

Policy Implications:

Tackling child poverty will raise health levels

The facts show that links between poverty and ill health go far beyond the immediate health effects of living on a low income. As people's lives unfold, the poor health associated with poverty limits their potential and has knock-on effects on the future lives of those affected and of their children. Repeated exposure of families to poverty intensifies this process.

Reducing and eventually eliminating child poverty would break this cycle, with profound benefits for the health of the population. The same government that has as its stated objective the halving of child poverty by 2010 and its elimination by 2020 also has in its public service agreements the following key objectives and indicators that would be addressed by reduction in child poverty (HMT 2007):

PSA 12: Improve the health and well-being of children and young people

Including the following key indicators:

- Breastfeeding at six to eight weeks
- Childhood obesity
- Child emotional health and well-being

PSA 13: Improve children and young people's safety

Including the following key indicators:

- Hospital admissions caused by unintentional and deliberate injuries
- Preventable child deaths

PSA 18: Promote better health and well-being for all

Including the following key indicators:

- All age, all cause (AAACM) mortality rate
- Gap in AAACM mortality rate in disadvantaged areas
- Smoking prevalence

An underlying objective of health policy today is to **move more towards preventing ill-health**, rather than concentrating only on treatment and cure. By intervening early in children's lives to **eliminate the economic deprivation** that so badly damages their health, we can take a major step towards meeting this goal.



What needs to be done:

1) Tackle Poverty to Prevent Ill-health

Poverty is the greatest preventable threat to health, and tackling it is fundamental to addressing health inequalities and boosting life chances. The Government needs to invest an additional £3 billion per year to help meet the interim target to halve child poverty by 2010.

2) Get it Right from Before the Start

Poverty damages children before birth and increases the chances of being born underweight, with major implications for mortality and morbidity risks throughout life. Investments made or proposed through child benefit (before birth) and the new Health in Pregnancy grant are very welcome. Alongside these the Government needs to improve income support scale rates to ensure an adequate minimum income in pregnancy.

3) Invest in Children as they Grow

School lunches (together with breakfast clubs) offer a great opportunity to ensure that all children, and particularly poorer children, get a decent meal. The 'Jamie Oliver effect' focused minds on quality, now we need to improve access. Free School Meal entitlement covers fewer children than live in poverty, and even then not all get their entitlements. Policy makers need to tackle stigma which stops families claiming and start learning from the creative solutions of widening access (for instance to low income families in work) being adopted by the Scottish Executive and in Hull.

4) Break the Inverse Care Law

Poorer people have worse health yet too often they get access to worse services – more poorly funded and staffed. Policy makers should bend spending more radically towards services dealing with poorer communities and develop services better fitting different needs to detect ill-health earlier so health care can be more effective.

1 in 3 children are living in poverty in the UK today. Child poverty is not inevitable, and progress has been made, but with one child in every three still experiencing poverty we have an urgent task on our hands.

The Campaign to End Child Poverty is a coalition of more than 100 children's and other charities, child welfare organisations, social justice groups, faith groups, trade unions, schools and others concerned about the unacceptably high levels of child poverty in the UK – all working together to eradicate child poverty.

This briefing is the latest in a series of briefings on key Campaign areas, others include:

- Child Poverty and Income,
- Child Poverty and Education,
- Child Poverty and Housing, and
- Employment and Childcare.

To learn about child poverty, take action and get involved in the Campaign, go to:

www.endchildpoverty.org.uk

Registered Charity no. 1099008.



Unhealthy Lives

Intergenerational Links Between Child Poverty and Poor Health in the UK



Briefing by Donald Hirsch and Professor Nick Spencer, published by End Child Poverty with support from GMB.



Summary

In many parts of the world, large sections of the population typically have short, unhealthy lives because of poverty. In the UK today, there remain powerful links between child poverty and poor health.

Poverty affects children's health before they are even born, and the compounded consequences of poverty at different ages influence development throughout the lives of those who grew up poor. When they go on to have children of their own, these effects are passed to the next generation.

