While every endeavour has been made to use accurate data in this report, there are currently variations in the way data are collected by various agencies that may result in errors, omissions, or inaccuracies in the information in this report. The Child Poverty Monitor does not accept liability for any inaccuracies arising from the use of these data in the production of this report, or for any losses arising as a consequence thereof.

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Introduction

Whakatōngia te kākano aroha i roto i ā tātou taitamariki
kia puāwai i roto i tō rātou tupuranga aranui oranga

‘Plant the seed of love in our children and they will blossom, grow and journey towards the greatest pathway of life.’¹

To children and young people in Aotearoa, a good life includes “having fun and feeling contented, having supportive family and friends, and having basic needs met” as well as being mentally and physically healthy, “feeling safe, having a good education and feeling valued and respected”.²

Poverty is a significant barrier to children enjoying their right to an adequate standard of living. Poverty is associated with a wide range of negative consequences for children, including poor outcomes in cognitive development, achievement at school, health and development.³ Families and children who lack material and financial resources struggle to meet everyday needs and miss out on opportunities that most in Aotearoa take for granted.⁴

This eighth annual Child Poverty Monitor updates progress made toward a society where every child is valued and enjoys their right to thrive and achieve their potential.⁵,⁶ This report uses a variety of data sources to measure indicators and impacts of poverty for households with children. Data in this report mostly precede the significant impact of the COVID-19 pandemic and the effects of the actions taken by the New Zealand Government to eliminate community transmission of the novel coronavirus. In addition to monitoring how Aotearoa meets its commitments to uphold the rights of every child and young person in non-pandemic contexts, having pre-COVID-19 information on the status of poverty and wellbeing in Aotearoa will assist with ascertaining the impact that the pandemic has had on the lives of all people and especially on the lives of our most vulnerable.⁷

The report is grouped into three chapters:

- **Ending child poverty:** The first group of indicators reflects progress toward a reduction in the number and proportion of children living in households that experience income poverty and material hardship.
- **Growing up in a safe and healthy environment:** The second group of indicators tracks progress toward goals to ensure healthy lives and promote wellbeing, ensuring access to affordable, healthy homes, ensuring access to sufficient and nutritious food, promoting nurture and protection within families and wider society as well as providing equitable, high quality education for all.
- **Resources to thrive:** The final section discusses the broader context in which families and whānau access resources to enable children to thrive. The discussion includes labour market circumstances, and information about children who are included in households who receive financial assistance from the State in the form of income-replacing benefits, hardship and other forms of assistance, and young people receiving financial assistance.
About the Child Poverty Monitor

The Child Poverty Monitor is a partnership between the J R McKenzie Trust, the Office of the Children’s Commissioner, and the New Zealand Child and Youth Epidemiology Service (NZCYES) at the University of Otago. Each year the Child Poverty Monitor partners choose indicators that reflect aspects of the extent to which children and young people in Aotearoa grow up in households with the resources for everyone to thrive. These indicators contribute to a broad picture of the scale and impact of poverty on children’s lives in Aotearoa. There is a lag between collection of data in national surveys and publication of the results. Much of the data in the 2020 Child Poverty Monitor stops short of providing information about the impact of COVID-19, as it reflects a time before the pandemic started and before the measures implemented to reduce infection in the communities. Timely processing of data will aid future monitoring of progress toward elimination of child poverty.

COVID-19 pandemic – a year like no other

In February 2020, the first case of COVID-19 was identified in Aotearoa. Statistical modelling showed that an uncontrolled epidemic of COVID-19 in Aotearoa could overwhelm hospital capacity more than 10 times and result in a large number of deaths. The COVID-19 pandemic would have disproportionately negative impacts on Māori in the event of community transmission, exacerbating existing inequity. Pacific Peoples in Aotearoa were also at risk of bearing a disproportionate health burden as a result of COVID-19. The New Zealand Government responded with a four-level alert system including one of the most stringent ‘stay at home’ orders internationally.

While addressing the COVID-19 pandemic is ongoing in Aotearoa and globally, it is clear and well-established that pandemics feed off and exacerbate national and global inequality. Children’s wellbeing is impacted directly by the COVID-19 pandemic, such as for those who become unwell or who experience the death of a parent or grandparent as a result of infection. The socioeconomic impacts of the measures implemented to control transmission of the virus have an even more profound effect on child wellbeing through increasing levels of child, family and whānau poverty. In the longer term there is a risk of undermining children’s rights and failing to achieve the global goals for sustainable development. Te Rōpū Whakakaupapa Urutā note that “experiences of colonisation, coloniality, racism, and a substantial body of evidence from Aotearoa me Te Waipounamu and Indigenous communities around the world, tells us that through pandemics and other crises, unchecked government action and ‘one-size–fits-all’ approaches will exacerbate existing inequities.”

2020 is a year like no other. In this report we provide some commentary on the impact of COVID-19 on the wellbeing of children and young people to provide a more complete picture. This is important, in light of the data lag associated with national data sources. We augment national data with indicators or stories where possible.

Key points

Ending child poverty
Adequate income

- In June 2019 (the most recent data) there were an estimated 235,400 children (21 children in every 100) living in households with equivalised disposable income below 50% of the 2017/18 base financial year median income after housing costs. Note that the full impact of the Families Package was not captured by these data.
- The 2020 budget anticipated an increase in child poverty numbers and proportions in response to the COVID-19 pandemic. This may be a barrier to reaching the Government target of reducing income poverty to 10% of children by 2028.
- In addition to current mitigating policy responses, there is a need for sustained, transformative action within the COVID-19 recovery to ensure that household incomes are adequate and that no child is left behind.
Essentials for a good life

- In June 2019 there were an estimated 150,000 children (13 in every 100) living in households unable to afford six or more essential items (in material hardship). There were an estimated 66,100 (6 in every 100 children) living in households experiencing severe material hardship (unable to afford nine or more essential items).
- Increases in the number of hardship grants since 2017, with a marked increase in 2020, show that many families and whānau in Aotearoa are living in precarious circumstances where there is little or no capacity to absorb sudden changes in income.
- To meet the Government target of 6% of children (80,000 fewer) living in households experiencing material hardship by 2028, we will need significant changes to the systems and structures to help families adequately provide for their children.

Adequate income and access to essentials

- Most recent data show 8.2% (92,300 children) were living in households experiencing both material hardship and income poverty. There has been an overall decline, since 2013, with an estimated 21,500 fewer children experiencing these circumstances. This encouraging change will need to be sustained in order for the government to reach its 3 and 10 year targets.

Safe and healthy environments

Affordable homes

- High housing costs contribute to income poverty and restrict opportunities for many households with children. More than 3 in 10 of the lowest income households with children spend more than half their income on housing costs, a state of very high housing stress.
- High housing stress is a particular issue for one adult households with children. Over half (53%) of low-income one-adult households with dependent children spent more than $40 per $100 income on housing costs, and nearly 4 in 10 (37%) experienced very high housing stress in spending more than $50 per $100 income on housing.
- Strong, bold policy is needed to improve housing supply and free families with children from housing stress.

Healthy homes

- It is important that children grow up in homes with good air quality that are free from mould and have amenities most people consider to be essential minimums for modern living, such as cooking facilities, showers or baths, and electricity supplies.
- In the 2018 census there were 282,228 children in Aotearoa who lived in damp housing and 237,543 in housing with mould.
- Around 25% of children lived in houses that were sometimes damp and 18% in houses that sometimes had mould larger than the size of an A4 sheet of paper. One in twenty children lived in housing that was always damp and 7% of children lived in housing that always had mould larger than A4 size.
- In the 2018 census there were 77,976 under-18 year olds without access to one or more basic household amenities such as safe tap water, cooking and washing up facilities, a bath or shower, a toilet, a refrigerator or a supply of electricity. An estimated 4,212 under-18 year olds missed out on most of the seven basic amenities (4 per 1,000 with 1-3 amenities available) and an estimated 4,833 children lived in dwellings with no amenities (5 per 1,000).
- Damp or mouldy housing, and inadequate access to basic amenities, are experienced disproportionately between ethnic groups. When compared to European/Other children, Maori and Pacific children are more likely to be exposed to damp, mouldy housing. Pacific, Asian and Middle Eastern, Latin American and African (MELAA) children disproportionately experienced higher rates of being unable to access basic household amenities.
- Implementation of housing standards is imperative to promote the health and wellbeing of children and young people.
Space to thrive

- In each census year since 1991 there have consistently been 16% or 17% of New Zealand children living in crowded households, including 5% of children living in severely crowded households. In the 2018 Census 128,680 children (16.1 percent) lived in crowded households including 40,000 children (5.3%) living in severely crowded households (requiring two or more bedrooms to meet the standard for a non-crowded household).
- The highest levels of household crowding in this age group were experienced by Pacific children, over 40% of whom lived in crowded households (41,230 children, 41.8%) and 18.1% (17,890 children) in severely crowded households.
- It is time for action to enable households to occupy housing with adequate space for each household member.

Food for wellbeing

- Low household income is strongly associated with the likelihood of food insecurity. In the 2015/16 NZ Health Survey, severe-to-moderate food insecurity was experienced in 42.8% of households including children with income at or below $50,000 per annum, compared with 8.3% of such households with gross income over $50,000 per annum.
- Over half (56%) of children living in families receiving financial assistance don't always have enough healthy food to eat, compared to just 12% of children living in families not receiving financial assistance.
- The number of hardship assistance grants for food increased from 675,894 in the year to March 2019, to over a million (1,120,733) in the year to March 2020.
- Proposed expansion of Ka Ora, Ka Ako (the healthy school lunches programme) is a good example of policy that may mitigate the impact of COVID-19 on children living in food-insecure households, while improving student learning and wellbeing, and supporting job creation and economic recovery from the pandemic.

Good health

- Policy decisions have helped improve access to primary health care services for children and young people under 14 years of age, including free health checks and removal of prescription fees
- In 2018/19, an estimated 189,000 children (19.9%) missed out on needed primary care services due to at least one barrier. The most common barrier was being unable to get an appointment at their usual medical centre within 24 hours (16.3% of children).
- The highest hospitalisation rates in under-15 year olds were observed for children living in areas with the highest deprivation scores. Children living in areas with the highest deprivation scores are twice as likely to be admitted to hospital than children in areas with the lowest deprivation scores.
- The gap in hospitalisation rates between children living in areas with the highest deprivation scores and their peers in less-deprived areas increased between 2007 and 2009 and the widened gap continued to 2019.
- Further population level action is required to improve health outcomes for infants, children, and young people. Such action will include equitable distribution of resources within society and explicit commitment and action to achieve health equity for Māori.

Nurturing and protecting children

- In the five years from 2015–2019 there were 991 hospitalisations of 0–14 year olds for injuries arising from assault, neglect or maltreatment. Age-specific hospitalisation rates for injuries arising from assault, neglect, or maltreatment were highest in the first year of life, were lower for children between 2 and 10 years of age, and increased again for those in their early teens.
- In 2019/20 there were 5,964 children in state care.
- Poverty has a profound impact on factors that enable families and whānau to nurture and care for their children.
Good opportunities for learning

- Educational opportunities that are welcoming, uplifting, and culturally respectful provide children with the good environments for learning. Unfortunately, many young people are not experiencing education in ways that make them feel cared about and encouraged to participate.
- From 2011–2019 an increasing number of children and young people in Aotearoa attended school regularly (attended more than 90% of Term 2), from 299,474 to 423,999 students. As school enrolment increased over this time; the proportion of all students who attended school regularly in Term 2 was fairly stable at around 69% from 2011–2015 and then declined to 58% in 2019.
- The proportion of young people who achieved Level 2 NCEA qualification or above increased from 68% of school-leavers in 2009 to 79% in 2019. The proportion of young people leaving school before having obtained an NCEA qualification decreased from 19% in 2009 to 10% in 2017 and increased to 12% in 2019.
- Inequity persists within the educational system, with significant differences in educational attainment by ethnicity and by school socioeconomic quintile. There is considerable variation in achievement rates within each quintile, indicating that the issue is arguably not the background of students but the importance of creating an environment where they can thrive. The issue is not the students, but rather a society that tolerates inequitable educational outcomes.

Resources to thrive

Good work

- In the June quarter of 2020, there were 111,000 New Zealanders who were officially unemployed, or 4% of all people in the labour force. At this same time, there were 346,000 New Zealanders seeking additional hours of work or potentially available to the labour force.
- Most of the 2020 increase in the underutilisation rates for women and men was driven by a large number of people becoming underemployed during the global COVID-19 pandemic, possibly through reduced hours of work for people would have liked to work more hours and were available to do so.
- Women were more negatively impacted than men by the change in labour market measures between March 2020 and September 2020. In that time the seasonally adjusted number of people in employment fell by 31,000 – over two-thirds of this number (22,000) were women.
- For families with children where at least one adult was working prior to lockdown, 51% experienced an economic shock due to someone in the household losing their job or some income, compared with 44% for the population overall. Such economic shocks were associated with declines in parent-rated family relationships especially for parents from lower income households.
- The opportunity to reset our labour market now exists, but the challenge is how to ensure more time at home with family does not mean families have inadequate income.

Adequate financial assistance

- In the year ending June 2020, 196,473 children aged under 18 years were living with a recipient of income-replacing financial assistance (26% of all children in this age group).
- Most 0–17 year olds included in income-replacing assistance were living with a recipient of Sole Parent Support (65%), with the remainder living with recipients of Jobseeker Support (25%), Supported Living Payments (9%), or Other Main Benefits (less than 2%).
- The number of young people receiving income-replacing financial assistance increased from 47,407 (8% of all 16–24 year olds) in June 2019 to 65,884 (11%) in June 2020.
- The New Zealand social security system is not yet achieving the vision of an adequate income and standard of living for people and families, in which people are treated with and can live in dignity, able to participate meaningfully in their communities.
Impact of COVID-19

- COVID-19 has highlighted existing inequalities in Aotearoa New Zealand, sometimes making them worse.
- Just as we came together to keep each other safe from COVID-19, it is possible to redesign our systems to solve poverty and ensure every child has what they need to flourish.
- Current and future Governments have the opportunity to invest in solutions to unlock the constraints of poverty, with sustainable wellbeing for all New Zealanders.
Ending child poverty

Financial and material resources are critical to providing children with an opportunity to reach their health, educational and socio-behavioural potential. Whānau want to be able to provide their children with not only a decent standard of living but the material and financial support that can empower their loved ones to thrive. Children want to live a ‘good life’ in which they have fun, feel content in the context of a supportive family/whānau, and have their basic needs met. Policy and legislative decision-making can support social, community, and economic environments in which all children have opportunities to add positively to their present and their futures. Ensuring that whānau are enabled to help their loved ones lead a good life reflects a state-level commitment to helping our youngest generation fulfill their potential. This chapter presents an overview of several indicators that indicate progress toward children and families having what they need to thrive.

All children and their whānau should have access to enough resources so they can live with dignity; with enough income and material resources to not only cover the essentials in life but also participate fully in the world around them. Information on what resources (financial and material) are available to children and their whānau provides an indication of what poverty looks like in day-to-day life. In day-to-day living, good access to material and financial resources can look like: having appropriate shoes and clothing, eating fruit and vegetables and appropriate food, going to the doctor when needed, having home appliances and repairing/replacing them when they break, feeling warm at home, and paying emergency bills when they come up. While situations of income poverty and material hardship are conceptualised as existing on a continuum of less to more severe, no child deserves to be excluded from the patterns of modern life nor miss out on the opportunities their peers have because of cost. No whānau should feel locked in a situation where they cannot support opportunities for their child because they have to allocate those resources to another essential. Decisions made by government and policy makers can build an environment that protects families from resource instability and stress, and situations where they are forced to make trade-offs.

The sections of this chapter present:

- Adequate income,
- Essentials for a good life,
- Combined measures of income and access to essentials

The chapter concludes with a discussion about what COVID-19 means for income poverty and material hardship.
Adequate income

Having an adequate disposable household income can lift children and their families out of impossible situations into a place where they do not need to make trade-offs on basics to survive and they can invest in adding value to their lives. Nurturing and enriching relationships are critical to children’s growth into healthy adulthood and these can be strained in cases where families experience high financial pressure and struggle with competing demands. In response to circumstances of low income and material hardship, children can feel that their emotions and available focus and energy are negatively impacted, which subsequently impacts on their ability to participate in aspects of life that are of value to them, such as social interaction and school aspirations.

The Sustainable Development Goals adopted in 2015 require governments to reduce the proportion of children in poverty, in all its dimensions, by at least half by 2030 (Goal 1.2). In December 2018, the Child Poverty Reduction Act was passed into law in New Zealand and three-year and ten-year targets were set with regard to reducing the proportion of children in low-income households.

Disposable income is calculated by taking the total of all income and deducting tax and ACC liabilities. Disposable income can also be referred to as net income or after-tax income. At a household level income is ‘equivalised’ which means it is adjusted for household size and composition. Equivalised household disposable income provides some indication of the amount of money available to children and their whānau that could help provide them with opportunities to get school stationery, a healthy breakfast, pay for power and internet, organise special occasion gifts or food for loved ones, and save for future goals, like a school trip or a bicycle. Income poverty (having low disposable income) is understood as existing on a continuum of less to more severe. The severity of resource restriction experienced by children can be identified through calculating where their households have very low incomes (incomes less than 40% or less than 50% of the median income).

Income before and after housing costs

Housing costs, which include mortgage and rent payments, are usually substantial and ongoing. These costs are not discretionary, as households cannot simply decide not to incur them. Looking at disposable income after housing costs are deducted provides a more accurate assessment of resources available for all other needs of the household. This is particularly true in New Zealand where housing costs have accounted for increasing proportions of disposable income, especially for those households in lower incomes. Many OECD countries do not collect housing costs and income in the same survey, so for international comparisons before housing costs data are used. For these reasons, measures are reported here that show disposable income without deducting housing costs, also referred to as before housing costs (BHC) and disposable income after deducting housing costs, also referred to as after housing costs (AHC). More detail on housing affordability can be found in the A place to call home section (page 23).

This section of the Child Poverty Monitor presents information on children living in households with low disposable incomes, using the equivalised income of the household that includes the child, as reported by the official measures of child poverty produced by Stats NZ Child Poverty Statistics and as reported in the Household Incomes Monitoring Report produced by the Ministry of Social Development.

Household income rates reported in the Stats NZ Child Poverty Statistics are calculated by Stats NZ using data from the Household Economic Survey (NZHES) and integrated data infrastructure (IDI). Disposable income is calculated for each household as the sum of taxable and non-taxable income, working for families’ tax credits, and total rebates, less ACC earner’s levy and tax payable. Disposable income is equivalised using the modified Organisation for Economic Co-operation and Development (OECD) equivalence scale which adjusts for the number of children (aged under 14 years) and adults (aged 14 and over) in the household.
Child Poverty Reduction Act measures

The Child Poverty Reduction Act 2018 seeks to “help achieve a significant and sustained reduction in child poverty in New Zealand” through encouraging government and society to focus on child poverty reduction, facilitating political accountability to achieve published targets, and requiring transparent reporting. The Act mandates ten primary and supplementary child poverty measures which are reported on by Stats NZ. Data are available to monitor progress on nine of these measures. The definition for a poverty persistence measure must be decided and reported on for the financial year beginning on 1 July 2025.

Low income measures specified in the Child Poverty Reduction Act are listed below (primary measures in bold):

- Percentage of children living in households with less than 50 percent of the median equivalised disposable household income for the 2017/18 base financial year after housing costs are deducted
- Percentage of children living in households with less than 50 percent of the median equivalised disposable household income before housing costs are deducted (contemporary financial year)
- Percentage of children living in households with less than 60 percent of the median equivalised disposable household income without deducting housing costs (contemporary financial year)
- Percentage of children living in households with less than 60 percent of the median equivalised disposable household income after housing costs are deducted (contemporary financial year)
- Percentage of children living in households with less than 50 percent of the median equivalised disposable household income after housing costs are deducted (contemporary financial year)
- Percentage of children living in households with less than 40% of the median equivalised disposable household income after housing costs are deducted (contemporary financial year)

Fixed-line measures, using the base financial year, compare income in a given year to the median income in the 2017/18 reference year, adjusted for inflation. A base financial year measure is most useful for examining short to medium term change. Improvement is considered to have occurred when household incomes rise in real terms between years, irrespective of what happens to the incomes of other households. The base financial year measure indicates if real incomes of households are increasing or decreasing.

Most of the mandatory low-income measures use a contemporary median poverty threshold which compares incomes in a given year to the median income for all households in the same year. Contemporary median measures (sometimes called moving-line measures) are most useful for assessing longer-term change. Improvement in poverty rates is considered to have occurred when the incomes of low-income households move closer to the median, irrespective of whether the incomes change in real terms.

The 2009 financial year is the first year for which data are available using the 2017/18 base financial year (fixed-line measure). Data for the contemporary median measures are available from 2007 (Table 1).

<table>
<thead>
<tr>
<th>Year</th>
<th>Before housing costs (BHC)</th>
<th>After housing costs (AHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;50% contemporary median</td>
<td>&lt;50% contemporary median</td>
</tr>
<tr>
<td></td>
<td>&lt;60% contemporary median</td>
<td>&lt;60% contemporary median</td>
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<tr>
<td></td>
<td>&lt;40% contemporary median</td>
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<td></td>
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<td></td>
<td>&lt;60% contemporary median</td>
<td>&lt;60% contemporary median</td>
</tr>
<tr>
<td></td>
<td>&lt;50% fixed-line median*</td>
<td>&lt;50% fixed-line median*</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>2007</td>
<td>150,800</td>
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</tr>
<tr>
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<td>155,900</td>
<td>14.5</td>
</tr>
<tr>
<td>2009</td>
<td>150,600</td>
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</tr>
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</tr>
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<td>2011</td>
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</tr>
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<td>2012</td>
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<td>16.3</td>
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<tr>
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<td>14.2</td>
</tr>
<tr>
<td>2018</td>
<td>183,400</td>
<td>16.5</td>
</tr>
<tr>
<td>2019</td>
<td>168,500</td>
<td>14.9</td>
</tr>
</tbody>
</table>

Source: Stats NZ Child Poverty Statistics. Years ended June; *Fixed-line measure is anchored to 2017/18 median household income

The New Zealand Government has set three-year and ten-year targets to reduce child poverty for selected thresholds. These thresholds are: reducing the proportion of children living in households with equivalent disposable income less than 50% of the contemporary median before housing costs and less than 50% of the base financial year (2017/18) median after housing costs.

While there has been an overall decline in the proportion of children living in households with equivalent disposable income less than 50% of the fixed-line median income after housing costs since 2009, and a steeper decline in the most recent years of data (2018–2019), the rate of decline in this measure will need to at least continue (if not accelerate) in order to achieve the 2021 Government target (Figure 1). In 2019 there were an estimated 235,400 children (21 children in every 100) living...
in households with equivalised disposable income below 50% of the 2017/18 base financial year after housing costs. Note that the full impact of the Families Package was not captured by these data.

