

Theme 1

Foundations of Health Promotion with Children/Young People

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Reducing Health Inequalities

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The aim of the National Service Frameworks (NSFs) for children, young people and maternity services (Education and Skills, Department of Health, 2004) is about setting standards that will help to tackle inequalities, addressing the particular needs of children, their families and communities, who are likely to achieve poor outcomes.

Introduction

In most cultures children/young people are seen as special and held in high regard by their families, the local community and the state. As children/young people are the future of a family and a nation, children and child welfare are often the topic of political debate and policy. The United Kingdom (UK) could be held up as an example of this; child and young people focused, as an examination of the political party manifestos over the past 30 years will show. Whether it is education in schools, the reform of the Child Support Agency or the development of new safeguarding arrangements following a child abuse inquiry, the health and well-being of children/young people are topics that strike a cord with parents, politicians and the population at large.

In this chapter the interlinked topics of *health inequalities* and *childhood deaths* are explored. In the first section of this chapter, patterns and causal factors of health inequalities are considered. The second section looks at how national policies can be translated into local action by the National Health Service (NHS) and its partner agencies. Interventions are illustrated by examining one part of North West England.

National perspective

Health inequalities

In 2003 the UK Government published its action plan for tackling health inequalities (Department of Health, 2003). Tony Blair in his foreword to this publication stated: 'Our society remains scarred by inequalities. Whole communities remain cut off from the greater wealth and opportunities that others take for granted', and he went on to say, 'We have to start to tackle this health gap' (Department of Health, 2003, p. 1).

The plan sets out the complex social and economic factors that were the causes of these inequalities. The Government's aim was to reduce health inequalities by looking at the wider determinants of health – poverty, poor educational outcomes,

unemployment – and the problems of disadvantaged communities.

In the UK, deaths of children/young people are unusual events, but sadly they do occur. In a review of child health by the Association of Public Health Observatories (APHO, 2006), over 16 500 deaths were recorded between 2002 and 2004 for children/young people under the age of 20 years in the UK:

- This equates to over 5500 deaths per year on average.
- The largest single-age group was children aged less than 1 year, accounting for 56% of the registered deaths.
- The second largest group consisted of young people aged 15–19 years, accounting for 21% of the registered deaths in this 3-year period.

So what are these health inequalities and what effect do they have on the life chances of children/young people? In its report on the patterns of health inequalities within the North West region of England, the North West Public Health Observatory highlights: 'A baby boy from Manchester has the lowest life expectancy in England, at 72.3 years compared to 80.8 years in East Dorset, a difference of 8.5 years', and 'A baby girl from Blackburn with Darwen can expect to live until 77.9 in comparison to 85.8 years of a girl born in Kensington and Chelsea, a difference of 7.9 years' (Wood et al., 2006).

Both of these examples illustrate a fundamental point that even in the UK, one of the wealthiest nations on the planet, there are differences in the life chances of children born in different parts of the country. Two reports originally published in the 1980s identified the health gap between the richest and poorest communities within the UK. In 1980 the Black Report was produced by an independent working group to highlight that whilst the overall health of the population had improved, there was a growing gap between the least and most affluent in the country (Townsend and Davidson, 1992). These findings were reiterated in 1987 in the *Health Divide* (Whitehead, 1992).

These reports have become key reference tools to public health practitioners in the UK. Arguably, their value to health practitioners and the public at large was not that the publications highlighted a new discovery. The authors demonstrated clearly

what most people knew instinctively, namely, that the more affluent you were, the greater the likelihood that you would live a longer and healthier life.

The Black Report was endorsed by Acheson (1998) in his *Independent Inquiry into Inequalities in Health Report*. This in itself has become a significant document, advocating effective interventions to tackle the wider influences on health inequalities.

In the context of child health, it was not just that a baby boy from Manchester would die at 72 years rather than 80 years. These independent reports confirmed that infant and child mortality rates were not just higher in the most deprived communities, but the gaps in the infant and child mortality rates for the least affluent and most affluent were widening.

To illustrate this point, consider three statistics listed by the Department of Health:

- (1) The infant mortality rate among children in social class V in 1998–2000 was double that for social class I.
- (2) Children in social class V are five times as likely to suffer accidental death than their peers in social class I.
- (3) The risk of residential fire death for children is much greater for those in social class V.

It can be seen from these examples that the difference between infant mortality rates in social class I and social class V is significant. Infant mortality rates for social classes III and IV, whilst lower than Class V, are higher than social class I. One of the causes for this variation in life chances becomes apparent from studying the other two statistics presented. Statistics 2 and 3 reveal the higher risk to children in lower social classes from accidents. The causes of infant and child mortality are explored later in the chapter.

