annual report on household incomes using information from the NZ Household Economic Survey (NZHES). The following section reviews the proportion of children aged 0–17 years living in households with incomes below the 60% income poverty threshold, by a range of demographic factors.

Data Source and Methods

Definition

1. *Proportion of dependent children aged 0–17 years living below the 60% income poverty threshold before housing costs (BHC)*
2. *Proportion of dependent children aged 0–17 years living below the 60% income poverty threshold after housing costs (AHC)*

Data Source

Statistics New Zealand Household Economic Survey (NZHES n=2,800–3,500 households per survey) via Perry 2012 [8]. Note: Child Poverty measures are reported on by the Ministry of Social Development using NZHES data [8] which was available 2-yearly from 1982–1998, and 3-yearly thereafter. Since 2007, income data has become available annually through the new HES Incomes Survey. The full NZHES (including expenditure data) however remains 3-yearly. For more detail on methodology see Perry 2012 [8].

Interpretation

Relative poverty measures set a poverty benchmark that rises and falls with changes in national median incomes (i.e. poverty is defined in relation to the incomes of others in the same year). Constant-value (CV) poverty measures select a median at a set point in time (e.g. 1998 or 2007) and then adjust forward and back in time for changes in consumer prices (i.e. they seek to maintain a constant buying power for the poverty benchmark over time). In his 2011 update, Perry [8] notes that in real terms, the median income in 1998 was similar to 1982 and thus there is a good case for using 1998 as the reference year for CV poverty calculations back to 1982, as well as forward from 1998. By 2007 however, the median was 16% higher than in 1998 and by 2009, 26%. Thus the reference year was changed to 2007.

While reporting CV poverty figures back to 1982 using 2007 as the reference tells us what proportion were 'poor' back then, relative to 2007, this approach is not useful for assessing the extent of hardship 'back then' relative to the standards of the day. Thus in the analyses which follow, 2007 CV figures are provided from 2007 onwards, with earlier years using 1998 as the reference year. The first two figures however, report 1998 and 2007 CV figures for the entire period, in order to demonstrate the impact the change of reference year has on the poverty rates produced.

Note: Most income poverty measures use equivalised disposable household income (i.e. after tax household income adjusted for family size and composition). Both measures can be calculated before or after taking housing costs into account. For more detail on the methodology used see Perry 2012 [8].

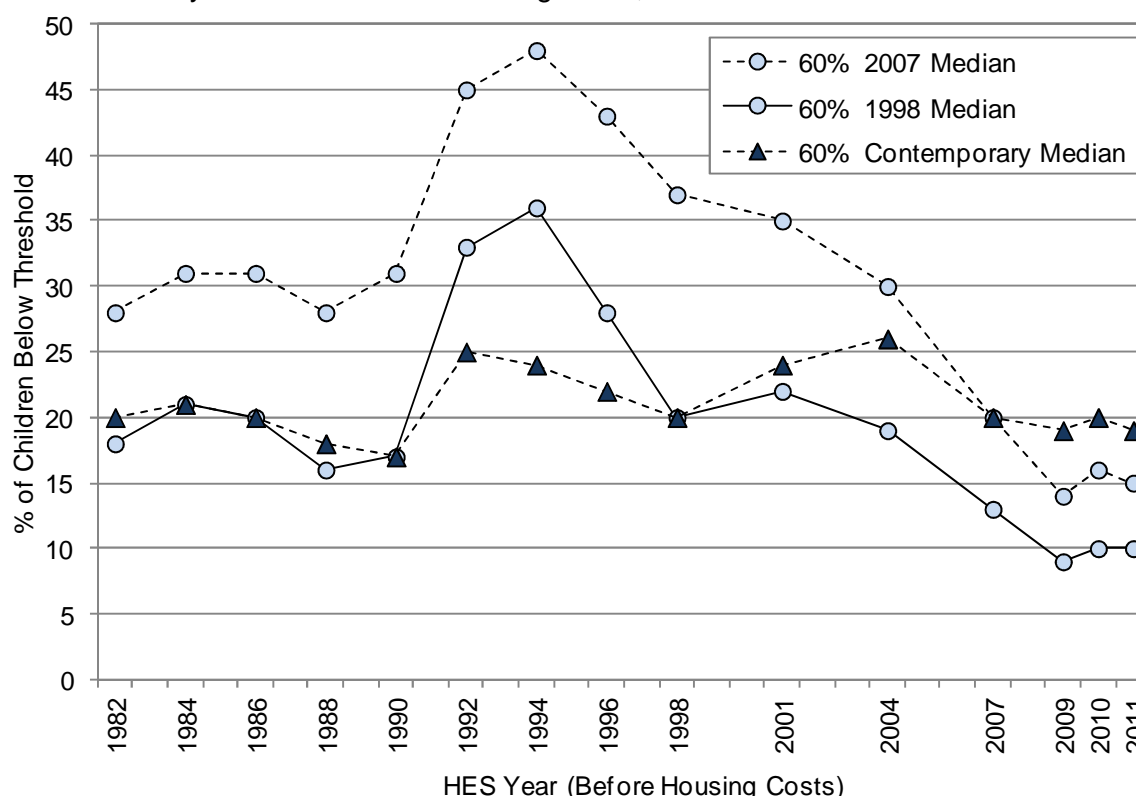
Child Poverty Trends Using Different Poverty Measures

Before Housing Costs (BHC)

Relative Poverty (<60% Contemporary Median): In New Zealand, relative child poverty rose rapidly during 1990–1992, with Perry [8] attributing this to rising unemployment and the 1991 Benefit Cuts (which disproportionately reduced incomes for beneficiaries). During 1992–1998, relative child poverty then declined, as a result of falling unemployment and the incomes of those around the poverty line rising more quickly than the median. After 1998 however, as economic conditions improved, median incomes again rose, while incomes for many low-income households with children did not, resulting in a rise in child poverty up until 2004. From 2004 to 2007 relative poverty rates again declined as a result of the Working for Families package. Child poverty rates however remained relatively static between 2009 and 2011. Before housing costs, relative child poverty rates in 2011 were similar to those in the 1980s [8] (**Figure 4**).

Fixed Line Poverty (<60% 1998 and 2007 Median): In New Zealand during the early 1990s, fixed line child poverty measures increased markedly, for similar reasons to those outlined above. During 1994–1998 however, child poverty rates declined, a trend which Perry attributes to improving economic conditions and falling unemployment. Rates fell more rapidly during 2004–2007 as a result of the Working for Families package. Between 2009 and 2011 child poverty rates remained relatively static [8] (**Figure 4**).

Figure 4. Proportion of Dependent Children Aged 0–17 Years Living Below the 60% Income Poverty Threshold Before Housing Costs, New Zealand 1982–2011 HES Years



Source: Perry 2012 [8], derived from Statistics NZ Household Economic Survey (HES) 1982–2011

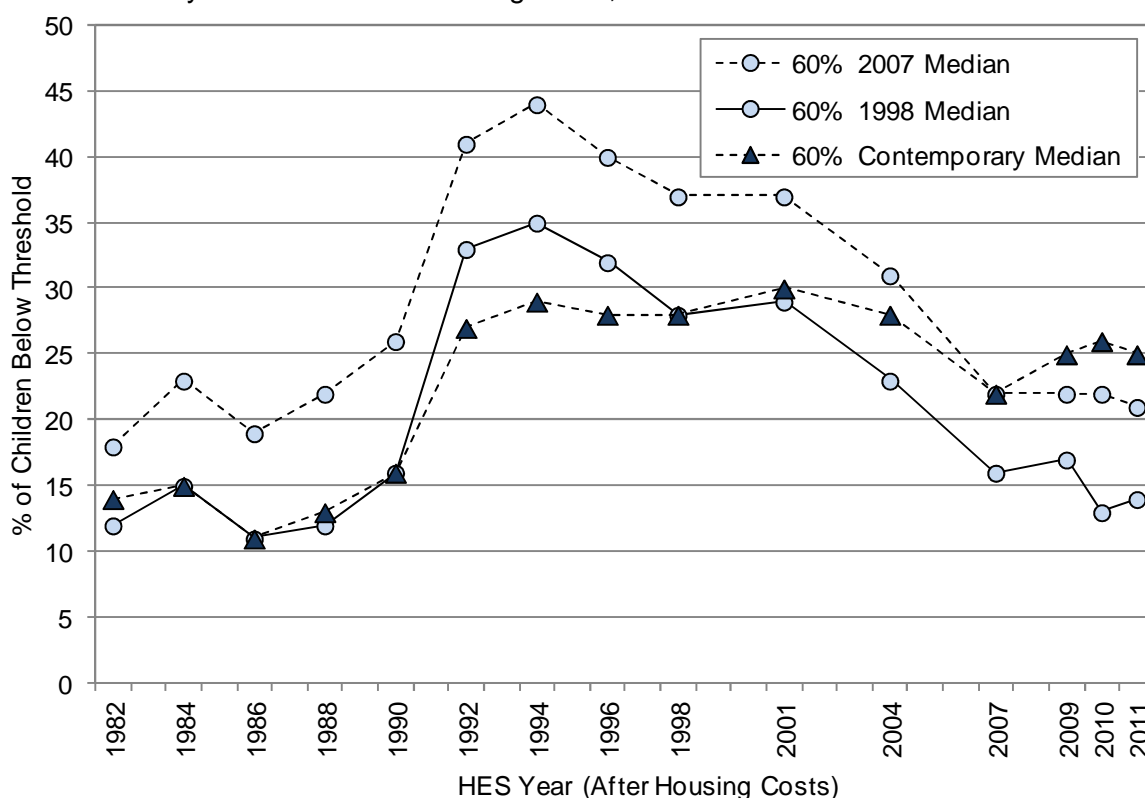


After Housing Costs (AHC)

Relative Poverty (<60% Contemporary Median): In New Zealand during 1982–2011, while trends in relative child poverty after adjustment for housing costs (AHC) were broadly similar to before housing cost measures (BHC), AHC child poverty rates in 2011 were higher than in the 1980s, while BHC measures were closer to 1980s levels. Perry [8] attributes these differences to the fact that housing costs in 2011 accounted for a higher proportion of household expenditure for low-income households than they did in the 1980s (in 1988 17% of households in the lowest income quintile spent more than 30% of their income on housing; in 2007 this figure was 39%). Perry notes however that the income-related rental policies introduced in 2000, along with later changes to Accommodation Supplements, helped reduce housing expenditure for some low income households and that these changes contributed to reductions in AHC child poverty during 2001–2007. There were no further policy changes during 2007–2009 however, with maximum rates of assistance remaining fixed, as housing costs continued to increase. This resulted in increases in AHC child poverty rates during 2007–2009 [8] (**Figure 5**).

Fixed Line Poverty (<60% 1998 and 2007 Median): In New Zealand during 1984–2008, trends in fixed line child poverty after adjustment for housing costs, were broadly similar to before housing cost measures, with the fixed line (AHC) poverty rate in 2007 being around the same as it was in the 1980s (in contrast to the relative AHC poverty rate, which was much higher than in the 1980s) (**Figure 5**).

Figure 5. Proportion of Dependent Children Aged 0–17 Years Living Below the 60% Income Poverty Threshold After Housing Costs, New Zealand 1982–2011 HES Years



Source: Perry 2012 [8], derived from Statistics NZ Household Economic Survey (HES) 1982–2011

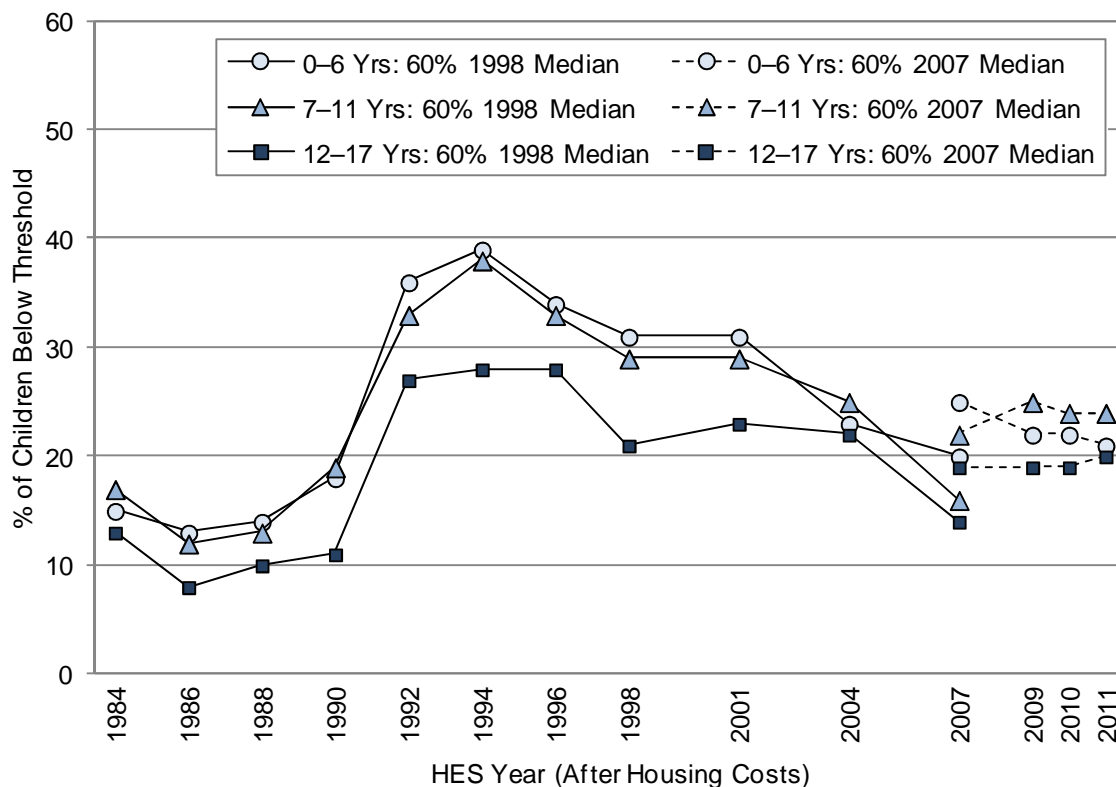
Child Poverty by Children's Age

In New Zealand during 1984–2011, poverty rates for younger children (0–6 years and 7–11 years) were generally higher than for older children (12–17 years) (**Figure 6**).

Child Poverty by Number of Children in Household

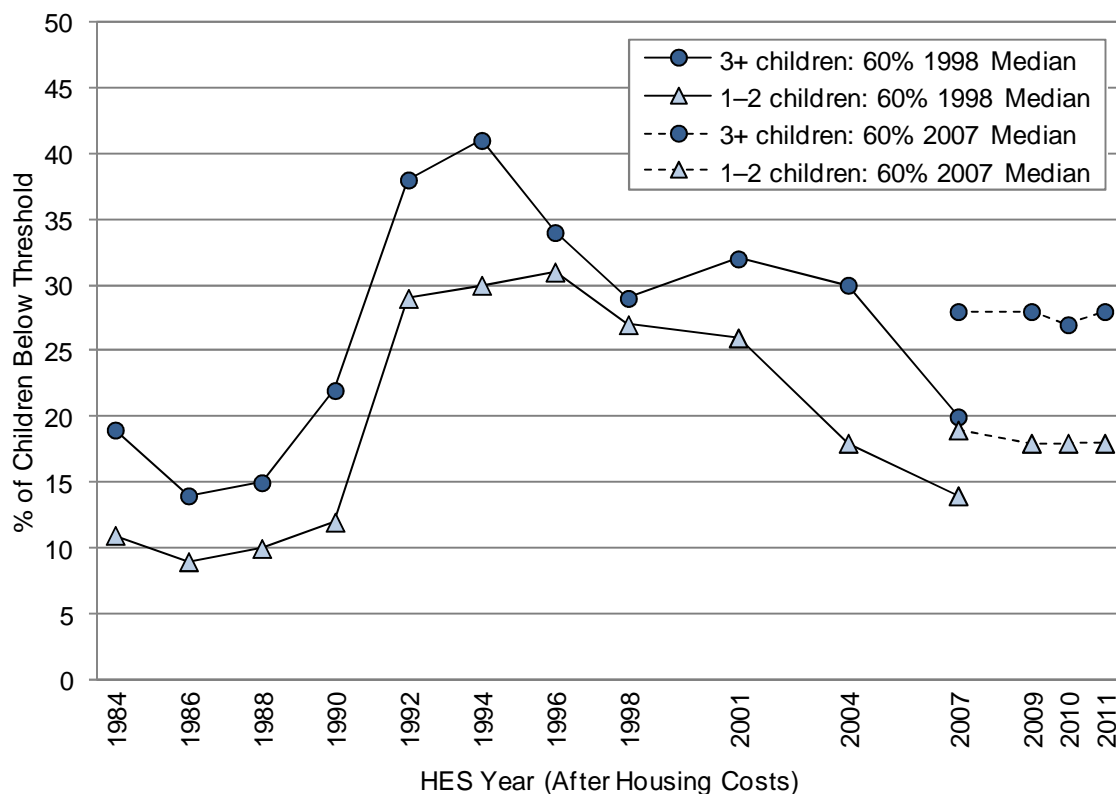
In New Zealand during 1984–2011, child poverty rates for households with three or more children were consistently higher than for those with one or two children (**Figure 7**). (Perry notes that in 2011, children from these larger households made up 48% of all poor children [8]).

