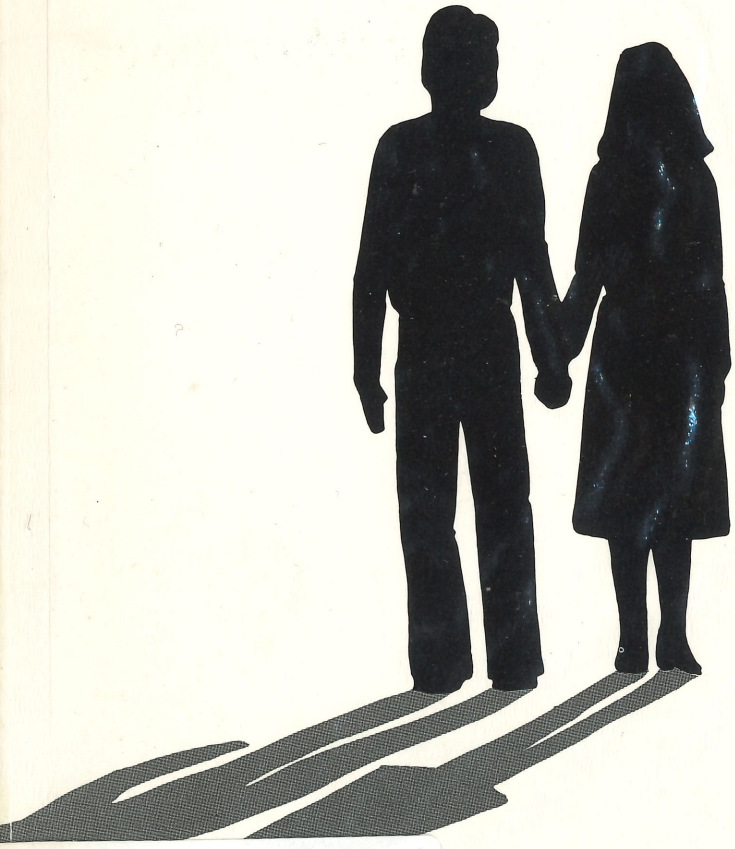
The First Report of the Social Monitoring Group

From Birth to Death



The First Report of the Social Monitoring Group

From Birth to Death

Published by the
NEW ZEALAND PLANNING COUNCIL
P.O. Box 5066, Wellington
July 1985

This report, published by the New Zealand Planning Council, was prepared independently by the Social Monitoring Group. The views expressed are the sole responsibility of the Social Monitoring Group and are not necessarily endorsed by the Planning Council or the Social Advisory Council.

ISSN 0112-6156
ISBN 0-908601-40-9

FOREWORD

This report attempts to overcome two difficulties that continue to confront the social sciences in New Zealand: the communication of research findings, and the relationship between research findings and social policies.

Many research findings included in the report are presented together for the first time and in a non-academic form. It is hoped that the wider communication of such research findings in this way will not only promote a better understanding of human behaviour, but also encourage greater use of existing research findings in the future.

Social science researchers have been hesitant to suggest policy solutions to the inequalities or injustices portrayed in their research findings. In this report a set of social objectives is established, which serve not only as the basis for monitoring change, but also as the connection between the findings and the suggested social policy implications.

It is hoped that the report will be read by policy-makers, social scientists and the general public.

P. G. Koopman-Boyden

Peggy G. Koopman-Boyden
Convenor
Social Monitoring Group

THE SOCIAL MONITORING GROUP

The Social Monitoring Group was set up jointly by the New Zealand Planning Council and the Social Advisory Council early in 1984. Its terms of reference are:

— to document current and emergent trends relevant to social development in New Zealand
— to explore the implications and significance of these trends
— to comment on the social implications of economic policies.

Membership of the Social Monitoring Group

Peggy Koopman-Boyden, New Zealand Planning Council (Convenor)
David Scott, Social Advisory Council
Max Abbott
Paul Brown*
Jane Chetwynd
David Haigh
Albie Williams

* Paul Brown replaced David Tait in August 1984. Both were involved as officers of the Department of Statistics and their contribution was to provide statistical advice and assistance.

Secretariat

Judith Davey
Anthony Hassall

CONTENTS

LIST OF INFOGRAMS

Overall Summary

Introduction

The first report of the Social Monitoring Group (SMG) is intended to be a broad overview of current and emergent social trends, documenting change over time and differences between groups in society. Its focus is at the national level and a range of data sources has been used. Material for the report has been selected on the basis of relevance to a set of social objectives adopted by the SMG, based on human needs, plus the values of equity, access and autonomy. The life event approach is used as a framework for the presentation of data to allow a range of human experience to be covered.

Birth

Birth rates for both the Maori and non-Maori populations are falling and are below replacement levels. The ex-nuptial proportion of births has been rising, but the majority of such children live with one or both natural parents. Although infant death rates have been declining, the post-neonatal rate is still of concern, especially that of Maori infants. This rate has been shown to be affected by social and economic conditions.

Families with babies are concentrated in the lower half of the income distribution for all families, particularly where the mother is unmarried, separated or divorced, or non-European. Most of such families live on one income and a lower proportion than families in general own their own homes.

The state provides a range of health services for infants, but these are not taken up equally through society, one example being immunisation. Although the vast majority of young children receive preventive health care, problems are likely to be concentrated in the small proportion that do not use such services.

Starting School

The income disadvantages of families with babies are seen again in families with a child aged five. However, a higher proportion of such families are home-owners and more mothers are in paid work. Most children begin school at five and the majority have some pre-school experience of an educational nature. Attendance at pre-school and length of attendance is at least partially determined by family background and the latter may be the more important factor influencing a child's progress at school.

Health services in schools vary in their availability and usage, but sometimes act as a substitute for visits to the doctor. Particular groups of children appear to be susceptible to risk from ill-health, accident and abuse. It is not clear, however, how social and economic factors operate in these cases.

Becoming a Teenager

A significant change occurs at about age 13, with a heightened desire for independence and changes in attitudes and relationships. At this stage, family income patterns are close to the overall distribution, although more children are in one-parent families compared with the younger age groups.

The teenage years open up new activities, not all of them beneficial, such as smoking, drinking alcohol and drug abuse. Peer group pressure is important, as are the attitudes and behaviour of adults. Stresses arising from relationships with family and authority figures, and developing sexuality, can be a threat to mental health.

Patterns of offending by young people vary according to age, sex and ethnic background. Corrective action may be inappropriate to attack the underlying problems which lead people into injurious and anti-social behaviour.

Starting Paid Work

Most people start paid work between the ages of 15 and 19, but recently more young people have been remaining longer in secondary education. Those leaving school, especially young women, are better qualified now than a decade ago but an increasing proportion are uncertain about their future work prospects.

Part-time work may be part of the transition from school to the workforce. Occupations of teenage workers are similar to those of the adult workforce, but growth in employment opportunities has been variable. School-leaver unemployment has increased markedly since 1978, and rates are particularly high for Maoris and women. Attitudes to the young unemployed may be discouraging, leading to lowering of morale, given that status and self-esteem is so closely associated with paid work.

Setting Up as a Couple

This event is seen in social rather than legal terms, including both formal and informal marriage. The number of marriages per year is fairly stable. One-third involve a partner or partners who have been married before. Fewer people are staying with the same partner through life. Most people in de facto marriages are aged under 30, but a high

proportion of older, divorced and separated people also enter such relationships.

Women still undertake the major responsibility for household management. Little information is available on the quality of marital relationships. Where both partners are earning, couples can be relatively affluent and many purchase a house at this stage. Government policies frequently assume that one partner will be financially dependent on the other, although there is now less emphasis on the "breadwinner" concept.

Becoming a Parent

Households made up of husband, wife and dependent children are a declining proportion of total households, and many couples are delaying the birth of children or remaining childless. The practice of contraception (including sterilisation) is widespread, but up to one-third of pregnancies within marriage are still unplanned, many resulting from contraceptive failure. Antenatal and parent education varies in availability and quality. The mental and physical health of women may be threatened at the stage of becoming mothers and caring for pre-school children.

Mothers have less leisure time than childless women, and women overall have less than men. Parenthood affects income through the direct costs of supporting children and loss of income by the care-giver. Financial hardship is more likely to occur when a family has young children, despite government support measures.

Breaking Up

There are no figures on the incidence of marital break-up. Divorce is often used as an indicator but it is an inadequate measure. The rate of divorce has doubled since 1970 and numbers of divorced and separated people are growing rapidly.

The trend is towards a "clean break" on separation, including the sale of the matrimonial home. One-parent households are increasing rapidly, headed mainly by separated or divorced women. Such households have lower incomes, fewer amenities, and are less likely to own their homes than households in general. Links between marriage break-up and unfavourable social trends have been suggested, but cannot be substantiated at present levels of knowledge.

Major Job Change

Pull factors which cause people to leave the paid workforce include the need to care for children or other dependents (which mainly involves women) and the desire to travel or study. Alternatively people are "pushed" out of the paid workforce through sickness or disability, or are made redundant. Unemployment is difficult to measure and is understated in official figures. It certainly falls unevenly on groups in society, and has implications beyond loss of income.

Changes between jobs while in the paid workforce depend on individual initiative and circumstances, but also on external factors such as discrimination. Changes while not in the paid workforce are also important, but not well documented. All major changes of occupation in adult life are seen as part of a working career.

Retirement

The proportion of people in the paid workforce after the age of 60 is falling. A proportion of both men and women work part-time before full retirement.

The income levels of retired people are lower than those still in paid work, although national superannuation has improved their financial situation. It is not, however, the only source of income for the majority.

Retired people have increased opportunities for leisure and recreation. Many are involved in voluntary work, but few take part in educational courses. Improvements in life expectancy mean people can look forward to nearly 17 years of life, on average, if they retire at 60.

Loss of Spouse

Four out of every five widowed people are aged 60 or older; fewer than one in 100 people under 45 has experienced the death of a spouse. Widows outnumber widowers by four to one. Widowed parents have fewer dependent children than other solo parents and are more likely to be home-owners. Income characteristics of widowed people are similar to those of the retired, but there are differences between men and women and between the older and the younger groups.

Widowhood is likely to be a stressful experience requiring readjustment from life in an intimate partnership to life alone.

Loss of Autonomy

Handicap and disability are more prevalent in old age, but even of those over 80, more than half suffer no disabilities. Hospital stays tend to be longer in old age and associated with degenerative conditions.

The majority of old people live independently, but some require special housing, ranging from pensioner flats to rest homes. Only 6%, however, are in institutional accommodation. Lack of social support, rather than their physical or mental state, brings many to residential homes. As the population ages, demand for services will increase, particularly those for sufferers from degenerative mental conditions. Community care is a

beneficial option for many elderly people if services are adequate and there is support for care-givers.

Death

For two out of three people, death occurs at age 65 or older, but more than half female deaths occur at 75 or older, and two-thirds of Maori deaths occur below 65 years. The major causes of death at all ages are cancer, heart disease and cerebrovascular disease (stroke).

A high proportion of premature death results from accidents, especially to men. Heart disease is second in importance, also affecting predominantly men, followed by cancer, suffered by both sexes. Deaths by accident are highest in the 15-24 age group and motor vehicle accidents account for two-thirds of these.

A growing proportion of people die in hospital, but specialised nursing services and hospice care have been developed recently and greater attention is now being given to the "quality of dying". Death has an important social and spiritual significance, the latter exemplified in the Maori *tangi*.

Policy Issues

The conclusions of the life event chapters are brought together as policy issues, grouped under key words derived from the SMG's statement of social objectives.

Several groups have been shown to suffer disadvantage in their standard of living, including families with young children, one-parent families, some elderly people and people in crisis situations. Low income is associated with other forms of disadvantage and the interplay of social and economic factors must be closely examined. Policies must be reviewed regularly to make sure assistance is sufficient and appropriate and reaches the groups for whom it is intended.

The use of health services is uneven and health standards vary. Young adults in particular are susceptible to lifestyle practices which endanger their physical and mental health. Measures to improve the situation will be a mix of educational, promotional and regulatory initiatives, and should include social support and community care.

All people need protection against premature death and injury, but there are areas where special action is needed, including protection of the very young and old against abuse, reducing road accidents, improving safety and security in family relationships and investigating the underlying causes of crime.

Certain groups are limited in their ability to participate in community life and enjoy self-determination. Of particular concern are the unemployed, especially young people, given that status is so clearly associated with paid work. The barriers are often attitudinal, but government action is justified in the areas of employment promotion, affirmative action in the workplace, the provision of childcare, and measures against all forms of discrimination.

A broader view of education and work would provide people with greater choice and help to reduce inequities in society. Unpaid work should be given greater recognition, and household work and childcare should be more equally shared. The relationship between physical and mental well-being and satisfaction in personal, household and group circumstances, must be recognised in policy development.

Introduction

"There is no cure for birth or death save to enjoy the interval"
George Santayana

CHAPTER 1

Introduction

What is Social Monitoring?

Social monitoring is concerned with detecting change and tracing the effects of change throughout society. Change may happen rapidly or gradually, and even gradual trends of change, unheralded by spectacular events, need to be described and their implications explored. Monitoring can be defined as describing events as they occur, documenting trends over time and differences between groups in society. Although monitoring can tell us a lot about the likely future as this is strongly influenced by present trends, it does not seek to predict the future. It is not an end in itself, but an aid to decision-making and planning in the broadest sense.

Approach to Monitoring

As this is the first report of the Social Monitoring Group, a "base-line" approach has been adopted rather than one which focuses on specific issues. This follows the model of the Population Monitoring Group's first report, which was also a "scene-setter".[1] The report concentrates on the first two terms of reference of the SMG:

- to document current and emergent trends relevant to social development in New Zealand
- to explore the implications and significance of these trends.

The focus of the report is at the national level. This is simply to contain the scope of the work. The SMG realises that this must overlook important regional differences in social trends and especially in social outcomes. Subsequent reports will endeavour to incorporate a regional perspective, and a more issues-oriented approach.

In addition to monitoring trends over time, the SMG recognises the importance of examining differences between groups in society. Therefore the approach pays attention to groups defined on the basis of age, sex, ethnicity, income, marital status and workforce status (e.g. in paid work, unemployed, retired, etc.).

The approach to monitoring adopted uses a range of information types and sources. These include the *Census of Population and Dwellings* and the *Household Sample Survey* as well as administrative data, such as those collected by the Departments of Education and Health. Non-government sources include large-scale projects such as the Dunedin and Christchurch Child Development Studies and small-scale "one-off" studies, for example surveys of unemployed school-leavers. Technical information on data sources is included in Appendix II.

The SMG has attempted to present its material in a form which is simple, clear and attractive, not overburdened with technicalities, so that it may have the widest possible audience. It aims to avoid being "data-led", that is, covering only those areas in which information is abundant and accessible. Where an area or a set of trends is considered important, but is not well-documented, the SMG has stated this, and sees as part of its work to press for the filling of obvious data gaps. At the same time, the SMG acknowledges its report is not comprehensive in its coverage. Because of the broad perspective taken, many issues and areas of interest have been left out, and many treated superficially.

Underlying Values

Whatever the approach to social monitoring, it is bound to be influenced by the values of the observer(s). The SMG has tried to handle this by making its own values explicit and by stating the assumptions inherent in its analysis.

The SMG has agreed that the principal values underlying its approach to social monitoring are:

- equity
- access
- autonomy

Equity is defined as what is seen to be "fair" — this is not the same as equality (Davey and Koopman-Boyden, 1983). The pursuit of social justice entails seeking to achieve more equal access and more equal opportunity, while still allowing for personal choice and initiative. To ensure more equal access, barriers of many types must be attacked — physical barriers of time and space, but also social, cultural and economic obstacles. Autonomy, as a concept, includes independence, self-determination and the freedom to choose. But it entails also a set of rights and responsibilities which are needed to order the behaviour of individuals in society.

These somewhat abstract principles can be expressed in more practical terms as social objectives.

Social Objectives

There is no generally accepted statement of social objectives for New Zealand. The Social Development Council (SDC) prepared such a statement in the mid-1970s and this has been widely used and quoted (Task Force on Economic and Social Planning, 1976). It

1. Population Monitoring Group, *The New Zealand Population: Patterns of Change*, New Zealand Planning Council, 1984

assisted the identification of social indicators in work by the Department of Statistics from 1980 onwards. The following list of objectives is strongly influenced by the SDC statement. It expresses in more concrete terms the philosophical base of SMG thinking and is, in the view of the SMG, a set of goals for government policy:

1. to ensure all people a standard of living sufficient to meet basic human needs, through an equitable sharing of resources
2. to provide adequate care (physical, social and psychological) for all those who are handicapped by age, temporary or permanent illness or incapacity, or suffering from crisis or disruption in their lives
3. to give all people access to preventive and curative health care and to encourage the adoption of a healthy lifestyle
4. to ensure personal security and security of property, giving emphasis to the prevention of crime
5. to promote full participation by all people in decisions which affect their lives, and to set up structures to ensure this
6. to guarantee the individual freedom and autonomy to the extent that this does not conflict with the rights of others
7. to ensure that all people have worthwhile occupations suitable to their capabilities
8. to provide educational and recreational opportunities for all people, appropriate to their potential.

Selection of Material

The basis for the selection of data and the presentation of trends in this report is therefore of relevance to these social objectives. That is, the SMG aims to show the extent to which society is moving either towards or away from them. In many cases, material is available for only one point in time. This will not show a trend, but is included to provide a baseline measurement. Given the link which has been made with policy and the SMG's sponsorship by the New Zealand Planning Council and the Social Advisory Council, a related criterion for the selection of material is its potential relevance to policy matters.

The Life Event Approach

The life event approach provides a framework for the presentation of data. It allows a range of human experience to be covered rather than emphasising "problem" areas. Also, by making the individual the focus of attention, the reader is provided with an immediate point of identification. The approach also helps to show how factors are interrelated — for example, personal well-being is influenced by the adequacy of income, health, housing and factors related to self-esteem and the capacity for forming satisfying relationships. By looking at these together, a more realistic picture of the situation can be obtained.

The individual life-cycle can be divided into four stages — childhood, young adulthood, adulthood, and old age. Within these stages, various "life events" have been identified, which represent important events or processes which most people experience or pass through. Many are associated with changes in status (e.g. beginning paid work), or have been linked with stress (e.g. loss of spouse). It must be emphasised, however, that these are not all of the significant life events which could have been included, nor is there any implication that everyone will, or should, experience them all. The events may occur in a different order for some people, and others may find events reoccur (for example, more than one marriage, several job changes). The framework is simply a context within which to look at the social situation.

Policy Issues

The concluding section of the report explores policy issues thrown up by the trends identified. This provides a link back to the statement of social objectives, and allows comment to be made on issues which cut across the life event stages.

Birth

"For we brought nothing into this world ..."
1 Timothy, 6, 7.

CHAPTER 2

Birth

Social Objectives
The needs of an infant in the first year of life

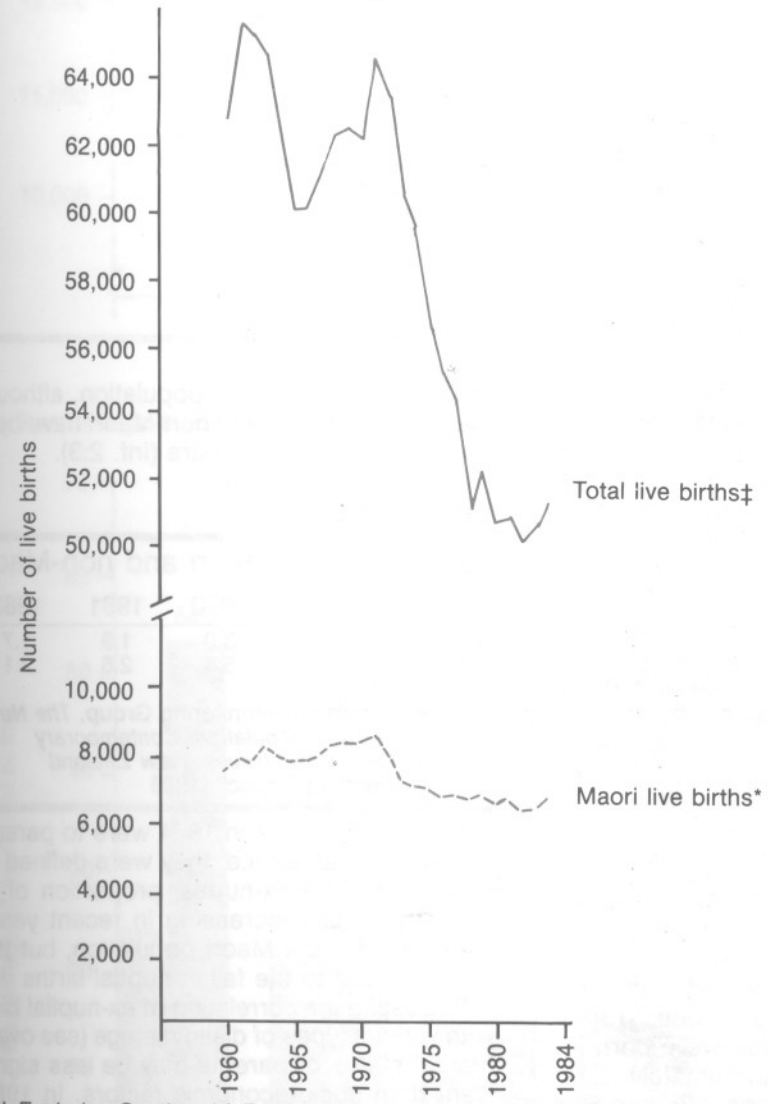
ADEQUATE STANDARD OF LIVING
CARE AND SECURITY
HEALTH CARE

We all experience birth. All of us have been equally vulnerable as infants and dependent for survival on the care of others, especially parents. The importance of early experience on the individual — on the extent to which physical and mental potential is achieved, on the success of social and psychological adjustment — is now recognised. The experience of birth is, however, not one-sided. It also brings about change for the parents of the new-born child. Their point of view is examined later in Chapter 7.

The immediate needs of a child at birth and during the first year of life are care and security; care in the form of nurture, security in the form of protection from threats to life and health. It is recognised that parents have the first responsibility for meeting these needs. Traditionally, the roles of parents have been determined on the basis of sex — the mother to provide physical and psychologi-

Infogram 2:1

Total and Maori Live Births, 1960–1984



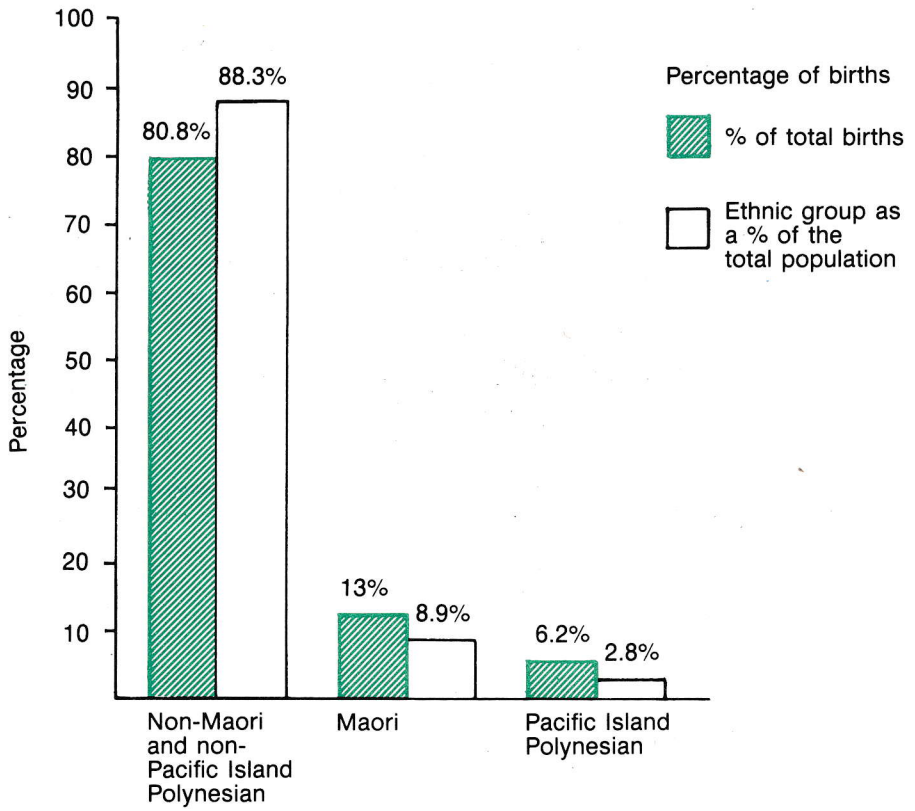
‡ Excludes Section 14 Registrations which are late birth registrations.

*There are several problems with measuring Maori births: (1) Maori births tend to be understated because they are recorded as non-Maori; (2) the Maori fertility rate measures only cultural identification; (3) the fertility rate may reflect other social factors (Population Monitoring Group 1985, pp 48, 49).

Source: *Vital Statistics*, Table 1, Department of Statistics

Infogram 2:2

Percentage of Births, by Ethnicity, 1984



Source: *Vital Statistics*, Table 2, Department of Statistics

cal nurture, the father to provide the means for an adequate home and standard of living. In the current context, however, a less rigid demarcation of roles between parents may be beneficial. While parents have considerable autonomy in how they bring up their children, it is also recognised that the state has an important role in relation to the care and protection of the newly-born. The state provides a "back-up" of financial support where a parent (most frequently the male partner) is absent, or unable/unwilling to "provide". The state encourages the use of health services for infants, often to the extent of full subsidy.

Demographic Trends

Declining numbers of births through the 1970s and early 1980s were part of an overall decline in fertility since the mid-19th century (Population Monitoring Group, 1984, 1985). In 1984, 51,636 babies were born in New Zealand, of which approximately 13% were Maori births (Infs 2:1 and 2:2), and 6% Pacific Island Polynesian births.[2] The fertility rate for the total population (the average number of live births a woman is likely to have over the whole of her life) is now under replacement level at 1.9 (replacement level is approximately 2.1). This is particularly the case for the non-Maori population, although the rates for Maori and non-Maori have been converging in recent years (Inf. 2:3).

Infogram 2:3

Fertility Rates: Maori and non-Maori

	1970	1981	1983
Non-Maori	3.0	1.9	1.7
Maori	5.4	2.6	2.1

Source: Population Monitoring Group, *The New Zealand Population: Contemporary Trends and Issues*, New Zealand Planning Council, 1985

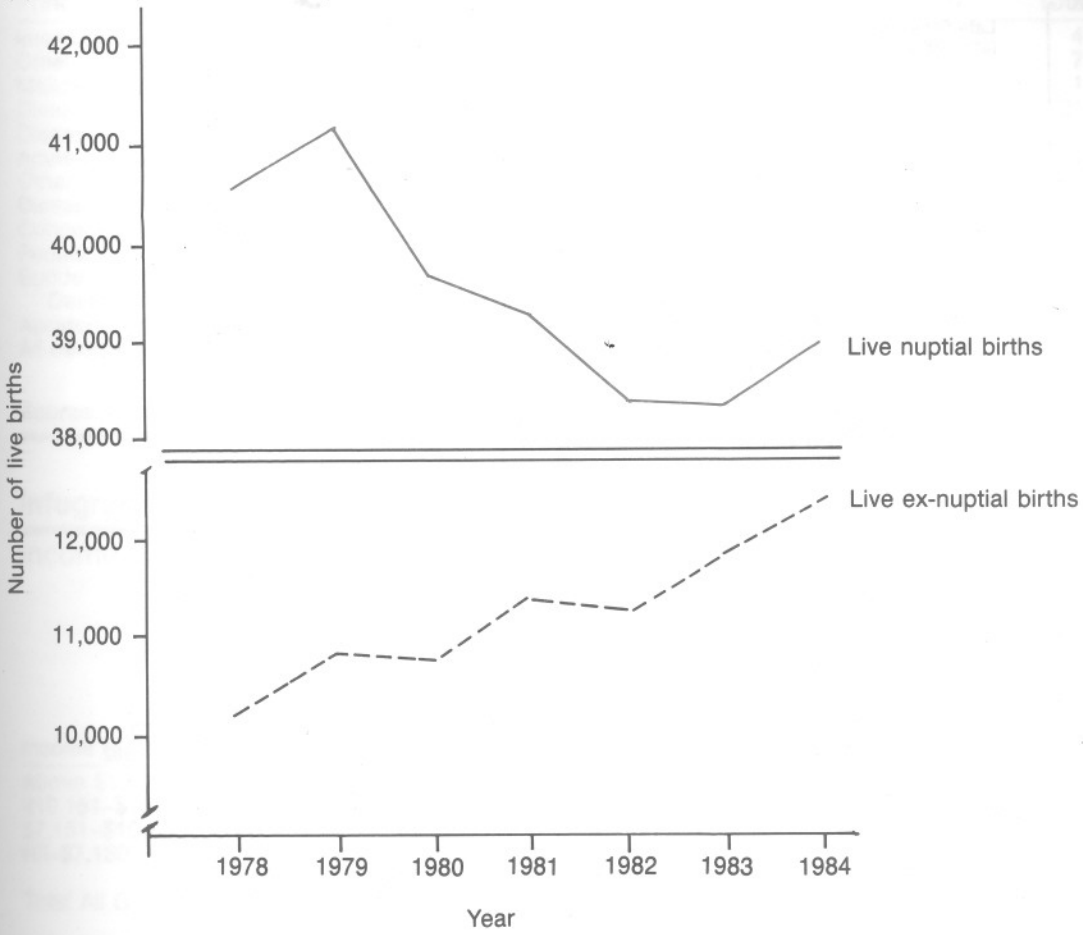
One in four births in 1984 were to parents not legally married (i.e. they were defined as ex-nuptial). The ex-nuptial proportion of all births has been increasing in recent years, especially for the Maori population, but this is mainly due to the fall in nuptial births (Inf. 2:4). Despite the correlation of ex-nuptial birth with various types of disadvantage (see over), marital status of parents may be less significant than socio-economic factors. In 1982,

2. The word "infogram" is used throughout the report to refer to all illustrated sets of data, whether they be tables, graphs, charts, diagrams or other forms of presentation. The use of the term "infogram" permits the sequential numbering of all data presented.

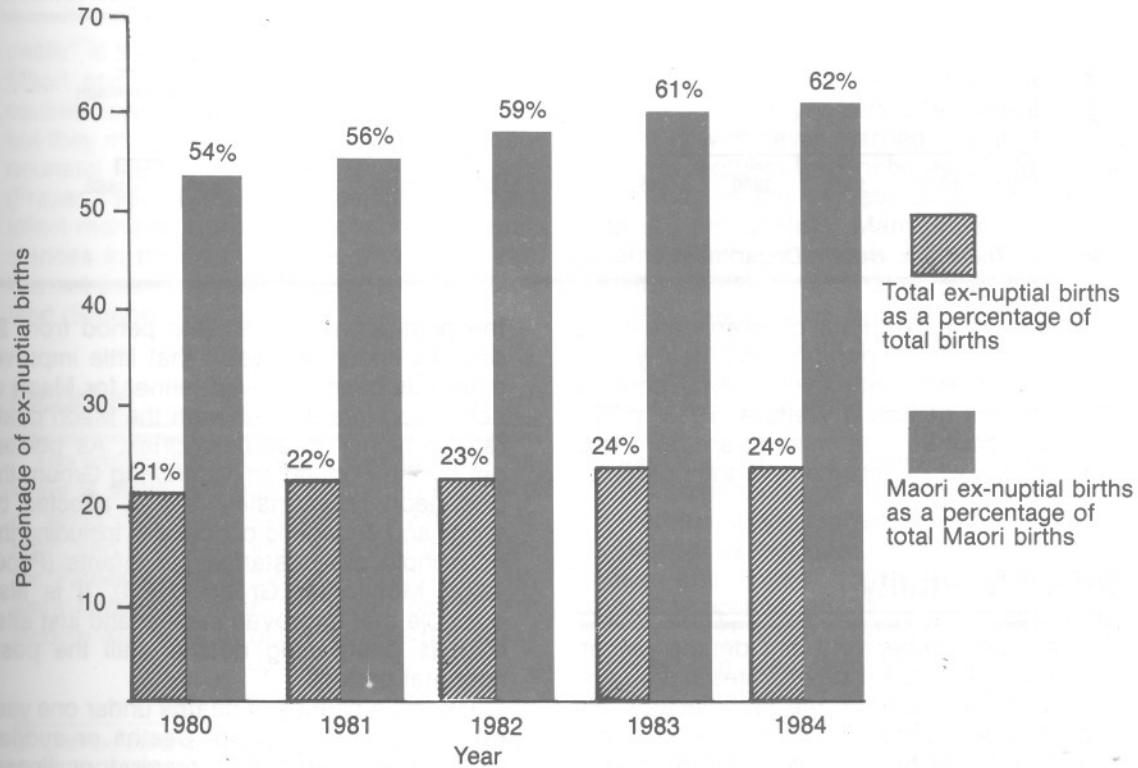
Infogram 2:4

Trends in Births

(a) Live Nuptial and Ex-nuptial Births, 1978-1984



(b) Percentage of Ex-nuptial Live Births, by Ethnicity, 1980-1984

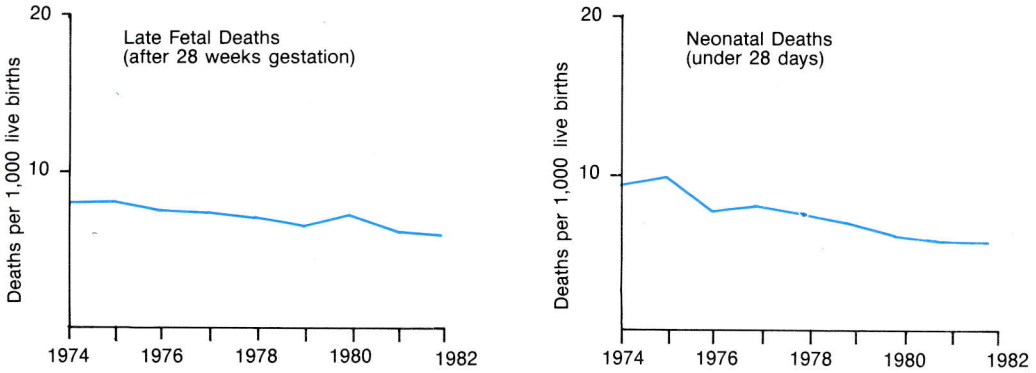


Source: *Vital Statistics*, Table 4, Department of Statistics

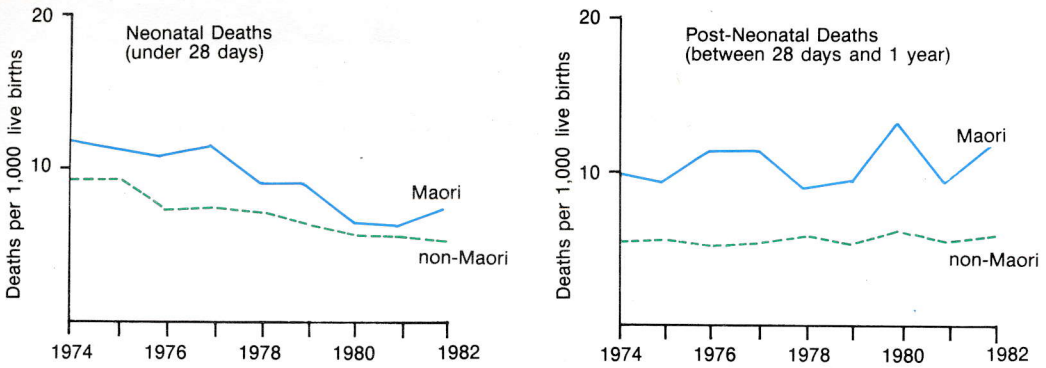
Infogram 2:5

Infant Mortality Rates, 1974-1982

(a) Total Population



(b) Maori and non-Maori



Source: *The Public Health*, Department of Health, 1984

four out of five ex-nuptial children were living with one or both parents and nearly half were living with both their natural parents (Department of Social Welfare, 1983, p.33). Overall, about 90% of children are born into households which include both their parents.

Infant Mortality

The total number of infant deaths (under one year), and infant death rates have continued to decline over the last decade, although the rate for Maori infants is static (Inf. 2:5). There has also been improvement in the rate of still births and deaths under 28 days (neonatal period). It is, however, in the post-neonatal area (the period from 28 days to under one year) that little improvement has been achieved, either for Maori or non-Maori infants, although the Maori death rate is higher in all categories. As pointed out by the Population Monitoring Group, the post-neonatal mortality rate is affected by social and economic conditions, including the household circumstances of infants (Population Monitoring Group, 1984). It is also possible that improved care at and just after birth is postponing deaths until the post-neonatal period.

The main causes of deaths under one year in New Zealand are cot deaths or sudden infant death syndrome, respiratory illness, and gastroenteritis (Inf. 2:6). These have all been associated with lifestyle factors. "Cot

Infogram 2:6

Causes of Infant Deaths, Maori and non-Maori, 1982

Principal causes of death	Number of Deaths 1982 Maori	non-Maori	Total
Intestinal infectious diseases	2	2	4
Other infectious and parasitic diseases	1	6	7
Maligant neoplasms	–	1	1
Diseases of the nervous system	5	16	21
Diseases of the circulatory system	4	3	7
Acute bronchitis, bronchiolitis, and pneumonia	9	27	36
Other diseases of the respiratory system	4	9	13
Diseases of the digestive system	2	1	3
Congenital anomalies	19	124	143
Perinatal causes (total of seven causes)	28	125	153
Sudden death, cause unknown (Sudden Infant Death Syndrome)	40	149	189
Accidents, poisonings and violence	3	10	13
All other causes	1	7	8
TOTAL	118	480	598

Source: *The Public Health*, Department of Health, 1984, p.76

Infogram 2:7

Income Group Distribution: All Families, by Family Type

Income group	Percentage of families in income group: All families %	Families with a child under 1 year %	Families with a child under 5 years %	Families with a child under 13 years %
Above $13,950	25	10	10	19
$10,151–$13,950	25	19	26	32
$7,161–$10,150	25	43	37	28
Nil–$7,160	25	28	27	21
Total All Groups	100	100	100	100

Note: Due to rounding, figures do not always sum exactly to totals shown. (Percentages have been rounded to the nearest unit or decimal point throughout this report.)
Source: 1981 Population Census 10% sample

death'' is the leading cause of death for both Maori and non-Maori babies. Its cause or causes have not been satisfactorily identified but they must be investigated further if post-neonatal death rates are to be reduced (Fraser, 1982). Overseas evidence has linked infant mortality rates with economic circumstances in the country as a whole, but this has not been analysed in detail for New Zealand (Brenner, 1973).

Income

The immediate and future well-being of an infant is strongly influenced by the standard of living of the household into which it is born, and hence income is an important factor. Families with babies in 1981,[3] however, were concentrated in the lower half of the income distribution for all families (Inf. 2:7).[4]

This concentration is even more marked where the mother of the child was not legally married, for only a very small proportion of families with never married, separated or divorced mothers had incomes above the median (i.e. in the highest or second income group) (Inf. 2:8(a)). Many mothers with incomes below this level would be living on welfare benefits.

The relationship between income distribution and ethnicity for families with babies is illustrated in Infogram 2:8(b). The relative disadvantage of Maori and Pacific Island Polynesian families with babies is very clear. Less than 20% of families with babies in these ethnic groups had incomes above the mean (i.e. in the highest and second income groups), as opposed to one-third of European and ''other'' families, and half of the total sample of families.

The vast majority of families with a child under one were living on a single income from paid employment. This is illustrated by the fact that 84% of mothers were not in paid work. Of those who did work for pay, about half worked for 20 hours or less per week (Inf. 2:9).

3. Defined here as families with a child under one year of age.
4. Refer to Appendix I for explanation of income group distribution.

Infogram 2:8

Income Group Distribution: Families with a Child Aged Under One

(a) By Marital Status of Mother

% of families in income group

Income group	All families %	Never married %	Married %	Separated %	Widowed %	Divorced %	Not specified %
Above $13,950	25	1	11	1	7	4	2
$10,151-$13,950	25	3	22	3	7	9	6
$7,161-$10,150	25	22	45	15	20	23	44
Nil-$7,160	25	74	22	81	66	64	48
Total All Groups	100	100	100	100	100	100	100

(b) By Ethnicity of Mother

% of families in income group

Income group	All families %	European %	Maori %	Pacific Island Polynesian %	Other %
Above $13,950	25	12	2	4	13
$10,151-$13,950	25	21	9	11	21
$7,161-$10,150	25	45	35	36	32
Nil-$7,160	25	22	53	49	34
Total All Groups	100	100	100	100	100

Source: 1981 Population Census 10% sample

Housing

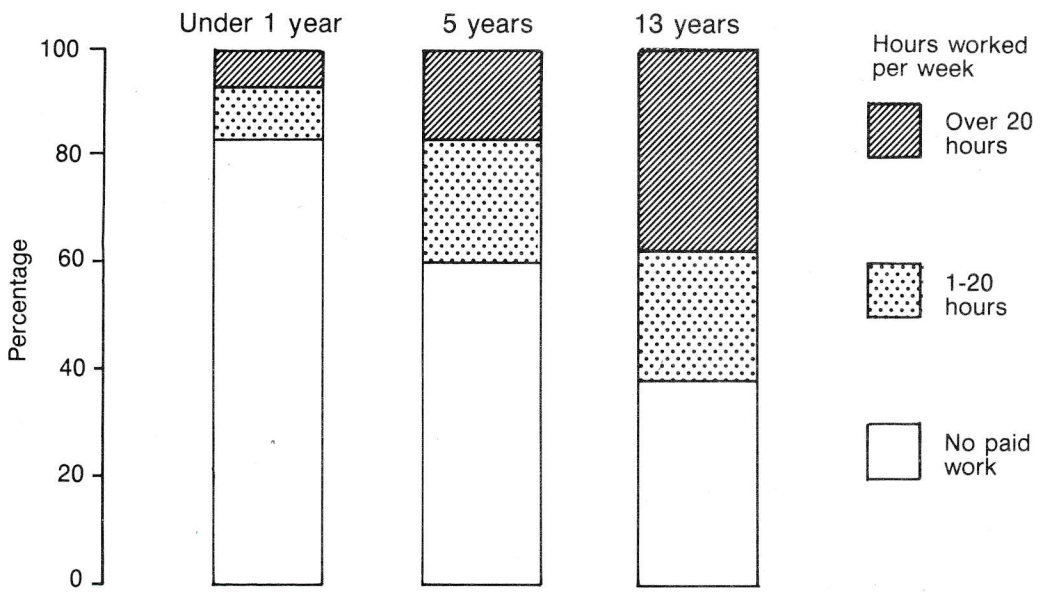
In 1981, 60% of families with babies owned their own homes with or without a mortgage, compared with 75% of all families in New Zealand in that year. The great majority of these were paying off mortgages (Inf. 2:10). Chapter 6 provides more information on house purchase in the early stages of family formation.

About one-third of families with babies rented their housing, compared with one-fifth of total families. Private landlords provided half of this housing, followed by the Housing Corporation (28%). The Housing Corporation provided a higher proportion of rented accommodation for families with a child under

Infogram 2:9

Mothers' Hours of Paid Work, by Family Type

Families with a child aged:



Source: Population Census 10% sample

one than for the total population. This follows the corporation's policy of housing families with modest incomes, especially those with children.

Summary

The family and household circumstances of children under one year in 1981 were:

- 90% lived with both parents
- 80% had a father aged 20–34
- 85% had a mother aged 20–34
- 70% were in a family with an income below the median for all families (i.e. below the middle level of the income distribution for all families)
- 10% were in a family with an income in the top income group for all families
- 83% had a mother who was not in paid employment
- 60% lived in a house which was owned, with or without a mortgage
- 34% lived in rented accommodation

Care at and after Birth

The vast majority of babies are born in hospitals, and although there has been growing interest in home births in recent years, these constitute a very small percentage of the total.[5] The limitations appear to be more in the form of organisational barriers than lack of demand, for example, opposition from some sectors of the medical profession, the cost to parents, conditions of work for midwives. Given greater emphasis on the wishes of mothers and acceptance that a choice should be available, it is probable that the number of home births will grow.

Little information is available on the "style" of birth. There is, however, some concern about the number of Caesarean section births, especially at some hospitals. Data on birth defects is also scarce. Between 2% and 3% of babies are born with congenital abnormalities (Department of Health, 1984b, p.57). The effects of mothers' behaviour before birth on the life chances of infants through smoking, alcohol and drug use have not been fully clarified.

Breast-feeding

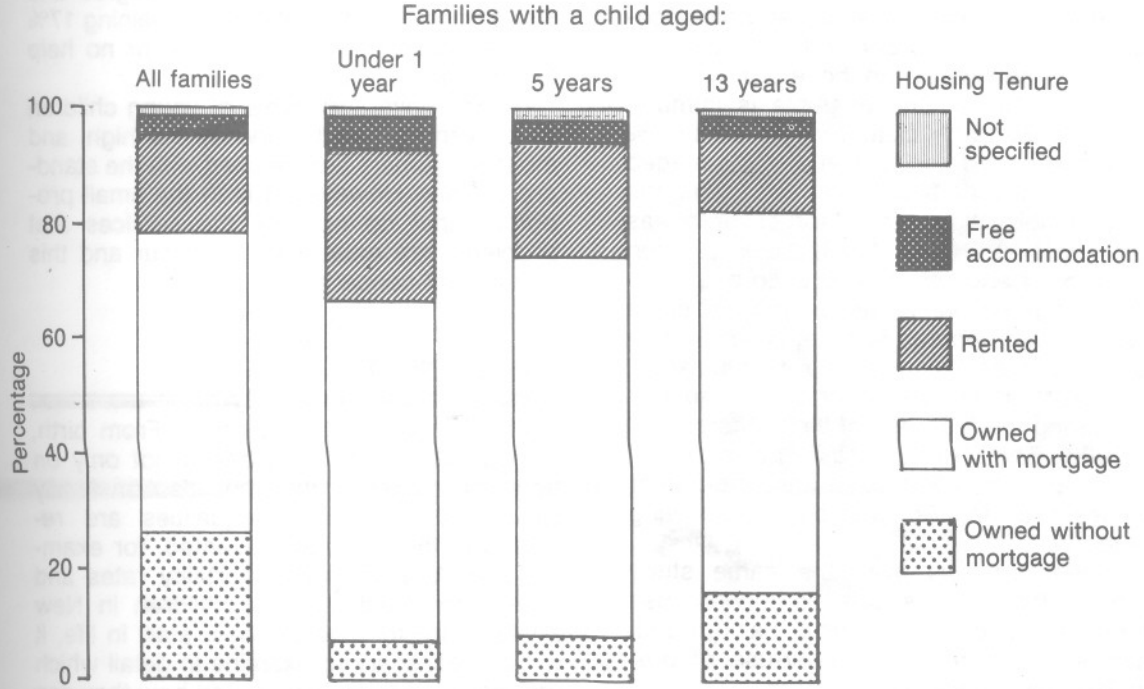
Breast-feeding confers a number of advantages to the child and in recognition of this, there has been an increase in the number of mothers choosing to breast-feed their babies. In a sample of 1,121 mothers in Christchurch, over 80% intended to do so (Starling, 1979). Bottle-fed infants have been shown to have greater susceptibility to gastro-intestinal disturbances, and there is evidence to suggest that breast-feeding may provide some protection against respiratory infection (Fergusson et al: 1978b, 1981c).

