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 set 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 services – more poorly funded and developed – to better fitting different needs to reduce ill-health earlier so health care can be more effective.

To learn about child poverty, take action and get involved in the Campaign, go to:
www.endchildpoverty.org.uk

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Briefing by Donald Hirsch and Professor Nick Spencer, published by End Child Poverty with support from GMB.
Poverty affects children’s health before they are ever 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.

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

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.

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 die 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.

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 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.

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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.

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 1990s 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.

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. These conditions would fall by nearly 60% if all children had the same risk as better-off children.

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.

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.

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 role 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.

Disability

Children born in 2000, being tracked by the Millenium Cohort Study, were already showing large differences in height status at the age of three, according to their family conditions. Among children in families with incomes below about £10,400 a year, 2.1% suffered from limiting chronic illnesses at this age, compared to just 1.7% among well-off families on over £32,000. About one in six of the poorer group suffered from asthma, compared to just one in ten 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 severer 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.

Mental and behavioural disorders

Children living in families with incomes below £10,400 are 2.5 times as likely as those in families with incomes above £52,000 to suffer from mental illness, according to the Department of Health survey of mental health of families in 2000, and in the 20% 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.

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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. Elicits of lower materian living standards on height and birthweight mean that mothers who have had a lot 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 also is part of this equation. Babes whose mothers have a poor diet in pregnancy have a greater chance of low birth weight, pretterm 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.

All the above factors mean that the health of children born into poverty is more at risk, and thus the cycle of poverty and adult ill health is the link

Thus, disadvantaged children are more likely to have:

• Lower birth weights;
• Higher risks of congenital abnormalities such as spina bifida;
• Higher rates of preterm births;
• Higher risks of low educational attainment;
• Higher risks of heart disease in adult life.

As children, disadvantaged children are more likely to have:

• Poorer nutrition;
• Higher risks of childhood psychological illnesses;
• Poorer educational qualifications.

As adults, disadvantaged children are more likely to have:

• Higher risks of heart disease, including stroke;
• Higher risks of low educational attainment;
• Higher risks of depression.

The cycle is completed once again when disadvantaged adults have children of their own.

References
Power et al, 2000
Power and Hertzman, 1999