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Reducing Inequalities in Child Health: What counts? What works? What Matters?

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My role this afternoon is simply to introduce proceedings. I'm grateful to the provost, academic board and staff of Gresham for allowing us to hold this meeting here; I'm very grateful to Andrea for chairing – she is not a woman with time on her hands, and nor are the other speakers. Thank you, and thank all of you for coming along.

Gresham is ideally located for a discussion of inequalities. We are close to the wealth of the city, and the relative poverty to the east. There is another reason why Gresham is a good place to be for this topic. This institution provides access to discussion, learning and debate – education for all - with no fees, no fuss, and no examinations.

These days, and probably for reasons of access to funding, locations are not quite as shy as they used to be to describe their position in the inequality league. Islington where I live, which is the next door borough to here, is the 14th most deprived in England. Here, we are in one of the wealthiest bits of the UK.

Now, we Brits tend to be not very optimistic as a nation (though maybe at the moment we have a bit of post Olympics perkiness left), so I was keen to have a meeting that would be at the positive end of what might be done about inequalities in health (and not just what we might tell other people to do).

Whilst health inequalities can only be reduced substantially if governments have a desire and a mandate to make the necessary policy changes, there *are* things that individuals, communities and charitable and other organisations can do, as Danny, Judy and Sharon will be showing, and as our young speakers at the end of the afternoon will be illustrating.
This slide addresses in a very nice way 'what matters' – which is the fight for the fullness of life. The poem (I know that the Gresham Professor of Poetry might not call it a poem) was written by a Danish scientist, Piet Hein. Even though time is short, I'll tell you a little story about him as it bears to some extent on what we are thinking about today.

CONSOLATION GROOK
Losing one glove is certainly painful,
But nothing
Compared to the pain,
Of losing one,
Throwing away the other,
And finding
The first one again.
Piet Hein

When the Nazis occupied Denmark, Hein felt that his choices were to do nothing, to flee to neutral Sweden or to join the Danish resistance. He explained, "Sweden was out because I am not Swedish, but Danish. I could not remain at home [the do nothing option] because, if I had, every knock at the door would have sent shivers up my spine, so I joined the Resistance." His pen was his weapon and his first little poem carried the message (which the Danes apparently understood) that even if things go wrong (losing one glove), don't throw in the towel.

Of course the situation we are in now in terms of the threat which inequalities in health pose is by no means the same, but we shouldn't under-estimate the challenges faced by those at the sharp end of inequalities, and the damage to us all as that inequalities pose. As the cover (admittedly the back cover) of the report of the *Commission on the Social Determinants of Health* makes clear, "Social injustice is killing people on a grand scale."

But here is a (sort of) positive thing. There has been something of a move towards political consensus that inequality is not very good for us (I know some of you will think I am deluded, so I should add that this consensus may just be at the level of rhetoric, but even that's a start).

When I was looking after R&D for the children's charity Barnardo's, we commissioned and published in 1996 Richard Wilkinson's *Unfair Shares.*[1] The then secretary of state for health, Virginia Bottomley wrote to my boss, Roger Singleton to say how disappointed she was with Barnardo's for doing this. To his credit, he didn't flinch. But here's the thing. In 2009, David Cameron was taking a very different line to Bottomley, in fact a Wilkinsonian line. In his Hugo Young Memorial Lecture [2] he said:

"*.... Ask anyone of any political colour the kind of country they want to see and they'll say . . . a country that is fairer and where opportunity is more equal. ... [T]he incredible wealth of the City exists side-by-side with some of the poorest neighbourhoods in our country. For every tube station along the Jubilee Line, from Westminster to the East End, Londoners … lose almost an entire year of expected life….. Research by Richard Wilkinson and Katie Pickett has shown that among the richest countries, it's the more unequal ones that do worse according to almost every quality of life indicator… they show that per capita GDP is much less significant … than the size of the gap between the richest and poorest in the population."*

I bet Richard and Kate (or Katie as the PM calls her) never thought they would have an endorsement from Mr Cameron.

