

AN EMPLOYMENT BARRIER: THE HEALTH STATUS OF DPB RECIPIENTS' CHILDREN

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Abstract

A sample of Domestic Purposes Benefit (DPB) recipients identified a number of issues preventing them from obtaining paid employment. This paper focuses on one of these issues, their children's health, and compares this with the health of all New Zealand children as represented in *Taking the Pulse: The 1996/7 New Zealand Health Survey* (Ministry of Health 1999b). The results indicate that the DPB recipients' children have greater long-term health problems and disabilities relative to children in the national survey. The DPB recipients' children also have greater unmet health needs, as many did not see a doctor when they needed to due to the cost, the inability to get a suitable appointment time, and transportation problems. The paper acknowledges that while a return to paid employment that results in increased incomes for these DPB recipients may have a positive impact on their children's health, there are significant issues that need to be overcome to make this possible.

INTRODUCTION

A sample of DPB recipients identified the health of their children as one issue preventing them from obtaining paid employment. This paper compares the health of these children with aspects of reported health, health service utilisation and levels of unmet need of all New Zealand children as represented in *Taking the Pulse: The 1996/7 New Zealand Health Survey* (Ministry of Health 1999b).

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BACKGROUND

Socio-economic factors have a major impact on a population's health. The relationship between poverty and poor health has been well documented in New Zealand literature (Pomare 1995, Ministry of Health 1999a, National Advisory Committee on Health and Disability 1998). Low income, unemployment and low levels of education are related to poor health outcomes and correlate with Māori or Pacific ethnicity (National Advisory Committee on Health and Disability 1998).

Overseas research also suggests that a widening income gap has adverse effects on the health and welfare of children and young adults (Roberts 1997), and, as in many other countries, the gap between upper and lower incomes in New Zealand has increased. Podder and Chatterjee (1998) found that income inequality in New Zealand increased substantially between 1983/84 and 1995/96. Specifically, their research found that the bottom 80% of New Zealand income earners suffered a reduction in their share of the total incomes paid out, while the top 5% enjoyed a 25% increase. Similarly, Stephens et al. (2000) found that real disposable income in decile-10 households (the wealthiest 10% of New Zealand households) increased by 43% between 1984 and 1998, while the real disposable income for the bottom 50% of households fell by 14%. Given these figures and the link between socio-economic factors and health, it is unlikely that the health of the majority of New Zealanders improved during this period.

While there is no official poverty line in New Zealand, research by the Poverty Measurement Project indicates that the number of people living in poverty is increasing (Waldegrave et al. 1995). For example, Waldegrave et al. (1995) found that the incidence of poverty in New Zealand increased from 4.3% of households in 1984 to 10.8% of households in 1993, before adjusting for housing costs. Furthermore, the Poverty Measurement Project found that 33% of children live in poverty and children make up 44% of the total poor in New Zealand after adjustments for housing costs have been made (Stephens et al. 2000). Children living in such conditions are disadvantaged with respect to survival, mental and physical development, educational achievement and future job prospects (Sarfati and Scott 2001) and are likely to suffer poor health. Research in the United States has found that children living in poverty are more likely to be reported as having poor-to-fair health, and as having an emotional or behavioural problem that lasted three months or more (Brook-Gunn and Duncan 1997).

In 1996 there were 126,585 lone-parent families in New Zealand, which corresponds to 27% of all families with dependent children (Sarfati and Scott 2001). This is a three-fold increase over the last 25 years (Goodger 1997) and is high in comparison to the United Kingdom (21%), Australia (21%) and Canada (19%), but less than the United States (32%) (Social Policy Agency 1999). According to Goodger (1997) the majority of lone-parent families are headed by women, live in poverty, are dependent on government

benefits or work in poorly paid occupations, and have poor access to affordable, high-quality childcare. Children reared in lone-parent families have higher exposure to social and economic disadvantage, family dysfunction, stress, and impaired or compromised parenting and child rearing (Fergusson 1998). An overseas study has also found that children living in lone-parent families were more likely to have disabling conditions (Newacheck and Halfon 1998).

