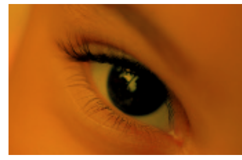

Whakapono: End child poverty in Māori whānau

A preliminary report

Author
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2017

CHiLD POVERTY ACTION GROUP

About Child Poverty Action Group

Child Poverty Action Group (Inc) (CPAG) is a non-profit group formed in 1994, and made up of academics, activists, practitioners and supporters. CPAG has a strong education and research role which enables it to contribute to better informed social policy to support children in Aotearoa New Zealand, specifically children who live in poverty. CPAG believes that our high rate of child poverty is not the result of economic necessity, but is due to policy neglect and a flawed ideological emphasis on economic incentives. Through research, CPAG highlights the position of tens of thousands of New Zealand children, and promotes public policies that address the underlying causes of the poverty they live in. If you are not already supporting CPAG and you would like to make a donation to assist with ongoing work, please contact us at the address below or through our website: www.cpag.org.nz.

In September 2017 CPAG adopted the whakatauki: He kai tahu me kikini, he kai tahu me tīhore, mā te tamaiti te iho" (Pinch off a bit, peel off a bit, the inside is for the child" (said of the potted bird)). This whakatauki speaks to keeping the best for children.

The four pou supporting CPAG's kaupapa are:

- **Mana** – We aknowledge and uphold the mana of all children.
- **Manaakitanga** – We believe our society should show respect, generosity and care for all children as taonga.
- **Kotahitanga** – We work collectively to uphold the mana of all children to ensure they flourish.
- **Mātauranga** – We believe that child-centred knowledge is essential to upholding their mana and enabling them to thrive.

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Preface

The purpose of this preliminary Child Poverty Action Group (CPAG) Backgrounder, Whakapono: end child poverty in Māori whānau, is to report the current situation for tamariki Māori, with particular focus on social and economic conditions, and the various ways that current health, education and housing policies are impacting, and in many cases, compromising their futures.

The Backgrounder begins with the Recommendations contained in the 2013 Report of the Māori Affairs Committee into the Determinants of Wellbeing for Tamariki Māori. The remainder of the Backgrounder is divided into sections, and each section concludes with the recommendations for action from the Māori Affairs Committee followed by additional CPAG recommendations.

CPAG intends this publication as an urgent and necessary call to action, to create a reason for whakapono, for hope. A cross-party agreement is required for enduring solutions to the poverty among all tamariki in this land. As we welcome the election of the new government in 2017, this has been recognised by the Prime Minister, Jacinda Ardern, as one of the most critical issues to consider.

CPAG gratefully acknowledges the contributions by Dr Hirini Kaa and Dr Alayne Hall to this Backgounder. Thanks also to Professor Cindy Kiro, Associate Professor Manuka Henare and Jennifer Braithwaite for their comments and suggestions.

Any errors or omissions are the responsibility of the author.

Executive Summary

The 2013 Report of the Māori Affairs Committee into the Determinants of Wellbeing for Tamariki Māori begins with key statements, including:

- The wellbeing of tamariki Māori is inextricable from the wellbeing of their whānau.
- Acknowledging the importance of collective identity for a Māori child is a first step in realising the potential of a whānau-centred approach to their wellbeing.
- Enduring change and success for whānau (and therefore tamariki Māori) is possible where whānau themselves are engaged in making the decisions that will affect them.
- The intergenerational nature of many of the problems facing tamariki Māori be acknowledged and addressed.

New Zealand's Government joined with 193 others In New York in September 2015 to endorse the United Nations 17 ambitious sustainable development goals, including the first: End poverty everywhere in all its forms by 2030. However much we support this pledge, it is difficult to have faith in the Government's endorsement when Aotearoa New Zealand is failing to honour the rights and pledges set out in other treaties and human rights instruments since 1840, including the Treaty of Waitangi, the United Nations Convention on the Rights of the Child (UNCROC), and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Official acknowledgement of poverty among children since 2002 has not led to solutions. In 2015, of 915,300 children aged 14 years and under, more than 230,000 were living below the poverty line; and just under half of these children living in poverty and hardship were Māori and Pasifika, yet Māori comprise only 15% of the total population, and Pasifika only 7.4%.

Māori poverty is considered here within the context of the impact of colonisation, the alienation of land and resources, and the consequent loss of a cultural, spiritual and economic base. Because Māori are still, on average, paid at measurably lower rates than Pākehā, low wages and casualised employment contribute to the disproportionate poverty experienced by Māori families and their children, and severely constrain wealth accumulation. Poverty and hardship create and contribute to present and future health, wellbeing and education risks for children.

Mitigating these destructive influences requires systemic and constitutional change. Solutions require a strengths-based, kaupapa Māori approach to building the capability of whānau to design and implement solutions to ensure the wellbeing of their tamariki.

This report provides information and discussion in sections on family incomes, child health, housing, and education. A consistent theme emerges: investing early in the lives of children averts later public and private health and justice costs, increases the resilience of tamariki and whānau, and benefits the wider economy.

Each section draws on the surveyed research to provide recommendations toward improving the wellbeing of tamariki, providing a rationale for whakapono, and contributing to ending child poverty in Aotearoa New Zealand. The recommendations of the Māori Affairs Committee, copied below and used throughout this report, provide the foundation for this preliminary report.

Maori Affairs Committee Recommendations to Improve and Ensure the Wellbeing of Tamariki Maori

(Māori Affairs Committee, 2013)

Research and Policy Recommendations

1. *Requiring extensive, high-quality research to be undertaken into the wellbeing of tamariki Māori, and developing whānau-focused health and social services policies and programmes based on the findings. The effectiveness of these programmes should be monitored by the developers against agreed targets for which providers should be held accountable and required to report progress annually.*
2. *Developing coherent cross-government policies and an interdepartmental culture of communication and collaboration to ensure that the wellbeing of tamariki Māori is a priority for all and the necessary information is accessible.*
3. *Requiring a strengths-based, kaupapa Māori approach to building the capability of whānau to design and implement solutions to ensure the wellbeing of their tamariki.*

Provision of Services – Practice

4. *Providing long-term funding (multi-year appropriations) for pertinent service providers, to allow them to develop trusting relationships with whānau.*
5. *Requiring services to be mapped demographically, or mesh-blocked, to ensure key services are available in areas of high need.*
6. *Developing the concept of mobile multi-disciplinary whānau teams to provide professional home-based services, particularly in low-income and isolated areas.*
7. *Determine which government agency is the most appropriate to support whānau following statutory intervention in the lives of children.*
8. *Requiring the Ministry of Corrections to strengthen and maintain the development and implementation of a plan to increase support for children of prisoners.*
9. *Reviewing the provision of services regarding youth offending, with a focus on rehabilitation, integration into society, and reducing reoffending.*

Provision of Services – Health

10. *Implementing early intervention programmes for at-risk whānau.*
11. *Implementing a national quadruple health enrolment scheme, involving enrolling every child with a general practitioner, a Well Child Tamariki Ora provider, on the national immunisation register, and with an oral health provider.*
12. *Developing community hubs, linked to Whānau Ora providers, to offer integrated health and social services from single locations.*
13. *Creating incentives for the health sector to find and use a consistent, robust, reliable way to assess and reach every whānau, with a particular emphasis on those that are hard to reach.*
14. *Working to build the Māori health workforce by increasing support for education and recruitment.*

15. *Funding evidence-based initiatives to reduce teenage pregnancy.*
16. *Ensuring access for all whānau to well-designed pre-birth programmes, ante-natal care and education, and early childhood development programmes.*
17. *Commissioning an intensive review of the provision of specialised mental health services for Māori.*
18. *Increasing support for the promotion of smokefree environments, by way of policy, cessation services, and mass media campaigns targeting Māori youth, pregnant women and parents.*
19. *Facilitating partnerships between health providers, community groups, and marae to encourage the production and consumption of healthy food.*
20. *Encouraging the medical profession to offer specific vocational training in order to serve Māori patients better as a routine component of on-going professional development.*
21. *Increasing promotion of and participation in Māori health promotion models such as Te Pae Mahutonga, Te Whare Tapa Whā, and Te Wheke.*
22. *Ensuring community services, including health services, operating out of school grounds are not at a cost to school budgets.*
23. *Ensuring that health literacy education is based on kaupapa Māori, and communicated in a culturally appropriate way. Recommendation 24: Encouraging whānau-friendly parenting programmes and adult education courses in schools to encourage all parents to take part in the school community.*
42. *Extending free after hours healthcare to all children to the age of 18.*
43. *Investigate the provision of free healthcare to all children to the age of 18.*

Provision of Services - Education Recommendations

24. *Taking steps to increase the number of Māori teacher aides as a pathway to increasing the number of Māori teachers.*
25. *Implementing teacher training programmes to improve teachers' awareness of the social justice issues regarding education and tamariki Māori in poverty, and to equip teachers to teach in empowering and culturally appropriate ways. These programmes should be a core part of teachers' initial training and ongoing professional development.*
26. *Extending programmes and interventions such as Te Kotahitanga to all schools.*
27. *Taking the lead in ensuring equitable access to technology for all tamariki Māori.*
28. *Address the funding inequities between kōhanga reo and other early childhood education services.*
29. *Requiring the Ministry of Education and the Ministry of Māori Affairs, in conjunction with teacher training providers, to develop and implement a plan to increase the number of Te Reo-speaking teachers and improve delivery of education services in Te Reo Māori, in both full immersion and bilingual settings.*

Provision of Services – Housing

30. *Promoting partnerships between central and local government, the Māori Trustee, and iwi organisations to utilise property assets to build housing for whānau on Māori land and address the shortage of affordable and appropriate social housing.*
31. *Implementing housing warrants of fitness for rental properties, in line with the recommendation*

from the Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty.

Provision of Services – Incomes and Employment

33. *Requiring government departments, in consultation with Māori authorities, to develop initiatives to target long-term unemployed young people and increase investment in tamariki Māori and rangatahi.*
34. *Develop region-specific sustainable economic and employment plans in areas of high Māori unemployment in collaboration with whānau, hapū, iwi, Māori corporations, the Māori business sector, and regional economic development agencies.*
35. *Develop, in cooperation with industry, educational institutions, iwi, and communities, skill acquisition and retraining opportunities in emerging sectors for workers in insecure or transitional industries in areas of high Māori population.*
36. *Develop clear higher education pathways and meaningful paid employment opportunities for parents and caregivers.*
37. *Continue to increase the minimum wage.*
38. *Review Working for Families to assess whether it is achieving its intended purpose.*
39. *Support the provision of financial literacy education and information, by government and non-government agencies, to help whānau.*
40. *Support the provision of new models of social lending.*

Additional recommendations

41. *Consider appointing a Cabinet Minister for Children and a ministry for children, with responsibility for a children's action plan and a Māori children's action plan, enshrined in a Children's Act, to set targets for children's health and wellbeing against which all ministries and departments would be required to report. A Children's Act should also take into account and refer specifically to New Zealand's obligations under the United Nation's Convention on the Rights of the Child and the United Nations Declaration on the Rights of Indigenous Peoples, and include a requirement for a child impact assessment of all new legislation to be prepared by the ministry for children, detailing each bill's potential impact on children.*
42. *Extending free after hours healthcare to all children to the age of 18.*
43. *Investigate the provision of free healthcare to all children to the age of 18.*
44. *Requiring the Ministry of Health, in cooperation with other ministries and departments as appropriate, to develop a cross-sectoral needs assessment tool for pregnant women, and ensure that all pregnant low-income vulnerable women are contacted by case workers to implement the needs assessment protocol and coordinate services.*
45. *Funding the expansion of effective teen parenting unit programmes in secondary schools to strengthen and support young Māori parents.*
46. *Improve the adequacy of benefits and incomes for whānau without paid work to ensure the wellbeing of their tamariki.*
47. *Investigate the introduction of a universal child payment.*
48. *Investigate partnering with employers, unions, local government, and iwi to address job shocks that may adversely affect whānau.*

Further CPAG recommendations

To address poverty and hardship:

1. Develop new measurements and indexes to reflect Māori values, spirituality and capabilities, including concepts of poverty and wealth.
2. Conduct independent, gender-neutral assessments of Māori and Pasifika employment to determine whether the pay rates are fair.
3. Add the Working for Families In-Work Tax Credit (IWTC) to the first child Family Tax Credit and adjust the income threshold for abatement to reflect growth in average wages. Return the rate of abatement to 20%.
4. Whānau Ora welfare providers give assistance and training in social security provisions to whānau to ensure their people are fully apprised of their entitlements.

To improve the wellbeing of tamariki Māori:

5. Adopt an official poverty line; monitor major indicators of child poverty and report these on a regular basis by ethnicity with specific target reductions to be met on the way to ending child poverty by 2022.
6. Fund child-impact assessments of existing and future national and local policies.
7. Set net income for those on benefits so that no-one is under the poverty line: income support for families with children, whether tax credits or welfare benefits, must be adequate to ensure the well-being of children. Remove work-based rules for child financial assistance and pay the equivalent of the IWTC to all low-income families.
8. Ministry of Social Development to monitor the discourse on poverty in government departments and the media to ensure the current demonising of the poor, including beneficiaries, is halted.

To improve the health of tamariki Māori:

9. Inequalities in access to health services be addressed by a dual approach: coordination across all Government departments, and coordination between policies for health and policies aimed at reducing income inequality and poverty.
10. Provide free access to healthcare for all children under age eighteen, 24 hours a day, seven days a week.
11. Urgently develop a national strategy to focus on under-nutrition in children.

To improve housing:

12. Introduce fair rent rules and other tenants' protections, including security of tenure.The Government develop and fund a national housing plan to address the increasing housing shortages, including a range of additional practical measures to increase the ability for Māori low-income households with children to purchase their own home.

To improve education outcomes:

13. Government allocates adequate funding provision to ensure that all teacher-led, early childhood care and education (ECCE) centres are fully staffed by 100% qualified teachers, and requires ratios of teachers to children and unit sizes to be maintained according to quality guidelines. Base the model of ECCE provision on a neighbourhood by neighbourhood and a town by town assessment of future early childhood education needs.

14. Ensure a minimum of proportional representation on school Boards of Trustees for Māori students.
15. Provide adequate funding for low-decile schools to ensure that all children have access to high quality education.
16. Government funds on-site health professionals in all-low decile schools.

Introduction

> *Hutia te rito o te harakeke, kei whea te korimako e ko? Ka rere ki uta, ka rere ki tai. Kī mai koe ki au, he aha te mea nui i te ao? Maku e kī atu, He tangata! He tangata! He tangata! (If you pluck out the flax shoot, where will the bellbird sing? It will fly inland, it will fly seawards. If you ask me, what is the most important thing in the world? I will reply People! People! People*!) (Metge & Jones, 1995, p.3)

Rather than the individualism that arrived with the Pākehā settlers, this whakatauki (proverb) celebrates the power of iwi, hapü and whänau. Like many whakatauki, it expresses the importance of collectivism implicit in the Māori worldview (Penehira, Green, Tuhiwai Smith, & Aspin, 2014, p.105)n.

The harakeke (flax plant) represents the whānau (family) in Māori thought. The cherishing, devotion and protection of tamariki (children) provided by the whānau is reflected in the naming of the various parts of the harakeke that provided the fibre for clothing, fishing twine, baskets, decoration, rope and a thousand other purposes fundamental to general well-being. The rito (shoot) is the child. It is protectively surrounded by the awhi rito (parents), and the outside leaves represent the tūpuna (grandparents and ancestors).[1]

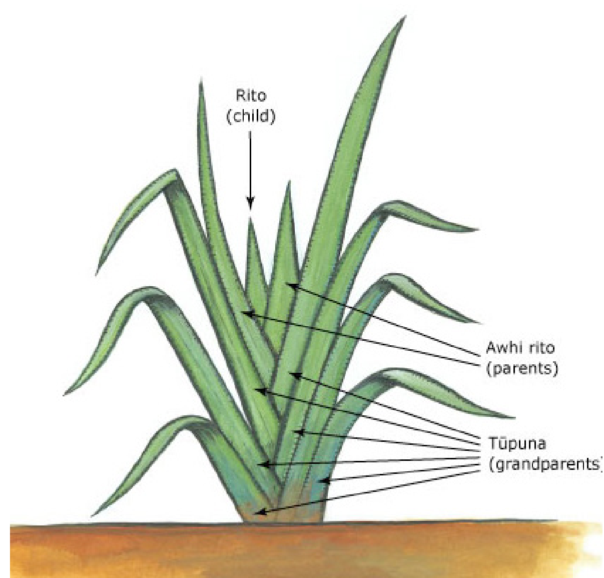

Figure 1: Harakeke

In early Māori society, a whānau was around 20 to 30 people, comprising kaumātua (chief), pakeke (parents, aunts and uncles) and tamariki. A whānau would be largely self-sufficient, with their own compound within a settlement, a plot in communal gardens, and their own places to fish and hunt (Kiro, 2011). In this society, the cooperation applied to childrearing was an extension of the fundamental expression of blood kinship and community, and every adult had a responsibility to care for all children (Jenkins, Mountain-Harte, & Ririki, 2011, p.22-23) Children were regarded as taonga (treasure), and early observers frequently commented on the loving care given to babies and children by the whānau.