Figure 6. Proportion of Dependent Children Living Below the 60% Income Poverty Threshold After Housing Costs by Age, New Zealand 1984–2011 HES Years



Source: Perry 2012 [8], derived from Statistics NZ Household Economic Survey (HES) 1984–2011

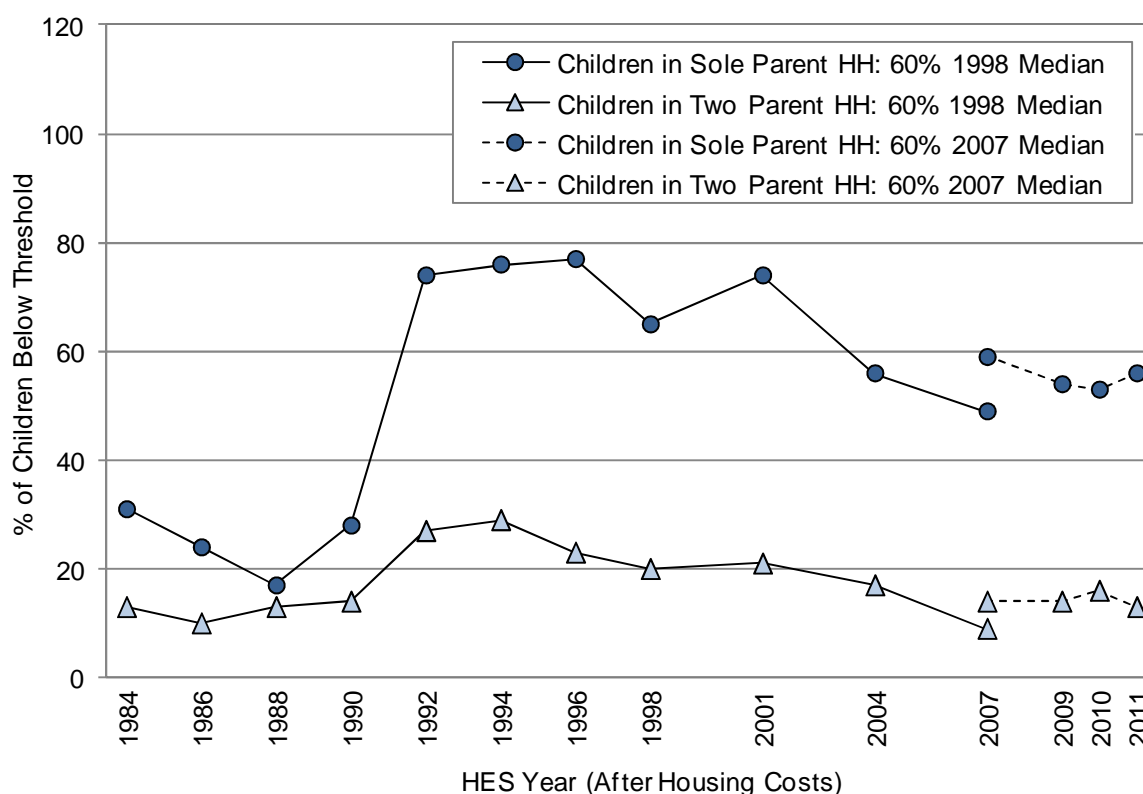
Figure 7. Proportion of Dependent Children Aged 0–17 Years Living Below the 60% Income Poverty Threshold After Housing Costs, by Number of Children in Household, New Zealand 1984–2011 HES Years



Source: Perry 2012 [8], derived from Statistics NZ Household Economic Survey (HES) 1984–2011

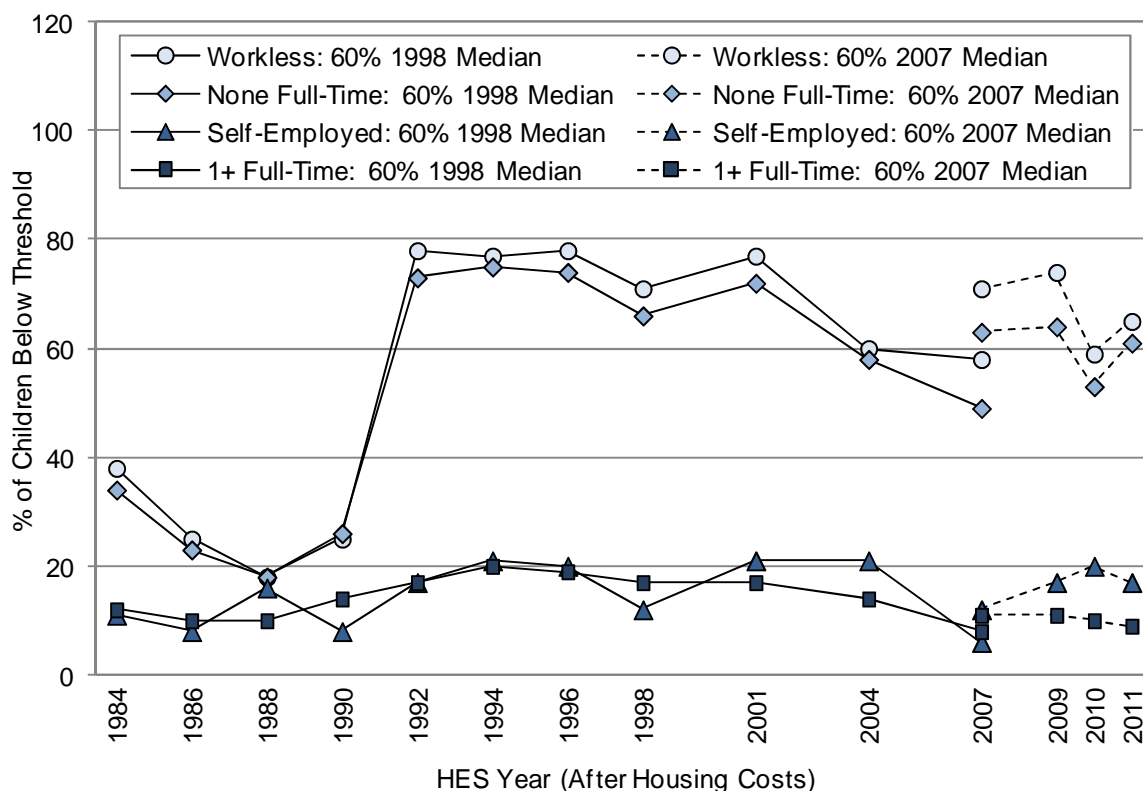


Figure 8. Proportion of Dependent Children Aged 0–17 Years Living Below the 60% Income Poverty Threshold After Housing Costs by Household Type, New Zealand 1984–2011 HES Years



Source: Perry 2012 [8], derived from Statistics NZ Household Economic Survey (HES) 1984–2011

Figure 9. Proportion of Dependent Children Aged 0–17 Years Living Below the 60% Income Poverty Threshold After Housing Costs, by Work Status of Adults in the Household, New Zealand 1984–2011 HES Years



Source: Perry 2012 [8], derived from Statistics NZ Household Economic Survey (HES) 1984–2011

Child Poverty Trends by Household Type

In New Zealand, child poverty rates for children in both sole-parent and two-parent households increased rapidly between 1988 and 1992. In absolute terms however, rates rose most rapidly for children in sole-parent households (rates peaked at 77% for sole-parent households in 1996 and at 29% for two-parent households in 1994). While rates for both household types declined between 2001 and 2007, during 2007 rates for those in sole-parent households remained higher than their 1980s levels, while rates for two-parent households were similar (**Figure 8**). (Perry notes that one in three sole parent families live in wider households with other adults, and that children living in these “other” households have significantly lower poverty rates than those living in sole parent households, because of the greater household resources available [8]).

Child Poverty Trends by Work Status of Adults in Household

In New Zealand, child poverty rates for children in workless households, or where no adults worked full-time, increased rapidly during 1988–1992. Poverty rates for children in these households remained elevated during the 1990s (range 66%–78%), before declining during 2001–2007. Even at their nadir in 2007, poverty rates for children in these households remained much higher than 1980s levels. In contrast, increases in child poverty for households where an adult worked full-time, or was self-employed, were much less marked, with rates in 2007–2009 being similar to those in the 1980s (**Figure 9**). (Perry notes that during the 1980s, children in workless households were around twice as likely to be in poor households; during 1992–2004 four times more likely; and during 2007–2011 six to seven times more likely [8]).

Families with Reduced Living Standards

The Ministry of Social Development has undertaken three national Living Standards Surveys, in 2000, 2004 and 2008. The 2008 Survey collected information from 5000 households on their material circumstances, including ownership and quality of household durables, their ability to keep the house warm, pay the bills, have broken down appliances repaired, and pursue hobbies and other interests [14]. The following section briefly reviews the living standards of children aged 0–17 years, using the 2008 Living Standards Survey's composite index of deprivation.

Data Source and Methods

Definition

Proportion of Children Aged 0–17 Years with Deprivation Scores of Four or More

Data Source

The Ministry of Social Development's 2008 Living Standards Survey [14].

In the 2008 Living Standards Survey, respondents provided information about themselves and others in their Economic Family Unit (EFU). A respondent's EFU comprised the respondent and partner (if any), together with their dependent children in the household (if any). This was a narrower concept than the census family unit which includes other family members such as adult children and parents of adult children.

In the survey, total response ethnicity was used, meaning that categories were not mutually exclusive, as one person could be in two or more categories depending on their response. When the analysis was repeated using prioritised ethnicity however, the change in classification had minimal impact on the results.

Deprivation Index Used in 2008 Living Standards Survey

In the 2008 Living Standards Survey, a 14 item material deprivation index was used to compare the relative positions of different population groups. Each item in the index assessed an 'enforced lack', with items being divided into two categories: ownership/participation, where an item was wanted but not possessed because of cost; and economising items, which focused on cutting back or going without in order to pay for other basic needs. The deprivation score for each respondent was the sum of all enforced lacks, with a cut off of 4+ being used as a measure of material hardship, as it represented the 15% of the population experiencing the most hardship (and was thus seen as being equivalent to the MSD's income poverty measures).



14 Items (*Enforced Lacks*) are included in 2008 Living Standards Survey Deprivation Index

Ownership/Participation

- A good bed
- Ability to keep main rooms adequately warm
- Suitable clothes for important or special occasions
- Home contents insurance
- Presents for family and friends on special occasions

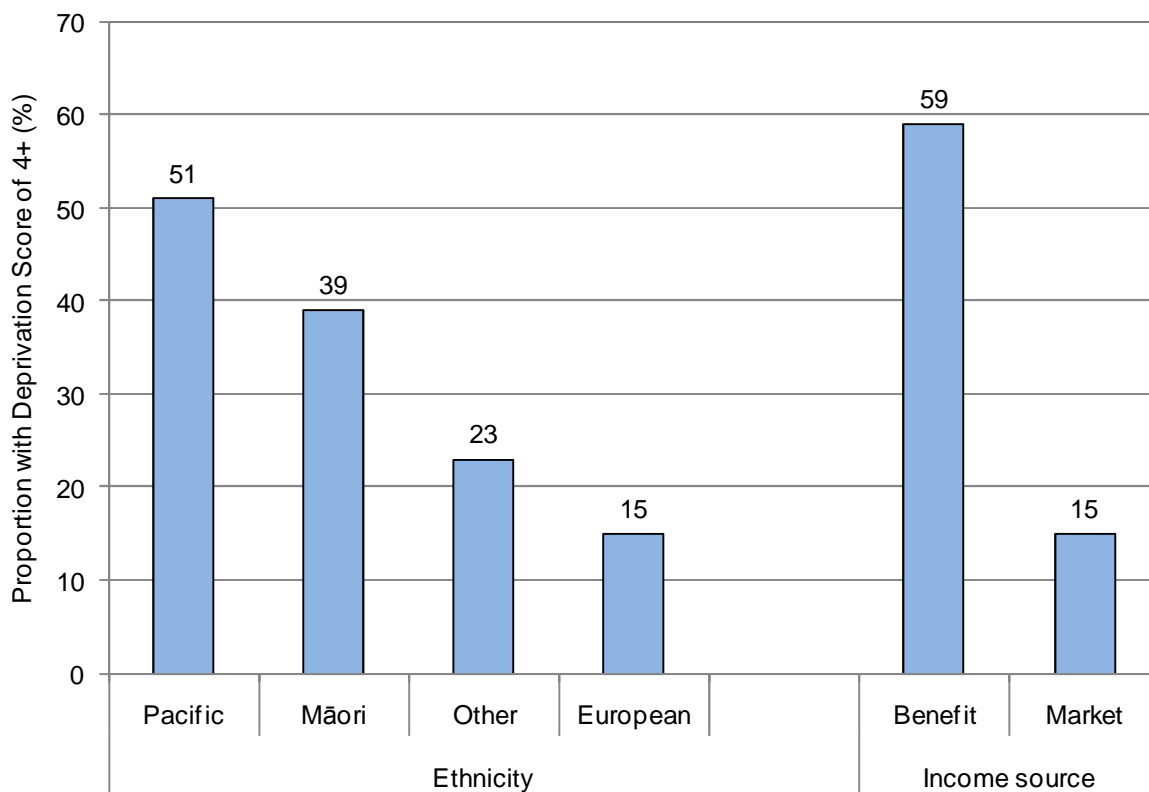
Economising 'A Lot' (To Keep Down Costs to Help Pay for Other Basics)

- Continued wearing worn out clothing
- Continued wearing worn out shoes
- Went without or cut back on fresh fruit and vegetables
- Bought cheaper or less meat than wanted
- Postponed visits to the doctor
- Did not pick up a prescription
- Put up with feeling cold to save on heating costs
- Went without or cut back on visits to family or friends
- Did not go to a funeral (tangi) you wanted to

Proportion of Children with High Deprivation Scores

In the 2008 Living Standards Survey, 51% of Pacific children, 39% of Māori children, 23% of “Other” children and 15% of European children aged 0–17 years scored four or more on the composite deprivation index, which measured a range of “enforced lacks”, as outlined in the Methods box above. In addition, 59% of children whose family’s income source was a benefit had scores of four or more (**Figure 10**). When broken down by individual item, those children who scored four or more on the composite deprivation index had much higher exposures to household economising behaviours such as having to wear worn out shoes or clothing, sharing a bed or bedroom, cutting back on fresh fruit and vegetables and postponing doctors visits because of cost (**Table 2**).