Defining social classes

As shown above, researchers have subdivided the UK population into several categories based on occupation. Although some of the occupations have changed over the years to reflect technological changes, the basic classification has essentially

remained unchanged. The five classes are as follows (Drever and Whitehead, 1997):

- (I) Professional occupations
- (II) Managerial and technical occupations
- (III) Skilled occupations – non-manual and manual
- (IV) Partly skilled occupations
- (V) Unskilled occupations

Government targets

To address these inequalities, the Government tasked the NHS with achieving significant changes in the life chances of local communities. In 2003 the Government's inter-departmental document, *Tackling Health Inequalities: A Programme for Action*, sets out the public service agreement targets to reduce key inequalities (Department of Health, 2003, p. 7):

- Public service agreement target: By 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

This target has two objectives. Starting with children under 1 year, the Government wants to reduce, by at least 10%, the gap in mortality between manual groups and the population as a whole, to be achieved by 2010. The second objective is for local authorities to reduce, again by 10%, the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole, by 2010.

The UK Government also identified a target in relation to road traffic accidents. By 2010 it wants to see a reduction in the number of people killed in road accidents by 40% and the number of children killed or seriously injured reduced by 50%, compared with the average for 1994–1998 (Department of Transport PSA5, 2006).

Causes of death in different age groups

The following provides details on the causes of death amongst children/young people. Data have been obtained from the APHO (2006). It relates specifically to 2002–2004 for England, but there are similarities with other parts of the UK. The original source for some of the data reported

by the APHO (2006) was sought from the Office of National Statistics, annual death extracts – <http://www.statistics.gov.uk>

Infant mortality

Definition – number of deaths at ages under 1 year per thousand of live births (APHO, 2006).

For children from birth to 1 year, the majority of deaths were due to immaturity and congenital abnormalities. Approximately 37% of the deaths were linked to immaturity with congenital abnormalities responsible for around 16% of deaths (APHO, 2006).

For immature babies with birthweight of under 1500 g, the mortality rates are 104 times higher than normal-birthweight babies. For babies over 1500 g but below 2500 g, the mortality rate is still 22 times higher than normal-birthweight infants (APHO, 2006). The APHO (2006) review of child health indicators also noted that low-birthweight babies were at greater risk of sudden infant death syndrome when compared to normal-birthweight children. The evidence suggests that they are four times more likely to suffer sudden infant death syndrome than those babies of normal birthweight.

Ethnicity was also identified as factor in infant mortality by the APHO (2006). Their analysis of the data points out that low-birthweight babies were more common amongst Asian mothers than other cultural groups.

Infant mortality data are commonly classified under two main headings: those occurring from live birth to 27 days and then from 28 days until 1 year of age. The APHO (2006) maintains that two-thirds of infant deaths occurred in the 0- to 27-day period, known as the neonatal period.

Causes of mortality in children and young people

Causes of mortality – in children aged 1–4 years per 100 000 of the population and in persons under 20 years per 100 000 of the population (APHO, 2006).

For children aged from 1 to 10 years, the commonest causes of death were unintentional injury, congenital abnormalities, cancer and diseases of the nervous system (APHO, 2006). As highlighted above, accidental injury was the greatest cause of childhood death, which includes transport

accidents, drowning, choking, suffocation and fire. The highest figures of unintentional injury were reported amongst the most disadvantaged groups in the population.

As the causes of these deaths were accidental then they were potentially preventable. It should be remembered that as well as causing deaths, accidents are also a cause of non-fatal injuries amongst more children. Interventions, therefore, that reduce the number of deaths are also likely to reduce the number and severity of such injuries too.

Most deaths due to congenital abnormalities were more common in the first year of life; however, 15% of deaths in 1- to 4-year-olds were also due to congenital abnormalities. Cancer, as a cause of death in childhood, is a relatively rare factor, accounting for approximately 14% of deaths in children aged 1–4 years (APHO, 2006). Conditions affecting the nervous system accounted for another 14% of deaths amongst this age group. Particularly important amongst these diseases in terms of prevention are meningitis and encephalitis.

For children/young people in the 5- to 14-year-old age group, around 26% of the deaths were due to injury, with a further 25% of deaths due to neoplasm. Just over 30% of the childhood cancers were due to leukaemia. Brain and spinal tumours account for a further 25% of childhood cancers. In the case of injury, road traffic accidents were the cause of approximately half of the deaths. Most of the serious injuries or deaths occurred when children/young people were pedestrians. Cycling accounted for almost 15% of serious or fatal injuries in children.

Ethnicity would also seem to have a bearing in relation to road accidents. There have been some studies which suggest that there may be a higher rate of child pedestrian accidents amongst minority ethnic communities (APHO, 2006).

