

## What Works in Reducing Inequalities in Child Health? – Summary

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### ***The 'What Works?' series***

Some ways of dealing with problems work better than others. Every child has the right to expect that professionals intervening in their lives will do so on the basis of the best available knowledge. But the majority of interventions in social care are not evaluated before they are introduced. In that sense, much of the work done with children is an uncontrolled experiment.

Barnardo's has a special interest in evidence-based practice, that is, finding out what works, and ensuring that the interventions we and others make in children's lives are as good as they possibly can be.

As Roy Parker and his colleagues have pointed out:

*'A hundred years ago, the benefits of providing separate care for deprived and disadvantaged children were thought to be self evident. It has since become increasingly apparent that unless outcomes in childcare can be adequately measured, we have no means of justifying the actions of social workers, which may have far reaching and permanent consequences for individuals.'*

Qualitative work, and user studies, for which the UK has a good record, are important in understanding the processes which enable interventions to work well, and understand what service users most value. They do not, however, help us to know what interventions work best, or why.

In order to understand cause and effect - the relationship between a particular intervention and an outcome - randomised controlled trials are important. RCTs in the UK and North America include studies of day care, home visits, accident prevention, and other early childhood interventions.

The cohort studies, such as the National Child Development Study (NCDS) enable us to see who does well after a poor start in life, and understand what factors may lead to resilience.

Barnardo's What Works reports draw on a range of research designs and evaluations which suggest that particular interventions are worthwhile.

## ***This report in brief***

The biggest differences to child health will not be made by the NHS, but by changes in other sectors. While the post war period has seen a sharp decline in deaths in childhood in the UK, continuing problems face children and young people. Despite medical and social welfare advances, inequalities in childhood remain stark. The most effective time to intervene to reduce inequalities in health is in early life. Child public health is potentially the most important – and most effective - activity in health and social care, encompassing as it does interventions in health, education, housing and public policy.

The report covers:

- A discussion of some of the methods which help us to judge the effectiveness of our interventions. How can we start to judge what works when faced with a barrage of conflicting studies?
- Interventions in pregnancy, early life and the pre-school period. This is an area where a relatively large amount of work has been done, and where we have strong evidence of the effectiveness of some interventions
- Interventions intended to keep children safe from accidental injury, the greatest childhood killer
- Interventions with groups we know to be particularly vulnerable, including children looked after by the state, and children whose educational opportunities are poor.
- Fiscal interventions and material benefits.
- A resource/contact list for those seeking good research evidence

## ***Inequalities in child health***

There is compelling evidence linking health and wealth. For us to make a meaningful difference to inequalities in health, we need to tackle not just health problems but the determinants of those problems.

- A child in the lowest social class is twice as likely to die before the age of 15 as a child in the highest social class
- The gap between the most and the least disadvantaged children in terms of the main cause of child deaths - accidents - has widened in the last decade
- There is a steeper social class gradient for child accidents than for any other cause of death.
- A child from the lowest social class is *nine times* more likely to die in a house fire than a child from a well-off home.
- At any one time, a fifth of children and adolescents experience psychological problems.
- While mortality has markedly decreased over the last century, reported ill health among children is rising, with particular increases in respiratory diseases, including asthma, and emotional problems.
- Families with disabled children have only 78% of the resources of all families with children
- It costs three times more to bring up a child with a disability than a child without disabilities
- Young women in and leaving care have babies much earlier than other women
- Children looked after are very much less likely to be protected from infectious disease through immunisation than other children
- Looked after children and young people get a particularly poor deal.

## ***What do health inequalities mean for children?***

If we listen to children's views, we often find that 'the environment,' 'play' and 'being safe from traffic' are close to the top of their agendas.

*'That my family could be safe all their lives in a safe street'* (Boy, 11)

Children born into poverty are more likely than their better off neighbours to:

- die in the first year of life
- be born small, be born early, or both
- be bottle fed
- die from an accident in childhood
- smoke and have a parent who smokes
- have poor nutrition
- become a lone parent
- have or father children younger
- die younger

## ***What can be done?***

Projects dealing with the effects of poverty, even when they are evidence-based, are elastoplast on a gaping wound. A focus on projects and a whole range of interventions (some more evidence-based than others) can be used to avoid having to confront the reality that child poverty can be reduced by political and economic action. Inequalities in health can only be fundamentally tackled by policies that reduce poverty and income inequality. This means poor people getting more money, a measure which has a degree of public support in the UK.

- The investment required to eliminate child poverty is relatively small, amounting to 0.48% of GNP in the UK.
- Ministers have pledged to take one million children out of poverty by the next election, and to eradicate child poverty by 2020.

- A secure family income is one of the most important elements in enabling children to be healthy, to gain a good education, to live in a safe environment and to make choices about their future.
- Adequate income, affordable child care, adult employment opportunities, an inclusive education system and accessible health, leisure and transport facilities are essential for the prevention and eradication of inequalities in child health.