Figure 10. Proportion of Children Aged 0–17 Years with Deprivation Scores of Four or More by Ethnicity and Family Income Source, NZ Living Standards Survey 2008



Source: NZ 2008 Living Standards Survey [14]. Ethnicity is Total Response

Table 2. Restrictions Experienced by Children, by the Deprivation Score of their Family, NZ Living Standards Survey 2008

	All	0	1	2-3	4-5	6+
Distribution of children across the DEP scores	100	41	18	18	10	12
Average number of children per family		2.2	2.3	2.5	2.7	2.7
Enforced lacks of children's items						
Friends to birthday party	6	-	-	5	9	31
Waterproof coat	8	-	2	8	11	39
Separate bed	5	-	-	3	13	20
Separate bedrooms for children of opposite sex (10+ yr)	8	2	3	6	14	24
All school uniform items required by the school	5	-	-	2	9	19
Economising 'a lot' on children's items to keep down costs to afford other basics						
Children continued to wear worn out shoes/clothes	8	-	-	5	15	39
Postponed child's visit to doctor	2	-	-	-	5	13
Did not pick up prescription for children	1	-	-	-	3	7
Unable to pay for school trip	3	-	-	-	6	17
Went without music, dance, kapa haka, art etc	9	2	4	8	18	37
Involvement in sport had to be limited	8	-	4	6	17	32
Multiple deprivation						
4+ of the 11 children's items above	6	-	-	2	11	35
5+ of the 11 children's items above	4	-	-	-	7	29
6+ of the 11 children's items above	3	-	-	-	2	24
Children's serious health problems reported by respondent						
Serious health problems for child in the last year	28	22	25	31	35	43
Enforced lacks reported by respondent in child's family						
Keep main rooms warm	9	-	3	8	18	37
Meal with meat/chicken/fish at least each second day	3	-	-	-	6	18
Cut back/did without fresh fruit and vegetables	14	-	-	15	32	63
Postponed visit to doctor	14	-	4	18	38	65
One weeks holiday away from home in last year	33	14	28	42	52	73
Home computer	8	3	6	8	13	25
Internet access	9	-	7	9	18	28
Housing and local community conditions						
Physical condition of house (poor/very poor)	7	-	3	7	15	28
Major difficulty to keep house warm in winter	22	9	13	27	38	58
Dampness or mould (major problem)	17	5	13	18	37	49
Crime or vandalism in the area (major problem)	11	6	6	11	13	31

Source: NZ 2008 Living Standards Survey [14]



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

Table 3 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, **Table 12** on **Page 103** reviews documents which consider the relationship between housing and health.

Table 3. Local Policy Documents and Evidence-Based Reviews Which Consider Policies to Address the Social Determinants of Child and Youth Health

Ministry of Health Policy Documents
<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>
<p>Public Health Advisory Committee. 2004. The Health of People and Communities. A Way Forward: Public policy and the economic determinants of health. Wellington: Public Health Advisory Committee. http://nhc.health.govt.nz/publications/phac-pre-2011/health-people-and-communities-way-forward-public-policy-and-economic</p> <p>This report reviews the relationship between socioeconomic status and health, and focuses on the role public policy can play in reducing health inequalities. The report begins with a review of socioeconomic and ethnic disparities in health, based on a literature review and Māori analysis; interviews with government and non-government agencies; and a workshop and hui that looked at possible policy responses to identified public health problems. Priorities for action are identified, including: an official poverty measure, reduction in child poverty; a "whole of government" responsibility for coordinating and monitoring policy for reducing health inequalities; focusing on making transparent the changing relationships of socioeconomic status and ethnicity to health outcomes and on tracing the health effects of central and local government policies; and funding research to identify more effective policy interventions and to better understand the causal paths linking socioeconomic status, ethnicity and health.</p>
<p>Jacobsen V, et al. 2002. Investing in Well-being: An Analytical Framework. New Zealand Treasury Working Paper 02/23. Wellington: New Zealand Treasury. http://www.treasury.govt.nz/publications/research-policy/wp/2002/02-23/</p> <p>This paper reports on a Treasury project to identify cost-effective interventions to improve outcomes for children and young adults, to maximise the value of government expenditure across the social sector and provide a framework to compare interventions across sectors. It includes a life-course view of child development that emphasises that experiences in childhood affect wellbeing throughout life. It also includes a review of the literature on how childhood experiences can affect later wellbeing; how child development and outcomes are influenced by individual, family and communal factors and how risk and resilience can be used to indicate individuals at increased risk of negative outcomes. Case studies of youth suicide, teenage pregnancy, educational underachievement and youth inactivity include literature reviews on the effectiveness of interventions.</p>

Mayer SE. 2002. **The Influence of Parental Income on Children's Outcomes**. Wellington: Ministry of Social Development. <http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/influence-parental-income/influence-of-parental-income.pdf>

This report reviews the theoretical basis of how parental income influences children's outcomes. It discusses a range of methodological issues before reviewing research into the effects of parental income on: cognitive test scores; socio-emotional functioning, mental health and behavioural problems; physical health; teenage childbearing; educational attainment; and future economic status. It considers whether the source of parental income matters, whether the effect of income varies with the age of the child, or their gender or ethnicity. The report finds that parental income is positively associated with all outcomes covered in the review, but when family background variables were controlled, the estimated size of the effect of parental income reduces, and the residual effects are generally small to modest on most outcomes. Effects were larger when low income persisted over time and there was some evidence to suggest that income in early childhood was more important for educational outcomes. There was too little research to draw strong conclusions about the impact of parental income on health. The report concludes that parental income contributes to many aspects of children's wellbeing, suggesting that that income gains have the potential to make a significant cumulative difference to the lives of children. A more recent follow-up study by the same author, examining evidence from the USA only, is available at <http://www.irp.wisc.edu/publications/focus/pdfs/foc272e.pdf>.

Cochrane Systematic Reviews

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 of the 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, 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.

Other Systematic Reviews

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.

This systematic review of systematic reviews (from developed countries, published 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.

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 of which 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 New Zealand Evidence

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/publications/child_poverty

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 are 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/_data/assets/pdf_file/0004/9850/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. A final report will be published in December 2012.

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 and young children.

Fletcher M & Dwyer M. 2008. **A Fair Go For All Children: Actions to address child poverty in New Zealand.**

Wellington: Office of the Children's Commissioner. http://www.occ.org.nz/home/childpoverty/the_report

This report, commissioned by the Children's Commissioner and Barnardos, summarises the level and distribution of child poverty in New Zealand. It reviews the consequences of child poverty, including the effects on child health, development, educational achievement and long term outcomes, and the cost to society including extra spending on services for preventable problems and long term costs of reduced economic capacity resulting from failure of individuals to reach their potential. A large number of proposals for action are identified including: giving children a good start (such as improving access to primary care and early childhood education and improving educational outcomes for young mothers); supporting parents to work (including improvements in paid parental leave and affordable out-of-school services); ensuring an adequate income for all families with children; and setting goals and measurable targets.

Other Relevant International Evidence

Macintyre S. 2007. **Inequalities in Health in Scotland: What are they and what can we do about them.** Glasgow: MRC Social & Public Health Sciences Unit. <http://www.sphsu.mrc.ac.uk/reports/OP017.pdf>

This report considered the basis for social inequalities in health and the current evidence for interventions and strategies to address them. It examined the characteristics of policies which are likely to be effective in reducing inequalities including structural changes in the environment (e.g. traffic calming, installing heating in damp cold houses); legislative and regulatory controls (e.g. drink driving legislation, house building standards); fiscal policies (e.g. increase price of tobacco and alcohol products); income support (e.g. tax and benefit systems); reducing price barriers (e.g. free prescriptions, school meals); improving accessibility of services (e.g. location and accessibility of primary health care); prioritising disadvantaged groups (e.g. multiply-deprived families and communities); offering intensive support (e.g. home visiting, good quality pre-school day care); and starting young (e.g. pre and post natal support pre-school day care). The report identifies potential for competition between the goals of producing aggregate health gain and reducing inequalities.

Marmot M, et al. 2010. **Fair Society, Health Lives: The Marmot Review.** London: The Marmot Review.

<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

This is the final report of the Marmot Review, an independent review set up at the request of the UK Secretary of State for Health to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The extensive report identifies a number key messages including: reducing health inequalities is a matter of fairness and social justice; there is a social gradient in health, action should focus on reducing the gradient; health inequalities result from social inequalities, action on health inequalities requires action across all the social determinants of health; focusing solely on the most disadvantaged will not reduce health inequalities sufficiently, reducing the gradient requires universal action, but with a scale and intensity that is proportionate to the level of disadvantage (proportionate universalism); action taken to reduce health inequalities has economic benefits; fair distribution of health, wellbeing and sustainability are important than economic growth and tackling inequalities in health and tackling climate change must go together. The report identifies six policy objectives to reduce inequalities, for which priority objectives and policy recommendations are made:

1. Give every child the best start in life
2. Enable all children young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

The report found that delivering these policy objectives requires action across sectors and national policies require effective local delivery systems focused on health equity in all policies, and effective local delivery requires effective participatory decision-making at the local level.

Note: The publications listed above were identified using the search methodology outlined in **Appendix 1**

UNEMPLOYMENT RATES

Introduction

In the quarter ending December 2009, seasonally adjusted unemployment rates rose to 6.9%, their eighth consecutive quarterly rise. Since then unemployment rates have remained in the mid to high 6% range, with rates in the June quarter of 2012 being 6.8% [15]. Throughout this period, unemployment has been higher for Māori and Pacific people, young people (particularly those 15–19 years) and those without formal qualifications [16]. Such increases are of concern for New Zealand children and young people for two reasons:

Firstly, research suggests that children in families where their parents are unemployed have higher rates of psychosomatic symptoms, chronic illnesses and low wellbeing, and that while the magnitude of these associations is reduced once other potentially mediating factors are taken into account (e.g. parents' former occupation, sole parent status, and migrant status), the associations do not disappear completely [17]. Further, research suggests that these negative effects may be mediated via the impact unemployment has on parents' mental health, with the mental distress associated with decreased social status, disruption of roles, loss of self-esteem and increased financial strain, all impacting negatively on parents' emotional state [17]. This in turn may lead to non-supportive marital interactions, compromised parenting, and children's internalising (e.g. withdrawal, anxiety, depression) and externalising (e.g. aggressive or delinquent behaviour, substance abuse) behaviour [18].

Secondly, for young people the research suggests that unemployment leads to a range of negative psychological outcomes including depression, anxiety and low self-esteem, which are in turn associated with adverse outcomes such as heavy tobacco, alcohol and drug use; and higher mortality from suicide and accidents [19]. While social support may reduce the psychological distress associated with unemployment, the type of support provided is important (e.g. while positive support from family and friends decreases psychological distress amongst unemployed youth, parental advice may at times increase distress, as it may be perceived as pressure to find a job [19]). On a more positive note, research also suggests that this psychological distress decreases once young people find permanent employment, or return to further education [19].

The following section uses information from Statistics New Zealand's Quarterly Household Labour Force Surveys, to review unemployment rates since 1986.

Data Source and Methods

Definition

1. *Unemployment Rate: The number of unemployed people expressed as a percentage of the labour force*

Data Source

Statistics New Zealand's Household Labour Force Survey (n≈15,000 households). Quarterly since March 1986 and available on Statistics New Zealand's website www.stats.govt.nz

Notes on Interpretation

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 [20]

Note 1: 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.

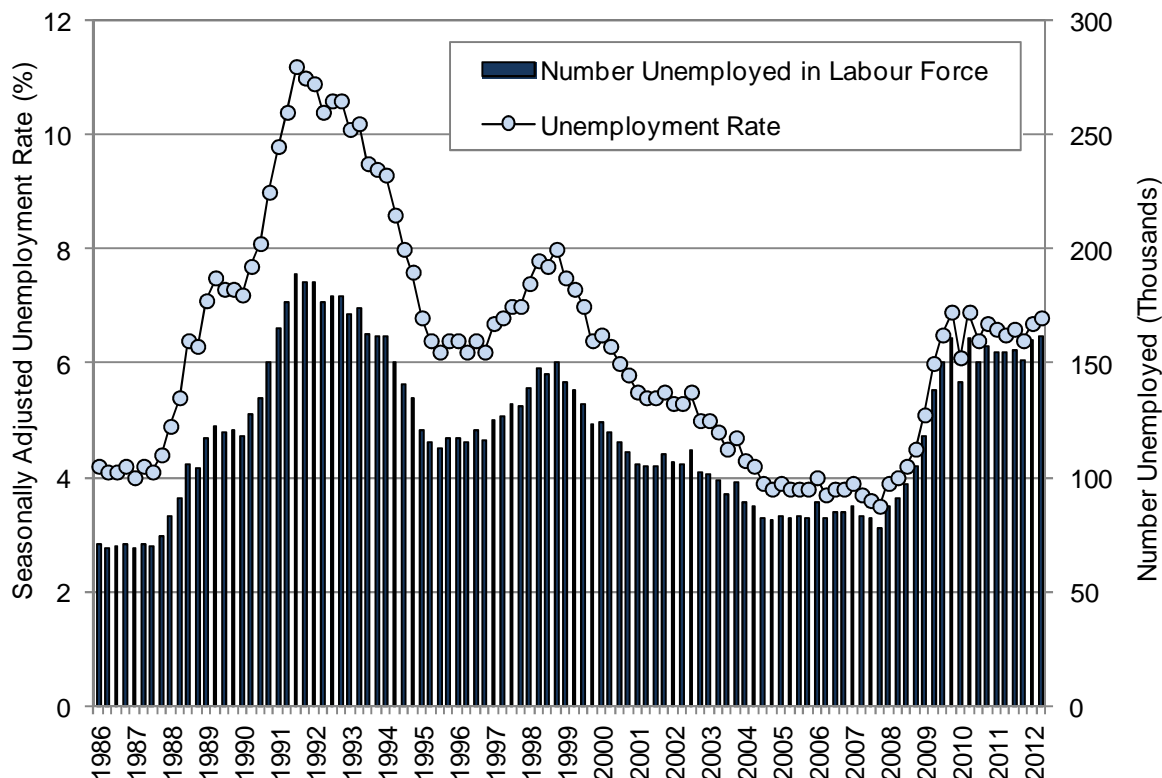
Note 2: Seasonal adjustment makes data for adjacent quarters more comparable by smoothing out the effects of any regular seasonal events. This ensures the underlying movements in time series are more visible. Each quarter, the seasonal adjustment process is applied to the latest and all previous quarters. This means that seasonally adjusted estimates for previously published quarters may change slightly [21].

New Zealand Distribution and Trends

Seasonally Adjusted Unemployment Rates

In the quarter ending June 2012, the seasonally adjusted unemployment rate rose to 6.8%, while seasonally adjusted unemployment numbers increased from 160,000 in the March 2012 quarter to 162,000 in the June quarter (**Figure 11**). The number of people employed decreased by 2,000 to reach 2,227,000 [15].

Figure 11. Seasonally Adjusted Unemployment Rates, New Zealand Quarter 1 (March) 1986 to Quarter 2 (June) 2012



Source: Statistics New Zealand, Household Labour Force Survey; Rates have been seasonally adjusted

Unemployment Rates by Age

In New Zealand during June 1987–2012, unemployment rates were consistently higher for younger people (15–19 years > 20–24 years > 25–29 years > 35–39 years and 45–49 years). During the year ending June 2012, annual unemployment rates were 23.7% for those aged 15–19 years and 12.8% for those aged 20–24 years (**Figure 12**).