Lone-parent households with children represent 21% of those living in poverty in New Zealand, with 73% of all lone-parent households living in poverty (Stephens et al. 2000). Māori and Pacific mothers are more likely to be lone parents than European mothers, with 43% of Māori mothers and 30% of Pacific mothers being lone parents, compared to 19% of European mothers (Social Policy Agency 1999). As Māori and Pacific ethnic groups are disproportionately affected by unemployment, increasing the incomes and therefore health outcomes for these lone parents and their children represents a significant challenge.

Zaslow and Emig (1997) state that maternal employment can contribute to improving outcomes in low-income families. Unfortunately the employment gap between sole and partnered mothers is increasing, with 65% of partnered mothers of dependent children employed in March 1996, compared to 36% of sole mothers (Social Policy Agency 1999).

Methodology

The population for this survey is children (aged six years or older) of female DPB recipients registered at three Department of Work and Income (DWI)² offices in northern New Zealand. Two hundred and forty-four women completed the questionnaire on behalf of their children. The three sites (Browns Bay, Otago and Kaitiaki) were chosen to give a stratified sample of women on the DPB. Browns Bay, situated on Auckland's North Shore, is an area of relatively high socio-economic status; its rating on the New Zealand Deprivation Index (NZDep1996)³ is 3 (Crampton et al. 2000). The majority of DPB recipients served by the Browns Bay office were of Pākehā ethnicity and the general population in that area would be expected to enjoy comparatively good health. Otago, in South Auckland, with an NZDep of 10, is an area of low socio-economic status, of comparatively poor health, and of high Māori and Pacific ethnicity. Kaitiaki, with an NZDep of 10, is a small town in a more isolated, rural district and is an area of low socio-economic status and high Māori population.

2 The Department of Work and Income has since become part of the Ministry of Social Development.

3 NZDep uses a scale of 1–10 where 10 represents the most deprived areas.

A questionnaire was posted out to all DPB recipients served by those offices. Recipients were asked to identify reasons preventing them from seeking or obtaining paid employment, and the questionnaire included questions that would allow comparison with results from *Taking the Pulse*. The responses were returned by post, although a small number of respondents completed the questionnaire by phoning the 0800 number. The response rate was 25.9%, with the highest response from Pākehā and the respondents in Browns Bay – the least deprived area.

Demographic Characteristics of the Sample

Overall the response rate was highest for Pākehā and lowest for Pacific women. The majority of the 244 respondents (71.8%) had either one or two children, with 10% having four or more. As Māori and Pacific families tend to have more children, these data were re-analysed on the basis of ethnicity. The results show that European, Māori and Pacific respondents had on average 1.8, 2.1 and 2.5 children, respectively. The national average is 1.95 children per family (Statistics New Zealand 1996).

DPB RECIPIENTS' CHILDREN'S HEALTH: A BARRIER TO EMPLOYMENT?

As part of the survey the DPB recipients were asked to identify issues preventing them from obtaining paid employment. The results are shown in Table 1.

Table 1 Issues Preventing Recipients Obtaining Paid Employment

Barriers	Beneficiaries
	(%) n = 244
Childcare	52
Inability to find a job	38
Lack of training	30
Recipient's health	29
Transport difficulties	27
Children's health	22
Other issues	18
Care of other dependants	9

Table 1 shows there are a number of barriers preventing respondents from obtaining employment, the most common being childcare (52%). Obviously, the significance of childcare is related to the respondents' dual role of child rearer and breadwinner. While several papers have been published from this study that focus on the respondents' health (Worth and McMillan 2004, Baker and Tippin 2004), Table 1 shows that the health of respondents' children is also a barrier to obtaining paid employment. Furthermore, 42.3% of respondents at a later stage in the survey stated that their

children's health had had some impact on their ability to seek paid employment. Of these, 24.2% indicated that their children's health had moderately, quite a bit, or extremely affected their ability to seek work within the last 12 months.