The rate seen for children living in households with less than 50% of the contemporary median before housing costs will need to experience an ongoing steep decline in order to reach the Government targets.

Figure 1. Children in low-income households (<50% contemporary median income before and after housing costs), New Zealand 2007–2018 extrapolated to Government targets

Figure 2 presents the proportion of children in low-income households using a less than 50% threshold, as relative to the contemporary median for each year and as anchored to the proportions of median household income in the 2017/18 financial year (the base financial year).

Without consideration of the income changes experienced by other households, disposable incomes in some low-income households with children have increased in real dollar terms between 2011 to 2019; however, when taking into account income changes experienced by all households, the disposable incomes in low-income households have remained relatively stable compared to the (contemporary) median household income for each year (Table 1, Figure 2).

Figure 2. Children in low-income households (income <50% of the contemporary median and <50% base financial year median household income) after housing costs (AHC), New Zealand 2007–2019

Source: Stats NZ Child Poverty Statistics. Years ended June. Base financial year is 2018 Children (0–17 years) in households with income <50% of the median household income (contemporary and fixed-line) after deducting housing costs (AHC)
In addition to the targets set by the Government itself, the New Zealand Government has committed to making progress towards the United Nations (UN) Sustainable Development Goals by 2030, which includes a commitment to reduce all forms of poverty to at least half of the values as at 2015. For measures without a Government target, Figure 9 applies the child poverty reduction targets set by the Sustainable Development Goals to the official measures of child poverty set out in the Child Poverty Reduction Act 2018. Up until 2018, the Child Poverty Monitor used the income poverty measure of children living in a household with equivalised disposable income less than 60% of the contemporary median as the main measure presented in reports.

For every 100 children in 2019, an estimated 15 children lived in a household with an equivalised disposable income less than 40% of the median household income for that year, after housing costs; 21 children lived in a household with less than 50%; and 29 children lived in a household with less than 60% (Table 1). In numerical terms, after taking housing costs into consideration, as shown in Table 1 and Figure 3, there were approximately:

- 167,600 children (14.8%) living in a very-low-income household (equivalised disposable income less than 40% of the contemporary median)
- 241,600 children (21.4%) living in a low-income household (equivalised disposable income less than 50% of the contemporary median)
- 328,200 children (29.0%) living in a household with equivalised disposable income less than 60% of the contemporary median.

Figure 3. Children in low-income and very low-income households (income less than 40%, 50% and 60% of the median household income) after housing costs (AHC), by income threshold, New Zealand 2019

Housing costs, on average, make up a large proportion of household expenditure for low-income households. Before housing costs were deducted, an estimated 263,400 children (23.3%, more than one in five children) lived in households with an equivalised disposable income less than 60% of the contemporary median household income in 2019 (Table 1, Figure 4). The impact of housing costs meant that an additional 64,800 children lived in a low-income household (less than 60% of the contemporary median) after housing costs were deducted (Table 1, Figure 4). This is equivalent to an additional 5.7% of children living in households experiencing income poverty (less than 60% contemporary median) due to the impact of housing costs on disposable household income.

A similar pattern is seen for children living in households with equivalised disposable income less than 50% of the contemporary median income. Using this measure, an additional 73,100 children lived in a household with an income less than 50% of the contemporary median after housing costs were deducted (Table 1, Figure 4). This increased the proportion of children living in low-income households (<50% contemporary median) from 14.9% to 21.4%.

Using contemporary median income poverty measures, the effect of housing costs on the proportion of children living in income-poor households has been consistent since around 2012 (Table 1, Figure 4). The magnitude and direction of the apparent fluctuation in child poverty rates in 2019 for children in households with less than 50% and 60% of the contemporary median, cannot be accurately discerned until the data for more years are available. The impact of the Families Package, and the long term consequences of COVID-19, will be reflected in data from future years.
Figure 4. Children in low-income households (less than 50% and less than 60% of the contemporary median income) before and after housing costs, New Zealand 2007–2019

Figure 5 presents by ethnicity children in low-income households with an equivalised disposable income less than 60% of the contemporary 2019 median household income before and after housing costs were deducted. After the impact of housing costs were taken into account, an estimated additional 12,500 children of Māori ethnicity were pushed into the low-income household threshold in 2019, which was a total of 35 Māori children experiencing income poverty for every 100 Māori children (Figure 5). Three additional Pacific children in every 100 (4,700 children) lived in households pushed into poverty by housing costs. For every 100 children of Asian ethnicity in 2019, 23 experienced income poverty before housing costs and an additional 9 children after housing costs. Nearly half of children in the Middle Eastern, Latin American and African (MELAA) ethnic group lived in low-income households after housing costs.

Figure 5. Children in low-income households (income less than 60% of the contemporary median household income) before and after housing costs (BHC, AHC), by ethnicity, New Zealand 2019

For most years in the past decade, an estimated third of a million children have lived in a household with an equivalised disposable income less than 60% of the median after housing costs for that year, and almost one in six lived in households experiencing severe income poverty (less than 40% of the median income) (Table 1, Figure 6). Since 2011, there has been little change in the proportion of children living in low-income households using the contemporary median measures (Figure 6). There was a fall in the proportion of children in households with low incomes, using a contemporary measure, between 2018 and 2019 although this was not statistically significant. The effects of the Families Package announced in 2017, through which Family Tax Credits and Accommodation...
Supplement payments were changed from April 2018, will not be fully reflected in child poverty statistics until the 2019/20 survey year (which will be reported in 2021).34,35,31

Figure 6. Children in low-income and very low-income households (<40% <50% and <60% contemporary median after housing costs), New Zealand 2007–2019

Longer term data series from the Ministry of Social Development22 (using older methodology for calculating income poverty) show that the gap between the proportion of children living in low-income households before and after housing costs increased in the early 1990s. (Figure 7). Some of this widening gap was influenced by policy decisions to introduce market rents for social housing.22 Since 2001, costs for families living in social housing have been capped at 25% of household income.22 As shown in Figure 6, the gap between before and after housing costs low-income measures narrowed in the years soon after this policy decision, and then widened a little in 2008. Perry22 notes that policy settings for the accommodation supplement did not change from 2005 to 2017 and that housing costs increased relative to BHC incomes, especially for low-income households.

Figure 7. Children in low-income households (income less than 60% of the contemporary median household income) before and after housing costs, New Zealand 1982–2019

The proportion of children living in low-income households, after housing costs, increased markedly in the early 1990s, at all income-threshold levels (Figure 8). At this time there was high unemployment, a fall in the average wage, a reduction in the level of benefits, and introduction of
market rents for social housing with increasing numbers of households with very low incomes. From 1994 to 2004 the AHC 60% contemporary median poverty measure was fairly flat and then declined between 2001 and 2007 (Figure 8). This latter time period was characterised by improving employment levels including increased employment for women, increasing average wages, income-related rents for social housing and the Working for Families package (WFF). The Working for Families package made a tangible difference to income distribution through transferring an extra approximately $1.6 billion per year to low- to middle-income households with children. The 2004 to 2007 period was the only one in the 25 years to 2007 in which the incomes of low- to middle-income households grew more quickly than those of households above the median.

These patterns over time (Figure 8) demonstrate that legislative and policy environments can better support households with lower incomes, to reduce the impact of housing costs and reduce the number and proportion of children experiencing income poverty and families exposed to high financial strain and toxic stress).

Figure 8. Children in low-income and very low-income households (income less than 40%, 50% and 60% of the contemporary median household income), after housing costs New Zealand 1982–2018

Government will need to implement effective policies to reduce the proportion of children living in low-income and very-low-income households in order to achieve the 2030 Sustainable Development Goal for child poverty reduction (Figure 9).
Essentials for a good life

There are items, opportunities and material conditions that most people agree are essential for children to grow with dignity and enjoy a good standard of living, and essential for the people who love them to add value to the children’s lives and development. 21, 36, 37 These essentials include children having suitable clothes and shoes, leisure activities, a good bed, means to keep warm, and sufficient food. Essentials include whānau with children having resources to pay utility bills on time, cope with unexpected demands on household budgets, enjoy occasional holidays, and access health services when they are needed. 21

Material factors influence the day-to-day living conditions in which children are growing, learning, and playing 21 and measures of material hardship can illuminate the tangible ways in which poverty can permeate the experiences of children. An enforced lack is where a household does not have the opportunity to have or do something, like an essential, because of cost. 21 When locked into this state of shortage, sometimes whānau go without one essential to provide a higher priority item for their child, or they cut back on or delay paying for other unavoidable costs. 21

Children and whānau who are restricted from access to essentials for a good life tend to be locked in these circumstances of disadvantage for prolonged periods of time. 36 Policy, funding, and programme decision-making have important roles to play in creating an environment in which every child and their whānau have reliable opportunities to access essentials for a decent living. This will mean an environment in which every child and whānau is freed from persistent poverty and has resources to grow and thrive.

Internationally, the Sustainable Development Goals require that material hardship, unacceptably low material wellbeing, 22 be reduced by at least half between 2015 and 2030 (Goal 1.2) as a dimension of poverty. 28 In New Zealand, material hardship is monitored as a non-income measure through a 17-item index (DEP-17) that calculates whether households, according to their objective and subjective experiences, are in a situation where they are missing out on essentials that enable them to live with dignity and, if so, how many of those 17 essentials. 21 While all children and whānau deserve access to the essentials for a decent standard of living, those who miss out are considered by the DEP-17 index to be in the ‘material hardship’ category if the household experiences enforced lack of six or more essentials. Children who are in circumstances of ‘severe material hardship’ live in households with a very high DEP-17 index scores, which is being deprived of nine or more essentials on DEP-17. 34

This section of the Child Poverty Monitor presents information on children aged 0–17 years living in households experiencing material hardship using data gathered in the New Zealand Household
Economic Surveys (NZHES) and analysed using DEP-17. The most recent data are from the 2019 NZHES year (ending June 2019).

<table>
<thead>
<tr>
<th>Data sources and methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
</tr>
<tr>
<td>Children in households experiencing material hardship (enforced lack of six or more essentials on the DEP-17 index)</td>
</tr>
<tr>
<td>Children in households experiencing severe material hardship (enforced lack of nine or more essentials on the DEP-17 index)</td>
</tr>
</tbody>
</table>

**Definitions**

*Children* are persons aged under 18 years.

A *household* is one person who usually resides alone or two or more people who usually reside together and share facilities (e.g., eating, cooking, bathroom and toilet, living area).

A child is a *member of a household* if they live there for four or more nights per week, or spend equal time in this and another household and were present during the survey week.

*Material hardship* is unacceptably low material wellbeing. Experienced by children, material hardship is living in households who were lacking basic/essential child-specific items because of cost. Where a household does not have the opportunity to have or do an essential because of cost, it is considered an *enforced lack*.

The *material hardship threshold* is an enforced lack of six or more (≥6) component items.21

The *severe material hardship threshold* is an enforced lack of nine or more (≥9) component items.21

**Data source**

Stats NZ Child Poverty Statistics

**Additional information**

DEP-17 is an index of material hardship or deprivation, particularly suited to capturing the living standards of those at the low end of the material living standards.

<table>
<thead>
<tr>
<th>DEP-17 items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enforced lack of essentials (because of cost)</td>
</tr>
<tr>
<td>- Do not have a meal with meat, fish or chicken (or vegetarian equivalent) at least each 2nd day</td>
</tr>
<tr>
<td>- Do not have two pairs of shoes in good repair and suitable for everyday use</td>
</tr>
<tr>
<td>- Do not have suitable clothes for important or special occasions</td>
</tr>
<tr>
<td>- Do not give presents for family and friends on special occasions</td>
</tr>
<tr>
<td>- Do not have home contents insurance</td>
</tr>
<tr>
<td>Economised, cut back or delayed purchases 'a lot' because money was needed for other essentials</td>
</tr>
<tr>
<td>- Went without fresh fruit and vegetables</td>
</tr>
<tr>
<td>- Bought cheaper cuts of meat or bought less than would have liked</td>
</tr>
<tr>
<td>- Postponed visits to the doctor</td>
</tr>
<tr>
<td>- Postponed visits to the dentist</td>
</tr>
<tr>
<td>- Did without or cut back on trips to the shops or other local places</td>
</tr>
<tr>
<td>- Put up with being cold (to keep costs down)</td>
</tr>
<tr>
<td>- Delayed repairing or replacing broken or damaged appliances</td>
</tr>
<tr>
<td>Restrictions</td>
</tr>
<tr>
<td>- Feel 'very limited' by money available when thinking about purchasing clothes or shoes for self</td>
</tr>
<tr>
<td>- Could not pay an unexpected and unavoidable bill of $500 within a month without borrowing</td>
</tr>
<tr>
<td>Financial stress and vulnerability</td>
</tr>
<tr>
<td>- In arrears more than once in last 12 months, because of shortage of cash at the time, not through forgetting:</td>
</tr>
<tr>
<td>- Rates, electricity, water</td>
</tr>
<tr>
<td>- Vehicle registration, insurance or warrant of fitness</td>
</tr>
<tr>
<td>- Borrowed from friends or family more than once in last 12 months to cover everyday living expenses</td>
</tr>
</tbody>
</table>

*Source: Stats NZ*21
Material hardship measures specified in the Child Poverty Reduction Act 2018 are listed below (primary measure in bold)

- Percentage of children living in households that experienced material hardship for all or any part of the financial year
- Percentage of children living in households in New Zealand in each financial year that experienced severe material hardship

In 2019, over 150,000 children in New Zealand were in households that experienced unacceptably low material wellbeing, having to go without six or more items that most people regard as essential for a decent standard of living (Figure 10). This represented 13.4% of all children. Examples of lacking essential consumption items (due to cost) included in the DEP-17 index are where the household respondent reports that they have to postpone a visit to the doctor, put up with feeling cold, do not have two pairs of good shoes, have to go without fresh fruit or vegetables, or were not able to pay the electricity or gas bills on time. The Government target is to reduce this proportion to 6% of all children living in households experiencing material hardship by 2028.

Six percent of children (approximately 66,100) experienced severe material hardship, having to go without nine or more essentials due to cost (Figure 10).

Barriers to material wellbeing were disproportionately experienced across ethnic groups. Nearly one in five Māori children lived in households that were forced to miss out on essentials due to cost and more than one in four Pacific children (Figure 11). Due to the difference in population size by ethnic group, there are 64,000 Māori, 40,600 Pacific and 72,700 European children living in households experiencing material hardship.

More than one in ten Māori and one in seven Pacific children lived in a household that was locked in a situation of severe material shortage, missing out on nine or more essentials due to the cost. Proportions for Middle Eastern Latin American and African (MELAA) and other ethnic groups should be interpreted with caution, as they are based on small numbers (Figure 11).
From 2015–2019 there was an overall decline in the proportion of children in households experiencing material hardship and severe material hardship, with 44,300 fewer children living in households missing out on six or more essentials in 2019 compared with 2015 (Figure 12). The lower rate of material hardship in 2016 needs to be interpreted with caution, noting that in the household economic survey ending June 2016 there were fewer than expected sole parent households and households with children receiving financial assistance.34

When compared to the New Zealand Government targets for children in material hardship, the percentage of children in material hardship is 3.4% above the 2021 target and 7.4% from the 2028 target (Figure 13). In the case of severe material hardship, where there is no Government target, Figure 13 applies the child poverty reduction targets (reducing this form of poverty by at least half the 2015 rate before 2030) set by the United Nations Sustainable Development Goals to the official measures of child poverty set out in the Child Poverty Reduction Act 2018.30 To reach the Sustainable Development Goal target, the gap for severe material hardship needs to be closed by at least a further 1.5% from the rate in 2019. Change in parallel with the Government target for material hardship would require greater reduction in levels of severe material hardship to negligible levels for New Zealand households with children.
Combined measures of income and access to essentials

Households vary not just with regard to available income and material opportunities. Children and their families may have different experiences about any support and goods received from their community, any assistance for food provided, any assets possessed, any debts and debt-related servicing requirements held, any health- and disability-related costs needing payment, and any role they have with assisting with and contributing to other people’s lives beyond their immediate household.\textsuperscript{34}

To better take into account the varying experiences of households, measures of poverty that are multidimensional can illuminate nuances in the day-to-day living conditions for children and the households they live in. The Expert Advisory Group on Solutions to Child Poverty\textsuperscript{27} recognised that monitoring poverty in a multidimensional way can help identify cases where children and whānau are trapped in circumstances at more severe and persistent ends of intersecting poverty continua, which has major long-term impacts on children having opportunity to flourish. Monitoring severe and persistent poverty is critical to understanding how New Zealand compares with the 2030 Sustainable Development Goal 1.2 of reducing the proportion of children in poverty in all its dimensions by at least half.\textsuperscript{28}

Where both available income and material opportunities are taken into account to measure poverty, households can fit into one of four categories, as listed below:

- Not experiencing low income nor material hardship
- Experiencing material hardship but not low income
- Experiencing low income but not material hardship
- Experiencing both low income and material hardship.

It is for those households that are situated in the last group, where experiences of both income poverty and unacceptably low material wellbeing intersect, that stress and need is likely to be the highest.\textsuperscript{22}

In 2019, 92,300 of New Zealand children (approximately 8.2\%) were members of households with equivalised incomes less than 60\% of the contemporary median household income after housing costs and who also experienced an enforced lack of six or more of items considered to be essential for a decent standard of living. There has been an overall decline in the proportion of children in households experiencing both material hardship and income poverty, with an estimated 21,500 fewer children in these circumstances in 2019 compared with 2013 (Figure 14). This overall decline will need to be sustained in order to at least meet the UN Sustainable Development Goal target of halving this measure of poverty for New Zealand children by 2030 (Figure 15).

The combined measure specified in the Child Poverty Reduction Act is:

- Percentage of children living in households with less than 60\% of the median equivalised disposable household income after housing costs are deducted and experiencing material hardship

20
Figure 14. Children in low-income households (income less than 60% of the contemporary median household income after housing costs) and experiencing material hardship (enforced lack of ≥6 component items, DEP-17 index), New Zealand 2013–2019

Figure 15. Children in low-income households (with income less than 60% contemporary median household income after housing costs) and experiencing material hardship (enforced lack of ≥6 component items, DEP-17 index), extrapolated to UN Sustainable Development Goal target, New Zealand 2013–2030

Children in low-income households (<60% contemporary median after housing costs) and in material hardship (enforced lack of ≥6 items, DEP-17)
Discussion: Impact of COVID-19 on income poverty and material hardship

In February 2020, when Stats NZ released its first set of annual measures of child poverty, there were reasons to be cautiously optimistic that there was the potential for the indicators to head in the right direction, particularly once the full effects of the Families Package came into force. As New Zealand responded to the global COVID-19 pandemic with border restrictions and full lock-down by late March this potentially positive outlook became more uncertain. All but essential workers were ordered to stay home. Some people were able to continue to work remotely -- those occupations were typically in the higher income roles – and unfortunately many families faced a reduction in income.

The government acted quickly to deliver COVID-19 relief packages in the form of both temporary and more permanent economic responses.

Families and whānau with children relying on income assistance received an income bump through temporary increases in the winter energy payment and a longer term rise in benefit payments. Wage subsidy payments to employers enabled them to continue paying up to 80% of wages through this period, and during the extended lockdown in Auckland. For those who lost jobs between 1 March and 30 October, there was a COVID-19 relief payment for up to 12 weeks.

These changes no doubt made a difference in the day-to-day lives of low-income families. Unfortunately, these changes are not expected to offset the economic impacts of extended periods in lock-down and global recession. There will be increases in poverty made up of those children in households already in poverty before COVID-19, plus those newly in poverty due income loss due to COVID-19. While much policy consideration is being focused on those moved into poverty due to COVID-19, the much larger group are those already living in poverty.

The amount of hardship assistance provided to individuals has increased overall since the 2017 and increased steeply in the quarters reported to September 2020. The increase could be indicative of a greater ease of access to the assistance they are entitled. It could also be indicative of greater overall need. Undoubtedly the impact of COVID-19 is responsible for a significant amount of the increase in 2020.

COVID-19 has shown that many families and whānau in Aotearoa are living in precarious circumstances where there is little or no capacity to absorb sudden changes in income. Transformational change is needed more than ever by providing adequate income support through tax transfers and adequate benefit payment levels.
Safe and healthy environments

Children in Aotearoa want to enjoy being healthy and safe with nurturing connections to people and the world around them. The physical and service environments in which children, families, and whānau live, grow, play, sleep, explore, and learn are intrinsically linked to their being empowered to enjoy good lives and care for each other. Enabling each and every child to experience current and future wellbeing requires that governmental and policy decisions ensure: homes are affordable and promote health; vegetables and fruits are affordable and accessible; community food production is accessible; safe transport is easily accessed; positive parenting programmes and support appropriate for child development are readily available. The United Nations Convention on the Rights of the Child is the most widely ratified United Nations human rights treaty and enshrines the State’s requirement to uphold children’s rights to health and to protection from abuse. Health outcomes, health determinants, and adverse experiences faced by children are some of the indicators to ascertain how well government and policy decisions are creating environments that support children to be safe and enjoy wellbeing. These indicators are clearly linked with poverty and their monitoring illuminates how the flow-on effects of poverty have real implications for the lives of children.

This chapter provides child-poverty related indicators relevant to growing up in safe and healthy environments:

- Affordable homes
- Healthy homes
- Food for wellbeing
- Good health
- Nurturing and protecting children
- Good opportunities for learning

COVID-19 has not only impacted household income and material wellbeing, it has affected all aspects of children growing up in safe and healthy environments. For this reason, we include short discussions of the COVID-19 impact relevant to each section of this chapter.

A place to call home

Children have strong desires for a sense of belonging and connection to community. A place to call “home” can not only provide sanctuary and stability for children, but its quality is strongly connected to their wellbeing outcomes. Healthy homes keep occupants warm, dry, and breathing good indoor air quality, and also protect them from communicable disease transmission and physical injury, while promoting mental and emotional wellbeing.
Affordable homes

Inextricably related to family financial and material resources is the affordability of the homes they live in. The affordability of suitable homes in which to raise children, and the operations of the housing market, are largely influenced by decisions and factors beyond the immediate control of families and whānau. Having a constrained range of choice due to cost can negatively impact on whānau access to safe and child-appropriate housing and neighbourhoods (and other determinants of health), and households overburdened with financial stress due to the impact of high housing costs can strain the relationships children have with people and communities close to them. A housing market with issues of affordability disproportionately disadvantages some groups more than others, eating into the disposable income available to families and families with children, exacerbating community experiences of wealth inequality, increasing difficulties for adults and caregivers of children to maintain good jobs for income, leading to adverse health outcomes for those who have to live in homes of poor quality, and negative social and educational consequences for children. Addressing the quality and affordability of housing (renting and home ownership) is arguably the most important action to mitigate the effects of inadequate household resources in New Zealand. Housing has important implications for protecting children from injury and from adverse health outcomes while also contributing to their mental wellbeing and connection with place.