Unemployment Rates by Age and Gender

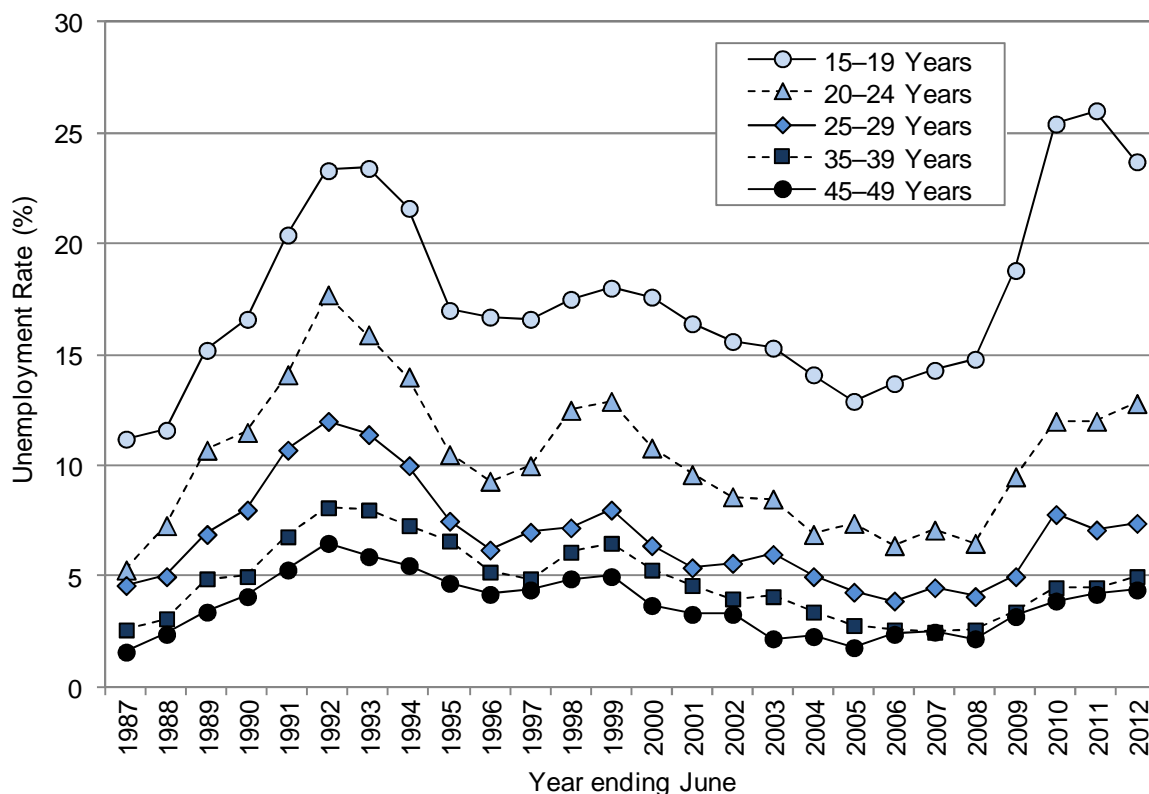
In New Zealand during June 1987–2012, there were no consistent gender differences in unemployment rates for young people aged 15–24 years. During the year ending June 2012, unemployment rates for those aged 15–19 years were 21.9% for females and 25.4% for males, while for those aged 20–24 years, rates were 12.8% for both females and males (**Figure 13**).

Unemployment Rates by Ethnicity

In New Zealand during 2008(Q1)–2012(Q2) unemployment rates were consistently higher for Māori and Pacific, followed by Asian/Indian and then European people. Unemployment rates increased for all ethnic groups during 2008 and 2009, but became more static during 2010(Q1)–2012(Q2). During 2012(Q2), unemployment rates were 12.8% for Māori, 14.9% for Pacific, 8.2% for Asian/Indian and 5.2% for European people (**Figure 14**).

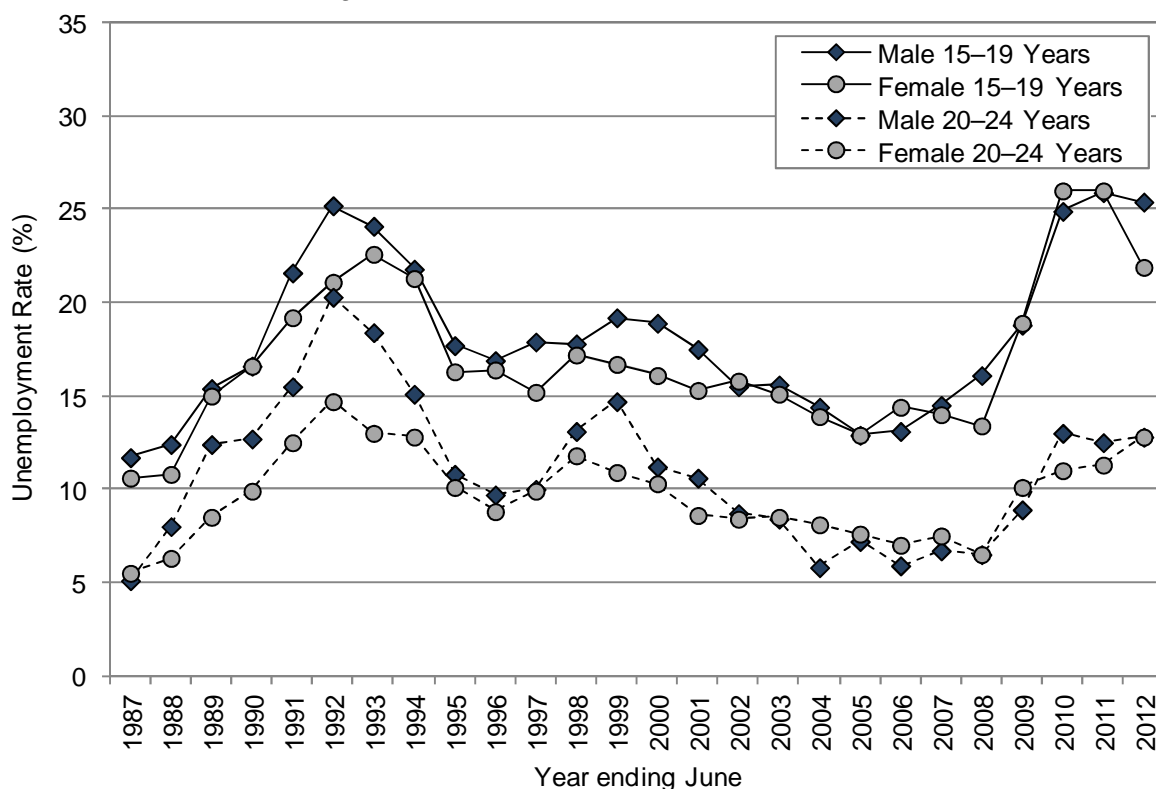


Figure 12. Unemployment Rates by Age (Selected Age Groups), New Zealand Years Ending June 1987–2012



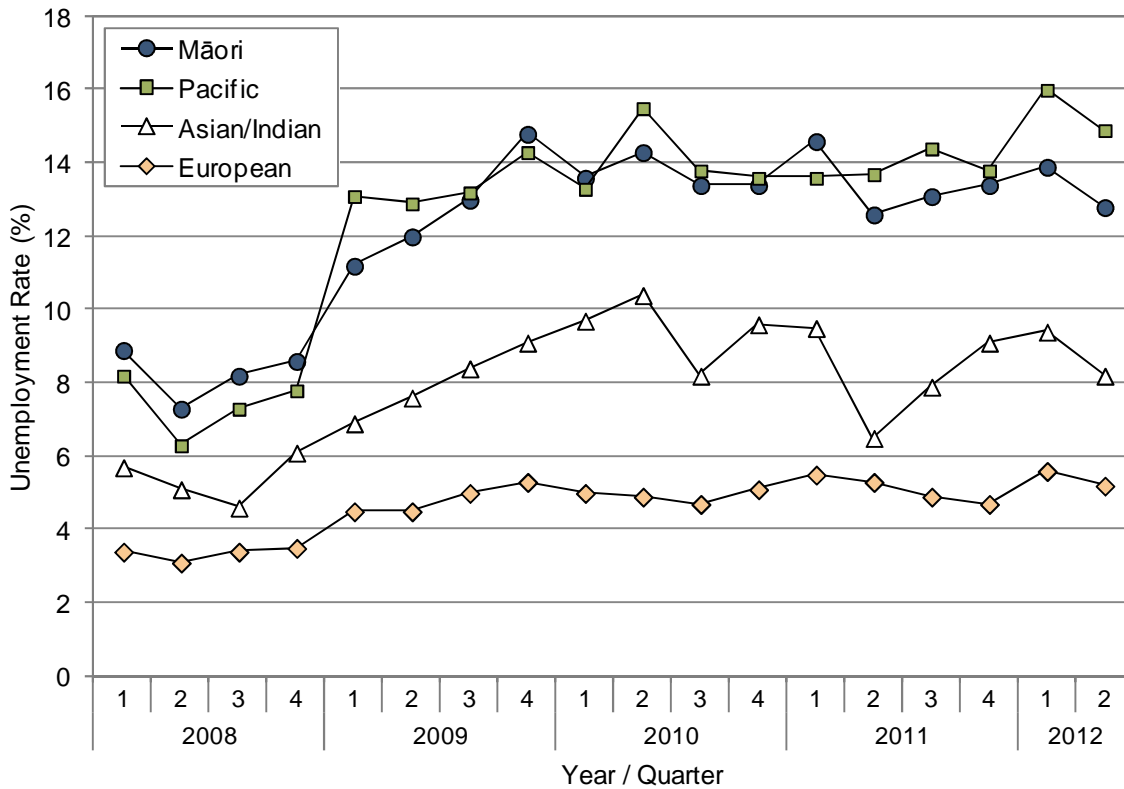
Source: Statistics New Zealand Household Labour Force Survey

Figure 13. Unemployment Rates by Age and Gender in Young People Aged 15–24 Years, New Zealand Years Ending June 1987–2012



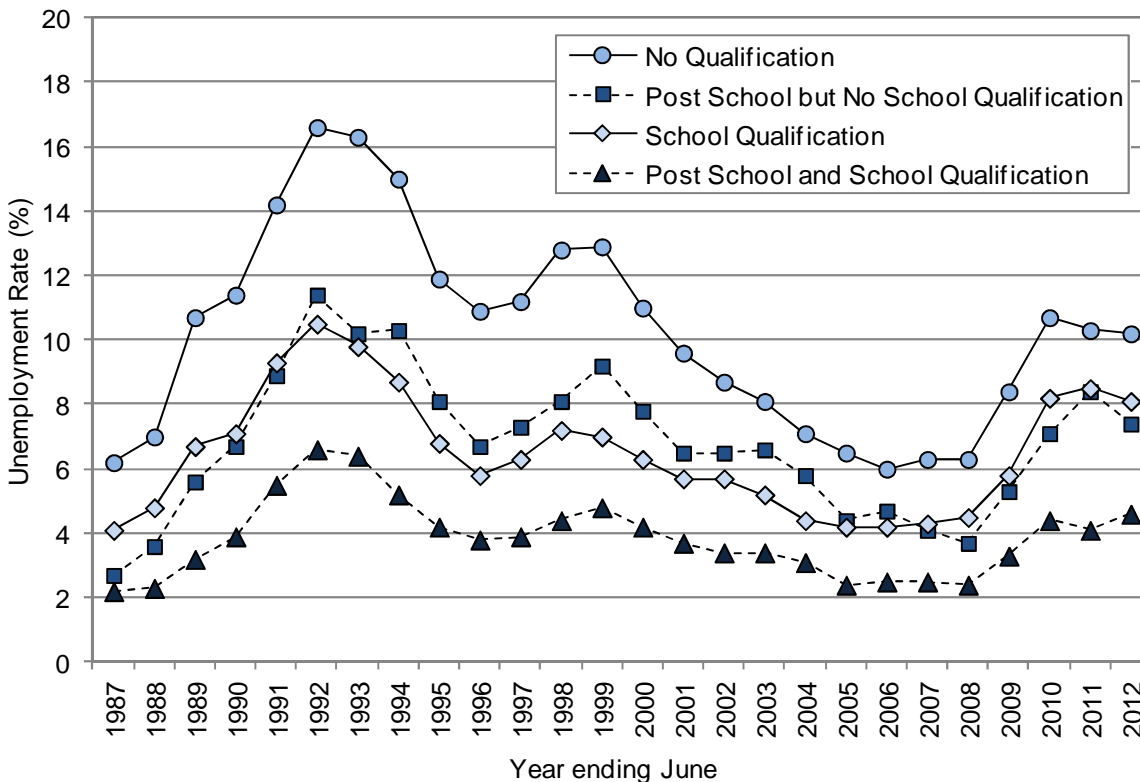
Source: Statistics New Zealand Household Labour Force Survey

Figure 14. Unemployment Rates by Ethnicity, New Zealand Quarter 1 (March) 2008 to Quarter 2 (June) 2012



Source: Statistics New Zealand Household Labour Force Survey; Note: Ethnicity is Total Response

Figure 15. Unemployment Rates by Qualification, New Zealand Years Ending June 1987–2012



Source: Statistics New Zealand Household Labour Force Survey



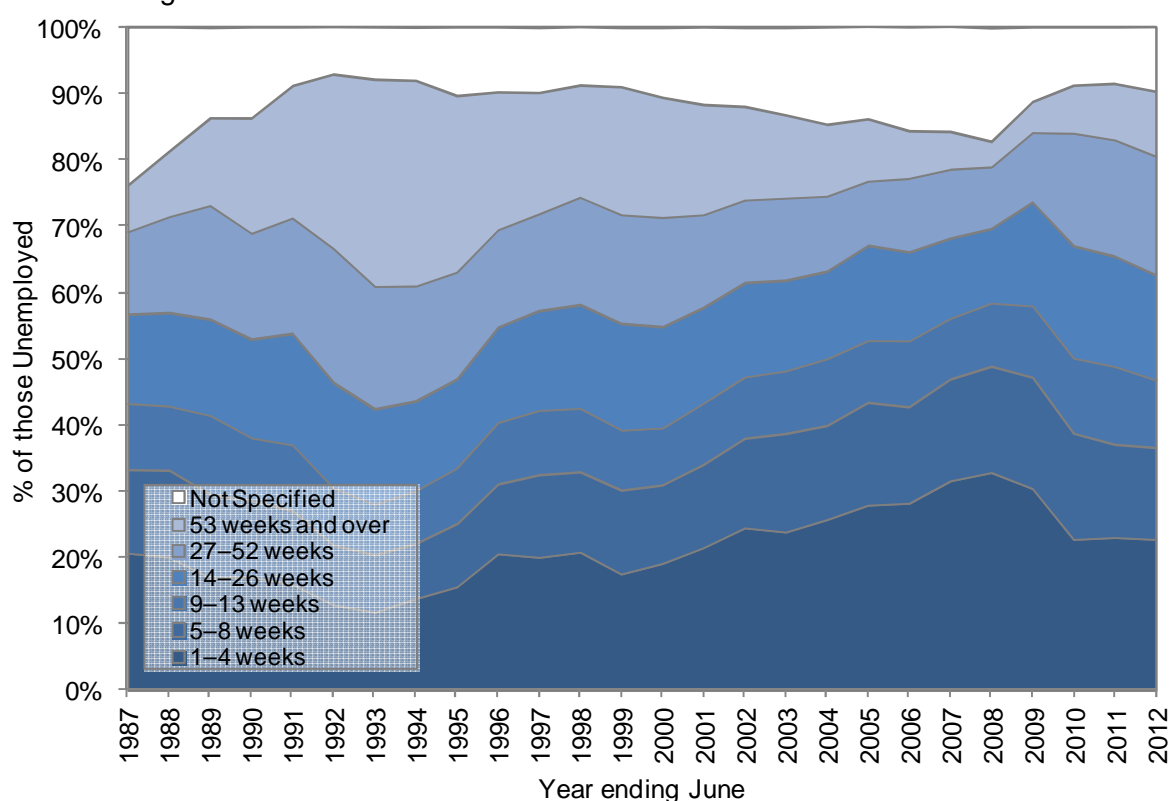
Unemployment Rates by Qualification

In New Zealand during June 1987–2012, unemployment rates were higher for those with no qualifications, followed by those with school qualifications, or post school but no school qualifications, followed by those with both post school and school qualifications. In the year ending June 2012, unemployment rates were 10.2% for those with no qualifications, 8.1% for those with school qualifications, 7.4% for those with post school but no school qualifications and 4.6% for those with post school and school qualifications (**Figure 15**).

Duration of Unemployment

In New Zealand during June 1987–2012, duration of unemployment varied markedly, and in a manner consistent with prevailing unemployment rates. Thus the highest proportion of people unemployed for 53+ weeks occurred during the early to mid 1990s, when unemployment rates were at their peak, while the highest proportion unemployed for only 1–4 weeks occurred in the mid to late 2000s, when unemployment rates were at their lowest. The proportion of people unemployed for more than 27 weeks however, has been increasing since June 2008 (**Figure 16**).