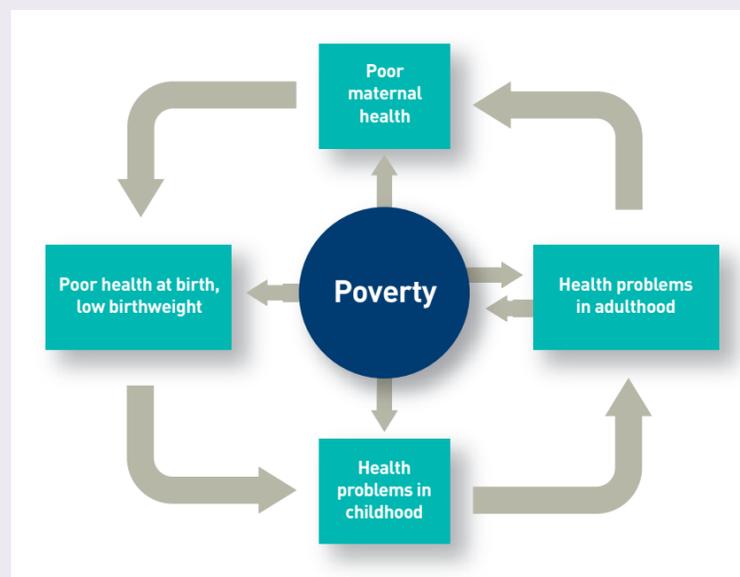
This briefing presents evidence of the poverty-health cycle, which is illustrated in the diagram below. At each stage of life, individuals' health can be affected both by the direct impact of poverty and by the knock-on effects of health difficulties at an earlier stage.

This briefing is based on data presented in two papers written by Professor Spencer of the University of Warwick. See: www.endchildpoverty.org.uk

In Summary:

- Poverty affects children's **birthweight**. One third of births with low weight are associated with economic inequalities.
- Children face far greater health risks if they are in disadvantaged families. For example, they are ten times as likely to **die suddenly** in infancy, 2½ times as likely to suffer **chronic illness** as toddlers, twice as likely to have **cerebral palsy** and over three times as likely to suffer **mental disorders**.
- Adults who suffered poverty as children are 50% more likely to have **limiting illnesses**. Adults who had low birthweight are over four times as likely to have Type 2 **diabetes** (associated with obesity) and 25% more likely to die from **heart disease**.
- Mothers who grew up socially disadvantaged are one-third more likely to **smoke during pregnancy**. They are also much more likely to be among those with low qualifications, who are more likely to smoke and less likely to **breastfeed**.

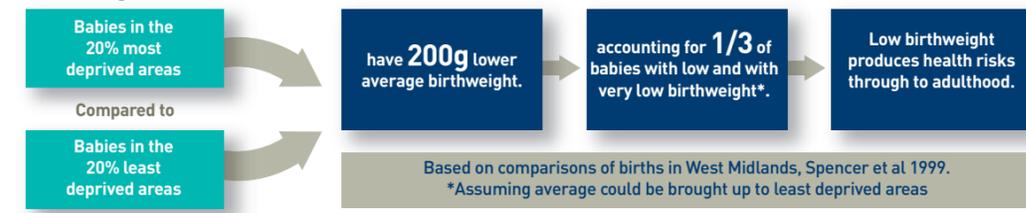
This evidence has profound implications for public policy. It suggests that effective action to tackle child poverty would make an important long-term contribution to many health-related policy objectives, including reducing obesity, reducing heart disease, increasing breast feeding and improving mental health.



Babies

Babies suffer health penalties if they are born into disadvantaged families. Babies whose parents are in poverty have far greater risk of having low birthweight. This has implications both for the risk of infant mortality and for health problems in later life.

Birthweight



Infant Mortality



Studies of **birthweight** in different parts of the country have compared babies born in more and less deprived neighbourhoods. Those in the 20% most deprived areas typically have a birthweight 200g lower than those in the 20% least deprived. This creates a substantial extra risk of babies being of low or very low birthweight, which in turn affects the chances of suffering ill health later in life.

For example, a study in the West Midlands showed that if all areas had had the same birthweight pattern as the 20% best-off areas, there would have been 30 per cent fewer babies born at below 2.5kg, and 32 per cent fewer below 1.5kg.

This finding reflects the consequences of health inequalities all the way across the income distribution. Children in poverty have worse health than everyone else, but among those who are not in poverty, there is a continuous improvement among those with higher incomes.

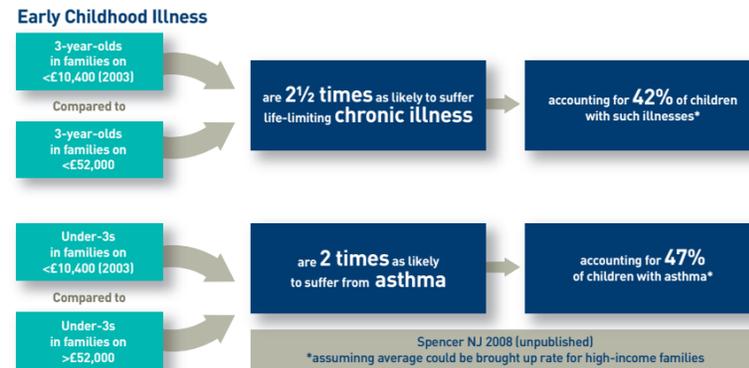
Closely associated with low **birthweight**, stillbirths and mortality in the first week of life are much higher in families with lower socio-economic status. Among families with professional and managerial occupations, this "perinatal mortality" rate halved from 12 to 6 per thousand births between 1979 and 1999, but among the least advantaged families it was still 11 per thousand in 1999. While the risk of dying at birth has declined among all groups, the relative risk for disadvantaged social groups has risen.