### ***The kinds of services we can provide:***

- The health service on its own cannot tackle inequalities in child health
- The best overall support for a disadvantaged start is a good education.
- Some of the inequalities seen in child health are widening
- Some measures taken to improve health may widen inequalities
- While many interventions intended to improve matters for the poorest sections of the community are targeted, there is a strong public health argument for universal services. Most poor children do not live in poor communities.
- There is not an effective intervention for every problem we can identify. This makes it important to act on the basis of those interventions with good evidence of effectiveness, and where there is no good evidence, recognise that we are experimenting.
- Where we are experimenting, we need to evaluate well so that we can know whether we are doing good, doing harm, or using resources which will leave matters much as they were.
- 'Strong' evaluation (rather than evaluation as justification) needs to be a routine part of ethical practice

### ***Practice messages - General***

- While it is never too early to make a difference to the lives of young people, and early life is the best time to intervene effectively, it is never too late.
- The desire to 'do something' can mean that interventions with vulnerable groups are not properly thought out and may be ineffective or worse.
- Promising interventions and associated evaluations need to be planned and discussed with vulnerable people on the receiving end of services.

- The imperative to be innovative undermines the use of the best available evidence. There is a middle way, building on the best available evidence, and robustly testing the next steps.

### ***Practice messages - Day care and early education***

- The quality and the content of pre-school provision matters. Poor day care may do more harm than good.
- Pre-school education such as High Scope can improve longer-term outcomes for disadvantaged children.
- Staff should be well-trained in child development, and well-supported to encourage minimal turnover.

### ***Practice messages - Social support***

- Social and emotional support can make a difference. If you are considering providing a service which does this, look at the systematic reviews on what seems to make the greatest difference.
- The Community Mothers scheme, described above, based on the findings of a randomised controlled trial, suggests good outcomes on a variety of dimensions.
- We need to know more about what kinds of parenting education and support work, and we will only know this with well designed and well evaluated interventions.
- Brief interventions by health visitors, diagnosing and treating post natal depression appear to be effective.

### ***Practice messages – Breastfeeding***

- Breastfeeding is associated with better outcomes for babies. Better off mothers are more likely to breastfeed, and breastfeed for longer.
- Giving women leaflets is of little value.
- There is scope for good evaluative research on peer support projects, and projects designed to influence other family members, in particular fathers.
- Hospitals whose policies support breastfeeding need to ensure that their practices are in line with those policies.
- There is an information deficit. In 1997, only eight out of 13 trusts visited by the Audit Commission could provide information on the number of new mothers breastfeeding on discharge from hospital. If we are going to intervene effectively, we need good data.

### ***Practice messages – Nutrition***

- The movement (probably best developed in Scotland) to promote cheap food in the community, and community cafes, appears a promising approach.
- Nutrition education through didactic means appears to be relatively ineffective in promoting good diets.

### ***Practice messages - Smoking reduction or cessation***

- Social attitudes, legislation and public health measures influence changes in tobacco use.
- Nicotine replacement therapy is effective.
- Generic self help materials are no better than brief advice but more effective than doing nothing. Personalised materials are more effective than standard materials.
- Advice from nurses as part of general health promotion has not as yet shown an effect.
- Many smokers give up without intervention.
- Brief cognitive behavioural interventions, with support, appear to be helpful in reducing passive smoking in households where the mother smokes.

### ***Practice messages - Keeping children safe***

- Pamphlets, and safety education are not very effective in reducing child accidents, and may increase parental anxiety, without addressing the core issues.
- It is possible to build child accident prevention into Children's Services Plans and Health Improvement Programmes (HIMPs), but this is not done as often as it might be.
- We can learn from children on how they keep themselves safe, and from parents on how they keep their children safe. Treating children and parents as defective in child safety matters is as ineffective as treating airline passengers as defective in air safety matters.
- Smoke alarms are likely to be effective in the reduction of injury through house fires, but only if they are installed and working well. We need to know more about this area.
- Day care is one way of reducing accidents in under 5s.
- Barnardo's *What Works in Child Protection* (Macdonald with Winkley, 2000) provides helpful guidelines on the prevention of non-accidental injury.

### ***Practice messages - Unwanted teenage pregnancy***

- A good general education is strongly associated with low rates of teenage pregnancy. A range of life choices may make early pregnancy in less than ideal circumstances, less attractive.
- Knowledge of, and access to, emergency contraception for young women is probably less good than it should be. However, pregnancies and terminations do occur in young women who have used emergency contraception in the past.

### ***Practice messages - Mental health services***

- More needs to be known (and used) about the effectiveness. *What Works for Troubled Children* in Barnardo's *What Works* series (Buchanan, 1999) gives helpful pointers. *Young Minds*, the Mental Health Foundation and *Focus*, also provide useful background material.

### ***Practice messages - Looked after children and young people***

- The Quality Protects initiatives offer a way to start to monitor and improve the looked after experience for children.

## ***Conclusions and recommendations***

Improving the prospects of children and young people is an investment rather than an expense.

- A minimum income standard is needed to maintain good health and the well-being of children.
- For sustainable impact of initiatives of known effectiveness, long term mainstream funding is needed.
- Approximately a quarter of all children are born to mothers under 25 years old. Therefore the supposition that people aged less than 25 require lower rates of benefit than those over 25 needs to be re-examined urgently
- Improving the health of children and young people needs to be a key R&D priority, with an emphasis on the 'D.'

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