ESSOP POSITION STATEMENT

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Social inequalities in child health – towards equity and social justice in child health outcomes

Introduction

"A society that wants to have a highly competent population for the future to cope with the demands of the emerging knowledge-based world and global economy will have to ensure that all its children have the best stimulation and nourishment during the critical early years of development, regardless of family circumstance". (McCain N, Mustard JF (1999) *Reversing the real brain drain – early years study final report*. Canadian Institute for Advanced Research, p.17)

The social determinants of health are well known [1] and children are particularly vulnerable to how economies create and distribute wealth and power. [2] Social inequalities in health can be defined as disparities within and between countries that are unfair, unjust, avoidable and unnecessary and that systematically burden populations rendered vulnerable by underlying social structures and political, economic, and legal institutions. [3] Social inequalities are, therefore, amenable to change through action at the societal level and, although present in all societies, vary in extent and significance between countries.[4] Social inequalities in health as they affect children are of particular relevance to child health professionals as they pervade most areas of child health practice.
Article 24 of the UNCRC [5] lays down an imperative to strive for the highest achievable levels of health for all children. This ESSOP policy statement aims to provide child health professionals with a framework to combat social inequalities in child health within their countries and between countries and develop national and international policy agendas based on equity of child health outcomes and social justice for all children.

Social inequalities in child health – extent and effects

Social inequalities in health affect children from their intra-uterine development through to adolescence and their influence then tracks into adulthood. [6] Social disparities in birthweight and gestational duration [7], infant mortality [8], illness and disability in childhood [2] and childhood accident rates [9] have been noted in many countries. Table 1 below, based on UK data, summarises the proportion of common childhood problems that would be avoided if all children had the same risks of adverse outcomes as the most socially privileged.

Table 1: Proportion of child health outcomes attributable to social inequality in the UK

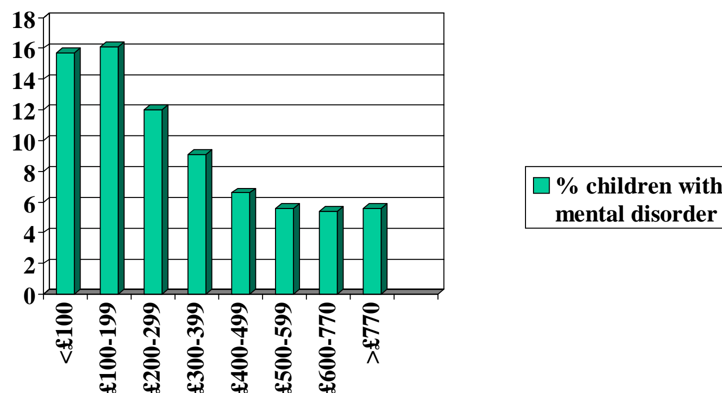
Child health outcomes	%age reduction if all children had same risk as most socially advantaged
Birthweight*:	
<2500g	30%
<1500g	32%
Very Preterm birth (<32 weeks)**	35%
Neonatal morbidity ***:	
Respiratory distress	32%
Infection	20%
Hypoglycaemia	18%
Disability**:**	
Cerebral palsy	30%
Educational disability	39%
Special educational needs	29%
Psychological and behavioural problems***:**	
Emotional disorders	34%
Conduct disorders	59%
Hyperkinetic disorders	54%
Registration for Child Abuse & Neglect**:**	
All categories	53%
Physical	34%
Sexual	50%
Emotional	35%
Neglect	56%

*Based on 210,000 births in the West Midlands region of the UK, 1991-'93
** Based on data from Trent region of England [10]
*** Based on data from the Wirral in the North West of England [11]
*** Based on data on 150,000 births in the West Sussex region of the UK, 1983-2001
**** Based on the UK survey of mental health among 5-15 year olds [12]

A key feature of social inequalities in health is that, for many outcomes, there is a finely graded stepwise increase in risk associated with increasing social disadvantage. This so-called social gradient is shown in relation to mental health problems in UK children aged 5-15 years in the figure 1.[12] However, social gradients are not seen for all outcomes or at all ages for the same outcome: for example, autism does not show a social gradient[13] and asthma shows a social gradient in early childhood but not in adolescence. [14]