Housing costs impact considerably on the resources remaining for families and can push them into situations where they are limited in their ability to provide healthy nourishing food and suitable clothing for their children as well as maintain the home with working appliances. High levels of housing stress also limits those resources that enable children and their whānau to access to transport, health services and educational opportunities. A report in 2016 showed a fall in New Zealand home ownership rates from 1986–2013, which disproportionately affected children, particularly Māori and Pacific children in one-parent households. This lower rate of home ownership persisted in the 2018 Census, which found overall 64.6% of private dwellings were occupied by households that owned the home (owned, partly owned or in a family trust).

Compounded by affordability issues in a housing market, home ownership influences the stability experienced by children and their families. Access to affordable, stable and suitable housing is a critical precondition for a person to secure and maintain employment upon which they may maintain their lease. Rates of mobility are higher for households who rent, which can have negative consequences for children in relation to schooling and social interaction. Children and young people experience severe stress when they have had to move house because their loved ones could not pay rent.

Policies implemented by successive Governments have meant that appropriate housing and home ownership has become increasingly unaffordable for many people in Aotearoa over the decades. When compared to other OECD countries, New Zealand has experienced the steepest increase in real house prices from 2000 to 2018. Starting from a baseline in 2000, house prices in New Zealand increased 500% by 2018, while the average OECD increase in house prices was 60%.

The housing crisis is also contributing to the growth in inequality in New Zealand by depriving low-income families of the same opportunities available to their peers, housing being the only chance most of these families have of acquiring an asset base. This has implications for a large amount of children in Aotearoa. In the New Zealand Household Economic Survey (NZHES) years 2013–2015, over half of children living in income-poor households lived with their families in private rental accommodation, and another 17% in Housing New Zealand Corporation (HNZC) homes. In 2019 Renters were approximately twice as likely than homeowners to spend 40% or more of their household income on housing costs.

There is an urgent need for policy decisions to create a funding and regulatory landscape that supports increased accessibility of housing for all, particularly for low-income families. Aotearoa must ensure access to adequate, safe and affordable housing for all as a universal human right (Sustainable Development Goal 11). No family should feel they have to sacrifice the safety and stability of their housing, or sacrifice their food, warmth, school supplies and other resources in order to make ends meet. Kia Piki Ake (the Expert Welfare Advisory Group) made five recommendations in relation to...
housing, including urgent expansion and acceleration of Government efforts to substantially increase
public housing, increasing the range of home ownership and tenure options for people on low and
low–middle incomes, subsidising of housing costs for people on low incomes and improving access to
affordable, suitable housing support for people on low and low–middle incomes, including a range of
affordable home-ownership products and papakāinga housing.\textsuperscript{3}

The following section provides information on housing costs for the New Zealand general population
and more specifically for households with children. The section focuses on households spending 30%
or more of their income on housing costs. Households that spend more than 30% of their income on
owner-occupied or rental accommodation meet the benchmark for having a high “outgoings-to-
income” ratio or OTI.\textsuperscript{22} A high OTI can indicate financial struggles because meeting high housing
costs relative to income can leave insufficient money to cover other basic needs such as food,
clothing, heating, transport, medical care and education, especially for low-income households.\textsuperscript{22}

### Data sources and methods

**Indicator**

*Households experiencing a high housing cost outgoings-to-income (OTI) ratio*

**Definitions**

*High housing costs*: when a household spends more than 30% of their income on owner-occupied or rental accommodation, they meet the benchmark for having a high “outgoings-to-income” ratio or OTI.\textsuperscript{22}

*Owned*: people who owned their home, partly owned their home, or held it in a family trust.

*Rental*: people who did not own their home, did not have it in a family trust, and were making rent payments to a private

person, trust, or business or were making rent payments to Housing New Zealand Corporation, local authority, or city
council, or other state-owned corporation or state-owned enterprise, or government department or ministry.

*Housing costs* include all mortgage outgoings (principal and interest) together with rent and rates for all household
members. Repairs, maintenance, and dwelling insurance are not included. Any housing-related cash assistance from the
government is included in household income.\textsuperscript{22}

*Income quintiles* All household incomes are ranked and then divided into five groups with equal numbers of households. The
first income quintile represents the 20% of households with the lowest equivalised income; the fifth income decile comprises
the 20% of households with the highest incomes. *Income deciles* are similar but there are ten groups with equal numbers of
households.

**Data source**

New Zealand Household Economic Survey (NZHES) via Perry\textsuperscript{22}

**Additional information**

Variations in housing costs do not necessarily correspond to similar variations in housing quality. This is because many older
individuals live in good accommodation with relatively low housing costs, for example, those living in mortgage-free homes,
whereas many younger people have a similar standard of accommodation but relatively high accommodation costs.\textsuperscript{22}

Many low-income households (lowest income quintile) with dependents are experiencing severe
housing stress as a result of high outgoings-to-income ratios (OTIs), with an average of around 42%
of low-income households with dependents spending more than $40 per $100 of their income on
housing costs over the 2017 to 2018 NZHES years and 31% spending more than $50 per $100 of
income (Figure 16).

Households with one adult and dependent children more commonly experienced high housing stress
and very high housing stress when compared to other households with dependents. Over half (53%) of
low-income one-adult households with dependent children spent more than $40 per $100 income on
housing costs, and nearly 4 in 10 (37%) experienced very high housing stress in spending more than
$50 per $100 income on housing (Figure 16).
Housing costs have been increasingly unaffordable Aotearoa for all households with children, primarily for children who are in low- and middle-income household thresholds.

There has been a steep increase in the proportion of low-income households with children (income quintile 1) experiencing the stress of high housing costs relative to their income, increasing from the late 1980s for a decade before dropping slightly and increasing overall since 2007 (Figure 17). The gap between the proportion of low-income households with children being burdened by housing stress and the proportion of high-income households with children being burdened with housing stress has widened since 1988, with an initial gap of 8% between these groups widened to 23% in 2018 (Figure 18). While the increased burden of housing stress is shared across children in all income quintiles, children in low-income households have disproportionately seen a much steeper housing stress increase than their high-income peers.

From 2008–2015, over half of the households in the lowest income quintile with children spent more than $30 per $100 income on housing costs (Figure 17). From 2010–2018 over 40% of these lowest-income households with children spent more than $40 per $100 income on housing costs (Figure 18). In 2017–2018 over 30% of households with children in the lowest income quintile spent more than half their income on housing costs.22
Children are members of a larger community in Aotearoa who has experienced increased housing stress since the late 1980s, especially low-income New Zealanders across the country (households in income quintile 1).

Of all households in Aotearoa, with and without dependent children, low- and middle-income households are more likely than high-income households to spend more than 30% of their income on housing costs (Figure 19). For every $100 of household income earned, a higher proportion of low- and middle-income households spent at least $30 on their rent, mortgage or rates than did high-income households.

Across the total population of Aotearoa, 43% of those in the lowest income quintile (quintile 1) and 39% of those in the second lowest income quintile (quintile 2) were spending more than $30 per $100 income on housing costs in 2018 (Figure 19). In comparison, 32% of households in the middle income quintile (quintile 3), 22% in quintile 4 and 15% of households in the highest income quintile (quintile 5) had high outgoings-to-income ratios (OTI).

Households with individuals over 65 years of age usually have low housing costs through 72% of over-65 year olds living in mortgage-free homes. When only looking at households with individuals under-65 years old, high housing costs were much more prevalent, as was seen in every income quintile and as was particularly apparent for the lower income households (Figure 20). In low-income (quintile 1) households with individuals aged under-65 year, 62% had high housing costs at over $30 per $100 income since 2012 (compared to 43% of total households). For those under-65 households in the second lowest income (quintile 2), 50% experienced high housing costs since 2012 (compared to 39% of total households).

For under-65 households, the proportion in the lowest income quintile spending more than $50 on housing costs for every $100 of income has increased steadily since 2004. In 2018, around 40% of these households spent more than half their income on housing costs. This represents very high housing stress.

While the proportion of low-income households (quintile 1) with high OTIs has been overall steady in the total population since 2010 (Figure 19), low-income households of under-65 year olds have experienced an increase in housing costs over the same period (Figure 20). When compared to 1988–1990, inequalities in high housing costs have increased among households of under-65 year olds, with gaps widening between the lowest and highest income households.
Among recipients of the Accommodation Supplement, almost all recipients of income-replacement financial assistance and almost all renters experienced high housing costs in 2018, spending at least $30 on housing for every $100 income (Table 2). In 2018, 52% of AS recipients in each of these categories experienced very high housing stress with housing costs of at least $50 per $100 income.
Table 2. Housing costs as a proportion of income, by household type, OTI threshold (30%, 40% and 50%), and selected NZHES year, Accommodation Supplement recipients, New Zealand for month of June

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Source: Perry (2019)22 derived from MSD Information Analysis Platform (iMSD) AS = accommodation supplement; NZ Super = NZ Superannuation; children = dependent children. *Categories are not mutually exclusive and thus do not sum to 100%

**Healthy homes**

Under human rights law56,57 and the UN Sustainable Development Goals,5 Aotearoa has an obligation to create an environment that ensures all children are enabled to live, grow, play and sleep in a healthy home that is affordable for their families.50 There is an urgent need for policy decisions to create a funding and regulatory landscape that ensures improvements be made to the quality of rental housing,55 in which over half of income-poor children live,22 and ensures housing improvements are able to be affordably made by low-income property owners.55

It is important that children grow up in homes with good air quality that are free from mould and have amenities most people consider to be essential minimums for modern living, such as cooking facilities, showers or baths, and electricity supplies. This section presents information on the quality of housing in which children live and the basic amenities available in these dwellings.

**Data sources and methods**

**Indicators**

0–17 year olds living in dwellings that are always and sometimes damp
0–17 year olds living in dwellings that always and sometimes have mould larger than A4 size
0–17 year olds living in dwellings that have less than seven basic amenities available
0–14 year olds living in crowded households

**Definitions**

A **dwelling** is any building or structure (or its parts) that is used, or intended to be used, for human habitation (temporarily or permanently). Dwellings include: houses, motels, hotels, prisons, motor homes, huts, and tents. More than one dwelling can be in a building (such as in the case of apartments in apartment buildings).

A **household** can be one person who lives alone, or two or more people who live together and share facilities (such as for cooking) in a private dwelling.58

A child is a **member of a household** if they live there for four or more nights per week, or spend equal time in this and another household and were present during the survey week.

**Access to basic amenities** indicates what basic amenities (e.g. cooking facilities, shower or bath, and electricity) are available inside an occupied private dwelling. The amenities need to be in working order to be counted.

A household is defined as **crowded** if one or more bedrooms are needed to meet the Canadian National Occupancy Standard (CNOS). Within this group a household is defined as **severely crowded** if two or more bedrooms are needed to meet CNOS. A household is defined as **not crowded** if no extra bedrooms are required to meet the Canadian National Occupancy Standard

**Data source**

Stats NZ Census 2018 (Census 2018).

**Numerator(s):** Sum of the respondents in the group

**Denominator:** Sum of all respondents in the total stated group
Dry and free from mould

Moulds in the home produce irritants and allergens that children are sensitive to, which has impacts on the respiratory and skin conditions children present at their doctor’s office or hospital.\textsuperscript{49,50} Housing was a primary concern of children consulted by the Expert Advisory Group on solutions to child poverty, with particular concerns about damp and cold houses affecting their health, high costs of heating, crowding, and the negative impact of insecure and unstable housing tenure.\textsuperscript{27} As they are at home for most of the day, babies and pre-school children are particularly affected by poor quality housing.\textsuperscript{27}

The 2018 Census recorded a total of 282,228 children in Aotearoa who lived in damp housing and 237,543 in housing with mould (Figure 21, Figure 22). Around 25% (just under a quarter of a million) of children lived in houses that were sometimes damp and 18% (170,000 children) in houses that sometimes had mould larger than the size of an A4 sheet of paper (Figure 21, Figure 22). One in twenty children (around 45,400) lived in housing that was always damp (Figure 21, Figure 22). Seven per cent of children (around 66,800) lived in housing that always had mould larger than A4 size (Figure 21, Figure 22).
There is marked inequity by ethnicity in housing quality indicators (Figure 23). For every one hundred Māori children, nearly 35 lived in housing that was sometimes damp and 9 lived in housing that was always damp (Figure 23). Half of all Pacific children were living in damp housing: around 37 in every 100 Pacific children lived in sometimes-damp housing and 12 in every hundred lived in always-damp housing (Figure 23).

Māori and Pacific children also disproportionately lived in housing that had mould larger than A4 size. For every 25 children of Māori ethnicity, nine had mould in their home sometimes and three had mould in their home all the time, while 11 of every 25 Pacific children lived with mould in their home sometimes and four all the time (Figure 24).

Asian and European/Other children saw the lowest proportion living in housing that was always damp (Figure 23) and housing that always had mould (Figure 24), at under 4% and under 6% respectively.

Māori and Pacific peoples are overrepresented in the population of people in Aotearoa locked in poverty and persistent cycles of low-income. This is an important contributor to constraining the choices whānau have available to them in securing a quality dwelling from the housing market so that their children can live and grow in a safe place.
When compared to their European/Other peers, Pacific children were nearly four times as likely to live in a home that was always damp and three times as likely to live in a home that was always mouldy (Figure 25). For housing that was always damp, Māori children experienced a rate nearly three times that of European/Other children and, for housing that always had mould, experienced a rate over twice that of European/Other children (Figure 25). Children of Asian ethnicity were significantly less likely than other ethnic groups to live in a home that was always mouldy (Figure 25).

Children aged under 10 years were more likely than their older peers to be living in housing that was always damp; there was no statistical difference by age in relation to living in housing that always had mould.
Figure 25. Children 0–17 years in dwellings that are always damp and always have mould larger than A4 size, by indicator and by ethnicity, New Zealand, NZ Census 2018

Source: NZ Census 2018; Rate ratios are unadjusted. Ethnicity is total response. Children (0-17 years) in private dwellings that have less than 7 and no basic amenities available.
Access to basic amenities

In the 2018 census there were 77,976 under-18 year olds without access to one or more of the seven household amenities considered to be basic for an acceptable standard of living (Figure 26); this represents eight children in every hundred missing out on an amenity such as safe tap water, cooking and washing up facilities, a bath or shower, a toilet, a refrigerator or a supply of electricity (Figure 27).

While all basic amenities should be available to every child and young person to lead a good life, most children and young people going without basic household amenities were in households lacking one amenity (i.e. with access to six out of seven amenities) (Figure 28). A smaller proportion had access to only 4–5 basic household amenities. There were an estimated 4212 under-18 year olds missing out on most of the seven basic amenities (4 per 1,000 with 1-3 amenities available) and an estimated 4833 children living in dwellings with no amenities (5 per 1,000) (Figure 28).

Inadequate access to basic amenities is experienced disproportionately between ethnic groups. When compared to European/Other children, under-18 year olds of Māori ethnicity were nearly two times as likely to have access to less than seven of the basic household amenities (10 out of every 100). Pacific, Asian and MELAA children disproportionately experienced higher rates of being unable to access basic household amenities, with 15 of every 100 Pacific children, 12 out of every 100 Asian children and 12 out of every 100 MELAA children missing out on one or more basic household amenities, compared with five out of every 100 European/Other children who went without (Figure 28).

Pacific, Asian and MELAA children disproportionately experienced higher rates of having no basic amenities available, compared with European/Other children (Figure 28).
Living in a crowded home is a barrier to children enjoying a good life. Household crowding occurs when there is no longer adequate shelter, space, and privacy because of the number of people living there. Living in a crowded household is associated with additional barriers to wellbeing including lack of enough money for everyday needs, problems with damp or mould, and having to delay a visit to the doctor because of cost. Around one-quarter of people in crowded households rate their life satisfaction as low (0–6 on a 10-point scale). Those who live in a crowded household for three years or more are much more likely to feel unhappy about their health than those who have never lived in a crowded space, or who lived in a crowded household for one or two years. Children admitted to hospital with lung infections in New Zealand have a high rate of exposure to known avoidable risk factors included crowded households. Reducing household crowding is an important intervention to reduce the high rates of hospitalisation for infectious diseases among New Zealand children and to address the inequitably high rates experienced by Māori and by Pacific children.

Crowding was one of the key housing concerns expressed by children who were consulted by the Expert Advisory Group on solutions to child poverty. Kia Piki Ake (the Expert Welfare Advisory Group) made five recommendations in relation to housing, including urgent expansion and acceleration of Government efforts to substantially increase public housing, increasing the range of home ownership and tenure options for people on low and low–middle incomes, subsidising of housing costs for people on low incomes and improving access to affordable, suitable housing support for people on low and low–middle incomes, including a range of affordable home-ownership products and papakāinga housing.

In the 2018 census there were almost 130,000 children aged under 15 years living in crowded households (128,680 children, 16.1 percent). Within this group there were 42,150 children (5.1%) living in severely crowded households with two or more bedrooms needed to meet the standard for a non-crowded household (Figure 29).
There was inequity for Māori children with over one-fifth of those aged under-15 years living in crowded households (48,730 children, 23.5%). This group includes 9% of Māori children who were living in severely crowded households (17,410 children). The highest levels of household crowding in this age group were experienced by Pacific children, over 40% of whom lived in crowded households. Despite this higher percentage, with the smaller population of Pacific children this equated to 41,230 Pacific children (41.8%) living in crowded households with very high levels of severe crowding experienced by 17,890 Pacific children (18.1%).

In each census year since 1991 there have consistently been 16% or 17% of New Zealand children living in crowded households, including around 5% of children living in severely crowded households (Figure 30). In contrast the proportion of children living in households with two or more spare bedrooms increased in the same time period.

Figure 29. Number of bedrooms spare or needed using the Canadian National Occupancy Standard, 0-14 year olds, New Zealand Census 2018

![Figure 29](image1.png)

Source: Stats NZ 2018 Census

Figure 30. Number of bedrooms spare or needed using the Canadian National Occupancy Standard, 0-14 year olds, New Zealand Census years 1991-2018

![Figure 30](image2.png)

Discussion: Impact of COVID-19 on affordable and healthy housing

Housing shortages and rising rents have been exacerbated by COVID-19. During COVID-19 lockdown there was a nationwide freeze on rent increases and limitations on tenancy terminations. These have since ended. House prices have continued to rise rapidly after lockdown, with rents trending upwards too.

Finding accommodation for the most vulnerable was a priority during COVID-19. It has been reported that the Government spent almost $22 million on housing New Zealand’s homeless in motels during lockdown. Constant moving and insecure housing can take children outside of familiar environments, disrupt schooling and disconnect children from important relationships in their lives.

In December 2019 the Government introduced an emergency housing contribution for people who were in emergency housing. This was due to come into effect in March 2020, the start date was delayed due to COVID-19 and instead came into effect in October 2020. This requires anyone who is in emergency housing to pay 25% of their income towards the cost of the housing, similar to what people in transitional or public housing are already required to pay. It is too soon to know what impact this additional cost with have on low-income families.

Annual net migration for Aotearoa in the year ended August 2020 is provisionally estimated at 71,500 individuals, with 69,800 of these in the seven months leading up to border restrictions. This is higher than the 53,000 average of the previous six years ended August. Since closing of our border in late-March due to COVID-19, net migration has averaged 300 persons per month. Internationally, Aotearoa is seen as a country with a strong COVID-19 strategy making it an attractive place to live, or for those citizens abroad, to return home to. It is still too early to determine how COVID-19 will impact on net migration and any associated increase in demand for housing in an already tight housing market.

Food for wellbeing

Inseparable from health service need and health outcomes is access to good food. Food security is critical for enabling children and their families to make healthier behaviour choices and feel secure. The flow-on effects of children and young people incorporating healthier behaviours into their lives and feeling less distress about food security can be felt in their increased enjoyment from social activities, improved mental wellbeing and ability to learn and stay in school, reduced risk of disease, as well as future adult and population health. Children who have to live in homes of poor quality experience flow-on adverse health outcomes.

Children and their families enjoy food security when they have the assured ability to acquire nutritionally adequate and safe foods that meet cultural needs in a socially acceptable way. Low food security exists in household situations with limited resources. In New Zealand, food insecurity is driven mainly by a lack of sufficient money for food. Households reporting low food security spend less on food overall than households with moderate food security, and particularly spend less on fruit, vegetables and cereals and tend to spend less on milk.

Food security is a child poverty related indicator that, as of 2020, is reported annually by the Department of the Prime Minister and Cabinet, with the next update in 2021. Robust data, comparable from year to year, will provide an opportunity to describe in more detail the effects of policy changes on access to health nutritious food for children in New Zealand.

The latest data on food insecurity available is the 2015/16 New Zealand Health Survey (NZ Health Survey). The 2015/16 NZ Health Survey estimated that 19% of New Zealand children live in a household where the primary caregiver indicated the household was food-insecure. This may not directly translate to the experience of individual children, as caregivers may shield children from the full effects of food insecurity by restricting their own intake.
Household income and income source were strongly associated with the likelihood of food insecurity. In households including children, with a gross income at or below $50,000 per annum, 42.8% reported severe-to-moderate food insecurity, compared with 8.3% of households with gross income over $50,000 per annum. More than half (56%) of children included in households receiving income-replacement financial assistance lived in households experiencing severe-to-moderate food insecurity. A significantly lower proportion of children where the primary caregiver was not supported by such financial assistance lived in food-insecure households (12%). Over half (52%) of the children living in households experiencing food insecurity were in households where the primary caregiver received an income-replacement welfare entitlement.

Hardship assistance is available for people with insufficient income and assets, who have immediate and specific needs that cannot be met by their own resources. In 2019 the Child Poverty Monitor reported that the number of hardship assistance grants for food has increased from 84,492 in the June 2014 quarter, to 229,132 in the June 2019 quarter. This increase could have been driven by rising need or an easier application process. Analysis of earlier data suggested that the number of hardship grants per household has increased, rather than the number of households requiring hardship assistance for food. As seen in the Hardship assistance section on page 84 of this report, the number of hardship grants for food increased even further from 675,894 in the year to March 2019, to 1,120,733 in the year to March 2020.

**Discussion: Impact of COVID-19 on food security**

The lockdown period presented some additional challenges to low-income individuals and families, many of whom were already struggling to meet essential living costs prior to COVID-19. Low-income individuals and families were adversely affected by movement restrictions, reduced access to lower cost food sources (e.g. friends, family, whānau, school and community food providers), and by bulk purchases of food due to fears of supply chain disruptions increasing food costs.

Reduced household income can force families with low incomes to cut back spending on essential food and health supplies. During COVID-19, community organisations providing food parcels reported a surge in provision in early to mid-April. While provision of food parcels has declined since the peak in May, figures have not yet returned to pre-COVID-19 levels, with some reports that levels are still twice those before the pandemic. Some areas such as Northland show consistent and higher than normal demand, illustrating regional variation in need for food-related assistance.