> *The fundamental principle for raising children was the underlying belief that children were favoured as gifts from the atua (spiritual beings), from the tipuna (ancestors) and preceded those unborn, which meant that they were tapu (under special rules and restrictions). Any negativity expressed to them was breaking the tapu by offending the atua and the tipuna gone before. Because of their intrinsic relationship to these spiritual worlds, the children inherited their mana (power, prestige). They were treated with loving care (aroha) and indulgence. Punitive discipline in whatever degree, as a method of socialising children, was an anathema to the tipuna.* (Jenkins, et al., 2011, p. x)

Anne Salmond (2016) writes that early European visitors to Aotearoa reported: “Māori domestic life

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1 See http://www.paharakeke.co.nz/pa-harakeke/about-harakeke/.

was generally harmonious, and the men were kind, loving and devoted to their children". Higgins and Meredith (2011) report the rationale underpinning devotion to and protection of children:

> *Māori children were … cherished by their hapū (subtribe) because they would be the tribe's future. … Children were often adopted by other family members. This was known as whāngai. Grandparents would adopt grandchildren to teach them tribal traditions. By watching others and copying them, children learnt everyday tasks such as tending gardens or gathering seafood. They also played games such as kite flying and knuckle bones. Some children were sent to whare wānanga (schools of higher learning) to learn sacred rites, karakia (prayers) and whakapapa (genealogy).*

For Māori, tamariki were the taonga of the whānau. This cultural value was among the many losses for Māori with colonisation.

> *The impact of colonisation has been well documented by the Waitangi Tribunal and a generation of historians, who have shown the social and economic devastation caused by colonisation leaving Māori vulnerable and in need of the support of the state. The theft of Māori land through military invasion and confiscation and through unjust legislation took away the Māori economic base, forcing dependency on the largesse of the state. This also worked within a constant environment of racism, in which Māori were constantly portrayed as simultaneously lazy and privileged.* (Kaa, 2015, p.23)

In 1840, Te Tiriti, the Treaty of Waitangi affirmed the prior rights of Tangata Whenua, and gave the Crown a set of rights and responsibilities that enabled Pākehā to settle in Aotearoa; "the promise of two peoples to take the best possible care of each other."

Te Tiriti has been interpreted by the Waitangi Tribunal as including the principle of equity:

> *A general equality of health outcomes for Maori as a whole is one of the expected benefits of the citizenship granted by the Treaty. Its achievement is a long-term goal that depends on a broad range of State policies and services. Until realised, failure to set Maori health as a health gain priority would be inconsistent with the principle of equity.* (Waitangi Tribunal, 2001b, p.62)

Te Tiriti also has been interpreted by the Waitangi Tribunal as including the duty to address disparities and to work in partnership:

> *"[T]he Crown has a duty under the Treaty to try to reduce disparities between Maori and non-Maori, regardless of their causes…In attempting to reduce disparity, however caused, the Crown has an obligation to do so in good faith and partnership with the hapu and iwi of Te Urewera. It cannot simply present Maori with its own solutions, however well-intentioned they might be; at minimum it must consult with Maori, and ideally it will either form a partnership with, or deliver funding and autonomy to, Maori organisations."* (Waitangi Tribunal, 2001a, p.659)

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), drafted by indigenous peoples, including Māori, was adopted by the United Nations General Assembly on 13 September 2007 (United Nations, 2008) and by the New Zealand Government in 2010. This Declaration sets out the minimum standards for the survival, dignity, wellbeing, and rights of the world's indigenous peoples (Human Rights Commission, 2016).

Article 21 of UNDRIP states that indigenous peoples have the right to "Improvement of their economic and social conditions", and Article 22 states that indigenous peoples have the right to "Particular attention to the needs of elders, women, youth, children and disabled people." Hence Māori poverty needs to be considered within the context of the impact of colonisation. The alienation of land and resources includes the loss of a cultural and spiritual base and also, importantly, the loss of an economic base (Cram, 2011).

Article 23 states that indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions (United Nations, 2008).

Regarding UNDRIP, the Human Rights Commission states:

> *The Treaty and Declaration are strongly aligned and mutually consistent. The Declaration assists with the interpretation and application of the Treaty principles. Partnership: Which entails good faith cooperation and shared decision making. Protection of rangatiratanga (self-determination) and taonga such as reo (language), tikanga (customs), mâtauranga (knowledge), land and resources. Participation in society on an equal basis to others, and freedom from discrimination*. (Human Rights Commission, 2016, p.4)

The United Nations Convention on the Rights of the Child (UNCROC) was adopted in 1989, and New Zealand became a signatory in 1993 (with some provisos).

> *UNCROC marked a milestone in the development of children's rights as the first internationallybinding instrument that recognised the need to assign special rights to children having regard to both their implicit vulnerability and their potential to contribute to society.* (Hancock & Walters, 2009)

Commitment to UNCROC principles has not been strong, and the response in Geneva from Vice-chairperson of the Committee on the Rights of the Child, UN, to New Zealand's Fifth Periodic Report included the comments:

> *[T]he convention on the rights of the child is not about vulnerable children, it is about every child living in the state party. What we appreciate more as a committee is the consideration of each right stipulated in the convention, of each and every child, living in the state party with equal importance. This can be achieved by developing one comprehensive national strategy in light of the provisions of the Convention for all children, including vulnerable children.* (Policy Watch, 2016)

The Committee reminded the Government of 2011 recommendations after the Fourth Periodic Report (CRC/C/NZL/CO/3-4), and urged that it ensure full protection against discrimination on any ground, including by:

> *25: (a) Taking urgent measures to address disparities in access to education, health services and a minimum standard of living by Maori and Pasifika children and their families…*
>
> *35: The Committee is deeply concerned about the enduring high prevalence of poverty*

among children, and the effect of deprivation on children's right to an adequate standard of living and access to adequate housing, with its negative impact on health, survival and development, and education. It is particularly concerned about the continuing disparities faced by Maori and Pasifika children with regard to the enjoyment of these rights. It is further concerned about the impact of recent welfare and benefit sanctions reforms on children living in benefit-dependent households. (United Nations Committee on the Rights of the Child, 2011)

In New York in September 2015, New Zealand's Government joined with 193 others to endorse the United Nations 17 ambitious sustainable development goals, including the first: "End poverty everywhere in all its forms". This goal includes the specific target of reducing "by at least half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions'' by 2030 (United Nations, 2015).

Aotearoa-New Zealand is failing to honour the rights and pledges set out in these and other treaties and conventions. Poverty among children has been officially acknowledged in New Zealand since 2002.[2] Of all the 915,300 children aged 14 years and under, more than 230,000 are living below the AHC (after housing costs 'anchored') poverty line; and just under half of these children are Māori and Pasifika (Perry, 2015, p.120).

Statistics New Zealand's (2015) median projection indicates that by 2038, Māori children will increase from a quarter to a third of all New Zealand children aged 0–14 years. The predictions of increasing proportions of Māori children in the future intensifies the urgency and importance of the current crisis of their widespread poverty and hardship. The parents of children in 2038 are the tamariki of today.

The following extract from Joanna Kidman (2017) reveals the reality of early 21st century Aotearoa:

> *The income gap between rich and poor New Zealanders was … widening and a corresponding change in public attitudes towards the poor began to surface — a sneering belief that poverty was a result of bad choices, bad attitudes, bad parenting and laziness. But at the same time, the expanding queues at the soup kitchen and the growing numbers of street beggars huddled in doorways … told me that the social narrative had shifted in some irrevocable way.*

Mitigating these major ethical and economic risks requires considered, respectful, principled and collaborative action. Repeating a key message from *He Ara Hou: The Pathway Forward* (Henare, Puckey, Nicholson, Dale, & Vaithianathan, 2011):

> *If we are to reduce the poverty experienced by too many Māori and Pasifika children then a poverty removal strategy must sit alongside the already accepted commitment to a wealth creation strategy.*

For a poverty removal strategy to be valid for Māori, it needs to capture Māori aspirations and matauranga (worldview):

> *The Māori world view, for example, locates humans within a matrix of spiritual, cosmic,*

2 St John and Rankin (2009, p.7-8) report: *"In the 2002 election year … Government's own research showed that in 1998 three out of every ten children were living below the unofficial poverty line of 60% of the after housing costs (AHC) of household-equivalised disposable income…. In pre-election speeches the Prime Minister pledged to review family tax credits. The MSD noted that: "the declining real value of family income assistance has been a key contributing factor to inadequate family incomes" (Ministry of Social Development, 2002-2004).*

> *environmental, kinship, and economic spheres of existence. Mauri is the binding force between the spiritual and the physical. Gross Domestic Product as a measure of standards of living fails to measure outcomes in all of these spheres. (Henare, et al., 2011, p. viii)*

In her 'Viewpoint' in *Te Ohonga Ake* Series 2 (Simpson, J., J. Adams, G. Oben, A. Wicken, & M. Duncanson, 2016, p.32), Bridget Robson clarifies the Māori concept of wealth:

> *Income provides the kai – what we need to survive every day. Wealth is with the whenua [land]. With whenua we can feed the people of today and the generations of tomorrow. We can store kai for lean times, grow our pa harakeke, and build our whare to house the people… Other concepts of wealth reveal the values motivating the strategic focus of many Māori – "our people are our wealth", "the marae is our principal home", "the Māori language is a taonga". Our people, our marae, our language, (our cultural capital) support our capacity to understand our environment, to nurture relationships with ancestors and with future generations. They nourish and sustain our cultural, spiritual, and social wellbeing.*

As extended family environments are eroded, parents have decreasing access to sources of advice and support from mothers, grandparents, siblings or aunties and uncles, who in the past would have lived in close proximity (Kiro, 2011). The children who grow up in hardship in this comparatively wealthy nation are evidence of the failure of our social and economic policies. Childhood experiences are critical for shaping outcomes throughout life (Gluckman & Hayne, 2011).

Investing in young children reduces the inequality associated with the accident of birth and also raises the productivity of society (Heckman & Masterov, 2007). At the same time, "social policies and services impacting on young people need to reflect the lived reality of young people if they are to meet young people's needs" (Sligo et al., 2016, p.1).

The presentation by Hirini Kaa at the 2015 Child Poverty Action Group Welfare Summit concluded:[3]

> *The pain of seeing your children go without food is universal; the grief of a family over a child dying of rheumatic fever due to poor housing is universal; the degradation of being rejected by your society based on your material well-being is universal. Thus the recent benefit increases must be celebrated, as small and complicated as they are. It's just that for Māori these challenges are systemic and never-ending. More than benefits, more than economic development and community development, we need broader strategies for mitigating the destructive influences of colonisation and poverty. We need to address issues of long term systemic and constitutional change. (Kaa, 2015, p.26)*

The Māori Affairs Committee's *Inquiry into the determinants of wellbeing for tamariki Māori* (2013) made multiple recommendations[4] to the Government, including, for research and policy: "Requiring a strengths-based, kaupapa Māori approach to building the capability of whānau to design and implement solutions to ensure the wellbeing of their tamariki." With political consensus, and a deliberately child-centred approach to social investment, all tamariki could thrive.

The following sections provide information and discussion on child poverty and hardship, health,

3 See http://www.cpag.org.nz/assets/Summit/151029SummitProceedings.pdf.

4 The full list of the Māori Affairs Committee's recommendations, are provided in the Executive Summary, and the 2014 National Government's responses to the recommendations is provided in Appendix 1.

housing, and education, with a close focus on the experiences of Māori children. Each section draws on research and reports, including those from the Māori Affairs Committee (2014), the Children's Commissioner's Expert Advisory Group (2012), and Child Poverty Action Group (2014), to reveal the political and structural nature of the problems. Each section ends with recommendations toward solutions to child poverty in Aotearoa New Zealand.

For hope to be restored, State action is required. The benefits for all Aotearoa far outweigh the costs.

Poverty and hardship

Definitions

Māori poverty must be considered within the context of the impact of colonisation, the alienation of land and resources, and the consequent loss of a cultural, spiritual and economic base. Those influences and impacts continue to shape and inform attitudes towards Māori, and the effects of ongoing racism and discrimination … are well documented (Expert Advisory Group on Solutions to Child Poverty, 2012).

> *Mäori are statistically much more likely than the majority population to have greater health problems, achieve lower education levels, and be economically and socially disadvantaged. These inequities, then, result in a reliance on the State, which in turn gives the State a certain level of control; for example, the State determines Mäori health and education provisions, social services, and levels of funding. (Penehira, et al., 2014, pp.105-6)*

"Income poverty and material deprivation are by definition unacceptable states of affairs." (Perry, 2015, p.69) Poverty and hardship create and contribute to present and future health, wellbeing and education risks for children. Poverty can be measured in purely monetary terms as income, or using non-monetary indicators (Perry, 2015), on a wider participation and belonging measure (Royal Commission of Inquiry on Social Security in New Zealand, 1972), or as access to resources (Public Health Advisory Committee, 2010). The Ministry of Social Development defines poverty as "unacceptable material hardship arising from limited financial resources" (Perry, 2010, p.68).

As well as a disadvantaged and insecure economic condition, poverty must be understood as a "shameful and corrosive social relation", as Lister (2004, p.7) explains, the non-material aspects of poverty include:

> *lack of voice; disrespect, humiliation and assault on dignity and self-esteem; shame and stigma; powerlessness; denial of rights and diminished citizenship … They stem from people in poverty's everyday interactions with the wider society and from the way they are talked about and treated by politicians, officials, the media and other influential bodies.*

Incidence

A general misconception is that all poor children live in sole-parent (SP) families, yet half of all poor children come from two-parent (2P) families. Although on average in 2013 and 2014, children living in SP households experienced significantly higher poverty rates (62%) than those in (2P) households (15%) and other family households (18%), children in households with three or more children tend on average to have poverty rates of 30% compared to the 20% of those with only one or two children, and in 2014, children in the larger households made up 45% of all poor children (Perry, 2015, p.122).

Another misconception is that it is only the children of beneficiaries who experience poverty and hardship. As shown in Table 1 (below), from 2009 to 2014, around two in five poor children came from households where at least one adult was in full-time paid employment or self-employed (Perry, 2015, p.122-124).

Table 1. Poverty rates and composition for children by ethnicity and household characteristics, based on 60% of median CV (fixed line) AHC measure: average over HES surveys 2011 – 2013 (Perry, 2016, Table H.8)

Dependent children (0-17 yrs): 1,060,000	**Children in income-poor households**		**All children**
	What % of this category are poor?	**What % of poor children are in this category?**	**What % of all children are in this category?**
	Poverty rate (%)	Composition of the poor (%)	Approximate composition for all children (%)
Household type			
Sole parent HH	64	47	18
Two parent HH	15	44	69
Multi-adult family HH	16	8	12
Family type			
Sole parent families	53	53	24
- in SP family on own	*69*	*45*	*16*
- within a wider HH	*23*	*8*	*8*
Two parent families	15	47	76
# of children in the household			
1 or 2	21	55	63
3+	29	45	37
Ethnicity			
Maori	34	34	24
Pacific	34	13	10
Other	27	14	12
Euro/Pakeha	17	38	54
Highest household educational qualification			
No formal qualification	55	15	7
School qualification only	35	38	25
Post-school non-degree	21	33	38
Degree or post-graduate	12	14	30
Main source of income for HH			
Benefit	75	63	22
Market	12	37	78
Tenure			
HNZC	54	19	9
Private rental	38	53	33
Own home	12	28	59
Children overall	23	100	100

Incomes

Wage inequalities reveal discrimination on the basis of both race and gender. Robson (2016, p.33)[5] notes that the impact for Māori families with the average hourly wage more than $5 lower than that of Pākehā (see Table 2).[6] The Treasury also reports that about 60% of Māori and Pacific wage earners earn below the Living Wage (then $18.40 per hour), while sole parents (predominantly Māori) are over-represented among those earning the minimum wage (The Treasury, 2013b).[7]

5 Robson (2016, p.33) also suggests three important modifiable factors that contribute to income disparities: growing inequalities in wages, wealth, and changes in redistribution (taxes and welfare). The removal of inheritance taxes and gift duties, the flattening of tax rates, the 18% increase in average hourly earnings since 1975 while GDP per capita has increased 60% implies that more of the nation's wealth is going to capital not labour and average top salaries have increased rapidly.

6 See Campaign for equal value equal pay 2015. http://cevepnz.org.nz/Gender%20pay%20gap/gender-ethnicity.htm.

7 An International Monetary Fund study found that erosion in union membership in New Zealand explained a 7% increase in the income shares of the top tenth (a much higher increase than in other countries), due to reduced bargaining power and diminished political influence on redistribution policy (Jaumotte & Buitron, 2015). Rosenberg (2015)þ Nj estimates this represents a loss to wage earners of $10,000 per wage earner per year.