Figure 16. Proportion of those Unemployed by Duration of Unemployment, New Zealand Years Ending June 1987–2012



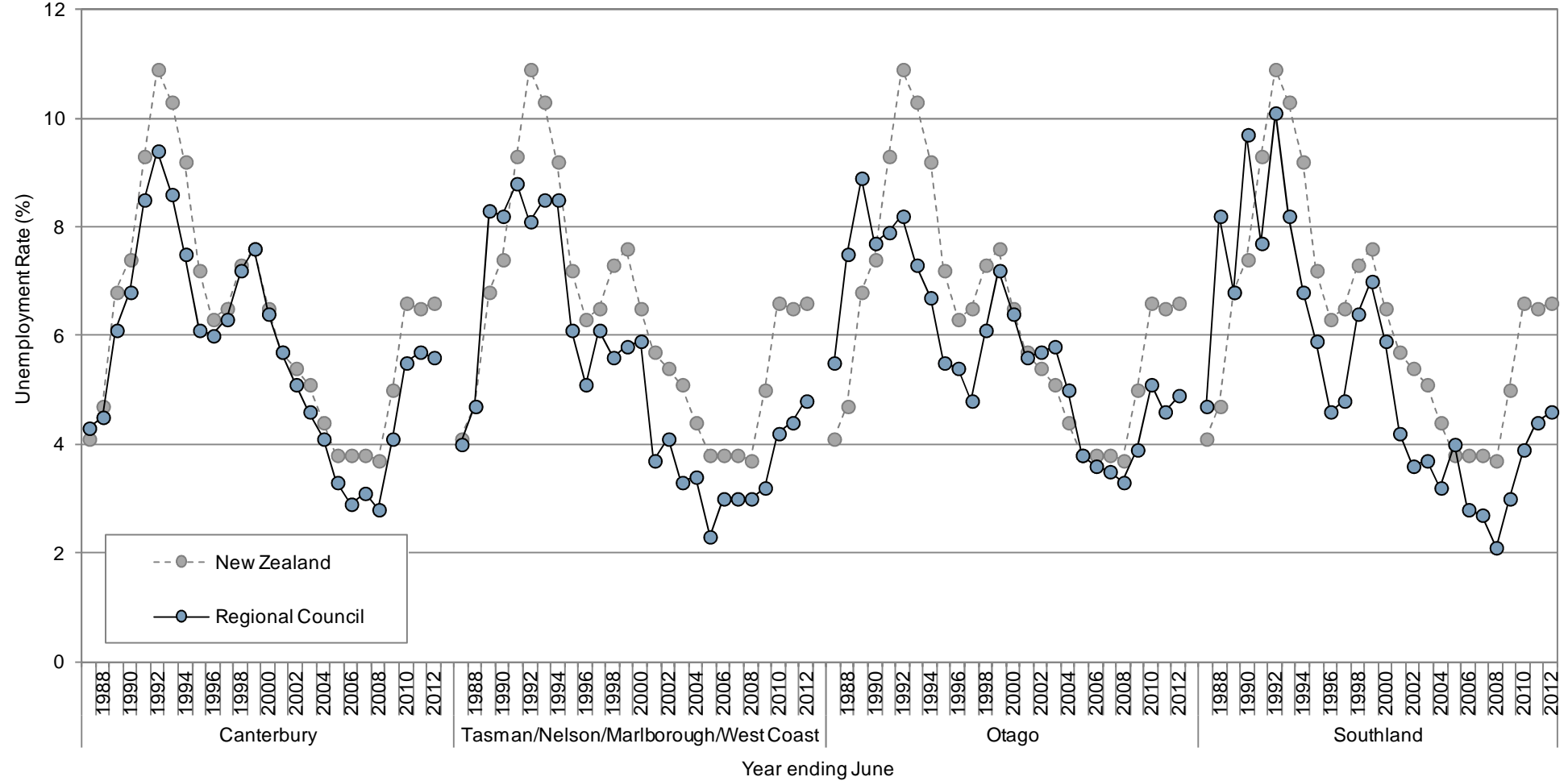
Source: Statistics New Zealand Household Labour Force Survey

South Island Distribution and Trends

Annual Regional Unemployment Rates

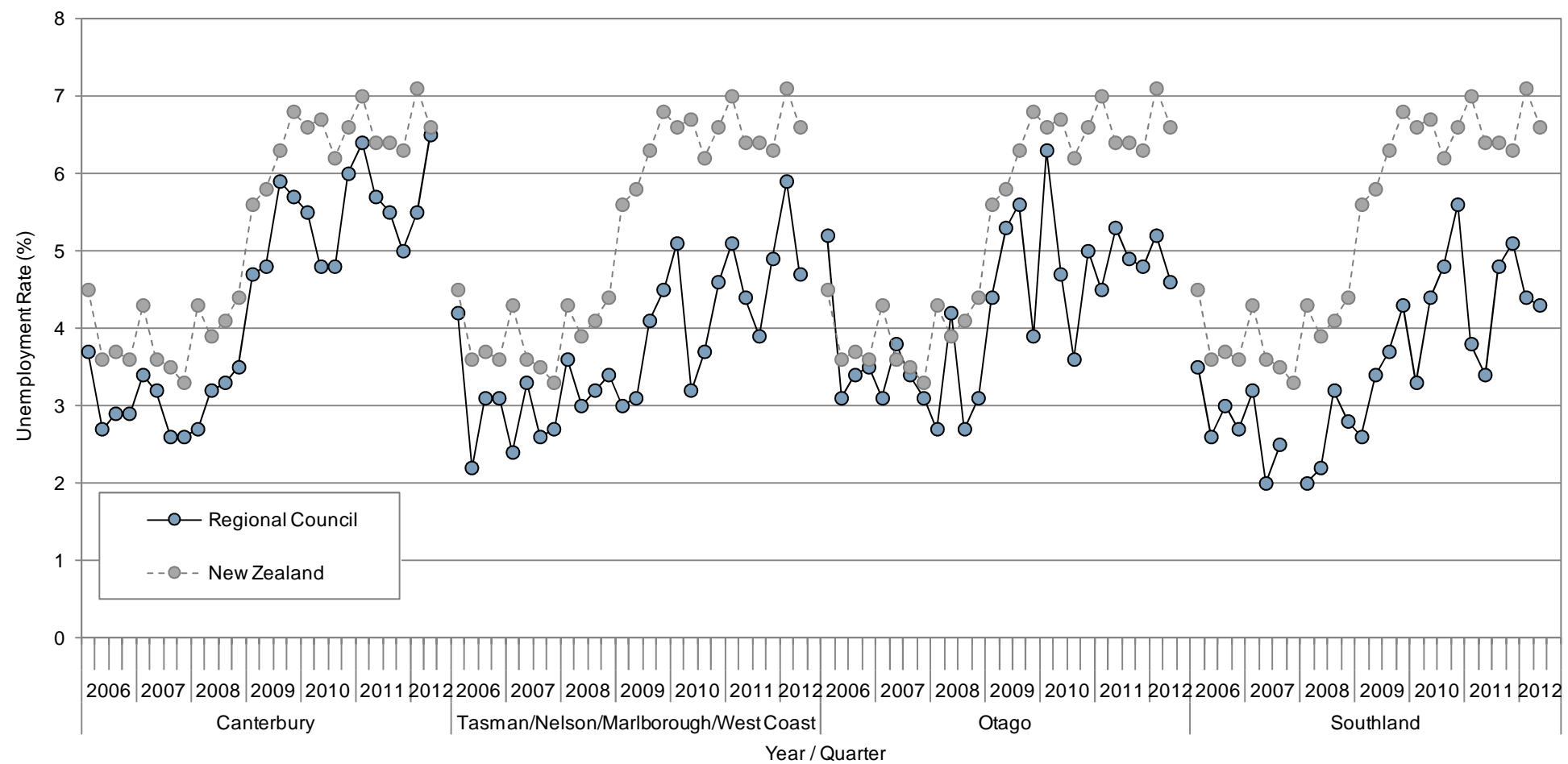
In the South Island during June 1987–2012, unemployment trends were similar to those occurring nationally, although since 2008, all regional councils in the South Island have experienced lower unemployment rates than the New Zealand rate. During this period, the highest rates in the South Island were seen in Southland the year ending June 1992, when they peaked at 10.1%. During the 2000s, rates reached their lowest point, again in Southland, at 2.1% in the year ending June 2008 (**Figure 17**).

Figure 17. Unemployment Rates by Regional Council, Canterbury, Tasman/Nelson/Marlborough/West Coast, Otago and Southland Regions vs. New Zealand Years Ending June 1987–2012



Source: Statistics New Zealand Household Labour Force Survey

Figure 18. Quarterly Unemployment Rates by Regional Council, Canterbury, Tasman/Nelson/Marlborough/West Coast, Otago and Southland Regions vs. New Zealand Quarter 1 (March) 2006 to Quarter 2 (June) 2012



Source: Statistics New Zealand Household Labour Force Survey

Quarterly Regional Unemployment Rates

In the South Island during 2006(Q1)–2012(Q2) unemployment trends were similar to those occurring nationally, with rates during 2010(Q1) to 2012(Q2) fluctuating at a higher baseline than they did in 2006(Q1) to 2007(Q4). For the majority of this period however, unemployment rates in the South Island were lower than the New Zealand rate. During 2012(Q2) unemployment rates were 6.5% in Canterbury, 4.7% in the Tasman/Nelson/Marlborough/West Coast, 4.6% in Otago and 4.3% in Southland (**Figure 18**).

Local Policy Documents and Evidence-Based Reviews Relevant to Unemployment

Table 3 on **Page 62** considers local policy documents and evidence-based reviews which are relevant to the social policy environment and the socioeconomic determinants of child and youth health.



CHILDREN RELIANT ON BENEFIT RECIPIENTS

Introduction

In New Zealand, children who are reliant on benefit recipients are a particularly vulnerable group, with the 2008 Living Standards [14] survey finding that 59% of children whose main source of family income was a benefit, scored four or more on a composite Deprivation Index. This Deprivation Index measured the extent to which families were economising on a range of items including being able to keep the main rooms of the house warm in winter, and having a meal with meat/chicken/fish at least every second day. Families scoring four or more on this Index were much more likely to report living in houses that were damp or mouldy, or in very poor physical condition; that their children were having to continue to wear worn out shoes or clothing; that they were cutting back on meat and fresh fruit and vegetables; and that they were postponing doctors visits because of cost, all factors which are likely to impact adversely on children's health and wellbeing.

Using a different measure, in 2009 Perry noted that 75% of all households (including those with and without children) relying on income-tested benefits as their main source of income were living below the poverty line (housing adjusted equivalent disposable income <60% of 2007 median) [14]. This proportion has increased over the past two decades, rising from 39% of benefit-dependent households in 1990, to a peak of 76% in 1994, and then remaining in the low to mid 70s ever since [14], with these trends being attributed to three main factors: cuts in the level in income support during 1991, growth in unemployment (which peaked at 11% in 1991) and escalating housing costs, particularly for those in rental accommodation [22].

The following section thus reviews the number of children aged 0–18 years who were reliant on a benefit recipient during April 2000–2012, using information from the Ministry of Social Development's SWIFTT database. While the number of children reliant on a benefit recipient does not correlate precisely with the number living in significant hardship, they nevertheless reflect a particularly vulnerable group, who may have higher health needs, and as a consequence, may impact significantly on future health service demand.

Data Source and Methods

Definition

1. Number of children aged 0–18 years reliant on a benefit recipient by benefit type

Data Source

Numerator: SWIFTT Database: Number of children aged 0–18 years who were reliant on a benefit recipient

Denominator: Statistics NZ Estimated Resident Population as at 31 March

Notes on Interpretation

Note 1: All data in this section was provided by the Ministry of Social Development (MSD) and are derived from the SWIFTT database. SWIFTT was developed by the NZ Income Support Service to calculate, provide and record income support payments and related client history [23]. It is thus able to provide information on the recipients of financial assistance through Work and Income.

Note 2: All figures refer to the number of children reliant on a benefit recipient at the end of April and provide no information on those receiving assistance at other times of the year.

Note 3: New Zealand trend data are for children 0–18 years, whereas Service Centre data may also include a very small number (n=3 in 2012) of young people aged 19+ years.

Note 4: "Other Benefits" includes: Domestic Purposes Benefit - Women Alone and Caring for Sick or Infirm, Emergency Benefit, Independent Youth Benefit, Unemployment Benefit Training and Unemployment Benefit Training Hardship, Unemployment Benefit Student Hardship, Widows Benefit, NZ Superannuation, Veterans and Transitional Retirement Benefit. "Other Benefits" does not include Orphan's and Unsupported Child's Benefits, or Non-benefit assistance.

To be eligible for a benefit, clients must have insufficient income from all sources to support themselves and any dependents and meet specific eligibility criteria. The current eligibility criteria for benefits can be found at <http://www.workandincome.govt.nz/individuals/a-z-benefits/>

New Zealand Distribution and Trends

Number of New Zealand Children Reliant on a Benefit Recipient

In New Zealand, the number of children aged 0–18 years who were reliant on a benefit recipient declined from 272,613 in April 2000, to 201,083 in April 2008, before increasing again to 234,572 in April 2011. By April 2012, 229,443 were reliant on a benefit recipient. Much of this variation can be attributed to changes in children relying on unemployment benefit recipients, with numbers falling from 49,499 in April 2000 to 5,289 in April 2008, before increasing again to 16,380 in 2010. In April 2012, 13,669 children were reliant on an unemployment benefit recipient. The number of children reliant on Domestic Purposes Benefit (DPB) recipients also fell from 188,216 in April 2000, to 158,173 in 2008, before increasing again to 180,845 in 2011 (**Table 4**).

Proportion of New Zealand Children Reliant on a Benefit Recipient

In New Zealand the proportion of children aged 0–18 years who were reliant on a benefit recipient fell from 24.9% in April 2000 to 17.5% in April 2008, before increasing again to 20.4% in 2011. By April 2012, 20.1% of all New Zealand children were reliant on a benefit recipient. A large part of the initial decline was due to a fall in the proportion of children reliant on unemployment benefit recipients (from 4.5% of children in 2000, to 0.5% in 2008; but increasing again to 1.4% in 2011 and 1.2% in 2012). While the proportion of children reliant on DPB recipients also fell (from 17.2% of children in 2000, to 13.8% in 2008; and back up to 15.8% in 2011 and 15.7% in 2012) (**Figure 19**), the rate of decline was much slower than for unemployment benefits, meaning that in relative terms, the proportion of benefit-dependent children reliant on DPB recipients actually increased, from 69.0% of benefit-dependent children in 2000, to 78.1% in 2012 (**Table 4**).

New Zealand Distribution by Age

At the end of April 2012, the proportion of children reliant on a benefit recipient was highest for those 0–4 years of age. Rates then tapered off gradually during middle to late childhood and – adolescence, then very steeply after 17 years (**Figure 20**).

South Island Distribution and Trends

Number of Children Reliant on a Benefit Recipient

At the end of April 2012, there were 33,604 children aged 0–18 years who were reliant on a benefit recipient and who received their benefits from service centres in the South Island (Nelson Marlborough (n=5,557), South Canterbury (n=1,874), Canterbury (n=16,018), West Coast (n=1,191), Otago (n=5,066) and Southland (n=3,898)). While the majority were reliant on DPB recipients, the number reliant on unemployment benefit recipients increased between April 2008 and April 2012 (**Table 5**).

Local Policy Documents and Evidence-Based Reviews Relevant to Benefit Reliant Families

Table 3 on Page 62 considers local policy documents and evidence-based reviews which are relevant to the social policy environment and the socioeconomic determinants of child and youth health.

