24 December 2010

The Secretariat
Welfare Working Group
PO Box 600
WELLINGTON 6140

Tēnā koe

Re: Welfare Working Group Long Term Benefit Dependency: the Options

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Welfare Working Group (WWG) document *Long term benefit dependency: the options*.

2. NZNO commends the WWG on the development of a timely paper that explores a number of options for addressing the issues they were mandated to examine through their terms of reference.

3. However, NZNO notes that the purpose of the document is limited by terms of reference which are too narrow to constitute a full review of the welfare system, and the lack of evidence to support key assumptions.

4. The punitive approach taken to 'dependency' is very concerning and the definition of 'work' as any activity for which a person is paid is unnecessarily

constrained: there are many examples of voluntary work that contribute to New Zealand society in positive ways.

5. Of particular concern to NZNO are the following:

    a. little evidence to support the assertion that child poverty is caused by long-term benefit dependency;
    b. no evidence to suggest that increasing paid work participation by solo parents improves child health and social outcomes;
    c. little acknowledgement or understanding of the social determinants of health and associated health inequities and how these can be addressed – in particular for Māori;
    d. a patronising perspective on Māori and benefit use; and a
    e. lack of reference to a whānau ora approach – the preferred approach of the Ministry of Social Development and Ministry of Health.

6. NZNO is a member of the New Zealand Council of Trade Unions and the ACC Futures Coalition and wholly supports the CTU and ACC Futures Coalition submissions. It is not our intention to reiterate the points made in the CTU or ACC Futures Coalition submissions, but to offer additional material pertaining to health issues that underlie or are concomitant to the need for benefits.

<u>Sole parents on a benefit</u>

7. While the figures presented suggest a clear link between children living in solo and workless families and high child poverty, there is no evidence presented to support the assertion that it is a high rate of long-term benefit dependency (and accompanying low employment rate) amongst solo parents that is the main cause of this relationship. The low monetary value of the benefit, the complex system of benefits, and poor support for women to enter

the workforce with poorly structured child care options (which recent government cutbacks of the 20 hours of free child care will further limit) are more likely to be contributing reasons to high child poverty. While the options presented suggest improving accessibility to childcare will be important to encouraging solo parents back to work, there are clear differences between childcare and quality childcare.

8. There is some evidence that attending poor quality early childhood education prior to one to two years of age can result in antisocial or worried behaviour among children both at the time and at entry to school, although this can be tempered by the subsequent provision of high quality education[1]. Studies have also shown that young children attending poor quality early childhood centres display an increased cortisol level, which is an indicator of stress. This can also leave them more prone to infection[2]. Any options that require children to enter child care before two years of age must ensure that the child care options are available, accessible and high quality. Meeting high audit, compliance, health and safety, and quality criteria for early childhood centres must be a requirement for the receipt of any funding associated with supporting those on benefit.

9. No evidence is offered to support the Report's suggestion that increasing paid work participation by solo parents improves child health and social outcomes. Parents who are required to work but have poor access to quality early childhood care and afterschool care likely means that young children will be left unattended and unsupervised, increasing their risk of injury.

10. Tying benefit receipt to a child's attendance at school and receipt of immunisations is punitive and unworkable. Improving health literacy, and

[1] Mitchell, L., Wylie, C., & Carr, M. (2008). *Outcomes of early childhood education: literature review. Report to the Ministry of Education*. Wellington: Ministry of Education.

[2] Mitchell et al. (2008).

supporting at risk families with comprehensive wrap-around health and social support is a more appropriate and productive approach. United States research demonstrates that registered nurses (RNs) undertaking intensive home visiting (up to 26 home visits in the first two years of life) results in a range of beneficial child health outcomes including children more likely to be enrolled in pre-school education, higher intellectual functioning and vocabulary scores, and fewer behavioural problems[3]. These effects:

- were apparent up to twelve years beyond the end of the nurse visits;
- were evident in children from a range of social and ethnic backgrounds (although the effects were stronger amongst children from lower socio-economic backgrounds);
- improved maternal life course; and
- *reduced government spending* among children through 12 years[4].

[3] Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., et al. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1560-1568.

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[4] Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., et al. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1550-1559.

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Kitzman, H. J., Olds, D. L., Cole, R. E., Hanks, C. A., Anson, E. A., Arcoleo, K. J., et al. (2010). Enduring effects of prenatal and infancy home visiting by nurses on children: Follow-up of a randomized trial among children at age 12 years. *Archives of Pediatrics & Adolescent Medicine, 164*(5), 412-418.

People on a sickness benefit and people on an invalid's benefit

11. Increasing the scope of the unemployment benefit to include people with temporary or mild and moderate ill-health and disability is unacceptable. People who experience temporary ill health or disability are likely to want to return to work; however early return to work may not be in the best interests long term for the person and *may result in longer term increased costs*. Early return to work where a person has been inappropriately assessed as ready, and/or is not offered significant health support to continue to gain health while working, will inevitably slow the person's return to full time work in the long term. Independent, ethical case management by a regulated health professional e.g. a RN or nurse practitioner (NP), to facilitate a person's return to health while working is vital.