Table 2. Average hourly earnings by gender and ethnicity, June 2014[8]

All women	All men	Ratio	All Māori	All Pākehā	Ratio
$25.35	$29.44	86.1%	$23.48	$28.66	81.02%
	Women		**Men**		**Average**
Pākehā	$26.13		$31.08		84.07%
Māori	$22.46		$24.48		91.75%
Pacific	$20.83		$22.80		91.36%
Asian	$23.81		$25.96		91.72%

Although the pay equity settlement for care and support workers in the aged and disability residential care and home and community support services in 2017 resulting from the TerraNova pay equity claim brought by E tū on behalf of care worker Kristine Bartlett was a milestone,[9] 'pay equity' has not been extended to other industries, and remains a fraught concept.

A high level of joblessness is also a major contributor to poor outcomes for children. Māori unemployment has remained high – even when New Zealand was enjoying exceptionally high Gross Domestic Product (GDP) growth rates in 2007. From 2008 the unemployment rates for Māori have risen more than those for other New Zealanders (see Tables 3 and 4).

Table 3. December Quarterly Unemployment[10]

	2003	2012	2015	2016
European	3.2%	5.5%	5.3%	4.1%
Māori	10%	14.8%	10.6%	11.9%

Table 4. December Quarterly Employment[11]

	2003	2012	2015	2016
European	66.7%	65.0%	64.8%	68.4%
Māori	58.1%	55.2%	57.8%[12]	61.6%

It is difficult not to assume some ethnic prejudice is in operation, particularly when the employment statistics are compared with prevailing pay rates. When Māori people are employed, on average, they are paid at measurably lower rates than Pākehā. Low wages, casualised employment and high unemployment all contribute to the disproportionate poverty experienced by Māori families and their children. Wage inequalities contribute to wealth inequalities as those with the highest salaries have the ability to save and build assets.

The Working for Families (WFF) package of tax credits implemented in 2007 produced improvements for those on low and middle incomes, but it has not improved conditions for the poorest children. While all families with children and gross annual income under $36,350 receive assistance from the Family Tax Credit (FTC), the additional In-Work Tax Credit (IWTC) of $72.50 per week per child (as

8 See http://cevepnz.org.nz/Gender%20pay%20gap/gender-ethnicity.htm and Statistics NZ's Income Survey.

9 See Ministry of Health at http://www.health.govt.nz/new-zealand-health-system/care-and-support-workers-pay-equity-settlement.

10 Statistics New Zealand, Household Labour Force Survey, December quarters 2005, 2012, 2015, 2016 at www.statistics.govt.nz.

11 Statistics New Zealand, Household Labour Force Survey, December quarters 2005, 2012, 2015, 2016 at www.statistics.govt.nz.

12 See http://www.mbie.govt.nz/info-services/employment-skills/labour-market-reports/maori-labour-market/maori-in-the-labour-market-fact-sheets/maori-dec-2015/document-image-library/dashboard-maori-dec2015.pdf.

at 1 April 2016) is available only to parents meeting the ‘paid work’ criteria (a minimum of 30 hours per week for a two-parent household, and 20 hours per week for a sole parent), and not receiving any of the main social welfare benefits or a student allowance. Although the tax credits are designed to assist with the living costs of children, the policy design excludes the children who are most in need of this extra assistance (Child Poverty Action Group, 2016; Dale, et al., 2014).[13]

The contribution WFF has made to reducing child poverty is reflected in the data: from 2007 to 2013, children in beneficiary households generally had poverty rates around six to seven times higher than for those in households where at least one adult was in full-time work (Perry 2016). What is painfully obvious is the inadequacy of the main welfare benefits made worse by the exclusion from the IWTC and parental tax credit for newborns. Although WFF has worked for families in paid work, WFF is being eroded over time even for them (Johnson, 2016, p.11).

Welfare benefits and WFF tax credits are linked to inflation as measured by the Consumer Price Index (CPI), but this has proved an inadequate indicator, excluding many unavoidable basic costs from the so-called ‘basket of goods’. Statistics New Zealand has developed a new set of household living-costs price indexes (HLPIs) to measure the particular inflation experience of 8 groups of households: Māori, beneficiaries, income quintiles (five groups), and superannuitants.[14] The HLPIs show that the CPI is a poor measure of the actual prices faced by lower income groups including Māori. This new evidence may drive positive change, including improvements to the adequacy of WFF and welfare benefits, although currently no commitment to change has been made.

Impact

It is particularly disturbing that Māori continue to have hardship rates two to three times higher than other groups (Perry, 2015). Child poverty can be halved, but as Jonathan Boston (2016) writes:

> *We would need a complete revamp of benefit rates, more generous financial assistance to low-income families, significant changes to housing policies including a large investment in social housing, a reformed system of child support, and stronger employment incentives and supports. Additionally, all forms of social assistance would need to be fully indexed to prices, with a direct linkage of family assistance to average wages – as we do for pensions.*

Children who grow up in severe hardship are likely to lack the resources necessary to thrive in the knowledge economy in which they will either participate as adults, or be excluded.

At the same time, current measurements of ‘success’ and ‘failure’ do not take account of the Māori world view. For example, in a recent series of interviews published by Whakawhetu Māori SUDI Prevention, an important recurring theme in the data was that whānau rarely defined themselves as being poor or in hardship, even though they often struggled to cover their basic needs for food, clothing and housing. “They did not self-define as poor. This meant they could feel positive about their circumstances and be grateful for what they had.” In most cases, as long as food was available, they were not “too poor”:

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13 For a full discussion of Working for Families, see St John in ale, M. C., M. O’Brien and S. St John, Eds. (2014). Our children, our choice: priorities for policy. Auckland, Child Poverty Action Group, at: http://www.cpag.org.nz/assets/Publications/1410063-0%20Our%20Children%20Our%20Choice%202014.pdf; see policy recommendations at: http://www.cpag.org.nz/campaigns/fix-working-for-families-fwff-campaign/policy-recommendations/.

14 See http://www.stats.govt.nz/browse_for_stats/economic_indicators/prices_indexes/hlpi-consultation-decisions.aspx.

Participants… considered "wealth" to be something that could be measured in non-materialistic terms: happiness was about family connection (whānaungatanga), pride in yourself and internal happiness, not money or a new car. A good life was one where their children were happy. (Houkamau, 2016, p.1)

Maori Affairs Committee Recommendations:

- **Recommendation 33:** *Requiring government departments, in consultation with Māori authorities, to develop initiatives to target long-term unemployed young people and increase investment in tamariki Māori and rangatahi.*
- **Recommendation 34:** *Develop region-specific sustainable economic and employment plans in areas of high Māori unemployment in collaboration with whānau, hapū, iwi, Māori corporations, the Māori business sector, and regional economic development agencies.*
- **Recommendation 35:** *Develop, in cooperation with industry, educational institutions, iwi, and communities, skill acquisition and retraining opportunities in emerging sectors for workers in insecure or transitional industries in areas of high Māori population.*
- **Recommendation 36:** *Develop clear higher education pathways and meaningful paid employment opportunities for parents and caregivers.*
- **Recommendation 37:** *Continue to increase the minimum wage.*
- **Recommendation 38:** *Review Working for Families to assess whether it is achieving its intended purpose.*
- **Recommendation 39:** *Support the provision of financial literacy education and information, by government and non-government agencies, to help whānau.*
- **Recommendation 40:** *Support the provision of new models of social lending.*

CPAG Recommendations:

1. Develop new measurements and indexes to reflect Māori values, spirituality and capabilities, including concepts of poverty and wealth.
2. Conduct independent, gender-neutral assessments of Māori employment to determine whether the pay rates are fair. The government has a direct responsibility under the Bill of Rights Act as it funds many of the caring, cleaning and cooking jobs of Māori people in the public health and education sectors.
3. Add the In-Work Tax Credit to the first child Family Tax Credit and adjust the income threshold for abatement to reflect growth in average wages. Return the rate of abatement to 20%.
4. Whānau Ora welfare providers give assistance and training in social security provisions to whānau to ensure their people are fully apprised of their entitlements.

Poverty and tamariki

Measures

New Zealand does not have an official measure for child poverty, although there are multiple available measures. The OECD defines the *child income poverty rate* as the proportion of 0–17 year olds with an income of less than 50% of the national annual median equivalised post-tax-and-transfer income.[15] The Ministry of Social Development (MSD) uses multiple measures for comparison, including 60% of the median annual equivalised (adjusted for household size and composition) disposable household income (Perry, 2016, p.3). While household income is a proxy measure of material wellbeing or hardship, MSD also uses non-income measures: the Material Wellbeing Index (MWI) comprises 24 items that give direct information on the day-to-day actual living conditions that households experience. To better compare the material wellbeing of households when using incomes, especially for "poverty" measurement, the MSD also uses household income after deducting housing costs (AHC incomes). Perry (2016, p.127) describes the poverty line at 50% of median household income as "more stringent".

Comparing 2012 child poverty rates internationally using the 50% of median threshold (BHC), New Zealand at 13% is a little above the median of 11% for the 34 OECD countries, very close to Australia (13%) and Canada (14%) (Perry, 2016, p.170). Child poverty in New Zealand in 2014 using the AHC 50% anchored line measure was 17-18%, and using the AHC 60% anchored line measure was 21%. Irrespective of the measure used, Māori children are over-represented in the child poverty statistics. Around one in six European/Pākehā children lived in poor households, one in four Pacific children, and one in three Māori children (Perry, 2011, p.113). Yet despite the barriers, Māori PhD levels are the highest in the world amongst indigenous people (Families Commission, 2012, p.31).

Children live with their families in households of many types, and the family income determines almost entirely whether or not the child experiences poverty and hardship.[16] For comprehensive monitoring of poverty and hardship, use of non-income measures of material deprivation is also essential (Perry, 2015, p.80-81). There is a set of basic human needs that are reasonably universal, although the way these needs are met varies over time and between countries and cultures. For New Zealand, the list includes: clean drinking water and adequate food / nutrition

- suitable clothes and shoes
- adequate housing: shelter/warmth; electricity; hot running water; sanitation, waste disposal
- dental and medical care as required
- household durable goods: food storage and cooking, sleeping, cleaning and maintenance
- transport (for employment, supplies, 'helping', children …., leisure)
- ICT including a computer in the household and broadband internet access
- social engagement, including engagement that involves financial cost
- financial resources to cope with unexpected essential expenses (Perry, 2015, p.81)

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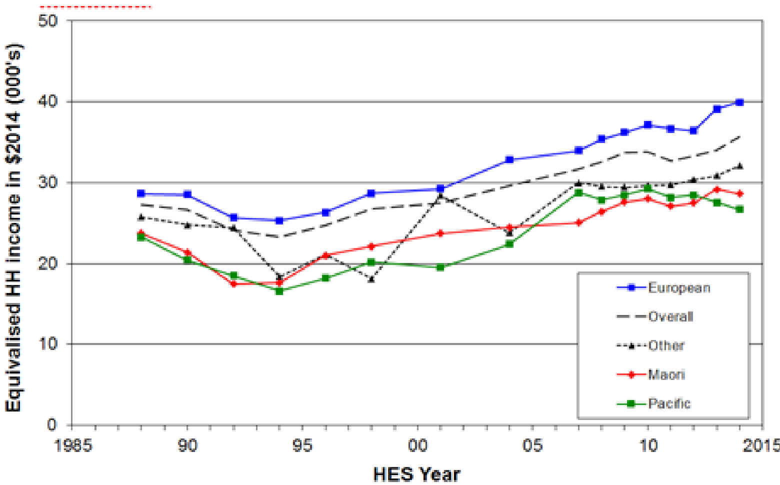
15 See: http://www.oecd.org/els/family/CO_2_2_Child_Poverty.pdf.

16 MSD reports that from 1982 to 2013, poverty rates for younger children (0 to 11 years) were consistently higher than the rates for older children (12 to 17 years), as shown in Figure 4 below. However, Perry (2015, p.120) notes that the large increase in rates for older children from 2012-13 to 2013-14 "should not be taken as a new or definitive finding – another year of survey data is needed to properly assess whether the change is 'real' or just a statistical blip".

The median household income, the mid-point of all family incomes, is a more useful indicator than the average household income. Perry (2015, p.67) reports some improvement with overall median household income rising 47% in real terms from 1994 to 2010, while for Māori, the rise was even stronger at 68%.[17] The median projection by Statistics New Zealand for the total population is shown in Figure 2.

Figure 2. Real equivalised median household incomes (before housing costs) by ethnicity, 1988 to 2014 ($2014) (Perry, 2015, Figure D.10)



Whatever measure is used, the poverty rates for Māori and Pasifika children are consistently higher than for those in the European/Pākehā ethnic group. Approximately 32% of all children are Māori or Pacific, yet from 2012 to 2014, these children comprised 46% of all poor children. On average over 2012 to 2014, using the after housing costs (AHC) 60% measure, around 16% of European/Pākehā children, but 33% of Maori children, lived in poor households (Perry, 2015, p.121).

Populations

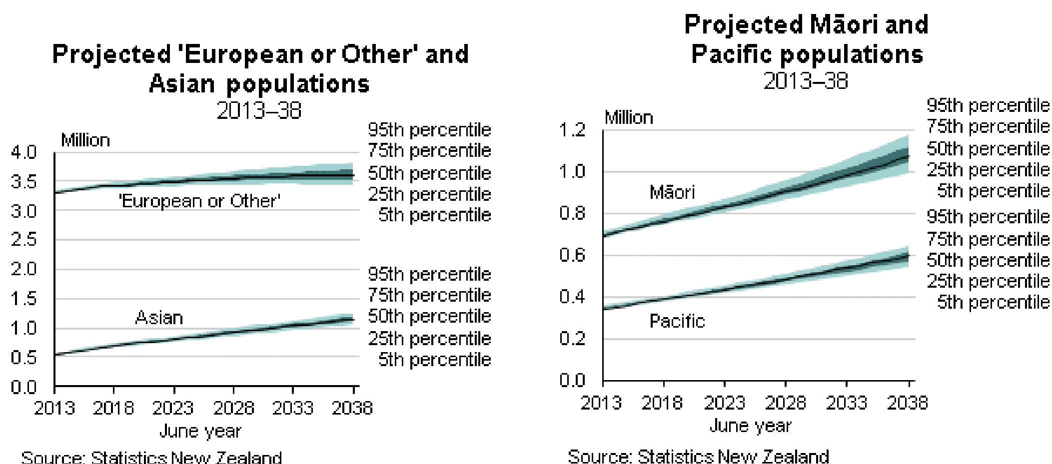
The Māori population has a median age of 23.9 years compared to non-Māori at 41 years.[18] Given this younger median age, and the added factor that Māori women tend to become mothers at younger ages than Pākehā women (Simpson J, Duncanson M, Oben G, Wicken A, & M, 2015, p.35), Statistics New Zealand projects a measurable shift in the ethnic proportions of children aged 0–14 years by 2038: 'European or Other' children will reduce to 63.2% (from 71.6% in 2013); Māori children will increase to 32.6% (from 25.6% in 2013); Asian children will make up 21.6% (11.9% in 2013); and Pacific children will increase to 19.6% (13.4% in 2013) (Statistics New Zealand, 2015).[19]

17 Statistics New Zealand's *Te Ao Marama*, a small collection of statistics relating to Maori, reports that median income from all sources declined for Maori from 2008 to 2011, whereas median income for the whole population remained reasonably steady. *Te Ao Marama* reports the incomes of individuals and Perry (2015) uses households so the trends are different.

18 See http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/infographic-culture-identity.aspx.

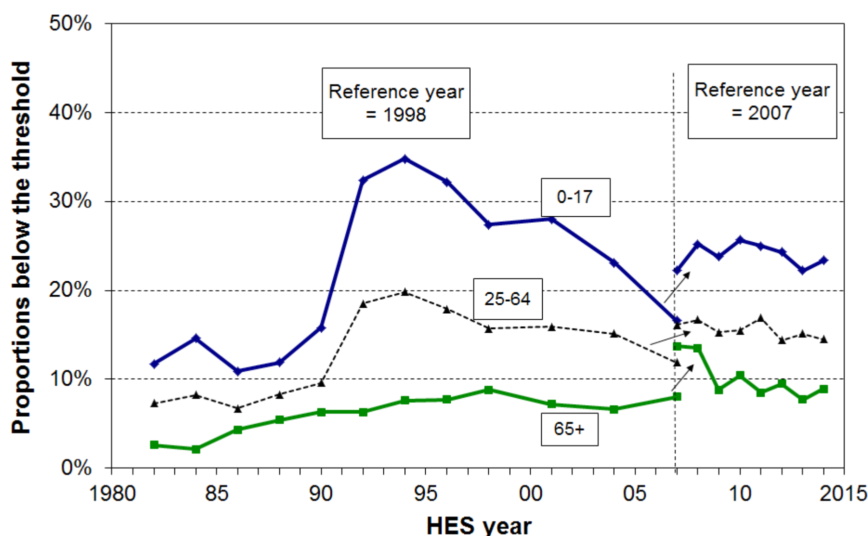
19 The proportions exceed 100% as a result of high incidence of multiple ethnicity (Statistics New Zealand, 2015).