Infant mortality rates, measuring deaths among under-1 year olds, are also much higher among more deprived families – about twice as high in the lowest than in the highest socio-economic group. Sudden unexpected death in infancy has decreased in recent years partly in response to the 'Back to Sleep' campaign, advising mothers to sleep their babies on their backs. However, babies who die unexpectedly in infancy are now more concentrated than ever in families on low incomes, who have ten times the rate of sudden infant death than families on relatively high incomes.

Children and Young People

Children and young people growing up in disadvantaged families face worse physical and mental health, and more disabilities

Infant and childhood deaths affect only a small minority of the population in developed countries, even among families in poverty. But social inequalities also extend to more common aspects of childhood health, including physical illness, disability and mental health and behavioural disorders.



Illness

Children born in 2000, being tracked by the Millenium Cohort Study, were already showing large differences in health status at the age of three, according to their family conditions. Among children in families with incomes below about £10,000 a year, 4.2% suffered from limiting chronic illnesses at this age, compared to just 1.7% among well-off families on over £52,000. About one in six of the poorer group suffered from asthma, compared to just one in 16 in the richer group – even though asthma was previously not thought to be associated with social background. If the risk of such illness among all children could be brought down to the level for the better-off group, the number of sufferers could almost be halved.

Other conditions with wide social differences during childhood include chronic ear infections and tooth decay. It is not just the risk of long-term illness but its severity that is greater among children living in poverty. For example, they are more likely to have severe forms of asthma. Children in poverty are no more likely than others to require insulin for diabetes, but are more likely to have an episode that requires admission to hospital.

Disadvantaged children are also more prone to sudden illness, such as acute infections including pneumonia and other respiratory illnesses. Tubercular infection among children is on the increase, particularly among ethnic minority children, and, as in the past, the association between TB and poverty is strong.

Many of these illnesses are associated with aspects of children's living conditions. For example, Shelter's report Against the Odds (2006) found that children in bad housing are twice as likely to suffer from bad health as other children. Evidence showing that social differences in acquisition of infectious diseases persists despite general improvements in sanitation points to the importance of environmental and material disadvantages, rather than behaviours, in explaining this link (Reading, 1997).

Disability

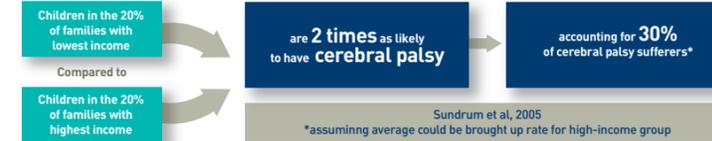
There are sharp differences in the prevalence of childhood disability according to the socio-economic status of the household, with working class children having a higher risk of being disabled than their better-off peers.

Cerebral palsy is the most common childhood physical disability. Data from West Sussex collected in the 1980s

and 1990s shows that children in the most deprived groups are twice as likely to suffer cerebral palsy as those in the most privileged group.

The same study shows that developmental delay in early childhood, particularly delay in speech and language, is associated with social disadvantage.

Disability



Mental Health and Behaviour

Children growing up in poverty are more likely to suffer a wide range of behavioural and emotional problems. A Department of Health survey of the mental health of children and young people showed that overall, one in six children in families with low incomes suffered from mental health disorders, compared to only just over one in twenty in better-off households.

This social difference is steepest for boys, with the risk three times as great in poor than in well-off families.

Disorders such as ADHD affecting children's behaviour show particularly high social differences. The incidence of these conditions would fall by nearly 60% if all children had the same risk as better-off children do now. Note however that autistic spectrum disorders show no social differences.

Other conditions with strong social patterns include bedwetting and self-harming behaviour. For children in poverty, self-harm can emerge at an alarmingly early age, with one in 40 children of low socio-economic status aged 5-10 engaging in such behaviour, compared to fewer than one in 100 of those with high socio-economic status.

At the extreme, young people from deprived groups, and especially young males are more likely to commit suicide than affluent young people. The suicide rate for young men is more than twice as high in deprived than in affluent groups.