There are many examples of communities working collaboratively to ensure families and whānau had access to food during lockdown. For example, iwi joined forces with Māori fishing agencies Sealord and Moana New Zealand to provide seafood and ready-to-eat meals to iwi at less than cost price.

Government spend to provide support to foodbanks, food rescue and community food services increased from $2 million 2019/20 to $15 million in 2020/21 as part of the Government recovery package. In April 2020 the Ministry of Social Development implemented a temporary increase in the limits for dollar value of food grants to $400 over six-months. Together with increased foodbank distribution networks, and use of foodbanks by a wider range of community members, this may have led to wider community acceptance of seeking help through food grants from MSD, use of foodbanks from NGO and community providers.

In response to the COVID-19 pandemic, Ka Ora, Ka Ako the healthy school lunches programme is being expanded to reach around 200,000 students by the end of 2021, including secondary students. By September 2020, over one million lunches have been served in 64 schools to over 13,700 students. The expansion aims to cushion the blow of COVID-19 impacts on students living in households which may now be experiencing heightened financial stress, job and income losses that can interfere with learning and wellbeing. Expanding the programme is also expected to support job creation and economic recovery from the pandemic.
Good health

This section includes three aspects of good health that can serve to indicate how well Aotearoa is supporting its youngest generations:

- **Primary care access**
- **Serious health conditions**
- **Early deaths**

We also conclude this section on the impacts of COVID-19 on child and youth health.

In Aotearoa, we value notions of justice, fairness, and children having equal opportunity to thrive and fulfil their potential. Monitoring the health conditions experienced by children and young people provides an indication of how well Aotearoa is working in accordance with these notions of fairness held by society.

Persistent inequity in children’s health outcomes are fully avoidable and unjust, and have been tolerated for too long. Children’s socioeconomic positions, identities (for example, ethnicity, gender, sexual orientation), and experience of being differently abled, can compromise their access to equal opportunity to wellbeing. All children should have their health outcomes and lives safeguarded by the decisions of government, policy, and health systems. Children in New Zealand deserve a much stronger ongoing commitment and focus to achieve health equity for all, including an explicit challenge to the persistent and systemic biases within our society that reinforce and tolerate unfair health outcomes.

The consistent failure to deliver equitable outcomes for Māori has been determined to be in breach of the constitutional obligations in te Tiriti o Waitangi (the Treaty of Waitangi). No tamariki and rangatahi Māori should be left behind by the impacts of legislative, funding and regulatory decision-making. Legislative change to include an explicit commitment to health equity for Māori is a key recommendation of the Health Services and Outcomes Kaupapa Inquiry.

Some children can experience higher clinical need due to their environment and can also experience compromised access to health care, which can be due to those services being too far away, not culturally responsive, or incurring high out-of-pocket cost. Key factors that impact on the chances of survival by infants, children, and young people include the availability and equitable distribution of resources within a society. Society’s youngest population can be protected through supportive social policy and redistributive fiscal measures.

The NZ index of deprivation (NZDep) is a small area index used as a proxy for socio-economic status in health analysis. Deprivation is considered to be a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which an individual, family or group belongs. Deprivation can include both material deprivation (involving goods, services, resources, amenities, and physical environment) and social deprivation (involving roles, relationships, functions, customs, rights and responsibilities of membership of society). The latest index, NZDep2013, combines nine variables from the 2013 census to reflect eight domains of material and social deprivation which are combined to give a score representing the average degree of deprivation experienced by people living in that area. The scores are ranked and then divided into five groups (quintiles) each representing an equal number of people in the general population.

Where health is progressively worse the higher the degree of social disadvantage, it is termed a social gradient (or, conversely, where health is progressively better the lower the degree of social disadvantage). The concept of inequity in health, as in the case of a social gradient, is where health inequalities between groups are avoidable and thus unjust.

This section presents health inequities experienced by under-15 year olds as they pertain to hospitalisations and early deaths, analysed by NZDep2013 index of deprivation score and ethnicity, using the National Minimum Dataset.
**Data sources and methods**

**Indicators**
- Unmet medical need for primary health care
- All cause hospitalisations of children aged 28 days to 14 years
- All cause early death of children aged 28 days to 14 years

**Definitions**
Child respondents (aged 0–14 years) are defined as having experienced an unmet medical need for primary care when they have experienced one or more type of barrier in the past 12 months when they had a medical problem that needed attention: could not go to a GP or an after-hours medical centre due to cost, could not go to a GP or an after-hours medical centre due to lack of access to transport, could not go to a GP due to lack of childcare services for other children, and inability to get an appointment at their usual medical centre within 24 hours.

Hospitalisations for medical conditions and injuries of 0–14 year olds, excluding neonates. Medical conditions = acute and arranged admissions. Injury hospitalisations exclude ED and waiting list.

Hospitalisation rate Hospitalisations per 1,000 age-specific population

**Deaths** of 0–14 year olds, excluding neonates

Mortality rate Deaths per 100,000 age-specific population

**Data sources**

<table>
<thead>
<tr>
<th>Barriers to accessing primary health care: New Zealand Health Survey (NZ Health Survey)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator(s):</strong> Sum of the weights for the respondents in the group</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Sum of the weights for all respondents/population group</td>
</tr>
</tbody>
</table>

**Hospitalisations and deaths**

<table>
<thead>
<tr>
<th><strong>Numerator(s):</strong></th>
<th>Hospitalisations: National Minimum Dataset</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deaths:</strong> National Mortality Collection</td>
<td></td>
</tr>
</tbody>
</table>

| **Denominator:** | NZCYES Estimated Resident Population (with intercensal extrapolation) |

**Additional Information**

Relevant NZ Health Survey question: unmet need for primary health care (C2.01–02, C2.05, C2.27–29, and C2.49–50).

Survey data (by financial year) is referred to by the year of data beginning. For more information on the NZ Health Survey, please refer either to the Ministry of Health website ([https://www.health.govt.nz](https://www.health.govt.nz)) or to appendices in this report.

**Indicator: Children who have an unmet medical need for primary health care**

**Question C2.01:** Do you have a GP clinic or medical centre that you usually go to when [Name] is feeling unwell or is injured?

- Yes / No

**Question C2.02:** What sort of health care service is this?

- A GP clinic, medical centre or family practice / A clinic that is after-hours only – not an Emergency Department at a public hospital / Other____ [Specify]

**Question C2.05:** In the past 12 months, has there been a time when you wanted [child’s name] to see a GP, nurse or other health care worker at your usual medical centre within the next 24 hours, but he/she was unable to be seen?

- Yes / No

**Question C2.27:** In the past 12 months, was there a time when [child’s name] had a medical problem but did not visit a GP because of cost?

- Yes / No

**Question C2.28:** In the past 12 months, was there a time when [child’s name] had a medical problem but did not visit a GP because you had no transport to get there?

- Yes / No

**Question C2.29:** In the past 12 months, was there a time when [child’s name] had a medical problem but did not visit a GP because you could not arrange childcare for other children?

- Yes / No / Doesn’t apply

**Question C2.49:** In the past 12 months, was there a time when [child’s name] had a medical problem outside regular office hours but you did not take him/her to an after-hours medical centre because of cost?

- Didn’t have a medical problem outside regular office hours / Yes, didn’t go because of cost / No
Ensuring equitable access to primary health care services is critical to future economic and population health and is implicit in the United Nations Convention on the Rights of the Child (Article 24). Barriers to accessing primary care can compromise the prevention or management of health issues in children, resulting in children requiring more acute health issues that require hospitalisation or lifelong health service support. Under international law, countries such as Aotearoa must strive to ensure no child is deprived of their right to access health care services. It is important that planning, funding, and infrastructure create an environment that ensures every child has access to care when they have a medical need (such as illness or an injury), and that no child is obstructed from having their needs met due to appointment unavailability of the needed services, out-of-pocket cost, inaccessibility of affordable transport, or unavailability of affordable childcare arrangements to look after other children in their family/whānau.

Policy decisions made in recent years have had an impact on ensuring that fewer children experience cost barriers that compromise their access to primary health care services. In July 2015, the New Zealand Government extended the Zero Fees policy (originally introduced in 2008 for children under the age of six years) to include children under the age of 13 years, meaning that all children under 13 were not to be charged for the costs of standard GP and after-hours medical centre visits. Also from July 2015, the $5 standard prescription co-payment charge for each item of prescription medicine was removed for children aged under 13 years. The 2018 Budget further extended these provisions to children under the age of 14 years (from 1 December 2018). Figure 34 presents over time the proportion of children who had an unmet medical need for primary care due to cost. After 2015, there has been an overall decline in the proportion of children missing out on seeing a general practitioner, seeing an after-hours medical centre, or fulfilling a prescription because of cost.

In 2018/19, an estimated 189,000 children missed out on needed primary care services due to at least one barrier, such as cost, transport, lack of childcare, or appointment unavailability (Figure 31). The most common barrier for children that caused them to have an unmet need for primary care was being unable to get an appointment at their usual medical centre within 24 hours (Figure 32). The large impact that the unavailability of services has on making many children miss out on needed care is likely to be indicative of Aotearoa’s need to improve health infrastructure through policy, legislative, and funding changes so as to better create an environment that ensures every child has access to an appointment when medically needed. Low-income families are rendered more vulnerable by service unavailability, as they may experience cost, transport, geographic and other barriers that make them unable to turn to a different primary care provider that does have an appointment available.

Figure 31. Children who have an unmet need for primary health care, New Zealand, NZ Health Survey 2018/19

<table>
<thead>
<tr>
<th>Have an unmet need for primary care</th>
<th>Number of children with an unmet need for primary health care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>50,000</td>
</tr>
<tr>
<td></td>
<td>100,000</td>
</tr>
<tr>
<td></td>
<td>150,000</td>
</tr>
<tr>
<td></td>
<td>200,000</td>
</tr>
</tbody>
</table>

Source: NZ Health Survey 2018/19. Year ending June.
Children (0–14 years) who have an unmet need for primary health care due to cost or other barriers to accessing care (estimate)
The proportion of children experiencing unmet needs for primary medical care due to cost or other barriers increased between 2011/12 and 2015/16 and then declined back to the previous level (Figure 33).

Nearly 7% of children were unable to fill a prescription in 2011/12 because of the cost, and 2% in 2019. Because of cost, nearly 5% of children experienced having a medical need but being unable to see a general practitioner in 2011/12, which fell to around 2% in 2019.
Figure 34. Children who have an unmet need for primary health care due to cost, New Zealand, NZ Health Survey 2011–2019

Figure 35 presents the proportion of children missing out on primary care due to lack of transport. The proportion of children missing out on needed general practitioner services due to lack of transport has shown some year-to-year variation and declined overall from 2011/12–2018/19. The proportion of children missing out on after-hours medical care due to lack of transport has remained relatively consistent since 2014 at around 1%.

The proportion of children missing out on receiving needed general practitioner services remained relatively stable from 2012–2019 at around 3%, and the rate of children missing out on after-hours medical care has remained relatively consistent since 2012 at around 1%.

Figure 35. Children who have an unmet need for primary health care due to lack of transport, New Zealand, NZ Health Survey 2011/12–2018/19
There is a social gradient in children’s unmet need for primary care. Barriers preventing children from accessing primary care due to at least one barrier are disproportionately experienced by Māori and Pacific children compared with European/Other, and children living in more deprived areas compared with children in the least deprived areas (Figure 36).

Figure 36. Children who have an unmet need for primary health care, by demographic variable, New Zealand NZ Health Survey 2018/19

Māori children, and Pacific children, were significantly more likely than other children to experience all of the barriers to primary health care due to cost and due to lack of transport in 2018/2019 (Figure 37, Figure 38).

Figure 37. Children who have an unmet need for primary health care due to cost, by unmet need and by ethnicity, New Zealand NZ Health Survey 2018/19

Figure 38. Children with an unmet need for primary care due to cost

Source: NZ Health Survey 2018/19 (year ending June).
Children (0–14 years) who have an unmet need for primary health care due to cost or other barriers to accessing care; Ethnicity is total response. Quintile is NZDep2013 (1 = least deprived; 5 = most)
In 2018/19, children living in areas with the highest NZDep13 scores (quintile 5) were significantly more likely than children living in areas with the lowest deprivation scores (quintile 1) to experience barriers to primary care. These barriers were statistically significant for an unmet need for primary care due to lack of transport, and for being unable to fill a prescription due to cost (Figure 39, Figure 40).

Figure 39. Children who have an unmet need for primary health care due to lack of transport, by neighbourhood deprivation, New Zealand NZ Health Survey 2018/19

Source: NZ Health Survey 2018/19 (year ending June).
Children (0–14 years) who have an unmet need for primary health care due to lack of transport to access care; Ethnicity is total response. Quintile is NZDep2013 (1 = least deprived; 5 = most)
**Figure 40.** Children who have an unmet need for primary health care due to cost, by unmet need and by neighbourhood deprivation, New Zealand NZ Health Survey 2018/19

**Serious health conditions**

Hospitalisations represent a snapshot of poor child health outcomes. Some potentially avoidable hospitalisations could be prevented through central and local government policies that provide families and whānau with access to healthy, good quality housing and a safe physical environment.95

Hospitalisation rates of under-15 year olds for medical conditions have risen from 50.2 hospitalisations per 1,000 age-specific population in 1991, to 79.3 hospitalisations per 1,000 age-specific population in 2019. This represented a rise from 39,361 in 1991 to 73,542 hospitalisations in 2019. Hospitalisation rates for injury in this age group rose between 1991 and 1994 to 15.6 hospitalisations per 1,000 age-specific population, and have since fallen to 11.2 hospitalisations per 1,000 age-specific population in 2019 (Figure 41).

**Figure 41.** All-cause hospitalisations in 0–14 year olds (excluding neonates), New Zealand 1991–2019

---

Source: NZ Health Survey 2018/19 (year ending June).
Children (0–14 years) who have an unmet need for primary health care due to cost barriers to accessing care;
Quintile is NZDep2013 (1 = least deprived; 5 = most)
The highest hospitalisation rates in under-15 year olds were observed for children living in areas with the highest deprivation scores. The gap between NZDep2013 quintile 1 and quintile 5 increased between 2007 and 2009 and has remained high (Figure 42).

Figure 42. All-cause hospitalisation rates in 0-14 year olds, by deprivation score, New Zealand 2000–2019

In the five years from 2015–2019, there were 408,036 all-cause hospitalisations of under-15 year olds, of which 356,994 (88%) were for medical conditions. The remainder of this section will focus on medical conditions.

The highest rate of hospitalisation for medical conditions was for children aged under five years compared with 5–14 year olds (Figure 43). Within the 0–4 year age group, hospitalisation rates for the most common conditions were highest in infants aged under one year. Among ethnic groups, hospitalisation rates were lowest for European/Other children, with higher hospitalisation rates for Pacific children, and those of Middle Eastern, Latin American and African (MELAA), Māori and Asian/Indian ethnicity (Figure 43). Hospitalisation rates for medical conditions were significantly different by NZDep13 deprivation score, with under-15 year olds living in areas with the highest deprivation scores (most deprived, quintile 5) experiencing twice the hospitalisation rate of those living in areas with the lowest deprivation score (quintile 1) (Figure 43).

This univariate analysis is not able to quantify the independent effect of each demographic factor.

Figure 43. Hospitalisations for medical conditions, by demographic factor, 0–14 year olds New Zealand 2015–2019


Medical conditions: acute and arranged admissions, Injuries: excludes ED and waiting list cases.
The most common diagnoses for children hospitalised with a medical condition in the five years from 2015–2019 were diseases of the respiratory system (Table 3). Respiratory diseases include acute infections, acute bronchiolitis, and asthma and wheeze. There were 131,012 hospitalisations with a respiratory disease in the five years from 2015–2019, accounting for 37% of all hospitalisations for medical conditions in this time period. Almost half (49%) of the 198,252 children hospitalised with a medical condition from 2015–2019 were hospitalised with a respiratory condition (Table 3). Many children hospitalised with respiratory infections are likely to be exposed to poor housing, which may negatively impact their risk of ongoing health problems.95

### Table 3. Hospitalisations for medical conditions, by selected primary diagnosis, 0–14 year olds (excluding neonates), New Zealand 2015–2019

<table>
<thead>
<tr>
<th>Primary diagnosis</th>
<th>Individuals (n)</th>
<th>Hospitalisations (n)</th>
<th>Rate per 1,000 0–14 year olds</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalisations of 0–14 year olds 2015–2019</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute bronchiolitis</td>
<td>20,590</td>
<td>31,249</td>
<td>6.79</td>
<td>6.72–6.87</td>
</tr>
<tr>
<td>Asthma and wheeze</td>
<td>20,359</td>
<td>32,838</td>
<td>7.14</td>
<td>7.06–7.21</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>13,138</td>
<td>15,734</td>
<td>3.42</td>
<td>3.37–3.47</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>6,310</td>
<td>8,019</td>
<td>1.74</td>
<td>1.70–1.78</td>
</tr>
<tr>
<td><strong>Communicable and infectious diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>16,035</td>
<td>18,028</td>
<td>3.92</td>
<td>3.86–3.97</td>
</tr>
<tr>
<td>Viral infection of unspecified site</td>
<td>22,063</td>
<td>24,062</td>
<td>5.23</td>
<td>5.16–5.29</td>
</tr>
<tr>
<td>Other communicable and infectious diseases</td>
<td>6,839</td>
<td>7,564</td>
<td>1.64</td>
<td>1.61–1.68</td>
</tr>
<tr>
<td>Other medical conditions</td>
<td>110,620</td>
<td>176,328</td>
<td>38.31</td>
<td>38.1–38.5</td>
</tr>
<tr>
<td><strong>Total medical conditions</strong></td>
<td>198,252</td>
<td>356,994</td>
<td>77.57</td>
<td>77.3–77.8</td>
</tr>
</tbody>
</table>

Numerator: National Minimum Dataset (excludes neonates) (excludes neonates), Denominator: NZCYES estimated resident population. *Acute respiratory infections = upper and lower respiratory infections

Hospitalisation rates for asthma and wheeze, acute bronchiolitis and acute respiratory infections increased from 2000–2019 with some year-to-year fluctuation (Figure 44). It is too early to comment on the apparent slight decrease from 2018 to 2019. There has been an overall decline in hospitalisation rates for all-cause pneumonia since 2008 (Figure 44) when vaccination against pneumococcal disease was introduced to the New Zealand childhood immunisation schedule.96 The Ministry of Health notes that the largest reductions in all-cause pneumonia hospitalisations were observed in Māori and Pacific children, and for children living in areas with high deprivation scores.96

**Figure 44.** Hospitalisations for select respiratory diseases 0–14 year olds, New Zealand 2000–2019

Numerators: National Minimum Dataset (acute and arranged admissions; excludes neonates), Denominator: NZCYES estimated resident population. *Acute upper, lower and inflammatory infections
Early deaths

Progress in child survival worldwide has been described as one of the greatest success stories of international development, with child deaths being reduced by half between 1990 and 2010. The concept of a social gradient evident in hospitalisations is also relevant when considering deaths of children and young people. Availability and equitable distribution of resources within a society impact on children’s life chances, and children’s lives can be protected through supportive social policy and redistributive fiscal measures. Investigation of child deaths is important to increase our understanding of why children die and help prevent future child deaths.

The all-cause mortality rate for under-15 year olds declined from 62.0 to 21.27 deaths per 100,000 age-specific population between 1990–91 and 2016–2017 (Figure 45). Because of delays in recording causes of deaths under coronial investigation, there is a lag in the release of New Zealand mortality data (2017 data were released in 2020).

In the five years from 2013–2017 there were 1,020 deaths of 0–14 year olds (excluding neonates). Of these deaths, 556 were as a result of medical conditions (an annual average of 111 deaths), 248 as a result of injury (annual average of 50 deaths) and 215 sudden unexpected deaths in infancy (SUDI) (annual average of 40 deaths) (Table 4).

From 2013–2017, the mortality rate was highest in the first year of life, mainly as a result of SUDI and of perinatal conditions and congenital anomalies as the main underlying cause of death. The most common main underlying medical causes of death were congenital anomalies and perinatal-related conditions, and cancers (neoplasms). The most common modes of fatal injury were motor vehicle traffic, suffocation, and drowning.

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>2013–2017 (n)</th>
<th>Annual average (n)</th>
<th>Rate per 100 population</th>
<th>95% CI</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Zealand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical conditions</td>
<td>556</td>
<td>111</td>
<td>12</td>
<td>11.17–13.21</td>
<td>55</td>
</tr>
<tr>
<td>Injury</td>
<td>248</td>
<td>50</td>
<td>5</td>
<td>4.77–6.14</td>
<td>24</td>
</tr>
<tr>
<td>SUDI</td>
<td>215</td>
<td>43</td>
<td>&lt;5</td>
<td>4.09–5.37</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>1,020</td>
<td>204</td>
<td>22.30</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Māori and Pacific under-15 year olds experienced a significantly higher mortality rate compared with Asian/Indian and European/Other children, in the five years from 2013–2017 (Figure 46). The mortality rate for children living in neighbourhoods with the highest NZDep2013 scores (greatest
deprivation, quintile 5) was just over three times as high as the mortality rate in quintile 1. Children in quintile 4 also experienced a significantly higher mortality rate than children in quintile 1 (Figure 46).

The social gradient in all-cause mortality rates in under-15 year olds has been present throughout the whole period from 1990–2017, with a marked gap between mortality rates for children living in areas with the highest deprivation scores (quintile 5) and others (Figure 47). Although mortality rates have declined in all NZDep quintiles, there has been no sustained narrowing of the gap between children living in the most deprived areas (quintile 5) and their peers (Figure 47).

Between 1996–97 and 2016–17, there has been persistent inequity between mortality rates for Māori and for Pacific children aged under 15 years, compared with mortality rates of their European/Other and Asian/Indian peers. A decrease in mortality rates has been seen across all ethnic groups, with some narrowing of the equity gaps (Figure 48). There is a need for effective policy and sustained effort to bring about a society where every child has an equitable opportunity to survive.

Figure 46. All-cause mortality in 0–14 year olds (excluding neonates), by demographic factor, New Zealand 2013–2017

Figure 47. Mortality rates in 0–14 year olds (excluding neonates), by deprivation score, New Zealand 1990–2017

Figure 48. Mortality rates in 0–14 year olds (excluding neonates), by deprivation score, New Zealand 1990–2017
Infant deaths

Health inequities (avoidable inequalities) in infants’ chances of survival are impacted by both the characteristics and effectiveness of health systems as well as the associated factors of household income, living conditions, indigeneity, and parent education status.99-101 The resources and choices available to whānau for preventing infant death are often contingent on factors outside their control.102 Differences in infant survival within high-income countries reflect commitment to support the flourishing of every parent-to-be, pregnancy, whānau and baby by means of good system capacity, appropriate allocated resources, and responsive service delivery.103

Infant mortality rates in most high-income countries, as in New Zealand, are lower than 10 infant deaths per thousand live births.103 The infant mortality rate in New Zealand is higher than the OECD average.104 The 2017 infant mortality rate for New Zealand was similar to the rates in Poland and Hungary, higher than Australia and more than twice the rates in Finland and Iceland (Figure 49).105 Some of the international variation in infant mortality rates is due to variations among countries in registering practices for premature infants. The United States and Canada register a much higher proportion of babies weighing less than 500g, with low odds of survival, resulting in higher reported infant mortality. In Europe, several countries apply a minimum gestational age of 22 weeks (or a birth weight threshold of 500g) for babies to be registered as live births and thus infant mortality rates may be lower.105
This section reviews infant deaths, including sudden unexpected death in infancy (SUDI), using information from the National Mortality Collection and the Birth Registration Dataset.