12. NZNO supports strengthening the links between ACC and welfare benefits. As outlined in the ACC Futures Coalition document, ACC is essentially social welfare in its nature and purpose so it makes sense that there is strong relationship between the two.

13. Accordingly NZNO supports in principle the idea that the non-compensatory elements of ACC be extended to beneficiaries, if they can assist them into work. There are some obvious caveats here. Much depends on the quality of the rehabilitation. It is also important that it is seen to be empowering rather than punitive and that the move would not encompass a reduction in entitlements for ACC beneficiaries and claimants. Any assessment of work capacity should be done by a regulated health professional. Specially trained RN and NPs (for example primary health care nurses such as practice nurses and public health nurses) working independently of the agency that administers the benefit, are ideally placed to provide cost effective, appropriate and expert work assessments for those requiring work capacity assessment.

14. The Report notes strong evidence that long-term sickness absence or disability depends more on individual and work-related psychosocial factors than it does on medical factors or the physical demands of work. RNs and NPs are also able to provide brief intervention and motivational interviewing to those identified as at risk of long-term benefit dependency, potentially preventing the longer term costs associated with long-term dependency.

15. ACCs Better @ Work campaign could be extended to include all those on sickness and invalid benefits, however funding incentives to GPs to return patients to work early are unethical and should not be included as part of the scheme.

16. Creating healthy workplaces and encouraging employers through incentives and demonstration of improved productivity and staff retention will be vital to prevention, early intervention and early return to work for those experiencing ill health. The NZNO/DHBNZ Safe Staffing Healthy Workplaces Unit and Positive Practice Environments: Quality Workplaces for Quality Care campaigns are examples of effective initiatives that recognise the benefits of creating healthy workplaces.

17. The Positive Practice Environments: Quality Workplaces for Quality Care campaign is supported by the World Health Professionals Alliance comprising the International Council of Nurses, the International Hospital Federation, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation and the World Medical Association. The campaign objectives over the course of five years are to:
    - make the case for healthy, supportive work environments through evidence or their positive impact on staff recruitment and retention, patient outcomes and health sector performance;

- build a global platform to catalogue good practices in healthy, supportive workplaces;
- drive the establishment and application of principles of positive practice environments across the health sector, and
- celebrate successes that support effective strategies that promote sustainable health systems.[5]

18. It is imperative that Aotearoa New Zealand undertake a comprehensive, cross-sector programme to address the social determinants of health that contribute to the significant health inequalities evidenced in Aotearoa New Zealand today. Such a cross-sector programme would contribute significantly to addressing child poverty and improving the health of the population generally (including workers). While accidents are likely to always occur, prevention of child poverty and ill-health such as cardio-vascular disease, mental illness, and other long-term conditions through comprehensively addressing the *social determinants* of health, will in the long term reduce the numbers of people reliant on sickness and invalid benefits.

19. The World Health Organisation[6] advocates for countries to:

- improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age;
- tackle the inequitable distribution of power, money and resources and;
- measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness of the social determinants of health as a means of improving health equity.

[5] International Council of Nurses. (2010). Positive practice environments: Quality workplaces for quality care: Campaign overview. Geneva: International Council of Nurses.
[6] Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the commission on social determinants of health. Geneva: World Health Organisation.

Māori and benefits

20. In regards to the chapter titled ‘Māori, and benefits’, it is apparent that further data is needed to accurately identify the length of time and specific benefit that people are on such as unemployment, domestic purposes, sickness or widows benefits, rather than lump all the data together in a vague overall figure, or as a specific age grouping, which does not allow for sound analysis to effect positive targeted solutions. Vague, general data which fails to identify the root causes of problems will only ever generate the same stock 'blanket solutions' which have failed in the past and which this working party was supposed to address. Nothing new has emerged.

21. NZNO recommends a summary, which provides a broader overview of Māori benefit recipients, including their age, length of time on a specific benefit, geographic location, and any other economic, whānau, and or environmental factors which have contributed to the need to be on a benefit at a particular time. This will offer detailed insight into the cause and therefore possible long-term useful solutions.

22. It's hardly surprising, for instance, that more Māori are on sickness benefits because there are significant actual health disparities and disparities in access to health care, which ensures this number is likely to increase rather than decrease. More needs to be done to ensure health and social equity from the beginning.

23. Of note is that health workers for Māori and iwi providers are generally paid up to 25 % less than their DHB counterparts, but unlike capped General Practitioner (GP) services, which exclude or require higher fees from non enrolled clients, iwi providers have a policy of not turning anyone away. The WWG's failure to even identify that Māori providers supporting a generally poorer and needier clientele are *additionally* meeting the shortfall of other

providers on humanitarian grounds, is a pointed reminder of the complexities of health equity issues.

24. We advise that Māori members of NZNO reacted strongly and negatively to what they perceived as this simplistic analysis of Māori use of benefits.