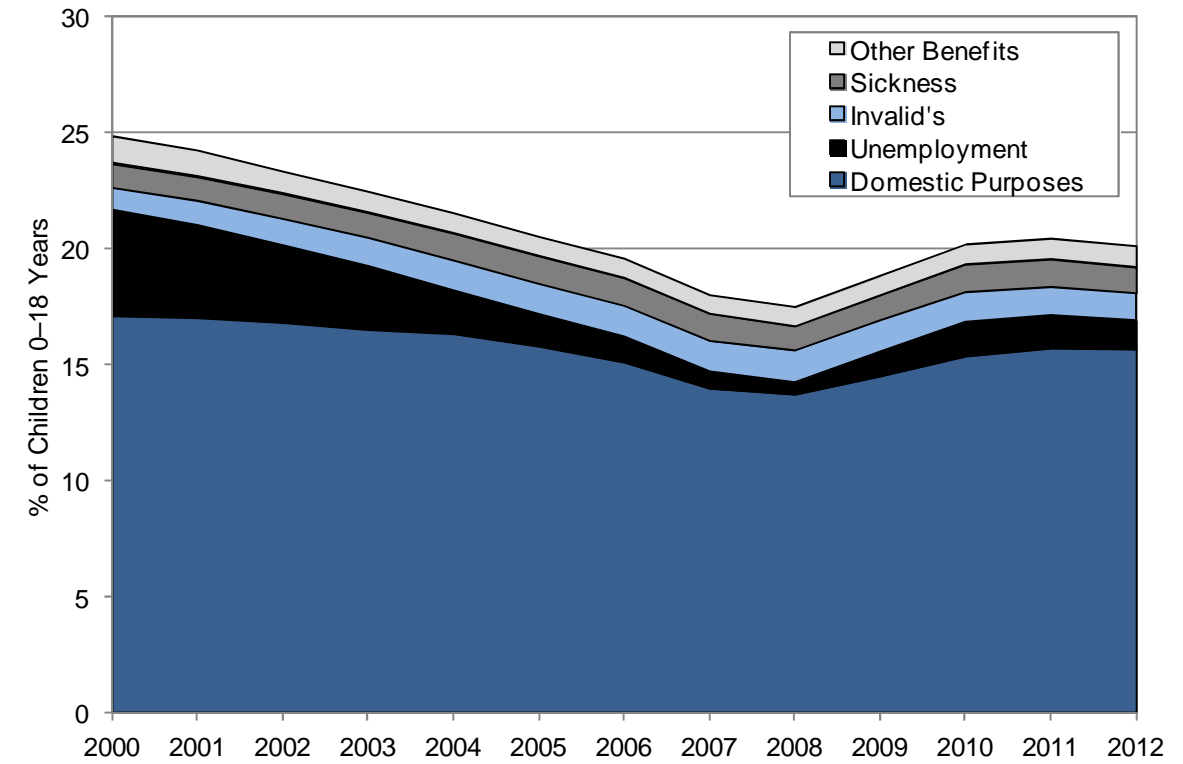


Table 4. Number of Children Aged 0–18 Years who were Reliant on a Benefit Recipient by Benefit Type, New Zealand April 2000–2012

Year	Domestic Purposes		Unemployment		Invalid's		Sickness		Other Benefits		Total
	Number	%*	Number	%*	Number	%*	Number	%*	Number	%*	Number
2000	188,216	69.0	49,499	18.2	11,120	4.1	11,295	4.1	12,483	4.6	272,613
2001	187,791	70.5	43,245	16.2	12,122	4.5	11,253	4.2	12,097	4.5	266,508
2002	187,207	72.3	36,342	14.0	13,219	5.1	11,983	4.6	10,205	3.9	258,956
2003	186,184	73.8	30,067	11.9	14,225	5.6	12,119	4.8	9,795	3.9	252,390
2004	185,610	76.0	20,663	8.5	15,053	6.2	13,182	5.4	9,566	3.9	244,074
2005	180,035	77.2	15,134	6.5	15,214	6.5	13,636	5.8	9,258	4.0	233,277
2006	172,995	77.4	12,069	5.4	15,332	6.9	13,797	6.2	9,429	4.2	223,622
2007	160,634	77.8	7,819	3.8	15,247	7.4	13,515	6.5	9,169	4.4	206,384
2008	158,173	78.7	5,289	2.6	15,962	7.9	12,128	6.0	9,531	4.7	201,083
2009	167,142	77.2	11,581	5.3	15,800	7.3	12,482	5.8	9,573	4.4	216,578
2010	177,226	76.3	16,380	7.1	15,116	6.5	13,752	5.9	9,757	4.2	232,231
2011	180,845	77.1	15,711	6.7	14,273	6.1	13,748	5.9	9,995	4.3	234,572
2012	179,204	78.1	13,669	6.0	13,552	5.9	12,774	5.6	10,244	4.5	229,443

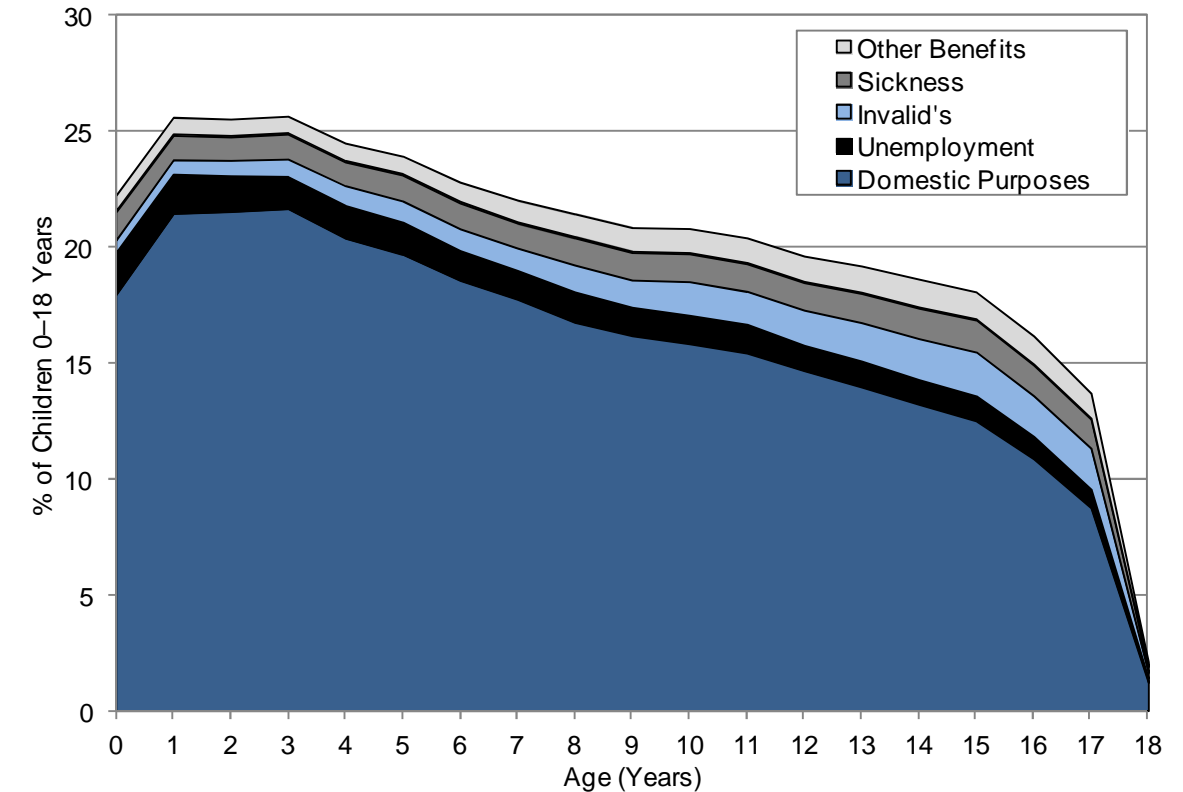
Source: MSD SWIFTT Database; Note: *% refers to % of children relying on benefit recipients, rather than % of all children; See Methods section for composition of "Other Benefits"; Non-benefit Assistance not included

Figure 19. Proportion of All Children Aged 0–18 Years who were Reliant on a Benefit Recipient by Benefit Type, New Zealand April 2000–2012



Source: Numerator: MSD SWIFTT Database; Denominator: Statistics NZ Estimated Resident Population; Note: See Methods section for composition of “Other Benefits”

Figure 20. Proportion of All Children Aged 0–18 Years who were Reliant on a Benefit Recipient by Age and Benefit Type, New Zealand April 2012



Source: Numerator: Numerator: MSD SWIFTT Database; Denominator: Statistics NZ Estimated Resident Population; Note: See Methods section for composition of “Other Benefits”



Table 5. Number of Children Aged 0–18 Years who were Reliant on a Benefit Recipient by Benefit Type, for Service Centres in the Nelson Marlborough, South Canterbury and Canterbury DHB Catchments, April 2007– 2012

Year	DPB		Unemployment		Sickness		Invalid's		Other Benefits		Total
	Number	%*	Number	%*	Number	%*	Number	%*	Number	%*	
Nelson Marlborough											
2007	4,027	80.2	29	0.6	253	5.0	567	11.3	147	2.9	5,023
2008	3,820	78.7	54	1.1	238	4.9	554	11.4	190	3.9	4,856
2009	4,009	80.3	93	1.9	228	4.6	458	9.2	207	4.1	4,995
2010	4,244	80.6	199	3.8	274	5.2	381	7.2	165	3.1	5,263
2011	4,473	80.8	262	4.7	276	5.0	355	6.4	169	3.1	5,535
2012	4,547	81.8	257	4.6	264	4.8	336	6.0	153	2.8	5,557
South Canterbury											
2007	1,292	74.0	62	3.6	56	3.2	296	17.0	39	2.2	1,745
2008	1,220	74.9	27	1.7	57	3.5	281	17.2	44	2.7	1,629
2009	1,277	74.1	64	3.7	82	4.8	256	14.8	45	2.6	1,724
2010	1,432	75.6	127	6.7	67	3.5	236	12.5	32	1.7	1,894
2011	1,485	75.6	136	6.9	87	4.4	212	10.8	45	2.3	1,965
2012	1,482	79.1	80	4.3	82	4.4	187	10.0	43	2.3	1,874
Canterbury											
2007	12,458	76.7	254	1.6	1,109	6.8	1,880	11.6	537	3.3	16,238
2008	12,195	77.5	142	0.9	895	5.7	1,933	12.3	562	3.6	15,727
2009	13,017	76.1	569	3.3	1,060	6.2	1,910	11.2	554	3.2	17,110
2010	13,834	75.4	886	4.8	1,182	6.4	1,874	10.2	578	3.1	18,354
2011	13,592	74.7	1,139	6.3	1,177	6.5	1,681	9.2	595	3.3	18,184
2012	12,473	77.9	719	4.5	769	4.8	1,497	9.3	560	3.5	16,018

Source: MSD SWIFTT Database; Note: *% refers to % of children relying on benefit recipients, rather than % of all children; See Methods section for composition of "Other Benefits"; Non-benefit Assistance not included; Service Centres include: Nelson Marlborough: Blenheim, Motueka, Nelson, Richmond, Stoke; South Canterbury: Timaru; Canterbury: Actionworks, Ashburton, Christchurch City (Including Christchurch Contact Centre, Fraud), Hornby, Kaiapoi, Linwood (including Super), New Brighton, Papanui (including Super), Rangiora, Riccarton, Shirley, NZ Super Christchurch Metro, Stanmore Rd, Sydenham (including Super)

Table 6. Number of Children Aged 0–18 Years who were Reliant on a Benefit Recipient by Benefit Type, for Service Centres in the West Coast and Southern DHB Catchments, April 2007– 2012

Year	DPB		Unemployment		Sickness		Invalid's		Other Benefits		Total
	Number	%*	Number	%*	Number	%*	Number	%*	Number	%*	
West Coast											
2007	854	70.6	57	4.7	44	3.6	224	18.5	31	2.6	1,210
2008	783	70.9	35	3.2	46	4.2	208	18.8	32	2.9	1,104
2009	810	70.2	60	5.2	60	5.2	189	16.4	35	3.0	1,154
2010	867	73.4	78	6.6	52	4.4	159	13.5	25	2.1	1,181
2011	869	75.0	78	6.7	60	5.2	123	10.6	29	2.5	1,159
2012	943	79.2	64	5.4	49	4.1	103	8.6	32	2.7	1,191
Otago											
2007	3,731	75.9	178	3.6	355	7.2	524	10.7	127	2.6	4,915
2008	3,572	76.9	149	3.2	312	6.7	478	10.3	133	2.9	4,644
2009	3,621	76.2	269	5.7	285	6.0	425	8.9	152	3.2	4,752
2010	3,903	77.1	336	6.6	307	6.1	392	7.7	122	2.4	5,060
2011	4,039	77.7	351	6.8	314	6.0	343	6.6	151	2.9	5,198
2012	4,031	79.6	282	5.6	267	5.3	352	6.9	134	2.6	5,066
Southland											
2007	2,835	81.2	145	4.2	133	3.8	313	9.0	64	1.8	3,490
2008	2,637	81.4	107	3.3	144	4.4	278	8.6	74	2.3	3,240
2009	2,825	81.0	193	5.5	132	3.8	269	7.7	67	1.9	3,486
2010	3,038	79.9	316	8.3	130	3.4	224	5.9	96	2.5	3,804
2011	3,278	80.7	300	7.4	150	3.7	219	5.4	114	2.8	4,061
2012	3,217	82.5	248	6.4	147	3.8	180	4.6	106	2.7	3,898

Source: MSD SWIFTT Database; Note: *% refers to % of children relying on benefit recipients, rather than % of all children; See Methods section for composition of "Other Benefits"; Non-Benefit Assistance not included; Service Centres include: West Coast: Greymouth, Westport; Otago: Alexandra, Balclutha, Dunedin Central, Mosgiel, Oamaru, South Dunedin; Southland: Gore, Invercargill, Queenstown

YOUNG PEOPLE RELIANT ON BENEFITS

Introduction

In New Zealand, young people who newly enter the benefit system comprise three main groups: those coming on to the Invalid's Benefit, many of whom have long-term disabilities; young mothers coming on to the Emergency Maintenance Allowance because they do not have financial support from their families; and young people taking up the Independent Youth Benefit because they do not have the support of their families. Research suggests that for these young people, being reliant on a benefit at a young age is linked to long-term benefit receipt. Of all young people aged 16 and 17 years who entered the benefit system in 1999, 42% were on a benefit in 2009 (although most of these people had not received a benefit for all of the ten year period) [24].

In New Zealand during the September 2012 quarter, there were 34,300 unemployed young people aged 15 to 19 years, resulting in a youth unemployment rate of 25.5% [25]. This high unemployment rate (compared to the total unemployment rate of 7.3%) reflects the relative difficulty encountered by young people in making an initial transition into their first job and the increased vulnerability of young people to unemployment in times of economic recession [25] [26]. Between the December 2011 quarter and September 2011, the youth NEET rate (15 to 24 year olds not in employment, education or training, calculated as a proportion of the total youth working-age population) was between 13.1% and 13.5% [25]. NEET rates were higher for Māori and Pacific young people than for European and Asian young people (September 2011 quarter: Māori 22.2%, Pacific 17.6%, NZ European 9.6%, Asian 7.2%) [27].

Pathways into non-participation in work, education and training are complex and likely to arise from a multifactorial accumulation of adversity. Risk factors for unemployment and long-term benefit reliance can be divided into individual, family/demographic, peer group, school, labour market and neighbourhood/community factors [28]. Individual factors include: conduct disorders, behavioural problems and attention difficulties; lower IQ; physical health problems; early pregnancy; and substance abuse. Family/demographic factors include: low family income; parental occupation and education level; younger mother; and family conflict. Peer group factors include problems relating to peers. School factors include: lack of school involvement and attendance; transitions from primary school; and school effectiveness. Labour market factors include: the strength of the economy and experience of unemployment. Neighbourhood/community factors include: socioeconomic factors and level of early school leaving.

Non-participation in work, education or training has been associated with a variety of adverse outcomes for individuals, families and society. Young people not in work, education or training: have worse employment opportunities and lower earnings; are more likely to be reliant on long-term benefits; are more likely to be involved in crime; are more likely to have an early pregnancy; have poorer mental health in later life; are at higher risk of substance abuse, suicide and homelessness; and can perpetuate the intergenerational transfer of poverty [28]. On a more positive note, research also suggests that some of these adverse outcomes decrease once young people find permanent employment, or return to further education [19].