Many mothers, however, have not been able to continue breast-feeding as long as

5. Estimated at one in every 200 births in 1983, according to data supplied by the New Zealand Home Births Association.

Infogram 2:10

Housing Tenure by Family Type



Source: 1981 Population Census 10% sample

they had intended. 66% of mothers in a Dunedin sample weaned their children due to lactation failure, the most significant factor behind this being "mismanagement by health professionals" (Hood et al, 1978). This included restricted suckling times, separation of mother and baby at birth and between feeds, bottle-feeding and test weighing. In another study, half the sample weaned their babies within the first three months. The more successful mothers tended to be older, to have higher educational qualifications and to live in two-parent family situations (Starling, 1979). Thus, mothers who breast-feed their children longer may be those who have social and economic advantages. The success of breast-feeding is apparently influenced by encouragement from husbands and members of the family.

In the long run, children who were breast-fed longer do not have significant advantages over those who were bottle-fed (Silva, 1978a). In New Zealand, standards of child health care are high, and breast-feeding does not make as great a difference as it might in a less developed country.

Health Services for Infants

The aim of state provision of medical services and health care for children is to extend such services to all sections of the community, irrespective of socio-economic status, ethnicity and other characteristics, and to maintain high standards from the point of view of both equity of access and quality of care (Board of Health, 1982). There is, however, concern about unevenness in the use of child health services, and particularly over infant mortality.

There is evidence that lower socio-economic groups in New Zealand society underuse health services, even those provided free (Salmond, 1975). One example is immunisation. In South Auckland, while about 8% of European and Pacific Island children aged 0-4 had no "combined" immunisation, the corresponding figure for Maori children was 20% (West and Harris, 1978). Maori children also more frequently lacked polio and measles immunisation. A similar picture came from the Christchurch sample, in which over 10% of babies "received no immunisation, incomplete immunisation or late immunisation during the first year of life" (Shannon et al, 1980). The children in this group tended to belong to non-European and one-parent families and "families with depressed living standards".

Another analysis from the same study found a significant association between use of preventive care and social background. Factors associated with under-use of preventive health care were:

- mothers of non-European ethnic origin
- one-parent families (as compared with two-parent families)
- low maternal education
- high residential mobility
- large families (Fergusson et al, 1981a).

Children born ex-nuptially or into one-parent families were also less likely to be immunised, to receive attention for respiratory illnesses and to use preventive nursing care. They appeared to have an increased risk of accidents and burns and more frequently arrived in hospital because of inadequate home circumstances (Fergusson et al, 1981b). The mechanisms underlying these associations of factors are, however, still unclear, so it is difficult, and unwise, to assume direct cause and effect relationships.

Such findings, nevertheless, give concern about the extent to which health service provision in New Zealand is meeting its aims. Also highlighted is the influence of socio-economic factors on health standards.

Attitudes to Health Services

Most parents appear to be satisfied with health care services for their babies. In one survey, only 5% of mothers were dissatisfied with their family doctors, but over half of these mentioned inadequacies in the doctor's management and treatment (Fergusson et al, 1981d). A larger percentage (13%) was dissatisfied with Plunket nurses, who were seen as being too authoritarian, inadequate as sources of information on the social and emotional aspects of child-rearing, and unwilling to accept alternative methods to those advocated by the Plunket Society. Another survey in Dunedin found that, while 98% of mothers used Plunket to some degree and 83% considered it helpful, the remaining 17% found the service to be of little or no help (Geddis and Silva, 1979).

Overall coverage levels of young children by preventive health services are high, and most consumers are satisfied with the standard of care. However, it is in the small proportion that do not use the services that problems are most likely to occur and this must be of concern.

Conclusion

Children are not born equal. From birth, inequalities are evident, based not only on personal characteristics but also on family circumstances. Such inequalities are reflected in the material presented, for example, the data on infant mortality rates and access to health care. If children in New Zealand are to have the best start in life, it will be necessary to examine in detail which groups are disadvantaged and how they can be helped.

Starting School

"Children have neither past nor future: they enjoy the present, which very few of us do."

La Bruyère

CHAPTER 3

Starting School

SOCIAL OBJECTIVES
The needs of a child at five years

ADEQUATE STANDARD OF LIVING
EDUCATION
CARE AND SECURITY

The Education Act 1964 requires all children between the ages of six and 15 to be at school, and parents are legally bound to see their children are enrolled. In practice, most children begin their schooling at the age of five and many have pre-school experience of an educational nature. The assumption underlying the provision of pre-school services (and the reason they are covered in this chapter) is that such experience is of benefit to the child in preparing for school life and for general development, especially in the acquisition of social skills. The further assumption that pre-school education should be flexible to meet the needs of all parents and children has allowed the encouragement of a variety of pre-school opportunities. However, such diversity does not continue into the formal primary school situation.

In this chapter, the event "starting school" provides a focus for examining the situation and needs of children in New Zealand at about the age of five years. Their needs, as indicated above, are not dissimilar to those of a child in its first year, so that the format of this chapter is somewhat similar to that on "birth". The main themes are family and household circumstances, pre-school and school education, and care and security.

Households and Families

In 1981, there was a total of 53,181 five-year olds in New Zealand (27,192 boys and 25,989 girls). The vast majority lived in families with two parents and dependent children only (a dependent child is one under 16 years of age, or under 19 and attending full-time schooling) (Inf. 3:1). Most of these families had three or four members (Inf. 3:2).

The majority of mothers of five-year old children were married — 86% — with the next largest category being those who were separated — 6% (never married 3%, widowed 1%, divorced 2%). Most of the parents were in their twenties and thirties (Inf. 3:3).

Taking the mother's ethnicity as an indication of the ethnic affiliation of the child, 14% of five-year olds in 1981 were Maori, and 5% Pacific Island Polynesian. Both these proportions are higher than the proportions of these groups in the population as a whole, reflecting higher fertility rates (Inf. 2:2). Four out of five children, however, were of European descent.

Infogram 3:1

Percentage of Families with a Child Aged Five: Family Type

Family type	%
One parent and one or more dependent children	10
One parent and one or more dependent and non-dependent children	1
Two parents and one or more dependent children	86
Two parents and one or more dependent and non-dependent children	3

Source: 1981 Population Census 10% sample

Infogram 3:2

Families with a Child Aged Five: Size of Family

Size of family	%
2 people in family	8
3 people in family	36
4 people in family	30
5 people in family	14
6 and over in family	12

Source: 1981 Population Census 10% sample

In 1981, the income group distribution for families with a five-year old was similar to that for families with a child under one year (compare Infogram 3:4 with Infogram 2:7). Income distribution by mother's marital status again shows the contrast between families with married mothers, and the rest (Inf. 3:4a). Non-married status of mothers appears to be a more important factor than ethnicity in placing families with five-year-old children in the lowest income group (Inf. 3:4b).

These two distributions are very similar to the comparable ones for families with babies (Inf. 2:8). It could be inferred that the income disadvantage of families with very young children has not been reduced by the time a child reaches school age.

There are, however, two points of difference between the groups of families — home-ownership and mother's involvement in the paid workforce. Compared with families with babies, a higher proportion of families with a five-year old have a mother participating in the paid workforce (36% as against 15%), and there is a large jump in those working more than 20 hours per week (Inf. 2:9). This may account for an increase in household income levels. The proportion of families which own their homes is 60% for families with babies, and 69% for families with a five-year old (Inf. 2:10). This reflects

Infogram 3:3

Families with a Child Aged Five: Age of Parents

Father's age	Mother's age 15-34 years %	35-44 years %	45 years & over %
15-34 years	57	2	–
35-44 years	18	15	–
45 years and older	2	4	2

Source: 1981 Population Census 10% sample

a more general relationship between home-ownership and life-cycle stage, measured by age (Chapter 6).

Pre-school Education

Before they start compulsory education at primary school, many children obtain pre-school educational experience from a range of institutions including kindergartens, play-centres, *Te Kohanga Reo* and childcare centres (State Services Commission, 1980). Pre-school education performs a number of functions. It is desirable for children to go beyond the immediate family for intellectual stimulation and to promote physical, emotional, linguistic and social growth. The assumption that this benefits the child, has led the Government to support pre-school education services and to provide both direct and indirect funding by way of subsidies and grants through organisations representing each type of institution (Department of Education, 1979, p.5).

For historical reasons, the Department of Education oversees kindergartens and play-centres, while the Department of Maori Affairs is concerned with *Te Kohanga Reo*, and the Social Welfare Department with childcare services.

A second assumption has been that pre-school education should meet the needs of parents. This has fostered the development of a variety of pre-school opportunities. Some pre-school institutions encourage the participation of parents in the child's development in both a supportive and practical manner. In recognition of these benefits, there has been an increasing demand on, and expectation of, services since the early 1970s. This is reflected in increased enrolments and in the proliferation of formal and informal schemes. A total of 88,344 children were enrolled in early childhood care and education services of all types in late 1983. The largest categories were free kindergartens and playcentres (Inf. 3:5). The great variety of pre-school experiences available is to be noted, and also the difficulty of distinguishing between childcare and early childhood education.

Infogram 3:4

Income Group Distribution: Families with a Child Aged Five

(a) By Marital Status of Mother

Income group	All families %	Never married %	Married %	Separated %	Widowed %	Divorced %	Not specified %
	% of families in income group						
Above $13,950	25	1	11	3	0	5	4
$10,151-$13,950	25	7	29	5	6	10	13
$7,161-$10,150	25	16	39	11	17	20	45
Nil-$7,160	25	76	21	81	77	65	38
Total All Groups	100	100	100	100	100	100	100

(b) By Ethnicity of Mother

Income group	All families %	European %	Maori %	Pacific Island Polynesian %	Other %
	% of families in income group				
Above $13,950	25	11	5	2	19
$10-151-$13,950	25	28	17	19	28
$7,161-$10,150	25	38	33	36	23
Nil-$7,160	25	23	45	43	30
Total All Groups	100	100	100	100	100

Source: 1981 Population Census 10% Sample

Infogram 3:5

Numbers Attending Early Childhood Care and Education Services, 1983

	No. of children	% of total
Free kindergartens	40,186	45
Playcentres	16,155	18
Childcare centres	6,995	8
Private and community kindergartens	6,152	7
Informal family play groups	5,800	6
Small non-profit-making pre-school groups	3,028	3
Groups with community pre-school workers	2,648	3
Te Kohanga Reo	2,500	3

Source: Department of Education, Early Childhood Education Division

The percentage of the eligible population enrolled in pre-school services appears high — 48% at 2.5 years, 53% at 3 years and 85% at 4 years — but the figures are certainly inflated as many children use two or more services at the same time. The true figures for enrolment are probably closer to one-third of three-year olds and two-thirds of four-year olds, including about the same proportions of girls and boys (Meade, 1984).

Enrolments in kindergartens and playcentres together have risen by 39% since 1970, but because of falling birthrates are not expected to continue to increase at this rate. Growth has been mainly in kindergarten rolls (up 68% since 1970). Other types of pre-school services whose enrolments have risen include childcare centres, family day-care and *Te Kohanga Reo*. Playcentre rolls on the other hand, have declined by nearly 4% since 1970. Informal play groups and community-based pre-school groups have also seen a fall in numbers of children involved in recent years.

This shows an underlying preference by parents for the kindergarten style of pre-school education, which places less emphasis on parental involvement than playcentres or play groups. The increasing participation of women in the paid workforce is also a factor. With less pressure on kindergartens through a falling birthrate, parents are able to enroll their children more easily and at an earlier age, in many cases withdrawing them from other services.

Although a higher proportion of pre-school children is using early childhood services, this increase has not been evenly distributed through the community. Nor, as has been shown, do all children receive pre-school experience. Internationally, it has been shown that the higher the socio-economic group, the greater the use of pre-school education (Mialaret, 1976). In New Zealand, several studies have shown that pakeha children and those with a socially advantaged background have made greater use of pre-school services than other groups (Barney, 1975; Fergusson et al, 1982a).

In the Christchurch Child Development Study, 95% of the sample used some pre-school services, but only 32% — less than one-third — received continuous pre-school education from the age of three years (Fergusson et al, 1984b). Those least likely to attend continuously were:

- Maori and Pacific Island children
- those with less well educated mothers
- children from large families
- children from families with depressed living standards or low incomes.

It was clearly evident that these family features had a cumulative effect.

Attendance at pre-school is thus, at least partially, determined by the socio-economic status of the family. Children with a continuous record of attendance are more likely to perform better at school entry than those without (Fergusson et al, 1982a). However, family background may play the larger part in determining the progress a child makes in the education system and hence through life. As Clay concludes:

"Despite the egalitarian aims of recent pre-school programmes we cannot expcet them to remove individual differences on entry to school if socio-economic factors determine whether a child gets to pre-school and for how long." (Clay, 1981)

Mother's education was found to be a factor in the 1980–81 *Social Indicators Survey* (Department of Statistics, 1985). Where mothers had no secondary school qualification, 34% of children attended pre-school, as opposed to 44% of children whose mothers had some school or higher qualification (overall 38%).

Despite large increases in attendance at pre-school institutions through the 1970s and 1980s, there are still proportionally fewer Maori than non-Maori children enrolled. According to the *Social Indicators Survey*, 21% of Maori pre-schoolers attended a pre-school or day-care centre, as opposed to 42% of non-Maori children (Department of Statistics, 1985).

In 1981, 11% of children at playcentres and 15% at kindergartens were Maori or Pacific Island Polynesian, while these ethnic groups comprised about 19% of the pre-school population. *Te Kohanga Reo*, or Maori "language nests", have grown rapidly since the programme began in 1981. The centres emphasise Maori language and culture, with fluent speakers, especially older Maori women, playing a vital part. However, ques-

tions are now being asked about the continuity of language teaching and use into primary schools and about the capacity of the primary system to provide for *Te Kohanga Reo* children.

Preventive Health Care and Safety

High on the list of needs for five-year old children are health care and protection. The scope for threats to health and security is widened as children move out from the family home and widen their range of experiences, activities and contacts with others.

Public health nurses are expected to assess new entrants to primary schools for health problems which may have been overlooked at home; in 1983, the coverage was 85.4% for hearing tests and 85.6% for vision tests. These are especially important as defects will affect language and speech development, adjustment to school (especially in learning to read) and, often, are associated with behavioural problems. Infogram 3:6 shows the results of testing at the school entry stage with trends for recent years (and figures for pre-school and Form 1 ages for comparison). The school entry stage appears to be where the greatest number of hearing defects are picked up.

Nursing services in primary schools provide valuable preventive and consultative health resources, especially where families are not making use of primary medical services. In a 1981 survey, it was found that 85% of the 247 primary schools responding had a public health nurse available, either on request or on a regular basis (Committee for Children, 1982). The pattern of availability, however, varied greatly from area to area.

School principals were asked whether children would go without primary health care if there were no school nurses — 79% thought definitely yes, and 6%, probably/possibly. Many commented on the very high workload of public health nurses and also on the demands made on teachers to attend to sick or injured children, especially sick children sent to school while both parents were in paid work. There was particular concern about the inadequacy of health care where schools had a high proportion of pupils in the lower socio-economic groups or large numbers of Maori and Pacific Island children.

The cost of medical consultations may be deterring some parents from taking their children to the doctor. It was found that child consultations in Otago had dropped by 19% between 1980 and 1983 (Clarkson and Lafferty, 1984).

Dental Care

It has already been shown that children from socially disadvantaged backgrounds often do not to make use of health services. This is also true with respect to free dental care for pre-school children (from the age of 2½), available on parental initiative, as opposed to school dental services, to which children are taken in school hours. In the Christchurch sample, there was a significant association between non-use of dental care services and family social background at the five-year old stage (Beautrais et al, 1982). Factors associated with lower use levels included:

- mother of non-European ethnic origin
- low family income
- one-parent family
- non-attendance at pre-school education facilities
- failure to attend community nurse services and a lower use of routine child health services including immunisations and routine checks.

However, the percentage of pre-school children using the pre-school dental service has been growing and is expected to increase further (Inf. 3:7). A recent national study of five-year old children found that almost half (47%) had been enrolled at three years, and most (87%) were enrolled by the age of five (Department of Health, 1984b).

Infogram 3:6

Vision and Hearing Screening Tests, by School Level of Children, 1980 and 1983

School level	Vision tests 1980	Vision tests 1983	Hearing tests 1980	Hearing tests 1983
Pre-school				
Number tested	16,189	25,877	12,505	21,834
% suspected defects	3.4	11.5	6.8	15.5
New Entrants				
Number tested	58,847	57,530	60,814	53,171
% suspected defects	7.5	11.8	12.4	19.2
Form 1				
Number tested	57,392	62,178	56,514	50,862
% suspected defects	5.7	11.9	4.8	8.3

Note: The differences between 1980 and 1983 results are partly due to different measurement criteria (Board of Health, 1984, p.38)

Source: Department of Health, Health Promotion Division

Infogram 3:7

Dental Treatment of Pre-School Children (2½ to 5 Years of Age), 1950–1984

Year ended 31 March	Number of pre-school children treated by school dental service	Approximate percentage of pre-school children
1950	22,514	19
1960	63,012	44
1970	87,197	60
1975	99,963	64
1980	87,791	66
1982	85,319	68
1984	93,209	74

Source: *The Public Health*, Department of Health, 1984, p.73

Hospital Care

By the age of five, it is not uncommon for children to have had an admission to hospital. In the Dunedin Child Development Study, just over one in four (27%) had been admitted to hospital, and 7% more than once. However, most admissions were for short periods of time (Simons et al, 1980). About one in every four hospital admissions of school age children (5-14 years) are for respiratory diseases, including asthma, and the number of such admissions has been growing since the 1960s. The incidence of asthma in the child population has not been accurately defined but could be increasing. Accidents and accidental poisonings account for a further 20% of hospital admissions.

Accidents

A number of studies have focused on accidents as a major threat to the well-being of children. In an analysis of primary school accidents, 58% were found to be due to falls from playground equipment and 25% were associated with sports equipment and "playthings" (Langley et al, 1981b). Most accidents of this nature are minor, with over half, particularly for six and seven-year olds, occurring at home, particularly in the kitchen (Langley et al, 1981a). Accidents involving children five and over are generally considered difficult to prevent without "heavy interference in the child's normal behaviour and development". Steps are advocated to create a safer environment, such as improving the design of recreational equipment, and reducing hazards in the home.

It has been estimated that at least one child in five in New Zealand will be poisoned or burned by the age of three years (Silva et al, 1978b). The majority of poisonings are by household medicines and cleaners when not in their usual place of storage. Certain family characteristics appear to increase the risk of poisoning. Children especially vulnerable include those:

- of young mothers
- who entered one-parent families at birth
- whose mother reported a large number of problems with the child
- from homes reporting a large number of stressful events (such as shifting house)
- whose parents had separated
- whose mothers had been prescribed antidepressants and/or tranquillisers (Beautrais et al, 1981).

Drowning is one of the three most common causes of death in children up to five. The most common water hazard for this group is the domestic swimming pool. From 1979 to 1981, 38 children under the age of 15 drowned in pools. In one survey, 63% of swimming pools to which children were exposed had no safety features (Geddis, 1984).

Child Abuse

Child abuse and child neglect can take many forms — physical, emotional and sexual. Physical and sexual abuse is often associated with obvious and immediate results such as personal injury, but psychological abuse, while less visible, may have equally serious repercussions. These may not be immediately manifest as with physical injury — it is possible for them not to surface for many years (Abbott, 1983). In 1982, there were 169 convictions in New Zealand courts for child abuse. However, there are estimated to be at least 1,500 cases each year of non-accidental injury to children below the age of five (Board of Health, 1982). The true extent of abuse cannot be determined as only a few cases are officially recorded.

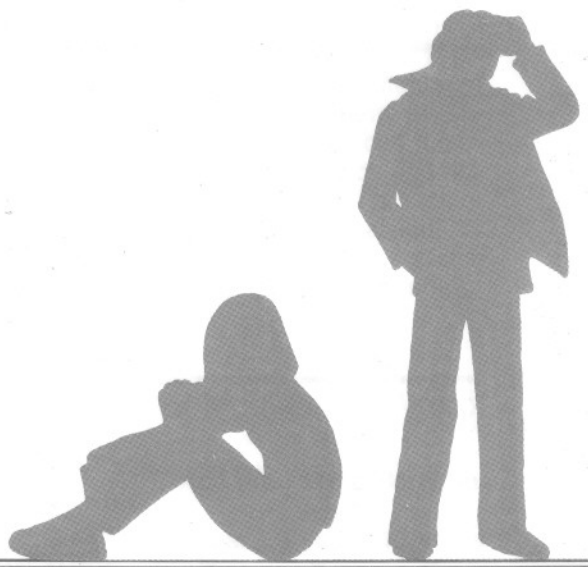
Conclusion

The picture which emerges adds to that presented in the previous chapter, indicating the susceptibility to ill-health and accident of children who come from a socially disadvantaged background. Particular groups which may be at risk include children of very young mothers, of solo parents, of parents on very low incomes, and those belonging to Maori and Pacific Island ethnic groups. The detailed interaction of these factors is difficult to untangle and causes are obscure. It is also evident, however, that the provision of services, even on a totally free basis, is not sufficient to ensure they are used, or used to their maximum effectiveness.

Becoming a Teenager

"Today's younger generation is no worse than my own. We were just as ignorant and repulsive as they are ... "

Al Capp



CHAPTER 4

Becoming a Teenager

SOCIAL OBJECTIVES

The needs of a young person at age 13

ADEQUATE STANDARD OF LIVING
HEALTH CARE AND CARE IN CRISES
EDUCATION AND LEISURE
FREEDOM/SECURITY/PARTICIPATION

The terms used for the period between childhood and adulthood say much about how young people in this stage are seen. "Puberty" tends to have purely physical connotations, associated with the beginning of sexual maturity. "Adolescence" tends to carry negative connotations, reflecting the views of parents, teachers and society at large. Few young people would use this term to describe themselves or their peers. "Teenager" may be almost as bad. "Adult" status and the legal and social rights, duties and responsibilities which this entails, is bestowed at different ages for different purposes. In the view of the young adults themselves, this seems to come earlier when they are required to pay full price, and later when some freedom is being bestowed!

Despite these problems of definition, there is no doubt that a significant change occurs in an individual's life at about the age of 13, usually coinciding with the beginning of secondary education. Changes occur in attitudes, lifestyle and relationships, including a heightened awareness of independence and sexuality, which may lead to considerable anxiety, especially in relationships with family members and with peers.

The needs of young adults include those of younger children, but are extended as the individual moves into the wider world. Teenagers make greater demands in terms of facilities for leisure including organised outdoor activities. They may be confronted with crises which require special types of care and some of these will be outlined in this chapter. Their right to freedom is likely to be asserted with some vigour, both at home and outside. At this stage autonomy begins to be passed from the parent to the child, but the hand-over is not always trouble-free.

Family and Household Circumstances

In 1981, there were 59,415 people aged 13 in New Zealand; 30,219 boys and 29,196 girls. This is a higher total than the five-year old and under-one-year groups examined in previous chapters, illustrating a decline in the birth-rate over the last ten to 15 years. Families with 13-year olds often contain a mixture of dependent and non-dependent children (Inf. 4:1).

Infogram 4:1

Families with a Child Aged 13: Family Type

Family type	%
One parent with one or more dependent child(ren)	10
One parent with one or more dependent child(ren) and non-dependent children	4
Two parents and one or more dependent child(ren)	65
Two parents and one or more dependent child(ren) and non-dependent children	21
	100

Source: 1981 Population Census 10% sample.

A higher proportion of 13-year old children live in one-parent families, compared with the younger groups (Inf. 4:2).

Infogram 4:2

One-Parent and Two-Parent Families, by Age of Child

	One-parent families %	Two-parent families %
At age one and under	8	91
At age five	11	89
At age 13	14	86

Source: 1981 Population Census 10% sample

This is reflected in the marital status of mothers (Inf. 4:3); 10% of mothers of 13-year olds were separated or divorced, compared with 8% for the five-year olds and 4% for the one-and-under group. Far fewer mothers, however, were "never married" or did not specify their marital status (which could imply a de facto relationship).

Infogram 4:3

Marital Status of Mothers, by Age of Child

	Age group of children in years		
Marital status	1 year %	5 years %	13 years %
Never married	5	3	1
Married	84	86	86
Separated	3	6	6
Divorced	1	2	4
Widowed	(0.5)	1	2
Not specified	7	2	1
	100	100	100

Source: 1981 Population Census 10% sample

Associated with a maturing family, the parents of 13-year olds are older, with the largest proportion in their mid-thirties to mid-forties (Inf. 4:4). The family groups themselves are above average in size, and compared with those with five-year old children, are more likely to have six or more members.

Infogram 4:4

Families with a Child Aged 13: Age of Parents
(percentages of total distribution)

Father's age	Mother's age 15-34	35-44	45-49	50+
15-34	6	2	–	–
35-44	11	45	1	–
45-49	1	11	5	1
50+	–	4	5	6

Source: 1981 Population Census 10% sample

Infogram 4:5

Families with Child Aged 13: Size of Family

Family size	%
2 people in family	1
3 people in family	9
4 people in family	28
5 people in family	29
6 people in family	17
7 people in family	9
8 and over	7
	100

Source: 1981 Population Census 10% sample

In 1981, the distribution of families with a 13-year old child between the income groups was more even than for families with a five-year old or a one-year old (Inf. 2:7). This, however, applied to European families more than to non-European families (using mother's ethnicity as an indicator) (Inf. 4:6b). As for the age groups discussed in Chapters 2 and 3, incomes were more equally distributed where mothers were married, but were concentrated in the lowest income group for other marital statuses (Inf. 4:6a).

Housing Tenure

Compared with families with younger children, a higher percentage of families with a 13-year old owned a home with or without a mortgage, and a smaller percentage rented their home (Inf. 2:10). This is to be expected as the principal earner or earners in the family are likely to be receiving close to their maximum incomes at this stage, and with older children there is more scope for mothers to be in paid employment.

Mother's Paid Work

Far more mothers with a 13-year old are in paid work (62%), compared with mothers in families with a five-year old or a baby (40% and 17% respectively) (Inf. 2:9). The proportion working from one to 20 hours is the same for mothers of both five-year olds and 13-year olds, but the proportion working more than 20 hours a week doubles from 17% to 38%.

Infogram 4:6

Income Group Distribution: Families with a Child Aged 13

(a) By Marital Status of Mother

% of families in income group

Income group	All families %	Never married %	Married %	Separated %	Widowed %	Divorced %	Not specified %
Above $13,950	25	7	21	7	5	6	10
$10,151-$13,950	25	18	33	13	17	15	38
$7,161-$10,150	25	14	29	22	20	25	31
Nil-$7,160	25	61	17	58	58	54	21
Total All Groups	100	100	100	100	100	100	100

(b) By Ethnicity of Mother

% of families in income group

Income group	All families %	European %	Maori %	Pacific Island Polynesian %	Other %
Above $13,950	25	22	6	8	21
$10,151-$13,950	25	32	25	24	36
$7,161-$10,150	25	28	25	31	24
Nil-$7,160	25	18	44	37	19
Total All Groups	100	100	100	100	100

Source: 1981 Population Census 10% sample

Health and Threats to Health

As already noted, the teenage years open up new opportunities, not all of them positive or beneficial. Society allows increasing freedom to young people as they approach adulthood, but also attempts to control access to activities deemed harmful. Where controls are enshrined in law (drinking alcohol), then young people can easily become offenders or criminals, which also enhances the negative aspects of adolescence. Adults, however, by virtue of their age may be legally participating in the same potentially harmful activity. The current controversy over whether "glue-sniffing" should be made an offence illustrates the difficulty of coping with such activities and also the continuing conflict between youthful risk-taking and adult censure, a situation which has gone on for centuries.

Smoking

Smoking seems to be learned by many at an early age: 84% of smokers in a sample of Form 3 and 4 students had begun in primary or intermediate school (Beaglehole, 1978). A Dunedin survey of nine-year olds showed that 35% had already tried to smoke a cigarette (Tian et al, 1984). Three-quarters of Beaglehole's sample had smoked on some occasion; 32% were regular smokers and 15% smoked two or more per day. There was a similar pattern among Form 4 students in Northland: 15% of boys and 23% of girls smoked seven or more cigarettes per week, with a higher incidence among Maoris (boys 31%, girls 35%) (Flight, 1984).

Smoking habits are associated with those of peers, parents and siblings. Teenagers appear to know about the harmful effects of smoking (95% of Beaglehole's sample agreed that smoking harms health, and 83% that it causes cancer), but many continue because there are social pressures urging them to do so (Newman, 1982). Comparatively few appear to find smoking enjoyable and a main reason for giving it up is dislike.

Census data on smoking are not available for people under the age of 15. Certain comparisons can be made, however, to put data from the studies quoted into perspective. In the age group 15-19, more females than males were regular smokers in 1981 (29.2% and 26.1% respectively). But whereas the percentage of male regular smokers in the age group had fallen, from 28.4% in 1976, the percentage of females had remained the same. This indicates some concern about smoking by young women.

Alcohol

A national survey in 1977/78 of 3,000 Form 2, 4 and 6 students found that alcohol use was common and increased with age (Inf. 4:7). In Form 2, boys were more likely than girls to be drinkers, but the differences between the sexes became smaller in the fourth form and almost disappeared among sixth

Infogram 4:7

Distribution of Drinkers and non-Drinkers among Secondary School Pupils

(a) By Form

Use of alcohol	Form 2 %	Form 4 %	Form 6 %	Weighted total %
Non-drinkers				
never drink	8	5	2	5
tasted once or twice	27	9	8	16
Drinkers	65	86	90	79
Sample Number	990	996	990	2,976

(b) By Form and Sex

Form level	Male %	Female %	All %
Form 2			
drinker	74	54	65
non-drinker	26	46	35
Form 4			
drinker	90	82	86
non-drinker	10	18	14
Form 6			
drinker	92	89	90
non-drinker	8	11	10

Note: The differences between form levels are statistically highly significant for both males and females.

Source: Routledge, A. and Taylor, A., *Young People and Alcohol*, New Zealand Council for Educational Research, 1981, pp 20, 21

formers. As young people matured, drinking occurred more frequently outside the family context and the amount consumed was related to that consumed by friends.

Basing her definition on the number of episodes of drunkenness or negative consequences of drunkenness, Casswell suggested that a quarter of female high school students and one-third of male students in her Auckland sample were problem drinkers (Casswell, 1982). This could, however, indicate transient experimentation with high levels of alcohol use. Nevertheless, in earlier work, the same author concluded that the popularity of alcohol was increasing among teenagers and reflected its acceptance and use in the adult population (Casswell and Hood, 1977). Drinking, smoking and drug use among secondary school students may also be linked and associated with the relief of tension (Mitchell, 1983).

Concern over the adverse effects of alcohol abuse by young people is growing and the extent of the problem is obviously much greater than Department of Justice statistics on minors' drinking offences show. More and more young people are entering alcoholism treatment programmes, and there is a strong linkage between alcohol use and accidental injury and death among young people (Chapter 13).

Glue-sniffing

Glue-sniffing or solvent abuse is another activity which, while not illegal, is injurious to health and has, over recent years, caused the death of several young people. It is an activity not confined to "street kids" or runaways, but has also been reported among children from affluent homes in provincial towns. There are no figures to show its overall prevalence or effects.

Suggestions have been put forward to declare glue-sniffing illegal, to deal with it under the Alcoholism and Drug Addiction Act, or to add something to the solvents to make them distasteful. All these tend to be remedial or corrective and do not attack the underlying social problems which may lead young people to behave in ways injurious to themselves or offensive to others.

Mental Health

Physical, psychological and social changes undergone during the teenage years can produce stresses which are a threat to mental health. Kroger has attempted to explain adolescent actions and reactions in terms of attitudes towards relationships, for example with parents, authority figures, friends, and persons of the opposite sex (Kroger, 1982). Her study also established the importance and role of peer group pressure. Information from the Auckland Youthline Counselling Service illustrates some of these points (Youthline Counselling Service, 1984). Over the 1980/83 period, the largest number of calls for assistance were about male/female and parent/child relationships.

Despite these stresses, there are gaps in mental health services and support for teenagers, and lack of communication between agencies serving the needs of young people (Abbott, 1983). Out of 100,000 13 to 19-year olds in Auckland, an estimated 10% suffer from some form of psychological distress warranting attention. Up to one in a hundred adolescent girls are likely to suffer from anorexia nervosa, a little understood, but potentially fatal, psychological disorder (Hall, 1981). Very few admissions to hospital for mental health problems, however, involve people aged 10 to 14, although figures for the 15 to 20 group are higher (Inf. 4:8).

Infogram 4:8

Youth Mental Health Admissions, by Age and Sex, 1982 (excluding mental retardation and observation only)

	10-14 years		15-20 years	
	No.	% of total	No.	% of total
Male	64	0.9	520	7.1
Female	45	0.7	455	7.1

Source: Mental Health data, 1982, Department of Health

The most common reasons for admission in the younger age group are personality disorders, stress and adjustment reactions, both affecting boys more than girls.

Sex Education

Learning to cope with physical changes and exploring one's own sexuality are major problems of adolescence. Apart from male/female relationships, a high proportion of calls to Auckland Youthline over recent years have been concerned with sexuality, including homosexuality and masturbation. Despite this, the subject of sex education is highly controversial in New Zealand, with strong views being pressed both for and against its introduction in schools. Support for greater access to information by children and young people has come from a variety of sources, including the Committee for Children and the Abortion Supervisory Committee. A link is frequently made between the need for such access and figures for exnuptial births and abortions experienced by teenage girls (Infs. 4:9 and 4:10) (see also Chapter 2). In 1983, 182 babies were born to girls under 16, and 269 girls of this age had abortions (as recorded in official statistics).

Infogram 4:9

Live Births, by Age of Mother and Nuptiality, 1983

(a) Total Population

Age of mother	Total	Nuptial	Ex-nuptial	% Ex-nuptial
Under 16*	182		182	100
16-19	4,618	1,059	3,559	77
20-24	15,753	10,991	4,762	30
25-29	18,371	16,155	2,216	12

(b) Maori Population

Age of mother	Total	Nuptial	Ex-nuptial	% Ex-nuptial
Under 16*	76		76	100
16-19	1,490	185	1,305	87
20-24	2,511	915	1,596	63
25-29	1,389	804	585	42

* Births to mothers under 16 are ex-nuptial by definition

Source: *Vital Statistics*, 1983, Table 4, Department of Statistics

A matter of concern has been the high percentage of ex-nuptial births to young Maori girls. The Abortion Supervisory Committee has expressed concern at the situation and suggested young people need information to help "*form a positive and responsible view of sexuality in order to counterbalance the one-sided and deceptive influence of certain mass media*" (Abortion Supervisory Committee, 1984, p.5).

Infogram 4:10

Abortions Performed, by Age of Patient, 1981 and 1983

	1981		1983	
Age	%	No.	%	No.
Under 16	4	255	4	269
16-19	24	1,639	23	1,682
20-24	29	1,987	31	2,247
25-29	19	1,261	20	1,410
30-39	21	1,399	19	1,372
40+	3	216	3	218
TOTAL	100	6,759	100	7,198

Source: *Report of the Abortion Supervisory Committee*, 1984, Abortion Supervisory Committee

A study of 1,000 abortion patients in New Zealand showed that a third were under 20, and two-thirds of those aged 16 and under did not use contraception (Sparrow, 1982). "*Polynesians are at least half as likely again as Europeans to have had sexual intercourse before the age of 16*", and the lower the socio-economic status, the higher the probability that first sexual experience will take place before the age of 16 (Davis, 1977, p. 122). Peer group pressure is a factor which acts independently, with the greater the influence, the greater the probability that the first experience will occur before 16.

A revised health syllabus for primary and secondary schools has now been approved for full implementation in 1986, and will include sex education, provided this is approved at local level in consultation with parents. Although better access to information should be beneficial, other factors also influence the actions of individuals: risk-taking behaviour; difficulties in communicating between sexual partners and with parents; psychological barriers; the use of less reliable contraceptive methods and the non-availability of services and supplies; age; race; educational attainment and socio-economic status.

Recreation and Leisure

The leisure interests of teenagers appear to include both very active and very passive activities. In the New Zealand Recreation Survey, children aged 10-14 had the highest levels of involvement in sports of any age group — 98% for males and 100% for females (Tait, 1984). These were active outdoor pursuits and team sports rather than individual and small group sports, particularly in the case of males. On the other hand, in the report *Round About 12*, when children were asked what they actually did at certain times over a weekend, the most frequently reported activity was watching television (Clay and Oates, 1984).

The highest involvement in cultural interests, especially hobbies, was recorded in the early teens (Tait, 1984). Arts- and education-related activities were more popular with females than males, as was the case in all age groups. The largest male/female differences were for home-based recreation (sewing, reading, cooking, knitting), with 21% male participation and 76% female participation. Thus, gender differences in recreation and leisure develop at a very early stage in life. This is despite the fact that 70% of Form 3 students in 1984 were in co-educational

Infogram 4:11

Children and Young Persons' Court Appearances, by Age, 1982

Age in years	Male	Female	Total	% of total for Male	% of total for Maori
13	48	11	59	81.4	64.4
14	1,643	350	1,993	82.4	51.9
15	3,223	607	3,830	84.2	51.4
16	4,825	926	5,752	83.9	42.6
Age unspecified	1,027	187	1,214	84.6	32.9
TOTAL	10,766	2,081	12,847	83.8	45.4

Source: *Justice Statistics 1982*, Part B, Tables 7 and 8, Department of Statistics

secondary schools (Department of Education figures).

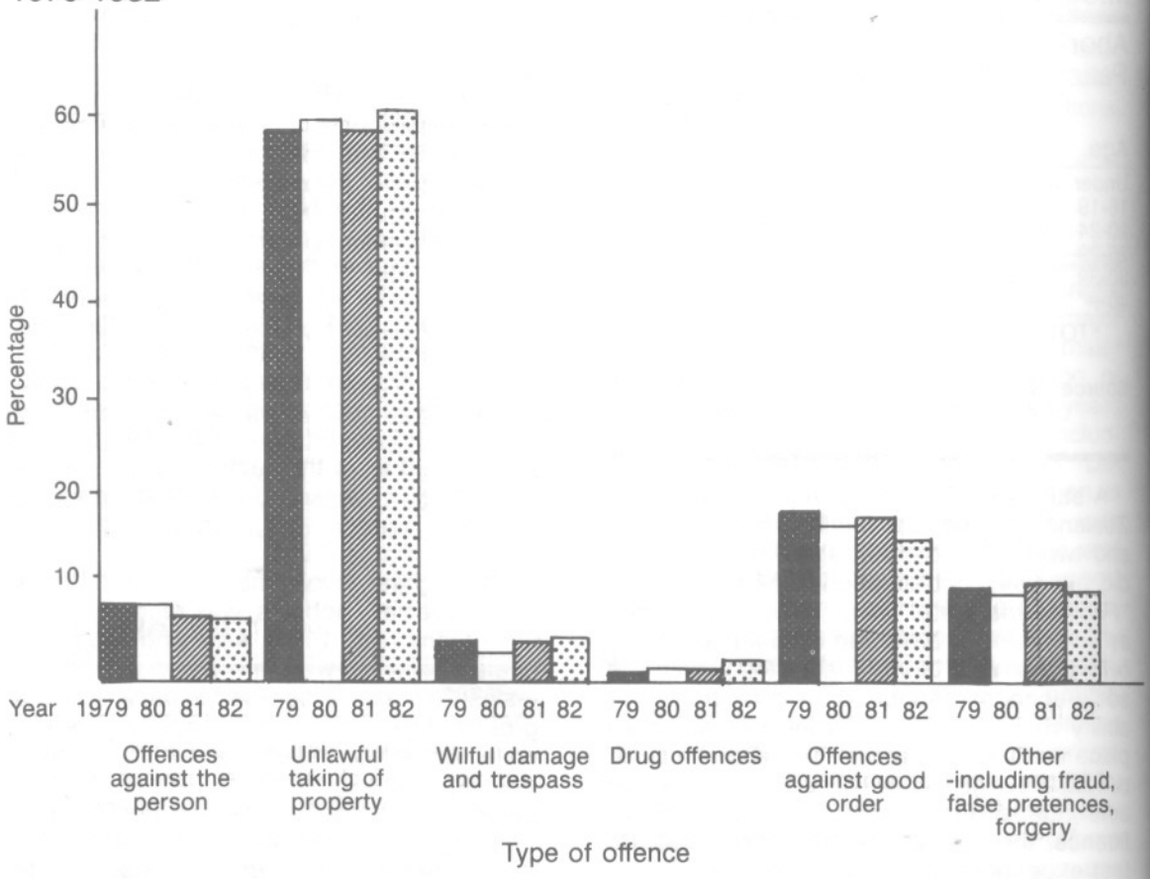
Offending Against the Law

Offending by young people varies by age and sex. It increases with age through the early teenage years with a large jump in Children and Young Persons' Court appearances between the ages of 13 and 14 (Inf. 4:11). The rates for male teenagers are much higher than for females; 84% of offenders in 1982 were male (81% of Maori offenders). The size of that jump is probably due to procedural factors. There is a greater tendency to use a "complaint" action (i.e. involving the parents) rather than prosecute 13-year olds. However, from 14 years on, there is a clear age-related increase (Inf. 4:11).

Unlawful taking of property was the leading type of offence for both boys and girls. Half of all cases concerned stealing by boys, with a higher proportion where Maori youths were involved. Other types of offences, each accounting for under 10% of cases, were traffic offences (low for females and Maoris), licensing law offences (second after taking of property for females), assaults and "offences against good order". The pattern of offences has not changed greatly over re-

Infogram 4:12

Children and Young Persons' Court Appearances, by Type of Offence, 1979-1982



Source: *Justice Statistics* 1981, p. 53, 1982, Part B, p. 45, Department of Statistics

cent years, although there has been an increase in drug offences (Inf. 4:12).

Cases in the Children and Young Persons' Court are dealt with mainly by way of fines and supervision orders (which have declined in recent years), or by the offender being admonished or convicted and discharged (increased in recent years).

The incidence of juvenile crime between Maori and non-Maori groups was studied in the early 1970s by the Committee on Young Offenders (Fergusson et al, 1975). This took a sample of 16 to 17-year old males and found that the risk of offending varied both with race and socio-economic status — members of the lower socio-economic groups had a higher risk of both offending and re-offending. Several reasons were suggested for this. For instance, official agents may react differently or in a biased manner toward non-Europeans. As the majority of offences are concerned with property, different cultural values may be operating to cause a mismatch in the way offences are viewed. However, it is also possible that further, less measurable, factors are operating, including socio-economic inequities and the breakdown of traditional values and sanctions, due to urbanisation and subsequent social dislocation.

The Children and Young Persons' Court also deals with "complaints" relating to children, e.g. neglect, truancy and failure to exercise parental duty. The incidence of complaints that a child is beyond control peaks at the age of 13 for boys and 14 for girls (Inf. 4:13). Of 985 such complaints in 1982, 58% applied to boys and 42% to girls, so there is a more even ratio of boys and girls in such complaints than for offending. The main outcomes of "beyond control" complaints were supervision orders (52% of cases) or committing the child to the care of the Department of Social Welfare.

There has been considerable discussion recently on the needs of children in this situation and the problems of placing disturbed teenagers in foster homes. A high proportion of children judged beyond control are of Maori background (Inf. 4:14). This has been the reason for the joint establishment by the Departments of Social Welfare and Maori Affairs of the *Maatua Whangai* programme. The programme aims to keep down the number of young Maoris in institutions by helping them in the court situation and placing them in the care of foster homes where appropriate cultural influences can be brought to bear, and individual identity and self-esteem can be developed.

Infogram 4:14

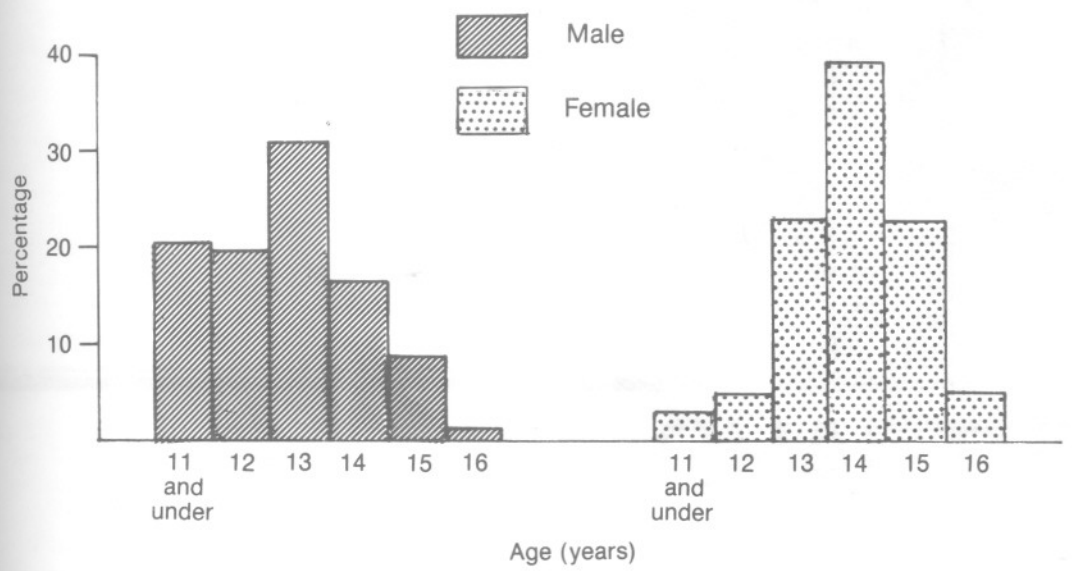
Children and Young Persons' Court Appearances for Complaints of being "Beyond Control", by Ethnic Origin, 1982

Ethnic origin	Number	%	% Female
European	340	34.5	52.6
Maori	472	48.0	33.6
Pacific Islander	34	3.4	29.4
Other	77	7.8	35.0
Mixed	62	6.3	54.8
TOTAL	985	100.0	41.5

Source: *Justice Statistics 1982*, Part B, Table 12, Department of Statistics

Infogram 4:13

Children and Young Persons' Court Appearances for Complaints of being "Beyond Control", by Sex and Age, 1982



Source: *Justice Statistics*, 1982, Part B, Table 9, Department of Statistics

"Street Kids"

Although considerable interest and concern has been aroused by the phenomenon of "street kids", little is actually known about the number of teenage runaways, their age, sex, type of background or personal history. Reports from the press or through detached youth workers suggest that Maori and Pacific Island children between 12 and 16, of both sexes, make up the majority of the street kid population, which is concentrated in Auckland. Those in the younger group, aged 12-15, are likely to be short-term runaways who return home voluntarily after spells on the streets. Those in the older group, 16 to 18-year olds, are more likely to have left home permanently, to be unemployed (rather than school truants), and to live on the streets for months at a time. The needs of the two groups obviously differ.