My title is what works, what counts and what matters in relation to inequalities in child health.

Returning to the Hein poem, you may have noticed from the programme that none of the speakers today is a medic (though I know there are some eminent ones in the room who have done a good deal of work in this area).

When considering health and ill-health in the UK, the NHS is often considered the principal contributor. We like to think of ourselves as one of the more privileged nations in which to bring up children. We have a health service of which most Britons are justly proud (and by the by, the NHS was set up at a time when we were very much worse off as a nation than we are now). The UK is a country where health outcomes for children are rather better than (for instance) the USA, to whom, ironically, politicians often look for policy ideas and research evidence.

That said, the vast majority of things which reduce inequalities in health are everything to do with health, but little to do with medicine. They are down to the achievements of engineers, teachers, and policy makers. As the Department of Health's strategy for public health in England[3] points out, health care services probably account for only about a third of the improvements in life expectancy. [4] However, in one crucial respect, the NHS plays a key part. Universal access to health care, free at the point of delivery is an important intervention[5]. So while it would be mistaken to see the NHS as the key player in addressing inequalities, there is a large body of evidence on the ways in which the NHS has improved the health of the nation.

In terms of public health pretty locally to here, when there was an outbreak of cholera in London in 1854, killing over 600 people in Soho, it was a doctor, John Snow, who organized the removal of the handle from Broad Street pump (but even then, this was more of a practical engineering solution than a medical one). According to one LSHTM scholar,[6] at the time, the theory underpinning the spread of cholera favoured explanations putting the blame where it so often rests - on the victims. The chairman of the medical council who undertook the investigation into the outbreak, reported that the underlying causes were: "local states of uncleanliness, overcrowding and imperfect ventilation.[7]"

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[1] Wilkinson R 1994 *Unfair Shares*, Barkingside, Barnardos
[2] Cameron D 2009 *Hugo Young Memorial Lecture*, November 10, 2009
[3] DH 2010 *Equity and Excellence, Liberating the NHS*, London, Department of Health
[4] Bunker J 2001 *Medicine matters after all: measuring the benefits of medical care*, London, The Nuffield Trust
[5] Arblaster L et al 1996 A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health, *Journal of Health Services Research and Policy*, 1 (2) 93-101
[6] S. P. W. Chave 1958 Henry Whitehead and Cholera in Broad Street, *Medical History*, 2 , pp 92-108 doi:10.1017/S0025727300023504
[7] General Board of Health, Report of the committee for scientific enquiries in relation to the cholera epidemic of 1854, London, Appendix p.158 (quoted by Chave above)

This rang a bell, reminding me of families I'd worked with in a piece of research in Glasgow in the 1990s. We were interested in accidental injuries to children (still the most important cause of death in childhood in the UK and one with a steep social class gradient). We wanted to know about the ways in which risks are experienced and managed in unsafe places.[8]

Chronic damp in the flat roofed tenement blocks was a problem and some of the folk we interviewed claim to have been told by officials that the damp was because they had left the soup on for too long, or were making love with the windows closed. (Humour works in Glasgow to keep you cheery, but it doesn't keep you alive for as long as us southerners).

Mothers – still the major carers for children, tend to attract adverse press and sometimes professional comment, with suggestions that when sickness or worse strikes, the main need for change lies with them.

The children of poor parents can be portrayed as suffering when mothers go out to work and when they do not. Their diets are not sensible, their discipline lacking, parenting skills wanting.

The 2011 riots in London saw two kinds of mother narrative in the press, the bad mother, usually single and parent to young people running riot and the feisty mother marching her miscreant child to the police station.

Such damaging portrayals come in spite of evidence that the majority of mothers living in poverty protect and promote the health of their children under the most unpromising conditions.

I have started with what matters – education, engineering, housing and of course a health service free at the point of need.

But what of what counts? Of course, it goes without saying that not everything that counts can be counted, but some metrics – and this is where the reports on which Michael Marmot's team have led are so important - are very powerful in helping us understand stuff which can often be presented in complex ways.