The following section uses data from the Ministry of Social Development's SWIFTT database to explore the number of young people aged 16–24 years who were reliant on a benefit during 2000–2012.

Data Source and Methods

Definition

1. Number of young people aged 16–24 years who were reliant on a benefit

Data Source

Numerator: SWIFTT Database: Number of young people aged 16–24 years who were reliant on a benefit

Denominator: Statistics NZ Estimated Resident Population (projected from 2007)

Notes on Interpretation

Note 1: All data in this section was provided by the Ministry of Social Development (MSD) and is derived from the SWIFTT database. SWIFTT was developed by the NZ Income Support Service to calculate, provide and record income support payments and related client history [23]. It is thus able to provide information on the recipients of financial assistance through Work and Income.

Note 2: All figures refer to the number of young people reliant on a benefit at the end of April and provide no information on those receiving assistance at other times of the year.

Note 3: "Other Benefits" includes: Domestic Purposes Benefit - Women Alone and Caring for Sick or Infirm, Emergency Benefit, Independent Youth Benefit, Unemployment Benefit Training and Unemployment Benefit Training Hardship, Unemployment Benefit Student Hardship, Widows Benefit, NZ Superannuation, Veterans and Transitional Retirement Benefit. "Other Benefits" *does not include* Orphan's and Unsupported Child's Benefits, or Non-benefit assistance.

To be eligible for a benefit, clients must have insufficient income from all sources to support themselves and any dependents and meet specific eligibility criteria. The current eligibility criteria for benefits can be found at <http://www.workandincome.govt.nz/individuals/a-z-benefits/>

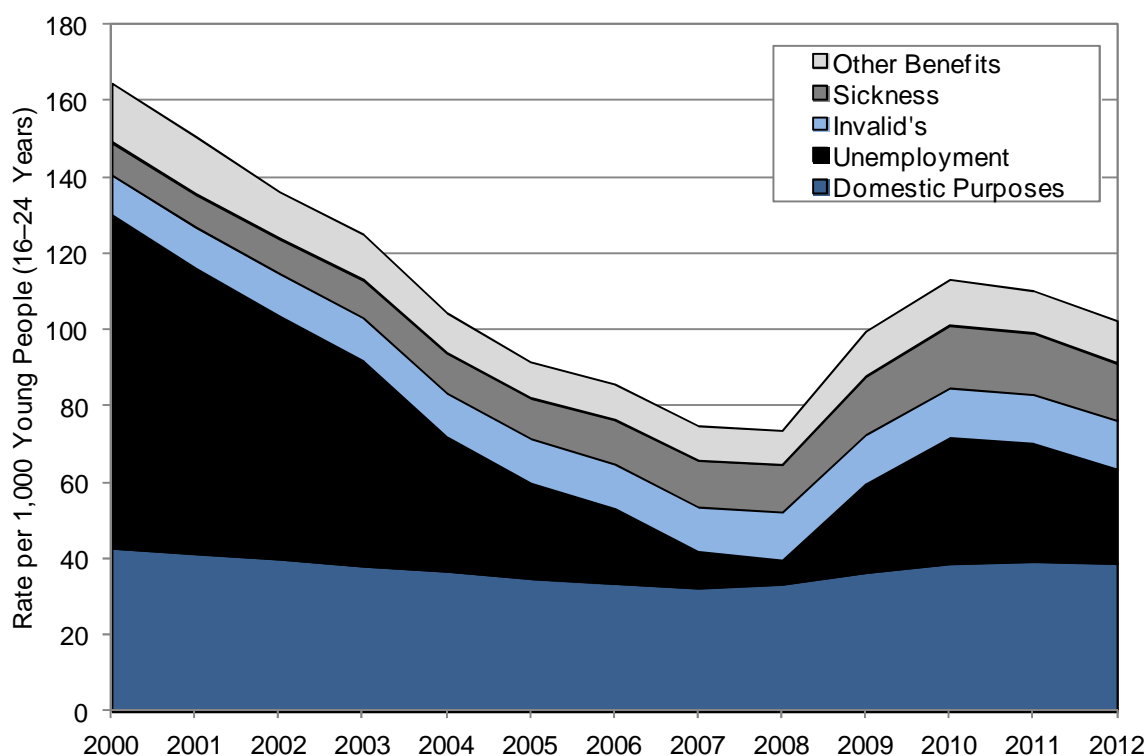
New Zealand Distribution and Trends

Proportion of New Zealand Young People Reliant on Benefits

In New Zealand during April 2000–2012, there were large fluctuations in the number of young people aged 16–24 years reliant on a benefit (**Table 7**), with rates falling from 164.4 per 1,000 in April 2000, to 73.8 per 1,000 in April 2008, before increasing again to 113.2 per 1,000 in April 2010. By April 2012, rates had again fallen to 102.4 per 1,000 (**Table 8**).

When broken down by benefit type, the largest initial declines were seen for those reliant on an unemployment benefit, with rates falling from 87.7 per 1,000 in April 2000, to 6.4 per 1,000 in April 2008, before increasing again to 33.2 per 1,000 in April 2010. By April 2012 rates had again fallen to 24.8 per 1,000. In contrast, the proportion reliant on a domestic purposes benefit declined much more slowly, from 42.6 per 1,000 in 2000, to 32.2 per 1,000 in 2007, before increasing again to 39.2 in 2011. The proportion reliant on invalid's and sickness benefits however, increased for the majority of 2000–2012. Thus by April 2012, 12.7 per 1,000 young people were reliant on an invalid's benefit and 14.6 per 1,000 on a sickness benefit (**Table 8, Figure 21**).

Figure 21. Proportion of Young People Aged 16–24 Years Receiving a Benefit by Benefit Type, New Zealand April 2000–2012



Source: Numerator: MSD SWIFTT database; Denominator: Statistics NZ Estimated Resident Population; Note: See Methods section for composition of "Other Benefits"; Non-benefit Assistance not included



Table 7. Number of Young People Aged 16–24 Years Receiving a Benefit by Benefit Type, New Zealand April 2000–2012

Year	Unemployment		Domestic Purposes		Invalid's		Sickness		Other Benefits		Total
	Number	%*	Number	%*	Number	%*	Number	%*	Number	%*	Number
2000	40,732	53.3	19,812	25.9	4,866	6.4	3,892	5.1	7,090	9.3	76,392
2001	35,808	49.9	19,645	27.4	5,185	7.2	4,066	5.7	7,085	9.9	71,789
2002	31,310	47.0	19,459	29.2	5,511	8.3	4,406	6.6	5,918	8.9	66,604
2003	27,071	43.2	19,053	30.4	5,755	9.2	4,940	7.9	5,901	9.4	62,720
2004	18,135	33.8	18,830	35.1	6,035	11.2	5,369	10.0	5,336	9.9	53,705
2005	13,257	27.5	18,245	37.8	6,288	13.0	5,566	11.5	4,890	10.1	48,246
2006	10,650	23.0	18,013	38.9	6,424	13.9	6,234	13.5	4,977	10.7	46,298
2007	5,257	12.8	17,647	43.0	6,580	16.0	6,669	16.2	4,911	12.0	41,064
2008	3,533	8.7	18,370	45.0	7,132	17.5	6,872	16.8	4,903	12.0	40,810
2009	13,054	23.4	20,294	36.4	7,353	13.2	8,519	15.3	6,525	11.7	55,745
2010	18,755	29.3	21,808	34.1	7,485	11.7	9,249	14.5	6,682	10.4	63,979
2011	17,737	28.2	22,341	35.5	7,444	11.8	9,159	14.6	6,218	9.9	62,899
2012	14,087	24.2	21,973	37.8	7,416	12.7	8,499	14.6	6,226	10.7	58,201

Source: MSD SWIFTT Database; Note: *% refers to % of young people receiving a benefit, rather than % of all young people; See Methods section for composition of "Other Benefits"; Non-benefit Assistance not included

Table 8. Proportion of Young People Aged 16–24 Years Receiving a Benefit by Benefit Type, New Zealand April 2000–2012

Year	Unemployment		Domestic Purposes		Invalid's		Sickness		Other Benefits		Total
	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000	Rate per 1,000
2000	40,732	87.7	19,812	42.6	4,866	10.5	3,892	8.4	7,090	15.3	164.4
2001	35,808	75.1	19,645	41.2	5,185	10.9	4,066	8.5	7,085	14.9	150.5
2002	31,310	64.0	19,459	39.8	5,511	11.3	4,406	9.0	5,918	12.1	136.1
2003	27,071	53.9	19,053	38.0	5,755	11.5	4,940	9.8	5,901	11.8	125.0
2004	18,135	35.3	18,830	36.6	6,035	11.7	5,369	10.4	5,336	10.4	104.4
2005	13,257	25.2	18,245	34.6	6,288	11.9	5,566	10.6	4,890	9.3	91.6
2006	10,650	19.8	18,013	33.4	6,424	11.9	6,234	11.6	4,977	9.2	85.9
2007	5,257	9.6	17,647	32.2	6,580	12.0	6,669	12.2	4,911	9.0	74.9
2008	3,533	6.4	18,370	33.2	7,132	12.9	6,872	12.4	4,903	8.9	73.8
2009	13,054	23.3	20,294	36.3	7,353	13.2	8,519	15.2	6,525	11.7	99.7
2010	18,755	33.2	21,808	38.6	7,485	13.2	9,249	16.4	6,682	11.8	113.2
2011	17,737	31.1	22,341	39.2	7,444	13.0	9,159	16.1	6,218	10.9	110.2
2012	14,087	24.8	21,973	38.7	7,416	13.0	8,499	15.0	6,226	11.0	102.4

Source: Numerator: MSD SWIFFT database; Denominator: Statistics New Zealand Estimated Resident Population; Note: See Methods section for composition of "Other Benefits"; Non-benefit Assistance not included

New Zealand Distribution by Ethnicity

Domestic Purposes Benefits

In New Zealand during April 2000–2012, domestic purposes benefit uptake was highest for Māori young people, followed by Pacific young people, with all ethnic groups experiencing a decline in benefit uptake during the early to mid 2000s, followed by an upswing in rates after 2008. By the end of April 2012, 100.0 per 1,000 Māori young people, 46.9 per 1,000 Pacific young people and 20.5 per 1,000 European/Other young people were reliant on a domestic purposes benefit (**Figure 22**).

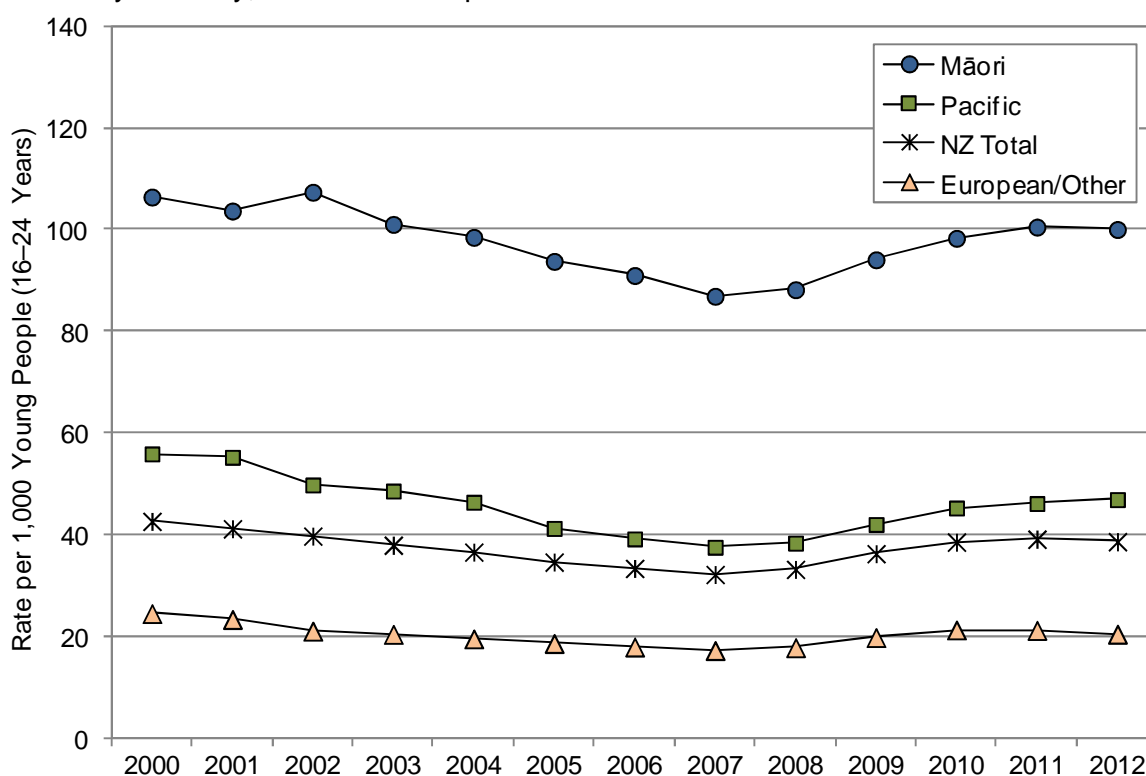
Unemployment Benefits

In New Zealand during April 2000–2012, unemployment benefit uptake was also highest for Māori young people, followed by Pacific young people, with all ethnic groups experiencing a marked decline in unemployment benefit uptake during the early to mid 2000s, followed by an upswing in rates after 2008. By the end of April 2012 however, rates had again fallen to 47.9 per 1,000 for Māori young people, 28.7 per 1,000 for Pacific young people and 17.8 per 1,000 for European/Other young people (**Figure 23**).

Sickness and Invalid's Benefits

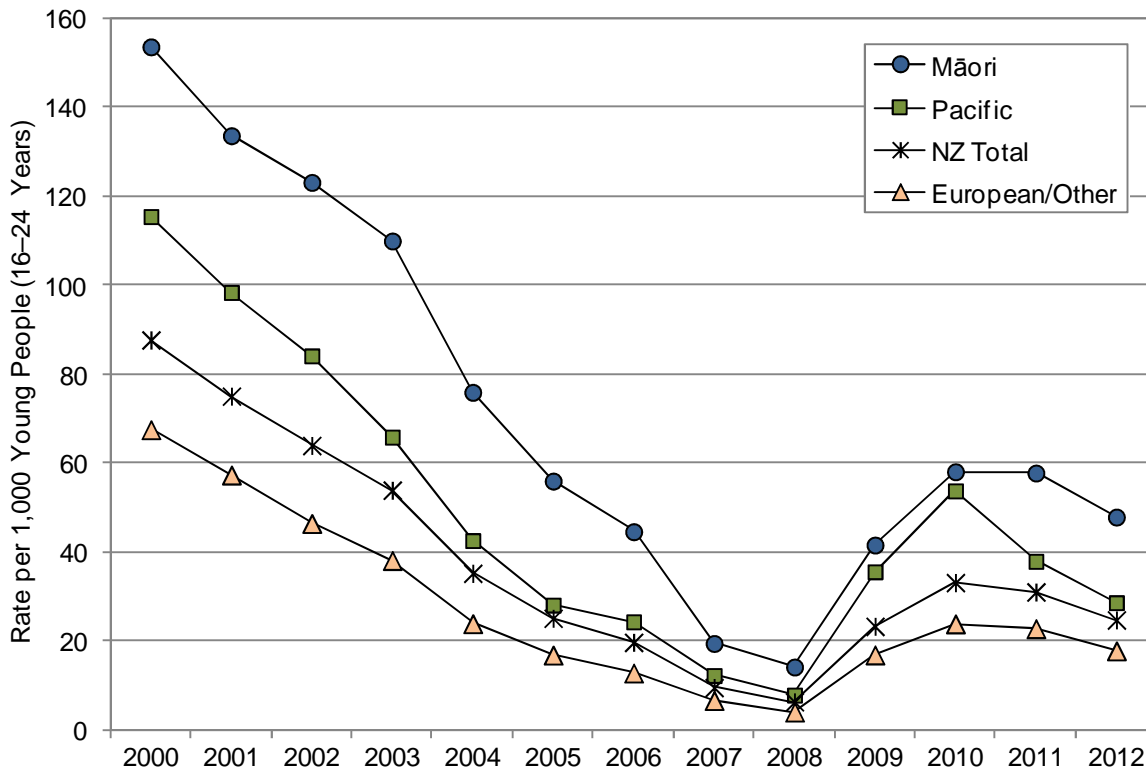
In New Zealand April 2000–2012, sickness and invalid's benefit uptake was consistently higher for Māori young people than for European/Other young people. While invalid's benefit uptake for Pacific young people was lower than for European/Other young people throughout April 2000–2012, sickness benefit uptake was only lower from April 2004 onwards. Invalid's and sickness benefit uptake increased for all ethnic groups during this period. Thus by April 2012, invalid's benefit uptake was 15.9 per 1,000 for Māori young people, 12.7 per 1,000 for European/Other young people and 9.2 per 1,000 for Pacific young people. Sickness benefit uptake was 24.6 per 1,000 for Māori young people, 12.9 per 1,000 for European/Other young people and 9.6 per 1,000 for Pacific young people (**Figure 24**).