Reasons for children leaving home appear to centre around breakdown in families — solo parents, fluctuating de facto relationships, both parents working, overcrowding, and loveless, neglectful or abusive homes. In non-European homes, there may be cultural clashes between the generations as well as language problems and difficulties with the education system. Many street kids also have histories of foster homes and institutional care (Bevan, 1982). They survive on the streets by resorting to petty theft and shop-lifting and many are involved with solvent abuse or other types of drug-taking.

The immediate need of street kids is for shelter, but this will often be accepted on their own terms only, i.e. non-institutional and informal accommodation. Open houses run by individuals ethnically similar to the youngsters appear to be successful in Auckland and Christchurch. Community-based schemes are more likely to be successful than correctional institutions. They provide greater flexibility to meet individual needs and better coordination of assistance — education, employment, health care, legal aid services.

The evidence suggests that street kids are essentially not youngsters who are psychiatrically disturbed, mentally subnormal or highly delinquent, and that a solution to the problem in the long term lies in the families and the young people.

Conclusion

These findings, associated with earlier conclusions on exposure to alcohol, smoking and early sexual experience, show that although teenagers are often distinguished as a unique and separate group (even as having their own sub-culture), the problems they face are also those of the wider society. Adolescence is a period of high risk, when young people are to some extent "set adrift" to fend for themselves. They go through a period of transformation which may lead to conformity or to the development of a new set of values, or to a new lifestyle which differs from that of the previous generation.

Starting Paid Work

"Find yourself something to do ... dear
Find yourself something to do.
Find a niche, a niche in which
You can blossom and know that it's you."

Reynolds and Slade ("Salad Days")

CHAPTER 5

Starting Paid Work

SOCIAL OBJECTIVES

The needs of a person on entering the paid workforce

EDUCATION
OCCUPATION
SECURITY
PARTICIPATION

The previous three chapters have covered the childhood stage of an individual's life, selecting important life events up to about the age of 15. The needs of children have much in common, regardless of age, and a somewhat similar format was adopted for these chapters. We now move into the adult world, and the life events which have been selected focus on more specific aspects of life, for example participation in paid work, or forming a household. It must still be emphasised, however, that all aspects of human life are inter-related, that success or failure in one aspect may influence well-being in other personal dimensions, and that people's needs must be examined and met in a rounded way.

From School to Work

Movement into the paid workforce takes place for most people between the ages of 15 and 19. By the age of 19, 99% of young people have left full-time secondary schooling, and 85% are in occupations other than full-time education (Infs 5:1 and 5:2). The proportions remaining in full-time education at ages 15, 16 and 17 have been increasing in recent years, indicating greater "retention" in the upper levels of secondary school. This is particularly the case for young women. The percentage of young women *not* in full-time employment in the age group 15-19 grew from 46% in 1971 to 59% in 1981, although not all of these will have been in full-time education. As Infogram 5:3 shows, about 7% of females aged between 15 and 19, are neither students, unemployed, nor in the paid labour force. Many of these young women could be caring for a child or children as supported mothers or welfare beneficiaries.

Greater retention in school has been linked with decreasing opportunities for paid work in recent years. Young people are remaining at school to avoid the risk of unemployment and to acquire more qualifications and skills which will help them to find a job (Catherwood, 1985).

For the 15% of 19-year olds who remain in full-time education, predominantly tertiary education, entry into the paid workforce will probably be delayed until age 20 to 24. In this age group, 91% of males and 64% of females are in full-time employment (Inf. 5:4). This proportion has increased for women since 1971, despite growing unemployment, probably because many young women are postponing having their first child (see Chapter 7).

Labour force participation rates almost reach their peak for males by the age group 25-29 (staying at about 98% until age 45, after which they begin to decline) (Chapter 10). Thus, for the vast majority of males, the "starting paid work" period occurs in the age group 15-24. Projections up to the end of the century suggest an overall fall in male participation rates, but a retention of the same pattern according to age (Population Monitoring Group, 1984).

Movement into the paid workforce is much less clear-cut for women — some may enter for a short time and return at a later stage; some establish a work record and have a later break in their careers; and some retain full involvement on a similar basis to men, because they have no children, because they have full-time childcare, or because their partners are taking on the main childcaring role (Chapter 9). The option of part-time paid work as a short or long-term form of paid employment is also more likely to be used by women. Their employment careers therefore tend to be more varied than those of men, although full-time participation rates for women in their twenties are projected to rise considerably by the end of the century.

School Qualifications

Young people leaving school today are more highly qualified than a decade ago. In 1983, two-thirds had some qualification (Inf. 5:5). This improvement is part of a longer-term improvement in educational standards which is particularly marked for female students, although Maori students are still more likely not to gain qualifications than their non-Maori counterparts. Of the 8,336 Maori students leaving secondary school in 1983, 62% had no formal academic qualifications, compared with 32% of all school-leavers.

Intentions on Leaving School

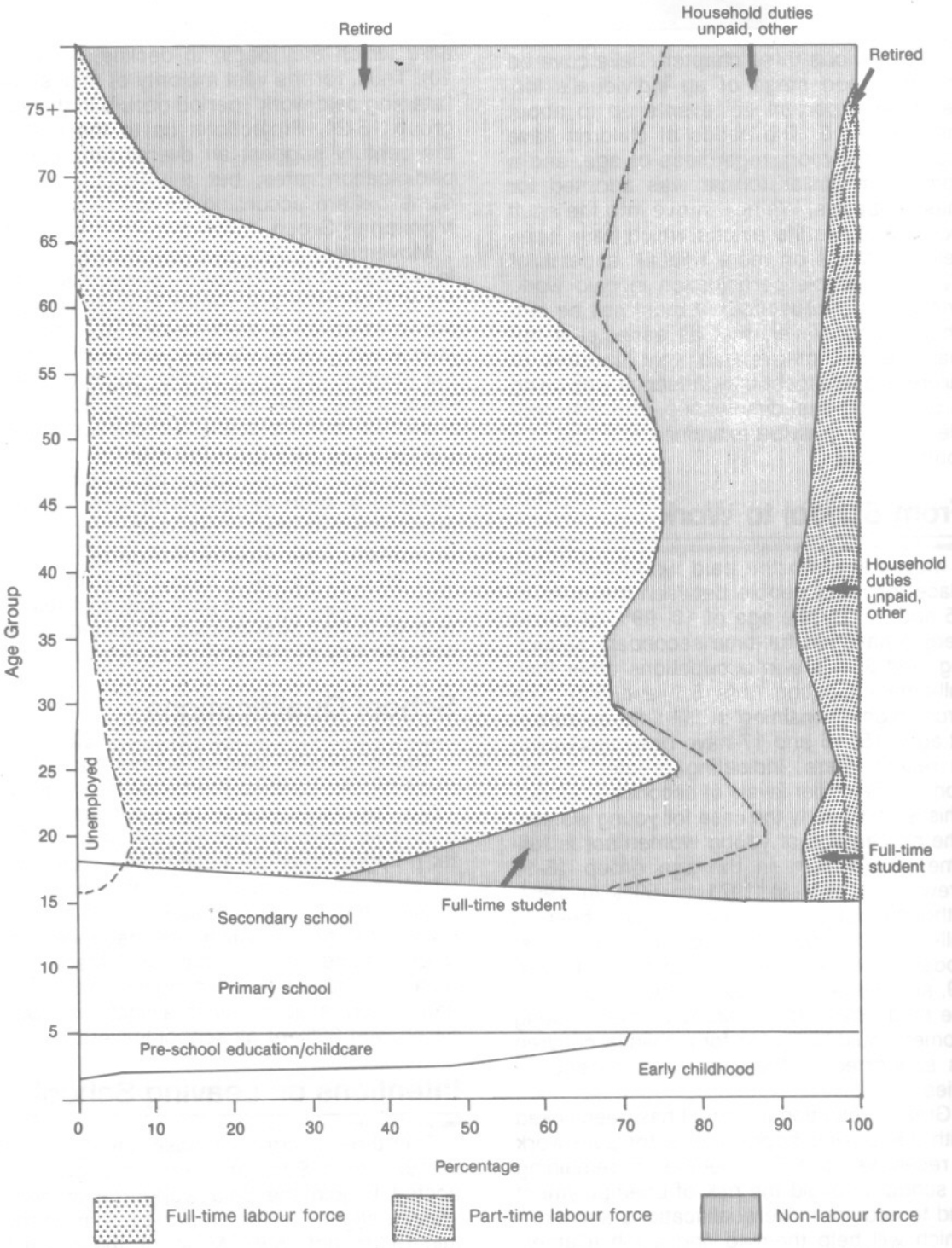
Over three-quarters of those leaving school in 1983 (and 90% of Maori students) expected to join the paid workforce immediately, a slightly lower proportion than in the mid-1970s (Inf. 5:6). Most of these were seeking unskilled and manual work and about 20%, clerical, sales and related work. Nearly a third did not know what they would do on

leaving school. The increase in this proportion since 1975 is of particular concern and is related to growing unemployment among school-leavers. About the same proportion of male and female school-leavers were unsure of their working future; but in 1983, 48% of Maori school-leavers were undecided on their future occupation, compared with 26% of non-Maoris.

A decline in apprenticeships and work requiring further education is also of concern (the latter can be partially explained by the transfer of nursing training to polytechnics). The proportion expecting to enter the paid labour force on an apprenticeship basis fell from 24.9% in 1975 to 16.6% in 1983, with the decline being especially dramatic for males — 42.5% to 25.5%. For young women, the figure has always been much lower, remaining fairly stable at about 5%.

Infogram 5:1

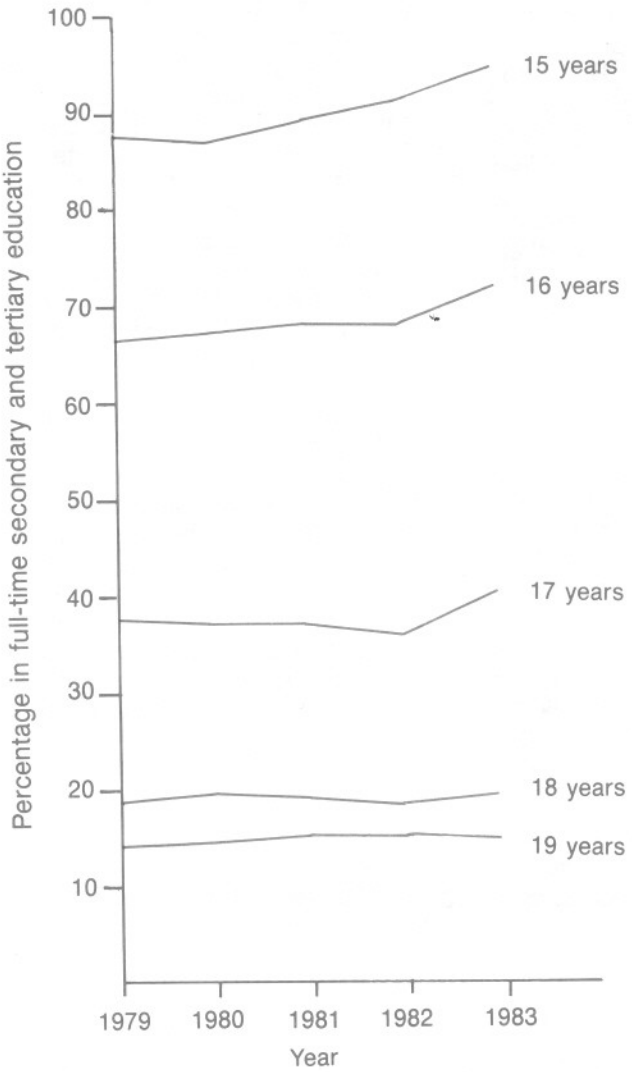
Education and Employment Life Stages, 1981



Source: *Census of Population and Dwellings*, 1981, Volume 4, Table 22, Department of Statistics, and *Education Statistics of New Zealand*, 1981, Tables 15, 23 and 24, Department of Education

Infogram 5:2

Enrolment in Full-time Secondary and Tertiary* Education, by Age, 1979-1983



* Enrolments for tertiary institutions other than universities, teachers' colleges and technical institutes are not available by age and have therefore been excluded. The institutions involved include private secretarial and business colleges, Flock House, the Telford Farm Training Institute, the ballet and drama schools and seminaries. The numbers of students involved are small by comparision with the total age cohort and are not likely to effect significantly the overall participation rates.

Source: *Education Statistics of New Zealand*, 1980-1984, Department of Education, and "Estimated Mean Age Distribution of New Zealand Population for Years Ended 30 June 1979-1983", Department of Statistics

Youth Unemployment

Before 1978, it could be expected that something like 98% of school-leavers would have found work by the January after they left school. Since then, school-leaver unemployment has increased markedly, so that in January 1984, 18% of the 56,057 previous year's (intended) school-leavers were registered as unemployed. This proportion fell during the course of the year, but still stood at 7% in October 1984.

Figures for October 1984, showed that 7% of the registered unemployed were school-leavers, and 53% of registered unemployed school-leavers were female (compared with just under 50% of total 1983 school-leavers). Altogether, nearly 55% of the registered unemployed were aged 15 to 24, the age range in which it has been established most people seek to join the paid workforce (Inf. 5:7).

1981 census data, which do not depend on registration with the Labour Department, illustrate a high rate of female and Maori unemployment in the younger age groups (Inf. 5:8). 60% of the total unemployed were aged 15 to 24, and 70% of the Maori unemployed were in this age group (Inf. 5:9). One striking feature is the high percentage of young unemployed females. In the 15-19

age group, females constituted more than half the unemployed. 47% of all unemployed women, and nearly 63% of unemployed Maori women, were under 20 years of age.

Unemployment levels for Maoris and Pacific Island Polynesians were higher than for non-Polynesians in all age groups, but the differences were greatest in the 15-24 age group (Bacica, 1984). Bacica concluded that over half the difference between the ethnic groups could be accounted for by differences in age, marital status and educational levels. However, a significant element remained, relating to socio-economic differences, institutional racism and unlike cultural attitudes to employment (cf. study of juvenile offending, Chapter 4).

As a group, the young unemployed have spent less time in secondary school and have lower educational qualifications than school-leavers who obtain paid work. Often, they find attitudes in society discouraging, especially the "dole bludger" and "work shy" stereotypes, which are often applied. In fact, the Birkdale study found that the great majority of the unemployed school-leavers had made many attempts to seek work (Haines and Macky, 1982), and in the Hutt Valley, the leading occupation for those unemployed was seeking work (Waldegrave and Coventry, 1981). In general, young women took longer to find jobs and were less likely to be doing the work they wanted to do. Furthermore, these surveys found sizeable proportions of the young unemployed, especially girls, who were not registered with the Labour Department and who were not receiving any form of financial benefit. Well over 90% of the young people interviewed said they would prefer to be in paid work and for the rest, their attitude was generally indifference, rather than antipathy to work.

In New Zealand, status is very much bound up with paid work, so that lack of paid work is associated with lack of status (Chapter 9). Unemployment has been associated in international literature with risks to self-image, self-esteem and ultimately to physical and mental health (Jahoda, 1979). New Zealand research supports this view, although many of the studies have been too small in scale to produce firm conclusions. There is a definite link between unemployment and a negative shift in psychological well-being, and, conversely, a gain in self-esteem when a paid position is achieved. Boredom is a major disadvantage of unemployment, coming after lack of money (Gray and Neale, 1985, p.27). Work is valued for contact with people and independence, as well as for money.

Infogram 5:3

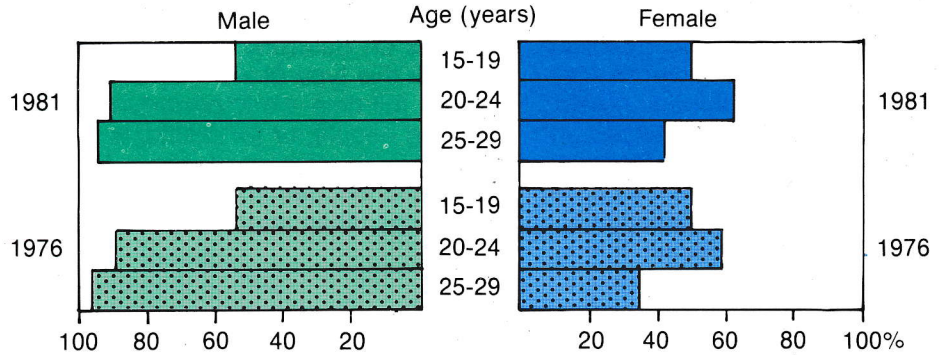
Employment Status of Persons Aged 15-19, 1981

Source: *Census of Population and Dwellings* 1981, Volume 4, Table 22, Department of Statistics

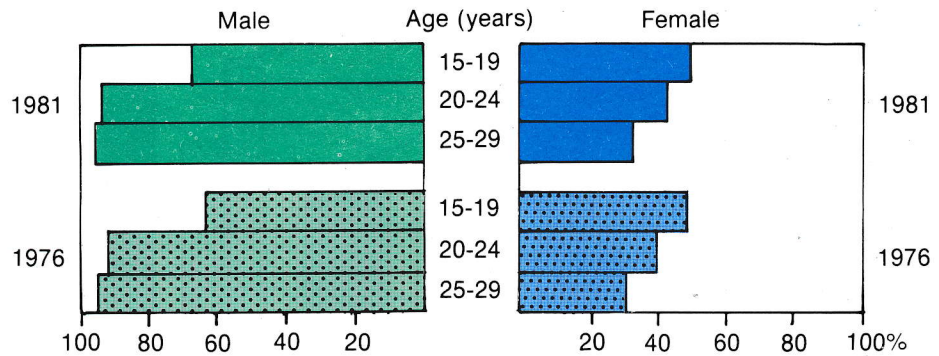
Infogram 5:4

Full-time Labour Force Participation Rates, by Age, Sex and Ethnicity, 1976 and 1981

(a) Total Population



(b) Maori Population



Source: *Census of Population and Dwellings*, 1976, 1981, Volume 4, Table 13 and Volume 8A, Table 14, Department of Statistics

Some studies have shown that the unemployed tend to cut themselves off from their friends and spend long periods in passive activity, such as watching TV and sleeping. Thus unemployment is not only a threat to career opportunities and standard of living, but also to independence and opportunities for participation so highly prized by young people at the beginning of their adult lives.

It is also obvious that the incidence of unemployment among school-leavers is uneven, and the burden is disproportionately borne by certain groups in society — the unqualified and inexperienced, the young women, and non-European youths.

Part-time Work

In 1981, 9.6% of the male teenage workforce (aged 15-19), and 11.7% of female teenage workers worked part-time (i.e. less than 20 hours a week) (Catherwood, 1985). Numbers working part-time in this age group grew markedly between 1976 and 1987 — a 59% increase for males and an 82% increase for females. The total number of part-time workers grew by 23% over the same period.

For males, part-time work is undertaken mainly at the beginning and the end of working life (see Chapter 10), but the female part-time workforce is spread more evenly. Whereas part-time work for older males may be seen as a transition to retirement, for young workers it is part of the transition from school to work. Most teenage part-time workers are also full-time students either at schools or tertiary institutions (93% of males and 84% of females). As more young people remain at school it appears an increasing proportion are seeking to earn money by part-time work.

This may be seen in a negative light as part-time workers tend to have lower pay, less favourable working conditions and less security of employment. Also, young people who have left full-time education and are not working full-time or are unemployed (the remaining 7% of males and 16% of females), may find part-time work a poor substitute for full-time employment when building the foundations of a career. On the other hand, part-time work while studying has positive aspects. It allows young people to experience paid work in a variety of settings and in a form they may not encounter in later life (e.g. students training for a profession but doing part-time manual work). Wages earned from

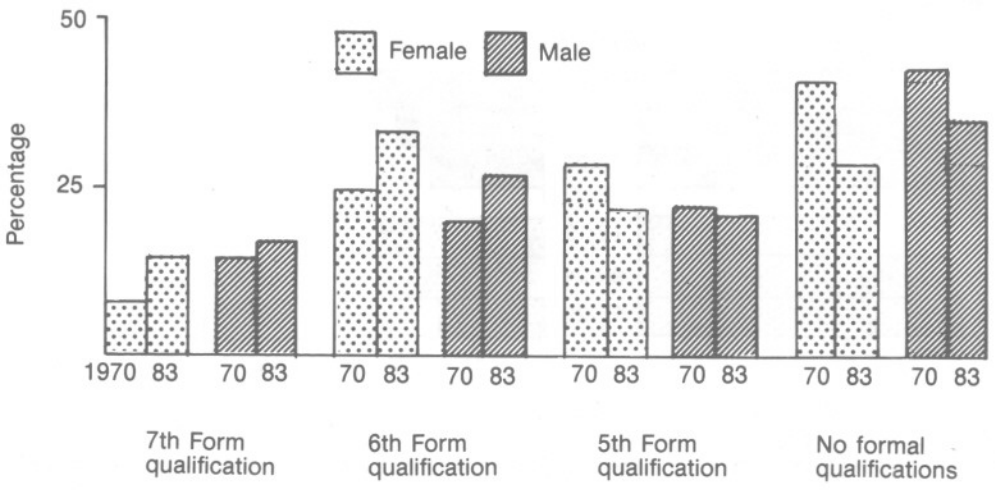
part-time work will also contribute to family income and give a degree of independence and experience of handling money.

The occupational distribution of part-time teenage workers is shown in Infogram 5:10, with the total part-time workforce given for comparison. A high proportion of part-timers, especially young women, are employed in sales and services, where the work may be cleaning, babysitting, restaurant work, etc. Male part-timers are better represented in labouring and agricultural work than females, illustrating the greater opportunities they have for vacation work on the land, on construction sites and in industry. Overall, most teenage part-time jobs require low levels of skill and little or no training. Hours of work are likely to be outside those of the usual working week, for example, restocking supermarket shelves in the evening, waiting in restaurants and bars at night and serving in shops on Saturday mornings. The extent to which this type of work by students detracts from full-time work opportunities for other young people, or for adults, is controversial, but it is an element of labour force mechanics and the demand for paid labour which must be taken into account.

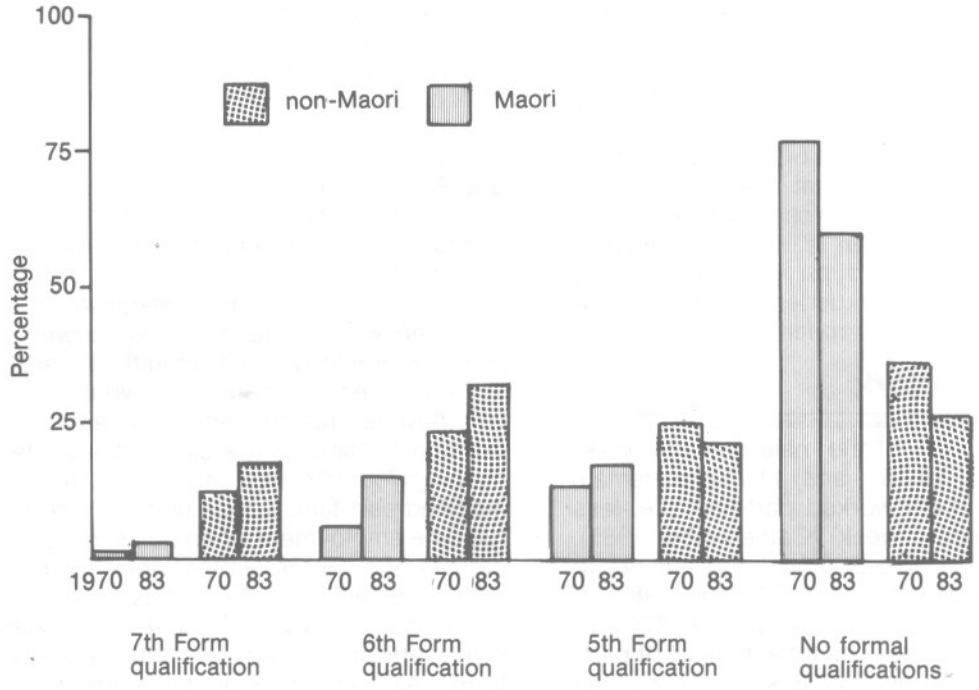
Infogram 5:5

Attainment of School-leavers, by Sex and Ethnicity, 1970 and 1983

(a) By Sex



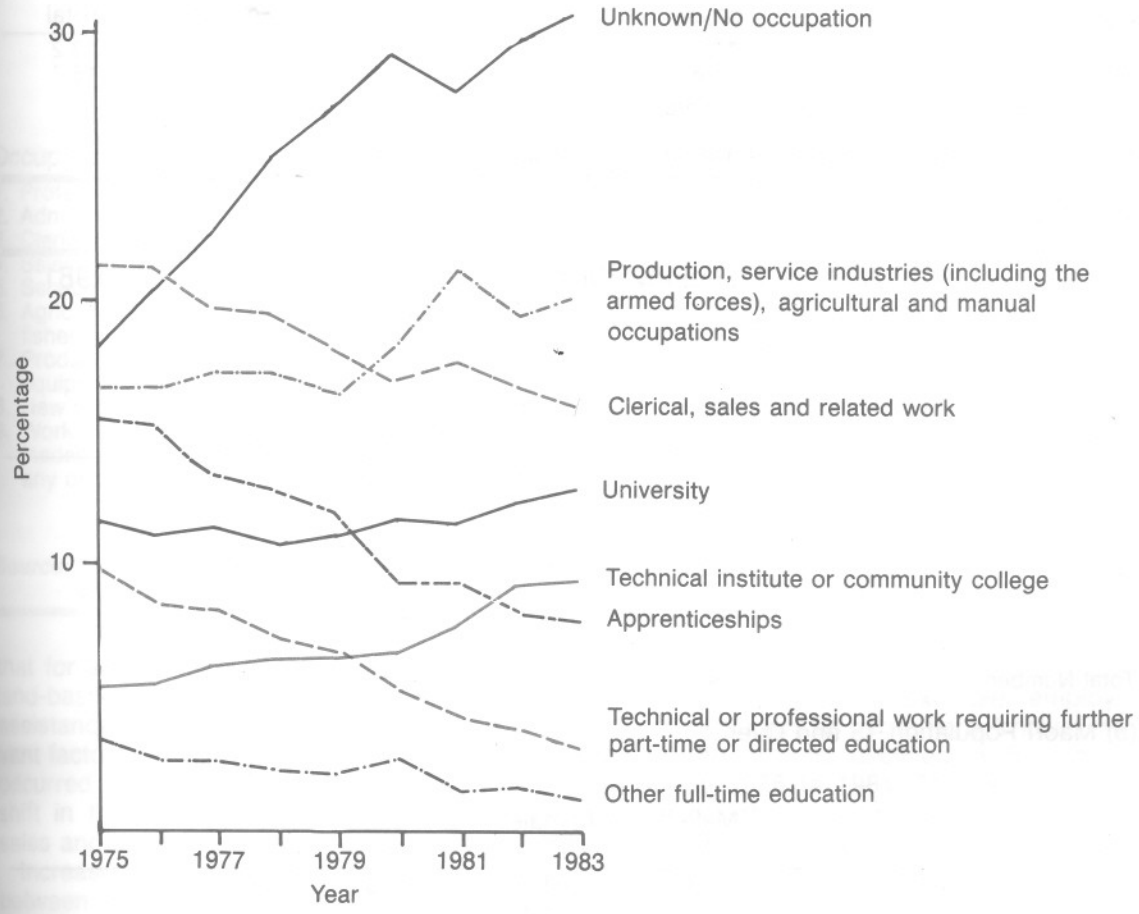
(b) By Ethnicity



Source: *Education Statistics of New Zealand*, 1971, 1984, Department of Education

Infogram 5:6

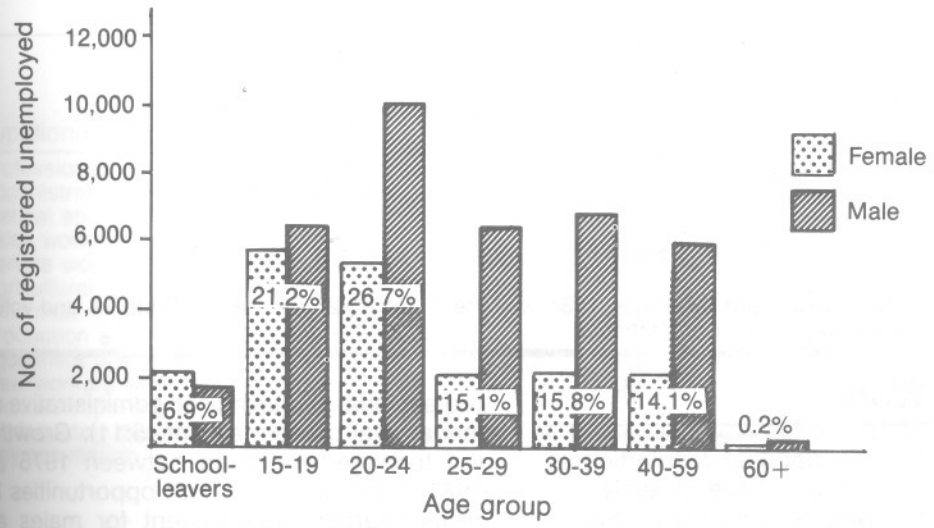
Intended Destinations of School-leavers, 1975-1983



Source: *Education Statistics of New Zealand*, 1976-1984, Department of Education

Infogram 5:7

Registered Unemployed by Age and Sex, October 1984
(excluding vacation workers)



Source: *Labour and Employment Gazette*, Vol. 34, No. 4, Department of Labour

Infogram 5:8

Unemployment Rates*, by Age, Sex and Ethnicity, 1981

Age group	Total population Male	Female	Total	Maori population Male	Female	Total
15-19	11.5	16.5	13.8	27.3	41.3	33.2
20-24	6.3	6.8	6.5	14.4	18.3	15.7

* unemployed as % of full-time labour force

Source: *Census of Population and Dwellings*, 1981, Volume 4, Department of Statistics

Infogram 5:9

Persons Unemployed and Seeking Work, by Age, Sex, and Ethnicity, 1981

(a) Total Population 15 and Over

Age	Male %	Female %	Total %	% of age group female
15-19	29.7	47.5	37.3	54.4
20-24	23.0	22.3	22.7	42.0
25-34	22.5	14.4	19.0	32.3
35-44	10.2	7.5	9.1	35.6
45-59	39.9	8.0	11.4	30.1
60+	0.6	0.6	0.5	27.3
	100.0	100.0	100.0	
Total Number	34,485	25,746	60,255	42.8% of total

(b) Maori Population 15 and Over

Age	Male %	Female %	Total %	% of age group female
15-19	39.6	62.6	49.0	52.2
20-24	22.9	19.9	21.6	37.5
25-34	20.4	10.0	16.1	25.3
35-44	8.9	4.6	7.2	26.3
45-59	8.0	2.8	5.8	19.8
60+	0.2	0.1	0.1	33.3
	100.0	100.0	100.0	
Total Number	8,622	5,964	14,586	40.9 % of total

(c) Pacific Island Polynesian Population 15 and over

Age	Male %	Female %	Total %	% of age group female
15-19	24.9	45.9	32.5	51.0
20-24	19.4	25.2	21.5	42.3
25-34	31.4	16.8	26.1	23.2
35-44	13.5	7.0	11.2	23.0
45-59	9.8	4.8	8.0	21.8
60+	1.0	0.3	0.7	12.5
	100.0	100.0	100.0	
Total Number	2,316	1,305	3,618	36.0% of total

Source: *Census of Population and Dwellings*, 1981, Volume 4, Table 22, Volume 8A, Table 14, and Volume 8B, Table 14, Department of Statistics

Full-time Work

In general, the occupational distribution of workers aged 15-19 who have recently entered the paid workforce is similar to that of the total full-time workforce, male and female, although very few appear in the professional and technical, administrative and managerial categories (Inf. 5:11). Growth in the teenage workforce between 1976 and 1981 (a period when work opportunities became scarcer) was evident for males and females in primary industry — agriculture and forestry — where the growth exceeded

Infogram 5:10

Occupational Distribution of Part-time Workers, Aged 15-19, and Total, by Sex, 1981

Occupational group	Males		Females	
	% of total male population	15-19 %	% of total female population	15-19 %
1. Professional, technical and related workers	11.1	1.2	18.2	3.0
2. Administrative and managerial workers	1.5	0.0	0.4	0.0
3. Clerical and related workers	6.7	4.1	20.8	7.7
4. Sales workers	24.7	42.9	16.1	40.0
5. Service workers	16.0	15.9	28.9	31.7
6. Agricultural, animal husbandry and forestry workers, fishermen and hunters	11.5	10.6	6.2	4.2
7. Production and related workers, transport equipment operators and labourers	19.2	16.4	6.3	6.7
8. New workers seeking employment	–	–	–	–
9. Workers reporting occupations unidentifiable or inadequately described, or workers not reporting any occupation	9.3	8.9	3.0	6.8
TOTAL	100.0	100.0	100.0	100.0

Source: *Census of Population and Dwellings*, 1981, Volume 4, Tables 5 and 23, Department of Statistics

that for adult workers. The development of land-based work schemes and government assistance to primary industry may be relevant factors. Growth in the retail sector also occurred and this too probably reflects a shift in the economy as a whole towards sales and services.

Increased employment for male teenagers between 1976 and 1981 was mainly in occupations such as labourers, farm hands, forestry workers, waiters, and storemen and packers. However, at the same time, there has been a decrease in numbers of young male workers in skilled trades, associated with decreases in apprenticeship contracts, already referred to. For example, employment of teenagers as carpenters, bricklayers and related workers declined by 54% over the period 1976 to 1981. This relates to a recession in the building industry, but trades such as motor vehicle mechanics, plumbing, welding, cabinet-making, electrical fitting and printing were also affected.

Decreases were also observed in technical areas such as draughting and electronics, where a drop in adult male employment also occurred between 1976 and 1981. Laboratory technicians showed a decline for both

Infogram 5:11

Occupational Distribution of Full-time Workers, Aged 15-19, and Total, by Sex, 1981

Occupational group	Males		Females	
	% of total male population	15-19 %	% of total female population	15-19 %
1. Professional, technical and related workers	11.8	3.2	17.7	11.2
2. Administrative and managerial workers	4.8	0.1	0.8	0.0
3. Clerical and related workers	7.7	7.2	32.4	35.2
4. Sales workers	8.6	5.4	11.4	11.3
5. Service workers	5.7	4.8	12.4	10.0
6. Agricultural, animal husbandry and forestry workers, fishermen and hunters	13.2	15.4	6.6	4.6
7. Production and related workers, transport equipment operators and labourers	44.6	54.5	14.8	15.8
8. New workers seeking employment	0.4	3.8	1.0	6.0
9. Workers reporting occupations unidentifiable or inadequately described, or workers not reporting any occupation	3.2	5.6	2.9	5.7
TOTAL	100.0	100.0	100.0	100.0

Source: *Census of Population and Dwellings*, 1981, Volume 4, Tables 5 and 23, Department of Statistics

sexes for both adult and teenage workers, perhaps associated with the introduction of new technology and automation.

A major occupational class for women of all ages is clerical work. Over the period 1976 to 1981, there has been increased female employment in this area, more so for adult women than for teenagers, despite technical change.

Another female intensive industry is retail trade. The teenage female workforce in this sector has grown faster than for adult females, but both were exceeded in growth terms by teenage males. Numbers of male shop assistants and salespersons aged 15 to 19 grew by 22.5% between censuses, as opposed to 6.2% for female teenagers (5.5% for adult males and 0.5% for adult females).

In other areas, it is possible that competition by adult females returning to the paid workforce is affecting the work opportunities of young women. Adult women have improved their position over teenage workers in the following areas — hairdressers and beauticians, house-staff, nurse aides and nurses, teachers, computing machine operators, telephone and telegraph operators. The reasons for such changes include different training policies (nurses), falling preschool and school rolls (teachers), and technological change (telephone operators).

An example of the dramatic effect of technical change is the 35% decline between 1976 and 1981 in teenage typists, card and tape-punching machinists (adults −1%). Young women have also been disproportionately affected by economic restructuring, for example in the clothing industry, where there was a 10% decline in female teenage tailors, dressmakers and seamstresses, and a 5% decline for adults between 1976 and 1981.

Conclusion

Overall, it would appear that new entrants into the workforce are disproportionately affected by changes in economic and technical conditions. They are unable to compete with more skilled adult workers in areas where opportunities are declining and have a marginal advantage in expanding areas of unskilled work only because they are cheaper to employ. This is despite the fact that young people entering the workforce are, in general, better qualified in educational terms than ever before.

Setting up as a Couple

"Marriage is the only adventure open to the cowardly"

Voltaire

CHAPTER 6

Setting Up as a Couple

SOCIAL OBJECTIVES

The needs of a couple setting up a home

SECURITY/PARTICIPATION/FREEDOM
STANDARD OF LIVING
HOUSING

The term "setting up as a couple" has been used to include both informal and formal marriage. The event is seen in social rather than in legal terms. A man and a woman setting up a household together in a heterosexual relationship would be recognised as marriage and as the first step towards family formation in a wide range of cultures. In New Zealand and many other "western" countries, this usually entails a separate housing unit. Thus housing must be an important element in this life event. Access to housing, to an adequate standard of living and an income to provide these, are the practical needs of couples setting up a home. Once a couple has taken this step, they tend to be viewed differently by society. They are expected to act as a unit in economic terms (e.g. sharing income and joint expenditure), they are treated differently by a wide range of public policies, and there are expectations that a "husband" and "wife" stereotype will be applied to the partners. Nevertheless, a greater variety of marriage "styles" are evident now than two decades ago.

The less tangible needs of couples entering such partnerships must not be overlooked. It is important that each must feel security in the relationship, must be able to participate in decision-making for the new household, and must retain a degree of autonomy consistent with self-respect and individual identity. The expectations of marriage fostered in men and women by society may not always go along with these individual needs.

Infogram 6:1

Percentage Ever Married, by Age, 1981

Age	%
15-24	16.8
25-34	80.4
35-44	92.2
45-59	93.3
60+	92.3

Source: *Census of Population and Dwellings*, 1981, Volume 2, Tables 4 and 19, Department of Statistics

Setting up as a couple, therefore, is an important event in a person's life, and one which the majority, although not all, will experience. Assuming the continuation of present trends, over 90% of people will marry at some time in their lives (Inf. 6:1).

Marriage and Marital Status

Having defined the event in broad terms it soon becomes apparent, as with many others in this report, that the indicators available are much more restricted. There are no records of the setting up of de facto or informal marriages (although there is some information on marital status in the census). Attention must therefore be given to legal marriage as an indicator.

Over the last 15 years, the number of marriages per annum has been fairly stable at between 22,000 and 25,000 — in 1984 the number was 25,272. The crude marriage rate (marriages per 1,000 mean population) declined through the 1970s, but was higher in 1982 and 1983 (1970, 9.2; 1975, 7.9; 1980, 7.3; 1982, 8.0; 1983, 7.6). The general marriage rate is a more specific measure — marriages per 1,000 mean not married population 16 years and over. This also has been fairly stable in recent years at about 28.

The average age at first marriage has been rising since 1970, and in 1983 was 26 for the bridegroom and 23 for the bride. The proportion of first marriages (i.e. where neither party has been married before) among the total has been falling from 86% in 1967 to 84% in 1971, 76% in 1976, and 67% in 1983. This is because of the increasing rate of remarriage especially involving divorced people, which is related, in its turn, to an increasing rate of marital break-up (Chapter 8). Marriages between two divorced people were 1.9% of all marriages in 1967, 2.8% in 1971, 5.2% in 1976, and 11.0% in 1983.

In 1983, almost one-third (30.6%) of marriages involved a partner or partners who had been married previously and divorced (7,542 out of 24,678). The average age at remarriage for divorced persons is about 40 for men and 36 for women. Thus the average age for all marriages is much higher than for first marriages — 30 for men and 27 for women.

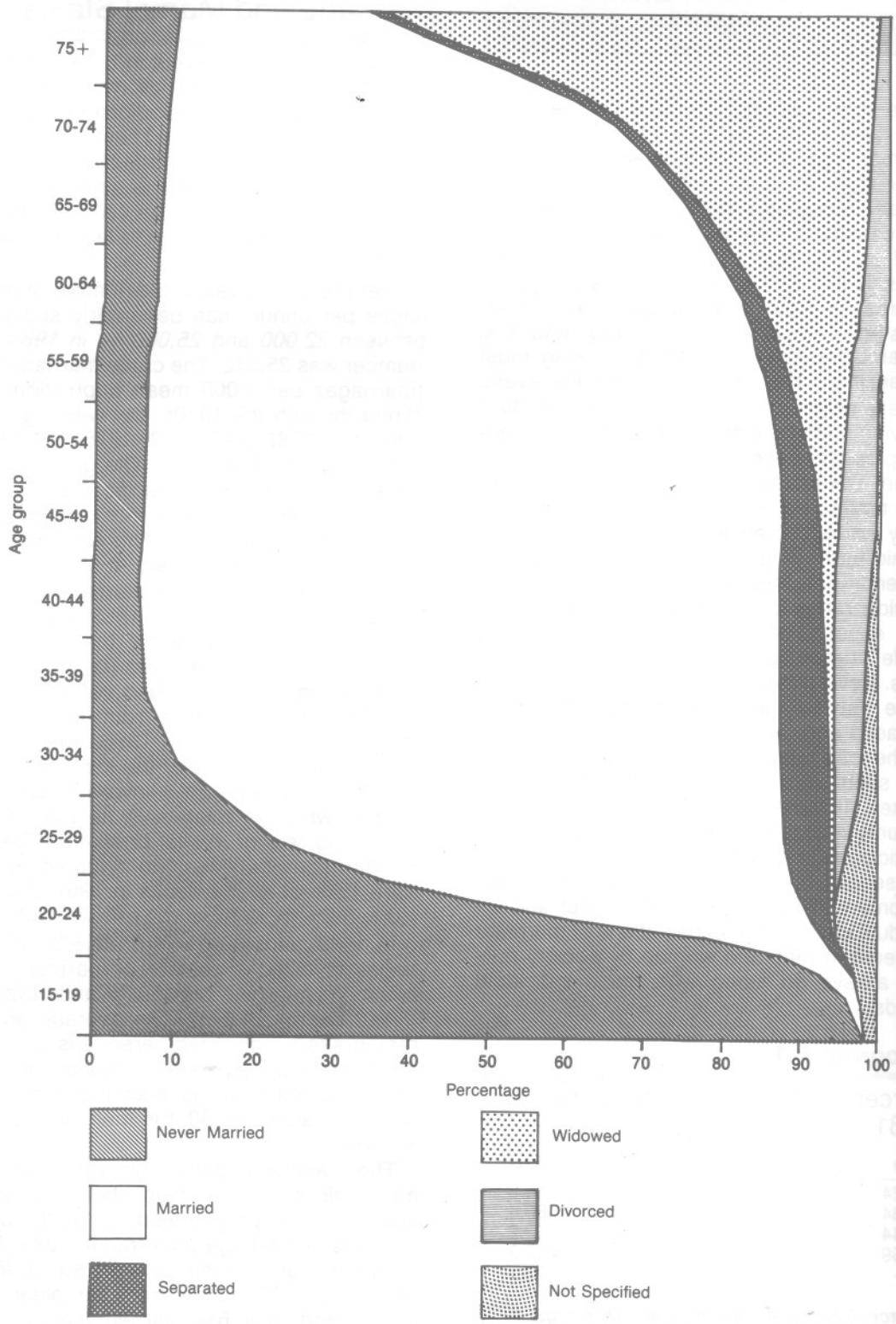
The traditional pattern in which women marry older men, or men about the same age, is still perpetuated, despite other changes in marriage patterns. In 1983, 56% of brides married men from the same broad age group; 37% men from an older age group; and only 6% married men from a younger group (the same proportion as in 1975). This is despite the fact that women

live longer and are becoming more independent financially.

Although a high proportion of the population marry, the number married at any one time is reduced through separation, divorce and widowhood (Inf. 6:2 and Chapters 9 and 11). At the 1981 census, 59% of men and 57% of women aged 16 and over described themselves as married, these being fairly evenly spread over the age groups, with the highest percentages between 30 and 40. This represents, however, a proportional and a numerical drop since the 1976 census in those married (Infs 6:3 and 6:4).

Infogram 6:2

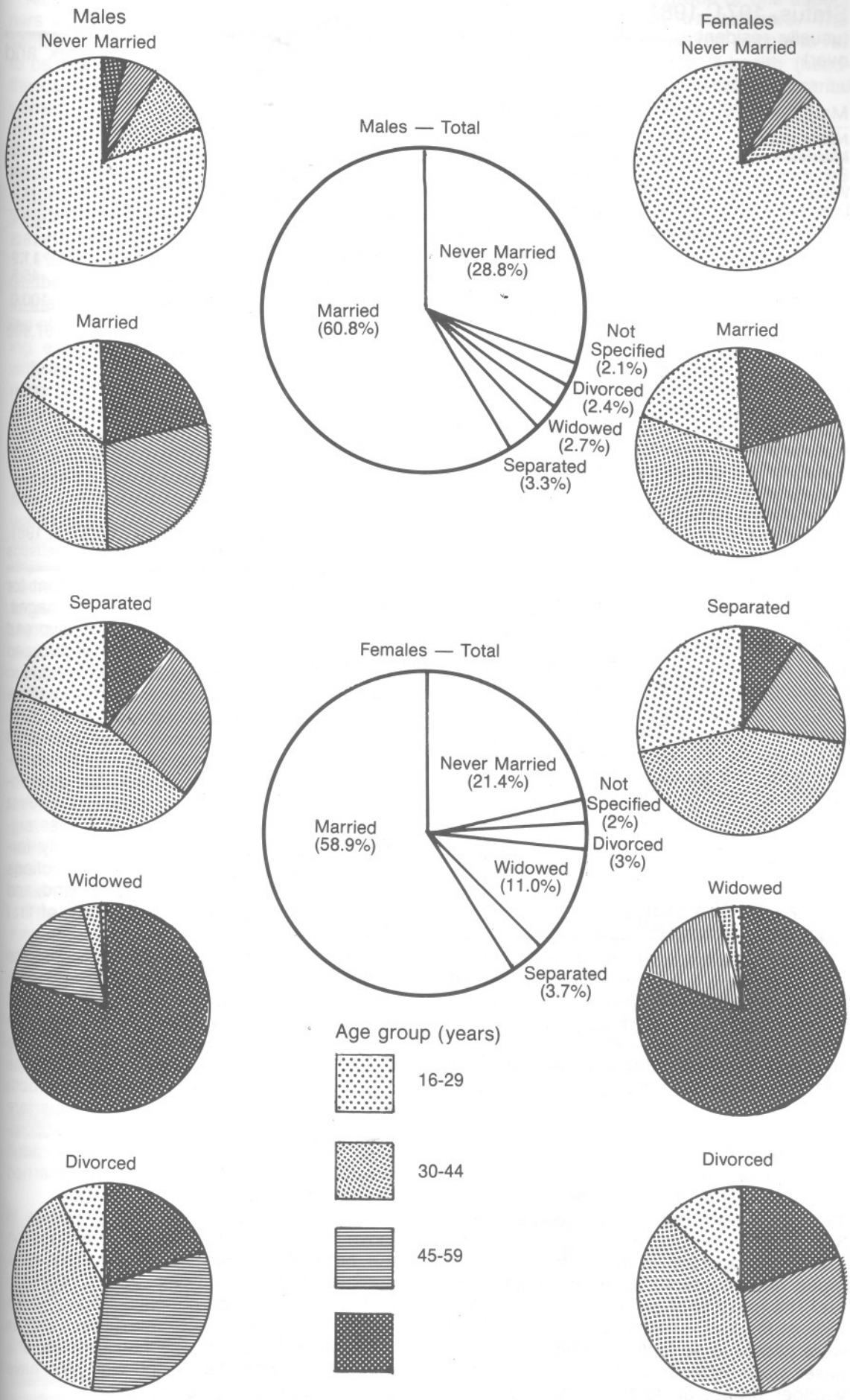
Age Group Distribution, by Marital Status, 1981



Source: *Census of Population and Dwellings*, 1981, Volume 2, Table 14, Department of Statistics

Infogram 6:3

Marital Status, by Age and Sex, 1981



Source: *Census of Population and Dwellings*, 1981, Volume 2, Table 14, Department of Statistics

Infogram 6:4

Intercensal Changes in Marital Status, 1971–1981

(usually resident population 16 years and over)

Marital status	% change 1971-76	% change 1976-81
Never married	+13.34	+14.04
Married	+11.09	−4.60
Separated	+51.48	+101.08
Widowed	+ 8.82	+9.71
Divorced	+35.34	+70.00
TOTAL	+12.24	+5.94
Not specified*	−31.06	+1567.68

*In 1976, 2,775 people came into this category; in 1981, 46,278. This is related to the inclusion of a question on de facto marriage in 1981.