COMPARISONS WITH NATIONAL DATA

The analysis indicates that the health status of the respondents' children is low in comparison to national data for children. The sections below discuss findings concerning long-term health problems and disability, health service utilisation and unmet need.

Health and Disability

Respondents were asked to identify whether their child had any long-term disability or handicap lasting six months or more. The results are shown in Table 2.

Table 2 Children with a Long-Term Disability or Handicap Lasting Six Months or More

Response	Beneficiaries	NZ children
	% n = 244	% n = 1,019
Yes	25.8	10.6
No	71.3	86.2
Not specified	1.2	0.1
Don't know	1.6	3.1

Table 2 shows that 25.8% of the DPB recipients' children have a long-term disability or handicap. This is significantly higher than the 10.6% of children identified in the national survey and also higher than the 20% identified in the 1996 Household Disability Survey (Statistics New Zealand 1997).

Recipients were asked whether their child had a health problem lasting six months or more that affected the child. These results are shown in Table 3.

Table 3 Impact of Children's Long-Term Health Problems and Conditions

Type of impact	Beneficiaries	NZ children
	% n = 239	% n = 1,019
Child has a health problem or condition that affects everyday activities that people his/her age can usually do	20.5	6.77
Child has a health problem or condition that affects communicating, mixing with others or socialising	17.2	4.86

Table 3 shows that 20.5% of the DPB recipients stated their child's health problem or condition affected their everyday activities, and 17.2% said it affected their child's ability to communicate and socialise. These are significantly greater than the 6.77% and 4.86% respectively reported in the national survey, and reveal a large disparity between the DPB recipients' children's health problems and conditions relative to children in the national figures.

Health Service Utilisation

Recipients were asked to identify whether their children had been admitted to hospital within the last 12 months. Hospital admission is a stay at a hospital for treatment for more than three hours, or a stay in hospital for one or more nights. Of the DPB respondents, 10.3% indicated that their children had been admitted to hospital for treatment for more than three hours and 9.9% had children that were admitted for one or more nights. These results are greater than the national figures, where only 7.1% of 5–9 year olds and 5.5% of 10–14 year olds were admitted to hospital overnight or for treatment of three hours or more (Ministry of Health 1999b).

DPB recipients were also asked to identify the number of times their children had seen a general practitioner (GP) in the last 12 months. These results are shown in Table 4.

Table 4 Children's (Aged Six or Over) Visits to a GP within the Last 12 Months

	Beneficiaries	NZ children
	% n = 244	% n = 1,019
Number of visits		
None	12.2	0.0
Once	12.6	24.4
Twice	16.8	22.8
3–5 times	35.3	38.8
6 or more times	20.1	12.9
Don't know	2.9	1.1

Table 4 identifies major differences between the recipients' responses and those given in the national survey. One difference is the under-utilisation of GPs by the recipients compared to the national data. Table 4 shows that the DPB respondents took their children to the doctor less often than those in the national survey in every category between zero and five visits. Significantly, 12.2% of the DPB respondents did not take their children to the doctor at all in the last 12 months. The under-utilisation of GPs will be discussed more fully in the next section.

Another major difference shown in Table 4 is that 20.1% of the DPB recipients' children visited a GP six or more times in the last 12 months, compared to 12.9% of the respondents' children identified in the national survey.

Unmet Need

A significant number of the DPB respondents (33.6%) indicated that their child did not see a doctor when they needed to within the last 12 months. This is far greater than the 6% reported in the national survey.

DPB recipients were asked to identify reasons why the child did not see a doctor. These results are shown in Table 5. The most frequently identified reason given for not taking their child to see a GP was the cost.

Table 5 Reasons Identified for Not Taking the Child to the Doctor

Reasons	Beneficiaries	NZ children
	(%) n = 82	(%) n = 61
Cost too much	70.0	58.0
Couldn't get an appointment at a suitable time	36.3	13.0
Had no transport	20.0	14.5
Couldn't contact the doctor	6.3	4.2
Other reasons	6.3	5.0
Didn't want to make a fuss/ Couldn't be bothered	5.0	4.3
Couldn't spare the time	1.3	9.8
Don't know why	1.3	0.0

Table 5 shows that the main reasons identified by the DPB respondents for not taking their child to a GP when they needed to go are similar to the national survey. However, a higher percentage of DPB respondents identified cost as a reason for not going to a GP, and DPB respondents identified being unable to get an appointment at a suitable time more often than transportation problems.