Figure 3. Projected populations 2013 – 2038 (Statistics New Zealand, 2015)



Between 1995 and 2015, the population aged 0–14 years increased by 8% to number 915,300.[20] In the 2013 census, 33.7% of Māori were aged less than 15 years, compared with 18.0% of non-Māori. Māori children made up 25.6% of all children aged 0–14 years, Pacific children are 13.4%, Asian children are 11.9%, and 'European or Other' children are 71.6%.[21] Of these 915,300 children, more than 230,000 live below the poverty line; and just under half of these children are Māori and Pasifika (Perry, 2015, p.121). As shown in the figure below, the burden of poverty is born by our children, in stark comparison to the situation for those aged 65 and over. Moreover, Māori children are disproportionately burdened.

Figure 4. Proportion of all individuals in low-income households by age, 60% CV threshold (AHC) (Perry, 2015, Figure G 1)



20 See http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationEstimates_HOTPAt30Jun15/Commentary.aspx#Three.

21 See http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalEthnicPopulationProjections_HOTP2013-38/Commentary.aspx#smaller.

Duration

Another cause of grave concern is that for many children in low-income families, poverty persists over most of their childhood:

> *Statistics New Zealand's Survey of Family, Income and Employment (SoFIE) for 2002−2009, indicated that, of the children who were aged 0–17 years in the first year of SoFIE (2002−03), 24% lived in households experiencing persistent poverty (i.e. an income which, when averaged across all seven years, was below 60% of the gross median) and 29% were deemed to be in current poverty (i.e. with an income below 60% of the gross in the year under review).* (Simpson, J, et al., 2016, pp., p.21)

As SoFIE results indicate, a quarter of our children are experiencing many years of poverty, and the rates of severe and persistent poverty among Māori children are at least double the rates for Pākehā children (Expert Advisory Group on Solutions to Child Poverty, 2012). There is urgent need for major systemic change to the formulation of policies, their implementation, and their evaluation.

Research from the Dunedin Longitudinal Study confirms the immediate and long-term effects of poverty on children. Compared with those from high socioeconomic status (SES) backgrounds, children who grew up in low-SES families had poorer cardiovascular health, poorer oral health, and more substance dependency problems. Importantly relief from poverty later in life "did not mitigate or reverse the adverse effects of low childhood SES on adult health." (Poulton, R et al., 2002, p.1640) A strong recommendation for improving population health, and protecting children, emerges: "Protecting children against the effects of socioeconomic adversity could reduce the burden of disease experienced by adults" (Poulton, R, et al., 2002, p.1641).

The future reality of increasing proportions of Māori and Pasifika children intensifies the urgency and importance of the current crisis of their widespread poverty and hardship. The nation's future economic and social health will depend on people who were deprived in childhood, denied access to the economic and social health they are expected to provide as adults to others. "Children who grow up in hardship in a comparatively wealthy nation are evidence of the failure of social and economic policies." (Henare, et al., 2011, p.22)

Maori Affairs Committee Recommendations:

- **Recommendation 41:** *Consider appointing a Cabinet Minister for Children and a ministry for children, with responsibility for a children's action plan and a Māori children's action plan, enshrined in a Children's Act, to set targets for children's health and wellbeing against which all ministries and departments would be required to report. A Children's Act should also take into account and refer specifically to New Zealand's obligations under the United Nation's Convention on the Rights of the Child and the United Nations Declaration on the Rights of Indigenous Peoples, and include a requirement for a child impact assessment of all new legislation to be prepared by the ministry for children, detailing each bill's potential impact on children.*
- **Recommendation 44:** *Requiring the Ministry of Health, in cooperation with other ministries and departments as appropriate, to develop a cross-sectoral needs assessment tool for pregnant women, and ensure that all pregnant low-income vulnerable women are contacted by case workers to implement the needs assessment protocol and coordinate services.*
- **Recommendation 45:** *Funding the expansion of effective teen parenting unit programmes in*

secondary schools to strengthen and support young Māori parents.

- **Recommendation 46:** *Improve the adequacy of benefits and incomes for whānau without paid work to ensure the wellbeing of their tamariki.*
- **Recommendation 47:** *Investigate the introduction of a universal child payment.*
- **Recommendation 48:** *Investigate partnering with employers, unions, local government, and iwi to address job shocks that may adversely affect whānau.*

CPAG Recommendations

1. Adopt an official poverty line; monitor major indicators of child poverty and report these on a regular basis by ethnicity with specific target reductions to be met on the way to ending child poverty by 2022.
2. Fund child-impact assessments of existing and future national and local policies.
3. Set net income for those on benefits so that no-one is under the poverty line: income support for families with children, whether tax credits or welfare benefits, must be adequate to ensure the well-being of children. Remove work-based rules for child financial assistance and pay the equivalent of the IWTC to all low-income families.
4. Ministry of Social Development to monitor the discourse on poverty in government departments and the media to ensure the current demonising of the poor, including beneficiaries, is halted.

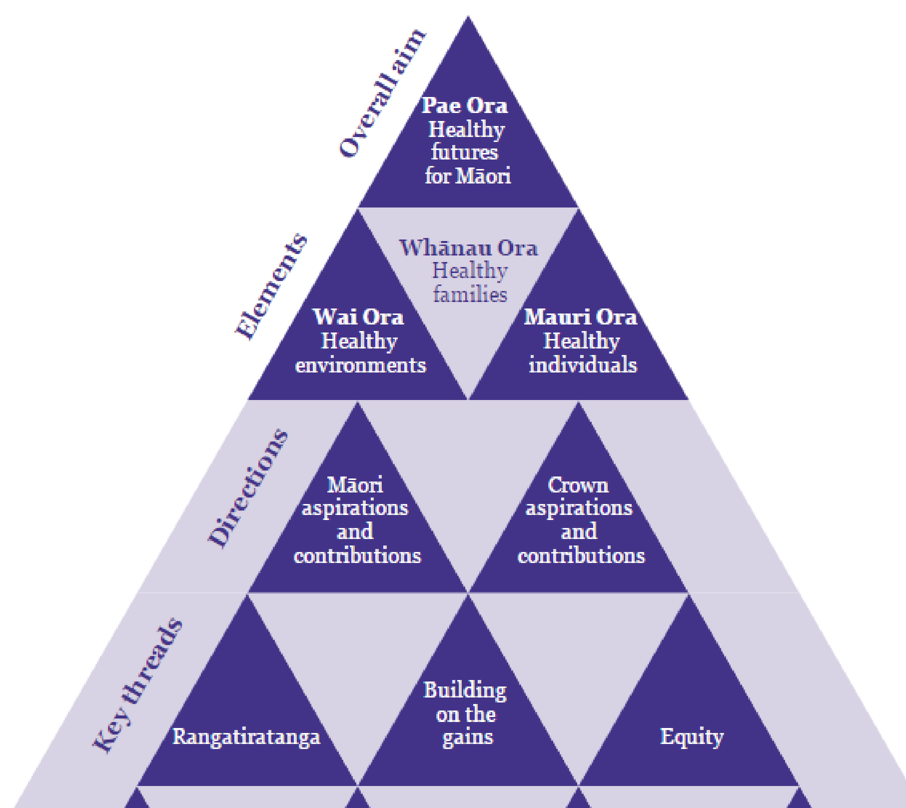
Health

Preliminary estimates by Mills, Reid and Vaithianathan (2012) suggest the societal costs of child health inequities between Māori and non-Māori in New Zealand are significant. A conservative "base case" scenario estimate is over $NZ62 million per year, while alternative costing methods yield larger annual costs of nearly $NZ200 million when the cost of potentially avoidable deaths of Māori children is included. This research suggests that "health sector spending is skewed towards non-Māori children despite evidence of greater Māori need". Furthermore, "Eliminating child health inequities, particularly in primary care access, could result in significant economic benefits for New Zealand." (Mills, Reid, & Vaithianathan, 2012)

He Korowai Oranga

New Zealand's Māori Health Strategy, He Korowai Oranga, sets the overarching framework that guides the Government and the health and disability sector toward achieving the best health outcomes for Māori and realising pae ora – healthy futures. The strategy was updated during 2013–14. The framework for He Korowai Oranga is shown below (Ministry of Health, 2015).

Figure 5. The framework for He Korowai Oranga (Ministry of Health, 2015)



Although implementing He Korowai Oranga is the responsibility of the whole of the health and disability sector, it requires the involvement of other sectors. The four pathways of the framework are: supporting whānau, hapū, iwi and community development; supporting Māori participation at all levels of the health and disability sector; ensuring effective health service delivery; and working across sectors.

Newborns

Poverty has a profound impact on infant mortality: the mortality rate for infants born in areas with the highest scores on the NZDep2013[22] index of deprivation (deciles 9–10)[23] was almost three times higher than the rate for those born in areas with the lowest scores (deciles 1–2) (Simpson J, et al., 2015, p.35). Infant and maternal factors associated with statistically higher rates of infant mortality include premature birth, living in areas with high scores on the deprivation index (Atkinson, Salmond, & Crampton, 2014), Māori and Pasifika ethnicity, male gender and young maternal age. The tendency for Māori women to become parents at a comparatively early age has some advantages, however the mortality rates for infants born to mothers aged under 24 years were 2–3 times higher than the mortality rate for infants born to mothers aged 30–34 years (Simpson J, et al., 2015, p.35).

Table 5. Infant mortality by demographic factor, New Zealand, 2008–2012 (Simpson J, et al., 2015, Table 4)

Variable	Rate	Rate ratio	95% CI	Variable	Rate	Rate ratio	95% CI
Infant mortality							
NZ Deprivation Index quintile				Prioritised ethnicity			
Deciles 1–2	2.77	1.00		Māori	6.96	1.68	1.51–1.87
Deciles 3–4	3.35	1.21	0.96–1.52	Pacific	6.72	1.62	1.40–1.88
Deciles 5–6	4.25	1.53	1.24–1.90	Asian/Indian	3.04	0.73	0.60–0.89
Deciles 7–8	5.00	1.80	1.47–2.21	European/Other	4.15	1.00	
Deciles 9–10	7.93	2.86	2.37–3.45	Gender			
Maternal age group				Female	4.54	1.00	
<20 years	10.18	2.88	2.43–3.42	Male	5.72	1.26	1.14–1.39
20–24 years	7.06	2.00	1.73–2.32	Gestation at birth			
25–29 years	4.44	1.26	1.08–1.47	20–36 weeks	37.94	18.08	16.34–20.02
30–34 years	3.53	1.00		37+ weeks	2.10	1.00	
35+ years	4.34	1.23	1.05–1.44				

Source: Numerator: National Mortality Collection; Denominator: Birth Registration Dataset. Note: Rates are per 1,000 live births; Rate ratios are unadjusted; Ethnicity is level 1 prioritised

The second major cause of death in the first year of life was sudden unexpected death in infancy (SUDI). The SUDI rate has fallen by more than two thirds between 1996-1997 and 2012, to 0.6 deaths per 1000 live births, with the largest reduction for Māori and Pasifika infants (Simpson J, et al., 2015, p.36-37). Again, the impact of poverty is clear: the SUDI rate for infants born in areas with the highest scores on the deprivation index (deciles 9–10) was six times higher than infant mortality rates for infants in areas with the lowest scores (deciles 1–2). More Māori families are in the highest scoring deciles.

> *The New Zealand Child and Youth Epidemiology Service has identified a number of injury types and medical conditions seen in children for which hospitalisation or mortality rates are correlated to scores on the NZDep index of deprivation. These conditions are said to have a social gradient: children living in the most deprived areas of New Zealand (areas with high NZDep scores) are about twice as likely or more to be hospitalised or die from these conditions than children living in the least deprived areas.* (Simpson J, et al., 2015, p.40)

22 See Appendix 2 for a Socioeconomic Deprivation Map of New Zealand.

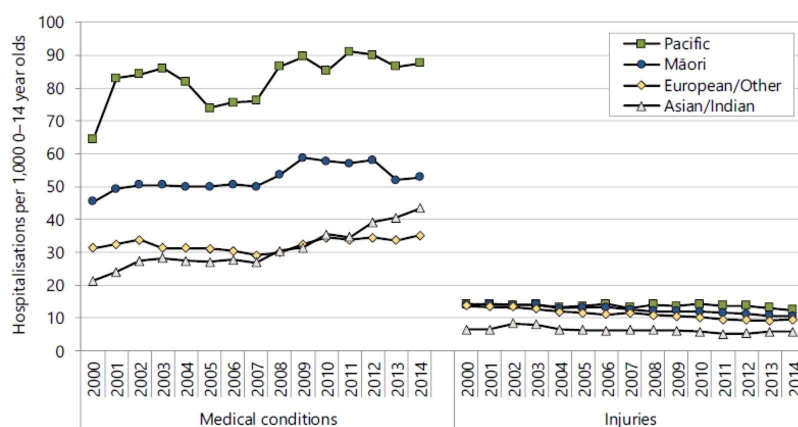
23 In health, decile 10 indicates the worst deprivation, whereas in education, decile 1 indicates the worst level of deprivation.

Tamariki

Poverty is also a major factor in medical conditions affecting children. Medical conditions with a social gradient include: acute bronchiolitis; acute lower and upper respiratory infection; asthma; bronchiectasis; croup/ laryngitis/ tracheitis/ epiglottitis; dermatitis and eczema; epilepsy or status epilepticus; febrile convulsions; gastroenteritis; inguinal hernia; meningitis; meningococcal disease; nutritional deficiencies or anaemias; osteomyelitis; otitis media; pneumonia; rheumatic fever or rheumatic heart disease; skin infections; tuberculosis; urinary tract infection; vaccine-preventable diseases; and viral infections (Simpson J, et al., 2015, p.41).

While a welcome decrease in hospitalisation rates for injuries with a social gradient was observed for all children from 2000 to 2014, hospitalisation rates for medical conditions with a social gradient increased for all children aged 0–14 years (see Figure 5) (Simpson J, et al., 2015, p.48-49).

Figure 6. Hospitalisations for conditions with a social gradient in 0–14 year olds (excluding neonates) by ethnicity, New Zealand 2000–2014 (Simpson J, et al., 2015, Figure 27)



Source: Numerator: National Minimum Dataset (neonates removed); Denominator: Statistics NZ Estimated Resident Population. Note: Medical conditions: acute and arranged admissions only; Injury: excludes emergency department cases and waiting list admissions; Ethnicity is level 1 prioritised

From 2008 to 2012 there was an average of 29 deaths per year from medical conditions with a social gradient (3.27 deaths per 100,000 children aged 0–14 years). The most common underlying causes of death in this category were communicable diseases such as pneumonia, meningococcal disease and gastroenteritis, and chronic diseases such as epilepsy and asthma. Table 6 shows the conditions underlying the hospitalisation each year of about 40,000 children from preventable diseases.

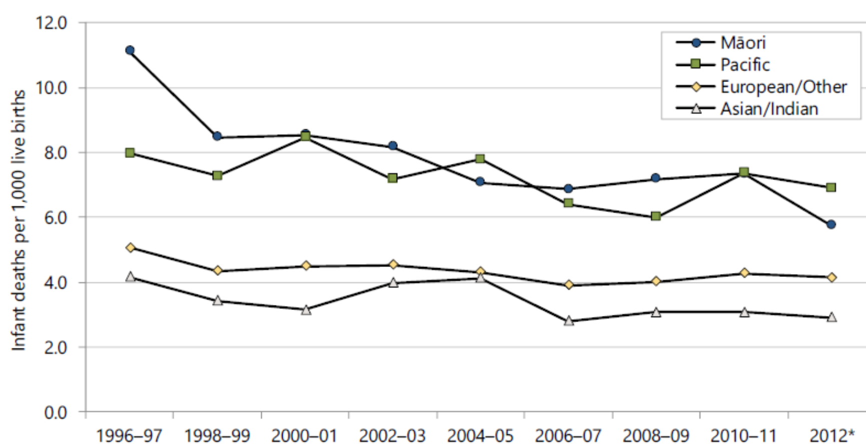
Table 6. Distribution of mortality with a social gradient in children aged 0 – 14 years, by demographic factors, New Zealand 2008 – 2012 (Simpson J, et al., 2015, Table 8)

Table 8. Distribution of mortality with a social gradient in children aged 0–14 years, by demographic factors, New Zealand 2008–2012

Variable	Rate	Rate ratio	95% CI	Variable	Rate	Rate ratio	95% CI
Death from conditions with a social gradient in 0–14 year olds							
Medical conditions							
NZ Deprivation Index quintile				Prioritised ethnicity			
Deciles 1–2	1.05	1.00		Māori	5.32	2.72	1.86–3.96
Deciles 3–4	2.38	2.26	1.02–4.99	Pacific	7.47	3.81	2.44–5.95
Deciles 5–6	2.12	2.01	0.90–4.47	Asian/Indian	1.35	0.69	0.29–1.60
Deciles 7–8	3.32	3.15	1.50–6.62	European/Other	1.96	1.00	
Deciles 9–10	6.48	6.15	3.07–12.3	Gender			

As shown in Figure 7 below, from 1996 to 2012 infant mortality rates fell for all ethnic groups in New Zealand, most noticeably for Māori and Pasifika infants.