% UK Children 5-15 with a mental health disorder by weekly household income, '99

(Meltzer et al 2000)



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Social disparities persist even in countries in which social policy ensures that social differences are minimised [15] but the disparities tend to be less marked and there is some evidence that the least advantaged in these countries have better health status than the advantaged in less equal societies. [16] The recently published UNICEF report [17] into child wellbeing in rich nations shows that wellbeing is poorer in less equal societies such as the UK and the USA.
Social inequalities in health have generated a longstanding causal debate. Having initially centred on the supposed genetic inadequacies of the poor, the debate polarised early in the 20th century into two schools of thought: the behavioural school that identified the poor health behaviour of poor people as the main cause of health disparities; the materialist or structural school that identified societal organisation and structures as the main drivers of health inequality. The Black [18] and Acheson [19] reports, commissioned 20 years apart by UK governments, supported materialist/structural explanations and it is recognised by many researchers that health-related behaviours are intimately linked with social status. [20]
Life course epidemiology [21] has advanced our understanding of the mechanisms by which social inequalities in health are generated and sustained. They are thought to arise from cumulative exposure to risk (and protective) factors longitudinally over the life course combined with cross-sectional clustering of risk (and protective) exposures. [22] This applies to children as well as to adults as the consequences of social risk and protective exposures can be transmitted across generations. [7] There appear to be critical periods when risk and protective exposures have most effect on health and pregnancy and early childhood is thought to be amongst the most important. [23] For this reason, the Acheson Report [19] reached the conclusion that reduction of risk exposures in pregnancy and childhood would be key to reducing social inequalities in health in childhood and adult life.

Policy implications for child health professionals – towards an equity and social justice agenda
Identifying, characterising, and understanding social inequalities in health are necessary but not sufficient in formulating an agenda for reducing, and eventually eliminating, social inequalities in the health of children. An agenda based on equity and social justice is needed to move from description of disparities to achievement of equity in child health. To realise equity in child health, child health professionals will need to challenge social structures that perpetuate inequity as well as strive to ensure equity in health care delivery. ESSOP proposes the following framework for an equity and social policy agenda through which child health professionals can contribute to the promotion of equity in child health and the realisation of Article 24 of the UNCRC for all children:

- **Advocacy for equity and social justice at local, national and international levels**: using data, informed by a strong evidence-base, to lobby for equity and social justice locally, nationally and globally. Wherever inequities in health outcomes and health care delivery exist, child health professionals should seek to publicise them and make constructive proposals for their elimination emphasising the advantages of social justice to the whole society.
- **Education and training:** equity and social justice in health should be an integral part of undergraduate and postgraduate training for all child health professionals. A good starting point would be training for all child health professionals to ensure awareness of the UNCRC and ways of using it in child health practice [see Training materials developed by Jeff Goldhagen and Tony Waterston]
- **Health care delivery:** even in 'free-at-the-time-of-use' health care services in which low income should not be a barrier to care children in low income households tend to receive poorer services. Ensuring that children in low

income households have equal access to high quality child health services is an important part of the equity and social justice agenda. Child health professionals should audit their local services to highlight and eliminate inequity in local service delivery.
- **Information and research:** all the above depend on reliable population level child health status data classified by social status, gender, ethnicity and age. The Child Health Information for Life and Development (CHILD) data set [24] provides a good template for the data systems to inform an equity and social justice agenda. Data on trends in inequalities are particularly important in this context. Although understanding of the processes by which social inequalities in health are generated and maintained has improved, further research is needed particularly to identify critical periods for intervention and to build an evidence-base for the effectiveness of interventions aimed at achieving equity and social justice.

Action points for paediatric organisations:
- Openly state their advocacy function in relation to the UNCRC
- Identify a named person or group responsible for advocacy
- Publish advocacy outcomes annually
- Ensure that paediatricians receive training in advocacy skills
- State the competencies required to work for social justice and equity & include them in the curriculum and examinations
- Develop educational strategies to achieve the above
- Develop a policy for participation by young people in planning services
- Ensure that their clinical services are accessible to children and their families from all ethnic, cultural and socio-economic groups
- Develop a research programme that: assesses the impact of social inequalities in terms of individual and population health outcomes including costs; develops an evidence base for the effectiveness of interventions aimed at achieving equity and social justice.