25. While the chapter briefly discusses the association of poor health with long term benefit receipt, it fails to provide any specific associated health conditions, or draw any reference to structural inequalities in the presence of social, economic, environmental and political determinants of health. [7]

26. The chapter is negative in its outlook on Māori and benefit usage, it has a patronising tone, and ignores available evidence indicating that Māori face discrimination in the labour market - in getting a job, in the type of job obtained, and the wages paid for a particular type of work.[8]

27. While a whānau ora approach is briefly touched on in the chapters closing remarks the chapter does not reflect the clearly defined principles of the whānau ora framework. NZNO recommends that you review this document.

<u>Young people and benefits</u>

28. A combination of all three options found in Table 6.1 for addressing the needs of young people will be beneficial. NZNO also points the Welfare Working Group to the research noted earlier that demonstrates that nurses undertaking intensive home visiting (up to 26 home visits in the first two years of life) results in a range of beneficial child health outcomes including children more likely to be enrolled in pre-school education, higher intellectual

[7] Te Rōpū Rangahau Hauora A Eru Pōmare. 2007. Hauora Māori Standards of Health IV: A Study of the Years 2000-2005. Wellington: Te Rōpū Rangahau Hauora A Eru Pōmare
[8] Sutherland, H & Alexander, R. 2002. The Occupational Distribution of Māori 1997-2000. Dunedin: Department of Economics, University of Otago.

functioning and vocabulary scores, and fewer behavioural problems[9]. These affects were apparent up to twelve years beyond the end of the nurse visits, were evident in children from a range of social and ethnic backgrounds although the effects were stronger amongst children from lower socio-economic backgrounds, improved maternal life course, and reduced government spending among children through 12 years[10].

29. Early interventions in the family incorporating a whānau ora approach will also be of benefit in preventing benefit dependency among young people. School-based RNs are often the first to identify at-risk young people and work with them and their family/ whānau to address health and social needs. These nurses are also in a key position to be preventing teenage pregnancy through the provision of appropriate sexual health care. Appropriately resourced RNs in all Aotearoa New Zealand secondary schools providing wrap-around youth services will enable early identification and intervention with at-risk young people[11]. School-based RNs provide a vital link between

[9] Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., et al. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1560-1568.

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[10] Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., et al. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1550-1559.

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[11] Kool B, Thomas D, Moore D, Anderson A, Bennetts P, Earp K, Dawson D, Treadwell N 2008 Innovation and effectiveness: Changing the scope of school nurses in New Zealand secondary schools. Australian and New Zealand Journal of Public Health 32(2): 177-180

education, health and social services, and the community for young people, reducing duplication and providing effective case management.

30. While the Options document makes some sensible suggestions (for example, encouraging at risk families to engage in budgeting activities, providing case management and support for families to locate and arrange childcare), the options offered do little to address the root causes of inequalities in health in Aotearoa New Zealand and reinforce the notion that beneficiaries are responsible for continuing benefit dependence.

Conclusion

31. In conclusion NZNO **does not** support this document and **recommends** that you:

- **note** that a sound **evidence base** is needed to ensure a rational approach to minimising welfare 'dependence';
- **agree** that international evidence overwhelmingly shows that addressing the social and economic determinants of health, and ensuring access to quality primary health care from the beginning of life (i.e. caring for *all* mothers and children) is the most efficient way to maximise productivity and minimise expenditure on social and justice support systems;
- **have** regard for the recommendations in the WHO Report: Closing the Gap in a Generation: Health equity through action on the social determinants of health;
- **agree** that access to high quality early childhood care and after school care must be available to solo parents returning to work;
- **agree** that funding for early childhood care must only go to those centres that meet strict quality criteria;
- **agree** that improving health literacy and providing wrap-around health and social services for at risk families is essential;

- **note** that early return to work for sickness and invalid beneficiaries must be carefully case managed to ensure health gains continue while the person is in work;
- **note** NZNO's support for a closer working relationship between ACC and the benefit system;
- **agree** that work capacity assessment should be undertaken by a regulated health professional (in particular a RN or NP);
- **note** NZNO's support for creating healthy workplaces in order to improve health outcomes for those experiencing or at risk of poor health;
- **agree** that a comprehensive, cross-sector programme to address the social determinants of health must occur concurrently with any changes to the benefit system;
- **agree** that a summary providing a broader overview of Māori benefit recipients must be provided;
- **note** NZNO's concern that the section on Māori and benefit usage is over-generalised and patronising;
- **note** NZNO's concern that a whānau ora approach to Māori health and wellbeing is not included;
- **agree** that RNs should have a strong presence in all Aotearoa New Zealand secondary schools;
- **note** NZNO's support for the CTU and ACC Futures Coalition submissions.

Nāku noa, nā

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ABOUT NZNO

NZNO is the leading professional body of nurses and nursing union in Aotearoa New Zealand, representing over 45 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is "Freed to care, Proud to nurse". Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.