Figure 7. Total infant, neonatal, and post neonatal mortality, New Zealand, by ethnicity, 1996–2012 (Simpson J, et al., 2015, Fig. 19)



Source: Numerator: National Mortality Collection; Denominator: Birth Registration Dataset. Note: Ethnicity is level 1 prioritised, 2012* is single year of data

For young people to flourish, they need a supportive, healthy, equitable and fair society that provides genuine opportunities. Deprivation contributes to inequities in child mortality. Children in NZDep 9-10 (most severe) have six times the chance of death compared to NZDep1-2, as shown in Table 6. Although child abuse is experienced across the spectrum of family incomes, the observed relationship between poverty and abuse has disastrous consequences, and Māori comprise 60% of children in Oranga Tamariki's care.[24] The incidence of violence towards children in New Zealand is high (Carroll-Lind, Chapman, & Raskauskas, 2011, p.11), and UNICEF research suggests that the operative factor is poverty which "disproportionately affects ethnic minority families" (UNICEF, 2003, p.13).

Poor health in childhood is a risk factor for poor outcomes in adult life and throughout the lifetime. Family poverty during the crucial early years of childhood increases the risk of longer term negative outcomes such as heart disease, poor dental health, antisocial behaviour (Boden, Fergusson, & Horwood, 2010) and drug abuse in adulthood (Poulton, R. et al., 2002).

Nga taitamariki

Adolescent health and well-being are influenced by healthy families and communities that are able to provide opportunities for teens to contribute and develop, as well as wider structural factors including poverty and unemployment. Such factors influence young people's ability to transition successfully into meaningful employment, to further their training and education, and to form long-term relationships and start families (Staff et al., 2010).

With regard to access to healthcare services, taitamariki Māori are less likely to report excellent health, less likely to have accessed a general practitioner (GP) in the previous 12 months and less likely to have obtained the healthcare they required in the previous 12 months. Taitamariki Māori are significantly more vulnerable to the poor health and wellbeing outcomes compared to New Zealand European/Pākehā students, as the 2012 Youth Health Survey reports (Clark et al., 2013).

The very welcome introduction of free GP visits for children aged 13 and under in 2015[25] have yet to

24 See http://www.radionz.co.nz/national/programmes/ninetonoon/audio/201799251/cyf-review-must-better-address-maori-says-researcher.

25 See Ministry of Health: http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/zero-fees-under-13s.

be statistically measured, but improved access to medical care, without cost as a barrier, will make a real difference for children. In particular, children from areas with the greatest poverty have nearly three times the likelihood of being admitted to hospital over those from the better resourced areas: between 2010 and 2014 there were 205,661 hospitalisations of children aged 0–14 years for medical conditions with a social gradient and 45,160 hospitalisations for injury with a social gradient. (NZ Child & Youth Epidemiology Service, 2015).

Technology also provides opportunities for improved healthcare, as shown by the MOKO programme, begun in Far North primary school health clinics by Dr Lance O'Sullivan to take throat swabs of any children presenting with sore throats (an early indicator of rheumatic fever).[26] Mobile technology has enabled the digital cloud-based, phone app version of the programme, iMOKO, to spread faster and further. Thanks to a low-cost broadband initiative, low-income families in the Far North can stay connected, allowing the iMOKO team to follow up on treatment and keep parents and whānau informed, and enabling parents to ask questions and get advice.

Solutions to the evident health inequalities are available and achievable.

Maori Affairs Committee Recommendations:

- **Recommendation 10:** *Implementing early intervention programmes for at-risk whānau.*
- **Recommendation 11:** *Implementing a national quadruple health enrolment scheme, involving enrolling every child with a general practitioner, a Well Child Tamariki Ora provider, on the national immunisation register, and with an oral health provider.*
- **Recommendation 12:** *Developing community hubs, linked to Whānau Ora providers, to offer integrated health and social services from single locations.*
- **Recommendation 13:** *Creating incentives for the health sector to find and use a consistent, robust, reliable way to assess and reach every whānau, with a particular emphasis on those that are hard to reach.*
- **Recommendation 14:** *Working to build the Māori health workforce by increasing support for education and recruitment.*
- **Recommendation 15:** *Funding evidence-based initiatives to reduce teenage pregnancy.*
- **Recommendation 16:** *Ensuring access for all whānau to well-designed pre-birth programmes, ante-natal care and education, and early childhood development programmes.*
- **Recommendation 17:** *Commissioning an intensive review of the provision of specialised mental health services for Māori.*
- **Recommendation 18:** *Increasing support for the promotion of smokefree environments, by way of policy, cessation services, and mass media campaigns targeting Māori youth, pregnant women and parents.*
- **Recommendation 19:** *Facilitating partnerships between health providers, community groups, and marae to encourage the production and consumption of healthy food.*
- **Recommendation 20:** *Encouraging the medical profession to offer specific vocational training in order to serve Māori patients better as a routine component of on-going professional development.*
- **Recommendation 21:** *Increasing promotion of and participation in Māori health promotion models such as Te Pae Mahutonga, Te Whare Tapa Whā, and Te Wheke.*

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26 See *Distinguished Alumni Award for healthcare leadership and innovation* at: http://www.voxy.co.nz/national/5/276465.

- **Recommendation 22:** *Ensuring community services, including health services, operating out of school grounds are not at a cost to school budgets.*
- **Recommendation 23:** *Ensuring that health literacy education is based on kaupapa Māori, and communicated in a culturally appropriate way.*
- **Recommendation 42:** *Extending free after hours healthcare to all children to the age of 18.*
- **Recommendation 43:** *Investigate the provision of free healthcare to all children to the age of 18.*

CPAG Recommendations

1. Inequalities in access to health services be addressed by a dual approach: coordination across all Government departments, and coordination between policies for health and policies aimed at reducing income inequality and poverty.
2. Provide free access to primary healthcare for all children under age eighteen, 24 hours a day, seven days a week.
3. Urgently develop a national strategy to focus on under-nutrition in children.
4. Improving access to and the quality of primary healthcare for Māori is a priority. Research shows that culture is an important factor in the use of health services, so attention must be given to encouraging Māori people to train for and join the health workforce.
5. An increased emphasis on Kaupapa Māori approaches in Oranga Tamariki's redevelopment is required.

Housing

As Superu (2017) states in the *Families and Whānau Status Report 2016*, Māori families are more likely to live in deprived areas and have associated housing problems than the national average, consequently, the health indicators for these families are slightly lower than average. These families are also less likely to believe that civil authorities, such as the Police and government departments, are fair.

Home

In 1993, New Zealand recognised the right of every child to adequate housing by signing the United Nations Convention on the Rights of the Child (UNCROC). *Article 27* of that convention states:

> *The government recognizes the right of every child to an adequate standard of living for the child's physical, mental, spiritual, moral and social development…. And the Government shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.*[27]

In the *Housing New Zealand Housing Pathways* 2016 study, key findings of analysis of what parents and caregivers said in relation to children and housing were: safe, secure, stable housing is crucial, but it needs to be accompanied by adequate household income; safe, well planned, and adequately serviced neighbourhoods achieve the most benefit; and tenants in state houses often become hubs for wider family which has benefits but can also lead to crowding (Scott, Laing, & Park, 2016).

Housing and property are the major sources of household wealth in New Zealand (Simpson, J, et al., 2016). In the early mid-1990s, 72% of children lived in households that owned their home, and 50 to 55% of children identified as poor came from households that owned their own home. The home-owning proportion of families with children had fallen from 72% to 57% by 2012, and 53% of poor children lived with their families in private rental accommodation, with another 19% in Housing NZ Corporation (HNZC) homes (Perry, 2015, p.122).

Because residential property is the major wealth source for many households/ individuals, the lower home-ownership rates among Māori affects their ability to accumulate wealth: in the 2009/10 SoFIE results, Māori were 13% of the population but owned 5% of the net worth (Statistics New Zealand, 2016).

Renting

Housing is recognised as a key determinant of health, and housing has a central role in child health inequalities (Simpson, J, et al., 2016). More than a third of the population, over 1.6 million people, including children, are deeply affected by the cost and quality of rental accommodation. Statistics New Zealand (2016) report that the proportion of all children aged under 15 years not living in owner-occupied dwellings increased between 1986 and 2013 from 26.1% to 43.1%. For Māori, the proportion of their population living in an owner-occupied dwelling fell at a faster rate than for the total population, particularly during the prolonged recession in the 1990s with high unemployment. In 1986, around half of Māori children lived in an owner-occupied dwelling, but by 2013, the proportion had fallen to 38.5%.

27 See http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

Tenant households are generally younger and poorer than owner-occupier households. Nationally, households in the lowest two JEAH income quintiles paid the largest proportion of their income in rent: between 32% and 49% for quintile four, and 49% and over for quintile five (Goodyear & Fabian, 2014, p.61). High housing costs aggravate the poverty experienced by low-income households and especially those households with children.

Tenant households move more frequently than owner-occupiers and this disrupts schooling for their children, especially for families who relocate frequently. This impacts negatively on children's education. High rental costs and low incomes affect the ability of households to pay for other essentials, such as heating. Throughout New Zealand, around 70% of households in unheated dwellings rented their home (Goodyear & Fabian, 2014, p.92), and lack of heating in the home can be used as an indicator of deprivation. Research evidence shows that:

> *New Zealand has a high rate of excess winter mortality compared with other OECD countries and fuel poverty is a likely contributor. A study linking census and mortality data showed a statistically increased risk of dying in winter among low-income people, those living in rented accommodation, and those living in cities.* (Goodyear & Fabian, 2014, p.90)

The good news for tenants is that legislation[28] proposed in 2016 is likely to be introduced that requires rental accommodation to meet minimum standards of insulation, weather tightness, ventilation, safe electrical wiring and heating, and to have fire alarms. Unfortunately, there is no suggestion yet that fair rent rules or other tenants' protections be introduced.

Crowding

Many rented and HNZC homes are crowded, adding health risk for children, and making it difficult for school-age children to study. Internationally, research has suggested correlations between crowding and meningococcal disease, acute rheumatic fever, tuberculosis, respiratory infections, hepatitis B and other enteric diseases, conjunctivitis, and poor mental health outcomes. Such associations arise from closer, more prolonged and frequent contact between children and people with infectious diseases (Simpson, J, et al., 2016, p.113).

Recent research by Statistics New Zealand (2012) found that crowding has been consistently higher among some ethnic groups: in 2006, just under a quarter of Māori lived in a crowded household:

> *The level of crowding experienced by Pacific peoples and Māori appears to be the result of a combination of factors. These include larger household size (including a higher proportion of households with multiple families or extended families) and affordability issues (the household cannot afford a dwelling large enough to accommodate its members).* (Statistics New Zealand, 2012, p.12)

Māori, followed by Pākehā, had the largest absolute numbers of people living in crowded conditions. Multi-family households have increased as a proportion of both severely crowded households (from 42.1% to 45.1%), and crowded households appeared to have significantly fewer financial resources available, for example, median Jensen Equivalised Annual Household[29] income for crowded

28 See Residential Tenancies Amendment Bill and Healthy Homes Guarantee Bill (No. 2).

29 Derived from the Jensen equivalisation scale, the JEAH income scale is widely used in New Zealand, for example, it is one of the components making up the New Zealand Deprivation Index and is used in the Ministry of Social Development's Social Reports (Goodyear & Fabian, 2014, p.49)

households in 2013 was $42,300 compared with $69,100 for those not crowded (Goodyear & Fabian, 2014).

Table 7. Crowded housing by ethnicity, 2013 census (Ministry of Health, 2014, Table 4a)

Ethnicity for all age groups	European	Māori	Pacific	Asian
Crowded (number)	119,430	110,940	108,660	82,143
Percent crowded	**4.3**	**20.0**	**39.8**	**18.4**
Not crowded	2,675,790	444,831	164,523	365,361
Percent not crowded	95.7	80.0	60.2	81.6
Total people stated	**2,795,220**	**555,771**	**273,183**	**447,504**

Ethnicity by selected age group	Aged 0–4	Aged 5–9	Aged 10–14	Aged 14–19	Total aged 0–19
Māori					
Crowded (number)	32,700	15,846	10,683	10,605	69,834
Percent crowded	25.9	21.9	19.2	22.3	23.1
Not crowded	93,729	56,421	45,048	36,963	232,161
Percent not crowded	74.1	78.1	80.8	77.7	76.9
Total people stated	**126,429**	**72,267**	**55,731**	**47,568**	**301,995**

Rates of crowding are particularly high among Māori children, as Table 8 shows. Overcrowding appears to be a contributing factor to children acquiring severe skin infections requiring hospitalisation (O'Sullivan, Baker, & Zhang, 2010), and researchers in New Zealand have linked household crowding to our alarming rates of rheumatic fever (Jaine, Baker, & Venugopal, 2008).

There is a clear correlation between levels of income and levels of crowding. People with full-time jobs are less likely to be living in crowded households than unemployed people (7% and 20%, respectively). In 2006, 17% of people receiving income support lived in crowded households (Ministry of Social Development, 2010, p.71). While crowding was extremely low for households in the highest JEAH income quintile, between 2006 and 2013, for people in Auckland in the lowest income JEAH quintile, crowding increased by 30.5%, and this group also experienced a decline in home ownership of 16.6% (Goodyear & Fabian, 2014, p.85).

A strategy

The *'Māori Housing Strategy – He Whare* Āhuru *He Oranga Tāngata'* (Ministry of Business Innovation and Employment, 2014) addressed the recommendations in a 2011 report from the 'Controller and Auditor-General: Government Planning and Support for Housing on Māori land' and the New Zealand Productivity Commission's 2012 report on its Housing Affordability Inquiry. The Strategy set out six directions to improve Māori housing over the period 2014 to 2025. The six directions are:

1. Ensure the most vulnerable Māori have secure tenure, and access to safe, quality housing with integrated support services;
2. Improve the quality of housing for Māori communities;
3. Support Māori and their whānau to transition to preferred housing choices;
4. Increase the amount of social housing provided by Māori organisations;
5. Increase housing on Māori owned land; and
6. Increase large scale housing developments involving Māori organisations.

The directions could be supported and implemented, following the Ministry of Health (2014, p.20) urging of care in the design of interventions to address crowding:

> *Interventions are likely to be more effective if agencies and providers enable communities to have meaningful input into service design and delivery of interventions to reduce crowding relevant to their community.*

That advice applies to all interventions to improve conditions in communities: genuine consultation, and then incorporation of the outcomes of the consultation into the determined action.

Sadly, the deepening housing crisis in Auckland as revealed by the widening spread of homelessness in 2016, suggests the recommended 'directions' remain merely words in Government's reports.

Maori Affairs Committee Recommendations:

- **Recommendation 31:** *Promoting partnerships between central and local government, the Māori Trustee, and iwi organisations to utilise property assets to build housing for whānau on Māori land and address the shortage of affordable and appropriate social housing.*
- **Recommendation 32:** *Implementing housing warrants of fitness for rental properties, in line with the recommendation from the Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty.*

CPAG Recommendations:

1. Introduce fair rent rules and other tenants' protections, including security of tenure.
2. The Government develop and fund a national housing plan to address the increasing housing shortages, including a range of additional practical measures to increase the ability for Māori low-income households with children to purchase their own home.

Education

In an economic and social system increasingly structured around participation in a skilled or 'knowledge' labour market, education is vital. In her novel, *LaRose* (2016, p.105), Louise Erdrich describes "chaotic families" in the worst poverty: children from such families don't get to school, or get sleep, or real food, or homework help. And the children don't ever get out of the chaos, whatever brand of chaos unless they get to school. To succeed in school, children have to attend regularly, eat regularly, sleep regularly, and study regularly. Children need some intervention, not a wrenching away but an intervention giving parents time to get on track.

Policy and practice could be redesigned and funded to provide such child-focussed supportive interventions. In Māori society, 'community' and the associated social responsibility and support are foundational. While this is not the framework in intensely individualistic New Zealand society, the potential benefits of a more collaborative approach are multiple.

Early Childhood Care and Education (ECCE)

Good quality early childhood care and education (ECCE) is a determinant for later educational success, but access to quality ECCE in low-income areas is limited. Overall ECCE participation has increased steadily since 2000, and New Zealand is ranked in the top third of OECD countries for participation in ECCE. The prior ECCE attendance of children starting school rose from 90.0% in June 2000 to 96.2% for the year ended June 2015.