Having good data and good people like Danny, Judy and Sharon who can interpret data makes all the difference in knowing where we stand in relation to inequality. But we know that statistics can be slippery. At least Winston Churchill was frank when he said to his researcher Iain Maclean:

"*The first lesson that you must learn is that when I call for statistics about the rate of infant mortality, what I want is proof that fewer babies died when I was prime minister than when anyone else was prime minister. That is a political statistic*."

Clearly, no politician in office wants bad news about infant mortality but rankings can serve as a call to action[9].

This slide, well known to those of you working on health inequalities (and to the PM as it turns out, since he referred to it in the speech I mentioned just now), demonstrates the stark realities. A baby born in St Mary's in Paddington (where the young princes were born) is down to live around 5 years longer than a baby born in Newham. Obviously this doesn't mean if you live in poverty in Newham, legging it onto the 25 bus and changing for the 205 to St Mary's will make a difference – it is all the other things which bring you (or your parents) to a rich or poor borough that matter.
Children who are born to poorer mothers and fathers are more likely to be born early, born small, and die in the first year of life. Death counts, and can be counted.

Health though is a bit more slippery. You can be in a wheelchair and be super-healthy as the Paralympics showed but you can be in tip top health as measured by a tip top paediatrician and be a miserable kid.

In 2007, UNICEF ranked the UK at the bottom of a league table for child wellbeing across 21 of the better off countries, looking at poverty, family relationships, and health. Last year, UNICEF looked at why children seem to do better in nations which are more equal than us – Sweden – and more unequal, Spain. Children in all three countries told researchers that what they need to be happy is time with family and friends and "plenty to do outdoors". So here is a good example of something that can be done in relation to outdoors.

When, last year, I was looking for good examples of initiatives which levelled the playing field in terms of inequalities, one which looked really promising was a scheme in Hull enabling old and young, able bodied and not, to get out and about together on their bikes.

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[8] Roberts H Smith S and Bryce C, (1995) *Children at risk: Safety as a social value*, Buckingham, Open University Press. Titmuss

[9] Kvale KM, Mascola MA, Glysch R, Kirby RS, Katcher ML. Trends in maternal and child health outcomes: where does Wisconsin rank in the national context? *WMJ* 2004;103:42-7.

What I liked so much about the scheme was that it was very practical. And what is best is that it's still running. I dreaded contacting Hull last month to see if the scheme had fallen victim to the cuts, and it hasn't.

Health services matter, housing matters, transport matters. But what probably matters most of all in levelling the playing field is education. Although early education has the greatest potential, just as it is never too early, it is also never too late to make a difference. Cyra and Tabitha are likely to have more to say about education later on.

Some young people may have particular problems in managing at university. Most young people in most families, however badly off, can count on their parents lending a hand, but for those brought up with the state as their mum and dad, university can be a big challenge. In an imaginative scheme, the Buttle Trust works with both universities and more recently colleges of further education, to make sure that the right supports are in place for looked after young people going to university or college.

And finally, what works? Education, housing, good sanitation, immunization 'work' in the sense that the right dose of these is associated with good outcomes overall. But many well-meaning public health interventions, just like clinical ones, are relatively untested. While the Cochrane Collaboration has done a great deal to improve the standards of evidence in medicine, many ideas with strong face validity in public health are still relatively untested – so as researchers are inclined to say, more high quality research is needed – though as the other speakers will show, we do already know quite a bit, and there already are some really positive and creative interventions.

One what works-y issue is does it work better to target the poorest people, or to have universal interventions?
Given the unequal distribution of ill health among children, it may seem to make sense to target interventions at those in greatest need. But there are good public health arguments for universal services.

Theoretically, targeting should be cheaper than measures aimed at whole populations, but only if it works. A case in point was an early trial of school breakfast clubs where some families who might have benefitted didn't use the service because of what they felt this might say about their own ability to provide breakfast for their children.

If targeting carries a stigma, it may be at best ineffective, as some eligible children and parents will avoid the service, or at worst harmful as children who used to have to queue separately for free school meals can testify.