Source: *Census of Population and Dwellings*, 1981, Vol. 2, Table 10, Department of Statistics

Given steady growth of the never married and widowed groups, it would seem that the married category has lost ground to the separated and divorced groups which have experienced considerable growth in recent years. These trends, in relation to the steady marriage rate, suggest that the tradition of setting up as a couple through a lifelong marriage is being replaced, for more and more people, by "serial marriage", implying periods of marriage (legal or informal) interspersed with periods of single or solo parent living. Although this undermines the norm of a lifelong marriage, this does not mean that living as a couple is no longer seen as a desirable type of relationship by the majority of people. It may, in fact, imply that higher standards are expected of such relationships, and that people are more willing to leave an unsatisfactory marriage to look for something better.

De facto Marriage

The 1981 census was the first to include information on de facto marriages, although they have always been widespread, particularly among Maori people (Quin and O'Neill, 1984). Differences between the main ethnic groups in the percentage of adults (15 years and over) in de facto marriages, are marked (Inf. 6:5).

The majority in the de facto group were aged 20 to 34 (62.9%). Overall, 4% of the total (usually resident) population aged 16 and over are de facto married (and one in 12 of the never married population aged 20-34).

A high proportion of the de facto married group did not specify any other marital status. The majority of these — 66% of males, 75% of females — were aged under 30, as were people in de facto marriages who had never been formally married. Thus for the younger group, de facto marriage may be seen as a precursor to legal marriage or, for some, a substitute.

Infogram 6:5

De facto Marital Status, by Sex and Ethnicity, 1981

(a) By Sex

Marital status of those recording de facto marriage	Male %	Female %	Total %
Never married	22.4	23.9	23.1
Separated	17.5	14.9	16.3
Divorced	12.0	11.8	11.9
Not specified	45.2	46.4	45.8
	100.0	100.0	100.0
Number	44,019	43,941	87,960

(b) By Ethnicity

% of group recording de facto marriage	Male %	Female %	Total %
European	3.2	3.1	3.1
Maori	11.6	12.0	11.8
Pacific Island Polynesian	7.6	6.3	6.9

Source: *Census of Population and Dwellings*, 1981, Vol. 2, Table 16, Department of Statistics

The previously married group account for about 30% of those in de facto marriages. Roughly one in five separated or divorced men, and one in seven separated or divorced women, recorded de facto married status in 1981. The proportion rises to one in three for separated and divorced men aged 25 to 39, and separated and divorced women aged 20 to 29. These figures, plus others on remarriage underline the importance of subsequent "marriage". First marriages or first marital relationships are becoming less significant in the overall pattern of family formation (and reformation) so that predictions of household numbers, housing demand, and so on, cannot be based on the rate of first marriage alone.

Overall, 5% of families, as defined in the census, had at least one partner who considered it was a de facto marriage. About half of these had dependent children. De facto couples without children tended to be young, over three-quarters had at least one partner under 30, and three-fifths had both partners in this age group. (Three-quarters of this group lived in private rented accommodation, again typical of the young adult pre-marriage stage, while among married couples the rate was 15%.)

There is a tendency for young couples to move from informal to formal marriage on the birth of children or when a house is purchased. This, however, is less likely to be the case for Maori couples, among whom the incidence of de facto marriage is higher (14% of de facto couples had at least one partner who was Maori), and who also have a lower rate of home-ownership.

Roles within Marriage

Although the pattern now is for both partners to continue in full-time paid work after setting up home together, adjustments have to be made to domestic arrangements and the carrying out of domestic work (89% of women aged 20-29 with no children were in the paid workforce, according to the 1981 census. Those not in paid work would include students.) New Zealand information suggests that comparatively few husbands participate frequently in housework — 18.5% in urban households (Novitz, 1978) and 17.1% in rural households (Gill et al, 1976). (Rather more, however, "frequently helped" in the care of children.) On study looked at the allocation of tasks in the home, comparing expectations before entering marriage with the actual situation one year after marriage (Abbott and Koopman-Boyden, 1981). Household task expectations prior to marriage tended to change to a more traditional and less egalitarian pattern after a year. For example, buying groceries and cooking had been expected to be shared but moved towards being mainly the wife's responsibility; mowing lawns and household repairs were expected to be "husband mainly", but became "husband only". The main factors found to influence task allocation were acceptance of feminist ideology by both males and females (i.e. beliefs in the equality of men and women and non-sex stereotyped attitudes), mixed flatting prior to marriage and higher levels of education for women. For men, more frequent church attendance (assuming acceptance of traditional role models) influenced task allocation in the non-egalitarian direction. Novitz also suggested that the more women become involved in work outside the home, the less they accept the traditional division of responsibility between husbands and wives.

The conclusion from the research is therefore that women still undertake the major responsibility for household management, often in addition to a full-time paid job. Even without children this burden can cause stress. However, overseas literature has shown that marriage, for both men and women, is related to better mental health than singleness (Haines, 1983). The New Zealand data is not conclusive, as most studies have been small-scale or related to one group or one aspect only (e.g. the use of tranquillisers. *The Social Indicators Survey* asked people to report symptoms of mental ill-health (headache, stress), but differences between marital status groups are not great (Inf. 6:6).

Infogram 6.6

Mental Ill-Health Symptoms, by Marital Status and Sex

(% experiencing symptoms)

Marital status	Female %	Male %
Never married	25	17
Married	23	17
Widowed	24	19
Divorced or separated	31	24

Source: Haines, H., *Women and Mental Health in New Zealand*, 1983

More information is required on the quality of marital relationships in New Zealand and its effect on well-being in both physical and mental terms.

Housing and Income

"Setting up as a couple" implies some type of independent accommodation and a shared economic base, so housing and income are important factors. At the stage where both partners are earning an income, couples are likely to be comparatively affluent. In the *Household Sample Survey* 1982-83, two-thirds of households comprised of two adults, excluding those retired, had incomes $20,000 and over. (This category will, however, include couples after the departure of children and before retirement, another stage of relative affluence in the life-cycle.) (Inf. 6:7).

Using data from the 1981 census, couples in the pre-family formation stage, classified as "couple under 35, no children", are under-represented in the lowest 25% of the family income distribution (Inf. 6:8). The 8% for this group in the lowest income group compares with 20% of couples with their

Infogram 6:7

Income by Household Type, 1982–1983

Household type	Annual household income ($) Under 10,000 %	10,000-19,999 %	20,000 and over %
One adult (retired)	86.8	10.7	2.5
One adult (other)	36.1	46.1	17.8
One adult and children	64.2	21.2	4.6
Two adults (retired)	25.0	64.3	10.7
Two adults (other)	7.4	25.3	67.3
Two adults and children	9.8	39.5	50.7

Source: Household Sample Survey, 1982-83, Table 4

youngest child under 5 years and 84% of solo parents with young children.

There are differences, however, by socio-economic group and ethnicity. Proportions in the lowest income groups are larger for unskilled workers than for professional or managerial workers and are particularly high for those not in the paid workforce, e.g. students and beneficiaries (Inf. 6:8). There are also very marked differences between the European and other ethnic groups (as has also been shown for other family types).

Infogram 6:8

Couples under 35 with no Children, Percentage in the Lowest Income Group

(a) Socio-economic Group	%
Upper professional (e.g. lawyers, dentists)	2.3
Lower professional (e.g. nurses, primary teachers)	4.7
Managers/supervisors	1.6
Skilled workers	6.3
Unskilled workers	12.0
Other (includes not in paid work force)	33.0
TOTAL	8.4

(b) Ethnicity	%
Maori	25.2
Pacific Islander	27.8
European	6.7
Other	18.0
TOTAL	8.4

Source: 1981 Population Census, 10% sample

"Setting up as a couple" is frequently associated with the acquisition of a home, usually by acquiring a loan or loans for purchase. Young people, in the pre-family stage (defined in this case as "married, under 40, no children"), are more likely than other non-home-owners to be saving to buy a house or to buy one in the near future (National Housing Commission, 1984) (Inf. 6:9 (a) and (b)).

Young, childless couples are even more likely to be saving for a house now than in 1980 when the first survey in the National Housing Commission series was carried out, but the percentage likely to buy within a year has remained at about 40.

Recent first home buyers, defined in the Housing Commission surveys as having purchased within the previous two years, are predominantly young childless couples (28% in 1984), or households with pre-school children (33% in 1984). The latter could well have been in the former category at the time of purchase.

The National Housing Commission surveys conclude that whereas age and life-cycle stage are the leading factors which predispose people to seek to purchase a home, it is income which is the limiting factor and inadequate income will delay house purchase. *Household Sample Survey* data confirm this hypothesis. The proportion of houses owned, with or without a mortgage, increases with age of the head of household (Inf. 6:10).

The likelihood of buying a home rises with income (Inf. 6:11) but the overall relationship of increasing ownership with higher household income is less clear.

Infogram 6:9

Intentions to Purchase a Home

(a) Home Purchase Savers

Life-cycle stage	% of non-owners who are saving for a house or flat
Single, under 40	24.4
Married, under 40, no children	70.6
Children under 5 in household	54.5
Children 5–14 only in household	20.5
Married, over 40, no children	51.8
Single, over 40	15.9
TOTAL	32.9

(b) Likelihood of House Purchase

Life-cycle stage	% of non-owners who expect to buy a house within a year
Single, under 40	12.5
Married, under 40, no children	38.6
Children under 5 in household	24.8
Children 5–14 in household	17.4
Married, over 40, no children	21.7
Single, over 40	4.2
TOTAL	17.7

Source: *New Zealanders and Home-Ownership*, National Housing Commission, 1984

Infogram 6:10

Home-Ownership, by Age of Head of Household

Age in years	% of heads of households who are home-owners
Under 25	19.6
25-29	48.4
30-39	64.7
40-49	74.5
50-59	76.5
60-64	78.9
65+	79.6
All	66.5

Source: *New Zealanders and Home-Ownership*, National Housing Commission, 1984

Infogram 6.11

Likelihood of House Purchase by Income

Household annual income ($)	% of non-owners who expect to buy a house within a year
6,000 and under	4.5
6,001-10,000	8.2
10,001-15,000	17.4
15,001-20,000	34.4
20,001-25,000	49.5
25,001 and over	54.0

Source: *New Zealanders and Home-Ownership*, National Housing Commission, 1984

Taxation and Income Maintenance Policies for Couples

Once established as a couple, a man and a woman are viewed differently from two individuals. They are also treated differently by central government policies, especially in the area of taxation, income maintenance and housing. For example, only one partner in a marriage may claim the principle income earner rebate against their income tax, whereas a brother and sister living together would both be eligible for the rebate (this rebate is 8.5% of taxable income, up to a maximum of $520, rebated from $12,000 per annum and lost at $15,152). There is no allowance against tax for a non-earning spouse in New Zealand. A childless couple with one earner is taxed on the same basis as a single person. This is in contrast to a more generous treatment of childless couples in other "western" countries, where some tax allowance is made for a dependent wife (Dwyer, 1984).

"Married" status, whether legal or de facto is a matter of self-reporting as far as the Inland Revenue Department is concerned The Social Welfare Department, however, is more active in its checking of eligibility criteria. For example, where a couple are living together and one is unemployed, the earnings of the other are taken into account (whether husband or wife), and the unemployment benefit is abated. The unemployment benefit for childless couples is also taxed. Married couples are also paid a lower rate of benefits than two single people living together (e.g. unemployment benefit: single, under 20, $77.36; aged 20 and over $99.82; couple, no child $166.36. National superannuation: single $133.83, couple $220.28. All figures are gross and as at March 1985.)

Conclusion

There is a strong assumption, implicit in both government policy and in the expectations of society, that married couples are, and should be, dependent on each other, and that their financial resources will be pooled, even though there is less emphasis now on the concept of a male breadwinner. This is despite a more individualistic trend within society and the greater social and economic independence of women. The attitude arises partly out of another assumption — that married couples will produce children or that they have the capacity to do so. Questions about policy issues such as dependence and the extent of the state's responsibility begin to be raised once this stage is reached.

Becoming a Parent

"Before I got married, I had six theories about bringing up children: now I have six children and no theories"

John Wilmot, Earl of Rochester
d. 1680

CHAPTER 7

Becoming a Parent

SOCIAL OBJECTIVES

The needs of parents

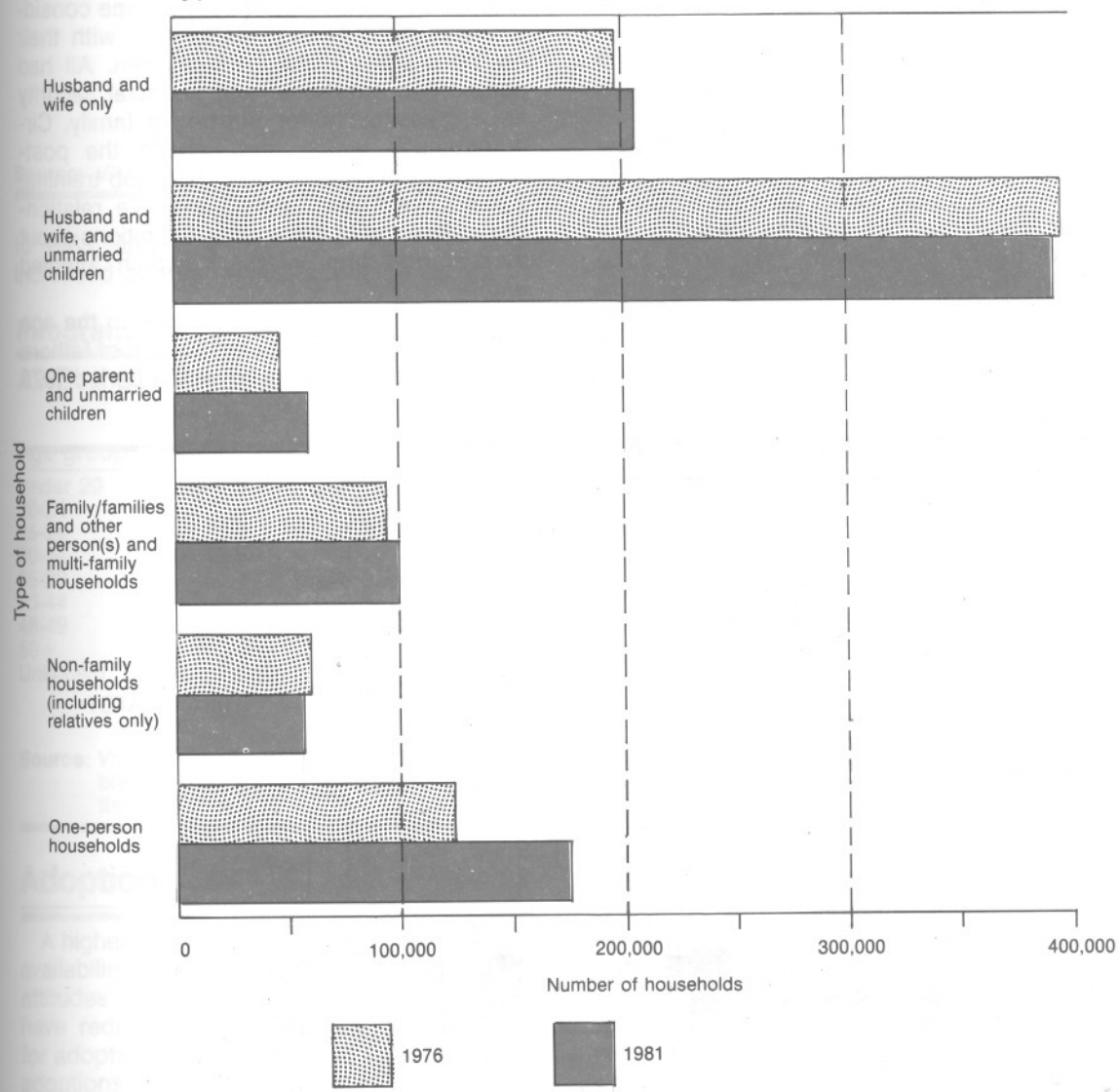
SECURITY AND SUPPORT
STANDARD OF LIVING
HEALTH CARE

The chapter on birth looked at the event from the child's point of view, as the beginning of the individual life-cycle. Here the focus is on parents — on how the birth of children affects the adults who take on the responsibility of caring for them. In the great majority of cases, adults care for children who are biologically "theirs", but this is not always so. As well as acquiring children through adoption, men and women are increasingly finding themselves in a parental role through marriage or cohabitation with partners who have children from a previous relationship. In addition, new reproductive technology, such as in-vitro fertilisation, is blurring the concept of "parent" and parental responsibility for some, as yet albeit only a small number, men and women.

Caring for children reduces, or even at times precludes the possibility of the care-giver earning an income from other work. Thus the care-giver's practical requirements must come through another adult (or adults) or an institution. The stereotyped roles are those of a "nurturing" female parent and a "providing" male parent, but these should not be reinforced where they are inappropriate for individuals and couples (in the same

Infogram 7:1

Household Types, 1976 and 1981



Source: *Census of Population and Dwellings*, 1976, 1981, Volume 10, Table 1, Department of Statistics

way that it should not be assumed that all adults will either form couples or become parents).

Health care in this chapter relates to the parents rather than to the children. Particular attention must be given to maternal health and to the mental health of parents, as caring for children has often been seen as a source of stress. Other less measurable needs include security and support. These can be provided in different forms by partners, relatives and friends, the community and by the state. Parents have rights to security and support in their role as such, and also rights to individuality and autonomy as adults whose lives need not be limited to the caring role.

Family Characteristics

Groupings of husband, wife and one or more children now account for 38.8% of households in New Zealand (Inf. 7:1). This represents a decreasing proportion of households compared with 1976 figures. Many "husband and wife only" households will become families with children, but an increasing proportion of this category are couples whose children have grown up and moved out of the family home.

Changes in the family life-cycle since the early 1970s include a higher average age at marriage (as discussed in Chapter 6), and a higher proportion of couples delaying the birth of their first child (Inf. 7:2). From 1970 to 1983, the percentage of women who gave birth in the first two years of marriage dropped from 66% to 45%, and those who gave birth five years or more after the marriage rose from 5% to 18%. Along with this has been a tendency for women to have their first child later in life. In 1970, women aged 30 to 44 who gave birth for the first time accounted for 7.1% of all first births. By 1983 this had risen to 15.8% (Inf. 7:3). (For an in-depth discussion on fertility in New Zealand see Population Monitoring Group, 1985.)

This trend is apparent in the United States and Britain, but there has been little research in New Zealand, apart from an exploratory study of women having their first child after 30 years of age (Society for Research on Women, 1984). This sample had the following characteristics:

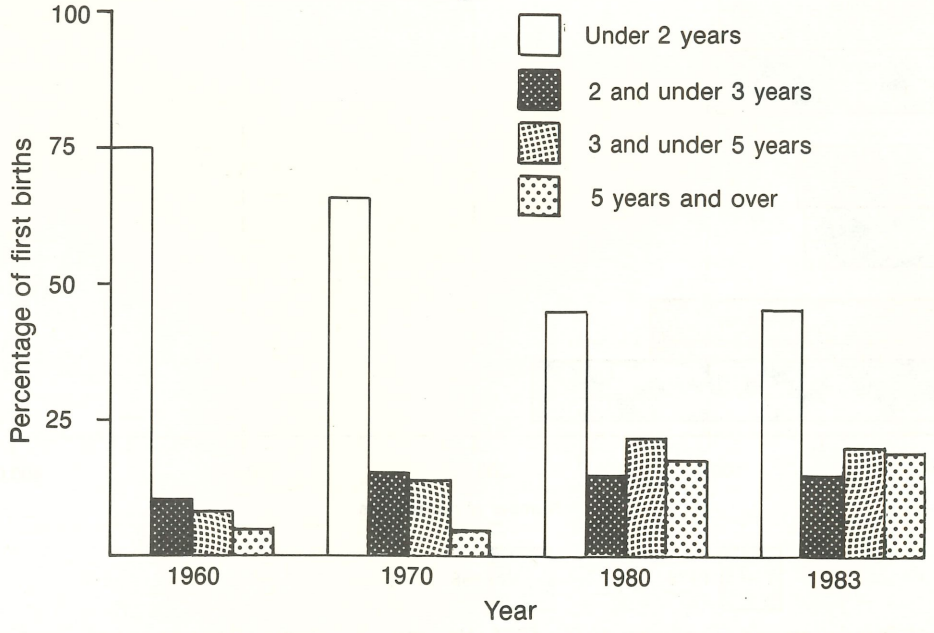
- above average educational attainment and occupational status
- the majority had a high degree of career commitment
- all had household incomes indicating a comfortable to high standard of living
- over 90% had travelled overseas
- all had been city dwellers since leaving home
- almost all were married and living with their partners.

For most of the women, the prime consideration was that the relationship with their partners was "right" for children. All had considered emotional and financial security as a prerequisite for starting a family. Circumstances which had caused the postponement of child-bearing were job training, careers, overseas travel, unstable relationships, feelings of immaturity, inhibitions about motherhood and infertility (which affected few).

There has been similar change in the age of fathers (Inf. 7:4). The proportion of fathers under 30 has decreased over the period 1975

Infogram 7:2

First Births, by Duration of Marriage



Source: *Vital Statistics*, Table 10, Department of Statistics

Infogram 7:3

First Births, by Age Group of Mother

Source: *Vital Statistics*, Table 11, Department of Statistics

to 1983, and that of fathers 30 to 39 has increased by nearly 10 percentage points.

Infogram 7:4

All Births, by Age of Father

Age group	1975 %	1980 %	1983 %
Under 20	3.3	3.2	2.8
20-24	22.4	19.2	17.5
25-29	35.4	33.9	32.8
30-34	18.9	24.1	26.1
35-39	7.4	8.0	9.7
40-44	2.9	2.6	2.7
45-49	1.1	0.9	0.9
50+	0.5	0.6	0.5
Unknown	7.8	7.2	6.8
TOTAL	100.0	100.0	100.0

Source: *Vital Statistics*, 1975, Table 11; 1980, Table 8; 1983, Table 8, Department of Statistics

Adoption

A higher level of contraceptive use, greater availability of legal abortion, and changing attitudes to child-bearing outside marriage have reduced the number of babies given for adoption in New Zealand. The number of adoptions has fallen from 3,513 in 1967 to 1,957 in 1981 and 1,544 in 1983. The proportion of adoptive children placed with strangers has also fallen, from about 50% in 1978 to 30% in 1983. It has thus become much more difficult to adopt children. At the same time, there has been a trend to assert the rights of adoptees to know and make contact with their birth parents (Dawson, 1984).

New Reproductive Technology

People who are seeking to adopt children because of infertility may find assistance through recent advances in medical technology, especially the achievements of the in-vitro fertilisation (IVF) facility in the Auckland National Women's Hospital. Whilst artificial insemination by donor programmes (AID) have been in operation in New Zealand for ten years, IVF technology and procedures are relatively new. The first New Zealand births from the "test tube baby" (IVF) programme were in 1984. The legal issues surrounding advances in reproductive technology are now under discussion and being investigated by the Justice Department.

Family Planning

Most couples do not find infertility a problem, although concern has been expressed that the growing incidence of some forms of sexually transmitted disease could result in higher rates of infertility in New Zealand. The knowledge and practice of contraception is

high (especially the use of oral contraceptives), and there is widespread use of sterilisation as a contraceptive measure, once the desired number of children have been born to a couple. Localised surveys have shown that as many as 40% of women in the reproductive age group, over the age of 30, are in unions where one or both partners have been sterilised (Department of Statistics, 1984).

The majority of pregnancies are planned. However, unplanned conceptions may still account for up to one-third of pregnancies in marriage (Fergusson et al, 1978a). In this study, there was little evidence to suggest that the children were unwanted; 98% of the mothers were pleased with their situation, although a quarter of the unplanned pregnancies had caused concern about finances. Approximately 40% of the unplanned pregnancies were the result of contraceptive failure or breakdown in the usage of the contraceptive pill. It is possible, however, that cultural differences may play a part in family planning practices, as a disproportionate number of unplanned pregnancies were reported by Maoris and Pacific Islanders.

Parent Education/Antenatal Classes

Mothers expecting a child decide on who their principal medical officer is to be during the pregnancy and at what hospital they wish to give birth. The decisions made determine whether or not antenatal education and midwife supervision are available and the standard of antenatal medical care given, as not all hospitals offer such services (Department of Health, 1983).

From 1972 to 1978, there was a significant increase in the numbers of participants in antenatal and relaxation classes in the Wellington region. However, the increase was for women who had already given birth, rather than for first-time mothers. Mothers from low-status suburbs were found to be under-represented at the courses offered.

Health of Parents

There is considerable evidence that women, on becoming mothers and caring for pre-school children, are particularly vulnerable in terms of their physical and mental health (Haines, 1983). Published national statistics, however, concentrate on the health of children and throw little light on maternal health or morbidity. Deaths from complications of pregnancy and childbirth are rare in New Zealand, with only three in 1981 and eight in 1982 — rates of 0.6 and 1.6 respectively per 10,000 live births.

Post-natal depression is very common. Many women experience "maternity blues" some time between the third and tenth day after the birth of a child. While distressing, this experience is transitory for the majority of mothers. However, approximately 10% suffer an episode of depression that lasts longer than a month, is at least partially disabling, and significantly impairs quality of life (Abbott, 1983).

The Dunedin Child Development Study found the self-reported level of general health in mothers to be lower than expected (Dodge, 1980). Younger mothers (20-39) indicated a lower level of physical and mental health than older mothers (40 years and over). More than 80% of all mothers experienced symptoms of physical ill-health, and more than 60% symptoms of mental ill-health. This was related to a depressed health status rather than defined illnesses, but it was apparent that the pressure of child-rearing, especially in families with pre-school children and larger families, contributed to a lower health status. Mothers aged 20 to 24 were found to have the largest number of symptoms, and women aged 40 years or more had the fewest. Anxiety and depressive symptoms are also positively correlated with the number of children at home. In the Christchurch Child Development Study, mothers of five-year olds experienced a high incidence of depression, only 32% being symptom-free (Fergusson et al, 1982a). The lives of solo mothers are particularly stressful and their problems are reported as being exacerbated by negative public attitudes; three-quarters of one sample of solo mothers reported emotional problems and two-thirds reported general health problems (Ritchie, 1980). However, the interpretation of such results needs to be treated with care. The symptoms recorded may be the result of short-term fatigue rather than severe depression (Haines, 1983).

In summary, there is evidence to associate stress with being a mother of young children, being a young mother, having several young children, or being a solo parent. There do not appear to be data associating stress with fatherhood, although the small group of solo fathers also showed high stress levels in the *Social Indicators Survey 1980-81* (Department of Statistics, 1985).

Spare Time/Leisure

The *Social Indicators Survey 1980-81* showed that adults had on average about four and a half hours of spare time per day, men having approximately one hour more than women. Whilst the reason for this difference cannot be ascertained from the survey, it is "*likely to be due to women's greater expenditure of committed time on childcare and housework*" (Dept of Statistics, 1985). The differences in spare time between the sexes existed for all employment statuses and most stages of the life-cycle. While men had an extra hour available per day, they

were no more or less satisfied with their leisure time than women.

Women engaged in "household duties" had a similar number of leisure hours but were more likely to be satisfied with this than women in the paid workforce. Married women with children, including solo mothers and in particular mothers with children under 15, had a lower total of leisure hours than childless women.

The survey also showed that the most popular leisure activities were reading, watching television and listening to music. Entertaining family and friends was more popular with women (36% participation) than men (22%). Family commitments, especially for women aged 25 to 44, were the most commonly quoted hindrance to taking up a new activity. Problems with transport to leisure activities were mentioned by 6% of women and only 1% of men.

Overall, married women have less spare time than men and it is essentially the marriage and children, and the work entailed with both, that make the difference. Despite this inequality between the sexes, however, women did not say they were less satisfied with their leisure time.

Family Income

As well as the high direct costs associated with child-rearing — for food, clothing, education and social activities — which increase as the child grows older,[6] there is the indirect cost of loss of income by the child-carer. Frequently one parent, usually the mother, is obliged to move out of the paid workforce to work in the family home. The loss of income means financial hardship is more likely to occur when the family has young children rather than when the children are in their teens (refer Chapters 2, 3 and 4 on income patterns).

As more and more mothers are entering the paid workforce, either by choice or of necessity, inequalities between families are likely to be exacerbated despite efforts by government in the area of family support/assistance. Income adequacy is strongly related to the number of children in a family so that even comparatively high incomes may not be sufficient. This relates to the way in which income maintenance policies operate, as well as to the size of the gross income.

In her assessment of the effects of the 1984 Budget on the financial position of families, Susan St. John emphasised the need to maintain family assistance in real terms, i.e. bearing in mind the influence of inflation (St. John, 1984). Adjustments made in the 1984 Budget almost restored the 1980/81 level of assistance in real terms, with an improvement for larger families through the weekly $6 family benefit and $10 family care payment per child. However, for families with few children, any improvement is only marginal because levels of abatement against income have not been changed.

Assistance to families living on social welfare benefits is, in real terms, now lower than 1980/81 levels. The level of assistance to a one-child beneficiary family is approximately one-third of that to a similar earner family and about 70% of that to a six-child family. Increases from March 1985, however, raise child supplements received by beneficiaries to $10 per week, on a par with family care.

St. John states three concerns about the present system of family support. Firstly, it still has three distinct "prongs" — family benefit, family care, family rebate — delivered in different ways, through different institutions, in a non-integrated way. Secondly, it is non-indexed, and the value of the family rebate in particular has been eroded over the years. Finally, there is some confusion between family assistance and incomes policy and there would be advantages if family assistance were to be fixed in real terms as is national superannuation (Chapter 10).

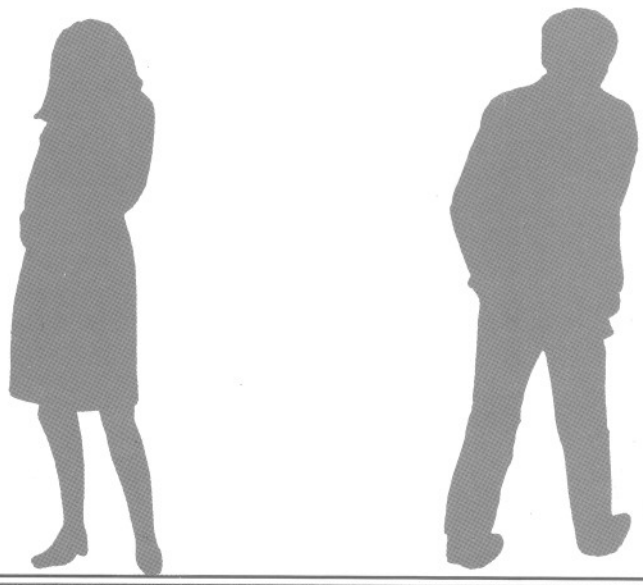
Conclusion

Taking an overall view, evidence presented in this chapter and in Chapters 2, 3 and 4 shows that families with children, are at an economic disadvantage compared with other types of households, especially those of one or two adults in paid work. At the same time, they form a declining proportion of total households. Becoming a parent may mean not only a lower economic standing, but also loss of leisure time and risk to mental and physical health. These negative aspects must be set against the benefits and rewards of parenthood, and borne in mind when considering to what extent, and how, the wider community should support those who become parents.

6. Basic food costs per week, as of February 1985, are estimated to be $8.00 for a child aged one; $12.25 for a five-year old; $17.00 for a child of ten; $20.25 for an adolescent girl and $23.75 for an adolescent boy (Home Science Information Service, University of Otago).

Breaking Up

"Breaking up is hard to do ... "
Neil Sedaka



CHAPTER 8

Breaking Up

SOCIAL OBJECTIVES

The needs of people leaving a marital relationship

CRISIS CARE AND SUPPORT
HOUSING
STANDARD OF LIVING

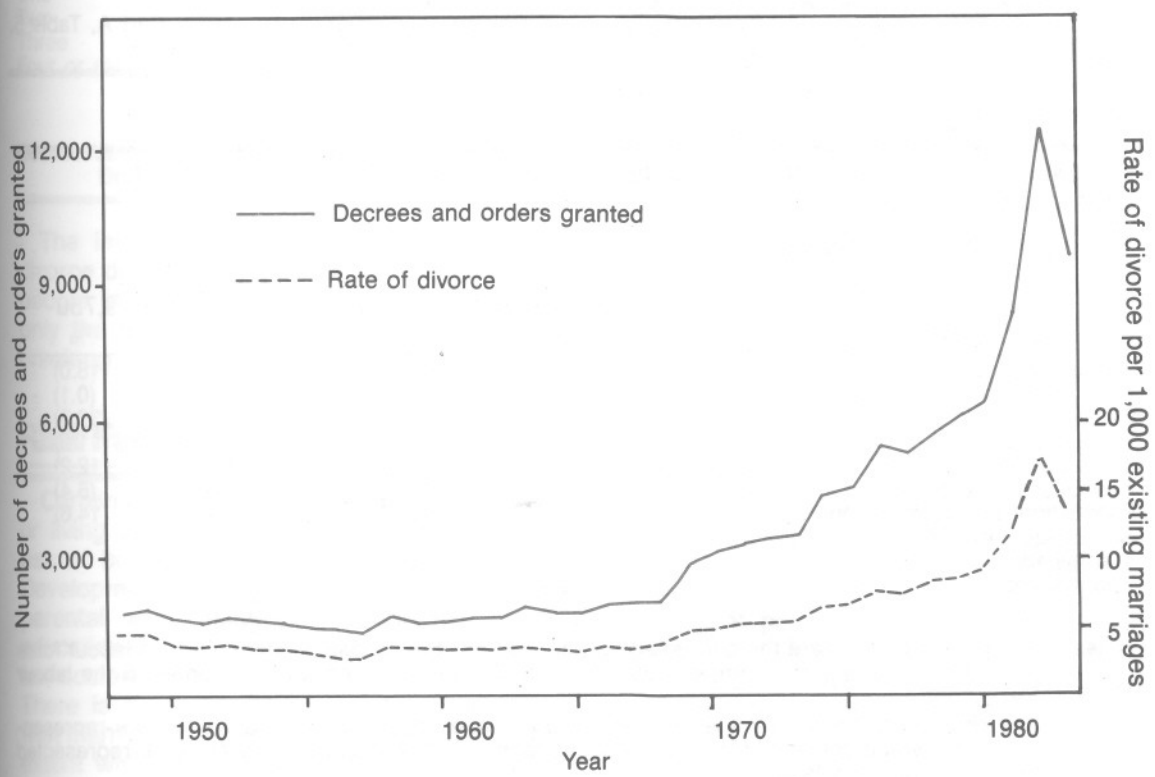
A happy marriage and a satisfying family life would be the aim of the majority of New Zealanders, and are widely portrayed as the norm. In reality, there is an acceptance that the strains which can develop in a marital relationship, from both external and internal factors, often result in separation and divorce. While the institutions of society frequently act to protect and foster marriage-based family life, the view generally taken is that provision must be made to end relationships which have become untenable and destructive.

People leaving marital relationships have short-term and longer-term needs. In the short term, they need care and support to cope with the impact of the immediate crisis. Long term, they require the means to re-establish their lives, in particular an income and adequate housing. People who are left to care for children single-handed have special needs, which may differ from those who find themselves in the same situation through widowhood (Chapter 11).

We are concerned here with the event of "breaking up", defined broadly as permanent separation of a man and woman in a sexual relationship, who have been living in the same dwelling and maintaining some degree of joint expenditure. This, therefore, also includes the break-up of de facto, or informal, marriages. Marriage breakdown, on the other hand, is defined as a process of deterioration within the marital (or quasi-marital) relationship which may or may not result in separation, i.e. break-up. This report cannot concern itself with marriage breakdown in this sense, nor with the causes of it, although it is recognised that the extent of marital breakdown is much greater than break-up. Many people persist in unsatisfactory relationships for a variety of reasons, among them the presence of children. However, as separation and divorce become easier and more acceptable, it could be suggested that the gap between breakdown and separation is narrowing, especially compared with times when divorce was either impossible or socially unacceptable.

Infogram 8:1

Divorce and Dissolution of Marriage, 1948-1984



Source: *Justice Statistics*, 1982, Part A, Section 4, Table 1, Department of Statistics

Marriage Break-up and Divorce

The common perception is that the rate of marriage break-up in New Zealand is increasing rapidly, but we have no figures to document this trend with any accuracy. Divorce figures, which have been used as indicators, show only part of the picture. Informal unions require no legal procedures when they break up. Yet it seems that de facto marriages may break up twice as frequently as formal unions (Fergusson et al, 1984b). No legal steps are needed on separation after legal marriage and not all separations lead to divorce. Where there are separation agreements (to deal with matters of property, custody of children, etc.), they are drawn up in private by lawyers and do not appear in the Justice Statistics. A formal court order is needed only where points are contested. For every separation order made in a court, there are about three applied for which do not come to the court stage. In 1981, three times as many divorces were granted on the basis of a separation agreement than on the grounds of a separation order. So it seems there are at least three uncontested separations for every one that requires a court order and therefore enters the statistics.

It is necessary, therefore, to fall back on the imperfect indicator of divorce. In addition to the problems noted, the divorce rate can vary with factors other than marriage break-up, e.g. changes in the law which make the procedure either more attractive or more difficult. The most recent change was the Family Proceedings Act 1980 (effective 1 October 1981), which replaced "divorce" with "dissolution of marriage", removed proceedings from the High Court to Family Courts and replaced all other grounds for divorce by irreconcilable breakdown of marriage, proved by two years' separation (i.e. introduced "no fault" dissolution).

The number of divorces and the rate per 1,000 existing marriages have been increasing steadily since the 1950s, with a jump recently which could be associated with the new legislation. In fact the rate has more than doubled since 1970 (Inf. 8:1).

The average duration of marriage to dissolution is currently 14 years, including an unknown period of separation. Over the 1971/81 decade, the proportion of divorcing couples married under five years fell from 11% to 6% but then rose to 9% in 1983, and that for couples married ten years or more rose — 59% to 64% (Inf. 8:2). Over half (53%) of the divorces which went through in 1983 concerned couples who had been married when both were aged 20 to 24, or when the husband was in this age group and the

Infogram 8:2

Duration of Marriages Ending in Divorce, 1983

Duration in years	% of decrees or orders
Under 5	9
5-9	27
10-14	24
15-19	16
20-29	18
30+	6
TOTAL	100

Source: *Justice Statistics*, 1983, Part A, Table 5, Department of Statistics

Infogram 8:3

Occupational Groups of Husbands and Wives Involved in Divorce or Dissolution, 1983

(all petitions and applications)

Occupational Group	Husbands n = 9,750 %	%	Wives n = 9,750 %	%
Professional/technical	10.7	(12.1)	8.8	(18.0)
Administrative/managerial	8.6	(5.5)	0.9	(0.1)
Clerical workers	4.8	(7.4)	13.7	(32.3)
Sales workers	7.5	(8.3)	4.8	(11.2)
Service workers	6.0	(5.8)	4.8	(12.2)
Agriculture, forestry, etc.	6.3	(13.2)	0.5	(6.4)
Production, transport, labourers, etc.	41.3	(43.9)	4.1	(14.6)
Not adequately reported/not stated/not applicable	12.7	(3.8)	61.6	
Unemployed	2.2		0.7	
	100.0		100.0	

Notes: Figures in brackets are the percentage breakdown for the usually resident full-time labour force aged 15 and over (10% sample, 1981 census). Those for wives are for women in the labour force only.

The census statistics are for all men and women, and not for those married, so over-representation in divorce statistics for certain occupations could be because they are over-represented in the married population.

Source: *Justice Statistics*, 1983, Part A, Table 14, Department of Statistics and 1981 Population Census 10% sample

wife under 20 (cf. age at marriage in Chapter 6). Four out of five wives and two out of three husbands divorcing in this year were aged under 25 at marriage.

Divorce figures are not available by race or ethnic group. Infogram 8:3 lists the occupational groups of those divorcing in 1983, with a comparison of the total 1981 labour force breakdown for males (comparisons are not valid for females as over two-thirds of divorcing wives did not state a paid occupation). There are problems of comparison because a high proportion of divorcing husbands did not state, or did not have, an occupation.

With a growing incidence of divorce, the number of dependent children involved (under 18 at time of divorce) has increased (1977, 7,685; 1981, 10,965; 1982, 15,827; 1983, 11,706), but the average number of children per decree/order is going down (1977, 1.43; 1982, 1.28; 1983, 1.20). This is consistent with an increased proportion of divorcing couples having no children. Where children were involved, most were of school age (Inf. 8:4).

Infogram 8:4

Children Involved in Divorces, 1983

Number of children per divorcing couple	%	Age of children involved Years	No.	%
None	39	0-4	1,404	12.0
One	21	5-9	4,141	35.0
Two	26	10-14	4,509	39.0
Three	11	15<18	1,652	14.0
Four or more	3			
TOTAL	100		11,706	100.0

Source: *Justice Statistics*, 1983, Part A, Table 3, Department of Statistics

The implication of these figures is that divorce directly affected the lives of 31,206 people in 1983. However, this represents only the formal and final aspect of marital break-up.

Risk Factors

Certain characteristics of couples, married or living as married, seem to heighten the risk of break-up. In the Christchurch Child Development Study, these included young parental age, unplanned pregnancy, low educational attainment by both parents and low socio-economic status of father (Inf. 8:5). There is a higher degree of break-up risk with marriages of short duration and to some extent with non-white ethnic status of one or both parents. The much higher rate of break-up among de facto marriages serves again to illustrate the extent to which divorce figures will understate marital break-up (Fergusson et al, 1984b).[7]

Infogram 8:5

Risk Factors in Marital Break-up

Highly significant correlation with family breakdown

Length of marriage - higher for marriages of short duration
Marriage type - higher for de facto marriage
Planning of pregnancy - higher for unplanned pregnancy
Maternal and paternal age – higher breakdown levels where parents under 25 and especially under 20
Parents' education - higher rate where no formal qualifications
Parents' church attendance - higher where never attend
Father's socio-economic level - higher level of breakdown with lower status

Moderately significant correlation with family breakdown

Parents' ethnic status - higher for non-white
Stability of maternal childhood - higher breakdown level where mother experienced her parents' separation before the age of 16

Source: Fergusson, D.M. et al, "A Proportional Hazards Model of Family Breakdown", *Journal of Marriage and the Family*, 1984

The overall results from the Christchurch study showed that by the age of five, about one child in eight had experienced a family break-up lasting three months or longer. Break-up affected about 2.3% of families in the study per annum. Fergusson and Horwood have also made predictions about the future family stability of their birth cohort (born in 1977). They estimate that 38% of the children would spend some time in a one-parent family by the age of 16. Well over half of the children born into a one-parent family, or one where the parents were not legally married, were expected to experience at least two changes of family circumstances (i.e. change from one to two parents or vice versa) by the same age. This study is one of the few attempts to estimate the overall rate of marital break-up in New Zealand (Fergusson and Horwood, 1983).

Marital Status

Another method of monitoring marital break-up is through census records of marital status, specifically the numbers and proportions of people classified as separated and divorced. In 1981, just over 6% of the adult population were in this situation (Inf. 8:6). Leaving out the 1981 figures because

7. Patterson's now rather dated study in Wellington (Patterson, 1976) identified pre-marital pregnancy, young age of bride (under 22), and a decline in socio-economic status among the strongest correlates of divorce.

Infogram 8:6

Marital Status: Total Population 16 Years and Over

(excludes "not specified": all figures are column percentages)

Marital status	1956	1961	1966	1971	1976	1981*
Never married	24.2	23.7	24.4	23.1	23.3	25.5
Married	66.4	67.1	66.5	67.2	66.5	61.1
Legally separated**	0.8	0.8	0.9	1.4	1.8	3.6
Widowed	7.4	7.3	7.1	6.9	6.7	7.1
Divorced	1.1	1.1	1.2	1.4	1.7	2.7
	100.0	100.0	100.0	100.0	100.0	100.0

* 1981 marital status was collected only for the "usually resident" population. Comparing the "usually resident" and total populations from the 1976 census does not show a very large difference.
** In the 1981 census, the category "legally separated" was changed to "married but permanently separated", so this could affect the 1976-1981 intercensal comparisons of the married and separated categories.

Source: *Census of Population and Dwellings*, Volume 2, Tables 12 and 13, Department of Statistics

of changes in definition, the number of separated people more than trebled between 1956 and 1976, and the number of divorced people more than doubled (total population, 16 years and over, grew 47%) (Inf. 8:7). In the earlier period, there were more divorced than separated people, but the situation is now reversed. The acceptance of de facto marriage has reduced the need for formal divorce before remarriage and it is likely that the Domestic Proceedings Act 1980 will also increase the numbers separated as they await the two-year period before dissolution of marriage.

Infogram 8:7

Intercensal Change in Separated and Divorced Group

(all figures are % change between stated dates)

	Male	Female	Total
1956-61	8.1	7.7	7.9
1961-66	13.6	16.8	15.3
1966-71	41.7	48.7	45.5
1971-76	40.1	46.6	43.7
1976-81*	92.9	81.3	86.3

* 1976-81 comparison is for usually resident population at each date

Source: *Census of Population and Dwellings*, 1981, Tables 12 and 13, Department of Statistics

Infogram 6:3 analyses marital status by age and sex. Although the greatest concentration of separated men and women is in the 30-44 age group, there were more separated women aged 16 to 29 and more separated men aged 45 to 59. The pattern for the divorced is similar. This is partly explained by the younger age of marriage for women and the general practice of women marrying men older than themselves.