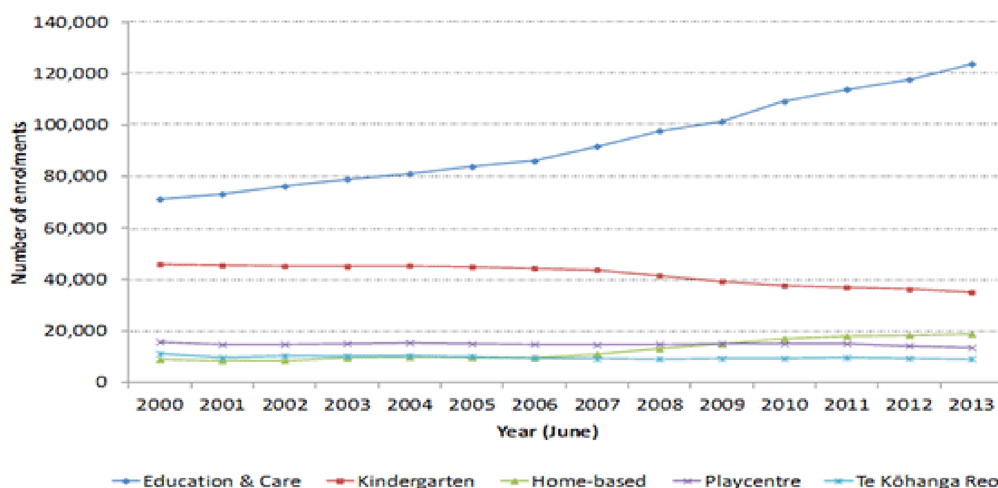
For profit 'education and care services' took 63% of the enrolments/attendances in licensed ECCE services in 2014. Kindergartens had the next largest share (16%), followed by home-based services (10%), Playcentres (6%), and Kōhanga Reo (5%). From 2000 to 2013, the number of enrolments in early childhood education increased by 30.5%: enrolments in Education and Care increased by 73.8%, and in Home Based Networks increased by 110.6%. However, enrolments in Kōhanga Reo decreased by 17.6%, in kindergarten decreased by 23.7%, and in Playcentre decreased by 14.2% (Simpson, J., J. Adams, G. Oben, A. Wicken, & M. Duncanson, 2016, p.23).

Decreased numbers for kindergartens, Playcentres and Kōhanga Reo are perhaps because overall, the growth in enrolment rates between 2000 and 2014 were highest for children aged one, two and three years: the proportion enrolled of all one-year-olds increased from 29% to 44%, the proportion of two-year-olds increased from 48% to 65% and the proportion of three-year-olds rose from 85% to 96% over the same period.[30] This suggests that increased enrolments are supporting parental employment. Largely in response to the introduction of government-funded 20 hours ECCE in 2007, over the period from 2000 to 2014, the average number of weekly hours per enrolment rose 53.3%, from 13.5 to 20.7 hours.[31]

30 See http://www.educationcounts.govt.nz/indicators/main/student-engagement-participation/1923.

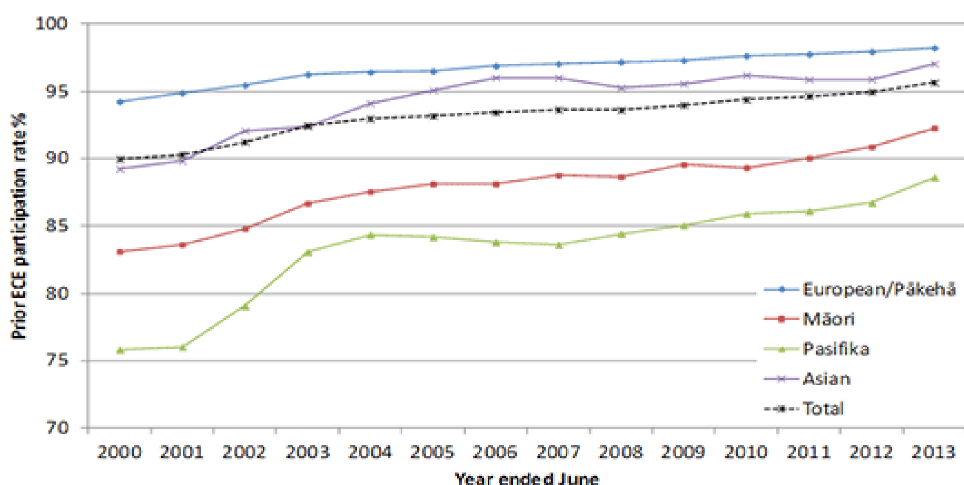
31 See http://www.educationcounts.govt.nz/indicators/main/student-engagement-participation/1923.

Figure 8. Number of enrolments/attendances by service type, 2000-2014



Since 2000, the gap in ECCE participation rates across different ethnic groups has narrowed, and participation rates for all groups increased between 2000 and 2015. By 2015, 94.0% of Māori children had participated in ECCE before starting school, compared with 83.1% in 2000.[32]

Figure 9. Prior participation in ECE of children starting school by ethnic group, 2000-2015



As a consequence of increased enrolments and increased hours of attendance, public expenditure on ECCE between 2002 and 2013, in current 2013 dollars, rose by 203% from $542 million to $1,641 million. The proportion of total public education expenditure that is allocated to ECCE has more than doubled since 2002, up from 6.4% in 2002 to 13.1% in 2013. Public investment in ECCE as a proportion of GDP increased 137% between 2002 and 2013, from 0.33% to 0.77%.[33]

Internationally, New Zealand ranks in the top group of OECD countries in terms of both its per-child public investment in ECCE and its proportion of total public spending allocated to ECE.[34] The spending on ECCE supports the politically-driven work compulsion for beneficiary families, with 'work' narrowly defined as paid employment. The drive to work as the solution to poverty, and hence to reliance on ECCE rather than parents and whānau largely ignores the importance of attachment, the enduring emotional closeness binding families in order to develop children neurologically in a stimulating,

32 See http://www.educationcounts.govt.nz/indicators/main/student-engagement-participation/1923.

33 See http://www.educationcounts.govt.nz/indicators/main/resource/public-expenditure-on-early-childhood-education-ece.

34 See http://www.educationcounts.govt.nz/indicators/main/resource/public-expenditure-on-early-childhood-education-ece.

secure and loving environment[35] and prepare them for independence. Children's dependency means that the nature of their family relationships profoundly influences their experiences in both health and illness.

> *Attachment allows children the 'secure base' necessary to explore, learn and relate, and the wellbeing, motivation, and opportunity to do so. It is important for safety, stress regulation, adaptability, and resilience.* (Rees, 2007)

The issue is whether children experience relationships as valuable, reliable, and safe. Attuned parenting teaches children that others recognise their needs, and establishes foundations for trust, empathy, understanding relationships, and verbal and non-verbal communication (Rees, 2007). It is extremely challenging for parents to establish such foundations when the compulsion to paid work requires that their children under three years spend most of their waking hours in ECCE.

Whitehurst (2016) notes the results of an important and well-designed study in Norway that evaluated the impact of receipt by lower income parents of a subsidy for childcare. The subsidy increased the family's disposable income by lowering their tuition bill rather than affecting their use of childcare.

> *This study shows that a modest boost in income for low-income families during one year of the lives of their preschoolers had substantial long-term impacts, including enhancing school performance in middle school. These effects were not mediated by preschool attendance. Instead, the additional income appears to have allowed the parents to function better and thereby increase their own and their children's human capital.* (Whitehurst, 2016, p.4)

This study supports the argument that, rather than provision of childcare outside the home, adequate family income is the critical first step toward reduced inequality, social justice, and the greater immediate and enduring well-being of children.

Older children: rangitahi

In a knowledge-based society, access to tertiary education or an entry-level job requires young people to have formal school qualifications. The desired minimum for school leavers is a National Certificate of Educational Achievement (NCEA) Level 2 qualification, giving opportunities for further education, employment, health outcomes and a better quality of life (Simpson, Adams, et al., 2016, p.131).

In 2013, students were required to obtain 10 literacy and 10 numeracy credits at level 1 to achieve an NCEA Level 1 qualification, an increase on the 8 credits previously required. In 2014, of a total of 60,588 school leavers, 52,706 (87%) had achieved NCEA Level 1 or equivalent. Of 12,754 Māori school leavers, 9,395 (74%) achieved NCEA Level 1 or equivalent.[36] As Table 8 below shows, a similar pattern of improvement is evident at NCEA Level 2 for Maori and Pākehā school leavers.

Table 8. School Leavers with a Minimum of NCEA Level 2 or Equivalent (Marriott & Sim, 2014, Table 7)

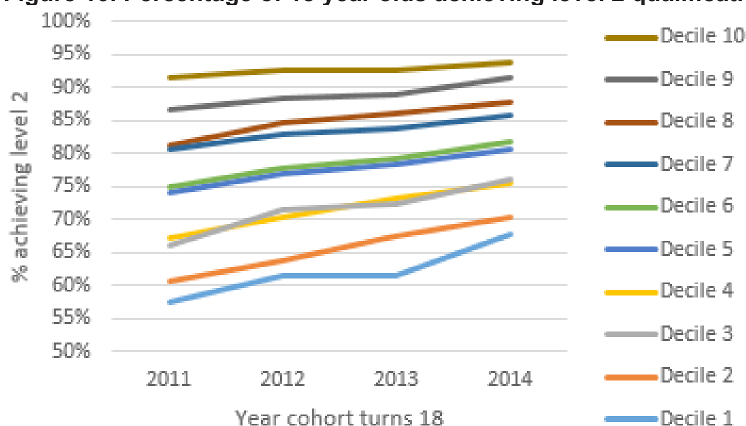
	2001	2012	Absolute Change (2012-2001)
European	68.5%	82.1%	+13.6%
Māori	40.6%	60.9%	+20.3%

35 See http://www.cyf.govt.nz/documents/info-for-caregivers/fds-cd-stages-of-brain-dec11-hu.pdf.

36 See http://www.educationcounts.govt.nz/statistics/schooling/senior-student-attainment/school-leavers2/ncea-level-1-or-above-numbers.

Threats to the decile funding system exacerbate an already punishing situation for the majority of Māori children who attend low-decile schools in low-income areas.[37] As shown in the figure below, income – of the family, the community, and consequently the school, is a critical 'success' factor.

Figure 10. Percentage of 18 year olds achieving level 2 qualifications[38]



The majority of Māori children live in the north of the North Island, with 57% living in one of the four northern regions of (Bay of Plenty, Waikato, Auckland and Northland). Other densely populated regions in terms of Māori children are Hawkes Bay, Taranaki, Manawatu-Wanganui, and Wellington. The north and east of the North Island, where there is a strong concentration of Māori children, are the most deprived regions (Sin & Stillman, 2005).

The educational achievement, health status and emotional and social adjustment of rangatahi are linked to a secure cultural identity nurtured by Māori language, custom, land, marae, whānau and community networks. The Youth'12 study found that high rates of cultural pride in one's cultural identity are reported for Māori students (72%) compared to other ethnicities (Clark, et al., 2013, p.12).

Māori medium education is delivered through bilingual (English/Te Reo Māori) classes, Te Reo Māori immersion classes, Kōhanga Reo early childhood education services, and kura kaupapa Māori schools at three levels. Kura Tuatahi deliver education from Years 1 to 8 as contributing primary, full-primary or intermediate schools; Kura Arongatahi deliver education from Year 1 to 13 as composite schools; and Wharekura deliver education to Years 9 to 13.

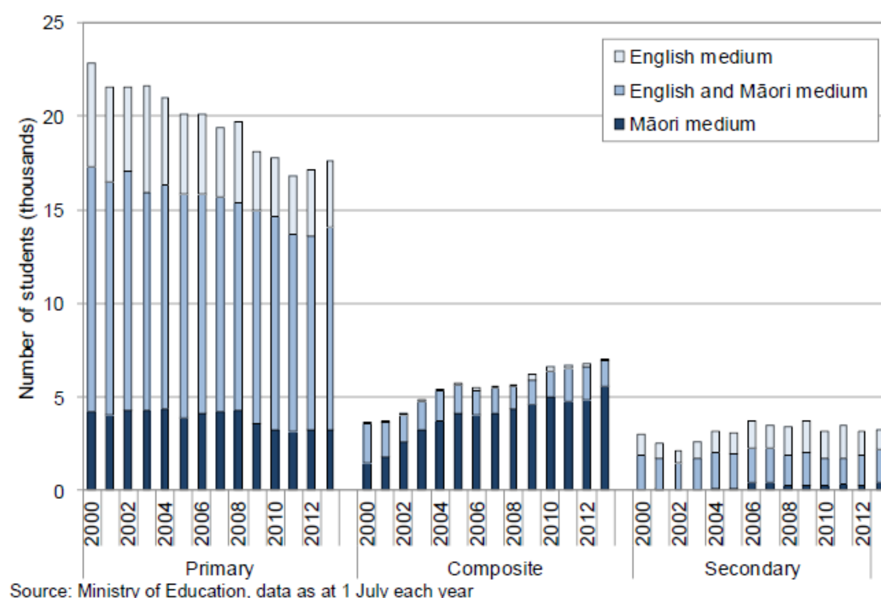
The number of Kura Kaupapa Māori and Kura Teina has increased from 59 in 2000, to 72 in 2013. In 2013, a total of 67 Kura Kaupapa Māori schools collectively enrolled a total of 6,352 students. All of the North Island District Health Boards (DHBs) had Kura Kaupapa Māori located within their catchments, but in the South Island there were none in Nelson, Marlborough, South Canterbury or the West Coast DHBs. Students who do not attend Kura Kaupapa Māori may still have access to some of their educational curriculum in the Māori language through attending a bilingual school or an immersion/ bilingual class in primary or secondary school (Simpson, Adams, et al., 2016, p.128). Research shows that:

> *Māori students participating in Māori medium secondary education have been more likely to succeed educationally than their Māori peers at English-medium schools.* (Simpson, Adams, Oben, et al., 2016, p.127)

37 In Health, decile 10 is the poorest, in Education, decile 10 is the richest.

38 See www.educationcounts.govt.nz/statistics.

Figure 11. Number of Students Involved in Māori Medium Education by School Sector and Form of Education, New Zealand 2000–2013 (Simpson, Adams, et al., 2016, Figure 48)



Source: Ministry of Education, data as at 1 July each year

Another important factor is the availability of school-based health services, which are funded through the Ministry of Health via DHBs. The services provided: a part-time nurse and/or doctor, physiotherapists, social workers, psychologists, depend on a school's location and the funding streams available to it. The programme is targeted by decile, with funding for decile 1 to decile 3 secondary schools, teen parent units and alternative education facilities. Access at school to confidential, affordable health professionals not only acts as a preventive of escalating problems, it offers role models. This can be supported, as at Otahuhu College, by offering extra science classes (Howie, 2017).

Disengaging

When a student is disengaging from school, there are clear signals. If underlying reasons are not identified and addressed, disengagement can lead to chronic truancy, stand-downs and suspensions, or in the more serious cases, expulsion of the student (Ministry of Education, 2012, p.39). A likely consequence of disengagement is non-completion of qualifications that assist in giving the student greater opportunities for their future, including gaining meaningful employment.

The proportion of young people who are not in employment, education or training (NEET) is used as an indicator of youth disengagement. As at December 2015, there were 130,600 Māori aged 15–24 years. Of these, 27,200 people were NEET, an increase from 25,800 from a year ago. Overall, Māori have higher NEET rates than other ethnic groups.[39] Among Māori aged 15–24 years, 15.7% of males and 25.9% of females were NEET in the year to December 2015.

While the overall NEET rates for both Māori females and males rose, the rate for Māori aged 15–19 years fell by 0.1 percentage points from December 2014 to 13.5% in the year to December 2015. This is likely to be a result of the increasing availability of the fees-free Youth Guarantee education opportunity.

39 See http://www.mbie.govt.nz/info-services/employment-skills/labour-market-reports/maori-labour-market/maori-in-the-labour-market-fact-sheets/maori-dec-2015/document-image-library/dashboard-maori-dec2015.pdf.

The number of students in level 1 to 3 increased substantially from 2012 to 2013, due to private training establishments switching from delivering Youth Training (discontinued in 2013) to delivering Youth Guarantee places. From 2013 to 2014, the number of Māori students enrolled in Youth Guarantee increased by 1,490 from 2013 to 2014. In 2014, there were 6,080 Māori students involved in Youth Guarantee – a programme providing fees-free level 1 to 3 qualifications for 16–19 year-olds. Partially offsetting the increase in student numbers at level 1 and level 3 were decreases in the number of students enrolled in level 2 certificates, level 4 certificates and level 5 to 7 diplomas/ certificates.

Another initiative focused on equitable outcomes for students who have been under-represented in tertiary education is the Starpath Project, based at the University of Auckland's Faculty of Education and Social Work. The project is an evidence-based whole school intervention focused on transforming educational outcomes for Maori, Pasifika and low-income students who are under-represented in degree-level study (Starpath, 2016). The project concentrates on a small number of schools in Northland and Auckland, promoting opportunities to learn and targeting the academic progress of students towards the University Entrance qualification.