Figure 22. Proportion of Young People Aged 16–24 Years Receiving a Domestic Purposes Benefit by Ethnicity, New Zealand April 2000–2012



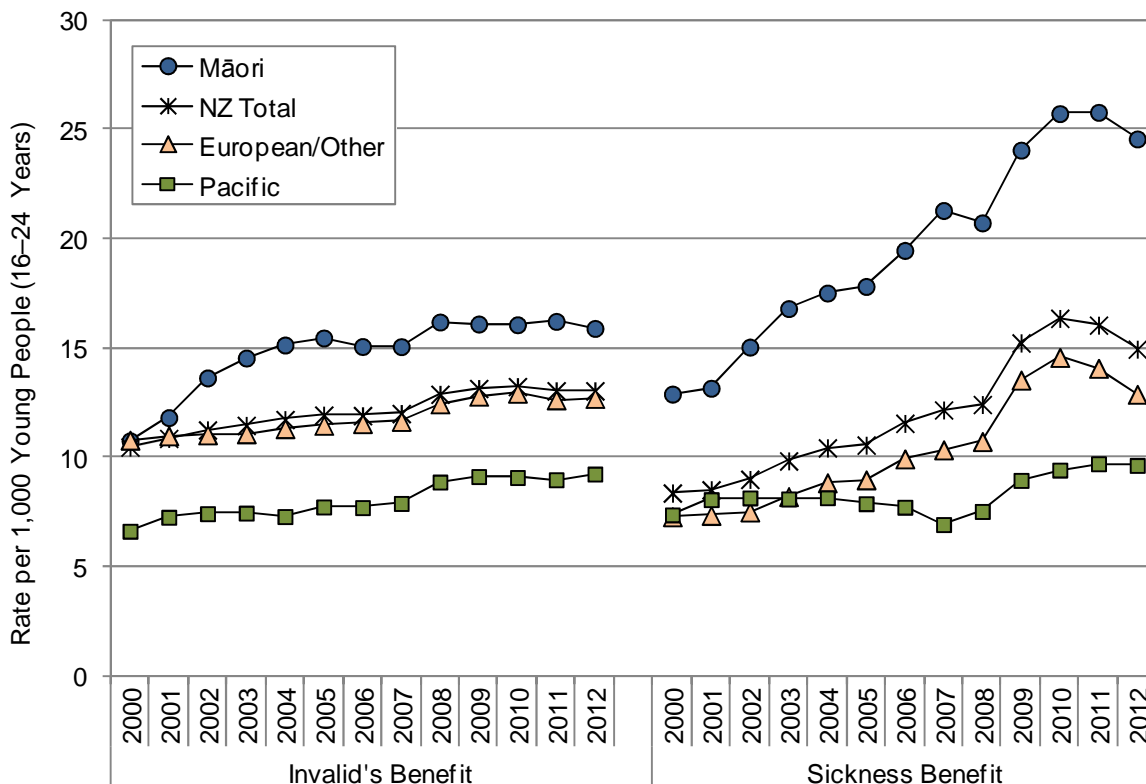
Source: Numerator: MSD SWIFFT database; Denominator: Statistics NZ Estimated Resident Population; Note: DPB includes DPB Sole Parent and Emergency Maintenance Allowance

Figure 23. Proportion of Young People Aged 16–24 Years Receiving an Unemployment Benefit by Ethnicity, New Zealand April 2000–2012



Source: Numerator: MSD SWIFFT database; Denominator: Statistics NZ Estimated Resident Population; Note: Training-Related Unemployment Benefits Excluded

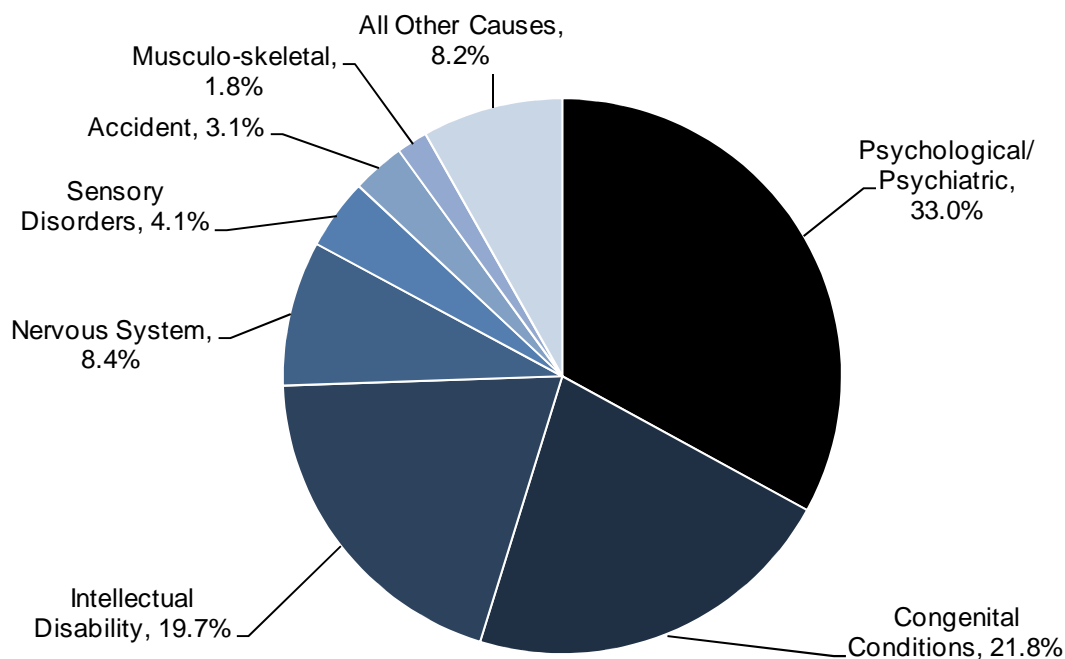
Figure 24. Proportion of Young People Aged 16–24 Years Receiving an Invalid's or Sickness Benefit by Ethnicity, New Zealand April 2000–2012



Source: Numerator: MSD SWIFFT database; Denominator: Statistics NZ Estimated Resident Population

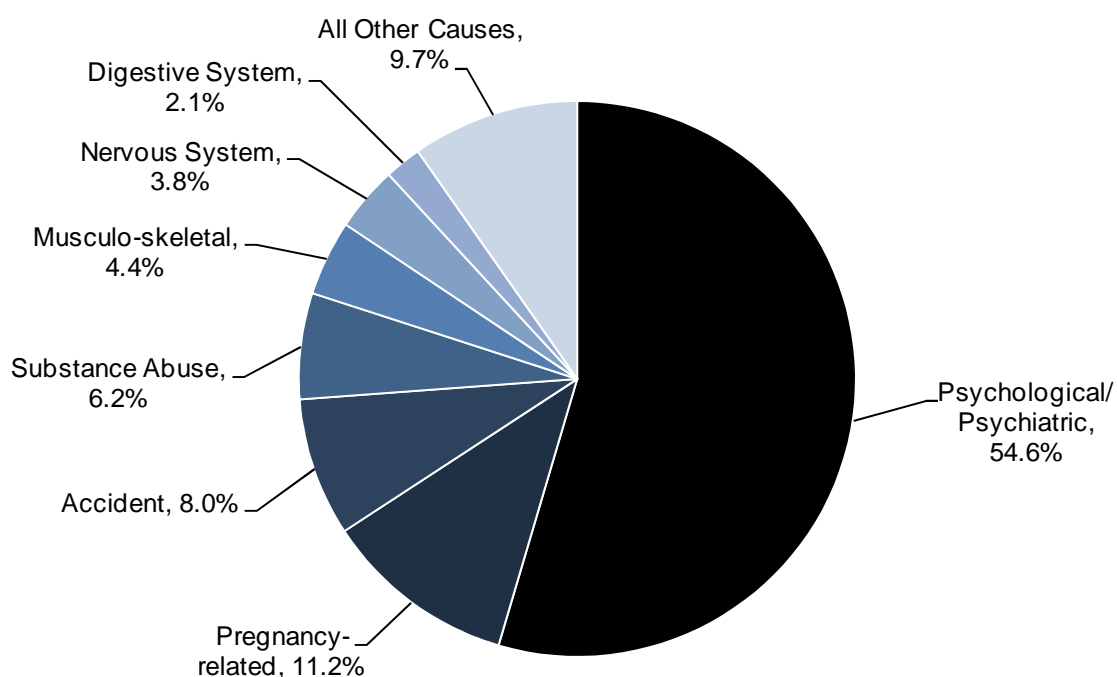


Figure 25. Young People Aged 16–24 Years Receiving an Invalid's Benefit by Cause of Incapacity, New Zealand April 2012 (n=7,416)



Source: Ministry of Social Development

Figure 26. Young People Aged 16–24 Years Receiving a Sickness Benefit by Cause of Incapacity, New Zealand April 2012 (n=8,499)



Source: Ministry of Social Development

Distribution of Sickness and Invalid's Benefits by Cause of Incapacity

Invalid's Benefit

In New Zealand during April 2012, 33.0% of young people receiving an invalid's benefit required financial support for psychological/psychiatric reasons, while 19.7% required support for intellectual disabilities. An additional 21.8% required support as the result of congenital conditions and 8.4% as the result of nervous system problems (**Figure 25**).

Sickness Benefit

Similarly during April 2012, 54.6% of young people receiving a sickness benefit required financial support for psychological/psychiatric reasons while 11.2% required support as the result of a pregnancy. Accidents (8.0%), substance abuse (6.2%) and musculoskeletal problems (4.4%) also made a significant contribution (**Figure 26**).

South Island Distribution and Trends

Number of Young People Reliant on Benefits

In the South Island, the number of young people aged 16–24 years receiving a benefit increased from 7,913 in April 2007 to 13,012 in April 2011, before falling to 10,666 in April 2012. While the DPB was initially the most common benefit received, large increases were evident in unemployment benefit uptake between April 2008 and April 2011 (**Table 9, Table 10**).

Table 9. Number of Young People Aged 16–24 Years Receiving a Benefit by Benefit Type, for Service Centres in the Nelson Marlborough, South Canterbury and Canterbury DHB Catchments, April 2007–2012

Year	DPB		Unemployment		Sickness		Invalid's		Other Benefits		Total
	No.	%*	No.	%*	No.	%*	No.	%*	No.	%*	No.
Nelson Marlborough											
2007	400	44.4	8	0.9	199	22.1	215	23.9	78	8.7	900
2008	383	42.7	18	2.0	193	21.5	225	25.1	77	8.6	896
2009	456	37.8	127	10.5	259	21.5	219	18.1	146	12.1	1,207
2010	502	37.3	201	14.9	262	19.5	218	16.2	163	12.1	1,346
2011	540	34.1	409	25.9	241	15.2	225	14.2	167	10.6	1,582
2012	494	35.8	290	21.0	224	16.3	219	15.9	151	11.0	1,378
South Canterbury											
2007	156	37.4	37	8.9	59	14.1	106	25.4	59	14.1	417
2008	150	39.8	20	5.3	63	16.7	100	26.5	44	11.7	377
2009	150	29.6	88	17.4	97	19.1	92	18.1	80	15.8	507
2010	189	29.2	177	27.3	95	14.7	101	15.6	86	13.3	648
2011	201	29.4	216	31.6	100	14.6	92	13.5	75	11.0	684
2012	189	37.1	86	16.9	79	15.5	92	18.0	64	12.5	510
Canterbury											
2007	1,447	36.7	354	9.0	943	23.9	874	22.2	326	8.3	3,944
2008	1,462	37.3	194	4.9	1,007	25.7	946	24.1	314	8.0	3,923
2009	1,611	29.3	1,087	19.8	1,396	25.4	990	18.0	407	7.4	5,491
2010	1,740	27.2	1,645	25.7	1,626	25.4	1,001	15.6	395	6.2	6,407
2011	1,641	24.2	2,355	34.8	1,479	21.8	953	14.1	347	5.1	6,775
2012	1,540	29.7	1,483	28.6	950	18.3	916	17.7	290	5.6	5,179

Source: Ministry of Social Development; Note: *% refers to % of young people receiving a benefit, rather than % of all young people; See Methods section for composition of "Other Benefits"; Non-Benefit Assistance not included; Service Centres include: Nelson Marlborough: Blenheim, Motueka, Nelson, Richmond, Stoke; South Canterbury: Timaru; Canterbury: Actionworks, Ashburton, Christchurch City (Including Christchurch Contact Centre, Fraud), Hornby, Kaiapoi, Linwood (including Super), New Brighton, Papanui (including Super), Rangiora, Riccarton, Shirley, NZ Super Christchurch Metro, Stanmore Rd, Sydenham (including Super)



Table 10. Number of Young People Aged 16–24 Years Receiving a Benefit by Benefit Type, for Service Centres in the West Coast and Southern DHB Catchments, April 2007–2012

Year	DPB		Unemployment		Sickness		Invalid's		Other Benefits		Total
	No.	%*	No.	%*	No.	%*	No.	%*	No.	%*	No.
West Coast											
2007	70	29.5	35	14.8	28	11.8	39	16.5	65	27.4	237
2008	85	32.3	38	14.4	34	12.9	50	19.0	56	21.3	263
2009	98	27.0	69	19.0	69	19.0	41	11.3	86	23.7	363
2010	102	25.7	106	26.7	59	14.9	38	9.6	92	23.2	397
2011	129	30.4	119	28.0	64	15.1	39	9.2	74	17.4	425
2012	126	33.8	82	22.0	54	14.5	44	11.8	67	18.0	373
Otago											
2007	387	26.3	298	20.3	296	20.1	314	21.4	174	11.8	1,469
2008	403	28.7	177	12.6	361	25.7	300	21.4	163	11.6	1,404
2009	442	23.5	496	26.4	412	21.9	281	14.9	251	13.3	1,882
2010	468	22.2	718	34.1	372	17.7	302	14.3	245	11.6	2,105
2011	485	22.4	841	38.8	356	16.4	308	14.2	177	8.2	2,167
2012	485	23.8	769	37.7	344	16.9	308	15.1	133	6.5	2,039
Southland											
2007	400	42.3	161	17.0	111	11.7	161	17.0	113	11.9	946
2008	375	44.4	92	10.9	105	12.4	160	18.9	113	13.4	845
2009	438	39.9	250	22.8	132	12.0	160	14.6	117	10.7	1,097
2010	497	37.2	402	30.1	138	10.3	160	12.0	139	10.4	1,336
2011	494	35.8	447	32.4	148	10.7	166	12.0	124	9.0	1,379
2012	440	37.1	375	31.6	113	9.5	171	14.4	88	7.4	1,187

Source: Ministry of Social Development; Note: *% refers to % of young people receiving a benefit, rather than % of all young people; See Methods section for composition of "Other Benefits"; Non-Benefit Assistance not included; Service Centres include: West Coast: Greymouth, Westport; Otago: Alexandra, Balclutha, Dunedin Central, Mosgiel, Oamaru, South Dunedin; Southland: Gore, Invercargill, Queenstown

Local Policy Documents and Evidence-Based Reviews Relevant to the Economic Environment for Young People

Table 3 on Page 62 considers local policy documents and evidence-based reviews which are relevant to the social policy environment and the socioeconomic determinants of child and youth health.