The 1981 census was the first to collect information on de facto marriage. Almost half the people in such relationships did not specify any other status, but 29.5% of the men and 26.7% of the women (28.2% overall) were separated or divorced (refer Chapter 6 on de facto marriage). If people living in de facto marriages are considered as married, and this would be a reasonable assumption in terms of living arrangements, housing need and so on, this would reduce the separated and divorced categories and hence indicators of marriage break-up. Setting up in a de facto marriage is hence equivalent to remarriage (see Chapter 6), and it should not be assumed that those who have seen the break-up of their marriage continue to live unpartnered (Quin and O'Neill, 1984).

Consequences of Break-up

Legal

As well as the legal procedures associated with the termination of the marriage bond (separation agreements/orders, dissolution), there are also a series of agreements or court orders which deal with consequences of marriage breakdown and separation. Custody of, and access to, children of separating couples is now handled, where easy agreement cannot be reached, through the Family Courts. Little detailed information is, as yet, available on the working of the courts (Leibrich and Holm, 1984) but there is an increasing incidence of joint custody arrangements and more fathers being granted custody (Inf. 8:8).

Under present law, the children are represented by a lawyer in disputed access and custody cases. Common concern for, and interest in, the children is the major, and perhaps the only, factor keeping ex-spouses in contact.

Property is another matter which requires settlement after separation. The Matrimonial Property Act 1976 is based on a presumption of equal sharing. Here again, the majority of cases are settled privately, and only the more contentious reach the court. These are in no way typical and so it is difficult to

Infogram 8:8

Nature of Custody Orders*, 1981 and 1983

	1981		1983	
	Number of children	%	Number of children	%
Mother only	2,880	81.5	2,333	72.1
Father only	347	9.8	454	14.0
Other party only	43	1.2	59	1.8
Custody divided	264	7.5	390	12.1
TOTAL	3,534	100.0	3,226	100.0

* Includes some extra-marital cases

Source: *Justice Statistics*, 1981, 1983, Part A, Table 9, Department of Statistics

monitor the more general picture. The principle of equal sharing is now well established, especially with respect to the matrimonial home, which is probably the only asset of great value in the majority of cases. The courts have moved towards the "clean break" principle, under which the house is sold to enable each partner to realise his or her equity. In practice, women may frequently be waiving their rights to matrimonial property, through lack of knowledge or because their priority is to escape an untenable situation. This may especially apply in cases where domestic violence has been a factor (Wylie, 1980).

Living Arrangements

In the short term, the immediate consequence of break-up is to create two households or potential households where there had previously been one. Where there are no children, ex-partners may live alone, with relatives or friends, or with a new partner. People aged under 45 and living alone are predominantly male (63%) and many of these are separated and divorced. They are likely to be the partners who do not have custody of children but, given the high rate of remarriage and de facto marriage among this group, living alone may be a temporary stage.

The other element is the custodial spouse, left with care of dependent children. Half the heads of one-parent households are separated or divorced (Inf. 8:9). Women outnumber men as solo parents by four to one, particularly where children under 15 are involved. Female solo parents are more likely to have dependent children in their households than their male counterparts, and this is especially true for separated and divorced mothers, i.e. 86% of separated solo mothers and 73% of divorced solo mothers have dependent children living with them.

One-parent family households have been growing rapidly in numerical terms over recent years, although in 1981 they still comprised only 6.2% of all households (1976 census, 5.1%).

Standard of Living

Comparing the material standard of living of one and two-parent families, the former were found to be substantially worse off in respect of income per capita and access to amenities such as a car, phone, washing machine, etc. (Mowbray and Khan, 1984). One-parent families were also less likely to own their home (53% owned with or without a mortgage, as opposed to 76% of two-parent families), and were more likely to be in public rental accommodation (24% as against 9%). If widows were excluded, solo

Infogram 8:9

One-Parent Households, 1981

(a) Total: Marital Status and Sex

Marital status of head	Male %	Female %	Total %
Never married	15.4	12.8	13.3
Married	8.0	4.4	5.0
Separated	28.6	31.9	31.3
Widowed	30.5	30.7	30.6
Divorced	16.5	19.6	19.0
Not specified	0.9	0.7	0.7
	100.0	100.0	100.0
Total one-parent households	15,030 (19%)	64,146 (81%)	79,176 (100%)

(b) With Children Aged 15 and Under: Marital Status and Sex

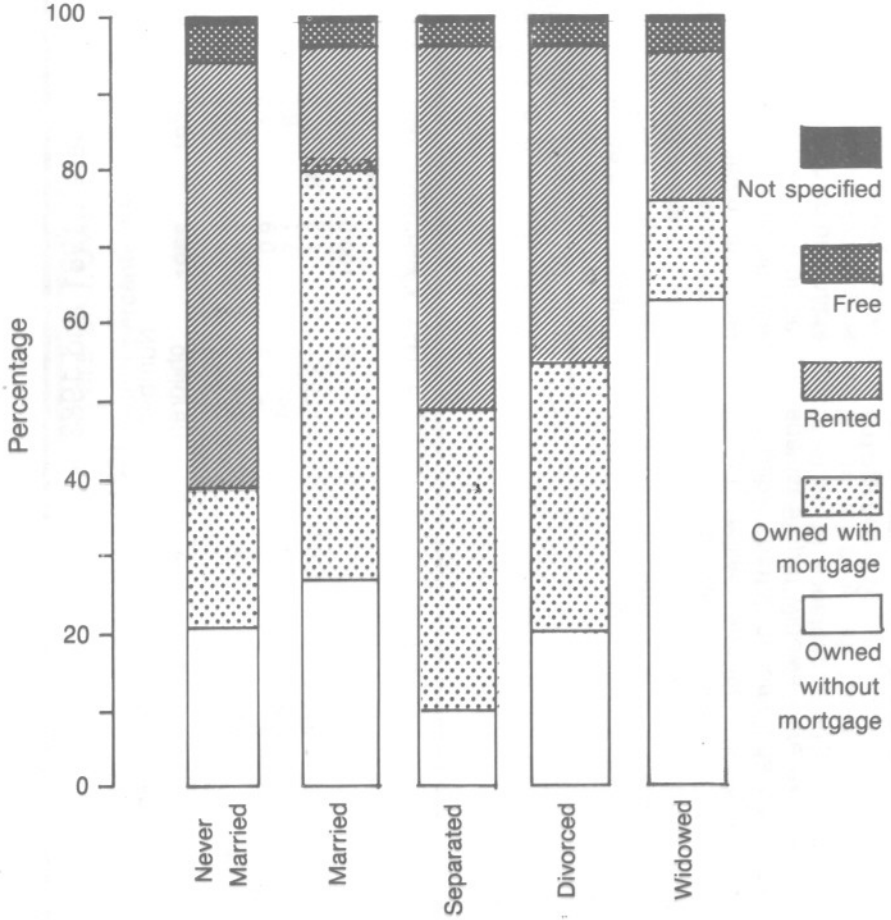
Marital status of head	Male %	Female %	Total %
Never married	9.0	16.8	15.6
Married	9.3	4.8	5.5
Separated	38.8	40.4	40.2
Widowed	22.6	16.1	17.1
Divorced	18.9	21.1	20.7
Not specified	1.4	0.9	1.0
	100.0	100.0	100.0
Total one-parent households with dependent children	8,016 (15.5%)	43,596 (84.5%)	51,612 (100%)

Source: *Census of Population and Dwellings*, 1981, Volume 10, Tables 17 and 18, Department of Statistics

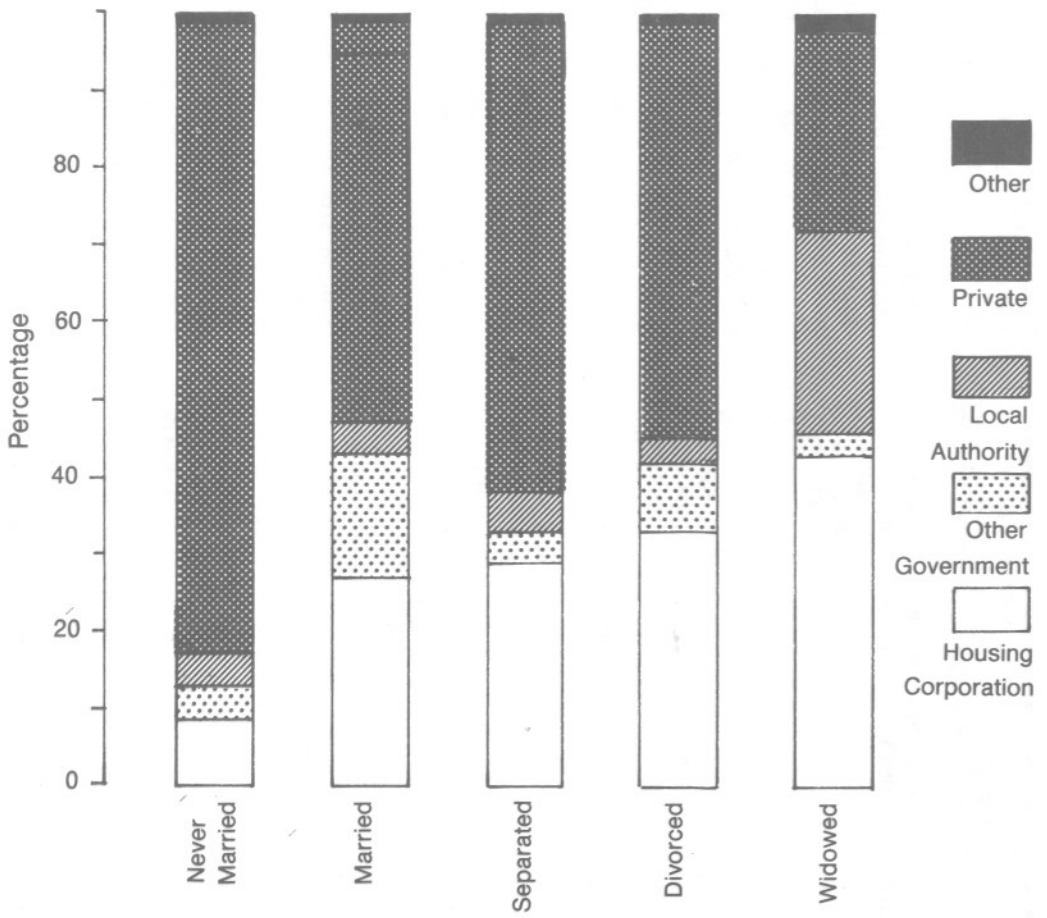
Infogram 8:10

Housing and Marital Status, 1981

(a) Marital Status of Occupier by Housing Tenure



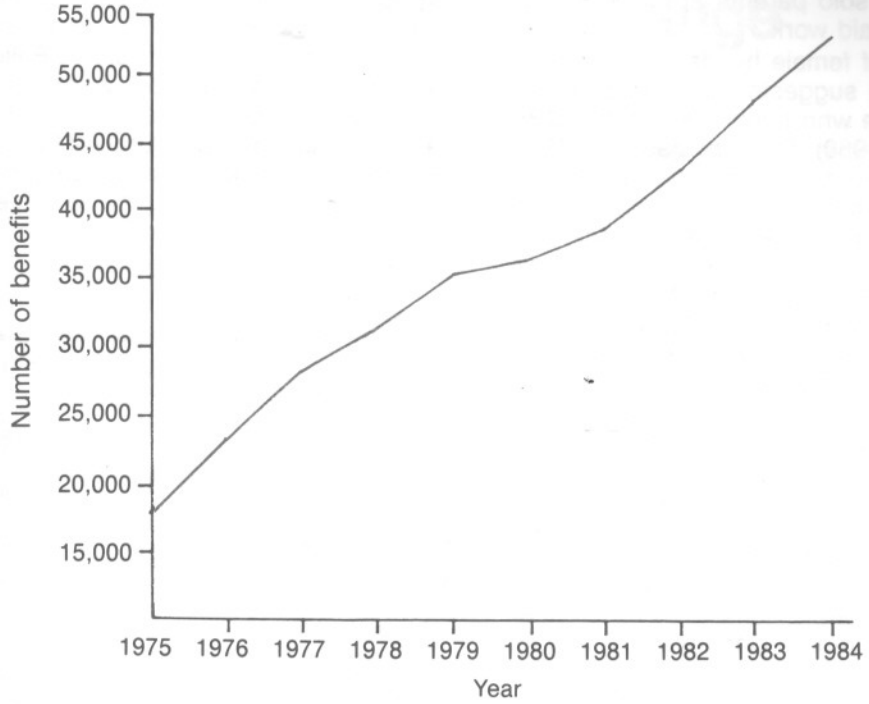
(b) Marital Status of Occupier by Type of Landlord (Renters only)



Source: 1981 Population Census 10% sample

Infogram 8:11

Number of Domestic Purposes Benefit Recipients, 1975–1984*



*Benefits in force at 31 March

Source: *Reports of the Department of Social Welfare,* 1975–1984, Department of Social Welfare

mothers were even less likely to own a home (Inf. 8:10).

This picture is similar to that in many other countries in which one-parent families, especially those headed by women, are concentrated in the lowest income groups. 69% of women divorced in 1982 had no paid occupation, or none recorded (Inf. 8:3). Given this low participation in the paid workforce, and the high level of dependent children in the households of separated and divorced women, it is not unexpected that increasing marital break-up is associated with growing recourse to the domestic purposes benefit (DPB), supplied through the Department of Social Welfare.

This benefit, initiated in its current form in the early 1970s, has grown rapidly in numbers of recipients and in cost (Inf. 8:11). In 1984, 86,623 dependent children were in the care of DPB beneficiaries. This number has increased by 44% since 1979, over a period when DPB's increased by 50% (i.e. in 1979 there were 1.84 children per solo parent beneficiary, and in 1984, 1.72).

The proportion of beneficiaries from broken marriages has been increasing in recent years — 1979, 69.8% separated or divorced; 1984, 74.5% — but this is predominantly an increase in those separated (from legal or de facto spouses), rather than those divorced (Inf. 8:12). Most other categories of beneficiaries have declined in proportional (but not numerical) terms. Thus marriage

Infogram 8:12:

Domestic Purposes Beneficiaries, by Marital Status and Sex, 1984

Marital status	Male		Female		Female as % of total
	No.	%	No.	%	
Living apart from spouse or de facto spouse	1,931	72.3	36,094	71.5	94.9
Divorced	161	6.0	1,432	2.8	89.9
Spouse or de facto spouse deceased	439	16.4	408	0.8	48.2
Unmarried	56	2.1	9,375	18.6	99.4
Other solo parent	19	0.7	315	0.6	94.3
All solo parents	2,606	97.5	47,624	94.3	94.8
Care of sick or infirm	64	2.4	271	0.5	80.9
Women alone			2,579	5.1	100.0
Total DPB beneficiaries	2,670	100.0	50,474	100.0	95.0

Source: *Report of the Department of Social Welfare*, 1984, Department of Social Welfare

break-up is the source of most of the increasing demand being made on DPB funding, although unemployment will also be a factor, in that solo parents are less able to find suitable paid work.

In a study of female heads of one-parent families, Wylie suggested that roughly one in two of those who could take up the DPB did so (Wylie, 1980). This was based on 1976 census and beneficiary figures. Assuming that the proportion of widowed solo parents with dependent children has not changed greatly, the take-up rate appears to have increased considerably by 1981 (Inf. 8:13). One-parent families are found disproportionately in the lowest income group (Inf. 8:14). This proportion, however, decreases when the youngest child is older, reflecting the ability of the parent to participate in the paid workforce.

This is true for all ethnic groups. In general, non-European, one-parent families have a greater likelihood of being in the lowest income group, but the difference is not as great for one-parent families as for other family types (compare Chapters 2, 3 and 4).

Conclusion — Marriage Break-up and Other Social Trends

The increasing rate of marriage break-up has, from time to time, been associated with (and even been suggested as causing) other social trends, many of them seen as unfavourable. "Broken homes" have been linked with crime, especially juvenile crime, and with low educational attainment. The stresses caused by break-up may well have an adverse effect on mental health, but this could also be said of the breakdown process, where a marriage is continuing. Financial stress, including that caused by unemployment is also seen as both cause and effect in relation to marital difficulties. Policies and services to assist people whose marriages have broken up have sometimes been seen as encouraging separation — the Domestic Purposes Benefit, state housing provision, women's refuges. In all these cases much more evidence is needed before the true relationships can be established.

Infogram 8:13

Take-up of Domestic Purposes Benefits, 1976 and 1981

	1976	1981
A. One-parent families with dependent children*	48,000	64,000
B. DPB recipients with dependent children**	11,230	37,084
B as % of A	23.4	57.9

Notes:
1. One-parent families will include a percentage of widows who received widow's benefit rather than the DPB. In 1976, 6,389 widow's benefit recipients had dependent children, just over one-third of such beneficiaries.
2. A dependent child is one under 16, or under 19 and attending full-time schooling.

Sources: * Mowbray, M.J. and Khan, A.R., "One and Two-parent Families from the Census", Demographic Society Conference, 1984
** *Report of the Department of Social Welfare*, Department of Social Welfare. Numbers as at 31 March in cited year.

Infogram 8.14

One-Parent and Two-Parent Families: Income Group Distribution

(a) % of Families in Lowest Income Group

	One-parent	Two-parent
Youngest child under 5	83.6	19.9
Youngest child 5-12	65.5	15.4
Youngest child 13-18	45.5	11.8

(b) % of One-Parent Families in Lowest Income Group, by Ethnicity

	Maori	Pacific Islander	European	Other
Youngest child under 5	87.7	79.4	82.7	88.9
Youngest child 5-12	77.8	68.2	63.4	67.4
Youngest child 13-18	61.5	52.4	43.7	54.5

Note: Percentages in Infogram 8:14b should be treated with caution as only small numbers of families are involved. See Appendix II for explanation of income groups.

Source: 1981 Population Census 10% sample

Major Job Change

"Work keeps at bay three great evils: boredom, vice and need"

Voltaire

CHAPTER 9

Major Job Change

SOCIAL OBJECTIVES

The needs of people in their working life

OCCUPATION
INDIVIDUAL DEVELOPMENT
PARTICIPATION

Everyone needs something to do, something which has meaning or purpose in relation to themselves and to the wider society, something which is within their capabilities and from which they gain satisfaction. Work has most frequently been associated with activities which attract a monetary reward through the market system, so that even the busiest housewife and mother is said to be "not working". Although it is recognised that work is the predominant means of gaining an income to sustain a standard of living for adults, the broader definition of work and its wider purpose must be remembered.

Thus, this chapter looks at major job change as including all changes of occupation in adult life — within the paid labour force, within the unpaid labour force and between the two. Infogram 9:1 illustrates the scope of these changes in diagrammatic form. Entry into the paid workforce from school is discussed in Chapter 5, and retirement in Chapter 10.

Not all the changes illustrated are covered in detail in this chapter, for reasons of space, because very little is known about them, or because they affect very few people. We also do not know the extent of involvement in voluntary work or part-time craft work. We know little about the extent and implications of promotion and demotion within the workforce — for example its linkages with stress. The full range of possible change has, however, been presented to make the point that occupation is much more than paid work and that changes in occupation are very varied and common in adult life.

Moving Out of the Paid Workforce

Leaving paid work to care for dependants

There are several reasons why people leave paid work, among these to care for children or for the sick, infirm or incapacitated.

Movement of women out of the paid workforce to care for children can be documented from several sources. As shown in Chapter 2, 84% of mothers with a child under one year of age were not in paid work (Inf. 2:9).

The 1981 census showed a fall in the female paid work participation between the age groups 20 to 24 and 30 to 34, the peak childbearing years (Infs 9:2 and 9:3). However, the decline does not occur for part-time work. For the majority of women, the responsibilities associated with being a mother restrict work opportunities to part-time involvement.

Few men leave paid work to care for young children on a full or even a part-time basis. In 1981, only 3,471 males were engaged in "household duties unpaid" compared with 402,648 females (Inf. 9:4). Males represented only 0.8% of those not in the labour force and working in the home, and 5% of those receiving Domestic Purposes Benefits in 1983/84 (Inf. 8:12).

It is not known how many people leave paid work to care for dependants other than children. Only 355 DPB's paid in 1984 were for people who cared for the sick or infirm, of which 64 were paid to men (Department of Social Welfare, 1984). Much more attention has been given to quantifying those in need of care. For example, it has been estimated that 8.7% of the population have some kind of disability (Jack et al, 1981).

Care of the elderly and handicapped may or may not require giving up paid work. In a Christchurch survey, 90% of the elderly people surveyed lived in the community, with the family being the main provider of community care. Apart from assistance of a spouse, the major responsibility for care usually fell on one or two family members — the daughter or daughter-in-law and the son or son-in-law (Koopman-Boyden, 1981). Daughters and daughters-in-law were the main providers of non-medical tasks traditionally carried out by women, such as housework and meals. An earlier study in 1978 showed that where a family member was helping, it was a woman in 76% of the cases, and a daughter in 44% of those cases.

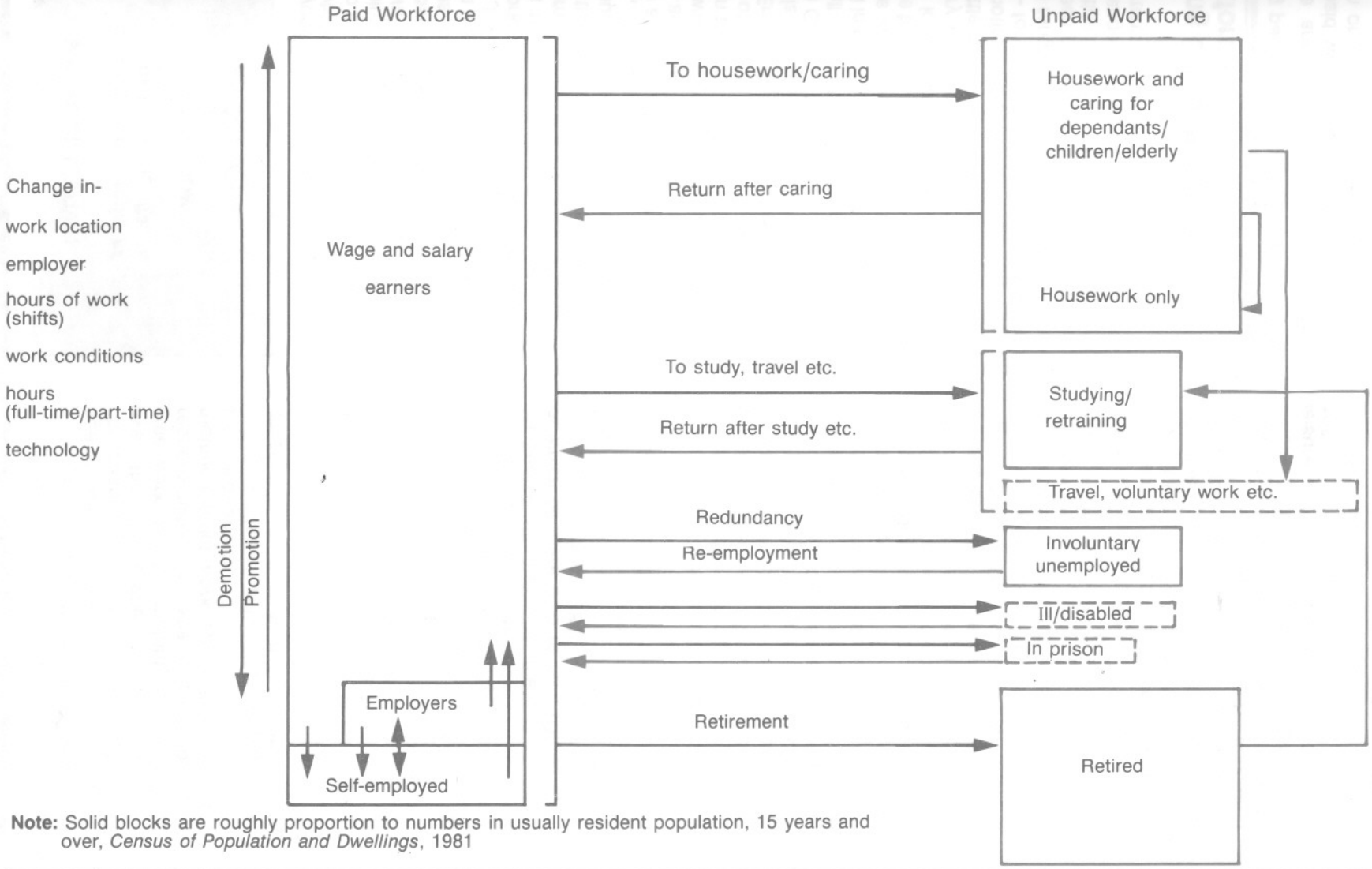
Other "Pull" Factors

The number of people who leave paid employment for further education or retraining in adult life is difficult to determine. While in 1983 there were 7,114 internal university students above the age of 30, and a further 26,773 attending continuing education classes at universities, many would be attending evening classes, for hobbies and leisure activities (Department of Education, 1984a).

Others may leave their jobs to travel. A survey of permanent and long-term departures from New Zealand showed that 77% had been wage and salary earners, and that 85% of those aged over 15 had been employed in either a full or part-time capacity in the previous 12 months (Barrington and

Infogram 9:1

Major Job Change



Note: Solid blocks are roughly proportion to numbers in usually resident population, 15 years and over, *Census of Population and Dwellings*, 1981

Davey, 1980). Overall, 94% of the men and 73% of the women were in the paid workforce prior to departure and only four out of 710 had been unemployed. The most commonly quoted reasons for leaving New Zealand were a working holiday opportunity (32%), desire for a change in the way of life (27%), work or career opportunities (26%) and the family situation (23%).

"Push" Factors

The circumstances under which people leave the paid workforce involuntarily are also varied. The situation may arise due to an illness, a disability or redundancy.

Recently, New Zealand has had unprecedented levels of registered unemployment, despite a 8.7% growth in jobs since 1974. However, the bulk of this growth took place before 1980. The number of jobs grew by only 0.6% from 1980 to 1984.

In New Zealand, the official employment statistics record those who are enrolled with the Labour Department for assistance in finding a job, who do not already have a job, and who are available and willing to accept full-time work. Unemployment is measured by the number of registered unemployed. It is not compulsory to register, but registration is a prerequisite to obtaining the unemployment benefit. Married people whose spouse earns over a certain amount, young people under the age of 16 years, and full-time students are not eligible for unemployment benefits.

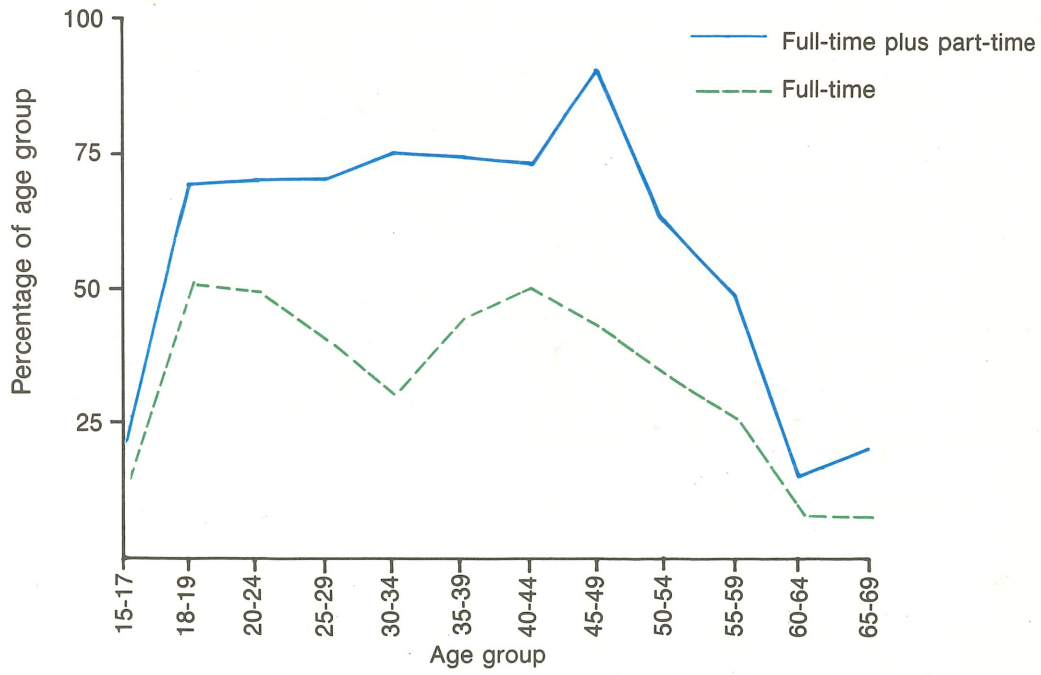
Chapter 5 showed that those under the age of 25 accounted for 56.8% of the unemployed in October 1983 and 54.8% in October 1984 (Inf. 5:7). Females make up smaller percentages of the registered unemployed compared with males. However, the "real" level of female unemployment, or involuntary unemployment is "disguised", as shown in the Palmerston North study (Shipley, 1982). This found that only one-third of unemployed females were registered, compared with four-fifths of the males. Women have little incentive to register, as many married women would not be eligible for the unemployment benefit.

Official statistics collected by the Labour Department do not record the rates of unemployment according to ethnicity. To ascertain the levels of unemployment amongst major ethnic groups in New Zealand, reference has to be made to the 1981 census. The Maori and Pacific Island Polynesian populations had a higher incidence of unemployment relative to their proportion of the total population (Inf. 5:9). Whilst Maoris represented 8.9% of the total population, they represented 24.2% of the total unemployed. Pacific Island Polynesians represented 2.8% of the total population and yet made up 6.0% of the unemployed.

Of those unemployed, only about one-

Infogram 9:2

Female Full-time and Part-time Labour Force Participation*, by Age



* Full-time participation was defined in the Palmerston North Study as 30 hours or more per week and part-time was less than 30 hours per week. The Labour Department uses this division, while the census uses "20 hours or more" and "less than 20 hours".

Source: Shipley, S.M., *Women's Employment and Unemployment*, a research project, Massey University, Department of Sociology, and the Society for Research on Women in New Zealand, 1982

quarter remain so for four weeks or less (Inf. 9:5). More than half the registered unemployed are out of work for between five and 26 weeks. Approximately one-fifth remain unemployed for 26 weeks or more and are described as the "long-term unemployed". Between October 1983 and October 1984 the percentage of long-term unemployed declined from 20.6% to 16.2% but this was due to some extent to the targeting of assistance to this group through the Project Employment Programme (Labour Department, 1984 — *Labour and Employment Gazette*, December). Of the long-term unemployed, 76% had no School Certificate passes and were less well skilled and qualified than the unemployed in general, and a high proportion were aged between 15 and 19 and between 30 and 59. The major factors that affected their future work prospects were age, skill level, educational qualifications and the level of unemployment in the district.

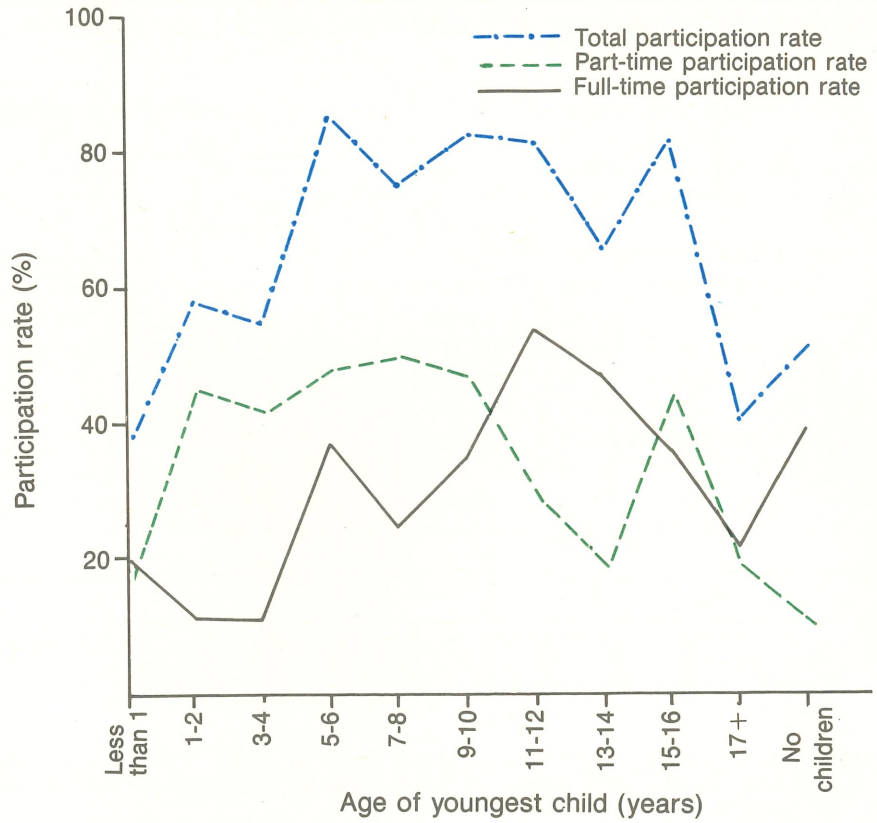
Involuntary unemployment brings costs to the individual apart from financial costs. Unemployment is a threat to the physical and mental health of the unemployed and those immediately affected by unemployment. There is evidence to suggest that "*unemployment has serious consequences for mental and physical health*" and has been "*associated with higher suicide risks, psychiatric distress, a higher rate of delinquency, depression, decay of self-esteem and morale*" and has led to changes in lifestyles (Macky and Haines, 1982). Attitudes to the unemployed often seem to suggest that they deserve a lower quality of life than those employed (Kearsley, 1982, p.22).

The involuntarily unemployed also include people who are permanently and temporarily unable to work because of sickness or disability. In the 1983/84 year, a total of 31,050 people had been on a sickness benefit at some stage during the year (Inf. 9:6). The average duration of such benefits in 1983/84 was 21.4 weeks for men, and 20 weeks for women, both figures an increase on those for the previous year (Department of Social Welfare, 1984). In 1983/84, 20,187 people received invalid's benefits. These are paid in the case of permanent disability.

Apart from sickness and invalid's beneficiaries, there were a further 12,136 individuals receiving a disability allowance in 1983/84. This is additional to other benefits. The rate of the allowance is determined according to the nature of the disability and expenses arising from the disability. A Wellington survey has shown that the severity of a disability or handicap (in terms of extent, e.g. total blindness compared with partial sight) did not determine whether or not they were unemployed, but that the disability imposed limitations on their ability to

Infogram 9:3

Female Labour Force Participation, by Age of Youngest Resident Child



Source: Shipley, S.M., *Women's Employment and Unemployment*, a research project, Massey University, Department of Sociology, and the Society for Research on Women in New Zealand, 1982

work (85%) (Jack et al, 1981). Amongst the unemployed handicapped, the rate of female unemployment (44.7%) was twice as high as for males (22.4%), and over 60% of unemployed handicapped persons had been out of work for more than a year.

Infogram 9:4

Involvement in Unpaid Household Duties, by Marital Status and Sex

Marital status	Male	Female
Never married	603	18,150
Married	1,377	302,391
Separated	627	17,442
Widowed	495	46,362
Divorced	234	9,414
Not specified	81	8,889
TOTAL	3,417	402,648

Source: *Census of Population and Dwellings*, 1981, Volume 4, Table 22, Department of Statistics

Entering or Returning to Paid Work

Each year a large number of people enter or return to the workforce after a period of absence. Many look forward to this change as an opportunity for wider experience and for financial independence. One group returning to the workforce is women whose children or dependants no longer require full-time care. It was seen earlier that women's participation rate in the full-time workforce declined over the age group 20-34 but afterwards increased again.

Many women find that their responsibilities as mothers and household managers restrict their work opportunities to positions which lack a career structure, pay low wage rates, with poor working conditions and no security of tenure (Shipley, 1982).

People seeking work without a continuous work record are at a disadvantage. The Labour Department has recognised the need to develop and update work skills for those who return after an extended absence, and has organised or supported courses to help meet this demand (Labour Department, 1984 — *Labour and Employment Gazette*, June, p.18). A Wellington survey found that while pre-training and retraining courses for women returning to the workforce provided attendees with a sense of confidence, the courses tended to be in occupational skills traditionally practised by women and lacked the flexibility to meet outside or domestic responsibilities (Society for Research on Women, 1982b). The family circumstances of solo mothers create special difficulties for them, and those who are beneficiaries may find abatement levels are a disincentive (Wylie, 1980).

Infogram 9:6

Sickness Benefits, 1983/84

(number ceased in March year)

Age at grant	Male	Female	Total
15-19	1,800	3,970	5,770
20-29	5,590	5,280	10,870
30-39	3,410	1,680	5,090
40-49	2,690	1,510	4,200
50-59	3,680	1,020	4,700
60+	360	60	420
TOTAL	17,530	13,520	31,050

Source: *Report of the Department of Social Welfare*, 1984, Department of Social Welfare

The disabled and rehabilitated people (including ex-psychiatric patients) who return to paid work, or attempt to, also experience difficulties. There have been a number of attempts to assist, including special courses held by the Departments of Labour and Social Welfare to promote and develop special skills in areas of potential employment. However, there is still a higher level of unemployment amongst the disabled than amongst the able-bodied population (Dowland et al, 1982).

People just released from prison are another disadvantaged group. Whilst in prison, they receive a small amount of money, but few have access to financial assistance on release apart from benefits paid by the Department of Social Welfare (Oxley, 1984). Hence a large number experience difficulty in providing themselves with basic requirements such as food and shelter, even before they begin to seek employment.

The return to paid employment is difficult for many unemployed persons and the longer

Infogram 9:5

Duration of Unemployment

Duration	October 1983 Number	October 1983 %	October 1984 Number	October 1984 %
4 weeks or less	16,648	22.6	14,378	24.7
5-8 weeks	13,420	18.2	10,794	18.6
9-13 weeks	10,508	14.2	8,864	15.2
14-26 weeks	17,991	24.4	14,739	25.3
More than 26 weeks	15,242	20.6	9,443	16.3
TOTAL	73,809	100	58,218	100

Source: *Labour and Employment Gazette*, March and December 1984, Department of Labour

they are unemployed, the more difficult it becomes (Labour Department, 1984 — *Labour and Employment Gazette*, December). A study of those unemployed for 26 weeks or more showed that the longer one is unemployed, the less likelihood there is of being able to find a job. The 1984 *Report of the Labour Department* stated that 116,740 people were placed in jobs by the department during the year. Not all would have been permanent placements. Job creation schemes managed by the Labour Department represent an attempt to help those in search of employment. They are designed to create jobs and provide training for specific unemployed groups. For instance, the project employment programmes are directed toward the long-term unemployed, but provide employment for six months only (Inf. 9:7).

Changes while in the Paid Workforce

Changes within and between jobs depend on individual ability and circumstances. For example, the employment pattern of women in the paid workforce has been shown to correspond to the requirements of care needed for dependants (Society for Research on Women, 1977). As demands upon their time decrease, such as when children move into secondary school and beyond, the number of paid work hours tend to increase. Promotion within the paid workforce is also influenced by external factors including levels of discrimination based on age, sex, marital status, ethnicity and other factors.

One specific example is in the banking industry where studies have shown a person's gender to be a factor in promotion. Comparing people with ten years' service, significantly more men (54%) than women (7%) had reached accountant status or above (Stechman, 1982; Neale, 1983).

This situation is further exemplified in Infogram 9:8 which sets out occupational groupings on the basis of sex and ethnicity. Females form a minority in professional occupations in the total population (43%), but a majority for Maoris (56%) and Pacific Island Polynesians (58%). In all three population groups, females were a minority of the administrative and managerial workers. They were, however, an overwhelming majority of clerical and related workers — positions of lower status.

Advances in technology have implications for the labour force as some jobs will dis-

Infogram 9:7

Public and Private Sector Job Creation Schemes

(a) Enrolments and Placements

	Year ended 31 March		1984		
	1982	1983	Males	Female	Total
Enrolments	295,632	356,439	242,329	156,400	398,729
Public sector job creation placements	49,870	45,347	34,986	16,922	51,908
Total placements	96,354	93,160	74,919	41,821	116,740

(b) Private Sector Job Creation Schemes

Programme	Number of persons placed during year ended 31 March 1984	Number of persons in subsidised employment at 31 March 1984
Additional Jobs Programme	7,311	6,111
Farm Employment Scheme	1,285	161
Private Sector Employment Incentive Scheme	24,970	10,811
TOTAL	33,566	17,083

(c) Public Sector Job Creation Schemes

Programme	Number of persons placed during year ended 31 March 1984	Number of persons in subsidised employment at 31 March 1984
Project Employment Programme (including PEP Student modification)	37,935	12,511
Work Skills Development Programme	11,536	7,298
Winter Employment Programme	516	–
Work Rehabilitation Programme	191	205
Voluntary Organisations Training Programme	1,730	1,244
Temporary Wage Worker Ceiling	–	195
TOTAL	51,908	21,453

Source: *Report of the Labour Department*, 1984, Labour Department

Infogram 9:8

Occupational Groups, by Sex and Ethnicity, 1981

	Total Population				Pacific Island Polynesian				Maori Population			
	Full-time		Part-time		Full-time		Part-time		Full-time		Part-time	
	M	F	M	F	M	F	M	F	M	F	M	F
Professional, technical and related workers	103,119	80,847	2,217	17,328	495	681	15	72	1,911	2,424	45	393
Administrative and managerial workers	42,273	3,720	303	378	87	21	–	–	336	57	3	3
Clerical and related workers	67,143	147,618	1,341	19,752	855	1,659	3	72	2,250	5,380	27	294
Sales workers	75,345	51,756	4,941	15,336	297	300	48	63	1,131	1,479	114	321
Service workers	50,307	56,322	3,204	27,525	948	2,643	93	558	3,468	6,738	111	2,160
Agricultural, animal husbandry, forestry workers, fishermen and hunters	116,091	30,204	2,304	5,916	453	117	9	9	9,348	2,484	126	246
Production and related workers, transport equipment operators and labourers	390,660	67,275	3,837	6,033	16,629	5,577	75	139	44,286	11,118	243	480
Total labour force	876,606	455,736	20,013	95,127	22,431	12,588	306	993	69,852	34,329	774	4,059

Source: *Census of Population and Dwellings*, 1981, Volume 4, Table 16, Volume 8A, Table 20, Volume 8B, Table 22, Department of Statistics

appear and others will be created, and some workers will need to be retrained to continue in their jobs (Vocational Training Council, 1979). One major area of impact will be on clerical workers as a result of the "chip" and microprocessor. Women constitute the majority of clerical workers and will be most affected by new technology (Shipley, 1982).

There are no figures to show how many workers are changing their hours of work, or moving, say, from shift work to normal time and vice versa. There was a large increase in part-time paid work between 1973 and 1983, especially for women. In many cases this represents a move into paid work from domestic work, but must be set within the context of a large increase in full-time involvement by women (Inf. 9:9).

Infogram 9:9

Trends in Full-time and Part-time Employment

	Full-time		Part-time	
	Male	Female	Male	Female
1973 (Oct)	554,873	258,020	33,062	84,927
1983 (Nov)	557,520	301,161	35,220	133,660
% change	0.5	16.7	6.5	57.4

Source: *Labour and Employment Gazette*, March 1984, p.2, Labour Department

Change while in Unpaid Work

This type of transition probably involves fewer people than other job changes (e.g. movements into and out of the paid workforce) but it is difficult to assess total numbers. Some of those involved are no longer required to give full-time care to dependants — children leave home, elderly parents die. Such a change produces an increased amount of time to pursue other interests, and to develop social, physical, cultural and intellectual talents. One possible outlet for spare time and energy is participation in voluntary services and organisations.

A major feature of non-statutory welfare organisations is their use of volunteers. In 1983/84, a total of 2,053 volunteers worked for non-statutory welfare agencies, including 1,491 females and 562 males who had worked a total of 5,425 hours per week (Darby et al, 1983). Voluntary work is undertaken for a wide range of organisations, such as the Prisoners' Aid and Rehabilitation Society (600 volunteers), care for the ill and handicapped, church and community groups.

A 1975 survey showed that 35% of women did voluntary work of between one and 30 or more hours per week (New Zealand Federation of University Women, 1976). The women volunteers were mostly aged over 50 (46%) — 43% assisted with dependants such

as the elderly and handicapped, 23% worked for children's organisations, 17% worked through churches, 12.5% did administrative work for clubs, and 1.5% supported community advice and service organisations.

Conclusion

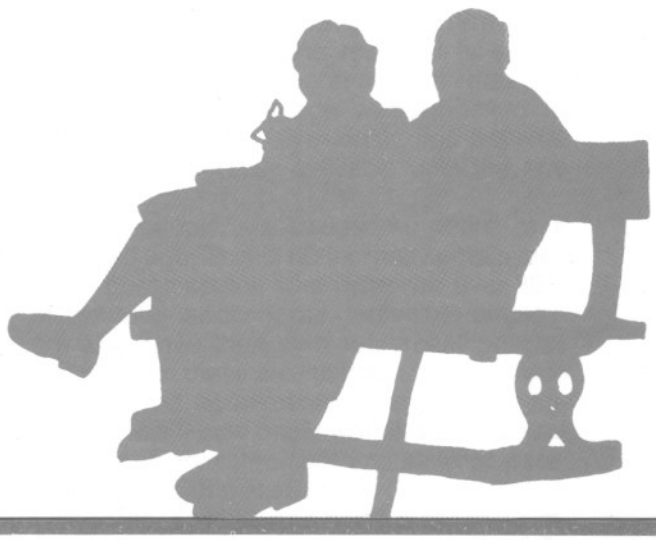
Clearly, a major job change as discussed in this chapter has affected or will affect, the majority of adults, whether they participate in the paid or unpaid workforce. It is apparent that women are more likely, as has traditionally been the case, to leave paid work and take on full-time childcare responsibilities. Women appear to be disadvantaged at nearly all stages of their working life compared with men, including when they enter the workforce, when they leave and later attempt to return, in their degree of responsibility in the home, and in their opportunities for advancement within an occupation. It is also apparent that the "real" level of female unemployment is disguised and that adjusted indicators are required to measure its true extent.

The burden of unemployment is disproportionately distributed through the community. Individuals at greater risk are those aged under 25, women, and Maori and Pacific Island Polynesian people. Access to particular occupations also appears to vary in relation to such characteristics. The measurement and effects of redundancy and unemployment are inadequately recorded, preventing a more "realistic" presentation of the situation. The initiation of a regular labour force survey in 1985 will go a long way to filling the gaps in data about access to various types of work and job change.

Retirement

"Will you still feed me, will you still need me, When I'm 64"

Lennon and McCartney



CHAPTER 10

Retirement

SOCIAL OBJECTIVES

The needs of people retiring from the paid workforce

STANDARD OF LIVING
SAFETY
PARTICIPATION AND OCCUPATION

Although it is easy to produce a definition of retirement which would emphasise voluntary, permanent withdrawal from the full-time paid labour force in old age, this is probably too simplistic a view and for many people the change will not be clear-cut. It is a change within an individual's working life (defining work in broad terms), as much as is leaving paid work to care for children or involuntary redundancy. Thus retirement could well have been included in the previous chapter on major job change. To see retirement in this context would be to remove the assumption that it is the end of economic and, (by implication, useful) life and the onset of old age and (by implication) senility.