Amongst young people in the 15- to 19-year age group, injuries accounted for 56% of deaths. Most of these were related to transport injuries. Other leading causes of death included self-harm 18% and neoplasms 13%. The marked rise in deaths from accidents in this age group compared to the other age groups, along with deaths from self-harming behaviour, highlights the increase in risk-taking behaviour associated with this age group.

It can be seen that there are a range of factors which have a bearing on the life chances of children

and young people. The second section of this chapter explores how some of these factors can be tackled by local initiatives.

Local interventions

The following will outline some health initiatives that have taken place in Sefton. Just north of Liverpool, in the North West England, is the metropolitan borough of Sefton. Its total population is almost 290 000. Almost 25% of the population is under the age of 20 years. In the south of Sefton there are higher levels of deprivation, with several parts of this area falling within the 20% of least deprived electoral wards in England (Sefton Health, 2004). Deaths in children (birth – 14 years) have been decreasing from a rate of 4.1 per 100 000 in 1994–1996 to 1.13 in 1997–1999.

Reviewing their accident prevention policy in 2003, the local primary care trusts and the local authority took stock of their plans to reduce accidents in the light of a new report, *Preventing Accidental Injury – Priorities for Action* (Department of Health, 2002). This report highlighted the following short-term priority areas:

- Falls at or near home.
- Road accidents.
- Dwelling fires.
- Play and recreation.

In response to the new guidance, a Sefton Injury Prevention Strategy was launched in 2003. The 5-year strategy focused on the development of projects and schemes to reduce accidents, affecting children in the home, school and community. Sometimes described as a *settings approach* to a public health issue, the strategy aimed to use local accident data to influence changes in these settings.

Set out over leaf are the main settings identified by agencies where accidents occurred in Sefton. Also included are the specific priority areas they believed needed to be addressed to reduce serious injury or death amongst children/young people.

It is easy to see how the strategy could call upon the knowledge and skills of local health visitors and school nurses to play a part in accident prevention. However, the strategy was not going to be limited to these branches of nursing. For example,

district nurses, whilst home visiting, were being called upon to provide advice to elderly patients and their carers. Although the main focus of their advice was towards reducing accidents amongst older people, there was also the opportunity to provide advice for grandchildren if any were present in the home.

Practice nurses or nurses staffing walk-in centres or accident and emergency departments were also in a position to provide advice to parents/carers, children/young people. This type of prevention would, of course, be a secondary prevention message, as the child/young person or parent/carer was attending the surgery or department as a result of an injury. Nonetheless, there was a clear opportunity to discuss how to prevent further injuries occurring to the patient, as well as other members of the family.

The information below identifies the key settings and priorities for local action.

Setting	Priority Area
● School/college	Risk taking behaviour Environmental risk Policy and practice
● Home	Physical home safety Safety awareness
● Neighbourhood	Reducing injuries to child pedestrians Drivers exceeding speed limits Use of seat belts Safe play areas Development of derelict sites and void properties

The settings approach to health promotion has been described by Ashton and Seymour (1993) in their book, *The New Public Health*.

Sure Start

To help improve the health of children in Sefton and to reduce accidents, the borough partners welcomed the opportunity provided by the Government to create Sure Start centres, in several of the most deprived electoral wards in the borough. Sure Start is a UK Government programme which aims to achieve better outcomes for children, particularly

those under 4 years of age. It also aims to help parents/carers and communities by the following:

- Increasing the availability of childcare for all children.
- Improving health and emotional development of younger children.
- Supporting parents/carers in their aspirations towards employment.

Three overarching aims underpinned these developments:

- (1) Better outcomes for all children, particularly closing the gap in outcomes between children living with a single parent/carer and the wider child population
- (2) Better outcomes for all parents/carers, increased opportunity to participate effectively in the labour market, ensuring pathways out of poverty and strengthen families and communities
- (3) Better outcomes for communities, including less crime, higher productivity, a stronger labour market and the building of a civic society

Further information can be found on these aims by accessing the Sure Start website – <http://www.surestart.gov.uk>

Writing in the borough's public health report for 2004, Linda Turner, the lead officer for accident prevention, described how the local accident prevention strategy was developing and the key role Sure Start was playing (Sefton Health, 2004). Turner (Sefton Health, 2004) highlighted that injury data had shown a high level of risk to children living in deprived communities. Sure Start centres were used as focal points for developing new skills and knowledge amongst parents/carers and children/young people.

For preschool children, who were unable to assess risk for themselves, the focus of the accident prevention campaign was their parents/carers. A programme called *Beany Bump* was provided. It includes training for parents/carers, a resource pack containing useful information and checklists, as well as a starter pack with safety devices. A safety equipment scheme enabled parents/carers to purchase larger items such as safety gates and

fireguards at cost price. Initial findings suggest that there has been a slight decrease in the number of accidents to children under five, which may be linked to these interventions.