Tertiary Education

Data from the Ministry of Education[40] shows that public spending on tertiary education is down across nearly every budget line since the National Government took office. For example, total tertiary education spending in 2008-09 was more than $4.3 billion, whereas in 2014-015 it was less than $4.2 billion, half a billion less than the public's investment in 2008-09 when adjusted for inflation. Industry training funding fell $25 million, and while research funding for science and innovation rose $9 million to $179 million, if it had kept pace with inflation it would have risen to $189 million.

Tertiary Education Union president Sandra Grey says:

> *If you look around New Zealand all students and their institutions need more money to prevent the ongoing redundancies restructures, course closures and turmoil that is undermining their education. But the areas that need it the most are the regions. If this government does nothing else for tertiary education this year, it needs to change direction on the way it treats people who don't live in big cities. Those people deserve to be able to study, to get the skills they need to work and support their community, in their own communities, near their families.* [41]

Despite such obstacles, Māori participate in formal tertiary education at higher rates than other ethnic groups. The age-adjusted participation rate of Māori was 15% in 2014, compared to Asian at 8.2%, European at 9.9% and 11% for Pasifika.[42]

Enrolments by Māori students in bachelors or higher qualifications increased by 519 from 2013 to 2014, mainly due to an increase in students undertaking Bachelor degrees.[43] The Chief Families Commissioner reported, Māori PhD levels are the highest in the world amongst indigenous people

40 See http://www.educationcounts.govt.nz/statistics/tertiary-education/resources.

41 See http://teu.ac.nz/2016/05/budget-restore-regions/.

42 To allow comparisons to be made with other ethnic groups, the tertiary education participation rates can be age-adjusted to eliminate the effect of the different age distributions of the ethnic groups. In 2014, the unadjusted tertiary education participation rate for Māori was 18%, compared to 9.1% for Europeans, 10% for the Asian ethnic group and 15% for the Pasifika ethnic group.

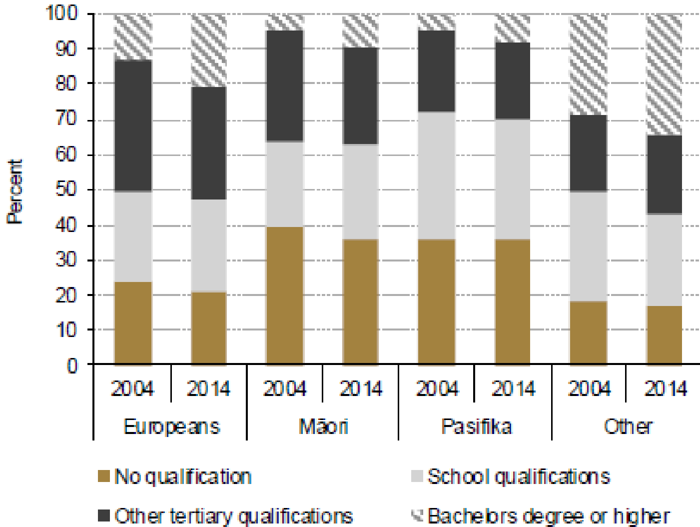
43 Note: 'Bachelors' includes graduate certificates/diplomas and 'honours' includes bachelors with honours degrees and postgraduate certificates/diplomas.

(Families Commission, 2012, p.31) Comparing 2004 with 2014, the proportions of Māori holding a bachelor's or higher qualification have increased steadily, from 4.3% in 2004 to 9.8% in 2014. The comparable figure for Europeans was 13% in 2004 and 21% in 2014 (Tertiary Sector Performance Analysis, 2015, p.6).

Outcomes

In 2014, the median hourly earnings of people with a bachelor's or higher qualification were 67% higher than for people without a qualification (Tertiary Sector Performance Analysis, 2015, p.10). The links between educational qualifications and employment are strong. Very few young people who complete a qualification at diploma level or above are on a benefit in the first seven years after study. Around 5% of level 5–7 diploma graduates are on a benefit and around 1% of bachelors graduates, in each of the first seven years after study, but around 12% of those who graduated with certificates at levels 1–3 are on a benefit in the first seven years after study.[44]

Figure 12. Population aged 15 years and over by highest qualification and ethnic group (Tertiary Sector Performance Analysis, 2015, Figure 2.4)



Education advantages the society as well as advantaging the individual. Yet tertiary students are struggling with the increasingly 'user-pays' regime that imposes hardship such as being unable to afford basic and essential items such as accommodation, food, clothing and medical treatment. This conflicts with the government's legal and moral obligations to ensure that tertiary education is accessible and that students are not suffering undue hardship. "Rising fees and inadequate support to mitigate the increasing cost of living may also be inconsistent with the National Government's Tertiary Education Strategy." (Lin, 2016)

Maori Affairs Committee Recommendations:

- **Recommendation 24:** *Encouraging whānau-friendly parenting programmes and adult education courses in schools to encourage all parents to take part in the school community.*
- **Recommendation 25:** *Taking steps to increase the number of Māori teacher aides as a pathway to increasing the number of Māori teachers.*
- **Recommendation 26:** *Implementing teacher training programmes to improve teachers'*

44 See Education Counts: http://www.educationcounts.govt.nz/publications/80898/what-young-graduates-do-when-they-leave-study.

awareness of the social justice issues regarding education and tamariki Māori in poverty, and to equip teachers to teach in empowering and culturally appropriate ways. These programmes should be a core part of teachers' initial training and ongoing professional development.

- **Recommendation 27:** *Extending programmes and interventions such as Te Kotahitanga to all schools.*
- **Recommendation 28:** *Taking the lead in ensuring equitable access to technology for all tamariki Māori.*
- **Recommendation 29:** *Address the funding inequities between kōhanga reo and other early childhood education services.*
- **Recommendation 30:** *Requiring the Ministry of Education and the Ministry of Māori Affairs, in conjunction with teacher training providers, to develop and implement a plan to increase the number of Te Reo-speaking teachers and improve delivery of education services in Te Reo Māori, in both full immersion and bilingual settings.*

CPAG Recommendations:

1. Government allocates adequate funding provision to ensure that all early childhood education
2. centres are fully staffed by qualified teachers, and requires ratios of teachers to children and unit sizes to be maintained according to quality guidelines. Base the model of ECCE provision on a neighbourhood by neighbourhood and a town by town assessment of future early childhood education needs.
3. Ensure a minimum of proportional representation on school Boards of Trustees for Māori students.
4. Provide adequate funding for low-decile schools to ensure that all children have access to high quality education.
5. Government funds on-site health professionals in all low-decile schools.

Concluding remarks

The preceding sections in this preliminary report reveal the depth and breadth of this most critical problem: poverty for tamariki Māori. The recommendations at the end of each section suggest possible solutions. Adequacy of tax credits and welfare benefits, support for good parenting beside the availability of high quality childcare and after school care, fair pay and accessible work opportunities, affordable, safe healthy housing, and access to healthcare and education, would all support the family life-cycle transitions, and increase the possibility of healthy, happy children. New Zealand is failing miserably to deliver on its pledges, formalised in national and international treaties and conventions.

Henare drew on his own earlier work to write in *He Ara Hou*, 2011:

> *Three traditional Māori terms, pōhara, tōnui and kōkiri inform a Māori sustainable response in terms of understanding moral issues and the removal of poverty and its consequences. Pōhara refers to poverty, of being poor or being cut off from opportunity. The other side of pōhara is tōnui, rendered as prosperous or prolific, not in a utilitarian sense but in terms of the common good and the quest for a good life. The plan of action is found in Kōkiri, meaning a group moving forward decisively with a purpose, a goal, a target. (Henare, et al., 2011, p.5)*

A fourth Māori term is used in this report: whakapono, means hope. Without hope for a better future, for kokiri, it is difficult to endure injustice and inequality of opportunity. Paraphrasing Anton Blank in his introduction to 'Unconscious bias in education' 2016:

> *Young Māori are digital natives whose identity is being shaped by a multiplicity of external forces. Diversity is the new thing. Diversity provides us with more ways of analysing and finding solutions for life and its challenges. … And hope, hope is there. (Blank, Houkama, & Kingi, 2016)*

There will be significant cost involved in delivering these recommended changes in incomes, work environments, and housing, health and education provision. The immediate and benefits for tamariki and for all New Zealand far outweigh the cost.

The situation requires cross-party agreement and urgent action. No country can afford ethically or economically to risk the futures of a quarter of its children, its taonga.

APPENDIX

Appendix 1: Government response to Report of the Maori Affairs Committee on its Inquiry into the Determinants of Wellbeing for Tamariki Maori (New Zealand Government, 2014)

Research and Policy

- **Recommendation 1:** *Requiring extensive, high-quality research to be undertaken into the wellbeing of tamariki Māori, and developing whānau-focused health and social services policies and programmes based on the findings. The effectiveness of these programmes should be monitored by the developers against agreed targets for which providers should be held accountable and required to report progress annually.* **Response: Accept in part**
- **Recommendation 2:** *Developing coherent cross-government policies and an interdepartmental culture of communication and collaboration to ensure that the wellbeing of tamariki Māori is a priority for all and the necessary information is accessible.* **Response: Accept**
- **Recommendation 3:** *Requiring a strengths-based, kaupapa Māori approach to building the capability of whānau to design and implement solutions to ensure the wellbeing of their tamariki.* **Response: Accept**

Provision of Services – Practice

- **Recommendation 4:** *Providing long-term funding (multi-year appropriations) for pertinent service providers, to allow them to develop trusting relationships with whānau.* **Response: Accept in part**
- **Recommendation 5:** *Requiring services to be mapped demographically, or mesh-blocked, to ensure key services are available in areas of high need.* **Response: Accept in part**
- **Recommendation 6:** *Developing the concept of mobile multi-disciplinary whānau teams to provide professional home-based services, particularly in low-income and isolated areas.* **Response: Accept**
- **Recommendation 7:** *Determine which government agency is the most appropriate to support whānau following statutory intervention in the lives of children.* **Response: Noted**
- **Recommendation 8:** *Requiring the Ministry of Corrections to strengthen and maintain the development and implementation of a plan to increase support for children of prisoners.* **Response: Accept**
- **Recommendation 9:** *Reviewing the provision of services regarding youth offending, with a focus on rehabilitation, integration into society, and reducing reoffending.* **Response: Accept**

Provision of Services − Health

- **Recommendation 10:** *Implementing early intervention programmes for at-risk whānau.* **Response: Accept**
- **Recommendation 11:** *Implementing a national quadruple health enrolment scheme, involving enrolling every child with a general practitioner, a Well Child Tamariki Ora provider, on the national immunisation register, and with an oral health provider.* **Response: Accept in part**
- **Recommendation 12:** *Developing community hubs, linked to Whānau Ora providers, to offer*

integrated health and social services from single locations. **Response: Accept in part**

- **Recommendation 13:** *Creating incentives for the health sector to find and use a consistent, robust, reliable way to assess and reach every whānau, with a particular emphasis on those that are hard to reach.* **Response: Noted**
- **Recommendation 14:** *Working to build the Māori health workforce by increasing support for education and recruitment.* **Response: Accept**
- **Recommendation 15:** *Funding evidence-based initiatives to reduce teenage pregnancy.* **Response: Accept**
- **Recommendation 16:** *Ensuring access for all whānau to well-designed pre-birth programmes, ante-natal care and education, and early childhood development programmes.* **Response: Accept**
- **Recommendation 17:** *Commissioning an intensive review of the provision of specialised mental health services for Māori.* **Response: Noted**
- **Recommendation 18:** *Increasing support for the promotion of smokefree environments, by way of policy, cessation services, and mass media campaigns targeting Māori youth, pregnant women and parents.* **Response: Accept**
- **Recommendation 19:** *Facilitating partnerships between health providers, community groups, and marae to encourage the production and consumption of healthy food.* **Response: Accept in part**
- **Recommendation 20:** *Encouraging the medical profession to offer specific vocational training in order to serve Māori patients better as a routine component of on-going professional development.* **Response: Noted**
- **Recommendation 21:** *Increasing promotion of and participation in Māori health promotion models such as Te Pae Mahutonga, Te Whare Tapa Whā, and Te Wheke.* **Response: Noted**
- **Recommendation 22:** *Ensuring community services, including health services, operating out of school grounds are not at a cost to school budgets.* **Response: Accept in part**
- **Recommendation 23:** *Ensuring that health literacy education is based on kaupapa Māori, and communicated in a culturally appropriate way.* **Response: Accept**

Provision of Services − Education

- **Recommendation 24:** *Encouraging whānau-friendly parenting programmes and adult education courses in schools to encourage all parents to take part in the school community.* **Response: Accept in part**
- **Recommendation 25:** *Taking steps to increase the number of Māori teacher aides as a pathway to increasing the number of Māori teachers.* **Response: Not accepted**
- **Recommendation 26:** *Implementing teacher training programmes to improve teachers' awareness of the social justice issues regarding education and tamariki Māori in poverty, and to equip teachers to teach in empowering and culturally appropriate ways. These programmes should be a core part of teachers' initial training and ongoing professional development.* **Response: Accept**
- **Recommendation 27:** *Extending programmes and interventions such as Te Kotahitanga to all schools.* **Response: Noted**
- **Recommendation 28:** *Taking the lead in ensuring equitable access to technology for all tamariki*

Māori. **Response: Accept**

- **Recommendation 29:** *Address the funding inequities between kōhanga reo and other early childhood education services.* **Response: Accept**
- **Recommendation 30:** *Requiring the Ministry of Education and the Ministry of Māori Affairs, in conjunction with teacher training providers, to develop and implement a plan to increase the number of Te Reo-speaking teachers and improve delivery of education services in Te Reo Māori, in both full immersion and bilingual settings.* **Response: Accept**

Provision of Services − Housing

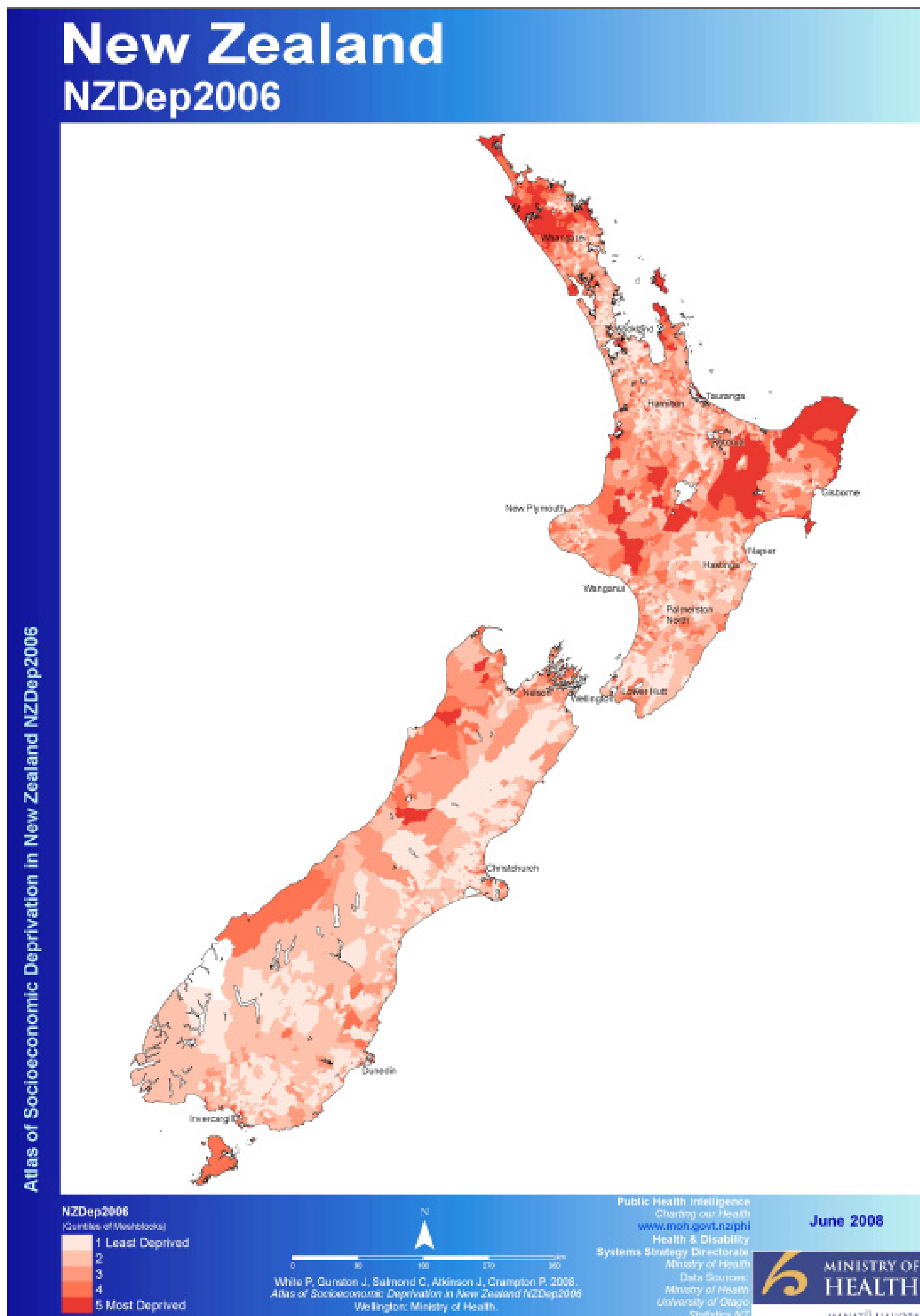
- **Recommendation 31:** *Promoting partnerships between central and local government, the Māori Trustee, and iwi organisations to utilise property assets to build housing for whānau on Māori land and address the shortage of affordable and appropriate social housing.* **Response: Accept**
- **Recommendation 32:** *Implementing housing warrants of fitness for rental properties, in line with the recommendation from the Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty.* **Response: Noted**
- Provision of Services – Incomes and Employment
- **Recommendation 33:** *Requiring government departments, in consultation with Māori authorities, to develop initiatives to target long-term unemployed young people and increase investment in tamariki Māori and rangatahi.* **Response: Noted**
- **Recommendation 34:** *Develop region-specific sustainable economic and employment plans in areas of high Māori unemployment in collaboration with whānau, hapū, iwi, Māori corporations, the Māori business sector, and regional economic development agencies.* **Response: Noted**
- **Recommendation 35:** *Develop, in cooperation with industry, educational institutions, iwi, and communities, skill acquisition and retraining opportunities in emerging sectors for workers in insecure or transitional industries in areas of high Māori population.* **Response: Noted**
- **Recommendation 36:** *Develop clear higher education pathways and meaningful paid employment opportunities for parents and caregivers.* **Response: Accept**
- **Recommendation 37:** *Continue to increase the minimum wage.* **Response: Noted**
- **Recommendation 38:** *Review Working for Families to assess whether it is achieving its intended purpose.* **Response: Noted**
- **Recommendation 39:** *Support the provision of financial literacy education and information, by government and non-government agencies, to help whānau.* **Response: Accept**
- **Recommendation 40:** *Support the provision of new models of social lending.* **Response: Noted**