### Data sources and methods

#### Indicators

**Infant mortality rate**

**Sudden Unexpected Death in Infancy (SUDI) rates**

#### Data sources

- **Numerator**: National Mortality Collection
- **Denominator**: Birth Registration Dataset (live births only)
- **Other countries**: OECD (via OECD data)

#### Definitions

**Infant death**: Death of a liveborn infant prior to 365 days of life.

**Infant mortality rate**: Death of a liveborn infant prior to 365 days of life per 1,000 live births

**Sudden unexpected death in infancy (SUDI)**: Death of a liveborn infant prior to 365 days of life, where the cause of death was sudden infant death syndrome (SIDS), accidental suffocation or strangulation in bed, inhalation of gastric contents or food, or ill-defined or unspecified causes

**SUDI rate**: SUDI per 1,000 live births

**SIDS**: Refers to refer to the sudden, unexpected death in an infant that is unexplained, even after a complete death scene investigation, thorough post-mortem (autopsy) and review of the infant’s clinical history.

#### Additional information

Cause of death is the main underlying cause of death. Refer to Appendix 1 for relevant codes.
Infant mortality rates fell overall from 1990 to 2017, with most of that decrease occurring during the 1990s followed by a more gradual decline from 2000 to 2007 (Figure 50). Infant mortality rates have been fairly stable from 2006–2015 with an apparent decrease in 2016–2017. Further years are needed to determine if this is an ongoing pattern.

The rates of infant mortality among Māori, Pacific and European/Other ethnic groups were lower in 2016–2017 when compared to rates in 1996. Māori and Pacific infants experienced persistent inequity in mortality rates during this time period, with mortality rates in their European/Other peers markedly lower in comparison (Figure 50).

During 2013–2017, infants experienced inequitable likelihood of surviving the first year of life according to neighbourhood socioeconomic deprivation (NZDep2013), maternal age, ethnicity and gender as shown by Figure 51. The mortality rate for infants born in areas with the highest socioeconomic deprivation scores (quintile 5) was more than twice as high as the mortality rate for infants born in areas with the lowest deprivation scores (quintile 1).

When compared to European/Other infants, Māori infants experienced a mortality rate that was 1.5 times as high, and Pacific infants experienced a mortality rate twice as high. Compared with infants born to mothers aged 30–34 years, the mortality rate for infants born to mothers aged younger than 20 years was almost three times as high, while the rate for infants born to mothers aged 20–24 years was 1.7 times as high. The mortality rate for male infants was significantly higher than the rate for female infants.

Infant deaths that occurred in the first month of life commonly resulted from congenital anomalies, extreme prematurity and other perinatal conditions (Table 5). Sudden unexpected death in infancy (SUDI), most commonly as a result of suffocation in bed or sudden infant death syndrome, was the most common cause of death for infants aged from 28 days to one year.
Table 5. Infant mortality by main underlying cause of death, New Zealand 2013–2017

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>2013–2017 (n)</th>
<th>Annual average (n)</th>
<th>Rate per 1,000 live births</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital anomalies</td>
<td>325</td>
<td>65</td>
<td>1.08</td>
<td>22.7</td>
</tr>
<tr>
<td>Extreme prematurity</td>
<td>302</td>
<td>60</td>
<td>1.00</td>
<td>21.1</td>
</tr>
<tr>
<td>Other perinatal conditions</td>
<td>418</td>
<td>84</td>
<td>1.39</td>
<td>29.2</td>
</tr>
<tr>
<td>SUDI SIDS</td>
<td>98</td>
<td>20</td>
<td>0.33</td>
<td>6.8</td>
</tr>
<tr>
<td>SUDI suffocation or strangulation in bed</td>
<td>109</td>
<td>22</td>
<td>0.36</td>
<td>7.6</td>
</tr>
<tr>
<td>SUDI all other types</td>
<td>12</td>
<td>2</td>
<td>0.04</td>
<td>0.8</td>
</tr>
<tr>
<td>Injury or poisoning</td>
<td>29</td>
<td>6</td>
<td>0.09</td>
<td>1.9</td>
</tr>
<tr>
<td>Intrauterine hypoxia or birth asphyxia</td>
<td>15</td>
<td>3</td>
<td>0.05</td>
<td>1.0</td>
</tr>
<tr>
<td>Other causes</td>
<td>125</td>
<td>25</td>
<td>0.42</td>
<td>8.9</td>
</tr>
<tr>
<td>Total</td>
<td>1,433</td>
<td>287</td>
<td>4.76</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Numerator: National Mortality Collection, Denominator: Birth Registration Dataset; Rate ratios are unadjusted, REF = reference group, Ethnicity is Level 1 prioritised, Quintile is NZDep2013 Index of deprivation (1 = least deprived; 5 = most deprived)

**Sudden unexpected death in infancy**

Sudden unexpected death in infancy (SUDI) is the leading cause of death for New Zealand infants aged from 28–364 days and usually occurs in otherwise healthy infants. Protection against this potentially avoidable tragic death is influenced by the support provided to whānau with regard to accessing: basic health services and transport to reach those services, appropriate and engaging health resources, adequate housing and safe places for infants to sleep, sufficient heating and financial resources, and effective smoking cessation interventions.

The rate of SUDI in New Zealand has significantly decreased since 1990 (Figure 52). Some of this decrease has been attributed to initiatives that occurred during the 1990s designed to make health messages more accessible (for example about appropriate sleeping positions for babies). From 2012–2016, half of the cases of SUDI occurred when the infant was in bed and had their airway blocked so they couldn’t breathe.

The rate of SUDI for Māori infants has decreased significantly since 1996. The SUDI rate for Pacific infants has fluctuated from year to year (Figure 52). Persistent avoidable inequities remain for Māori and Pacific infants, with consistently higher SUDI rates compared to their European/Other peers (Figure 52).
During 2013–2017, SUDI was experienced inequitably according to neighbourhood socioeconomic deprivation (NZDep2013), ethnicity, maternal age, ethnicity, gender and gestational age at birth and as shown by Figure 53. The mortality rate for infants born in areas with the highest socioeconomic deprivation scores (quintile 5) was almost ten times as high as the mortality rate for infants born in areas with the lowest deprivation scores (quintile 1). Māori and Pacific infants experienced SUDI rates four times as high as the rates for European/other infants. The SUDI rate for infants born to mothers aged under 20 years was six times as high as the rate for infants born to mothers aged 30 years or older, while for those born to mothers aged 20–25 years it was four times as high. The SUDI rate for infants born before 37 weeks gestation was three times as high as the SUDI rate for infants born at or after 37 weeks gestation.

Figure 52. Trends in sudden unexpected death in infancy (SUDI) by ethnicity, New Zealand 1990–2017

Figure 53. Sudden unexpected death in infancy, comparison by demographic factor, New Zealand 2013–2017
Discussion: Impact of COVID-19 on child and youth health

As at 22 November 2020, there were 254 reported COVID-19 cases in New Zealand children and young people aged 0–19 years (13% of all cases), with four hospitalised cases and no deaths from COVID-19 in this age group. There will, however, be children and young people who experienced the death of a family or whānau member as a result of the pandemic.

It is likely that children and whānau who struggle to access health services in non-pandemic environments will have found doing so even harder during COVID-19. As health services braced for an influx of adult patients, services for children were less accessible and there have been reports of serious consequences of delay in care.

Children’s health services, especially access to antenatal care, and care in the immediate post-natal period have been disrupted by the pandemic. Provisional immunisation data for children whose immunisations were due since March 2020 suggest a decrease in immunisation rates. Curtailing of routine health services for children can have detrimental impact through missed vaccinations, and lack of access to the surveillance provided in well-child care. There are concerns that out-breaks of measles and whooping cough could re-emerge once borders open if there are large numbers of children with missed vaccinations. In order to improve protection of children from communicable diseases, more vaccinations in homes are being offered for hard-to-reach groups, and health boards are working with Māori community groups to better support whānau access. From the 1 October 2020 the MMR vaccine is be able to be given to babies aged 12 and 15 months, instead of at 15 months and then four-years.

A surprising consequence of the COVID-19 pandemic response was a dramatic decrease in hospitalisations of babies and toddlers with respiratory infections during the winter of 2020 in paediatric wards throughout New Zealand. Middlemore Hospital would usually admit about 1000 under-two year olds with respiratory infections each winter; in 2020 there were fewer than 200 such admissions. Several factors may have contributed to this, including the lockdown in March and April reducing transmission of viruses other than the novel coronavirus, closed border potentially reducing imported pathogens, social distancing, hand hygiene and staying at home when sick reducing spread of disease. However there were increased hospitalisations of children with rheumatic fever in 2020, which may have been due to household crowding, poor access to primary care and inability to have appropriate testing of sore throats.

Temporary prescription restrictions were put in place in New Zealand during lockdown to prevent major strains on the supply chain of pharmacy drugs, this was uplifted at the end of July. International medical supply changes are still heavily affected by COVID-19, potentially impacting on families and whānau being able to access the medications they and their children need.

Children and young people need access to health services, including adequate GP numbers for children to be seen urgently when necessary and vaccination services that meet families and whānau where they are. Continued availability of sick leave so that unwell parents and children can stay at home is a further consideration of how we can maintain good child health.

Nurturing and protecting children

Responsive and nurturing parenting that provides children with opportunities for skill building provides critical foundations for children’s journeys towards current and lifelong wellbeing and fulfilment. Child maltreatment in a community can compromise children’s senses of belonging and have flow-on effects on their educational and health outcomes as well as their trajectory into adulthood. The section on Nurturing and protecting children provides an overview of indicators associated with children being nurtured by all levels of society so they are safe from hospitalisations due to assault, from deaths due to assault, and from physical force used to discipline. We also comment on the impacts of COVID-19.
Every child deserves to have their wellbeing safeguarded. Governments have a responsibility to realise ways in which institutions, services, policy, and legislation can uphold the rights and safety of children and strengthen the care they receive. Whānau and communities need an environment that empowers them to care for children in nurturing ways and empowers them to help safeguard their loved ones from accidents and harm.

**Effective discipline**

In New Zealand, many parents and whānau pride themselves on the care they take to nurture their children towards good morals, values, attitudes and behaviours that they can carry with them into adulthood. Children are cherished and it is widely appreciated that children need to have opportunities to be inquisitive and explore, which can sometimes lead to accidents or getting up to mischief. This knowledge is illustrated in the whakataukī (proverb): Ko te mahi a te tamariki, he wāwāhi tahā – the activities of children break calabashes.

When children’s activities don’t go to plan, whānau play an important role in safeguarding children while also helping them learn from the events that happen. Until relatively recently in New Zealand legislation, it was acceptable for adults to use corrective force (physical punishment, such as “smacking”) in schools or in the home. However, an abundance of evidence highlights that physical punishment and responding to unwanted behaviour with anger are ineffective means of disciplining children. The use of force in punishment has been causally associated with compromising the developmental, social and emotional potential of children as well as undermining parent-child relationships.

Physical punishment has been prohibited in schools since 1989 and for parental use since 2007, when the Crimes Act was amended to protect all children from any assault in any context. Refusing to use physical punishment for correction is of benefit to parenting as well as the ultimate goals of helping children flourish and live with dignity. All levels of government and all sectors can work to ensure environments and communities support caregivers and whānau to acquire resources and knowledge so they can look after children in ways that are positive and nurturing. In New Zealand, practical guidance to help parents and caregivers to raise children in a positive way is available through S.K.I.P (Strategies with Kids Information for Parents) and parenting resources for those who support whānau are available through Oranga Tamariki, Ministry for Children.

This indicator presents information from the New Zealand Health Survey on the prevalence of physical punishment of 0–14 year olds by parents or primary caregivers in the 4 weeks preceding the interview.

<table>
<thead>
<tr>
<th>Data sources and methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
</tr>
<tr>
<td>Children who received physical punishment in past four weeks</td>
</tr>
<tr>
<td><strong>Definitions</strong></td>
</tr>
<tr>
<td>Children aged between 0–14 years old have received physical punishment in the past four weeks if the child’s parent or caregiver has done ‘Physical punishment, such as smacking’ in the past four weeks when the child misbehaved, as reported by the parent or caregiver.</td>
</tr>
<tr>
<td><strong>Data sources</strong></td>
</tr>
<tr>
<td>New Zealand Health Survey (NZ Health Survey)</td>
</tr>
<tr>
<td>Numerator(s): Sum of the weights for the respondents in the group</td>
</tr>
<tr>
<td>Denominator: Sum of the weights for all respondents/population group</td>
</tr>
<tr>
<td><strong>Additional information</strong></td>
</tr>
<tr>
<td>Relevant NZ Health Survey question: physical punishment (C3.15 and C3.16a). Survey data (by financial year) is referred to by the year of data beginning. For more information on the NZ Health Survey, please refer either to the Ministry of Health website (<a href="https://www.health.govt.nz">https://www.health.govt.nz</a>) or to appendices in this report.</td>
</tr>
</tbody>
</table>
In the 2019 NZ Health Survey, 38.2% of parents agreed that “there are certain circumstances when it is alright for parents to use physical punishment”.

There was an overall fall in the percentage of children aged 0–14 years who received physical punishment in the past 4 weeks from 2007 to 2019 (Figure 54). While there is an apparent fluctuation in children receiving physical punishment in 2019, the magnitude and direction of the apparent change cannot be accurately estimated until the 2020 NZ Health Survey data are available.

The percentages of 0–14 year olds who received physical punishment are presented as unadjusted rates by demographic factor in Figure 55 and as adjusted rates in Figure 56. Rates of physical punishment were significantly higher for under-ten year olds when compared with older children. Rates of physical punishment were significantly higher for Māori and Pacific children (almost two times as high as rates for European/Other children). Factoring in confidence intervals, there was a significant difference in rates of physical punishment for 0–14 year olds by level of neighbourhood deprivation, with rates of physical punishment higher for children in more deprived neighbourhoods, quintile 4 and 5 (Figure 55, Figure 56).

**Figure 54.** Physical punishment in 0–14 year olds, by survey year, New Zealand 2006/07–2018/19

Source: NZ Health Survey (year ending June); Children who received physical punishment in past four weeks (0–14 years)
Children are cherished in modern New Zealand society, as they have been in long-standing traditions of Māori society. Feelings of guardianship and love have been strong foundations for many parent-, whānau- and community-child relationships as people want good relationships with their children and want to protect their welfare. Children have the right to live safe from harm, abuse and neglect.\(^{56,47}\)

It is devastating that child assault, neglect and maltreatment continue to infringe on the rights of children and are serious, international public health issues.\(^{125,126}\) A child’s safety is strongly associated with factors at several different levels, including: the social, cultural and economic context; the community context; the parent and whānau context; and the individual.\(^{127-130}\)

Poverty and inequity and their contextual drivers have a profound impact on factors that protect children from maltreatment.\(^{127-129}\) Systems can find it difficult to provide support that prevents relationships from resulting in child maltreatment and, when child maltreatment does happen, systems can also find it difficult to be a safety net for children and whānau\(^{131-133}\) and to coordinate and deliver responsive support.\(^{129,133-135}\) People at community or whānau levels, when overburdened with the toxicity of multiple stressors while locked in what seems like an impossible situation of
poverty,\textsuperscript{127,136,137} may find they cannot focus on monitoring and safeguarding the welfare of children as much as they want to.

Information on hospitalisations for child maltreatment are the “tip of the iceberg” and such data alone will underestimate the prevalence of how many children are experiencing maltreatment.\textsuperscript{138} Even if a child is being cared for by a hospital, maltreatment-related injuries may be undercounted and some children may be more readily identified with suspected or real maltreatment.\textsuperscript{139,140} Despite these limitations, data on hospitalisations allows for the monitoring of child experiences of maltreatment in a way that can be sensitive and respectful of the privacy of children.\textsuperscript{138}

The following section reviews deaths and hospitalisations of New Zealand 0–14 year olds that involved injuries due to assault, neglect or maltreatment, using data from the National Minimum Dataset and the National Mortality Collection.

\begin{table}[h]
\centering
\begin{tabular}{|c|}
\hline
\textbf{Data sources and methods} \\
\hline
\textbf{Indicators} \\
Deaths from injuries arising from the assault, neglect, or maltreatment of 0–14 year olds \\
Hospitalisations for injuries arising from the assault, neglect, or maltreatment of 0–14 year olds \\
\hline
\textbf{Definitions} \\
Deaths in 0–14 year olds is where intentional injury is a cause of death. \\
Hospitalisations\textsuperscript{*} of 0–14 year olds is where there is a primary diagnosis of injury and an intentional injury (assault) external cause code in any of the first 10 external cause codes.\textsuperscript{7} \\
\hline
\textbf{Data sources} \\
\textbf{Numerator(s)}: Deaths: National Mortality Collection; \\
Hospitalisations: National Minimum Dataset. \\
\textbf{Denominator}: NZCYES Estimated Resident Population (with intercensal extrapolation) \\
\hline
\textbf{Additional information} \\
\textsuperscript{*} As outlined in Appendix 3, in order to ensure comparability over time, all hospitalisations with an emergency department specialty code on discharge were excluded, as were hospitalisations with a non-injury primary diagnosis. \\
\textsuperscript{7} Refer to Appendix 1 for the codes included in this section. \\
\end{tabular}
\end{table}

\textbf{Hospitalisations due to assault, neglect or maltreatment}

There was an overall slight fall in both the number and rate of hospitalisations for injuries arising from assault, neglect or maltreatment of New Zealand children aged 0–14 years from 2009 to 2019. This followed an earlier sharp decline in such hospitalisations between 1990 and 1995 and fluctuating rates from year to year between 1995 and 2009 (Figure 57).

In the five years from 2015–2019 there were 991 hospitalisations of 0–14 year olds for injuries arising from assault, neglect or maltreatment (Figure 58), 401 hospitalisations of girls and 590 of boys. Age-specific hospitalisation rates for injuries arising from assault, neglect or maltreatment were highest in the first year of life, were lower for children between 2 and 10 years of age and increased again for those in their early teens (Figure 58).
Overall, the most common injuries sustained in hospitalisations as a result of assault, neglect or maltreatment were head injuries, including 183 traumatic brain injuries which comprised 18.5% of all hospitalisations for assault, neglect or maltreatment, 136 (13.7%) superficial head injuries and 134 (13.5%) other head injuries.

The nature of the injuries differed by age group. In the period 2015–2019, maltreatment (81 hospitalisations) and traumatic brain injuries (71 hospitalisations) were the most commonly reported diagnoses in children aged under five years. Fractured femoral bones as a result of assault were more common in these youngest children compared with their older peers (Table 6). In the 5–9 year old age group other head injuries, and injuries to the abdomen, lower back, and pelvis were the most common diagnoses (Table 6). Among 10–14 year olds, traumatic brain injuries comprised 20.8% of injuries from assault, and fractures of the skull or facial bones were more common than in other age groups (Table 6).
Table 6. Hospitalisations due to injuries arising from assault, neglect, or maltreatment in 0–14 year olds, by age groups and nature of injury, New Zealand 2015–2019

<table>
<thead>
<tr>
<th>Primary diagnosis</th>
<th>2015–2019 (n)</th>
<th>Annual average</th>
<th>Rate per 100,000 population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault, neglect, or maltreatment hospitalisations of 0–14 year olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>0–4 year olds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injuries</td>
<td>71</td>
<td>14</td>
<td>4.35</td>
<td>20.5</td>
</tr>
<tr>
<td>Superficial head injury</td>
<td>61</td>
<td>12</td>
<td>3.73</td>
<td>17.6</td>
</tr>
<tr>
<td>Fracture skull or facial bones</td>
<td>9</td>
<td>2</td>
<td>0.55</td>
<td>2.6</td>
</tr>
<tr>
<td>Other head injuries</td>
<td>26</td>
<td>5</td>
<td>1.59</td>
<td>7.5</td>
</tr>
<tr>
<td>Injuries to the neck</td>
<td>&lt;5</td>
<td>s</td>
<td>s</td>
<td>s</td>
</tr>
<tr>
<td>Injuries to thorax (including rib fractures)</td>
<td>12</td>
<td>2</td>
<td>0.73</td>
<td>3.5</td>
</tr>
<tr>
<td>Injuries to abdomen, lower back, and pelvis</td>
<td>18</td>
<td>4</td>
<td>1.10</td>
<td>5.2</td>
</tr>
<tr>
<td>Injuries to upper limb</td>
<td>29</td>
<td>6</td>
<td>1.77</td>
<td>8.4</td>
</tr>
<tr>
<td>Fractured femur</td>
<td>6</td>
<td>1</td>
<td>0.37</td>
<td>1.7</td>
</tr>
<tr>
<td>(Other) Injuries to lower limbs</td>
<td>16</td>
<td>3</td>
<td>0.98</td>
<td>4.6</td>
</tr>
<tr>
<td>Maltreatment</td>
<td>81</td>
<td>16</td>
<td>4.96</td>
<td>23.4</td>
</tr>
<tr>
<td>Other injuries</td>
<td>13</td>
<td>3</td>
<td>0.80</td>
<td>3.8</td>
</tr>
<tr>
<td>Total</td>
<td>346</td>
<td>69</td>
<td>21.18</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>5–9 year olds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injuries</td>
<td>10</td>
<td>2</td>
<td>0.66</td>
<td>6.5</td>
</tr>
<tr>
<td>Superficial head injury</td>
<td>16</td>
<td>3</td>
<td>1.05</td>
<td>10.3</td>
</tr>
<tr>
<td>Fracture skull or facial bones</td>
<td>5</td>
<td>1</td>
<td>0.33</td>
<td>3.2</td>
</tr>
<tr>
<td>Other head injuries</td>
<td>26</td>
<td>5</td>
<td>1.71</td>
<td>16.8</td>
</tr>
<tr>
<td>Injuries to the neck</td>
<td>7</td>
<td>1</td>
<td>0.46</td>
<td>4.5</td>
</tr>
<tr>
<td>Injuries to thorax (including rib fractures)</td>
<td>5</td>
<td>1</td>
<td>0.33</td>
<td>3.2</td>
</tr>
<tr>
<td>Injuries to abdomen, lower back, and pelvis</td>
<td>23</td>
<td>5</td>
<td>1.51</td>
<td>14.8</td>
</tr>
<tr>
<td>Injuries to upper limb</td>
<td>18</td>
<td>4</td>
<td>1.18</td>
<td>11.6</td>
</tr>
<tr>
<td>(Other) Injuries to lower limbs</td>
<td>18</td>
<td>4</td>
<td>1.18</td>
<td>11.6</td>
</tr>
<tr>
<td>Maltreatment</td>
<td>20</td>
<td>4</td>
<td>1.31</td>
<td>12.9</td>
</tr>
<tr>
<td>Other injuries</td>
<td>7</td>
<td>1</td>
<td>0.46</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>155</td>
<td>31</td>
<td>10.17</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>10–14 year olds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injuries</td>
<td>102</td>
<td>20</td>
<td>7.06</td>
<td>20.8</td>
</tr>
<tr>
<td>Superficial head injury</td>
<td>59</td>
<td>12</td>
<td>4.08</td>
<td>12.0</td>
</tr>
<tr>
<td>Fracture skull or facial bones</td>
<td>43</td>
<td>9</td>
<td>2.98</td>
<td>8.8</td>
</tr>
<tr>
<td>Other head injuries</td>
<td>82</td>
<td>16</td>
<td>5.68</td>
<td>16.7</td>
</tr>
<tr>
<td>Injuries to the neck</td>
<td>26</td>
<td>5</td>
<td>1.80</td>
<td>5.3</td>
</tr>
<tr>
<td>Injuries to thorax (including rib fractures)</td>
<td>16</td>
<td>3</td>
<td>1.11</td>
<td>3.3</td>
</tr>
<tr>
<td>Injuries to abdomen, lower back, and pelvis</td>
<td>35</td>
<td>7</td>
<td>2.42</td>
<td>7.1</td>
</tr>
<tr>
<td>Injuries to upper limb</td>
<td>61</td>
<td>12</td>
<td>4.22</td>
<td>12.4</td>
</tr>
<tr>
<td>(Other) Injuries to lower limbs</td>
<td>29</td>
<td>6</td>
<td>2.01</td>
<td>5.9</td>
</tr>
<tr>
<td>Maltreatment</td>
<td>13</td>
<td>3</td>
<td>0.90</td>
<td>2.7</td>
</tr>
<tr>
<td>Other injuries</td>
<td>24</td>
<td>5</td>
<td>1.46</td>
<td>4.9</td>
</tr>
<tr>
<td>Total</td>
<td>490</td>
<td>98</td>
<td>33.92</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Numerator: National Minimum Dataset, Denominator: NZCYES Estimated Resident Population

There was a clear social gradient with increasing hospitalisation rates for children living in areas with higher scores on the NZDep2013 index of deprivation. Hospitalisation rates were over nine times higher for children who lived in areas with the highest NZDep2013 scores compared with children living in areas with the lowest scores. There was also inequity by ethnicity, with hospitalisation rates for Māori children nearly three times the hospitalisation rates of European/Other children, and with rates for Pacific children over two times (Figure 59).