Road safety

For children/young people of school age, the injury prevention programme switched its focus to the children/young people themselves. With this programme the aim was to reduce risk-taking behaviour. It focused on locations frequented by children/young people. The campaign known as *Think On* publicised its risk-reduction messages at bus stops, in schools and youth clubs, and in other places used by young people. The campaign also targeted road safety as many of the accidents to children were related to traffic.

Children from low-income households are more likely to live near main roads, more likely to play by or in roads (due to the lack of safe places to play) and to walk rather than travel by car. It is not surprising then that four out of every five pedestrian or cycle accidents involving children/young people can occur within 1 km of their home. Led by the borough council, efforts were made to create safer play areas closer to the communities where most children lived. A range of other measures were introduced to reduce accidents, including the following:

- Traffic calming and pedestrian crossings.
- Marked pedestrian and cycle routes to improve access.
- Improved lighting.
- Education and training initiatives.

Key players in all these local initiatives have been nurses. In some cases they have played leading roles in the development of programmes. The primary care trusts in Sefton took the innovative step several years ago to invest in a Public Health Neighbourhood Nursing scheme. Community nurses from a range of backgrounds were freed up from some of their clinical caseload duties to enable them to work more closely with small local communities. The new responsibilities of the neighbourhood nurses

included carrying out local needs assessments and leading health promotion programmes on such issues as accident prevention, positive parenting and healthy eating.

Needs assessments have taken two forms: the first focuses on assessing the needs of a community, whilst the second focuses on assessing the needs of individual children/young people. Techniques such as health equity audits can be used to assess the vulnerable groups, particularly how they access health services within a community. As part of *Every Child Matters* (Education and Skills, 2003), the Government published a new tool for assessing the needs of an individual child or young person. Known as the common assessment framework (Education and Skills, 2006), this tool enables a wide range of practitioners to carry out a holistic needs assessment of an individual child, taking into account family and environmental factors.

One of the local health promotion initiatives on healthy eating and accident prevention included in the Neighbourhood Nursing scheme was *Health Sac*. A public health neighbourhood nurse adapted a scheme used by a primary school in her area to incorporate health promotion material. The material was provided in such a way that the school children and their parents/carers could share learning about health issues such as *5 a Day* (Department of Health, 2004), first aid and injury prevention. The scheme was very popular with all concerned and has been extended to all the neighbourhood regeneration areas of Sefton.

Tackling lifestyle factors

In another initiative the neighbourhood nurses took part in a survey which explored the views of local children/young people about their knowledge on a range of lifestyle issues. Known as *Rampworx*, the information from the survey has informed health promotion programmes, ensuring that they run in partnership with children/young people. Themes include avoiding/reducing use of alcohol, smoking and preventing sexual health problems. The aim of these health promotion programmes is to equip young people with age-appropriate knowledge and

skills to safeguard their future health and well-being.

Reducing smoking amongst young women was felt to be important. It can have a long-term impact on infant mortality as nearly two-thirds of teenage mothers smoke before pregnancy and around 50% smoked during it. Of the modifiable risk factors in relation to preventing low-birthweight babies, reducing smoking is seen as a key area for nurses to intervene either to prevent young women from taking up smoking or helping them to stop. Combined with initiatives such as the *Back to Sleep* campaign (Department of Health, 2007), smoking cessation programmes have helped to reduce the number of cases of sudden infant deaths significantly.

The examples above illustrate the coordinated and multi-layered approach that is needed to reduce the factors that could injure or kill children/young people. These health promotion activities need to be sustained in order to protect each child and young person as they grow.

Conclusion

The causes of health inequalities are complex and deep rooted. Health inequalities affect the life chances of children/young people in terms of early death or in life years lost in adulthood. Such inequalities have been linked to poverty and social class. These variations in health opportunities can be seen across the UK. Both the causes and the effects of such inequalities can be altered by concerted action at national and local levels. In the UK, the Government has set targets for the NHS and other statutory agencies to reduce health inequalities. At local level, nurses can make a major contribution to improving the health chances of children/young people through health promotion initiatives. To maximise their contribution, nurses need to have knowledge about the causes of health inequalities and their potential impact on the health of children and young people. Nurses also need knowledge of the health promotion techniques that can be used to assist children/young people and their parents/cares to reduce the chances of serious injury, illness or even death. The role of nurses in caring for children/young people must begin with pre-

vention. As the largest group of health care practitioners, nurses are well placed to make a significant difference to the life chances of children/young people.

Resources

<http://www.apho.org.uk>
<http://www.dft.gov.uk>
<http://www.everychildmatters.gov.uk>
<http://www.isdscotland.org/isd/4339.html>
<http://www.nwpho.org.uk>
<http://www.statistics.gov.uk>

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