Retirement for many may also be a process of withdrawal, rather than a clean break. Formal retirement may be preceded, or followed, by a period of part-time employment at the same workplace. Retired people may continue a part-time job with another employer, take up some form of self-employment or even begin a completely new career. The latter is frequently the case for groups such as armed services officers, pilots (and probably, in the future, police officers), for whom formal "retirement" is comparatively early. Retired people may return to paid work after a recreational break or take on voluntary work which may be quite demanding.

How and when retirement happens depends on a variety of factors, including conditions of work, mandatory retirement policies, the health and inclinations of the individual, family and financial circumstances and the existence or otherwise of attractive alternative forms of occupation.

Nevertheless, retirement remains a significant life event or life transition and one which produces special physical, social and psychological needs. It encompasses changes in personal life which go beyond those related to paid or unpaid work. The process of ageing affects personal and family life, health and physical abilities. As well as an adequate standard of living in the absence of income from paid work, people need some meaningful occupation to give purpose to their lives. They must find a means of continuing participation in social and community life once the status-defining work-role is no longer available. This special collection of needs is the rationale for treating retirement as a topic separate from other forms of job change.

Workforce Participation

Rates of participation in the paid workforce are approximately halved between the ages of 55-59 and 60-64, although this change is much more marked for men than for women (Inf. 10:1). However, rates begin to fall through the late forties and fifties age groups and continue through to the seventies. There are more non-Maori men and women in paid work in their sixties, but the position is reversed for Maori men in their seventies. The fall-off of participation in the older age groups is part of a long-standing trend, which has affected men particularly (Inf. 10:2). Over the 1971/1981 decade, the proportion of men aged 60-64 who were in paid work fell from two-thirds to under half, and for those 65-69 the fall was from one-third to under a fifth. The fall for women is much less marked and is related to their much lower participation rate overall.

There are several reasons for these changes. One is undoubtedly the tighter employment conditions which are encouraging earlier retirement. When labour is scarce, older workers may be encouraged to remain in their jobs and delay retirement, but the opposite is now more likely to be the case. The universal availability of national superannuation at age 60, since 1977, has also been a factor encouraging withdrawal from paid work. This is, however, paid (but taxable) whether or not the recipient is still in paid employment. Superannuation rates are 80% of the net average wage indexed to overall wage rates. Previously age benefits were not universally available until the age of 65.

Many people are obliged to retire at a specified age. This is 60 for many employees in the public sector, who comprise over 30% of the total labour force. Individual employers also have their own retirement policies and many of these are incorporated into trade union award agreements. There are no figures to show how many workers are subject to compulsory retirement and at what ages.

The occupational structure of the "elderly" workforce (aged 60 and over) is broadly similar to that of the total workforce (Inf. 10:3). Elderly men are, however, over-represented in primary industry, especially as farm managers and supervisors. They are also over-represented among the self-employed, illustrating the ability of this group to set their own retirement age and manage the transition to retirement. Elderly workers in general are found disproportionately in the "white

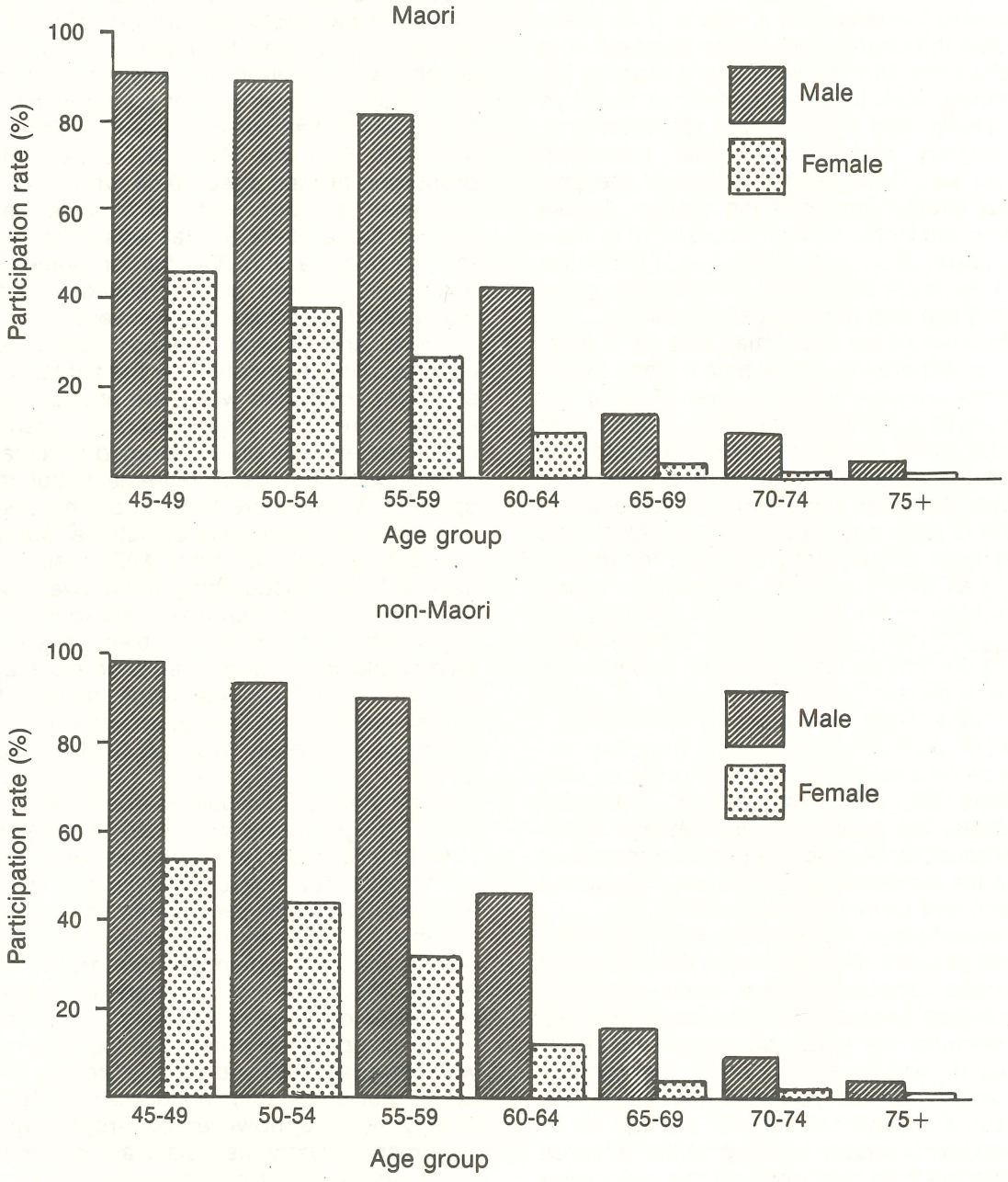
collar'' occupations but are under-represented as production and transport workers, and labourers (even though this is the largest group in numerical terms).

While they are 14% of the total population, persons aged 60 and over comprise only 4% of the full-time paid labour force, and 9% of the part-time workers group. Full-time paid work involvement for older men and women has been decreasing, but more are now working part-time, even though this is only 2-3% of the total population 60 years and over (Inf. 10:4). In recent years, the part-time labour force as a whole has been increasing. Whereas women comprise the larger proportion of part-time workers under 60, almost equal numbers of men and women work part-time among older people.

Three-quarters of men 60 and over, and 93% of women, are not in the paid workforce. For older women who have spent all or part of their adult lives working in the home in an unpaid capacity, retirement may never occur in the sense of withdrawal from

Infogram 10:1

Labour Force Participation Rates for Maoris and non-Maoris, by Age and Sex, 1981

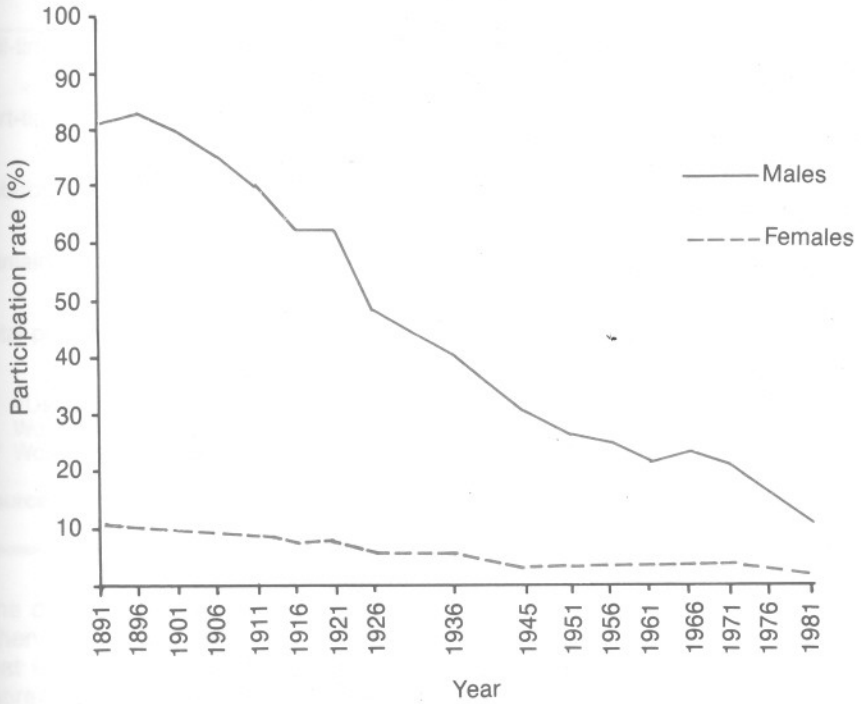


Note : Full-time labour force, employed 20 hours or more per week, includes persons unemployed and seeking work

Source: *Census of Population and Dwellings*, 1981, Volume 4, Table 22, and Volume 8A, Table 14, Department of Statistics

Infogram 10:2

Males and Females Aged 65 and Over Actively Engaged in the Labour Force, 1891-1981



Source: *Census of Population and Dwellings*, 1891-1981, Department of Statistics

work. Most women continue to carry out household duties until they die or are incapacitated. This means that they do not experience an increase in leisure time as their husbands do on their retirement. On the other hand, it may be an advantage to them to continue in activities to which they are accustomed, and in which they are skilled. Thus they may avoid the sense of loss, disorientation and a possible lowering of status and self-esteem experienced by men on withdrawal from their lifelong, paid occupations and workplaces.

Income

A drop in income, commonly experienced in the early part of old age, comes with retirement from paid work, rather than as a result of reaching a certain age.

All people, however, are entitled to receive national superannuation from the age of 60, provided they meet residence requirements. The number of recipients has risen from 371,697 in 1977 to 451,128 in 1984 (years ending March 31), an increase of just under 3% per annum. Over recent years, national superannuation has represented 40% of all welfare benefits and two-thirds of welfare benefit expenditure. The married rate of superannuation was $220.28 (gross) per week as at March 1985 (a higher rate than for other benefits even bearing in mind tax at standard rates), and the single rate $133.83 (gross). In the 1984 Budget, a surcharge of income tax was added where income exceeds $5,200 per annum for a married person and $6,240 for a single person. It has been estimated that this will have the effect of reducing national superannuation for 80,000 people and recouping the benefit entirely for another 20,000 (about 20% and 5% respectively of those 60 and over).

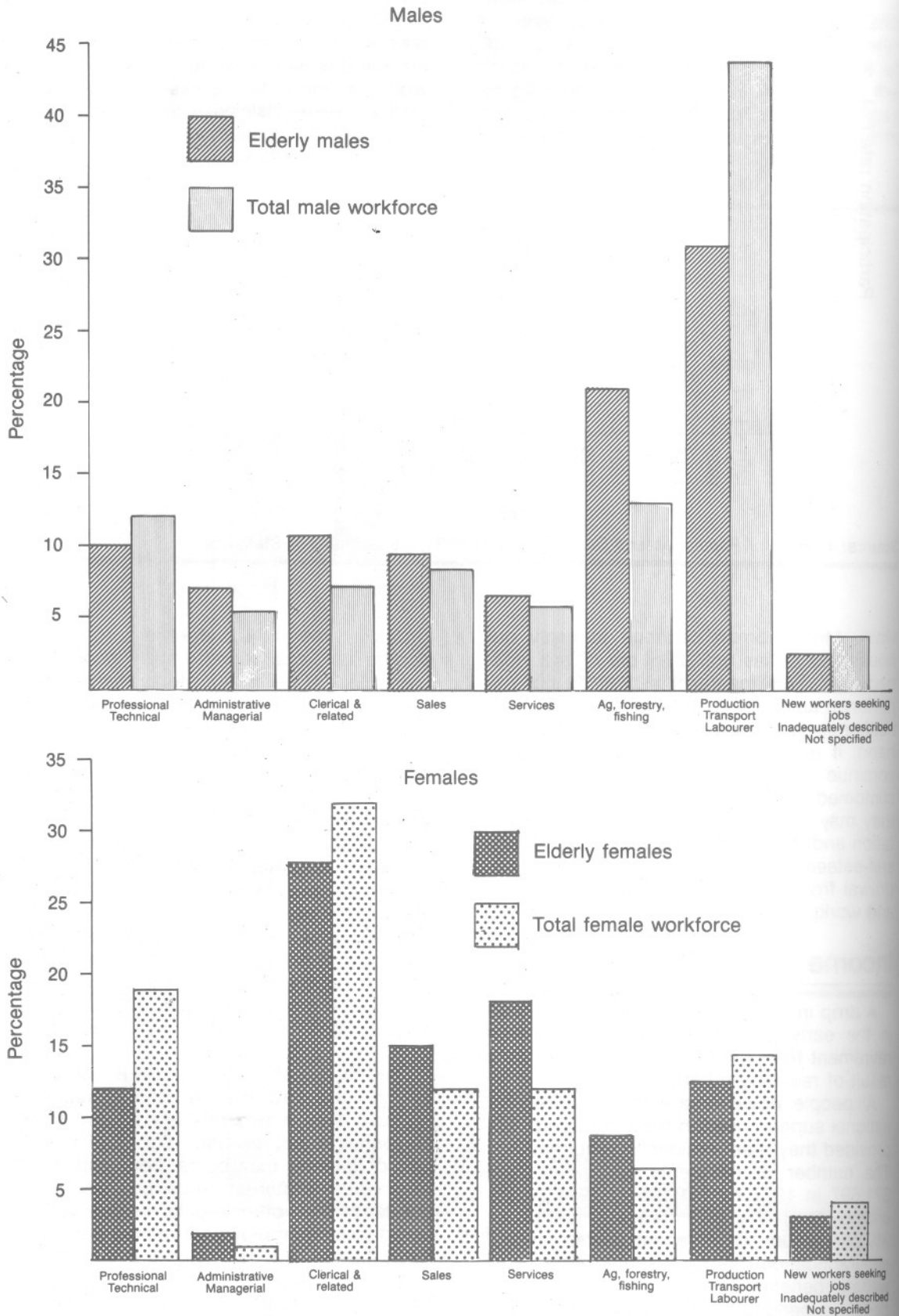
Nevertheless, national superannuation represents a comparatively generous rate of benefit payment, which has raised the income levels of many elderly people since its inception and reduced the level of relative and absolute poverty among the elderly. Even so, households of retired people have lower incomes on average than similar households where members are still in the paid workforce.

The income of retired people is not, however, wholly derived from national superannuation, even where this is declared to be the principle source (Inf. 10:6). Up to one-fifth of income may come from capital investments — interest, rents, etc., and up to one-tenth from other regular income, which would include employment-related pensions. Nevertheless, it is estimated that about one-third of retired people have no other significant income apart from national superannuation (Jones, 1984).

An appreciable amount of income in the 60-64 age group is derived from wages and salaries and from self-employment (Inf. 10:7).

Infogram 10:3

Full-time Workforce 60 Years and Over and Total Full-time Workforce, by Major Occupational Groups and Sex, 1981



Source: *Census of Population and Dwellings*, 1981. Regional Statistics Survey, Bulletin 11, National Summary, Table 17, Department of Statistics.

Infogram 10:4

Workforce 60 Years and Over, Full-time and Part-time, by Sex, 1976 and 1981

		1976		1981*	
		No.	%	No.	%
Full-time**	M	54,510	30.3	41,860	21.8
	F	13,636	6.0	11,810	4.8
Part-time***	M	4,608	2.6	5,480	2.9
	F	4,455	2.0	5,170	2.1
Sub-total (labour force)	M	59,118	32.9	47,340	24.7
	F	18,090	8.0	16,980	6.9
Remainder of age group	M	120,798	657.1	144,350	75.3
	F	208,728	92.0	229,190	93.1
Total population 60+	M	179,916	100.0	191,690	100.0
	F	226,819	100.0	246,170	100.0

* "Usually resident" population only
** Work 20 hours or more per week
*** Work less than 20 hours per week

Source: *Census of Population and Dwellings*, 1976, Volume 4, Bulletin 2, 1981 and Provisional Statistics Series Bulletin 2, Department of Statistics

The drop in income comes at 65 and over, when the pattern changes to one closer to that of retired heads of household. Clearly, retirement rather than age is the important factor.

To summarise, income levels of retired people are lower than those of people in similar households who still have paid employment, although the financial position of the retired has improved since the introduction of national superannuation. Although this benefit accounts for a sizeable proportion of retired people's income, it is not the only source for the majority. Retirement is a more important factor than age in explaining a fall in income, but 65 rather than 60 appears to be the age at which the change takes place.

Personal Safety

There has been concern recently for the personal safety of older people in relation to a rise in violent crime. Older people, especially women, live in small households, frequently alone. They go out less and do not have a workplace where they are able to mix with others. Information from the *Social Indicators Survey* collected in 1980-81, however, shows that they are less likely to be victims of crime than younger people (Inf. 10:8). Nevertheless, older people, and especially women, express considerable fear of walking alone by night (Inf. 10:9).

At the same time, confidence in the police increases with age. The percentage of *Social Indicators Survey* respondents who said they had a great deal of confidence in the police rose from 27 for those aged 15 to 24, to 54 for those 55 to 64, and 61 for the 65-and-over group (overall figure 43%) (Department of Statistics, 1985).

This appears to show that the fear of crime may be greater than the rate at which it is experienced and that well-publicised cases in which older people are the victims may receive more attention because of their emotional impact, but their incidence is actually lower than crimes against younger men and women.

Infogram 10:5

Household Income by Characteristics of Head of Household

Annual household income ($)	Age group of head 60-64 %	65+ %	Retired head %	Total household survey %
Under 10,000	29.5	47.5	46.9	19.9
10,000-19,999	32.3	36.4	39.2	30.7
20,000-24,999	11.2	6.2	5.5	14.0
25,000+	27.0	9.8	8.4	35.3
	100.0	100.0	100.0	100.0
No. of households surveyed	322	865	926	4,488

Source: Household Survey, 1982-83, Table 5, Department of Statistics

Infogram 10:6

Source of Household Income for Retired People

Source of income	Household type: One adult %	Two adults %	All households with national superannuation as principal source of income %
Wages & salary	–	–	1.8
Self-employment	–	–	0.6
National superannuation	70.0	66.4	78.8
Other govt. benefits	2.7	1.9	2.0
Interest, rent, dividends, royalties	18.7	21.7	10.4
Other regular income	8.7	9.9	6.3
	100.0	100.0	100.0
Average gross weekly household income ($)	149.77	256.14	184.74
No. of households surveyed	364	403	818

Source: Household Survey, 1982-83, Table 6, Department of Statistics

Infogram 10:7

Source of Income of Head of Household

Source of income	Age group of head: 60-64 %	65+ %	Retired head all age groups %
Wages & salary	34.1	6.4	1.2
Self-employment	7.6	5.0	1.1
National superannuation	37.0	59.8	59.3
Other benefits	2.5	1.8	2.5
Interest, rent, dividends, royalties	11.7	17.9	23.9
Other regular income	7.1	9.0	12.0
	100.0	100.0	100.0
Average weekly income ($) of head of household	256.83	166.18	159.24
No. of households surveyed	322	865	926

Source: Household Survey, 1982-3, Tables 5 and 7, Department of Statistics

Recreation and Leisure

An important aspect of the increase in discretionary time which comes with withdrawal from the paid labour force is increased opportunity for leisure and recreation. Although little information specifically related to the recreation of older people is available, general recreation studies frequently supply information by age. The *Auckland Isthmus Recreation Study* shows that home-based recreation becomes more important with age, especially for women, although it is high for all women (Inf. 10:10).

A very high proportion of men over 60 engage in sports, although this is lower than for young men. Participation by women falls off rapidly after 60. Interest group activity by the elderly is lower than in middle age, but higher than the rate for young adults (15-30 age group). Participation in cultural activities and "other" recreation also tends to fall with age. The fall in arts-related activities is quite marked, although higher for men than women in all age groups.

Infogram 10:8

Experience of Crime Against Person or Property, by Age and Sex

(% rate of victimisation)

Age group	Male %	Female %
15-24 years	20	15
25-34	14	12
35-44	14	8
45-54	16	8
55-64	7	6
65+	4	5
All age groups	14	10

Source: *Social Indicators Survey 1980-81*, Table 6.1, Department of Statistics, 1985

Six out of the ten most popular activities for people 60 and over in the Auckland study were home-based, with gardening the most

popular. Socialising was also popular with this age group — visiting and entertaining friends, playing cards, and family activities. The leading forms of active recreation were bowls and walking. This survey was concerned particularly with the need for recreational facilities. Provision of libraries and senior citizens' social rooms was the priority for this age group, although they also showed concern for recreation activities for young people, e.g. youth centres and adventure playgrounds.

A different viewpoint on recreation and leisure is provided by the *Social Indicators Survey* (Department of Statistics, 1985). This showed a greater interest in politics and more involvement with religious groups by people over 65. The importance of socialising is shown in that this group were more likely than others to talk to their neighbours. However, about one in five retired respondents said they had too much spare time, which may indicate a lack of adjustment to retirement, lack of personal resources to fill time satisfactorily, or a lack of recreational or social opportunities in the community.

Infogram 10:9

Fear of Walking Alone at Night, by Age and Sex

(% expressing fear of walking alone at night in their neighbourhood)

Age group	Male %	Female %
15-24 years	17	59
25-34	11	48
35-44	7	48
45-54	8	47
55-64	12	48
65+	18	55
All age groups	12	52

Source: *Social Indicators Survey 1980-81*, Table 6.2, Department of Statistics, 1985

Infogram 10:10

Involvement in Recreation of People Aged 60 and Over, by Sex

Type of recreation	% of group participating: Male	Female
Home-based	76	92
Cultural (hobbies, education, arts, religion & philosophy)	74	87
Interest groups	38	37
Sports	84	54
Other (include related, casual)	81	76

Source: *Auckland Isthmus Recreation Study 1982-83*, Auckland City Council

Infogram 10:11

Free Time Activities of People 60 Years and Over

Leading interests	% of group participating
Gardening	56
Television	53
Reading	49
Walking	27
Visiting friends	18
Knitting	17
Swimming	10
Card games	10
Indoor bowls	9
Lawn bowling	9

Source: *Auckland Isthmus Recreation Study 1982-83*, Auckland City Council

Other Use of Time

Little information is available on voluntary or community work involvement by the retired, although it is known to be considerable (e.g. workers for meals-on-wheels and similar support services). Similarly, there is not a great deal of data on educational activities by older people. At the 1981 census, 270 people 60 years and over were "still attending school" and a similar number were enrolled at university. Older people are estimated to constitute between 1% and 5% of enrolment in continuing education programmes. So in all these areas, retired people are under-represented, compared with the adult population as a whole (Battersby, 1982). This is despite the fact that access to educational institutions is easy for older people (for example, there are no entry requirements for university), and a wide variety of continuing education opportunities are available throughout the country. Battersby suggests this is related to attitudes — "too old to learn" — on the part of both the elderly themselves and educators, and also to the under-development of teaching methods appropriate to this age group. In fact, it is suggested that mental deterioration of the old may be hastened by lack of stimulation.

Housing

The vast majority of elderly people live in private accommodation in the community (Chapter 12). In most cases, accommodation standards are adequate although concern has been expressed for a minority, especially elderly people living alone and/or in private rental housing (Salmond, 1976).

Retirement can affect housing circumstances, through a drop in income. However, by the age of 60 or 65, most adults are not only home-owners, but have paid off their mortgages and so reduced their housing outgoings (Inf. 10:12).

Infogram 10:12

Weekly Expenditure on Housing, by Age Group of Head of Household

(as % of total net weekly expenditure)

	All households	60 & under 65	65+
Rent	3.6	1.8	2.5
Mortgage payments	5.8	1.8	0.6
Other housing costs	9.1	11.4	6.4
Total housing expenditure	18.5	15.0	9.5

Source: Household Survey 1982-83, Table 2, Department of Statistics

The Household Survey also showed that 63% of households with heads between 60 and 65, and 73% of those with heads 65 and over, owned their homes without mortgages, compared with 30% of all households. Over 60% of houses owned freehold had household heads aged 60 or over.

Conclusion

With increasing life expectancy, the average person can look forward to another 17 years of life if they retire from paid work at 60 — more if they are white and female, less if they are Maori (Inf. 10:13).

Infogram 10:13

Life Expectancy at Age 60

	Expected years remaining	
Year	Male	Female
1901-05	15.40	16.64
1921-22	16.03	17.29
1950-52	16.19	18.53
1960-62	16.00	19.27
1970-72	15.74	19.78
1983	16.95	21.27

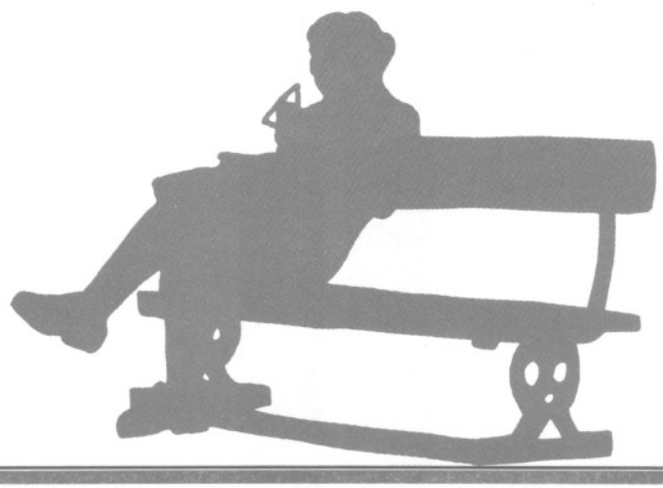
Source: *New Zealand Abridged Life Tables*, (prior to 1955, tables refer to non-Maoris only), Department of Statistics

The process of retirement entails a great deal of change, not all of which can be documented in statistical terms. This section has noted a drop in income, narrowing of the social sphere, and increasing discretionary time. A change, and frequently a decline, in social status is less easy to define. A more positive and constructive approach to ageing would mean that the years of retirement could be used to better effect both for the individuals concerned and society as a whole (Social Advisory Council, 1984).

Loss of Spouse

"Till death us do part"

1662 Book of Common Prayer



CHAPTER 11

Loss of Spouse

SOCIAL OBJECTIVES

The needs of a person when their spouse dies

STANDARD OF LIVING
SECURITY
CARE AND SUPPORT IN CRISIS

The impact on the individual of the death of a spouse may be compared to some extent with that of marital break-up. The event gives rise to both long-term and short-term needs. These needs may be practical or less tangible. Both types of crisis require readjustment and change from life in an intimate partnership to life alone. Both create one-parent households. The differences between break-up and widowhood are, however, very important in social terms, as this chapter will show. They arise mainly from the age at which the event occurs and hence the stage in the family life-cycle, and the material circumstances of those involved (a widowed spouse is likely to inherit property and have his or her assets increased; a divorced spouse will have to share matrimonial property and probably lower his or her standard of living). The social status of the widowed has traditionally been higher than that of the divorced and separated, and they have been treated more generously by public and private welfare policies. This distinction is perhaps now less likely to be made, as a greater number of adults are spending periods of their lives as single people, after having experienced a marital relationship.

Characteristics of the Widowed

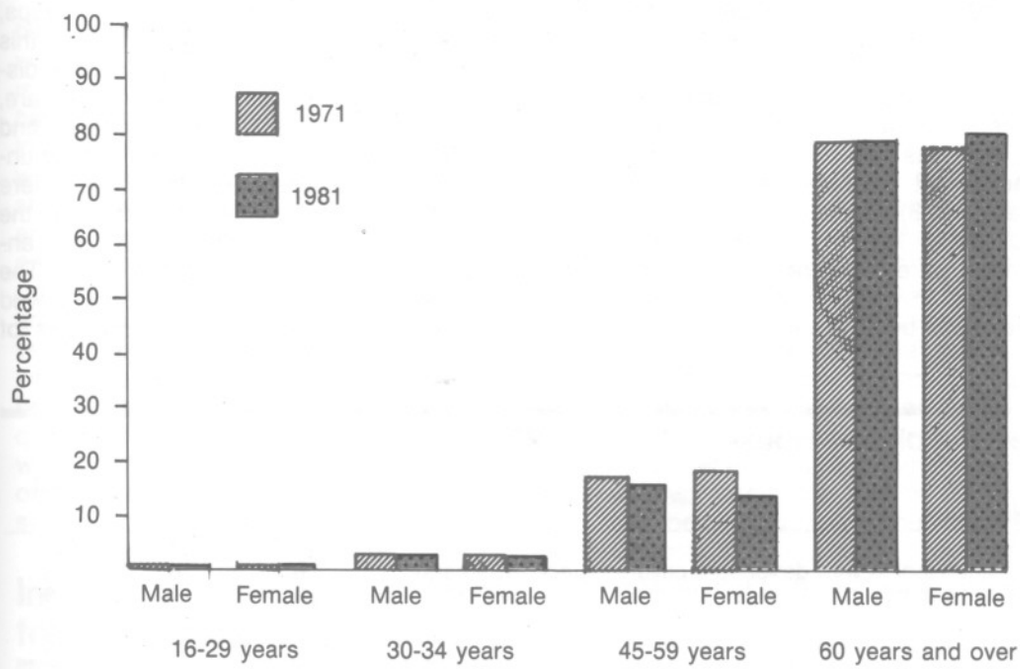
For most people, losing a spouse through death (as opposed to marital breakdown) happens at an older age, but this is not necessarily always the case.

There has been very little change in the age structure of the widowed group from 1971 to 1981, and little difference between the sexes (Inf. 11:1). Overall, the widowed have comprised about 7% of the adult population at each census over the last 30 years. Numerical change in the widowed group has been close to that of the adult population, a little behind the 1971/76 growth rate (8.8% as against total 12.2%), but a little ahead in the latest intercensal period (9.7% as against 5.9%), probably reflecting the overall ageing of the population. Four out of every five widowed people are aged 60 or over, so that almost one in three people in this age group are widowed. In the age groups under 45, fewer than one person in a hundred has experienced the death of a spouse.

There are very obvious differences between men and women as proportions of the

Infogram 11:1

Widowed Men and Women, by Age, 1971 and 1981



Source: *Census of Population and Dwellings*, 1981, Volume 2, Table 13, Department of Statistics

widowed group. For every widower, there are four widows and this imbalance in the ratio is increasing (1971, 1:3.9; 1981, 1:4.2). While 3% of adult men are widowers, over 10% of adult women are widows. This reflects both the longer life expectancy of women, and their tendency to marry men older than themselves. There are lower proportions of widowed people in the main minority ethnic groups — 2.3% of maori males and 6.6% of Maori females are widowed; 1.3% of Pacific Island Polynesian males and 4.3% of females are widowed. This is related to the age structure of these populations.

Just over half of the widowed live in one person households (Inf. 11:2). One-person households of widows and widowers account for 44% of all one-person households and 59% of female one-person households, but only 20% of male one-person households. This is because of the high incidence of separated and divorced men among one-person households, especially those where the occupier is under 50.

Infogram 11:2

Widowed People Living Alone

(% of widowed people who live in one-person households)

Age group	Male %	Female %
Under 45	11	7
45-59	32	35
60+	55	58
Total	49	50

Source: *Census of Population and Dwellings*, 1981, Volume 10, Table 23, Department of Statistics

A typical widowed person is therefore over 45, four times more likely to be a woman than a man, and has a 50% chance of living alone.

However, loss of a spouse may also result in solo parenthood for the survivor. In earlier decades, this was the predominant way in which one-parent households came about (Carmichael, 1983). Carmichael shows that in the mid-1890s, 18% to 19% of non-Maori children lost a parent before they turned 16. This had fallen to 14% by about 1910, and to 11% to 12% by the mid-1930s. It was probably at least as common for children to have a parent die (or alternatively to be made a solo parent through loss of a spouse) in the late 19th and early 20th century, as it is now for legally married parents to separate. The incidence of remarriage (and informal unions) is, and probably was, lower among widowed solo parents than those separated and divorced, so that they were likely to experience a longer period of living alone. This is related to the age of widowhood and probably to the fact that widowed parents tend to have fewer dependent, generally older, children, than other solo parents (Inf. 11:3).

At the time of the 1981 census, 31% of one-parent households had a widowed head, about the same proportion for male and female solo parents. However the majority of widowed one-parent households had no dependent children, and very few had dependent children under 15 years old (Inf. 11:3). This is in contrast to one-parent households headed by separated, divorced or unmarried people, which very frequently include dependent children (see Chapter 8). There were 8,823 households headed by widowed people with dependent children — 1,815 headed by men and 7,008 by women. 1,590 households were headed by widowed people with children under 5 years, 309 headed by men and 1,281 by women. But, although only 20% of widowed solo parents with dependent children were men, there were more widowers caring for children on their own than fathers who were previously either unmarried or married.

Income and Housing

Because of the strong concentration of widowed people in the older age groups, income and housing characteristics for this group are very similar to the retired, discussed in the previous chapter. There are, however, differences between widows and widowers, and between widowed people under and over the age of 60 (Inf. 11:4). There is a higher concentration of women in the lower income group (under $10,000 per annum), in the age group 60 and over. The strongest contrasts by sex are for widowed people under 50. Almost three-quarters of

Infogram 11:3

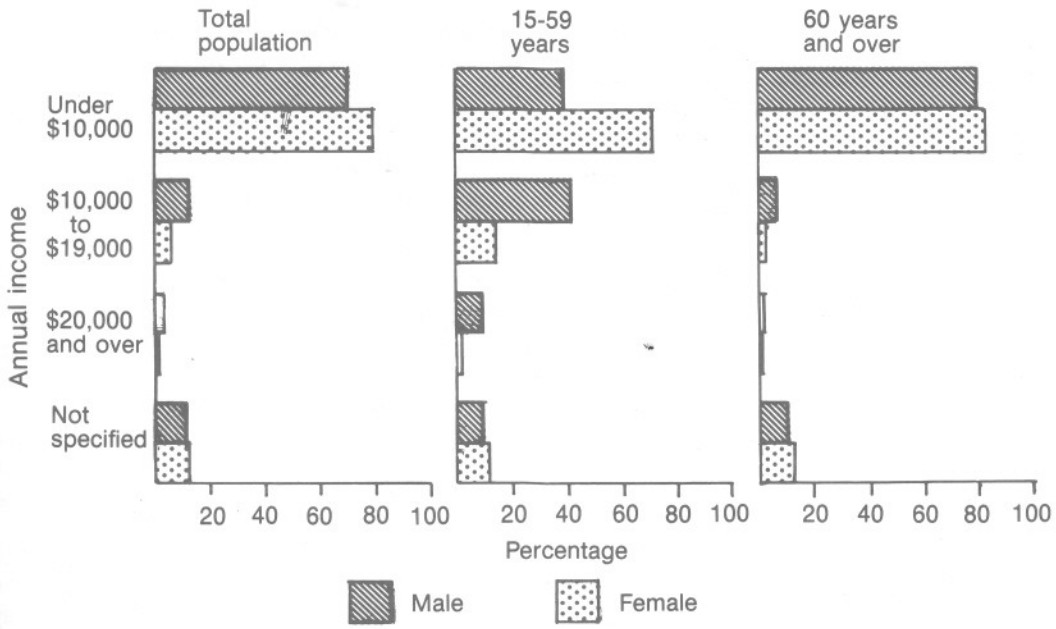
Widowed People, by Household Type, 1981

Household type	Male %	Female %	Total %
Living alone	49	53	52
One-parent households with dependent children (under 15 years)	6	6	6
One-parent households no dependent children	9	10	10
Other	36	31	32
	100	100	100

Source: *Census of Population and Dwellings*, 1981, Volume 10, Table 23, Department of Statistics

Infogram 11:4

Incomes of Widowed People



Source: *Census of Population and Dwellings*, 1981, Volume 5, Table 12, Department of Statistics

younger widows are in the lowest income group (corresponding to 72% for separated women and 69% for divorced women — see Chapter 8), compared with 38% of widowers. Less than 2% of younger widows are in the high income category ($20,000 or more per annum), and almost 10% of widowers. (Comparisons for married people are 9% of married men and 5% of women in this income group.) Younger widows thus have many of the income characteristics, and hence the income difficulties, of separated and divorced mothers, especially those with the care of dependent children.

One area in which widowed people may be at an advantage compared with those who have lost a spouse through separation, is housing. Many widows and widowers inherit sole ownership of the family home, and in many cases, a mortgage-linked insurance will be of assistance in achieving freehold status. Hence rates of home-ownership among the widowed are high. This is not only a function of age (Inf. 8:10). More serious may be problems of home maintenance and repairs, which can be a burden for women left without male assistance, and which can be costly when paid help has to be sought. Such problems come up frequently in discussions of assistance to the widowed (New Zealand Widows and Widowers Association, 1982; Society for Research on Women, 1975).

Income Maintenance Policies for the Widowed

Although the widowed have for centuries been recognised as a group in need of support by society, in recent decades they have progressively become a smaller proportion of those entitled to receive social welfare assistance (New Zealand Widows and Widowers Association, 1982). This is because the welfare state has extended its support to more groups. The widows' benefit accounted for 7.5% of total benefits in 1940, 1.7% in 1980, and 1.3% in 1984.

Widows' benefits are payable to all widows with a dependent child or children, subject to an income test, on the same rates and conditions as other benefits — that is, the same as the domestic purposes benefit. Widows 60 and over receive national superannuation instead of the widows' benefit. The benefit can be paid to widows without dependent children usually only if they are 50 or over and unlikely to earn a living. As at 31 March 1984, there were 13,921 widows' benefits in force, two-thirds payable to widowed people without dependent children (Department of Social Welfare, 1984). 90% of beneficiaries without children, and 73% of all beneficiaries, were aged 50 and over. The 4,584 widowed beneficaries with children were concentrated in the age group 40-49, and had 7,604 children among them.

Comparing the 1981 census figures with Department of Social Welfare data for widows' benefits, it is estimated that 59% of widows under the age of 60 are receiving this benefit (compare this to DPB take-up, Chapter 8).

Most of the recipients of widows' benefits are in their late forties and fifties, and many women in this situation find it difficult to enter the paid workforce if they do not already have such employment (Inf. 11:5). Thus they require long-term social welfare assistance

— probably more so than domestic purpose beneficiaries who tend to be younger and are also more likely to marry or enter new marital relationships.

Infogram 11:5

Widows and Widows' Benefit Recipients, by Age

Age in years	Widows %	Widows' benefit recipients %
Under 25	0.6	0.4
25-29	0.7	1.2
30-34	1.0	2.5
35-39	1.6	4.5
40-44	2.5	7.6
45-49	4.6	10.9
50-54	7.6	22.2
55-59	11.5	39.5
60+	70.0	11.2
TOTAL	100.0	100.0

Source: *Census of Population and Dwellings*, 1981, Volume 2, Table 14, Department of Statistics, and *Report of the Department of Social Welfare*, 1982, Department of Social Welfare

The Widows and Widowers Association has been active in pointing out to government the implications of this long-term need, and also of the abatement levels for widows' benefit. These levels, it is maintained, are a disincentive to those who wish to support themselves, perhaps through part-time work, and results in under-use of personal resources by a group of mature people. Where there is a disincentive effect, widows may not take up interests and activities outside the home which would help them to adjust and serve as an aid to mental health.

Widowers with dependent children face special problems. They are entitled to the DPB if they care for their children full-time, but few do so — roughly 400 out of 1,815 men in this situation at the time of the 1981 census (less than one in every four). Widowers are, however, as has been pointed out, more likely to have higher incomes than widows at the age when they are caring for dependent children and so are in a better position to afford paid childcare.

There have also been moves to improve the tax situation of widowed people who may not only find that they have to meet continuing expenses for a family home and standard of living on a much reduced income, but also face additional expenses for home maintenance, childcare and house-keeping.

Conclusion — Support for the Widowed

Widowhood at any age, and whether it occurs suddenly or is anticipated by ill-health, is likely to be a stressful experience, and one which entails a threat to mental health and stability. The initial challenge is to deal with the grief of bereavement and it is now accepted that it is healthier for people not to stifle or hide their feelings at this stage. The period of readjustment which follows may require people to make a considerable effort to rejoin society and find their way as single people. Advice is offered by supportive organisations to become involved with the community, to become independent and to look to the future:

"To realise that life goes on even without a partner; to pull up one's socks as soon as is possible and above all not to mope and dwell forever in the past" (Quoted by Schlesinger, 1980).

Without support from friends, family and voluntary organisations, however, widowed people may be prone to depression and loneliness. Loneliness, lack of social life, and home maintenance problems were the most frequently quoted areas of difficulty in a 1979 survey of widowed people in Auckland (Schlesinger, 1980). More understanding and tolerance on the part of society is needed, but self-help also offers scope to alleviate many of these problems.

Loss of Autonomy

"My diseases are an asthma and a dropsy, and, what is less curable, seventy-five"

Samuel Johnson

CHAPTER 12

Loss of Autonomy

SOCIAL OBJECTIVES

The needs of people who lose their physical and mental capabilities

SELF-DETERMINATION
HEALTH CARE
CARE IN DEPENDENCY

The helplessness of a child and its utter dependence on adults for its survival and nurture is often seen as an appealing characteristic, but the stage of heavy dependence does not last long; the child progressively develops physical and mental capabilities which make it more autonomous. However, the deterioration of the same capabilities in adult life, and especially in old age, may be a retrogressive development, which offers little prospect of improvement. Few would see as many positive features in caring for an 80-year old who is incontinent, incapable of dressing and feeding and liable to put him or herself in all types of dangerous situations, as in caring for a one-year old with the same limitations. Yet people who have lost some or all of their capabilities are still entitled to care, on an equal basis, and still have a right to dignity. While they are able to exercise autonomy and make reasoned choices, then this must be allowed to them to the greatest extent possible. It is accepted that the state should support dependent and handicapped adults by policies of income maintenance and service provision. This responsibility must not be eroded. Needs in this area should extend beyond the direct and material and include an understanding of the feelings of dependent people. More indirectly, the physical and psychological needs of those who care for people who are losing their capabilities must not be overlooked, especially those doing this caring on a voluntary basis.

Levels of Disability and Ill-health

Although it is incorrect and damaging to assume that all elderly and retired people will lose their physical and mental powers, it is nevertheless a fact that handicap and disability is more prevalent in old age than in other age groups. The *Social Indicators Survey* showed that 44% of respondents aged 65 and over reported some functional disability (as opposed to 13% of the total sample). This disability was mainly in connection with walking, going up and down stairs and carrying heavy objects. This, however, is self-reported disability. A more clinical measure was contained in a Department of Health survey, the results of which are summarised in Infogram 12:1 (Salmond, 1976).

Infogram 12:1

Disability Among the Elderly

(% of respondents in age group experiencing disability)

(a) Incidence of Disability

Disability	65+	75+
Mobility — needs aid	11	21
— impaired	3	5
Vision — fair	9	16
— poor	2	6
Hearing — fair	13	24
— poor	1	2
Mental capacity — forgetful	6	10
— disturbed	3	6

(b) Classification

Disability Level	65+	75+	80+
Slightly disabled	11	20	25
Seriously disabled	2	5	7
Mentally disabled	1	3	4
Severely disabled	3	6	9

Source: Salmond, G.C., *Accommodation and Service Needs of the Elderly*, Management Services and Research Unit, Department of Health, 1976

This survey showed lower levels of disability. Four out of five people aged 65 and over were not disabled; two-thirds of those 75 and over were not, and even in the group 80 and over, more than half were not disabled. Similar disability levels were found among older people in a Wellington region study (Inf. 12:2).

Infogram 12:2

Disability Levels: Wellington Region

	Age group (years)	
Disability level	65-74 %	75+ %
Sensory impairment	2.7	4.2
Other impairment	10.1	15.2
Sensory handicap	7.5	20.1
Appreciable handicap	6.2	11.9
Severe handicap	2.7	8.7
Very severe handicap	0.9	4.4

Source: Jack, A. et al, *Physical Disability: Results of a Survey in the Wellington Hospital Board Area*, Management Services and Research Unit, Department of Health, 1981

Because of longer life expectancy, there are greater numbers of elderly disabled women than elderly disabled men, and they

Infogram 12:3

Public Hospital Admissions and Hospital Stays in 50 Disease Groups for Patients Aged 65 to 74, 1983

Disease group	% total admissions	Mean No. of days' stay per admission
Cancer, malignant disease	15.2	14.1
Heart disease including rheumatic fever	14.8	14.4
Nervous system diseases including diseases of ears and eyes	7.5	17.8
Musculoskeletal diseases (arthritis, rheumatism)	6.6	18.5
Respiratory diseases	7.6	13.8
Digestive system diseases	9.8	9.9
Genito-urinary system diseases	6.3	8.5
Accidents	7.2	18.1
Cerebrovascular disease (stroke)	5.4	67.0
	80.4	All causes 17.9

Source: *Hospital & Selected Morbidity Data 1983*, Table 9, Department of Health, 1984

handicaps such as deafness, while women more frequently experience conditions affecting mobility, such as arthritis (Jack, 1982). Social services tend to be geared more to the care, support and rehabilitation of men. For example, very little assistance is provided with heavy outdoor tasks which men usually perform, but more is available for housework and the provision of food.

A high proportion of elderly people are taking regular medication for chronic conditions. In a study of self-medication in Wellington, 56% of the men and 78% of the women 65 and over had taken medication in the 24 hours before being interviewed (Urban Research Associates, 1978). Most of these were prescribed remedies and most of the respondents took more than one type of medication. Preparations acting on the cardiovascular system and diuretics (for hypertension, angina etc.) were the most common type of medication taken, followed by tranquillisers and hypnotics (for stress, sleeplessness). Third in importance were analgesics, mainly for pain and rheumatism. Nevertheless, well over half the people in the older age groups in this and other surveys suggest that their health is good — reduces or eliminates painful symptoms.

Hospital admissions for the 65-74 age group are, to a very great extent, for degenerative conditions (Inf. 12:3). A high percentage of patient days are for disabling diseases such as stroke, diseases of the nervous system including Parkinson's disease, and musculoskeletal diseases. Mental disorder accounts for 22% of patient days, but this is a less important reason for hospital treatment than in the younger adult age groups.

The major causes of hospital admission for those 75 and over are broadly similar, as are the diseases which account for the highest percentages of patient days (Inf. 12:4). A high proportion of patient days, however, are accounted for by "symptoms, ill-defined conditions" — 15% — which could be associated with old age.