Caution should be used when interpreting this information as more data is needed to better understand the disproportionate burden of assault-related hospitalisations by demographic variable and thus identify effective systems and community action to better prevent and intervene in cases of child maltreatment.
Deaths from assault, neglect or maltreatment

From 1990–2017 an average of eight children per year (aged 0–14 years) died from injuries arising from assault, neglect, or maltreatment, a stable rate of around one death per 100,000 children per year. Lower rates in 2002–03, 2012–13 and 2016–17 were not statistically different from the rates in other year-pairs (Figure 60).

In the five years from 2013–2017 there were 27 deaths of 0–14 year olds as a result of assault, neglect or maltreatment. Ten of these deaths were of female children and 17 were of male children. The highest mortality rate from assault, neglect, or maltreatment was observed for infants aged under one year (4 deaths per 100,000 age-specific population). Eleven of the total 27 deaths (41%) occurred in the first year of life, 12 deaths were of children aged 1–4 years, and four were children aged 5–10 years (in these five years there were no deaths from assault of children aged 11–14 years).

Figure 60. Deaths due to injuries arising from assault, neglect, or maltreatment of 0–14 year olds, New Zealand 1990–2017

Indicator: Injuries arising from the assault, neglect, or maltreatment of children (0–14 year olds)
Year is year of death registration.
Care and protection

Oranga Tamariki believes that every child can flourish when they live in an environment that is right for them, surrounded by nurturing adults. One of the key functions of Oranga Tamariki is to work with children and whānau in a situation where there is current or future risk to a child or young person’s welfare. This includes but is not limited to: receiving reports of concern where there is a belief that a child or young person has been harmed or is at serious risk of harm; assessing which of those notifications require further action; working with whānau to build a safer environment at home; and, in cases where it is not considered possible for a child or young person to remain at home, Oranga Tamariki will organise new care arrangements for the child or young person so they can continue to grow up safely.

This section on care and protection provides information on children and young people from Oranga Tamariki data. The section reports on care and protection notifications, investigation assessment outcomes and their substantiated findings, and children and young people in the custody of the Chief Executive.

Data sources and methods

Indicator
Care and protection notifications requiring further action
Investigation assessment outcomes of children and young people notified to Oranga Tamariki
Substantiated findings of abuse in children and young people notified to Oranga Tamariki
Children and young people in the custody of the Chief Executive (CE)

Data source
Oranga Tamariki

Further information
For more information on Oranga Tamariki data please refer either to the Oranga Tamariki website https://www.orangatamariki.govt.nz/, or to the data source appendix in this report.

Figure 61 presents an overview of the number of care and protection notifications for children and young people from 2003/04 to 2019/20 and also presents the proportion of care and protection notifications that required further action from Oranga Tamariki, as assessed by a social worker.

Figure 61. Care and protection notifications and proportion requiring further action, New Zealand 2003/04–2019/20

![Figure 61](image_url)
The total number of Reports of Concern varied from year-to-year from 2010/11–2019/20. In 2019/20 Oranga Tamariki received 80,928 Reports of Concern for 58,588 individual children (Figure 62). A child or young person may have more than one notification for each year.

Figure 62. Reports of Concern and distinct children with Reports of Concern, New Zealand 2010/11–2019/20

Figure 47 shows, from 2003/04–2019/20, the outcomes from investigation assessments (abuse, non-abuse, and not found), and the type of abuse where abuse was substantiated through investigations.

In 2019/20 there was a ‘not found’ outcome for 55% of investigations, abuse was substantiated in 38%, and in the remaining 7% there was a ‘non-abuse’ outcome. The majority of non-abuse outcomes are findings of “behavioural relationship difficulties”.

Since 2005/06 the most common type of substantiated abuse has been emotional abuse. In 2019/20, emotional abuse was found in 51% of substantiated cases, neglect in 22%, physical abuse in 20%, and sexual abuse in 7%.
In 2019/20 there were 5,964 children and young people in custody of the Chief Executive (CE) (Figure 64). The number of children and young people in CE custody increased between 2016 and 2018, partly due to extending the age that young people can remain in care.

In 2019/20, children and young people who identified as of Māori ethnicity represented nearly 6 in 10 children and young people in CE custody. A number of current and recent reviews and inquiries highlight areas for urgent improvement in the care and protection system to improve outcomes for tamariki, rangatahi and whānau Māori.

Figure 64. Children and young people in the custody of the Chief Executive (CE), New Zealand 2012/13–2019/20

Source: Oranga Tamariki.
Years ending June. “Individuals” pertains to children and young people.
**Discussion: Impact of COVID-19 on child safety**

COVID-19 lockdown saw reports of family violence spike. During level 4 to level 2, the number of family harm incidents reported ranged from 345 to 645 a day, compared to between 271 and 478 in the same period in 2019. While reports of family violence increased, reports of concern to Oranga Tamariki saw a 24% decrease during lockdown. This may in part be due to teachers, doctors and other external agencies were not being able to provide the community insight that helps keep children safe during lockdown.146 Children access a lot of safety, security and routine at school, which was absent during lockdown.

Protection orders issued in the Auckland region during Level 4 were down 29 per cent on the previous year, due to the reduced operation of the Family Courts and the initial difficulties victims had accessing lawyers. Family Court responded quickly, with legislation changed to allow people to file affidavits unsworn. For those children where violence is present in the home, lockdown would have likely increased their exposure to violence.146

Some community services are suggesting there is a lag in demand for additional supports, and that the impact of COVID-19 on child safety is only now becoming apparent.

**Good opportunities for learning**

Education provides important foundations for children’s quality of life, health-related decisions, future employment opportunities, and access to continuing education.116 Legislative and policy decision-making have a role in ensuring children are not preoccupied with any stress about hardship, so they instead have the mental and emotional bandwidth for achieving, exploring, and learning in educational opportunities that are inclusive and empowering. This section on Good opportunities for learning provides an indication of how Aotearoa is performing in encouraging young people to pursue academic interests and invest in goals through schooling.

Educational opportunities that are welcoming, uplifting and culturally respectful provide children with the good environments for learning.2 Unfortunately, many young people are not experiencing education in ways that make them feel cared about and encouraged to participate.2 A need to focus on survival and managing shortage of resources can drain the mental and emotional energy that children and young people would otherwise direct towards the interests, connections, and aspirations that are of meaning to them.27 Cycles of hardship may make children feel “that there are things in life that are beyond their reach, that are not for them, and they are already feeling it in ways that make them burn inside.”20

Participation in education is a fundamental right of every child.47 Children want to have ‘good lives’ where they are enjoying, achieving, feeling valued, and making positive contributions to their life journeys and to the world around them.2,134 Where educational opportunities are inclusive and provide a culture in which individuals can see themselves thriving and succeeding, and larger environmental factors alleviate any burden and stress on growing minds, children can better involve themselves in what schooling has to offer.2

New Zealand’s National Certificate of Educational Achievement (NCEA) is comprised of three tiers of achievement, NCEA Levels 1, 2 and 3, while a University Entrance award is also made available as a minimum requirement for a direct pathway into tertiary education from high school.147 For those who leave school, a Level 2 qualification continues to be the recommended educational attainment.148 Achieving a qualification of NCEA Level 2 or higher helps develop in school leavers foundations and readiness to transition into employment and learning pathways.147,148 Level 1 has been retained in the curriculum so that those who leave school with it as their highest level qualification can continue to gain value from it as a record of achievement.148 With this in mind, work is planned so as to enhance the content and learning value of Level 1 to those young people who will leave school before obtaining other Levels.148

The following section presents Ministry of Education information on the educational attainment of school leavers from 2009–2019.
An increasing proportion of young people in Aotearoa left school having achieved an NCEA or equivalent qualification from 2009 to 2017 with a slight decline from 2017 to 2019 (Figure 65).

The proportion of young people who achieved the recommended Level 2 NCEA qualification or above before leaving school saw the steepest increase of all qualifications, rising from 68% of people leaving school in 2009 to 79% in 2019. Over the same period, the proportion of young people who achieved Level 1 or above before leaving school has increased from 81% in 2009 to 88% in 2019, while the proportion achieving the University Entrance award from 37% to 39%. Since 2009, Aotearoa saw a decreased percentage of young people leaving before having obtained an NCEA qualification, from 19% in 2009 to 10% in 2017 and increased to 12% in 2019.
Inequities continue to be seen in educational attainment by ethnicity and by school socioeconomic quintile. The Ministry of Education notes that there is considerable variation in achievement rates within each quintile. A higher proportion of students in some schools in the lowest quintiles achieve qualifications at NCEA Level 2 than in some of the highest quintile schools. The issue is arguably not the background of students but the importance of creating an environment where they can thrive.

For every qualification, young people of all ethnic groups saw overall increases in the proportion of who achieved qualifications before leaving school (Figure 66). Between 2009 and 2017, there was an increase in the proportion of students achieving NCEA Level 2 or higher across all ethnic groups, most marked for Māori and Pacific students (Figure 66). In 2017, compared with 2009, an additional 23% of Māori and 20% of Pacific young people achieved Level 2 NCEA and a further 18% and 6% respectively (Figure 66).

For young people who have left school before having obtained an NCEA qualification, there has been a decrease overall for all ethnic groups over the past decade (Figure 66).

From 2017 to 2019, there was an apparent decrease in the proportion of students achieving the NCEA Level 2 qualification and an increase in the proportion leaving school before obtaining Level 1. More data is needed to understand if this is an ongoing trend.
School quintile 1 includes the 20% of schools with the highest proportion of students from low socioeconomic communities; school quintile 5 comprises the 20% of schools with the lowest proportion of students from low socioeconomic communities. The ranking of school socioeconomic quintiles is in the opposite direction to that of the NZDep2013 index of deprivation used with health data in this report.

The proportion of young people leaving school having achieved a NCEA qualification was higher in schools where students were from communities of lower socioeconomic disadvantage (were in higher quintile schools) (Figure 67).

In 2019, the proportion of students who left school before obtaining an NCEA qualification was higher in schools which have students from communities with the highest degree of socio-economic disadvantage (low quintile schools) (Figure 67). Of those young people in school communities with highest degree of socioeconomic disadvantage, 78% achieved Level 1 before leaving school and 65% achieved Level 2; while 96% of those at schools with the lowest degree of socioeconomic disadvantage achieved Level 1 and 91% achieved Level 2.

In the highest quintile schools 4% of young people left school without achieving an NCEA qualification, compared with 21% in the lowest quintile schools (Figure 67).

Figure 67. School leavers in school socioeconomic quintile, by qualification and by deprivation quintile, New Zealand 2019

From 2011–2019 an increasing number of children and young people in Aotearoa attended school regularly (attended more than 90% of Term 2), from 299,474 to 423,999 students (Figure 68). School enrolment increased over this time; the proportion of all students who attended school regularly in Term 2 was fairly stable at around 69% from 2011–2015 and has since declined to 58% in 2019 (Figure 68).
Between 55% and 63% of children in school years 1 to 9 attended regularly in 2019 (Figure 69). Regular school attendance was lower for students in school years 10–12 (50–55%) and lower again for students in Year 13 (41% of female students and 45% of male students).

Students of all ethnic groups and across school deciles saw overall decreases in the proportion of those who attended school regularly from 2015–2019 (Figure 70, Figure 71). School decile 1 includes the 10% of schools with the very highest proportion of students from low socioeconomic communities; school decile 10 comprises the 10% of schools with the very lowest proportion of students from low socioeconomic communities.

Inequities in regular school attendance by ethnicity and by school socioeconomic quintile have persisted over time (Figure 70, Figure 71). Inequities by school decile appear to be increasing between students in school decile 1 and students in school decile 10 (Figure 71).
Discussion: Impact of COVID-19 on children and young people’s learning

COVID-19 lockdown presented a digital challenge for households where internet access and access to devices was not sufficient to support online learning. The Ministry of Education in July estimated that this affected 145,000 school students in 40,000 households. A study of children shortly after lockdown found that 63% of children had their own device and 22% had to share their device during lockdown. Only 74% had access to sufficient data. Tamariki and rangatahi Māori were more likely to not have any access to a device. This ‘digital divide’ in access existed prior to the pandemic, but the need for online learning as a result of lockdown heightened awareness of its impact on children and young people.

As part of its support the Government earmarked much of an $87.7 million COVID-19 education package to give computers and free six-month internet packages to 82,000 homes with school-aged children that were not online when the country went into lockdown. For many the Governments scheme to provide additional support came too late or schools received support for students that didn’t need it.
Māori students were impacted further, teachers in Māori medium schools reported shortfalls in Te Reo hard copy packs. In research undertaken by Ngāti Whātua Ōrākei, kaiko te reo packs were reported arriving much later than mainstream ones and being less educationally challenging. Iwi also distributed 400 Chromebooks, filling a gap left by the Ministry of Education’s device distribution programme.

Following lockdown schools reported that some children were not returning to schools. Concerns about health and safety at school, income pressures at home, and moving away from the area as a result of COVID-19 related job loss or change, have all contributed to this. Recent reports have highlighted the mounting responsibility that some young people have taken to support their families at this time. Manurewa High School principal Pete Jones claimed that about 10 per cent of his school roll – more than 100 students – had failed to return at the end of the first lockdown, with most dropping out to work to contribute to their families, as adults in their homes lost jobs or hours as a result of the stalled economy.
Resources to thrive

Creating an environment that supports vibrant communities, which drives healthy economies, is important for providing the resources children and young people need to thrive. This chapter is closely related to having adequate income to meet the needs of the family or whānau.

Employment and labour environments are influenced by complex pathways that are often beyond the immediate control of the children themselves or that of their families.68,157 Governmental and policy decisions have power and a responsibility to create a funding and regulatory environment that enables community vibrancy and cohesion through good jobs with good wages, supports economic growth, and supports greater equality.55

A rise in the unemployment rate is associated with a wide range of adverse outcomes for all children and young people in a community, not just those whose parents lose employment.158 An increasing gap between the average hourly income and economic productivity is an indication that the income gains that workers take home has been decreasing.159

This chapter considers:

- Good work
- Good hourly earnings
- Adequate financial assistance
- Discussion of the impacts of COVID-19 on resources to thrive

Good work

‘Good’ work means that there is a fair balance of rights and responsibilities, a safe working environment and healthy workplace culture where everyone has a baseline of protection, and scope for people to develop new skills and progress in their work.160,161 Good work can increase worker participation, productivity, community vibrancy and social cohesion, and overall economic performance.162 At an individual level, good quality, meaningful work improves wellbeing as well as general and mental health for most people.160,162 Low quality opportunities for work can push people out of the labour market or push people into work that does not fully utilise their skills and experience, leading to reduced wellbeing and productivity.161

Both unemployment and underutilisation labour statistics are important to getting a picture of the economy and workforce in Aotearoa.163 The unemployment rate provides a picture of the economy overall, reflecting the conditions of the labour market and the number of people seeking work.164 A rise in the unemployment rate is a key marker of an economic downturn that stresses the strength and social cohesion of communities,28,158 with effects on a wide range of outcomes for all children and young people – not only for those directly affected by job loss within their own household.158
Underutilisation is a broader concept than unemployment rate, and gives an indication of the unrealised potential in the labour market. “Underutilisation” in the workforce is calculated from those people who are in the following categories: are unemployed, are underemployed and are in the potential labour force. People who are working part-time hours and would like to work more hours (and are available to do so) fall into the “underemployment” category. Where the “potential labour force” is discussed, it refers to both those people who are not actively seeking work but do want a job and are available for an opportunity, and also those people who are actively seeking work are will be available to work in the next four weeks (but not currently). The underutilisation rates can provide an indication of any unmet need for good work and can suggest any shortfalls in the market with regards to creating good employment opportunities and with regards to supporting how easy and accessible it is for people to find and secure good work. Hours-underemployment is associated with worker and community psychological distress and dissatisfaction, and can indicate a sense of financial strain among workers or stressed economic circumstances among families, the impacts of which are felt by children. An increase in the rate of underutilisation also has implications for a country’s overall productivity and growth.

The following section is a review of unemployment from 1986–2020 and underutilisation from 2004–2020 using data from the Stats NZ Household Labour Force Survey.

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**Unemployment rate**

- **Numerator(s):** The number of people unemployed.
- **Denominator:** The total number of people in the labour force.

**Underutilisation rate**

- **Numerator(s):** The number of people underutilised (that is: the sum of the number of people unemployed, under employed, and in the potential labour force).
- **Denominator:** The total number of people in the extended labour force (that is: the sum of the number of people in the labour force and the number of people in the potential labour force).

**Definitions**

**Unemployed:** all people in the working-age population who, during the reference week, were without a paid job, available for work, and had either actively sought work in the past four weeks or had a new job to start within the next four weeks.

**Unemployment rate:** number of unemployed people expressed as a percentage of the labour force.

**Working age population:** usually resident, non-institutionalised, civilian population of New Zealand aged 15 years and over.

**Underutilised:** sum of those unemployed, underemployed, and in the potential labour force.

**Potential labour force:** people who are not actively seeking work but are available and wanting a job, and people who are actively seeking but not currently available for work, but will be available in the next four weeks.

**Underemployment:** people who are in part-time employment who would like to, and are available to, work more hours.

**Underutilisation rate:** number of underutilised people expressed as a proportion of those in the extended labour force.

**Extended labour force:** people in the labour force, or in the potential labour force.

**Actively seeking work:** 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.

**Additional information**

When seasonal adjustment program is run each quarter, all previously published figures are subject to revision. 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.

For information on the Household Labour Force Survey, see Stats NZ’s DataInfo+ for an overview.
In the June quarter of 2020, there were 111,000 New Zealanders who were officially unemployed, or 4% of all people in the labour force. The seasonally adjusted unemployment rate remained under 6% since March 2013, and below 5% since March 2017. Looking back over the past 30 years the highest observed unemployment rate was 11.2% in the September quarter of 1991 and the lowest rate was 3.3% in December 2007 (Figure 72).

Unemployment rates, in absolute terms, differ by age, with the highest rates consistently observed for young people aged 15–19 years. In the year to June 2020, the unemployment rate for young people aged 15–19 years was 16.7% compared with rates less than 3% for adults aged 35 years and over (Figure 73). While the unemployment rate is highest for the youngest working-age population, a high proportion of this age group is engaged in education or training. However, there were 30,100 young people aged 15–19 years (9.6% of the total youth working-age population) who were not in employment, education or training in the year to June 2020. For all 15–24 year olds, there were 79,500 young people not in employment, education or training (NEET). This number of young people not in employment, education or training is still higher than the number of people unemployed in other age groups, including a number of 23,000 for 25–34 year olds to a number of 12,100 for 55–64 year olds during the same period.

Figure 72. Unemployment numbers and rates (seasonally adjusted) by quarter, New Zealand 1986–2020

Figure 73. Unemployment rates by year, by selected age groups, New Zealand 1987–2020 years ending June
Unemployment rates by ethnicity show persistent inequity between ethnic groups which worsened after 2007. In June 2020, the unemployment rate for Māori was 6.7% and for Pacific peoples 6.4% compared with 3.3% for the European ethnic group (Figure 74).

The underutilisation rate includes persons underemployed (in part-time employment and would like to work more hours and are available) and in the potential labour force (people who are not actively seeking work but are available and wanting a job, or who are actively seeking work and although not currently available, will be available for work in the next four weeks), as well as those people officially unemployed. In June 2020, there were 346,000 New Zealanders seeking additional hours of work, actively seeking work but not available in the next week, or available but not actively seeking work (Figure 75).

The underutilisation rate increased following the 2008 global financial crisis and remained high although falling slowly (Figure 75). During the global pandemic of 2020, there has been an increase in the national underutilisation rate.