Why do children in poverty display so much higher rates of mental and behavioural disorders? The reasons are complex, but certainly related to the extra stress on families in poverty, which can also contribute to family instability and its consequences.

Mental and behavioural disorders



The Height of Poverty

Social historians have noticed strong links between changes in a society's affluence and its average height. In modern Britain, adult height appears to be partly determined by the class-related rate of childhood growth (Wadsworth and Kuh, 1997). By the age of 10, one study showed children living in deprived areas about 5cm shorter on average than those in the least deprived areas (Reading et al 1994; confirmed by Clark et al, 2005).

Being short is not an illness or disability, but short stature does increase the risk of certain conditions among adults, and in the case of mothers among their children (see page 7 below). Height differences provide a stark indicator of differences in the physical well-being of children from different backgrounds.

About 40% of children in poverty live with a lone parent. Given that lone parenthood is an established feature of our society (affecting one in four children), this poses the challenge of giving economic, social and practical support to help relieve such stresses.

A large social difference in teenage parenthood helps pass these strains on to subsequent generations. Girls in the lowest social class are ten times as likely to have children as teenagers than those in the highest social class.

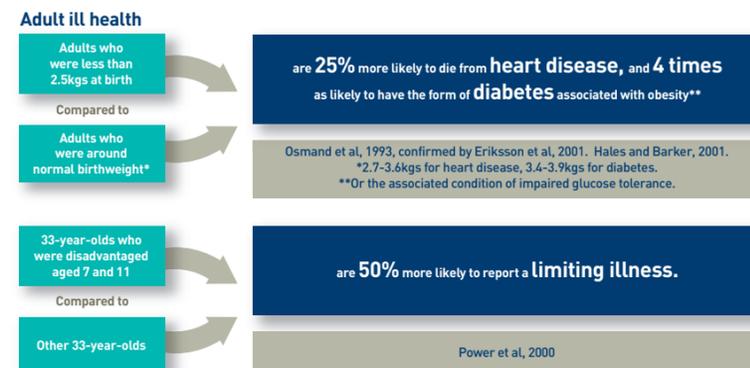
Adults suffer worse health on average if they had low birthweight or grew up in poverty

Many factors influence health in adulthood including the immediate conditions in which people are living. But the long-term influences of childhood poverty on lifetime health are clear.

The evidence shows that the transmission of family poverty into future health risks is particularly marked through what happens during pregnancy and birth. Low birthweight is a predictor of a range of adult diseases, including:

- Fatal heart diseases, with deaths markedly higher for those with low birthweight;
- Non-fatal heart diseases;
- Some respiratory diseases, although not lung cancer;
- "Type 2" diabetes, associated with obesity.

The reduced average birthweight of children born in poverty (see page 2 above) therefore has wide-ranging health implications.



Furthermore, adults who faced financial hardship during childhood are more likely to have:

- High blood pressure and other conditions associated with heart disease;
- Certain disabilities, particularly related to sickness in childhood;
- Respiratory illnesses, especially if they experienced overcrowding;
- Symptoms of mental ill-health, such as distress, hopelessness and depression.

Overall, adults who suffered disadvantage in childhood are 50% more likely to report facing limiting illness in mid-life.

Among the important factors that lie behind this link between childhood poverty and adult ill health is the link between poverty and low educational attainment. Those without qualifications find it harder to get good jobs, and thus to face recurring poverty and other disadvantages harmful to their health.

Mothers who grew up in poverty may pass health disadvantages on to their own children

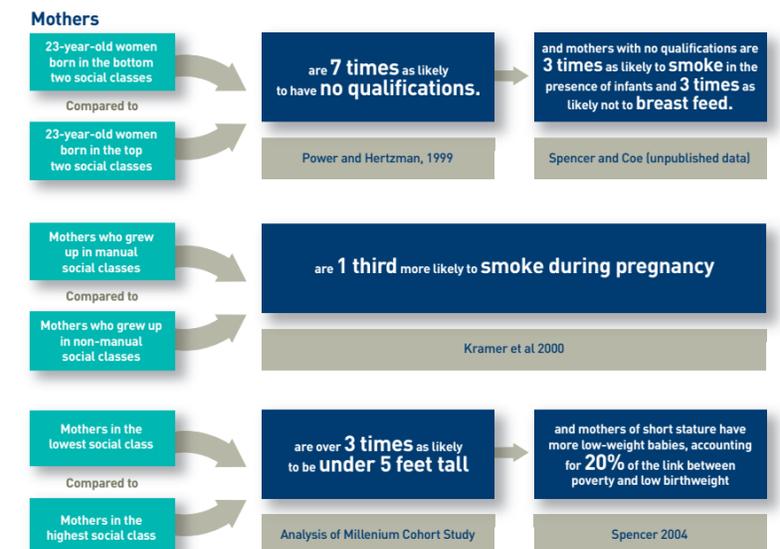
The cycle of poverty and poor health is completed when mothers affected by their own childhood poverty have characteristics that may adversely affect the health of their own children.