A very striking contrast between Infograms 12:3 and 12:4 is the much longer length of stay for all conditions in the older age group. In fact, the average number of patient days per admission increases steadily over the age groups from childhood onwards. Thus spells of hospital attendance in

Infogram 12:4

Public Hospital Admissions and Hospital Stays in 50 Disease Groups for Patients Aged 75 and Over, 1983

Disease group	% of total admissions	Mean No. of days' stay per admission
Cancer, malignant disease	11.3	20.7
Heart disease	13.2	22.6
Nervous system diseases	6.0	44.2
Musculoskeletal disease	5.2	48.2
Respiratory diseases	7.6	31.1
Digestive system diseases	8.9	13.1
Accidents	11.2	20.6
Cerebrovascular disease (stroke)	7.5	100.0
	70.9	All causes 36.1

Source: *Hospital & Selected Morbidity Data 1983*, Table 9, Department of Health, 1984

old age are likely to be comparatively long, and more disruptive of normal life.

Housing and Care

Although it is the expressed preference of most old people that they should retain self-care and independent living for as long as possible, for many there comes a time when, because of frailty, disability, or illness, they must move to special housing or live with family or friends. Pensioner housing, which is adapted to the needs of the aged but may not incorporate any other special services, is provided by local authorities, religious and welfare organisations. As at 31 March 1982, 12,746 pensioner flats were available, providing 14,695 places (about a quarter are double units) — 4.6 places for every hundred people over 65 years (Barker et al, 1982). Of these, 78% were provided by local authorities. Up to 1983, however, there was a decrease in numbers of flats completed per year, despite growth in the elderly population, but 1984 figures reversed this trend (Inf. 12:5). The earlier fall could have been due to the asset limit on pensioner tenants, the availability of flats of this type elsewhere, or the general decrease in building activity.

The elderly living in pensioner flats were found to be generally the older group, and one-third had significant disability (Salmond, 1976). The more severely disabled were living with their spouses, also likely to be elderly. There are other schemes for providing housing specifically for the elderly, e.g. "*kaumatua*" housing and relocatable granny flats, but, like pensioner housing, these assume a fair degree of independence.

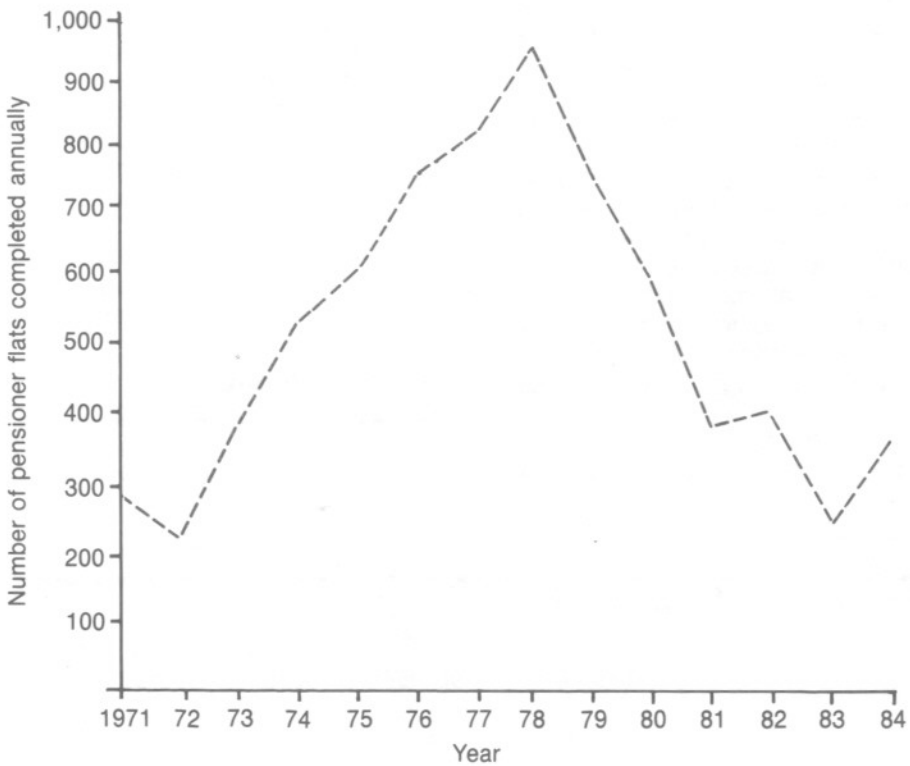
The continuum towards rest homes and geriatric hospitals includes semi-independent or "sheltered" housing, which may be sited alongside homes or hospitals. Some local bodies and welfare organisations employ social workers to assist elderly tenants, but the "warden" system, common in Britain, has not been developed here.[8]

Contrary to what is widely thought to be the case, only about 3% of the population 65 and over live in old people's homes because they are unable to care for themselves or receive care in their own homes (11,687 beds as at 31 March 1981). Of the 426 homes, averaging just under 30 beds each, 63% were run by religious and welfare organisations, 29% were private (profit-making), and 8% were operated by hospital boards. The number of people using residential home beds has been increasing annually. However, the current level of provision — 36.8 beds per 1,000 people aged 65 and over — exceeds the Department of Health guideline of 30 per 1,000. These beds are,

8. Under this system, blocks of housing for elderly people have a residential warden to "keep an eye on" and assist residents.

Infogram 12:5

Pensioner Flats Completed Annually, 1971-1984



Source: *Reports of the Housing Corporation of New Zealand*, 1972–1984, Housing Corporation of New Zealand

however, unevenly distributed through the country. Concern has been expressed over the standards of care in some rest homes in the private sector and over the ability of the Department of Health to enforce such standards. Conditions obviously vary from home to home and throughout the country, but there appears to be scope for better control in this area, especially with respect to mentally disturbed residents.

Infogram 12:6

Age, Sex and Ethnicity of People Over 70, and Over 80

(mean population for year ending December 1982, estimated age distribution)

(a) People aged 70 and Over

	Male	Female	Total
Maori	1,740	1,860	3,600
Non-Maori	80,200	121,700	201,900
TOTAL	81,940	123,560	205,500

(b) People aged 80 and Over

	Male	Female	Total
Maori	280	370	650
Non-Maori	17,690	37,590	55,280
TOTAL	17,970	37,960	55,930

Source: *Mortality and Demographic Data 1982*, Table 1, p.21, Department of Health

The characteristics of residential home residents are fairly uniform — nearly two-thirds are over 80, 70% are women, and most are either widowed or single. There is, however, variation in their functional capacity (Salmond et al, 1981). About one-third were not disabled and one-third only slightly disabled. These tended to lack family support and a strong social network, which may account for their placement. Bereavement and family pressure were among the factors which led people to enter a home. It would appear, therefore, that many elderly people are "misplaced" in residential homes and may be losing their autonomy for social reasons, rather than because of their physical or mental state.

Although it is likely that some form of institutional care will continue to be needed in some cases, older people who are not severely disabled or disoriented should be given the opportunity to remain in the community, cared for by family, friends or paid helpers, professional or lay. There is discussion at present as to how this can be achieved without excessive strain on carers (Social Advisory Council, 1984). "Meals-on-wheels" is an example of a service which helps elderly people remain independent by delivering one hot meal a day, using volunteer drivers. Fewer than one in five elderly people live with people other than their spouse, but it is not known how many frail and dependent old people are being cared for in the homes of their children and other relatives (Koopman-Boyden, 1978). The stress on these relatives is a matter of great concern. A Christchurch study found high levels of stress amongst carers of the elderly, with the most commonly reported causes being "worry about the old person" and "decreased leisure and social time for the carer". There was also some evidence of possible financial stress in that almost 20% of the carers had given up paid work to care for the dependent person (Bellamy et al, 1982). It is likely that support services in the future will need to take account of the needs of the carer as well as the needs of the elderly person. The Auckland Attendant Care Scheme is a programme which offers support for carers of the disabled.

Considerable progress has been made in recent years in geriatric medicine, in the training of geriatric specialists and in the assessment of geriatric cases. There are currently just over 18 long-stay beds for every 1,000 people over 65 in hospitals, which is about the guideline level set by the Department of Health, even though the beds are not evenly distributed. Religious, welfare organisations and private hospitals supply an increasing proportion of long-term beds (36% in 1978, 52% in 1981) under special subsidy schemes. Overall, 2.5% of elderly people 65 and over live in public or private hospitals, and 0.9% in mental hospitals, (a total of 6.2% in institutional accommodation).

Mental Health

Elderly people with long-term mental disorders are generally cared for in psycho-

Infogram 12:7

Inter-censal Change of Age Groups

	% change				
Age group	1956-61	1961-66	1966-71	1971-76	1976-81
60+	7.4	9.3	11.1	13.6	9.6
80+	26.4	14.1	7.1	5.9	14.4
Total population	11.1	10.8	6.9	9.3	1.5

Source: *Census of Population and Dwellings*, 1981, Volume 2, Table 1, Department of Statistics

geriatric units attached to psychiatric hospitals. There are about five psycho-geriatric beds per 1,000 elderly.

As the population ages, it is expected that the number of sufferers from Alzheimer's disease and other types of dementia will increase rapidly. There are estimated to be about 19,000 New Zealanders suffering from Alzheimer's disease, and this figure is projected to grow to 26,000 by 1991 and 33,000 by 2001. About one in ten people aged over 65, and two to three in ten people over 80, are likely to develop Alzheimer's or a related disease. The progress of the disease is slow and there is no known cure. Early symptoms are difficult to diagnose and may progress through confusion and disorientation to total dependence and loss of personality (Mental Health Foundation of New Zealand, August 1984). Services to support patients and their families are, however, reported to be inadequate (Mental Health Foundation of New Zealand, November 1984). Measures required include education for general practitioners, psycho-geriatric day centres, home help services, support groups for carers and more innovative housing schemes for the elderly generally.

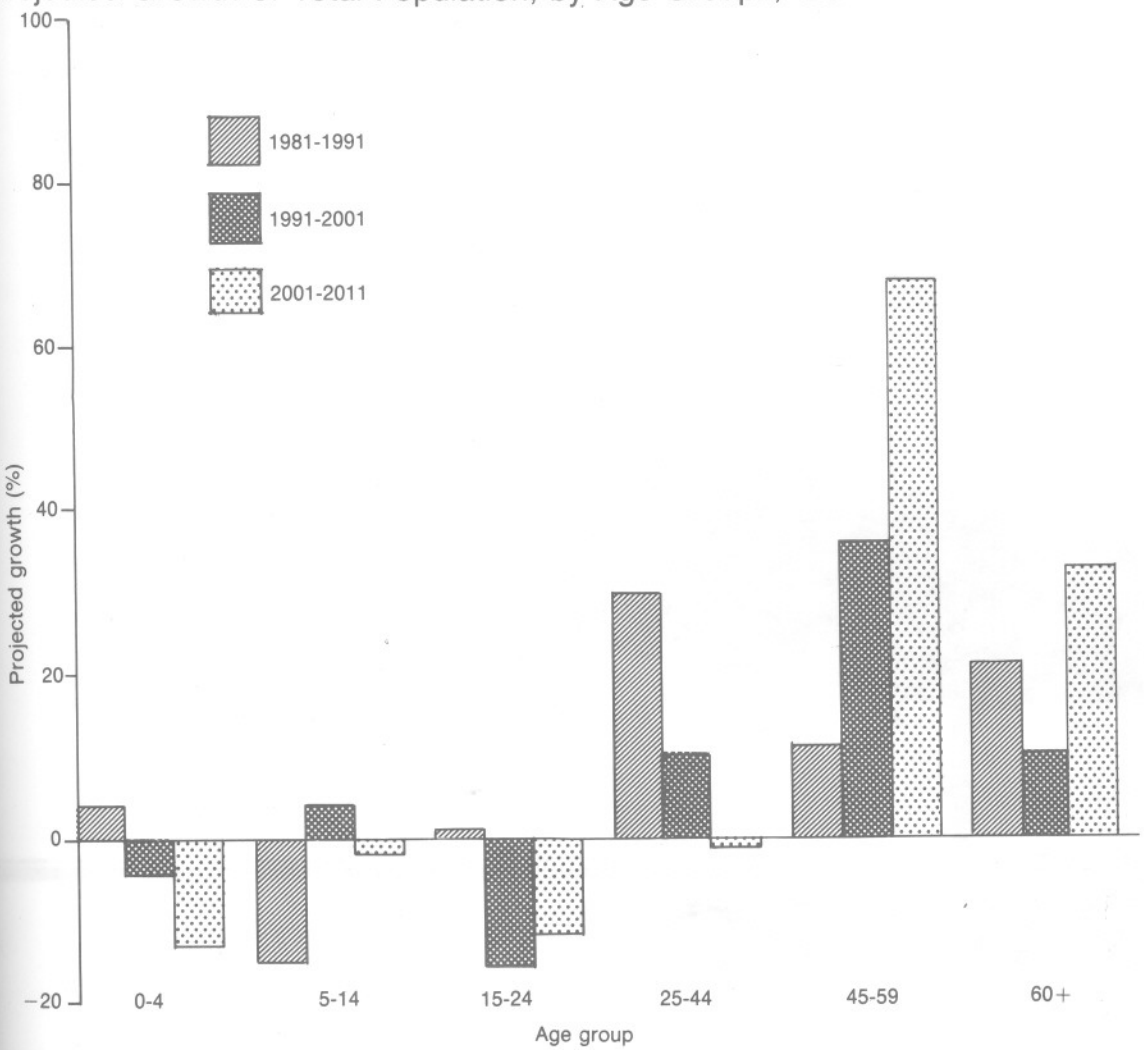
Increase in Numbers of Very Old People in the Population

Conditions likely to cause dependency and loss of autonomy have been shown to increase and intensify with age. It is thus important to know more about the numbers and characteristics of the very old. Infogram 12:6 shows the age and ethnicity of people over 70 and over 80.

Women predominate in these age groups because of their longer life expectancy, accounting for 60% of people 70 and over and 68% of those 80 and over. Their predominance is less marked in the Maori population (52% of those 70 and over, 57% of those 80 and over). Maoris are a very small proportion of the very old and account for fewer than two in every 100 people 70 or over (compared with 9% of the total population). The very old group is therefore comprised mainly

Infogram 12:8

Projected Growth of Total Population, by Age Groups, 1981-2011



Source: *Census of Population and Dwellings*, 1981, Projections of the Total New Zealand Population 1983-2016 (Base: 31 March 1982), and Population Monitoring Group, *The New Zealand Population: Patterns of Change*, Table 5, p. 44, New Zealand Planning Council, 1984

of non-Maori women (59%) and non-Maori men (39%).

The elderly group has been growing faster than the total population in proportional terms (Inf. 12:7). Increase in the 80 and over age was high in 1976-81 (but not as high as 1956-61). In 1981, 14% of the total population was aged 60 and over (1961, 12.2%; 1971, 12.5%). The proportion aged 80 and over has not changed over the last 20 years (1961, 1.5%; 1971, 1.6%; 1981, 1.5%).

However, projections quoted by the Population Monitoring Group show large increases in the elderly and middle-aged population through to the early 21st century (Inf. 12:8). In 2001, 16% of the population is likely to be 60 and over, and 8%, 70 and over.

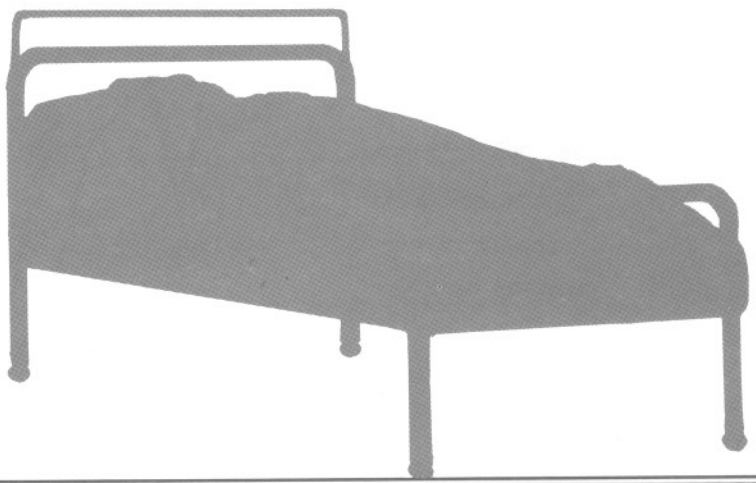
Conclusion

The increasing numbers of very old people in the New Zealand population suggest the demand for services to care for the dependent elderly can only grow. This is assuming that major advances in the cure of degenerative diseases and conditions such as dementia, are not imminent. It is likely that there will always be people who are dependent on others, but methods of care must ensure they are allowed the fullest degree of independence and that they retain their autonomy as long as possible.

Death

"The long habit of living indisposeth us for dying"

Sir Thomas Browne



CHAPTER 13

Death

SOCIAL OBJECTIVES

The needs of people at death

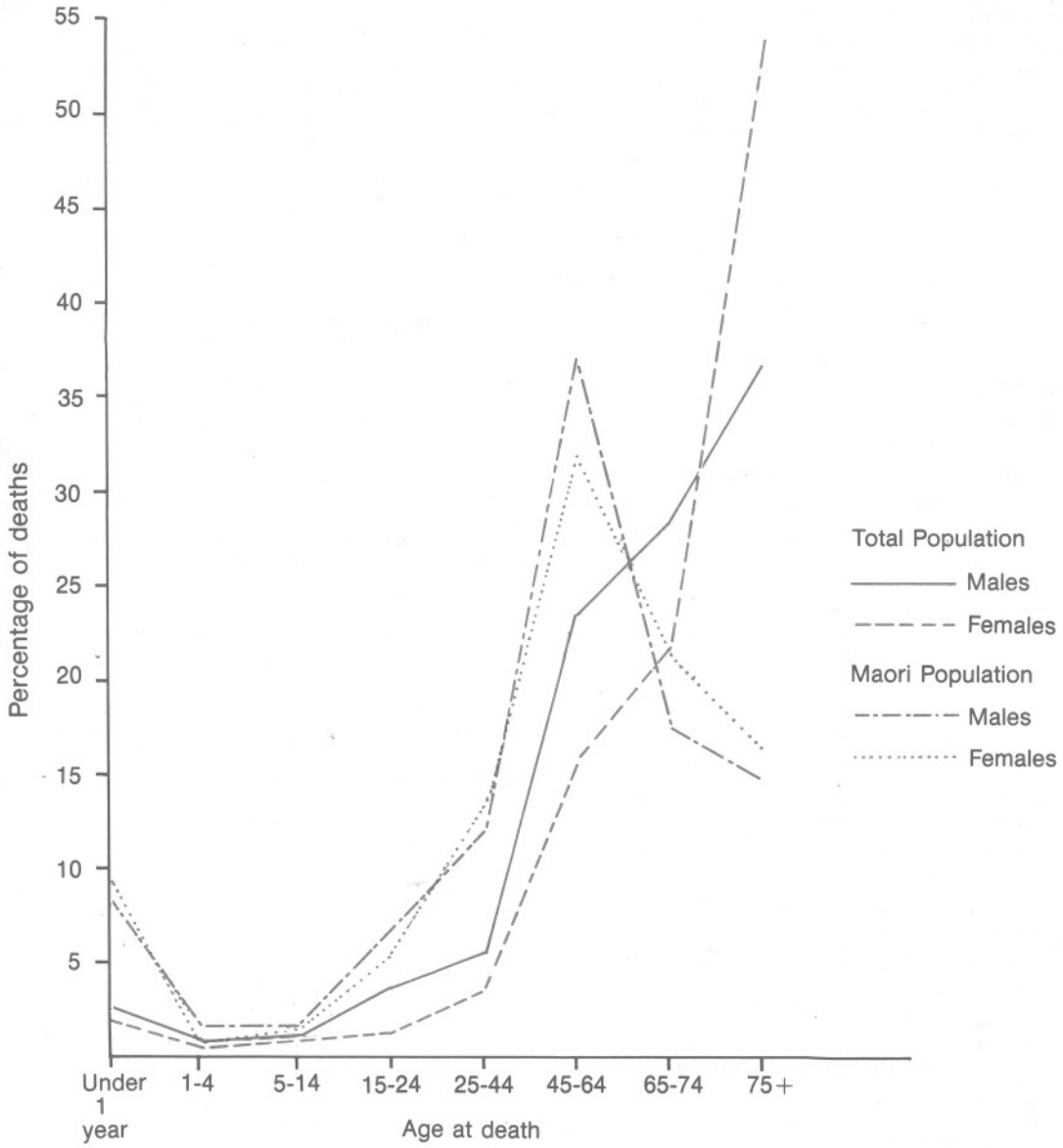
SECURITY AGAINST PREMATURE DEATH
CARE
PROTECTION OF RIGHTS AND DIGNITY

As far as present knowledge and technology is concerned, death is inevitable for all human beings and will continue to be so in the foreseeable future, despite organ transplants and the imagination of science fiction writers. We cling to the value, however, that death should be postponed for as long as possible. This value expresses itself particularly in hospitals, where intensive care units bristle with machines to prolong breathing and heart function, machines for which the demand appears insatiable. The result has been that even medical science is now confused about when death can be said to have occurred. More attention needs to be given to the rights, dignity and wishes of those *in extremis*, so that death does not become an impersonal, mechanical event — switching off — and some control is retained by the dying person.

Far less emphasis is placed on the avoidance of premature death. This chapter will

Infogram 13:1

Deaths, by Age, Sex and Ethnicity, 1983



Source: *Vital Statistics*, 1983, Table 20, Department of Statistics

show the extent of premature death caused, directly or indirectly, by accidents and self-inflicted risk. Action could be taken to avert these deaths, but the balance between protection ("for their own good") and the preservation of rights to individual autonomy is a hard one to find.

Age and Causes of Death

For two out of every three people in New Zealand, death occurs in old age, over the age of 64. This is particularly the case for women, for more than half the female deaths in 1982 were women aged 75 and over (Inf. 13:1). Male deaths are concentrated in the age group 67-78 (around 400 deaths in each year of age in 1983) and female deaths in the age group 77-83 (around 350 deaths in each year of age in 1983). Only 3.4% of male deaths occurred at ages 90 and over, as opposed to 10.1% of female deaths.

The situation is somewhat different for the Maori population which has a generally lower life expectancy. One-third of Maori deaths occur at 65 or older, but another third are of people aged 45 to 64 years (Inf. 13:1). The differences between male and female deaths by age is much less marked for the Maori population. There are, however, more female Maori deaths 90 and over than male deaths (2.5% as opposed to 1%).

Although the emphasis will therefore be on deaths in old age and trends related to this, consideration is also given to what has been defined as "premature death", i.e. death before 70 years (see Chapter 2 for a discussion of perinatal mortality and death under one year).

The leading causes of death in New Zealand are heart disease, cancer and cerebrovascular disease (stroke) (Inf. 13:2). This list differs from the major causes of death in 1900, mainly through the virtual elimination of infectious diseases, including tuberculosis (20.5% of deaths in 1900). Respiratory diseases were an important cause of death at that date (13.7%), but cancer and cerebrovascular disease were less common and caused 6% and 5% of deaths respectively in 1900.

For the age groups 65-74, and 75 and over, heart disease accounts for around one-third of deaths, a higher proportion for men than for women (Inf. 13:3). Cerebrovascular disease becomes more important with age and accounts for more female than male deaths. Cancer accounts for a quarter of the deaths between the ages of 65 and 74, but accounts for a lower proportion of deaths over 75. Respiratory and arterial disease are more evident at 75 plus, and other causes of death remain about the same.

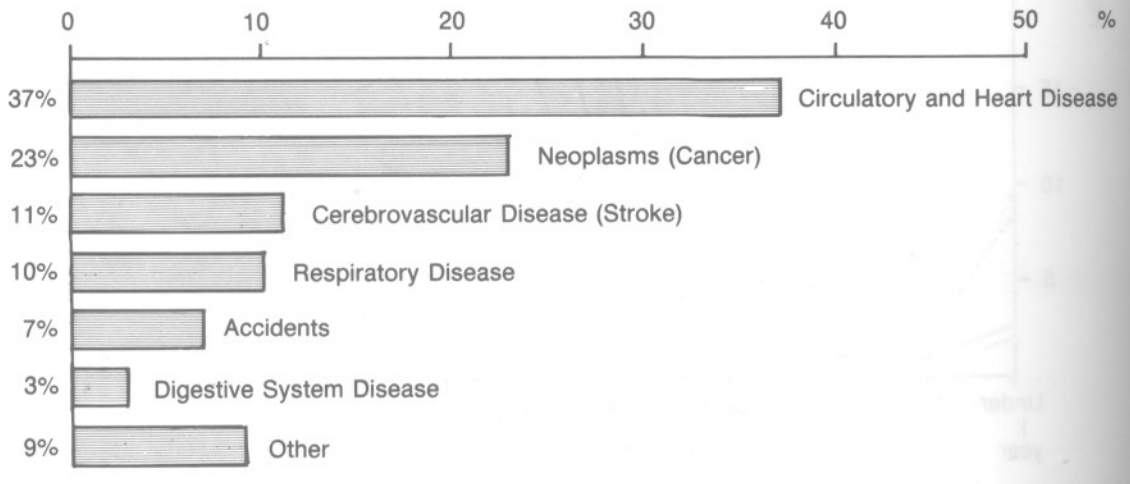
Mortality from heart disease, the leading cause of death for the older age groups, has been declining in recent years, and over the period 1968 to 1978 fell by 17% and 14% for European men and women respectively (a further decrease is indicated to 1982). More recently there has been a corresponding decline in mortality for Maori men and women (Beaglehole et al, 1981). Rates of death from cerebrovascular disease and diseases of the arteries have also fallen in recent years, but for deaths from cancer there has not been an equivalent improvement. Deaths from lung cancer, especially female deaths, have risen sharply since the 1950s.

Premature Death

Potential years of life lost (PYLL) can be used as an indicator of premature death. This is measured by summing the number of deaths in an age group and multiplying them by the remaining years up to 70. Thus a death at age 20 means a loss of 50 potential years of life (Hyslop et al, 1983).

Infogram 13:2

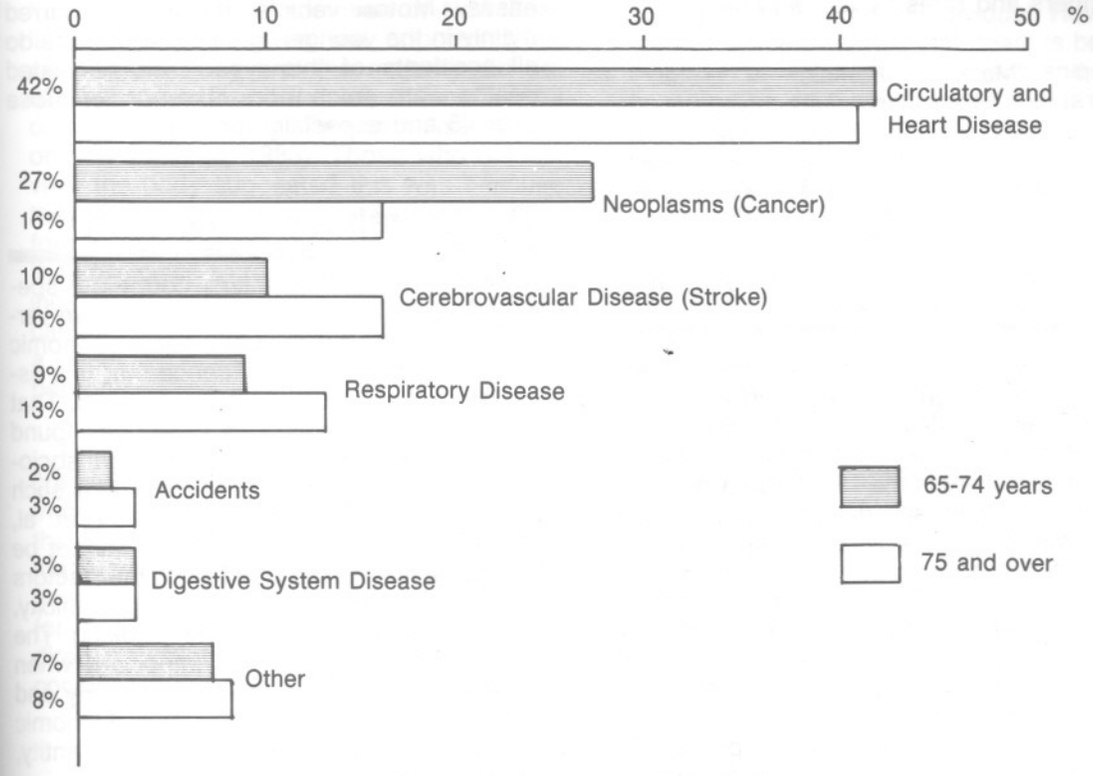
Major Causes of Death, 1982



Source: *Mortality and Demographic Data*, 1982, Department of Health

Infogram 13:3

Major Causes of Death in the Age Groups 65 to 74 Years, and 75 and Over, 1982

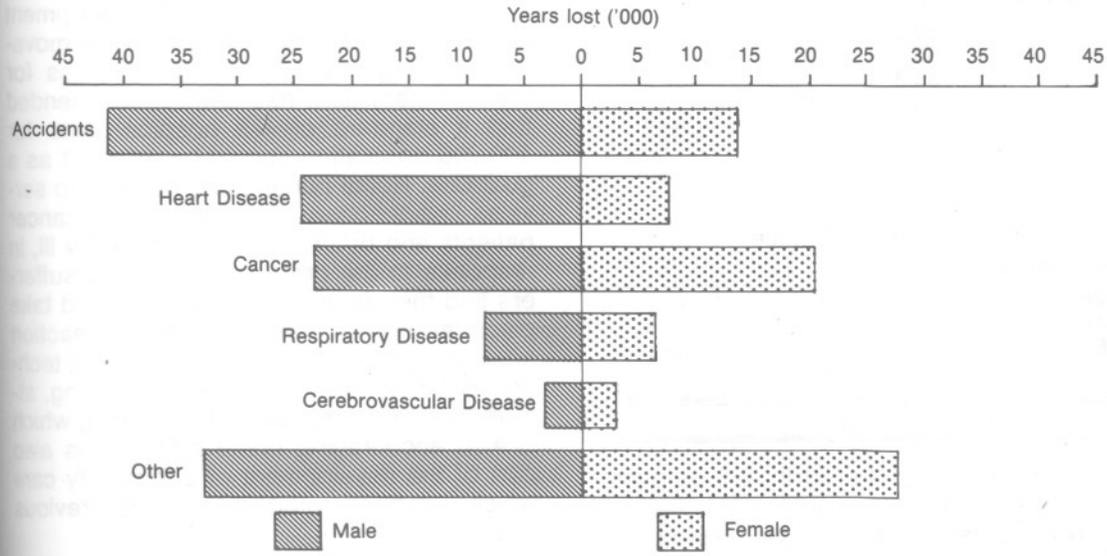


Source: *Mortality and Demographic Data*, 1982, Department of Health

One-fifth of PYLL results from accidents. Three times as many years are lost through accidental deaths for men as for women (Inf. 13:4). Motor vehicle accidents account for 41% of years lost by accident, drowning for 31%, and suicide for 13%. Heart disease is the second ranking cause of premature death and is much more important for men than for women. Cancer is the third most important cause for loss, affecting both men and women (with breast cancer for women and lung cancer for men the most important types). These three together account for about two-thirds of PYLL.

Infogram 13:4

Potential Years of Life Lost Between Ages 0 and 70, by Major Causes of Death, and Sex, 1982



Source: *Mortality and Demographic Data*, 1982, Table 11, ICD Numbers 800-899, 410-429, 140-207, 460-519,430-438, Department of Heath

Infogram 13:5

Deaths by Accident, by Age and Sex, 1982

(numbers and rates by age and sex)

Age group (years)	Male No.	Male Rate	Female No.	Female Rate	Total No.	Total Rate
1-4	44	0.4	34	0.3	77	0.3
5-14	49	0.2	31	0.1	80	0.2
15-24	367	1.3	90	0.4	457	0.8
25-44	360	0.8	98	0.2	458	0.5
45-64	190	0.8	109	0.4	292	0.6

Source: *Mortality and Demographic Data 1982*, Department of Health

Rates of death by accident are highest among the age group 15-24 and higher for males than females in all age groups (Inf. 13:5). Motor vehicle accident deaths are especially prevalent in the 15-24 age group (Inf. 13:6a). Deaths by suicide increase in importance with age, more so for women than for men (Inf. 13:6b). Suicide rates are higher for men than for women, but women attempt suicide more frequently. The methods they use — poisoning, drug overdoses — are less likely to be successful than methods used more often by men — hanging, shooting, motor vehicles. The very high proportion of premature deaths caused by accidents, especially among children and young adults, is a cause for serious concern, as many of these ought to be preventable.

Infogram 13:6

Deaths by Motor Vehicle Accident and Suicide, 1982

(a) % Deaths in Motor Vehicle Accidents

Age group	Male %	Female %	Total %
0-4 years	20.5	32.4	26.0
5-14	57.1	58.1	57.5
15-24	66.8	70.0	67.4
25-44	43.6	35.7	41.9
45-64	31.6	29.4	30.8

(b) % Deaths by Suicide

Age group	Male %	Female %	Total %
15-24 years	14.2	12.2	13.8
25-44	24.4	29.6	25.5
45-64	34.7	44.0	38.1

Source: *Mortality and Demographic Data 1982*, Department of Health

Deaths which can be attributed to over-indulgence in alcohol must also be classed as preventable. In 1978, it was estimated that 1,568 men and 545 women died as a direct or indirect effect of alcohol use (Rayner, Chetwynd and Alexander, 1984);193 male deaths and 81 female deaths were motor vehicle fatalities, and the rest were associated with other types of accident (including drowning) and alcohol-related diseases. Motor vehicle fatalities occurred mainly in the younger adult age group as do all accidents of this type. Disease-related deaths were much more common for those over 45 and especially for men.

The Correlates of Mortality

Studies in other western countries, specifically Canada and Britain, have shown variations in mortality with socio-economic status. There is some evidence that this association also occurs in New Zealand. That is, age-related death rates have been found to be lower among people of high socio-economic status, and in areas where such people are concentrated (Reinken et al, 1985). This conclusion, however, cannot be said to be fully established and other factors are obviously important, including ethnicity, type of housing and cigarette smoking. The implications are, however, important when measured against our values of equity and access. Exposure to social and economic deprivation may be associated with quantity, as well as quality, of life.

The "Quality of Dying"

In 1984, nearly two-thirds of all deaths occurred in hospitals, as opposed to less than half 20 years ago. This change is associated both with increased technology in medical practice and survival of older people needing intensive nursing. One-quarter of the elderly die at home. This is particularly the case for men, who are frequently cared for by wives who tend to outlive them.

Recent years have seen the development in New Zealand of both the hospice movement and specialised nursing services for the terminally ill. It has been recommended that a standard of 4-5 hospice beds for 100,000 population should be adopted as a guideline. Home nursing and home help services have been developed for cancer patients and others who are terminally ill, in response to the preference of many sufferers and their families that death should take place at home. This is partly a reaction against what is seen as the impersonal, technology-based, and therefore intimidating, atmosphere of many hospitals (a feeling which is also encouraging home births). It is also part of the development of community care which has been referred to in the previous chapter.

Most funerals are now conducted by specialist firms who provide a wide range of services to the bereaved family and friends.

This means that a body is often taken directly from the hospital to the funeral director's premises and does not return home. In a recent survey of families served by the Funeral Directors Association of New Zealand, 93% were given the opportunity of viewing the body and the majority did so; 83% of these found the experience helpful or consoling (Funeral Directors Association of New Zealand, 1983). Those who did not view the body suggested this was because they had seen the deceased either just before or immediately after death, or because they preferred to retain memories of the living. There is evidence that viewing the corpse can be beneficial in helping people to accept a death, especially that of a child or young person.

The majority of funerals now proceed to cremation, as services become available throughout the country. Cremation is cheaper than burial. Average retail price data from the Department of Statistics for August 1984 gave a figure of $1,238 for a burial and $1,069 for a cremation. In the survey of funeral directors' clients already referred to, 70% considered the amount charged was fair.

Conclusion

Much less attention has been given to matters surrounding death than most other events in the life of the individual. However, there is some evidence that death is becoming less of an avoided subject and more accepted as an inevitable event. For example, hospices are recognised as places where people go to die. This has meant more attention is being paid to the "quality of dying" as part of the quality of living. There are also moves to protect the rights and dignity of the dying, which in their more extreme form call for the acceptance of voluntary euthanasia. Death is an event which is not only of medical interest, but also has social and spiritual significance. This is well illustrated in Maori culture, where the *tangi* symbolises family and tribal solidarity and continuity, and where gatherings of kin assist the bereaved to express their grief and adjust to their loss. Recent attempts to accede to Maori requests for early release of bodies from hospital mortuaries show how medical and administrative practices can become more sensitive to these other dimensions of dying and death.

Policy Issues

CHAPTER 14

Policy Issues

In this chapter, the conclusions of the life events/social trends chapters are brought together as policy issues. The present situation (insofar as we have been able to describe it) is compared with the statement of needs for each life stage. These in their turn relate back to the social objectives and values set out in Chapter 1. The chapter is arranged around key words derived from the statement of social objectives. Given the policy orientation of the SMG's work, most of the issues raised are relevant to central government policy.

Income/Standard of Living

Expressing standard of living in terms of monetary income only is inadequate, but it does provide a measurable and easily recognised indicator. Throughout this report, incomes of families and groups have been presented in relative, rather than absolute, monetary terms. The measure used takes into account the number of people in the family and their differing income needs. The analysis has been focused on those families in the lower haif of the family income distribution, because these are the families most likely to suffer from a lower material standard of living, and to which government assistance should be targeted.

The widely-held principle that the state has some obligation to assist parents in raising children has not prevented families with preschool and primary school age children from being concentrated in the lower levels of the income distribution for all families. To make improvements would require that levels of support should not only keep up with inflation, but that they also be appropriate in social terms. New patterns of family formation are developing. More mothers are participating in the paid workforce. Fewer children are being born. New policy developments must take account of these factors and they should be borne in mind by the proposed Royal Commission on social welfare.

Special measures may be needed to help certain groups of families who have extra income disadvantages. These include families with large numbers of children, families where the mother is separated, divorced or unmarried, and Maori and Pacific Island Polynesian families. Of these, one-parent families are most heavily concentrated in the lower income levels, and many also lack amenities considered essential to an adequate standard of living.

A major factor influencing a family's standard of living is the ability of the parent or parents to earn an income. At the same time as reviewing levels of income support, assistance could be given to allow parents who wish to enter, re-enter or remain in the paid workforce. This would include better provision of childcare of good quality (including efforts to present childcare as an acceptable and beneficial option for parents). The Social Advisory Council sees this as a "key area" for development in family policy (Social Advisory Council, 1985). It would also include encouraging employers to make available part-time work, flexible work hours and jobsharing, and to take a more adaptable approach to the needs of parents, both mothers and fathers, and children. How can the sharing of childcare between parents be encouraged? What assistance with retraining is needed by parents returning to the paid workforce? Levels of abatement of benefits against earned income need to be examined. At the same time, it is essential adequate income support is sustained for those families who wish to maintain a parent in the home to care for children.

Low income is often found to be associated with other forms of disadvantage to children, e.g. susceptibility to disease and accident, poor health practices, under-use of health and other services. More complex statistical analysis is required to describe the interaction of other factors, such as ethnicity, age of parents etc., which may be relevant to the problem.

The introduction of the indexed national superannuation scheme has reduced relative and absolute poverty among the elderly. The concentration of retired people in the lower income levels is off-set by the fact that their households are usually small, with few dependants, and housing out-goings are usually low. For some older people, e.g. those with high housing and heating costs, low income still causes deprivation and these require assistance. However, the provision of adequate support services may be the major area where policies for the elderly require development (see later section on participation and autonomy). At the same time it is necessary to explore the long-term effects of national superannuation on New Zealand's economy and society, given an ageing population.

People in crisis situations at any stage of their lives also require assistance to maintain their standards of living, e.g. unemployed people, people with long-term health problems, people who have lost the earners who supported them. The state accepts responsibility for income support to these groups, but policies must be continuously reviewed to make sure that such assistance is adequate in amount and form, and reaches the groups for whom it was intended.

Housing is a major component of standard

of living. The costs of housing can determine whether income is adequate or not. Levels of home-ownership increase with age, and life-cycle stage is an important factor in leading people to seek to buy a house. How soon and how easily this is achieved depends heavily on income. Families with young children have lower home-ownership levels than those with older children or families of adults only. Maori and Pacific Island families are also less likely to own their homes, but one-parent families (excluding those of widowed people) have very low ownership rates. The state assists low-income families with dependent children to buy houses or to rent through the Housing Corporation, but its policies are less sympathetic to solo parents if they have been home-owners. Whose responsibility should it be to house a mother and children once the marital home has been sold? Assistance, in the public and private sectors, to young couples wishing to buy appears to assume they will produce children. This may be so, but where both partners are earning, do these couples have less of a case for assistance than one-parent families with young children?

Attention needs to be given to making home ownership more "affordable" through the provision of mortgage finance, flexible pay-back arrangements etc., and to exploring how greater variety and flexibility in housing could be provided, including variety in choices of tenure.

Variety and flexibility are needed also to cope with the housing needs of an increasingly independent elderly population. Suitable housing can help people retain their autonomy, especially where it is accompanied by services such as neighbourhood support groups, and help with home maintenance.

Special housing needs, in the form of emergency and transitional housing, arise when people experience crises in their lives, and services of a supportive or remedial nature may also be required here. These are being provided through a combination of state support and voluntary sector initiatives, e.g. women's refuges, houses for young runaways, hostels for handicapped people, sheltered pensioner housing, rest homes. The state needs to be able to react, quickly and flexibly, to these needs as they arise. The "welfare" aspects of housing must be recognised in policy, but in addition to this, housing and welfare policies must be more closely coordinated.

Caring and Health

At all stages of life people need help to maintain or regain health in its widest sense. There are, however, times at which people are especially in need of care, when they are particularly dependent and vulnerable. These include childhood and old age.

Lack of adequate care in childhood has been shown to have long-term detrimental effects. As already pointed out, little is known about how social and economic factors operate to produce disadvantage. Apparent relationships may mask more fundamental underlying factors. The term "disadvantage" is not adequately defined, and perhaps cannot be defined, as what is considered appropriate care will change in time and between groups. What is the relationship between ex-nuptial birth and the quality of care received? Why are children of young mothers more susceptible to ill health, accidents and abuse?

Measures intended to improve the quality of care for children will often impinge on the freedom of parents to bring up their children in their own way. What is the state's responsibility? Can there be any compulsion on parents to provide better care? to have their children immunised?

The state already provides a range of health services for babies and children. Hospital care at birth is free, but there are criticisms that the non-medical needs of mothers and babies are not receiving adequate attention. How can competing aims be reconciled? For example, home births may be preferred by mothers on social grounds but doctors consider they entail a higher medical risk for the child. More attention to the social and economic context of care for infants may improve infant mortality and morbidity rates to a greater extent than technological improvements in medicine. This could include promotion of parental education and community-based services, e.g. mothers' support groups. Young people may need to be made more aware of the implications of early childbearing and this needs to be incorporated into school syllabuses.

The use of child health services is uneven. We need to know why this is so, from both consumers and providers. What aspects of the health services make some groups less likely to use them? If cost is a barrier, should child consultations and medicines be totally free? What part is played by problems of physical access? Are there biases in the health services based on class and culture? Beneficial health practices may also be concentrated in certain groups and not in others for cultural reasons, and public education could be helpful to promote better caring practices. Campaigns targeted to special groups may be needed, e.g. nursing services in schools with high proportions of children likely to be at risk.

Parental health is important in its own right, and people who become parents have special needs for care and support. Although medical risks to mothers at birth are low, we need to know more about the mental and physical health implications of birth styles, e.g. Caesarean births and technology used at birth. The problem of post-natal depres-

sion and the implications of early births should be investigated. Caring for young children has an effect on parental health which is perhaps not fully appreciated by health professionals. Levels of stress on mothers seem particularly high, especially in the pre-school years. This is another area in which more investigation of processes and causal mechanisms is warranted.

There is a high level of contraceptive knowledge, but many unplanned pregnancies still occur through contraceptive failure. Contraceptives are provided free through the state. Does this imply an obligation to examine and to publicise the possible harmful effects of some forms of contraception?

Older children and teenagers are susceptible to lifestyle practices which are damaging to their physical and mental health — smoking, drinking alcohol, drug and substance abuse. Many of these are accepted by adults, but others have legal sanctions applied to control them. Social pressures, especially peer pressure, are important and may lead young people into practices they know are harmful. What is the best approach to discourage such practices? What is the role of education in schools and in the community, and what can be done through legal sanctions and penal provisions? The Alcoholic Liquor Advisory Council's prevention policy statement is a model for developing polices in this area (Alcoholic Liquor Advisory Council, 1983).

Young people are faced with a variety of pressures — pressures to conform, to achieve in the education system and in the workforce, and those exerted by various forms of advertising, which set unrealistic standards for appearance and behaviour. Conflict may be an inevitable part of the transition from childhood to adulthood. If so, can it be channelled into positive action? Adult society transmits conflicting and confusing messages but young people need sympathetic and accurate information on the implications and consequences of the choices which face them. Should they then be allowed or expected to take responsibility as individuals, as adults are in many areas?

Given the association of smoking with health problems, specific measures are needed to help the young combat pro-smoking pressures. Should the promotion of tobacco products (including sports sponsorship) be more tightly controlled? Should access by the very young to cigarettes be more severely restricted? Similar measures may be needed to combat over-indulgence in alcohol, both for health reasons and because of its association with accidents, especially on the roads. These could include educational campaigns, heavier taxation, and the encouragement of alternative consumption of low-alcohol and non-alcoholic drinks.

Early and indiscriminate sexual activity can also be harmful and young people need information on its consequences. Instruction on aspects of human development, including sexual behaviour, should be integrated in school curricula and introduced at an early stage (the Johnson Report is a valuable contribution in this area) (Committee on Health and Social Education, 1977). Greater availability of non-drug contraceptive supplies would reduce not only unplanned pregnancies but also the health risk from sexualiy transmitted diseases.

The stresses placed upon teenagers can result in mental health problems, but services of a specialised nature appropriate to this age group may not be adequate. Support to counselling services such as Youthline would be a useful preventive measure. One source of stress is pressure for academic achievement and a high status job. Attitudes towards the unemployed are often negative and judgemental, and this does nothing to alleviate the loss of morale which frequently accompanies long-term unemployment. Unemployment has been linked with lowering levels of both mental and physical health. The best solution is the supply of appropriate and satisfying work. In addition, support for the unemployed, including training, counselling, community service and recreational activities, will act as preventive health measures.

Other crises in adult life produce threats to mental and physical health. These include marital conflict and separation, loss of a spouse, child, close relative or friend through death, serious illness or handicap of the same, stress related to work, or to loss of a job. These produce a need for care and support of a personal nature which cannot always be supplied through family, friends or traditional channels such as the church. Specialised community and voluntary services to meet such needs should be encouraged, especially where self-help principles are applied. This approach has the potential to help not only in the immediate crisis, but also with rehabilitation and long-term follow-up. Often people who have suffered a crisis are able to assist others in the same situation. Investment in preventive services can have substantial savings in the long term, e.g. in reducing the demand for state housing, welfare benefits, hospital beds and prisons.