Useful materials:
Child Rights Training Programme – available from Jeff Goldhagen jeff_goldhagen@doh.state.fl.us or Tony Waterston a.j.r.waterston@ncl.ac.uk
CHILD data set is available at
www.europa.eu.int/comm/health/ph/programmes/monitor/fp_monitoring_2000_frep_08_en.pdf)

References:

[1] Marmot M, Wilkinson R (eds). *Social determinants of health*. Oxford University Press, Oxford, 1999
[2] Spencer |NJ. *Poverty and child health*. Radcliffe Medical Press, Oxford, 2000
[3] Krieger N. A glossary for social epidemiology. *Journal of Epidemiology & Community Health* 2001;55:693-700
[4] Koupilová I, Vågerö D, Leon DA, Pikhart H, Príkazsky, Holčík J, Bobák M. Social variation in size at birth and preterm delivery in the Czech Republic and Sweden, 1989-91. *Paediatric and Perinatal Epidemiology.* 1998;12:7-24
[5] UNCRC. www.uncrc.info
[6] Peck MN. The importance of childhood socio-economic group for adult health. *Social Science and Medicine.* 1994;39:553-62
[7] Spencer NJ. *Weighing the evidence: how is birthweight determined?* Radcliffe Medical Press, Oxford, 2003
[8] Pamuk ER. Social class inequality in infant mortality in England and Wales from 1921 to 1980. *European Journal of Population* 1988;4:1-21.
[9] Roberts I, Power C. Does the decline in child injury mortality vary by social class? A comparison of class specific mortality in 1981 and 1991. *BMJ* 1996;313:784-6
[10] Smith LK et al. Socioeconomic inequalities in very preterm birth rates. *Archives of Disease in Childhood Fetal Neonatal Edition* 2007;92:11-14
[11] Manning D, Brewster B, Bundred P. Social deprivation and admission for neonatal care. *Archives of Disease in Childhood Fetal Neonatal Edition* 2005;90:F337-8
[12] Meltzer H, Gatward R, Goodman R, Ford T. *The mental health of children and adolescents in Great Britain.* The Stationery Office, London, 2000
[13] Fombonne E. The epidemiology of autism: a review. *Psychological Medicine* 1999;29:769-86
[14] Chen E, Matthews KA, Boyce WT. Socioeconomic differences in children's health: how and why do these relationships change with age? *Psychological Bulletin* 2002;128: 295-329
[15] Halldórsson M, Kunst AE, Köhler L, Mackenbach JP. Socioeconomic inequalities in the health of children and adolescents: a comparative study of the five Nordic countries. *European Journal of Public Health* 2000;**10**:281-88
[16] Vagerö D, Lundberg O. Health inequalities in Britain and Sweden. *Lancet* 1989;2:35-6
[17] UNICEF. *An overview of child wellbeing in rich countries*. Innocenti Research Centre, Florence, 2007
[18] Townsend P, Davidson N**.** *Inequalities in health: the Black Report*. Penguin, Harmondsworth, 1982.
[19] Department of Health. *Independent Inquiry into Inequalities in Health (the Acheson Report).* The Stationery Office, London, 1998

[20] Lynch JW, Kaplan GA, Salonen JT. Why do poor people behave poorly? Variations in adult health behaviour and psychosocial characteristics, by stage of the socioeconomic lifecourse. ***Social** Science and Medicine*, 1997;44:809-20
[21] Kuh D, Ben-Shlomo Y (eds.) *A life course approach to chronic disease epidemiology*. Oxford University Press, Oxford, 1997
[22] Bartley M, Blane D, Montgomery S. Health and the life course: why safety nets matter. *BMJ*. 1997;314:1194-6
[23] Hertzman C, Power C, Matthews S, Manor O. Using an interactive framework of society and lifecourse to explain self-rated health in early adulthood. *Social Science and Medicine* 2001; 53:1575-85
[24] Rigby M, Kohler L, Blair M, Metchler R. Child health indicators for Europe: a priority for a caring society. *European Journal of Public Health* 2003;13 (3 Supplement):38-4 (see also www.europa.eu.int/comm/health/ph/programmes/monitor/fp_monitoring_2000_frep_08_en.pdf)