The attraction of a universal approach to child public health can be illustrated with a medical analogy. Writing in the British Medical Journal, Geoffrey Rose and Simon Day[10] point out that traditional prevention strategies aim to eliminate the 'tail' of the distribution, but not to interfere with the rest of the population. Looking at data from 32 countries, they found that average blood pressure predicts the number of hypertensive people; average weight the number of obese people and average alcohol intake the number of heavy drinkers. In practice, dealing with a problem by cutting off the tail is unlikely to work. The statistical 'tail,' as Day and Rose point out, is part of the animal.

A number of studies of child weight for instance, suggest that parents from families with weight problems tend to normalise size:[11]

"*You look at me and his father, so he's not gonna be little either*"

As we become more overweight as a society, bigger children may start to look more normal-sized.

To conclude, being an academic is not the most practical job in the world (though it is a real job, contrary to public opinion, and we are cheaper to keep than bankers).

There are competing narratives on what needs to be changed and a powerful one which I mentioned earlier is 'some mums, especially poor ones, are bad for your health, so come on commissioners, buy a parenting programme.' This despite overwhelming evidence that the vast majority of mothers, as Hilary Graham and others have pointed out, protect and promote the health of their children. The 'blame the mums' view is by no means new.

In the early 1940s, following the publication Richard Titmuss's book *Birth Poverty and Wealth*[12] newspapers reported 'Babies beware of poor parents.' Titmuss was suggesting that children's deaths were related to the occupations of their fathers, and that the gap between the life chances of working class and middle class infants was increasing. The *Evening Citizen*

[10] Rose G and Day S (1990) The population mean predicts the number of deviant individuals, *British Medical Journal*, 310,1122-6
[11] Lucas P et al (2007) A systematic review of lay views about infant size and growth, *Archives of disease in childhood*, 92, 120-7
[12] Titmuss R 1943 *Birth Poverty and Wealth*, London, Hamish Hamilton

suggested that the book ignored 'the criminal ignorance and neglect of many mothers,' inclined to give their babies 'fish and chips, pickles, strong tea, lollipops, chocolate biscuits and toffee apples.[13]'

Graham's work on women and smoking and ours on safety as a social value demonstrated mothers trading off one risk against another. A cigarette can give a mum a moment of peace:[14] "I'll be with you when I've had this ciggy" or a mother might trade off leaving children alone for a few minutes if she lives in a tenement four floors up, and needs to hang the washing out on the green.[15]

It may be the statistical studies which grab the headlines, but the seam of qualitative work on the coalface of domestic or school life, [16] on the streets and in hospitals, has become less fashionable and less fundable, though there are admirable exceptions, including Lisa Arai's work on teenage pregnancy,[17] Katherine Tyler's on children with diabetes[18], and Patricia Lucas[19] on infant growth.

As I am a researcher, I am going to end on a somewhat nerdy (but positive) methodological point.

Investigate, experiment, and go on trying to put things right and build bridges.
Don't throw in the towel.
And this brings me to close with my 3rd Piet Hein poem:

The road to wisdom
Well it's plain and simple to express
Err and err and err again
But less and less and less
Piet Hein

[13] Oakley A 1996 *Man and Wife, Richard and Kay Titmuss*, London, Harper Collins
[14] Graham H (1984) *Women Health and the Family*, Brighton, pp. 171-2, Wheatsheaf Books
[15] Roberts et al 1996 op cit
[16] Reay D (1998) *Class Work : Mothers' involvement in children's schooling London:* University College Press.
[17] Arai, L. (2009) *Teenage pregnancy: The making and unmaking of a problem*. Bristol: Policy Press
[18] Curtis-Tyler K (2010) Levers and barriers to patient-centred care with children: findings from a synthesis of studies of the experiences of children living with type 1 diabetes or asthma. *Child: Care, Health and Development*
[19] Lucas, PJ, Arai, L, Baird, J, Kleijnen, J, Law, C & Roberts, H. 'A systematic review of lay views about infant size and growth', *Archives of Disease in Childhood*, 92 (2), (pp. 120-127), 2007. ISSN: 0003-9888