Ethnicity is total response

* Rates are seasonally adjusted
Analysis by Stats NZ showed that from 2004–2016 unemployment and underutilisation data followed similar patterns over time with the underutilisation rate much higher than the unemployment rate. In the June 2016 quarter, underutilisation and unemployment rates followed the same pattern across the ethnic groups; Māori and Pacific people experienced the highest underutilisation and unemployment rates of all ethnic groups. The highest underutilisation rate in the June 2016 quarter was observed for 15–19 year olds (over 45%). The 15–19 and 20–24 year old age groups had the highest numbers and rates of underemployment, unemployment, potential labour force, and underutilisation.165

Since 2010, there has been a wider gap in the underutilisation rate for women when compared to men, with women experiencing a consistently higher rate of underutilisation (Figure 76). While there has been a narrowing of this gap in rates in recent years, it has widened again between March and September 2020, when 48,000 more women and 36,000 more men became underutilised.172.

Most of the 2020 increase in the underutilisation rates for women and men was driven by a large number of people becoming underemployed during the global COVID-19 pandemic. Reduced hours of work may have contributed to the rise in underemployment where people would have liked to work more hours and were available to do so (Figure 77).
Good hourly earnings

The gross domestic product (GDP) is the official measure of economic growth in New Zealand and provides a snapshot of economic performance. Economic policy changes in the decade from 1984–1994 successfully halted a decline in GDP per capita, and also contributed to large increases in income inequality and poverty. In most OECD countries over the last three decades growth in real wages has fallen behind growth in productivity; this indicates that “labour’s share” of the income gains from productivity growth has been falling. Key drivers of this disparity include rapid technological change, globalisation and decreases in labour’s bargaining power.

This section compares growth in GDP with average hourly earnings using data from Stats NZ. Since 1989, both GDP and average hourly earnings have increased in New Zealand. The increase in GDP has been steeper than the increase in earnings received by workers. In 2017 dollar, real GDP per capita increased by 56% from $37,500 in March 1989, to $59,000 in June 2019, while real average ordinary time hourly earnings increased by 30% from $24.07 to $31.37 during the same period (Figure 78).

Figure 78. Real gross domestic product (GDP) per capita and real average ordinary time hourly earnings, New Zealand 1989–2019

Source: Stats NZ

Adequate financial assistance

Poverty is complex and inextricably linked to the environmental factors in which it operates. In ways beyond the immediate control of children and their whānau, the socio-political landscape impacts on whether whānau have adequate opportunities and safety nets offered to them that ensure their adequate access to resources. Governments have a responsibility to safeguard the access children and whānau have to resources by ensuring they can access financial assistance programmes when needed.

The Government’s vision for the New Zealand social security system is that it include an adequate income and standard of living for people and families, that people be treated with and can live in dignity, and that people be able to participate meaningfully in their communities. Children included in households that receive financial assistance are more likely than other children to live in income-poor households and to experience material deprivation. Kia Piki Ake (the Welfare Expert Advisory Group) found evidence that the current levels of main benefits are well below the level necessary for an adequate standard of living, and do not meet the level required for even modest participation in society. Even modest levels of spending on essential items like food, electricity and housing leave many households receiving income-support with total expenditure greater than their income entitlements. Government policies in areas such as access to, and value of, income support benefits have substantial effects on household incomes for families dependent on benefit payments.

Kia Piki Ake stated in their report:
The Government must urgently increase the incomes of people in receipt of a benefit and in low-wage work and maintain these increases over time so that they keep pace with the incomes of the rest of the community. It must also reduce the barriers to people accessing this support and commit to a social security system where people are treated with dignity.

The following section uses data from the Ministry of Social Development to review the proportion of children included in recipients of financial assistance. The Ministry of Social Development provides financial assistance to eligible households through income replacing financial assistance, non-benefit/non-income-replacing financial assistance (e.g. Working for Families tax credits) and through emergency payments or grants. This section focuses on those 0–17 year olds who are included as recipients of non-emergency financial assistance and emergency hardship assistance, hardship assistance provided across Aotearoa, and young people directly receiving financial assistance.

**Data sources and methods**

**Indicator**

Number of 0–17 year olds included in recipients of financial assistance, by type of assistance

**Data sources**

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<th>Denominator</th>
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<tr>
<td>Number of 0–17 year olds included in recipients of financial assistance</td>
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**Definitions**

*Main benefits* (up to June 2013) include: Domestic Purposes Benefit (DPB)-Care of Sick and Infirm, DPB- Woman Alone, Emergency Benefit, Independent Youth Benefit, Youth Payment, Young Parent Payment, Unemployment Benefit Training and Unemployment Benefit Training Hardship, Unemployment Benefit Student Hardship, Widow’s Benefit.

*Main benefits* (from June 2014 onwards) include: Jobseeker Support, Sole Parent Support, and Supported Living Payment

*Other benefits* (from June 2014 onwards) include: Emergency Benefit, Youth Payment, Young Parent Payment, and Jobseeker Support Student Hardship.

Financial assistance is not always *income-replacing*. Financial assistance can be provided by the government for people experiencing financial stress in a way that is in addition to a person’s benefit or in addition to their working income. Assistance not intended to replace income includes but is not limited to: Unsupported Child’s Benefit and Orphan’s Benefit and Non-Beneficiary Assistance/Non-Benefit Assistance.

*Non-benefit financial assistance* is assistance provided to those who are not beneficiaries, such as accommodation supplements.

*Hardship Assistance* is the term used to describe emergency grants and one-off payments. The two main types of payment are Special Needs Grants (non-recoverable) and Advance Payments (also known as Recoverable Assistance Payments).

**Additional information**

All figures are as at the end of June. The number of children in recipients of financial assistance as at the end of June provides no information on the number receiving assistance at other times of the year. The data count children, not clients. An adult client who has more than one child included in their financial assistance will have their financial assistance counted more than once.

Three new benefits were introduced in a welfare reform and implemented from July 2013, which replaced many of the previously existing benefits, and changed the eligibility criteria for financial assistance. The benefits up to data as of June 2013 are not directly comparable to the benefits on and after June 2014. The welfare reform changes have been described at Changes to benefit categories from 15 July 2013 – Ministry of Social Development and Benefit Fact Sheets – Ministry of Social Development.

To be eligible for financial assistance, clients must have insufficient income from all sources to support themselves and any dependents, and meet specific eligibility criteria. Information about current eligibility criteria can be found at Check what you might get – Work and Income.
Children included in financial assistance

In the year ending June 2020, over a quarter of a million children aged under 18 years were living with a recipient of government-provided financial assistance (Figure 79), which was over a quarter of all children in the age group (Figure 80). For nearly 200,000 children living with a recipient of financial assistance, the assistance provided was income-replacing (Figure 79). Within the time frame of Figure 80, the highest rate of income-replacing financial assistance was seen in 2000 (26% of under-18 year olds). The proportion of children in households receiving assistance declined from 2000 to 2008, rose between 2008 to 2010 following the global financial crisis, declined again until 2018 and increased from 2018 to 2020 (Figure 80). Overall, the number and percentage of 0–17 year olds who were included in recipients of income-replacing assistance declined from 271,463 (26% of all children in this age group) in June 2000 to 196,473 (18% of all children in this age group) in June 2020 (Figure 80).

While the proportion of children included on income-replacing assistance was lower in 2020 than in 2000, there has been an overall increase in the proportion of children living with someone receiving financial assistance that was in addition to their income (i.e. was not income-replacing) (Figure 80). Of the children included in assistance that was not income-replacing, most were living with a person receiving Non-Beneficiary Assistance such as accommodation supplement (80%), with the remainder living with recipients of the Unsupported Child’s Benefit or Orphan’s Benefit.

In June 2020, most 0–17 year olds included in income-replacing assistance were living with a recipient of Sole Parent Support (65%), with the remainder living with recipients of Jobseeker Support (25%), Supported Living Payments (9%) or Other Main Benefits (less than 2%) (Figure 81).

Figure 79. Number of children aged 0–17 years included in recipients of financial assistance, by assistance category, New Zealand as at end of June 2020

Figure 80. Children aged 0–17 years included in recipients of financial assistance, by assistance category, New Zealand as at end of June 2000–2020
Figure 81. Children aged 0–17 years included in recipients of income-replacing financial assistance, by selected type of assistance, New Zealand as at end of June 2000–2020

Figure 82 presents the children included in financial assistance as a proportion of all children in that year of age. The percentage of children who were included in recipients of financial assistance reduced with increasing age, from 25% of children aged one year to 15% of children aged 17 years. The percentage of children living with a recipient of Sole Parent Support declined with increasing age from around 13% of 1–8 year olds to fewer than 5% of 15–17 year olds. While there was a decrease in the proportion of children living with a recipient of Jobseeker Support by increasing age, 15–17 year olds more commonly lived with a recipient of Jobseeker Support than their younger peers. For 15–17 year olds, the percentage of children reliant on a recipient of Sole Parent Support was lower than the percentage of children reliant on recipients of Jobseeker Support (Figure 82). The proportion of children living with a recipient of Non-Beneficiary Assistance increased with increasing age up to 11 years before decreasing for older children.

At 30 June 2020 there were 78,141 children aged under 18 years included in recipients of Non-Beneficiary financial assistance. Non-Beneficiary financial assistance is a type of assistance that is not income-replacing and is targeted to supporting low-income earners. Children included on this type of assistance...
assistance lived in households not eligible for income-tested main benefits because one or more adults in the household were employed. The household income was below the income threshold for supplementary assistance such as Accommodation Supplement, Disability Allowance or Child Care Subsidy. In the year ending June 2000, around 13% of all children were included in Non-Beneficiary financial assistance, which increased steeply from 2005 to 2007 to around 25% of children. Since 2015, 27–28% of 0–17 year olds have been included in recipients of Non-Beneficiary financial assistance each year.

There are times when parents cannot care for a child, due to family breakdown or serious long-term health conditions, and times when parents have died or cannot be found. In these circumstances the child may be included as a recipient of the Unsupported Child’s Benefit or the Orphan’s Benefit, which is assistance paid to adults who are caring for someone else’s children. These types of non-income-replacing financial assistance are not income-tested; a child could be included in both income-replacing assistance or supported by a caregiver’s working income and also receive an Orphan’s Benefit/Unsupported Child’s Benefit. Although these benefits make up a very small proportion of all financial assistance provided by the Government, there has been an increase in the number and percentage of 0–17 year olds included in recipients of orphan’s benefit and unsupported child’s benefit from 7,419 (0.7% of children in this age group) in 2000 to 19,131 (2% of children in this age group) in 2020.

**Hardship assistance**

Hardship assistance is available for people with insufficient income and assets, who have immediate and specific needs that cannot be met by their own resources. Hardship assistance can be provided for several reasons so to help people make ends meet, including for electricity and gas bills, school education costs, driver license costs, essential costs for people affected by benefit stand-downs, medical and health-related costs, food costs, and accommodation bills.

The number of hardship grants provided per quarter decreased slightly between 2011 and 2012, was stable from 2012 to 2017 and then increased substantially from 2018 through to 2020 (Figure 83). These data reflect the number of hardship grants and not necessarily the number of individuals (one individual may receive more than one hardship grant).

Trends for hardship assistance are affected by the degree of underlying need and by operational policy and practice within the Ministry for Social Development. An increase in hardship grants could be indicative of greater ease of access and could also be indicative of socio-economic factors pushing people into situations where their income, assets and current government and community assistance are not sufficient to meet immediate and unavoidable costs for essentials. More data is required to understand the apparent change and ascertain its relationship to need.

**Figure 83.** Hardship assistance provided, by financial year (ending March), New Zealand 2011–2020

![Figure 83](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAIgAAADECAIAAADc9XW5AAABjSURBVHjaIAAAAAA....)
A total of 1.5 million grants for hardship assistance were provided in the quarters of the financial year ending March 2019, and 2.2 million grants in the year ending March 2020 (Table 7).

In recent years, MSD has provided a steeply increasing number of hardship assistance where people have had immediate needs for food but no way of paying for it (Figure 84). Over one million grants were provided for food hardship in the year ending March 2020 compared with just over 346,700 in 2014 (Figure 84).

The provision of hardship assistance has increased since 2017 for where people are experiencing hardship in trying to cover essential accommodation-related costs or covering required emergency housing (Figure 84, Table 7). In the most recent financial year (ending March 2020), 122,330 grants provided assistance for accommodation hardship and 115,922 for emergency housing (Table 7).

Housing-related hardship grants (including accommodation-related costs and emergency housing) comprise the largest dollar cost spent to help people pay for necessary and unaffordable costs (Figure 85, Table 8). Low-income households required $266.7 million in the year ending March 2020 to help pay rent or to pay their mortgage (for example), through hardship assistance grants. A total amount of $178.1 million was paid to needed emergency housing (Table 8). Together, the accommodation related and emergency housing grants represented 41% of the total amount spent on hardship assistance in 2019/20 (Table 8), reflecting the precarious nature of housing affordability for many New Zealand households. Since 19 October 2020, the emergency housing grant has been partly recoverable with recipients who occupy emergency housing for more than seven nights required to make an emergency housing contribution of 25% of their income.182

In Aotearoa, most entitlements (also known as ‘benefits’) have a stand-down period of one or two weeks where an individual will not be provided with any money from that entitlement.183 The assistance provided to people who are already in hardship and are affected by a stand-down period in a way that they have immediate costs they cannot pay for has nearly doubled since 2015. A total of 36,800 grants over the 2020 financial year were provided to help people affected by stand-down periods (Table 7). The costs of hardship assistance in stand-down periods was over $4 million in 2019/20 (Table 8).

In the year ending March 2020 there were over 50,433 hardship grants for electricity or gas costs, up from 24,594 grants in 2015 (Table 7). These grants cost just over $19 million in the most recent year (Table 8). The Families Package includes a winter energy payment for households where the main income is from government assistance.73 When the impact of COVID-19 first hit, the Government set out a $12.1 billion dollar support package for New Zealanders and business. This included an increase to benefits by $25 and doubled the Winter Energy Payment. The full effects of this package will not be evident until the 2021 reporting year.22

School education costs were another reason for needing hardship assistance that has changed since 2011, decreasing overall from 2011 to 2016 (37,655 to 26,927) and then nearly doubling by 2020 to around 52,200 (Figure 85) at a cost of almost $13 million in 2019 (Table 8).
Table 7. Hardship assistance provided, by financial year and by reason, New Zealand 2015–2020

<table>
<thead>
<tr>
<th>Reason</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>Total number of hardship assistance provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>361,581</td>
<td>372,714</td>
<td>426,453</td>
<td>518,324</td>
<td>675,894</td>
<td>1,120,733</td>
<td></td>
</tr>
<tr>
<td>Accommodation Related</td>
<td>97,106</td>
<td>95,335</td>
<td>104,869</td>
<td>106,619</td>
<td>113,068</td>
<td>122,330</td>
<td></td>
</tr>
<tr>
<td>Medical and Associated Costs</td>
<td>72,533</td>
<td>69,850</td>
<td>73,663</td>
<td>75,571</td>
<td>83,782</td>
<td>92,006</td>
<td></td>
</tr>
<tr>
<td>People Affected by Benefit Stand Downs</td>
<td>15,868</td>
<td>19,887</td>
<td>29,569</td>
<td>38,635</td>
<td>41,257</td>
<td>36,875</td>
<td></td>
</tr>
<tr>
<td>Electricity and Gas</td>
<td>24,594</td>
<td>21,584</td>
<td>26,623</td>
<td>30,657</td>
<td>38,696</td>
<td>50,433</td>
<td></td>
</tr>
<tr>
<td>School Education Costs</td>
<td>28,772</td>
<td>26,927</td>
<td>32,268</td>
<td>32,243</td>
<td>52,171</td>
<td>52,211</td>
<td></td>
</tr>
<tr>
<td>Re-establishment Grants</td>
<td>10,051</td>
<td>10,344</td>
<td>11,769</td>
<td>12,524</td>
<td>12,562</td>
<td>12,756</td>
<td></td>
</tr>
<tr>
<td>Driver Licence</td>
<td>10,000</td>
<td>10,494</td>
<td>11,872</td>
<td>12,206</td>
<td>14,455</td>
<td>14,852</td>
<td></td>
</tr>
<tr>
<td>Health Related</td>
<td>6,044</td>
<td>5,895</td>
<td>7,003</td>
<td>8,284</td>
<td>9,725</td>
<td>11,311</td>
<td></td>
</tr>
<tr>
<td>Long-Acting Reversible Contraception</td>
<td>229</td>
<td>180</td>
<td>151</td>
<td>210</td>
<td>95</td>
<td>..</td>
<td></td>
</tr>
<tr>
<td>Emergency Housing Grant</td>
<td>..</td>
<td>..</td>
<td>18,078</td>
<td>32,915</td>
<td>56,202</td>
<td>115,922</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>195,550</td>
<td>199,341</td>
<td>265,707</td>
<td>299,696</td>
<td>427,338</td>
<td>601,766</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>822,328</td>
<td>832,551</td>
<td>1,008,025</td>
<td>1,167,884</td>
<td>1,523,235</td>
<td>2,231,195</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ministry of Social Development. Year is financial year (ending March). An individual may have >1 grant per quarter.

Figure 85. Dollar amount spent on provided hardship assistance, by financial year and by selected reason, New Zealand 2016–2020

Source: Ministry of Social Development. Year is financial year (ending March). Total dollar amount of selected hardship assistance provided in each quarter. An individual may have >1 grant per quarter.
Table 8. Dollar amount spent on provided hardship assistance, by financial year and by reason, New Zealand 2015–2020

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total dollar amount spent on provided hardship assistance</td>
<td>38,051,623</td>
<td>39,811,435</td>
<td>45,241,879</td>
<td>53,918,827</td>
<td>70,350,953</td>
<td>108,826,942</td>
</tr>
<tr>
<td>Food</td>
<td>52,474,162</td>
<td>53,681,036</td>
<td>62,493,317</td>
<td>65,648,672</td>
<td>75,093,438</td>
<td>88,528,336</td>
</tr>
<tr>
<td>Accommodation Related</td>
<td>26,154,220</td>
<td>25,392,620</td>
<td>27,849,002</td>
<td>29,458,953</td>
<td>33,862,808</td>
<td>37,590,498</td>
</tr>
<tr>
<td>Medical and Associated Costs</td>
<td>1,996,579</td>
<td>2,118,706</td>
<td>3,278,804</td>
<td>4,358,914</td>
<td>4,558,978</td>
<td>4,171,103</td>
</tr>
<tr>
<td>People Affected by Benefit Stand Downs</td>
<td>10,392,012</td>
<td>9,971,356</td>
<td>12,390,637</td>
<td>13,368,071</td>
<td>16,141,096</td>
<td>19,011,428</td>
</tr>
<tr>
<td>Electricity and Gas</td>
<td>5,671,356</td>
<td>5,955,628</td>
<td>6,932,524</td>
<td>7,014,935</td>
<td>12,071,585</td>
<td>12,787,064</td>
</tr>
<tr>
<td>School Education Costs</td>
<td>3,427,252</td>
<td>3,950,209</td>
<td>4,094,322</td>
<td>4,300,174</td>
<td>4,325,375</td>
<td>4,395,897</td>
</tr>
<tr>
<td>Re-establishment Grants</td>
<td>1,032,072</td>
<td>1,074,154</td>
<td>1,213,379</td>
<td>1,239,874</td>
<td>1,248,535</td>
<td>1,474,222</td>
</tr>
<tr>
<td>Driver Licence</td>
<td>519,499</td>
<td>524,315</td>
<td>645,398</td>
<td>721,655</td>
<td>875,652</td>
<td>958,425</td>
</tr>
<tr>
<td>Health Related</td>
<td>1,696,579</td>
<td>2,118,706</td>
<td>3,278,804</td>
<td>4,358,914</td>
<td>4,558,978</td>
<td>4,171,103</td>
</tr>
<tr>
<td>Long-Acting Reversible Contraception</td>
<td>37,145</td>
<td>36,844</td>
<td>27,135</td>
<td>37,046</td>
<td>875,652</td>
<td>958,425</td>
</tr>
<tr>
<td>Total Other</td>
<td>203,808,957</td>
<td>208,134,949</td>
<td>276,028,819</td>
<td>314,172,257</td>
<td>426,046,637</td>
<td>649,101,906</td>
</tr>
</tbody>
</table>

Source: Ministry of Social Development. Year is financial year (ending March). Total is sum of assistance provided in quarters over a year. A client may receive more than one grant in a quarter and year.

Young people receiving financial assistance

In the year ended June 2020, a total of 74,471 young people aged 16–24 years (13% of all young people in this age group) were receiving financial assistance (Figure 86, Figure 87).

Most of the 16–24 year olds in receipt of financial assistance were being provided with income-replacing assistance (Figure 86), including 44,932 young people receiving Jobseeker Support (8% of all young people in this age group), fewer than 10,000 (2% of this age group) receiving Sole Parent Support and fewer than 8,000 (1%) receiving Supported Living Payment (Figure 87).

Most 16–24 year olds receiving assistance that was not income-replacing received Non-Beneficiary Assistance, such as such as Accommodation Supplement, Disability Allowance or Child Care Subsidy. A few hundred 16–24 year olds received the Unsupported Child’s or Orphan’s Benefit (Figure 87).

The number of 16–24 year olds receiving income-replacing financial assistance increased from 47,407 (8% of all children in this age group) in June 2019 to 65,884 (11% of all children in this age group) in June 2020.

Figure 86. Proportion of young people aged 16–24 years in receipt of financial assistance, by assistance category, New Zealand as at end of June 2020

Numerator: MSD. Denominator: NZCYES Estimated Resident Population. Year ended June 2020

Proportion of young people aged 16–24 years in receipt of income-replacing and not-income-replacing financial assistance
Figure 87. Number of young people aged 16–24 years in receipt of financial assistance, by assistance category and by type of assistance, New Zealand as at end of June 2020

Income equality and inequality

Growth that disproportionately benefits those in higher income groups while leaving others behind leads to social, political, economic, and fairness concerns in the long-term.¹⁸⁴

Comparisons about income inequality can be made within Aotearoa through analysing the income distribution between households in the “bottom”/lowest percentile of equivalised household income to their peers in households in the “top”/highest percentile of income.¹⁸⁵ Equivalising income estimates enables analysis to account for difference in household size and composition, while comparison of income after deducting housing costs (rather than before) indicates the income left over for households to live on and pay towards other essentials after paying for housing,¹⁸⁵ the costs of which have had larger impacts on the income available to households since the 1980s.²²

The incomes of households in higher income deciles rose more quickly than incomes for households in lower deciles, both in proportion and in absolute terms between 1994 and 2018. This led to a greater gap between those on higher incomes (the 10th or top decile, P10) incomes and those on lower incomes (the 1st or bottom decile) (Figure 88).

In 2018, households in the lowest income decile (P10) had an equivalised after housing costs income of $11,800 or less, while household in the top decile (P90) had an equivalised after housing costs income of $70,300.