While the majority of DPB respondents did take their children to the doctor when they needed to see one, 24.8 % did not collect a prescription item after seeing the doctor. This is substantially higher than the 5.6% reported in the national survey. The main reason why DPB respondents did not pick up a prescription item was cost (76.3%), unlike the national survey where the most common reason given was that the prescription was not needed any more (42%). Only 28% of respondents in the national survey identified cost as a reason why the prescription item was not collected.

DISCUSSION

The results reported in this paper indicate significant health issues for the children of the DPB recipients in this study. These children have higher reported rates of long-term health problems and disabilities, which have a substantial impact on their lives when compared to children in the national data. It is therefore not surprising that the DPB recipients' children are over-represented in the percentage of children that had visited a GP six or more times in the last 12 months.

There are also higher rates of children not having visited a doctor in the past 12 months, and higher rates of unmet need. The cost of going to the doctor, inability to get a suitable appointment time and transportation problems were reasons given by the 33.6% of the recipients who did not take their children to the doctor when they needed

to go. In comparison, only 6% of respondents in the national survey did not take their children to the doctor when they needed to go. Similarly, a greater percentage of DPB recipients than of the national survey did not pick up a prescription item after having taken their child to the doctor. The main reason given by the recipients was again the cost of the prescription, which contrasts with the national survey where respondents stated that the prescription was no longer needed.

The decision not to visit the doctor or not pick up a prescription item due to financial constraints is also reflected in the Women and Poverty Project, 2000. This research found that some women deferred visits to the doctor for both themselves and the children, while others did their own research to make an assessment on the nature and seriousness of the problem rather than seek medical attention (Waldegrave and Stephens 2000).

The results raise serious issues concerning the health of these children but suggest that providing additional access to a doctor and reducing the cost of doctor consultations would help decrease the number of children who do not see a doctor when they need to.

The recipients' children's admission to hospital within the last 12 months is greater than the national rate even when age adjustments are made to the national figures. These figures mirror those outlined above, suggesting that the children of these DPB recipients suffer from poor health that has a significant impact on their lives.

These data suggest that there is a strong correlation between low socio-economic status (65.8% of the respondents had an annual household income of \$20,000 or less) and poor health for these DPB recipients' children. While this correlation is in itself worrying, there is evidence that poor socio-economic status and poor health have wider societal impacts. For example, Roberts (1997) states that the effects extend beyond morbidity and mortality and can be seen in the areas of crime, violence, and educational attainment.

Income is the single most modifiable determinant of health (National Advisory Committee on Health and Disability 1998). Therefore it may be logically concluded that a return to the workforce for these women would result in better health outcomes for their children. There are two problems with such a conclusion. Firstly, while 22% of the respondents identified their children's health as having a moderate to extreme impact on their ability to seek work, it was only one of several barriers identified. To enable these women to actively seek and obtain employment presents an enormous challenge. Secondly, even if these women are successful in overcoming the identified barriers to employment and obtain paid work, research suggests that this may not necessarily raise their income and subsequently improve the health of their children. For example, Larner et al. (1997) state that their review of the research suggests that single mothers

who succeed in finding employment are likely to remain poor after paying for employment expenses and childcare, and losing the benefit.

In addition, overseas studies have found that half to two-thirds of welfare recipients who obtain employment lose their job within a year (Larner et al. 1997). While Zaslow and Emig (1997), as previously noted, state that maternal employment can contribute to improving outcomes in low-income families, they acknowledge low wages and poor working conditions can undermine this improvement. Furthermore, it is likely that the poor health of their children would put considerable pressure on the women's ability to maintain her employment.

Paid employment that raises the income of these women may result in better health outcomes for their children, but significant hurdles need to be overcome to make this a reality.

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