Some adults become dependent on others through illness and disability. This is most likely to occur in old age. Even though the vast majority of old people remain independent and in good health, people over 60 make heavy use of the health services. Many chronic conditions can be controlled through medication, but hospital admissions in old age are likely to be for degenerative diseases which are the most frequent causes of death. Most people, in fact, die in hospital,

but how many would prefer a less impersonal and technology-ridden environment for their demise? This calls for domiciliary nursing and hospice care.

A very low proportion of old people are in institutional care. Some are there, however, through lack of social support. This suggests more emphasis should be given to community care in the form of services to the elderly and the handicapped which will allow them to remain in their own homes and be independent as long as possible. Considerable attention is also needed by those who care voluntarily for adult dependants. How can they be protected from exploitation, deprivation or threats to their health and well-being?

A range of types of care for the elderly will still be required. A close watch must be kept on standards of care in rest homes and geriatric hospitals with attention being paid to mental health needs and adequate activity and stimulation to the patients. More needs to be known about the causes and prevention of conditions which cause disability and loss of autonomy, including mental disorders which are likely to increase with greater numbers of old people. Policies are needed which will allow sufferers to continue independent lives as long as possible, to maintain their dignity (even at the very end of their lives), and to support those who care for them.

Security and Safety

Children and young people under the age of 25 are especially susceptible to accidents. For young children, accidents most frequently happen at home or at school and improvements are best seen in terms of creating a safer environment rather than curtailing activities. Parents have the first responsibility to prevent accidents, but legislative action or action by local authorities is appropriate in some areas, e.g. fencing of swimming pools. Promotional work can assist in others, e.g. education on the prevention of burns and poisoning, and on road safety.

Child abuse is a problem which needs examination in terms of its extent, causes and prevention, and may be related to stress on parents. Early intervention measures and ways of avoiding a perpetuating cycle of abuse over the generations must be found. Several types of initiative have been shown to be effective and should be promoted, including parents' support groups and other community programmes.

Teenagers and young adults have high rates of death by accident, especially in motor vehicle accidents. This represents a costly and traumatic loss of life. The causes of such accidents need to be studied with special attention given to the role of alcohol, drugs, and psychological states ("macho" image for young men), as well as the role which could be played by education and changes to vehicles or to the road environment. Sanctions such as disqualification from driving or raising the driving age could be investigated for their likely effectiveness.

Young people are the most likely group to be the victims of crime as well as its perpetrators. Certain groups are especially at risk of both offending and being victims. Specialised services are needed in the community, working with police and other institutions, such as Rape Crisis Centres, houses for street kids, and *Maatua Whangai* programmes. Policing may not be an appropriate solution to problems which are rooted in family breakdown. There are special problems in the rehabilitation of young people which are best approached through special educational and fostering schemes rather than penal institutions which may perpetuate criminal behaviour. The security of a satisfying and adequately paid job is denied many young people, and the incidence of youth unemployment is concentrated in groups which may have other disadvantages, such as young women and Maori and Polynesian youth.

Security within a marriage-type relationship was previously confined to legal marriage, but in more and more situations informal marriage is recognised and taken to imply interdependence and an obligation to provide support. How far should this recognition be extended? Little is known about the quality of marital relationships and their influence on health and security. This is an area where policy initiatives are limited, although the state is expected to assist in cases of conflict and separation.

Government policies, including the provision of the domestic purposes benefit, state houses, and assistance to women's refuges, may influence rates of marital separation, but anecdotal evidence is not sufficient to make these effects clear. Should the state have an interest in preventing the breakdown of marital relationships? Can links between breakdown and other social ills, including long-term disadvantage to children, be proved? Within a private relationship between a man and a woman, the partners have a right to expect protection from violence (including rape) and exploitation, and women whose marriages break up must be protected from their former spouses. Yet the lack of feasible alternatives, especially in housing, lack of knowledge about services available, and attitudes in society may force women to remain with violent spouses.

Although the incidence of crime against person and property is increasing alarmingly, its causes and prevention are not well understood, especially the social environments which encourage it. Older adults express the greatest fear of crime although they are less likely to be victims than younger people.

Measures to ease fear are justified and many of these could be provided through community action — neighbourhood watch schemes, telephone networks, alarms. These are especially important given the large number of older people, especially widows, living alone. Support for such measures should not, however, divert attention away from the underlying causes of crime, including economic disadvantage.

The question of abuse of the elderly has received little attention, but physical and mental ill-treatment and neglect needs to be investigated, both in households and in institutions.

Although death in old age must be accepted, premature death is wasteful and disruptive to families and communities. More action is needed to prevent premature death, especially cot death, heart disease and cancer, taking into account the social and behavioural, as well as the medical, aspects. There is evidence that mortality rates are associated with socio-economic factors, so that groups suffering deprivation may also lose quantity, as well as quality, of life.

Accidents are a major cause of premature death and must be seen as preventable. What level of restriction of personal freedom is acceptable to protect people from fatal accidents, for example on the roads and through sporting and recreational accidents?

Participation and Autonomy

Expressions of individuality and the assertion of independence are important elements of the transition from childhood to adulthood and may be the source of much of what adults call "adolescent rebellion" or "teenage problems". As already noted, adult society has the obligation to provide young people with the information they require to decide how they will live their lives. Can and should teenagers participate in decision-making which involves them? What messages and expectations are conveyed from adults to young people — messages about materialism, honesty, sexual behaviour, respect for others? Are the problems of teenagers simply a reflection of the problems of wider society? Many problems arise from tensions between the generations and between individual and group perspectives. Cultural differences in approaches to decision-making are an additional factor which must be recognised.

Unemployment is a threat to the ability to be independent and to participate, both of which are highly valued by young people at the beginning of their careers. If status in society is so much dependent on paid work, what obligation does the state have towards young people, to provide them with work? What claims do they have over and above adults also seeking jobs? To what extent should the state protect young people from the hazards of unemployment if it is assumed they are more vulnerable to damage from it?

The marriage relationship has traditionally been based on stereotyped roles for husband and wife, unequal in terms of power over resources and decision-making. There is movement towards greater equality in marriage, but this is not yet fully developed, and stereotyped attitudes about male prerogatives give them greater opportunities for participation. Where women are expected to retain responsibility for household management as well as being in the paid workforce, their freedom to participate in recreation, community and public life will be restricted. Childcare is shared to a greater extent than previously, but is also widely seen as mainly a female responsibility — hence the predominance of female solo parents. Not only are childcare services scarce, but there is also some feeling against institutionalised childcare. The rights of mothers to some independence and opportunities for participation should be recognised. Policy initiatives may be limited, however, in this area, except through education, in schools and in the community, and through the promotion of new role models.

Action is possible to remove some of the restrictions faced by women in the workforce, based on sex and marital status (e.g. legislation allows maternity leave, but not parental leave). Women predominate among the young unemployed. They are likely to interrupt their careers to care for children and other dependants. They have difficulty in re-entering the paid workforce, in gaining promotion within it and access to training opportunities which would lead to promotion. Affirmative action programmes, at least in the medium term, would assist women to achieve greater participation in this area.

Other groups suffer forms of discrimination in work and other spheres of life. Ageism entails attitudes that older people have outlived their economic and social usefulness, and can be very damaging to the autonomy of older people, who have much to contribute. Institutional racism is often unrecognised (for example in the courts and by the police) but may reduce the opportunities of minority cultural and ethnic groups to full participation. Such discrimination may be illegal but is perpetuated through attitudes and must also be combated through affirmative action programmes.

As the population ages, there will be increasing numbers of able, older people wishing to continue to participate in society and retain their autonomy rather than withdrawing into dependence. The independence of elderly women especially must be recognised, and women throughout their lives should be made aware of their rights and responsibilities in areas previously left to men, for example in the management of

money and family law. The involvement of elderly Maori people in community life is an example to be admired. Recommendations in the Social Advisory Council's report *The Extra Years* are especially relevant to increasing full participation by older people (Social Advisory Council, 1984).

People should be able to retain autonomy and self-determination as long as possible and to the extent that they are able, even in the face of physical or mental handicap. They should be provided with the fullest range of choices, with support services for those who wish, and are able, to continue to live independently. The same principle applies to the dying, whose wishes, as well as their right to dignity, should be respected. This implies the ability to make choices and to have some control about how and where they die.

Education and Occupation

Education is seen in the context of self-development, extending to recreation and leisure and as much more than a purely vocationally-oriented exercise. Education in this sense is needed throughout life, in the form of stimulation for the smallest child through to purposeful activity for the elderly or the handicapped. There is an overlap with occupation, which is not just a means of earning an income, but any type of purposeful activity.

Education, even in the narrower institutional sense, begins before the time of official school age. Pre-school education has been shown to be beneficial to children, although home influence may be more important and largely determines access to pre-school experience.

Pre-school and childcare services now accommodate greater diversity in cultural and socio-economic contexts and are expected to have an educational orientation. Thus the children receive intellectual stimulation and begin to acquire social and personal skills. Such services are also beneficial to parents who may feel (or be made to feel) that they are abrogating their responsibilities if the children do not remain in their sole care. The *Kohanga Reo* movement is providing both a pre-school alternative and a means of cultural revitalisation intended to benefit parents, family and community, and deserves support. Rationalisation of pre-school services between providing and supervising bodies would be beneficial. Where groups of children are not receiving pre-school experience, this needs to be investigated. Are there circumstances where it is not appropriate?

Pre-school experience cannot, however, compensate for difficult home circumstances. Home influence is of paramount importance to school performance. Improvements in living standards plus the removal of social inequalities will have beneficial effects on educational progress.

In the later stages of school education there is an emphasis on acquiring formal qualifications and a higher proportion of young people are staying on to take public exams, especially young women and young Maoris. How well are their needs being met, especially the needs of children who do not fit the model of attainment based on written expression? Is school attendance after age 15 a purposeful activity or a "holding pen" for young people? More attention appears necessary to what have been described as "life skills", which include knowledge of human development, handling of money and budgeting, childcare, and practical domestic skills for both sexes. The central question is whether education should be oriented towards vocational skills or life skills. If both, in what combination and at what stages?

Access to education beyond school is unevenly distributed, by sex, ethnicity and socio-economic group, although some inequities are being evened out. The cost of tertiary education directly and indirectly (in postponing earning) is a factor. Some forms of training aimed at skilled manual workers, e.g. apprenticeships, have been declining in their availability. This should be investigated. Young women have not had free access to many forms of training and need special support and opportunities.

Most people enter the paid workforce in their late teens or early twenties. The present economic situation means many are not able to find work, or to find work for which they are inclined or trained. Unemployment is not only damaging personally and takes away the right to a meaningful occupation, but is also economically damaging, through the waste of human resources, and socially damaging, because unemployment is uneven in its incidence and hence social inequities are enhanced and perpetuated. It is especially harmful when groups in society are compelled to compete for jobs, e.g. teenage workers versus married women returning to paid work.

All adults depend on work done in the household, but both household work and childcare are undervalued and mostly unpaid. They tend to be ascribed to women as part of the stereotyped wife-and-mother role. Unequal sharing of domestic work and childcare in households is a form of social inequity which has already been referred to.

Not a great deal is known about job satisfaction in adult life, especially comparing workers in the paid and unpaid sectors (but see McLennan and Gilbertson, 1984). There is little recognition that unpaid work can be on a par with paid work in terms of its usefulness to society and its capability to provide stimulation and satisfaction. The overwhelming emphasis on paid work as conferring social status is very damaging to

the morale of those who are not in the paid workforce.

If policy is based on the premise that income to meet basic needs will be provided through the labour market, then everyone must be provided with paid work suitable to their capabilities. This implies moves to achieve full employment. If, however, paid work is not the only way of providing income, then questions of dependency, on family and the state, arise. People who are changing their work status, i.e. entering or leaving the paid workforce, or moving within the paid or unpaid workforces, must be helped, along with those who are not able to face the full competition of the labour market, e.g. handicapped people.

A recognition of the importance of meaningful work (in the broadest sense) to self-esteem, to good physical and mental health, should underlie policy in this area. At the same time, the harmful effects of work must be guarded against.

Retirement from the paid workforce does not mean the need for meaningful occupational and education disappears. Older people also need stimulation and satisfaction in what they do and are capable of continuing their contribution to society, as already noted. Are compulsory retirement policies, therefore, justified or fair?

Educational opportunities for older people are needed, especially those adapted to adult approaches to learning and adult interests. This is especially so for people who have disabilities, including social disabilities (e.g. membership of a deprived group). The need for mental stimulation and social contact may be overlooked when people are losing their physical capacities.

More needs to be known about the interaction of mental health, physical health and satisfaction in what an individual is doing with his or her time.

Conclusion

The material presented in this report shows that New Zealand is some distance from fulfilling the social objectives which have been set up by the SMG. Many illustrations have been given of areas of shortfall and many barriers to progress towards the objectives have been identified. These barriers lie in attitudes, in behaviour and in institutions. Attitudes, for example, prevent women from participating fully in the workforce and in public life because of the expectation that they will accept certain domestic responsibilities. Lifestyle factors including smoking and alcohol abuse, mean many people are at risk of physical and mental ill-health. Institutional barriers are found in many forms, including those within the education system, which is geared towards academic qualifications.

How can the situation be improved? The removal of barriers does not depend on massive state intervention and direction, on the injection of huge sums of money, or on efforts to produce ever more advanced technology. The role of the state is firstly to create an environment in which a wide range of opportunities and choices exist, for example, economic management should aim to provide meaningful employment and an adequate standard of living for all. The state must then support and assist people so that they can take control of their lives and make their own choices, in the full knowledge of what the implications of these choices will be, to themselves and to other people. This support and assistance should be more direct where special difficulties are being encountered, for example in cases of severe illness or family breakdown. However, further state support in any one area may entail a reduction of support in another area, and so priorities will have to be established.

People require assistance from the state at several levels. As individuals they need support, for example, medical treatment or vocational guidance. Groups of people need help, for example, families require childcare services if they are to decide freely how they will earn their living. The state can also assist classes of people in removing institutional discrimination, such as disadvantaged ethnic minorities, especially Maoris and Pacific Islanders. In all these areas the paramount considerations should be to see people in a holistic way, not compartmentalised as to their functions, or labelled as stereotypes, and to respect their right to individuality and self-determination.

Appendix I

TECHNICAL GLOSSARY

Abatement The reduction of social welfare benefits as the income of the recipient rises.

Abortion Induced abortion.

Antenatal Concerning the period of time before birth occurs.

Cohort A group of individuals who experience the same demographic event during a specified brief period and who may be identified as a group at successive later dates on the basis of that common demographic experience, e.g. birth cohorts, marriage cohorts.

Cohort Analysis Cohort analysis focuses on the size and composition of particular population cohorts and follows them through their life-cycle, just as individuals can be followed through career paths or their family life-cycle.

Cot Death See "sudden infant death".

Ethnicity The ethnic classification of individuals throughout the report varies according to the sources from which the information was obtained. For example, the "ethnic origin" of individuals recorded in *Vital Statistics* is based on the ancestry of the parents, whereas the "ethnic group" of individuals in the *Social Indicators Survey 1980-81* is based on self-reported cultural affiliation. For a more detailed and comprehensive description of ethnic classifications in official statistics, see Brown, P.G., *An Investigation of Official Ethnic Statistics*, Department of Statistics, Occasional Paper No. 5, 1983.

Ex-nuptial Birth A child born out of wedlock, including those born to a mother in a de facto relationship. In New Zealand, the birth may be re-registered as a nuptial birth within three months after the date of marriage.

Family Income See Appendix II.

Fertility Actual reproductive performance of an individual or group of individuals.

Fertility Rate The rate at which individuals or groups reproduce. In this report, the total fertility rate has been used. This refers to the number of children that would be born to a woman were she to follow the pattern of fertility operating in one calendar year for her entire reproductive span. In order to replace itself, a given population would require a fertility rate of about 2.1.

Infant Death Live-born infant dying before first year of life is completed. (Includes "neonatal death", "perinatal death" and "post-neonatal death".)

Income Groups See Appendix II.

Late Fetal Death Termed a "still-birth" and defined as occurring after 28 weeks of gestation.

Life Expectancy The average (expected) number of years of life remaining at a given age for a given population cohort. "Life expectancy" normally refers to life expectancy at birth. Any other age is specified — e.g. life expectancy at age 1, 60 etc.

Morbidity The unhealthiness in a given population, usually measured in terms of the prevalence of specific diseases and illnesses.

Mortality The death rate in a given population.

Neonatal Occurring in, or relating to, the period from birth up to the age of 28 days.

Neonatal Death Live-born infant dying before the 28th day of life.

Nuptial Birth	A child born to parents who are legally married.
Participation Rate (Labour Force)	The percentage of a particular cohort or group in full-time employment, or seeking full-time employment.
Perinatal Death	Fetal deaths after 28 or more weeks of gestation (i.e. "still-birth") and deaths of live-born infants aged seven days or less (i.e. "early neonatal deaths").
Post-neonatal	Occurring in, or relating to, the period from one month after birth until the age of up to 12 months.
Post-neonatal Death	Live-born infant dying between 28th day and completion of first year of life.
Serial Marriage	Refers to the legal or informal marriage of individuals which is interspersed with periods of time when those individuals are single or solo parents.
Still-birth	See "late fetal death".
Sudden Infant Death (SID)	Refers to the death of an infant in the first year of life when, for reasons that are not altogether clear, the infant stops breathing. (Also called "cot death".)

Appendix II

MAJOR SOURCES OF INFORMATION

The 1981 Population Census

The 1981 *Census of Population and Dwellings* volumes were used extensively to compile the report. Where the 1981 census has been used, full references have been indicated.

Income Groups

In this report the family income groups were used to identify four income groups as follows:

Lowest group	nil to $7,160
Second group	$7,161 to $10,150
Third group	$10,151 to $13,950
Highest group	above $13,950

By definition, each group contains 25% of all families. However, sub-populations of all families (e.g. families with a child aged less than one year) were not necessarily equally represented in the four income groups. This indicates differences in income distribution of these sub-populations relative to the total population.

Population Census Family Data

Much of the information about families in this report was obtained from a 10% sample of the 1981 Population Census. A *family* is defined as a couple (married or not married) with or without a dependent child or children present; or a single parent with a dependent child or children present. A *dependent* child is defined as a child aged up to and including 15 years who is still living at home, or a child aged up to and including 18 years who is still living at home and enrolled in full-time schooling. The definition of families excludes persons living alone in households. It should also be noted that some households contain more than one family.

Family Income

Throughout this report, statistics referring to *family income* were derived from a 10% sample of the 1981 Population Census. In the census, *income* (of an individual) was defined as gross income from all sources over the past year. For the purposes of this report, *disposable income* (i.e. net of taxes and transfers) was estimated using the ASSET computer model (see Mowbray, M.J. and Khan, A.R., "One- and Two-Parent Families" in *Demographic Bulletin* 6:1, Department of Statistics, 1984, for more details). *Family income* was defined as the sum total of the estimated disposable incomes of the spouses in a family, adjusted by an equivalence scale developed by the Australian Bureau of Statistics. The purpose of an *income equivalence scale* is to approximate the "real" value of income by taking into account the number and type of people who are dependent on that income. Incomes are therefore adjusted according to the number of adults and children in a family. This produces a *standardised disposable family income* for each family, referred to simply as *family income* in this report. The Australian Bureau of Statistics weighting scale was used in preference to other scales because it is sensitive to the labour force status of families (e.g. whether or not one or both spouses were working) and to a wide range of family types, including one-parent families. The weights used are shown below:

(a) For one-parent families	
One parent with non-dependent offspring	0.62
One parent with one dependent child	0.84
One parent with two dependent children	0.97
One parent with three or more dependent children	0.99
(b) For couples only	
Couples with no offspring living at home	1.00
Couples with only non-dependent offspring living at home	1.00
(c) For couples with dependent children and the mother working	
Couple with one dependent child	1.12

Couple with two dependent children	1.27
Couple with three dependent children	1.33
Couple with four dependent children	1.37
Couple with five or more dependent children	1.46
(d) For couples with dependent children and mother not working	
Couple with one dependent child	1.08
Couple with two dependent children	1.13
Couple with three dependent children	1.29
Couple with four dependent children	1.38
Couple with five or more dependent children	1.68

Vital Statistics

Vital Statistics volumes from numerous years were used, up to and including the 1983 volume. Full references are indicated in the text.

The New Zealand Household Survey

The Household Survey is carried out by the Department of Statistics to provide details on the expenditure pattern of private households. Apart from updating the Consumer Price Index, socio-economic data is also collected and the sample size is between 3,500 and 4,500 households. The main advantage of the survey is that it is carried out regularly and provides details on employment status, the level and sources of income, occupations, industry and hours of work, on a weekly basis.

The Social Indicators Survey, 1980-81

The *Social Indicators Survey* was carried out by the Department of Statistics in 1980/81. The survey involved interviews with 6,891 respondents selected to provide a nationally representative sample of adults living in private households. The survey provides information on employment, housing, leisure, income and social participation.

The Christchurch Child Development Study

The Christchurch Child Development Study is a prospective study which began in mid-1977 and focused on the health and social history of children from birth. The study initially included 1,265 children born in maternity units in the Christchurch urban area. At the age of four years, the sample size represented 90% (1,128) of the original sample and 96% of the children who were still alive and resident in New Zealand.

The aims of the study included an examination of issues relating to health and illness in children, community health services and their use, and social, economic and other factors which may disadvantage children socially, physically or educationally.

The children involved were examined at regular intervals and this is continuing. Apart from the information obtained from the examination and interviews which included over 3,000 questions, supplementary information was obtained from general practitioner records, the child's Plunket book, and a diary report kept by the mother. The findings of the study have been published in numerous journals, including the *New Zealand Medical Journal*, and a booklet entitled *The First Four Years*, listed in the bibliography under Christchurch Child Development Study.

The Dunedin Multidisciplinary Child Development Study

The Dunedin study is also a prospective study. It began in 1975, but is concerned with different areas of child health then the Christchurch study. The study involved a sample of over 950 children born between 1 April 1972 and 31 March 1973 at the Queen Mary Hospital in Dunedin. 1,139 children were eligible and 91% (1,037) were followed up within three months of their third birthday. Of the 1,037, a large percentage was included in further studies carried out at ages five (96%), seven (92%), nine (92%) and eleven.

The general focus of the study has been the health, development, and related problems in children and young people and the correlates of these problems. There has also been concern with developing improved means of identifying and diagnosing various disorders. The main focus of the study has been the sample of over 950 children and it is intended to follow the sample past adolescence.

BIBLIOGRAPHY

Where the same author (or authors) has published more than once in the same year, the works are distinguished in the text by the letters "a", "b", etc. These letters do not appear in the bibliography but indicate the order in which the publications are listed.

Abbott, M. (ed), *Symposium on Unemployment*, Mental Health Foundation of New Zealand and New Zealand Psychological Society, 1982

Abbott, M. (ed), *Child Abuse Prevention in New Zealand*, Mental Health Foundation, 1983

Abbott, M., "Overview of Post-natal Depression", paper presented to 1983 World Congress for Mental Health, Washington D.C., July 22-27, 1983

Abbott, M. and Koopman-Boyden, P.G., "Expectations and Predictors of the Division of Labour within Marriage", *New Zealand Psychologist*, 1981

Abortion Supervisory Committee, *Report of the Abortion Supervisory Committee*, 1984

Accident Compensation Commission, *Biannual Journal of the Accident Compensation Corporation*, Vol. 2, No. 1, Vol. 3, No. 1

Alcoholic Liquor Advisory Council, *Living with Alcohol: Preventing Misuse*, 1983

Auckland City Council, *Auckland Isthmus Recreation Study, 1982-83*

Bacica, L., "Components of Unemployment", *New Zealand Population Review*, Vol. 10, No. 3, October 1984, pp 69-75

Barker, R.A. et al (eds), *Ageing New Zealanders: A Report to the World Assembly on Ageing*, 1982

Barnes, H., *Women Night Cleaners*, Research and Planning Division, Labour Department, 1981

Barney, D., *Who Gets to Pre-School?*, New Zealand Council for Educational Research, 1975

Barrington, R.E. and Davey, J.A., *Migrants and Their Motives*, New Zealand Planning Council, 1980

Battersby, D., "Education" in Barker, R.A. et al (eds), *Ageing New Zealanders: A Report to the World Assembly on Ageing*, op.cit., 1982

Beaglehole, R., "Cigarette Smoking Habits: Attitudes and Associated Social Factors in Adolescents", *New Zealand Medical Journal*, 1978, 87:239-242

Beaglehole, R. et al, "Trends in Coronary Heart Disease Mortality and Associated Risk Factors in New Zealand", *New Zealand Medical Journal*, 1981, 93:371-375

Beautrais, A.L. et al, "Accidental Poisoning in the First Three Years of Life", *Australian Paediatric Journal*, Vol. 17, 1981, pp 104-109

Beautrais, A.L. et al, "The Use of Pre-School Dental Services in a New Zealand Birth Cohort", *Community Dentistry and Oral Epidemiology*, Vol. 10, 1982, pp 249-252

Bellamy, M.A. et al, "Caring for the Elderly in the Community", *5th Year Student Projects*, Department of Preventive Medicine, Christchurch Clinical School, 1982

Bevan, C., *Review of Literature on Street Kids*, Planning and Development Division, Department of Justice, Monograph Series No. 5, 1982

Board of Health, *Child Health and Child Health Services in New Zealand*, Board of Health Report Series No. 31, Department of Health, 1982

Board of Health, *The Hearing Report*, Committee on Hearing, 1984

Borman, B. and Leiataua, S., *A General Mortality Atlas of New Zealand*, Department of Health, National Health Statistics Centre, Special Report No. 71, 1984

Brenner, M.H., "Fetal Infant and Maternal Mortality During Periods of Economic Instability", *International Journal of Health Services*, Vol. 3, No. 2, Spring 1973

Briggs, J. and Allan, B., *Maternal and Infant Care in Wellington 1978: A Health Care Consumer Study in Replication*, Department of Health, Special Report Series No. 64, MSRU, 1983

Business Development Centre, *The Social and Economic Impact of the Collapse of Mosgiel Limited on the Towns of Ashburton and Mosgiel*, Otago University, 1982

Carmichael, G., "Solo-Parent Families in New Zealand: Historical Perspective and a 1976 Census Profile", *New Zealand Population Review*, Vol. 9, No. 1, April 1983

Casswell, S., "Alcohol Use by Auckland High School Students", *New Zealand Medical Journal*, 1982, 95:856-858

Casswell, S. and Hood, L.J., "Recreational Drug Use Among Auckland High School Students", *New Zealand Medical Journal*, 1977, 85:315-319

Catherwood, V., *Young People, Education and Employment*, New Zealand Planning Council, 1985

Christchurch Child Development Study, *The First Four Years*, Christchurch Clinical School of Medicine, 1982

Clarkson, J. and Lafferty, T., untitled article in *Committee for Children Newsletter*, November 1984

Clay, M.M., *Engaging with the School System: A Study of Interactions in New Entrant Classrooms*, University of Auckland, Department of Education, 1981

Clay, M.M. and Oates, R.E., *Round About 12*, Department of Education, 1984

Committee for Children, Submission to the Primary Medical Services Review Committee, April 1982

Committee on Health and Social Education, *Growing, Sharing, Learning*, (Johnson Report), Department of Education, 1977

Coope, P.A., "Age at Menarche: A 1981-82 Christchurch Sample", *New Zealand Family Planning Physician*, Vol. 11, No. 1, Summer 1984

Cree, M., *The Politics of Rehabilitation*, University of Canterbury, Department of Social Work, working paper, 1984

Darby, J. et al, *Towards 1984: Issues for Voluntary Agencies*, prepared for Palmerston North Community Service Council, 1983

Davey J.A. and Atkin, N.R., *Housing and the Matrimonial Property Act 1976*, National Housing Commission Research and Information Series, Research Paper 81/1, 1980

Davey, J. and Dwyer M., *Meeting Needs in the Community: A Discussion Paper on Social Services*, New Zealand Planning Council, 1984

Davey, J. and Koopman-Boyden, P., *Issues in Equity*, New Zealand Planning Council, 1983

Davis, P., "Early Sexuality and Sexual Socialisation: Some Recent Data for New Zealand", *Australia and New Zealand Journal of Sociology*, Vol. 13, No. 3, 1977, pp 119-125

Dawson, L., "This is a Rare and Precious Person: He's Just been Adopted", *More Magazine*, September 1984

Department of Education, *Education Statistics of New Zealand*, 1971, 1979, 1980-1984

Department of Education, *Report of the Department of Education*, 1979 to 1984

Department of Health, *New Zealand Health Statistics Report*, National Health Statistics Centre, 1978

Department of Health, *Mental Health Data 1977-78*, New Zealand Health Statistics Report, National Health Statistics Centre, 1980

Department of Health, *Mortality and Demographic Data 1978*, National Health Statistics Centre, 1981

Department of Health, "Teenagers and Food", *Health*, Vol. 33, No. 3, 1981

Department of Health, *Child Health and Child Health Services in New Zealand*, Board of Health, Report Series No. 31, 1982

Department of Health, *Mortality and Demographic Data 1982*, National Health Statistics Centre, 1982

Department of Health, *Trends in Health and Health Services 1983*, National Health Statistics Centre, 1983

Department of Health, *Hospital and Selected Morbidity Data 1983*, National Health Statistics Centre, 1984

Department of Health, *The Public Health*, Annual Report, 1984

Department of Health and Social Security, *Committee of Inquiry into Human Fertilisation and Embryology*, HMSO, 1984

Department of Social Welfare, *Report of the Department of Social Welfare*, 1976 to 1984

Department of Social Welfare, *Report of the Rehabilitation Committee*, 1982

Department of Statistics, *Defining Unemployment*, Social Indicators Division, Working Paper No.1, 1982

Department of Statistics, *Estimated Mean Age Distribution of New Zealand Population for Years Ended 30 June 1979-1983*, 1983

Department of Statistics, *New Zealand Life Tables* (Abridged), 1978-1983

Department of Statistics, *Census of Population and Dwellings*, Bulletins on Cigarette Smoking, 1976 and 1981

Department of Statistics, *Country Statement, New Zealand*, International Conference on Population, Mexico City, 6-13 August, 1984

Department of Statistics, *Social Indicators Survey 1980-81*, 1985

Dodge, J., "A Study of Mother's Health", *New Zealand Medical Journal*, Vol. 91, 1980, pp 353-355

Dowland, J. et al, *On Their Own: Disabled Persons Living Alone*, Department of Health, Occasional Paper No. 20, MSRU, 1982

Dwyer, M., *Family Income Support*, New Zealand Planning Council, unpublished working paper, 1984

Easton, B., "The Economic Life-cycle of the Modern New Zealand Family", *Australia and New Zealand Journal of Sociology*, Vol. 13, No. 1, Feb. 1977, pp 85-89

Easton, B., *Poverty in New Zealand: Five Years After*, paper for Conference of New Zealand Sociological Association, Nov. 1980

Easton, B., "Introduction: Unemployment and its Consequences", *New Zealand Journal of Industrial Relations*, 1982, Vol. 7, pp 101-105

Fergusson, D.M. et al, *The Effects of Race and Socio-economic Status on Juvenile Offending Statistics*, Research Report No. 2, Research Unit, Joint Committee on Young Offenders, New Zealand, 1975

Fergusson, D.M. et al, "Factors Associated with Planned and Unplanned Nuptial Births", *New Zealand Medical Journal*, 1978, 88:89-92

Fergusson, D.M. et al, "Infant Health and Breast-feeding during the First Sixteen Weeks of Life", *Australian Paediatrics Journal*, 1978, Vol. 14, pp 254-258

Fergusson, D.M. et al, "Smoking During Pregnancy", *New Zealand Medical Journal*, 1979, 89:41-43

Fergusson, D.M. et al, "Parental Smoking and Respiratory Illness in Infancy", *Archives of Disease in Childhood*, 1980, Vol. 55, No. 5, pp 358-361

Fergusson, D.M. et al, "Health Care Utilisation in a New Zealand Birth Cohort", *Community Health Studies*, 1981, Vol. 5, No. 1, pp 53-60

Fergusson, D.M. et al, "Birth Placement and Childhood Disadvantage", *Social Science and Medicine*, 1981, 15E:315-326

Fergusson, D.M. et al, "Breast-feeding, Gastrointestinal and Lower-Respiratory Illness in the First Two Years", *Australian Paediatrics Journal*, 1981, Vol. 17, pp 191-195

Fergusson, D.M. et al, "Maternal Satisfaction with Primary Health Care", *New Zealand Medical Journal*, 1981, 94:291-294

Fergusson, D.M. et al, "Parental Smoking and Lower Respiratory Illness in the First Three Years", *Journal of Epidemology and Community Health*, 1981, Vol. 35, No. 3, pp 180-184

Fergusson, D.M. et al, "Family Ethnic Composition, Socio-economic Factors and Childhood Disadvantage", *New Zealand Journal of Education Studies*, Vol. 17, No. 2, 1982, pp 171-179

Fergusson, D.M. et al, "The Prevalence of Illness in a Birth Cohort", *New Zealand Medical Journal*, 1982, 95:6-10

Fergusson, D.M. et al, "Attitudes of Mothers of Five-Year Old Children to Compulsory Child Health Provisions", *New Zealand Medical Journal*, 1983, 96:338-340

Fergusson, D.M. et al, "Who Doesn't Get to Pre-School?", *New Zealand Journal of Education Studies*, Vol. 19, No. 1, 1984, pp 79-82

Fergusson, D.M. et al, "A Proportional Hazards Model of Family Breakdown", *Journal of Marriage and the Family*, 1984, 46(3):539-549

Fergusson, D.M. and Horwood, L.J., "A Markovian Model of Childhood Family History", *Journal of Mathematical Sociology*, 1983, Vol 9, No. 2, pp 139-155

Fifield, J. and Donnell, A., *Socio-economic Status, Race and Offending in New Zealand*, Joint Committee on Young Offenders, Research Report No. 6, 1980

Flight, R.J. et al, "The Health Status of Fourth Form Students in Northland", *New Zealand Medical Journal*, 1984, 97:1-6

Fraser, J., *Post-neonatal Mortality: Results of a National Survey 1978-1979*, Department of Health, Special Report Series No. 61, National Health Statistics Centre, 1982

Funeral Directors Association of New Zealand (Inc.), *Survey Report*, 1983

Geare, A.J., *Redundancy in New Zealand*, Public Sector Research Papers, New Zealand Institute of Public Administration, Vol. IV, No. 3, 1983

Geddis, D., "The Exposure of Pre-School Children to Water Hazards and the Incidence of Potential Drowning Accidents", *New Zealand Medical Journal*, 1984, 97:223-226

Geddis, D.G. and Silva, P.A., "The Plunket Society: A Consumer Survey", *New Zealand Medical Journal*, 1979, pp 507-509

Gill, T. et al in conjunction with the Women's Division of the Federated Farmers of New Zealand, *The Rural Women of New Zealand*, Christchurch, University of Canterbury, 1976

Gray, A. and Neale, J., "Study of the Project Employment Programme", *Studies of Employment and Training Programmes*, Employment Promotion Conference, 1985

Haines, H., "Women and Mental Health in New Zealand: Facts and Figures", paper presented to Women's Studies Association (N.Z.) Conference, August 1983

Haines, H. and Macky, K., "Employed and Unemployed School-leavers in a New Zealand Community", *Symposium on Unemployment*, Mental Health Foundation of New Zealand and New Zealand Psychological Society, 1982

Hall, A., "Anorexia Nervosa", *The New Zealand Medical Journal*, December 1981

Hood, L.J. et al, "Breast-feeding and Some Reasons for Electing to Wean the Infant: A Report from the Dunedin Multi-disciplinary Child Development Study", *New Zealand Medical Journal*, 1978, 88:273-276

Horwood, L.J. et al, "The Safety Standards of Domestic Swimming Pools", *New Zealand Medical Journal*, 1981, 94:417-419

Housing Corporation of New Zealand, *Report of the Housing Corporation of New Zealand*, 1972-1982

Howell, R.J. et al, "Fatal and Non-fatal Deliberate Self-Harm in the Wellington Region 1978: A Social Analysis", *New Zealand Medical Journal*, 1980, Vol. 92:468-471

Human Rights Commission, *Women in Banking: A Report on the Complaints of Sex Discrimination in the Employment of Women in the New Zealand Banking System*, 1983

Human Rights Commission, *Convention of the Elimination of All Forms of Discrimination Against Women: "What's it all about?"* —- A Review Paper, 1984

Hunton, R.B. et al, "Social Characteristics of Patients Attending a Private Early Pregnancy Termination Service in Auckland", *New Zealand Medical Journal*, 1977, 85:220-222

Hyslop, J. et al, *Health Facts: New Zealand*, Department of Health, MSRU, 1983

Jack A. et al, *Physical Disability: Results of a Survey in the Wellington Hospital Board Area*, Department of Health, Special Report Series No. 59, MSRU, 1981

Jack, A. et al, *Disabled Women: A Double Disadvantage*, Department of Health, Occasional Paper No. 21, MSRU, 1982

Jahoda, M., "The Impact of Unemployment in the 1930s and the 1970s", *Bulletin of the British Psychological Society*, 1979, Vol. 32:309-314

Jones, A., *The Implications of Selected Dimensions of Social and Demographic Change for the Department of Social Welfare*, Social Programme Education Unit, Department of Social Welfare, 1984

Justice Department, *Justice Statistics*, 1981, 1982

Kammerman, S. and Kahn, A., "Income Transfers, Work and the Economic Well-Being of Families with Children: A Comparative Study", *International Social Security Review*, No. 2, 1982

Kearsley, G.W., "Subjective Social Indicators and the Quality of Life in Dunedin", *New Zealand Geographer*, Vol. 38, No. 1, April 1982, pp 19-24

Koopman-Boyden, P.G. (ed), *Families in New Zealand Society*, Methuen, 1978

Koopman-Boyden, P.G., "Community Care of the Elderly", *New Zealand Medical Journal*, 1981, 94:11-15

Kroger, J., "Relationships During Adolescence: A Developmental Study of New Zealand Youths", *New Zealand Journal of Educational Studies*, Vol. 17, No. 2, 1982, pp 119-127

Labour Department, *Labour and Employment Gazette*, March, June, September, December, 1984

Langley, J.D. et al, "Accident Injuries in the Sixth and Seventh Years of Life: A Report form the Dunedin Multidisciplinary Child Development Study", *New Zealand Medical Journal*, 1981, 93:344-347

Langley, J.D. et al, "Primary School Accidents", *New Zealand Medical Journal*, 1981, 94:336-339

Laws, G.F. et al, "Contraception for the Young", *Pharmaceutical Journal of New Zealand*, Vol. 42, No. 1, 1982

Leibrich, J. and Holm, S., *The Family Court: A Discussion Paper*, Monograph Series, Department of Justice, Vol. 6, 1984

McLennan, R. and Gilbertson, D., *Work in New Zealand: A Portrait in the Eighties*, A.H. and A.W. Reed, 1985

Macky, K. and Haines, H., "The Psychological Effects of Unemployment: A Review of the Literature", *New Zealand Journal of Industrial Relations*, 1982, Vol. 7, pp 123-135

Meade, A., *Public Participation in New Zealand Pre-School Education*, Victoria University, Department of Sociology, Occasional Papers in Sociology and Social Work, No. 4, 1981

Meade, A., Personal Communication, 1984

Mental Health Foundation of New Zealand, *Mental Health News*, April, August, December, 1984

Mialaret, G., *World Survey of Pre-School Education*, UNESCO, 1976

Mitchell, D.R., "Alcohol Consumption of High School Students in Relation to Ethnicity, Socio-economic Status and Sex", *New Zealand Medical Journal*, Vol. 96, 1983, pp 572-575

Mowbray, M.J. and Kahn, A.R., "One- and Two-Parent Families from the Census", *New Zealand Population Review*, Vol. 10, No. 3, 1984

National Housing Commission, *New Zealanders and Home-Ownership*, Research Paper 84/2, Report of Fourth Survey, Davey, J.A., 1984

Neale, J., *Women and Men in Banking: A Survey of Career Patterns*, New Zealand Bank Officers' Union, 1983

Newman, I.M. et al, "The Role of Attitudes and Social Norms in Adolescent Cigarette Smoking", *New Zealand Medical Journal*, 1982, 95:612-621

New Zealand Educational Institute, "The New Zealand Scene", *Journal of the New Zealand Educational Institute*, August 1981, Vol. 63, No. 651, pp 133-136

New Zealand Federation of University Women, *Women at Home*, 1976

New Zealand Planning Council, *Towards an Active Employment Policy*, 1980

New Zealand Planning Council, *The Effects on Family Income of New Zealand Taxation and Transfer Policies*, 1984

"The New Zealand Scene", *Journal of the New Zealand Educational Institute*, Vol. 63, No. 651, August 1981

New Zealand Widows and Widowers Association (Inc.), *The Widowed in New Zealand*, 1982

Novitz, R., "Marriage, Family and Women's Liberation" in Koopman-Boyden, P.G. (ed), *Families in New Zealand Society*, op. cit., pp 57-86

O'Donnell, L.J. et al, "Health Care in Early Infancy", *New Zealand Medical Journal*, 1978, 88:315-317

Oxley, P., *Financial Assistance for Released Prisoners: An Evaluation of the Pilot Programme at Paparua Prison October to December 1983*, Department of Justice, Study Series No. 13, 1984

Patterson, S.M., *Divorce in New Zealand: A Statistical Study*, Department of Justice, 1978

Population Monitoring Group, *The New Zealand Population: Patterns of Change*, Report No. 1, New Zealand Planning Council, 1984

Population Monitoring Group, *The New Zealand Population: Contemporary Trends and Issues*, Report No. 2, New Zealand Planning Council, 1985

Post Primary Teachers Association News, Vol. 5, No. 16, October 1984

Quin, E.A. and O'Neill, C.J., *Cohabitation in New Zealand: Legal and Social Aspects*, University of Waikato, Department of Sociology, Working Paper No. 21, 1984

Rayner, A.C., Chetwynd, S.J. and Alexander, A., *The Economic Costs of Alcohol Abuse in New Zealand*, report to the Alcoholic Liquor Advisory Council, 1984

Recreation in South Auckland, report of the South Auckland Recreation Planning Committee, 1981

Reinken, J. et al, *Health and Equity*, Department of Health, Special Report Series No. 72, 1985

Ritchie, J., *Chance to be Equal*, Cape Catley, 1978

Ritchie, J., "Social Characteristics of a Sample of Solo Mothers", *New Zealand Medical Journal*, 1980, 91:350-353

Routledge, A. and Taylor, A., *Young People and Alcohol*, New Zealand Council for Educational Research, 1981

St. John, A., *Financial Assistance for Families and the 1983 Budget*, University of Auckland Working Papers in Economics, No. 8, 1983

St. John, S., *Interim Report on the Financial Position of Families Incorporating the Effects of the 1984 Budget*, New Zealand Committee for Children, 1984

Salmond, G.C., *Maternal and Infant Care in Wellington: A Health Care Consumer Study*, Department of Health, Special Report Series No. 45, 1975

Salmond, G.C., *Accommodation and Service Needs of the Elderly*, Department of Health, MSRU, Special Report Series No. 46, 1976

Salmond, G.C. et al, *Accommodation Change in Old Age, Wellington*, Old People's Welfare Council, 1981

Schlesinger, B., "Widows and Widowers in New Zealand: General Information", *Journal of Comparative Family Studies*, Vol. XI, No. 1, 1980

Shannon, F.T. et al, "Immunisation in the First Year of Life", *New Zealand Medical Journal*, 1980, 91:169-171

Shipley, S.M., "Women's Employment and Unemployment", paper delivered to Women's Studies Conference, 1981

Shipley, S.M., *Women's Employment and Unemployment: A Research Report*, Massey University and the Society for Research on Women, 1982

Siew, S. Poh, "Contraceptive Use and Pregnancy Planning in the Hutt Valley", *New Zealand Medical Journal*, Vol. 85, 1977

Silva, P.A., "Some Maternal and Child Developmental Characteristics Associated with Breast-feeding: A Report from the Dunedin Multidisciplinary Child Development Study", *Australian Paediatrics Journal*, 1978, 14:265-268

Silva, P.A. et al, "Poisoning, Burns and Other Accidents Experienced by One Thousand Three-Year Olds", *New Zealand Medical Journal*, 1978, 87:242-244

Simons, J.F. et al, "Hospital Admissions During the First Five Years of Life: A Report from the Dunedin Multidisciplinary Child Development Study", *New Zealand Medical Journal*, 1980, 91:144-147

Social Advisory Council, *The Extra Years: Some Implications for New Zealand Society of an Ageing Population*, 1984

Social Advisory Council, *Child Care Services: Impact and Opportunities*, 1985

Society for Research on Women, *Solo Mothers*, 1975

Society for Research on Women, *Tawa Women*, 1977

Society for Research on Women, *Urban Women*, 1982 (1981 revised)

Society for Research on Women, *What Now? A Study of Pre-Training Courses for Women in the Wellington Area*, 1982

Society for Research on Women, *The Right Time: A Study of Women Expecting their First Child After the Age of Thirty*, 1984

Sparrow, M.J., "Sex Information and Attitudes in Young People", *New Zealand Medical Journal*, 1978, 88:483-486

Sparrow, M.J., "The Contraceptive Practice of One Thousand Abortion Patients", *New Zealand Medical Journal*, 1982, 95:885-887

Starling, J., "Breast-feeding Success and Failure", *Australian Paediatrics Journal*, Vol. 15, 1979, pp 271-274

State Services Commission, *Early Childhood Care and Education*, report of the State Services Commission Working Group, 1980

Stechman, W., *Women and Men in Banking: Is Sex a Factor in the Promotion/ Career Path of Bank Officers?*", New Zealand Bank Officers' Union, 1982

Tait, D., *New Zealand Recreation Survey, 1974-75*, New Zealand Council for Recreation and Sport, 1984

Task Force on Economic Planning, *New Zealand at the Turning Point*, 1984

Thomas, D., "Communication Patterns Among Pakeha and Polynesian Mother-Child Pairs: The Effects of Class and Culture", *New Zealand Journal of Educational Studies*, Vol. 13, No. 2, 1978

Tian, P.S. et al, "The Prevalence of Smoking Amongst Dunedin Nine-Year Olds", *New Zealand Medical Journal*, 1984, 97:528

Trlin, A. and Perry P., "Contraceptive Knowledge, Contraceptive Use and Pregnancy Risk Experience among Young Manawatu Women", *New Zealand Medical Journal*, Vol. 96, 1983

Urban Research Associates, *Self Medication: A Study Undertaken in Wellington, New Zealand*, 1978

Vocational Training Council, *The Impact of New Technology on the Training and Employment of Women*, Women's Advisory Committee, discussion paper, 1979

Waldegrave, C. and Coventry, R., "Unemployed School-leavers, Their Feelings, Their Experiences and Their Suggestions", The Family Centre, Anglican Social Services, Lower Hutt, 1981

West, R. and Harris, B., *Health Needs Survey*, South Auckland 1978, division of Primary Health Care, School of Medicine, University of Auckland

Wylie, C.R., *Factors Affecting the Participation in the Workforce of Female Heads of One-Parent Families*, Department of Social Welfare, 1980

Youthline Counselling Service, Auckland, Personal Communication, December 1984

BY AUTHORITY: V. R. WARD, GOVERNMENT PRINTER, WELLINGTON, NEW ZEALAND—1986

49320A—86PTK