Figure 88. Real equivalised household incomes after housing costs, by income decile, New Zealand 1982–2018 NZHES years

Source: Perry 2019, derived from Statistics New Zealand Household Economic Survey (NZHES). Income expressed in 2018 NZ dollars. P10 is bottom decile incomes; P90 is top decile incomes. P10 = the top income of the bottom decile; P50 = median income.
Discussion: Impact of COVID-19 on resources to thrive

After the COVID-19 lockdown unemployment statistics are not as high as those initially forecast. The September 2020 quarter employment statistics saw a rise in unemployment to 5.3%, well below the Treasury’s forecast of 9.8 per cent in the 2020 Budget and below the 6.4 per cent forecast in the Pre-Election Update. The change in labour market measures between March 2020 and September 2020 show that women are more negatively impacted than men. The seasonally adjusted number of people in employment fell by 31,000 between the March and September 2020 quarters – over two-thirds (22,000) were women. Nationally, the underutilisation rate reached 13.2 percent over this period, with a rate for women of 16.2 percent. This came relatively equally from underemployment (up 22,000) and unemployment (up 19,000). A far greater proportion of the increase in underutilisation for men came from underemployment (up 20,000), as the number of employed men working part-time increased from 10.9 percent to 11.7 percent. In the September 2020 quarter, the seasonally adjusted number of women not in the labour force (NILF) rose 1,000, while male NILF fell 6,000.172

For families with children where at least one adult was working prior to lockdown, 51% experienced an economic shock due to someone in the household losing their job or some income. This compares with a rate 44% for the population overall. All working parents who reported an economic shock during lockdown, regardless of household income, reported declines in how they rated their relationship with their family. For parents from lower income households, this drop in family well-being was deeper.39

Children and young people surveyed about their experience of lockdown talked about one of the positive things about lockdown was being able to spend time with family.152 The opportunity to reset our labour market now exists, but the challenge is how to ensure more time at home with family does not mean families have inadequate income.
Appendices

Appendix 1: ICD-10-AM codes

Infant mortality including sudden unexpected death in infancy (SUDI) as underlying cause of death

<table>
<thead>
<tr>
<th>Category</th>
<th>ICD-10-AM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme prematurity</td>
<td>P07.2</td>
</tr>
<tr>
<td>Intrauterine hypoxia or birth asphyxia</td>
<td>P20, P21</td>
</tr>
<tr>
<td>Other perinatal conditions</td>
<td>P00–P19, P22–P96</td>
</tr>
<tr>
<td>Congenital anomalies</td>
<td>Q codes</td>
</tr>
<tr>
<td>SUDI: SIDS</td>
<td>R95</td>
</tr>
<tr>
<td>SUDI: unspecified</td>
<td>R96, R98, R99</td>
</tr>
<tr>
<td>SUDI: suffocation or strangulation in bed</td>
<td>W75</td>
</tr>
<tr>
<td>SUDI: inhalation of gastric contents or food</td>
<td>W78, W79</td>
</tr>
<tr>
<td>Injury or poisoning</td>
<td>V01–Y36</td>
</tr>
</tbody>
</table>

Hospitalisations

<table>
<thead>
<tr>
<th>Category</th>
<th>ICD-10-AM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
<td>Up to 14 years, neonates under 28 days excluded</td>
</tr>
<tr>
<td>Medical hospitalisations</td>
<td>Acute and arranged (where arranged is within 7 days of referral)</td>
</tr>
<tr>
<td>Injury hospitalisations</td>
<td>Exclude ED admissions and waiting list admissions</td>
</tr>
<tr>
<td>SES Eligible admit type (excludes waiting list)</td>
<td>AA (Arranged Admission), AC (Acute), RL (Psychiatric patient returned from leave), ZA (Arranged Admission, ACC covered), ZC (Acute, ACC covered)</td>
</tr>
<tr>
<td>ED cases (based on health specialty code)</td>
<td>M05–M08</td>
</tr>
<tr>
<td>Medical causes (primary diagnosis)</td>
<td>A–R</td>
</tr>
<tr>
<td>Injury (primary diagnosis)</td>
<td>S–T79</td>
</tr>
</tbody>
</table>

Selected diagnoses/external causes

| Pneumonia                                                                | J10.0 or J11.0, J12–J16, J18 |
| Asthma and wheeze                                                       | J45–J46, R062                 |
| Acute bronchiolitis                                                     | J21                               |
| Acute respiratory infections                                            | J00–J06, J22                   |
| Other respiratory                                                       | Other J codes not listed above  |
| Gastroenteritis                                                         | A00–A09, K529                  |
| Viral infection of unspecified site                                     | B34                               |
| Other communicable                                                      | Other A&B codes not listed above |
| Assault                                                                 | X85–Y09                          |

Injury range does not include diagnostic codes of late effects of injuries, poisonings, toxic effects, and other external causes
Appendix 2: New Zealand Index of deprivation

The NZ index of deprivation (NZDep) was first created using information from the 1991 census, and has been updated following each census. It is a small area index of deprivation, and is used as a proxy for socio-economic status. The main concept underpinning small area indices of deprivation is that the socio-economic environment in which a person lives can confer risks or benefits which may be independent of their own social position within a community. They are aggregate measures, providing information about the wider socio-economic environment in which a person lives, rather than information about their individual socio-economic status.

The latest index, NZDep2013, combines nine variables from the 2013 census to reflect eight dimensions of material and social deprivation (Table 9). Each variable represents a standardised proportion of people living in an area who lack a defined material or social resource. These are combined to give a score representing the average degree of deprivation experienced by people in that area. Individual area scores are ranked and placed on an ordinal scale from 1 to 10, with decile 1 reflecting the least deprived 10% of small areas and decile 10 reflecting the most deprived 10% of small areas.

The advantage of the NZDep is its ability to assign measures of socio-economic status to the older population, the people who are not in employment, and to children, to whom income and occupational measures often don’t apply, as well as to provide proxy measures of socio-economic status for large datasets when other demographic information is lacking. Small area indices have limitations, however, as not all individuals in a particular area are accurately represented by their area’s aggregate score. While this may be less of a problem for very affluent or very deprived neighbourhoods, in average areas, aggregate measures may be much less predictive of individual socio-economic status. Despite these limitations, the NZDep has been shown to be predictive of mortality and morbidity from a number of diseases in New Zealand.

Table 9. Variables used in the NZ index of deprivation 2013 (NZDep2013)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Variable in order of decreasing weight in the index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>People aged &lt;65 with no access to the Internet at home</td>
</tr>
<tr>
<td>Income</td>
<td>People aged 18–64 receiving a means tested benefit</td>
</tr>
<tr>
<td>Income</td>
<td>People living in equivalised* households with income below an income threshold</td>
</tr>
<tr>
<td>Employment</td>
<td>People aged 18–64 who are unemployed</td>
</tr>
<tr>
<td>Qualifications</td>
<td>People aged 18–64 without any qualifications</td>
</tr>
<tr>
<td>Owned home</td>
<td>People not living in own home</td>
</tr>
<tr>
<td>Support</td>
<td>People aged &lt;65 living in a single parent family</td>
</tr>
<tr>
<td>Living space</td>
<td>People living in equivalised* households below a bedroom occupancy threshold</td>
</tr>
<tr>
<td>Transport</td>
<td>People with no access to a car</td>
</tr>
</tbody>
</table>

* The setting of the household equivalised income threshold was based on two principles: 1) the proportion of the population identified as being socio-economically deprived by the threshold should be broadly consistent with the other variables in the index, and 2) the threshold should be broadly consistent with other measures of income poverty.
Appendix 3: Data sources

The Child Poverty Monitor presents information derived from several national administrative datasets. These are described briefly below, and limitations and issues to be aware of when interpreting results drawn from these sources are outlined.

**National Mortality Collection**

The National Mortality Collection is a dataset managed by the Ministry of Health which contains information on the underlying cause, or causes, of death along with basic demographic data for all deaths registered in New Zealand since 1988. Fetal and infant death data are a subset of the Mortality Collection, and cases in this subset have additional information on factors such as birth weight and gestational age. Each of the approximately 28,000 deaths occurring in New Zealand each year is coded manually by Ministry of Health staff. For most deaths the Medical Certificate of Cause of Death provides the information required, although coders also have access to information from other sources such as Coronal Services, Police, NZ Transport Agency, the NZ Cancer Registry, the Institute of Environmental Science and Research, and Water Safety NZ.

**National Minimum Dataset**

The National Minimum Dataset (NMDS) is the national hospital discharge dataset and is maintained by the Ministry of Health. It is used for policy formation, performance monitoring, and research purposes, providing key information about the delivery of hospital inpatient and day patient health services both nationally and on a provider basis. It is also used for funding purposes. Information in the NMDS includes principal and additional diagnoses, procedures, external causes of injury, length of stay and sub-specialty codes; and demographic information such as age, ethnicity, and usual area of residence. Data have been submitted by public hospitals electronically since the original NMDS was implemented in 1993, with additional data dating back to 1988 also included. The private hospital discharge information for publicly funded events has been collected since 1997. The current NMDS was introduced in 1999.

**Birth Registration Dataset**

Since 1995 all NZ hospitals and delivering midwives have been required to notify the Department of Internal Affairs within five working days of the birth of a live or stillborn baby. This applies to stillborn babies born at or more than 20 weeks gestation, or those weighing 400g or more; prior to 1995, only stillborn babies reaching more than 28 weeks of gestation required birth notification. Information on the hospital’s notification form includes maternal age, ethnicity, multiple birth status, and the baby’s sex, birth weight, and gestational age. In addition, parents must jointly complete a birth registration form as soon as reasonable practicable after the birth, and within two years of delivery, which duplicates the above information with the exception of birth weight and gestational age. Once both forms are received by Internal Affairs the information is merged into a single entry. This two-stage process is thought to capture 99.9% of births occurring in New Zealand and cross-checking at the receipting stage allows for the verification of birth detail.

**Dataset limitations**

There are limitations when using any of these datasets. The following are of particular relevance to this report.

**Clinical coding accuracy and coding changes over time**

The quality of data submitted to the administrative national datasets may vary. While the data for the National Mortality Collection and the Birth Registration Dataset are coded by single agencies, the clinical information held in the NMDS is entered by health providers before being collated by the Ministry of Health. In a 2001 review of the quality of coding in the data submitted to the NMDS,
2,708 events were audited over ten sites during a three month period. Overall the audit found that 22% of events required a change in coding, although this also included changes at a detailed level. Changes to the principal diagnosis involved 11% of events, to additional diagnoses 23%, and to procedure coding, 11%. There were 1,625 external causes of injury codes, of which 15% were re-coded differently. These findings were similar to an audit undertaken a year previously. While the potential for such coding errors must be taken into consideration when interpreting the findings of this report, the average 16% error rate indicated by the 2001 review may be an overestimate as, in the majority of the analyses undertaken in this report, only the principal diagnosis is used to describe the reason for admission.

Changes in the coding systems used over time may result in irregularities in time series analyses. New Zealand hospitals use the clinical coding classification developed by the World Health Organization and modified by the National Centre for Classification in Health, Australia. The current classification is called The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), the Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS). The introduction of ICD-10-AM represented the most significant change in classification in over 50 years, expanding the number of codes from ~5,000 to ~8,000, to provide for recently recognised conditions and allow greater specificity about common diseases.

From 1988 until 1999, clinical information in the NMDS was coded using versions of the ICD-9 classification system. From July 1999 onwards, the ICD-10-AM classification system has been used. Back and forward mapping between the two systems is possible using predefined algorithms, and for most conditions there is a good correspondence between ICD-9 and ICD-10-AM codes. Care should still be taken when interpreting time series analyses which include data from both time periods as some conditions may not be directly comparable between the two coding systems.

Stats NZ Child poverty statistics

The Stats NZ’s Child Poverty Statistics are produced for the 2017/18 year and previous years using the Household Economic Surveys (HES), administrative (admin) data via the Integrated Data Infrastructure (IDI) and quarterly Household Labour Force Survey (HLFS). The NZ HES is a survey of between 3,000 to 5,500 households, randomly sampled, of which around 30% are households with children. For more information, please refer to the Child Poverty Statistics Technical Appendix 2017/18.

Table 10. Number of survey participants and coverage, New Zealand Household Economic Surveys

<table>
<thead>
<tr>
<th>Survey year (1 July–30 June)</th>
<th>Achieved sample size</th>
<th>Coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand Household Economic Surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011/2012</td>
<td>3,565</td>
<td>83</td>
</tr>
<tr>
<td>2012/2013</td>
<td>3,003</td>
<td>67</td>
</tr>
<tr>
<td>2013/2014</td>
<td>3,392</td>
<td>814</td>
</tr>
<tr>
<td>2014/2015</td>
<td>5,561</td>
<td>78</td>
</tr>
<tr>
<td>2015/2016</td>
<td>3,499</td>
<td>78</td>
</tr>
<tr>
<td>2016/2017</td>
<td>3,703</td>
<td>83</td>
</tr>
<tr>
<td>2017/2018</td>
<td>5,482</td>
<td>76</td>
</tr>
</tbody>
</table>

New Zealand Health Survey

The Ministry of Health’s New Zealand Health Survey (NZHS) became an annual survey in 2011. The survey is conducted by interviewing a sample of adults and children’s parents or caregivers. The NZHS consists of a core set of questions that cover a range of health-specific indicator areas, including health behaviours, conditions, and use of health services. The survey also includes a flexible programme of rotating topic modules, which change every 12 months. Table 11 presents the number of participants selected for each NZHS conducted and the corresponding coverage rate (an indicator of the extent to which the population has been involved in the survey).
The NZHS reports present adjusted rate ratios to account for the potential influence of other demographic factors on comparisons between groups. Gender comparisons are adjusted for age, ethnic comparisons are adjusted for age and gender, and deprivation comparisons are adjusted for age, gender and ethnicity.\textsuperscript{194}

Table 11. Number of survey participants and coverage, New Zealand Health Survey

<table>
<thead>
<tr>
<th>Survey year (1 July–30 June)</th>
<th>Adults (15 years and over)</th>
<th>Children (0–14 year olds)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n )</td>
<td>Coverage (%)</td>
</tr>
<tr>
<td>New Zealand Health Survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006/2007</td>
<td>12,488</td>
<td>59</td>
</tr>
<tr>
<td>2011/2012</td>
<td>12,370</td>
<td>54</td>
</tr>
<tr>
<td>2012/2013</td>
<td>13,009</td>
<td>59</td>
</tr>
<tr>
<td>2013/2014</td>
<td>13,309</td>
<td>54</td>
</tr>
<tr>
<td>2014/2015</td>
<td>13,497</td>
<td>59</td>
</tr>
<tr>
<td>2015/2016</td>
<td>13,781</td>
<td>67</td>
</tr>
<tr>
<td>2016/2017</td>
<td>13,598</td>
<td>63</td>
</tr>
<tr>
<td>2017/2018</td>
<td>13,869</td>
<td>61</td>
</tr>
<tr>
<td>2018/2019</td>
<td>13,572</td>
<td>62</td>
</tr>
<tr>
<td>2018/2019</td>
<td>13,572</td>
<td>62</td>
</tr>
</tbody>
</table>

Source: New Zealand Health Survey Methodology reports 2006/07–2017/18

**Estimated prevalence**

The NZHS presents the demographic factors for each surveyed condition using unadjusted prevalence rates and adjusted rate ratios. The survey uses the calibrated weighting method to construct survey weights that rate up the responding sample to represent the target population. This method takes into account the probability of selection of each respondent, and uses external population benchmarks (typically based on the most recent population census) to correct for any discrepancies between the sample and population benchmarks (by age, sex, ethnicity and the 2013 New Zealand Index of Deprivation).\textsuperscript{194}

The prevalence of a condition, or the proportion of the population with the condition was estimated by calculating the sum of the weights for the survey respondents with the condition divided by the sum of the weights of all survey respondents. For example, the sum of the weights for survey respondents with self-reported diabetes is divided by sum of the weights for all survey respondents.\textsuperscript{194}


**Ethnicity in National Datasets**

There were inconsistencies in the manner in which ethnicity information in New Zealand was collected prior to 1996. This report presents ethnic-specific analyses for 1996 onwards and, unless otherwise specified, prioritised ethnic group has been used to ensure that each health event is only counted once.

Despite significant improvements in the quality of ethnicity data in New Zealand’s national health collections since 1996, care must still be taken when interpreting the ethnic-specific rates as the potential still remains for Māori and Pacific children and young people to be undercounted in our national data collections. The data presented in this report may undercount Māori and Pacific children to a variable extent depending on the dataset used; in the case of the hospitalisations for Māori, this undercount may be as high as 5–6%.
Appendix 4: Statistical methods

Counts of events

Some of the data presented in this report are counts of events, such as hospitalisations and deaths, and rates which represent the number of these events per head of population in a certain time period. The rates are crude age-specific rates, calculated by dividing the number of events, such as hospitalisations or deaths, in a particular age group by the corresponding “at-risk” population in the same age group and then multiplying the result by a constant (such as 100,000) to derive the rate. Age-specific rates are commonly expressed per 1,000 or per 100,000 population.

Some of the graphs of rates of events in this report include 95% confidence intervals. Confidence intervals are a statistical tool used to indicate the range of variation that occurs in the number of randomly occurring discrete events that occur per unit of measurement (such as per year). It is usual to use 95% confidence intervals, which indicate that there is a 95% probability that the number of random events that occur with a particular probability in a given time period will be within the range of the confidence limits.

To compare rates between different demographic groups in New Zealand, some tables and graphs in this report include rate ratios. The rate ratio is the rate for one particular category divided by the rate for a category chosen as the reference category, for example the rate for Māori divided by the rate for European/Other. Rate ratios calculated this way are properly known as crude or unadjusted rate ratios, because their calculation does not take into account differences in population demographic structure between the two categories being compared.

Rate ratios can be interpreted as follows:

- A value of 1 indicates that there is no difference between the group of interest (for example Māori) and the reference group (for example European/Other).
- A value higher than 1 shows that the rate is higher for the group of interest than for the reference group.
- A value lower than 1 shows that the rate is lower for the group of interest than for the reference group.

Proportions

Some of the data in presented these reports are proportions. It is common practice to use data from a subset of the population (such as survey participants) to estimate the proportion of the whole population who have the characteristic of interest.

Proportions are commonly expressed as percentages, for example:

\[
\text{% of babies fully breastfed at 6 weeks} = \frac{\text{number of babies fully breastfed at 6 weeks}}{\text{number of babies whose breastfeeding status at 6 weeks is known}} \times 100
\]

For the purposes of estimating 95% confidence intervals, the subset of the population used to estimate the proportion in the total population is regarded as a random sample of people from the total population, who can either have, or not have, the characteristic of interest.

In this situation the 95% confidence interval is the range of values that has a 95% probability of including the value of the proportion for the whole population. It quantifies the uncertainty resulting from random variation in the estimation of the population proportion. The width of the 95% confidence interval depends on the sample size (larger samples yield more precise estimates) and the degree of variability in the phenomenon being measured.

Proportions can be compared between two population groups using the rate ratio: the ratio of the estimated proportion having the characteristic of interest in the comparison group to the estimated proportion having the characteristic of interest in the reference group.

The rate ratios for proportions presented in this report that are derived from the New Zealand Health Survey have been adjusted by the Ministry of Health for differences in demographic factors between...
the groups being compared that might influence (confound) the comparison. The adjustments are as follows:

- The gender comparison has been adjusted for age.
- The ethnic comparisons have been adjusted for age and gender.
- The deprivation comparison have been adjusted for age, gender and ethnic group.

Adjusting for potential confounding factors makes comparisons more accurate and meaningful because it removes the effect of these confounding factors.

Appendix 5: Indicators used in the Child Poverty Monitor

The indicators reported upon in the Child Poverty Monitor Technical Reports (2013-2017) combine measures of child poverty recommended by the 2012 Children’s Commissioner’s Expert Advisory Group on Solutions to Child Poverty, with children’s health and well-being measures being developed for the Children’s Social Health Monitor that was produced by the NZ Child and Youth Epidemiology Service from 2009 to 2012. The indicator set needs to be methodologically robust and able to be monitored consistently over time. The data selected are mainly from population surveys or routine administrative datasets that provide complete population coverage.

Appendix 6: Measures of material hardship

DEP-17 is a 17 item deprivation index that includes a range of items considered essential and enjoyed by the majority of New Zealand households. This is working on a spectrum from lower to higher levels of hardship. A score of 6+ is considered to indicate households experiencing material hardship and 9+ indicates households experiencing severe material hardship.

Table 12. Items used in the New Zealand Household Economic Survey and scoring details for the material deprivation index (DEP-17)

<table>
<thead>
<tr>
<th>Item description</th>
<th>Item number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enforced lack of essentials (for respondent or household as a whole)</td>
<td>1-5</td>
</tr>
<tr>
<td>Meal with meat, fish or chicken (or vegetarian equivalent) at least each 2nd day</td>
<td></td>
</tr>
<tr>
<td>Two pairs of shoes in good repair and suitable for everyday use</td>
<td>2</td>
</tr>
<tr>
<td>Suitable clothes for important or special occasions</td>
<td>3</td>
</tr>
<tr>
<td>Presents for family and friends on special occasions</td>
<td>4</td>
</tr>
<tr>
<td>Home contents insurance</td>
<td>5</td>
</tr>
<tr>
<td>Economised, cut back or delayed purchases ‘a lot’ because money was needed for other essentials (not just to be thrifty or to save for a trip or other non-essential)</td>
<td>6-10</td>
</tr>
<tr>
<td>Went without or cut back on fresh fruit and vegetables</td>
<td></td>
</tr>
<tr>
<td>Bought cheaper cuts of meat or bought less than wanted</td>
<td></td>
</tr>
<tr>
<td>Put up with feeling cold to save on heating costs</td>
<td></td>
</tr>
<tr>
<td>Postponed visits to the doctor</td>
<td></td>
</tr>
<tr>
<td>Postponed visits to the dentist</td>
<td></td>
</tr>
<tr>
<td>Did without or cut back on trips to the shops or other local places</td>
<td></td>
</tr>
<tr>
<td>Delayed repairing or replacing broken or damaged appliances</td>
<td></td>
</tr>
<tr>
<td>In arrears more than once in last 12 months (because of shortage of cash at the time, not through forgetting)</td>
<td>11-13</td>
</tr>
<tr>
<td>Rates, electricity, water</td>
<td></td>
</tr>
<tr>
<td>Vehicle registration, insurance or warrant of fitness</td>
<td></td>
</tr>
<tr>
<td>Financial stress and vulnerability</td>
<td></td>
</tr>
<tr>
<td>Borrowed money from family or friends more than once in the last 12 months to cover everyday living costs</td>
<td>15</td>
</tr>
<tr>
<td>Feel ‘very limited’ by the money available when thinking about purchase of clothes or shoes for self (options were: not at all, a little, quite limited, and very limited)</td>
<td>16</td>
</tr>
<tr>
<td>Could not pay an unexpected and unavoidable bill of $500 within a month without borrowing</td>
<td>17</td>
</tr>
</tbody>
</table>
References


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159. Fraser H. 2018. The Labour Income Share in New Zealand: An Update. Staff Research Note 2018/1 New Zealand Productivity Commission