Additional recommendations

- **Recommendation 41:** *Consider appointing a Cabinet Minister for Children and a ministry for children, with responsibility for a children's action plan and a Māori children's action plan, enshrined in a Children's Act, to set targets for children's health and wellbeing against which all ministries and departments would be required to report. A Children's Act should also take into account and refer specifically to New Zealand's obligations under the United Nation's Convention on the Rights of the Child and the United Nations Declaration on the Rights of Indigenous Peoples, and include a requirement for a child impact assessment of all new legislation to be prepared by the ministry for children, detailing each bill's potential impact on children.* **Response: Noted**

- **Recommendation 42:** *Extending free after hours healthcare to all children to the age of 18.* **Response: Not accepted**
- **Recommendation 43:** *Investigate the provision of free healthcare to all children to the age of 18.* **Response: Not accepted**
- **Recommendation 44:** *Requiring the Ministry of Health, in cooperation with other ministries and departments as appropriate, to develop a cross-sectoral needs assessment tool for pregnant women, and ensure that all pregnant low-income vulnerable women are contacted by case workers to implement the needs assessment protocol and coordinate services.* **Response: Accept**
- **Recommendation 45:** *Funding the expansion of effective teen parenting unit programmes in secondary schools to strengthen and support young Māori parents.* **Response: Accept**
- **Recommendation 46:** *Improve the adequacy of benefits and incomes for whānau without paid work to ensure the wellbeing of their tamariki.* **Response: Noted**
- **Recommendation 47:** *Investigate the introduction of a universal child payment.* **Response: Not accepted**
- **Recommendation 48:** *Investigate partnering with employers, unions, local government, and iwi to address job shocks that may adversely affect whānau.* **Response: Noted**

Appendix 2: DHB Maps and Background Information from the Atlas of Socioeconomic Deprivation in New Zealand NZDep2006 (Ministry of Health, 2008)



References

Atkinson, J., Salmond, C., & Crampton, P. (2014). NZDep2013 Index of Deprivation. Wellington: Department of Public Health & Division of Health Sciences, University of Otago.

Blank, A., Houkama, C., & Kingi, H. (2016). Unconscious Bias and Education. A comparative study of Māori and African American students. Analysis & Policy Observatory: Oranui Diversity Leadership.

Boden, J. M., Fergusson, D. M., & Horwood, L., J. . (2010). Risk factors for conduct disorder and oppositional/defiant disorder: evidence from a New Zealand birth cohort. *Journal of the American Academy of Child & Adolescent Psychiatry, 49(11), 1125-1133.*

Boston, J. (2016, 10 May). Goal of halving child poverty feasible, *Otago Daily Times. Retrieved from* http://www.odt.co.nz/opinion/opinion/382618/goal-halving-child-poverty-feasible

Carroll-Lind, C., Chapman, J., & Raskauskas, J. (2011). Children's Perceptions of Violence: The Nature, Extent and Impact of their Experiences. *Social Policy Journal of New Zealand, 37(June).*

Child Poverty Action Group. (2016). Working for Families Tax Credits, from http://www.cpag.org.nz/assets/CPAG%20WFF%20Tax%20Credit%20descriptions%20FINALrevised.pdf

Clark, T. C., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., . . . Utter, J. (2013). Youth'12 Overview. The Health and Wellbeing of New Zealand Secondary School Students in 2012 *Youth2000 Survey Series (pp.36). Auckland, New Zealand: University of Auckland.*

Cram, F. (2011). Poverty. In T. McIntosh & M. Mulholland (Eds.), *Māori and Social Issues. Wellington: Huia.*

Dale, M. C., O'Brien, M., & St John, S. (Eds.). (2014). *Our children, our choice: priorities for policy. Auckland: Child Poverty Action Group.*

Erdrich, L. (2016). *LaRose. USA: Corsair.*

Expert Advisory Group on Solutions to Child Poverty. (2012). Working Paper no. 14: Reducing Child Poverty in Māori Whānau (pp.29). Wellington: Office of the Children's Commission.

Families Commission. (2012). Te pümautanga o te whänau. Tuhoe and South Auckland Whanau *Research Report No. 4/12. Wellington: Families Commission.*

Gluckman, P., & Hayne, H. (2011). Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence. A report from the Prime Minister's Chief Science Advisor. Wellington: Office of the Prime Minister's Science Advisory Committee.

Goodyear, R., & Fabian, A. (2014). Housing in Auckland. Trends in housing from the Census of Population and Dwellings 1991 to 2013. Wellington: Statistics New Zealand.

Hancock, J., & Walters, V. (2009). Seen but not yet heard. . *NZLawyer Online, 125. Retrieved from*

Heckman, J., & Masterov, D. (2007). The Productivity Argument for Investing in Young Children *National Bureau of Economic Research Working Paper No. 13016. Cambridge, MA: National*

Bureau of Economic Research.

Henare, M., Puckey, A., Nicholson, A., Dale, M. C., & Vaithianathan, R. (2011). *He Ara Hou: Getting it right for Aotearoa New Zealand's Maori and Pasifika children. Auckland: Every Child Counts.*

Higgins, R., & Meredith, P. (2011). Ngā tamariki – Māori childhoods. from New Zealand Government http://www.TeAra.govt.nz/en/nga-tamariki-maori-childhoods

Houkamau, C. (2016). Māori Narratives of Poverty: Whakawhetu Māori SUDI Prevention.

Howie, C. (2017). Life and death on front line of teen health, 22 October, *Herald on Sunday.*

Human Rights Commission. (2016). The Rights of Indigenous Peoples: What you need to know. Wellington, New Zealand: Human Rights Commission.

Jaine, R., Baker, M., & Venugopal, K. (2008). Epidemiology of acute rheumatic fever in New Zealand 1996-2005. *Journal of Paediatric Child Health, 44(10), 564-571.*

Jaumotte, F., & Buitron, C. (2015). Inequality and Labour Market Institutions. *IMF Staff Discussion Note. SDN/15/14. Retrieved from* http://www.imf.org/external/pubs/ft/sdn/2015/sdn1514.pdf

Jenkins, K., Mountain-Harte, H., & Ririki, T. (2011). *Traditional Maori Parenting. An Historical Review of Literature of Traditional Maori Child Rearing Practices in Pre-European Times. Auckland, New Zealand: Te Kahui Mana Ririki.*

Johnson, A. (2016). A BandAid Budget. CPAG's analysis of the 2016 Government budget. Retrieved from http://www.cpag.org.nz/assets/Budget/CPAG%202016%20May%20Budget%20Review%20Final.pdf

Kaa, H. (2015). A view from Aotearoa. In M. C. Dale (Ed.), *Proceedings: Welfare fit for families in a changing world (p.65). Auckland: Child Poverty Action Group.*

Kidman, J. (2017). In A Brown Study. *Māori Youth And The Future. Retrieved from* http://inabrownstudy.nz/maori-youth-and-the-future/

Kiro, C. (2011). Ngā mātua – *Māori parenting. from New Zealand Government* http://www.TeAra.govt.nz/en/nga-matua-maori-parenting

Lin, M. (2016). *Laybying our Future: the state of student hardship in New Zealand. Auckland: Child Poverty Action Group.*

Lister, R. (2004). *Poverty: Blackwell/Polity Press.*

Māori Affairs Committee. (2013). *Inquiry into the determinants of wellbeing for tamariki Māori (pp.100). Wellington: New Zealand House of Representatives.*

Marriott, L., & Sim, D. (2014). Indicators of inequality for Māori and Pacific people. *Working Papers in Public Finance, Victoria University of Wellington(Working Paper 9/2014).*

Metge, J., & Jones, S. (1995). He Taonga Tuku Iho no Nga Tupuna Maori proverbial sayings -a literary treasure *New Zealand Studies Retrieved from https://ojs.victoria.ac.nz/jnzs/article/viewFile/471/381*

Mills, C., Reid, P., & Vaithianathan, R. (2012). The cost of child health inequalities in Aotearoa New

Zealand: a preliminary scoping study. *BMC Public Health, 12(384). doi: 10.1186/1471-2458-12-384*

Ministry of Business Innovation and Employment. (2014). He Whare Āhuru He Oranga Tāngata – The Māori housing strategy. *Directions 2014 to 2025 (p.56). Wellington: Ministry of Business Innovation and Employment.*

Ministry of Education. (2012). *Pasifika education plan monitoring report 2010 (p.109). Wellington: Ministry of Education.*

Ministry of Health. (2008). *DHB maps and background information from the Atlas of socioeconomic deprivation in New Zealand NZDep2006. Wellington: Ministry of Health.*

Ministry of Health. (2014). *Analysis of household crowding based on Census 2013 data. Wellington: Ministry of Health.*

Ministry of Health. (2015). *He Korowai Oranga. New Zealand's Māori health strategy. Retrieved from* http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

Ministry of Social Development. (2002-2004). *The Working for Families cabinet papers. From* www.msd.govt.nz/work-areas/working-age-people/future-directions.html

New Zealand Government. (2014). *Government response to report of Māori Affairs Committee on inquiry into the determinants of wellbeing for tamariki Māori (p.44). Wellington: House of Representatives.*

NZ Child & Youth Epidemiology Service. (2015). *Child Poverty Monitor: Technical report. Wellington: Office of the Children's Commissioner, the University of Otago's NZ Child and Youth Epidemiology Service, the JR McKenzie Trust.*

Penehira, M., Green, A., Tuhiwai Smith, L., & Aspin, C. (2014). Mäori and Indigenous Views on R & R: Resistance and Reilience. *MAI Journal, 3(2), 96-110.*

Perry, B. (2010). *Household incomes in New Zealand: Trends in indicators of inequality and hardship (p.111). Wellington: Ministry of Social Development.*

Perry, B. (2011). *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2010. Wellington: Ministry of Social Development.*

Perry, B. (2015). *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2014. Wellington: Ministry of Social Development.*

Perry, B. (2016). *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2015. In Ministry of Social Development (Ed.). Wellington.*

Policy Watch. (2016). UNCROC questions selective focus on children. *September. Retrieved from* http://nzccss.org.nz/news/2016/09/uncroc-update/

Poulton, R., Caspi, A., Milne, B., Thomson, W., Taylor, A., Sears, M., & Moffitt, T. (2002). Association between children's experience of socioeconomic disadvantage and adult health: a life-course study. *Lancet, 360 (9346), 1640-1645.*

Public Health Advisory Committee. (2010). *The best start in life: Achieving effective action on child*

health and wellbeing. Wellington: Ministry of Health.

Rees, C. (2007). Childhood attachment. *British Journal of General Practice, 57(544), 920-922.*

Rosenberg, B. (2015). Wages and inequality. *Policy Quarterly, 11(1), 63-72.*

Royal Commission of Inquiry on Social Security in New Zealand. (1972). *Social Security in New Zealand. Wellington: Government Printer.*

Salmond, A. (2016). Anne Salmond: Maori once were tender fathers, 26 May, *New Zealand Herald. Retrieved from* http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11644786

Scott, K., Laing, P., & Park, J. (2016). Housing Children: South Auckland. The Housing Pathways Longitudinal Study *Research in Anthropology and Linguistics (RAL-e) (Vol. 6, p.82).* Auckland.

Simpson J, Duncanson M, Oben G, Wicken A, & M, P. (2015). Child Poverty Monitor 2015 Technical Report. Dunedin: NZ Child & Youth Epidemiology Service, University of Otago.

Simpson, J., Adams, J., Oben, G., Wicken, A., & Duncanson, M. (2016). *Te Ohonga Ake. The Determinants of health for Māori children and young people in New Zealand. Series 2 (pp.277). Dunedin: New Zealand Child and Youth Epidemiology Service for the Ministry of Health.*

Sin, I., & Stillman, S. (2005). *The Geographical Mobility of Maori in New Zealand. Motu Working Paper 5/2005 (p.46). Motu Working Paper: Motu Economic and Public Policy Research.*

Sligo, J., McAnally, H., Tansley, J., Baxter, J., Bolton, A., Skillander, K., & Hancox, R. (2016). The dynamic, complex and diverse living and care arrangements of young New Zealanders: implications for policy. *Kōtuitui: New Zealand Journal of Social Sciences Online, 1-15.*

St John, S., & Rankin, K. (2009). Escaping the welfare mess: Working Paper 267, Department of Economics, The University of Auckland.

Staff, J., Schulenberg, J. E., Maslowsky, J., Bachman, J. G., O'Malley, P. M., & Maggs, J. L., et al. . (2010). Substance use changes and social role transitions: Proximal developmental effects on ongoing trajectories from late adolescence through early adulthood. *Development and Psychopathology, 22(Special Issue 04), 917-932.*

Starpath. (2016). November 2016. *Starpath Newsletter Retrieved from https://cdn.auckland.ac.nz/assets/education/about/research/starpath/documents/Starpath%20Newsletter%20Nov%20 2016%20FINAL.pdf*

Statistics New Zealand. (2012). *Ethnicity and crowding: A detailed examination of crowding among ethnic groups in New Zealand 1986–2006. Wellington: Statistics New Zealand.*

Statistics New Zealand. (2015). *National ethnic population projections*: 2013(base)–2038. Retrieved from http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalEthnicPopulationProjections_HOTP2013-38.aspx

Statistics New Zealand. (2016). *Changes in home-ownership patterns 1986-2013: Focus on Māori and Pacific people. Wellington: Statistics New Zealand.*

Superu. (2017). *Families and Whānau Status Report 2016. Wellington: Superu.*

Tertiary Sector Performance Analysis. (2015). *Profile & Trends 2014: Tertiary Education Outcomes and Qualification Completions (pp.32). Wellington: Ministry of Education.*

The Treasury. (2013b). Living Wage Information Release. Wellington.

UNICEF. (2003). *A league table of child maltreatment deaths in rich nations. Florence: Unicef Innocenti Research Centre.*

United Nations. (2008). *United Nations Declaration on the Rights of Indigenous Peoples. New York: United Nations.*

United Nations. (2015). Sustainable Development Goals. *Knowledge Platform. Retrieved from https://sustainabledevelopment.un.org/?menu=1300*

United Nations Committee on the Rights of the Child. (2011). Concluding observations: New Zealand *Consideration of reports submitted by States parties under article 44 of the Convention. (Vol. CRC/C/NZL/CO/3-4): United Nations Committee on the Rights of the Child.*

Waitangi Tribunal. (2001a). Te Urewera Report Part (VI) *Legislation Direct. Wellington.*

Waitangi Tribunal. (2001b). Wai 692 Napier Hospital and Health Services Report *Legislation Direct. Wellington.*

Whitehurst, G. J. (2016). Family support or school readiness? Contrasting models of public spending on children's early care and learning *Evidence Speaks (Vol. 35): The Brookings Institution.*