Some of this effect is purely physical. Effects of lower material living standards on height and birthweight mean that mothers who have had a life of poverty are more likely to have small babies who will be at greater risk of health-damaging conditions through their lives. The development of the foetus during pregnancy has a crucial impact on health throughout life, in ways that are only recently starting to be understood.

The current conditions in which a mother lives is also part of this equation. Babies whose mothers have a poor diet in pregnancy have a greater chance of low birth weight, preterm birth and congenital abnormalities such as spina bifida (James et al, 1997).

These physical phenomena interact with maternal behaviours, which are also influenced heavily by a mother's life experiences. Women who have

not gained educational qualifications and who have experienced poverty are more likely to engage in behaviour that is risky for their children, most notably to smoke during pregnancy.



References

Clark EM, Ness A, Tobias JH and ALSPAC team (2005), "Social position affects bone mass in childhood through opposing actions on height and weight" Journal of Bone and Mineral Research 20:2082-89

Eriksson JG, Forsén T, Tuomilehto J, Osmond C, Barker D. (2001) "Early growth and coronary heart disease in later life: longitudinal study", BMJ 322:949-53

Exeter DJ and Boyle P (2007). Does young adult suicide cluster geographically in Scotland? Journal of Epidemiology and Community Health 2007;61:731-6.

Fleming P, Blair P, Bacon C and Berry J (2000) 'Sudden Unexpected Deaths in Infancy: the CESDI SUDI studies 1993-9', The Stationery Office.

Golding J, Thomas p and Peters T (1986). 'Does Father's Unemployment put the Fetus at Risk?' British Journal of Obstetrics and Gynaecology 93, pp704-10.

Hales CN and Barker DJ (2001) "The thrifty phenotype hypothesis" British Medical Bulletin 60:5-20.

Howard M, Garnham A, Fimister G and Veit-Wilson J (2001). Poverty: the facts, Child Poverty Action Group.

James WP, Nelson M, Ralph A and Leather S. (1997) "Socioeconomic determinants of health. The contribution of nutrition to health inequalities" BMJ 314; 1545-9).

Kramer MS, L Séguin, J Lydon and L Goulet, "Socio-economic Disparities in Pregnancy Outcome: why do the poor fare so poorly?", Paediatric and Perinatal Epidemiology 14, 2000, pp194-210.

McLoone P (1996) 'Suicide and Deprivation in Scotland', BMJ 312, pp543-4.

Meltzer H, Gatward R, Goodman R, Ford T. (2000) The Mental Health of Children and Adolescents in Great Britain, The Stationery Office.

ONS (2004) Focus on Social Inequalities, The Stationery Office, London.

Power C and Hertzman C (1999) 'Health, Well-being and Coping Skills' in D P Keating and C Hertzman (eds), Developmental Health and the Wealth of Nations, The Guilford Press, pp41-54.

Power C, Li L and Manor O (2000) 'A Prospective Study of Limiting Longstanding Illness in Early Adulthood', International Journal of Epidemiology 29, pp131-39.

Reading R, Raybould S and Jarvis S (1994). 'Deprivation, Low Birthweight and Children's Height: comparison between rural and urban areas', British Medical Journal, 307, pp1458-62

Reading, R. (1997), 'Social Disadvantage and Infection in Childhood', Sociology of Health and Illness 19.

Spencer NJ, Bambang S, Logan S and Gill L (1999) 'Socio-economic Status and Birthweight: Comparison of an Area-based Measure with the Registrar General's Social Class', Journal of Epidemiology and Community Health 53, pp495-98.

Spencer NJ (2004) 'Accounting for the social disparity in birth weight: results from an intergenerational cohort' Journal of Epidemiology and Community Health 58:418-9.

Sundrum R, Logan S, Wallace A and Spencer NJ (2005). 'Cerebral Palsy and Socio-economic Status: a retrospective cohort study', Archives of Disease in Childhood, 2005;90:15-18.

Wadsworth MEJ and Kuh D (1997). 'Childhood Influences on Adult Health: a review of recent work from the British 1946 national birth cohort study, MRC National Survey of Health and Development' Paediatric and Perinatal Epidemiology 11, pp2-20.