Policy for Child Health in the United Kingdom

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ABSTRACT. The Issue. It is argued that health policy is determined by many influences, including research evidence. However, the evidence base needs further development if it is to be used effectively. If health policy is to promote equity in child health, then it must not be confined to health services. This article is, essentially, a personal perspective on UK health policy for children, particularly as it relates to inequalities in health and using scientific evidence. Many issues are general and apply to all health policy, including child health. Furthermore, in cases in which children can be included in mainstream policy agendas, we may make faster progress in improving child health than when we have to make a special case. Pediatrics 2003;112:722–724; child health policy—United Kingdom, UK health policy for children.

POLICY FOR HEALTH—OR HEALTH POLICY? The Ottawa Charter for Health Promotion lists the prerequisites for health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. The current UK government has recognized that influences on health run through the roots of society, a contrast to earlier governments that concentrated on individual responsibility. This recognition has led to the so-called “third way” of determining health policy; this is seen as a middle ground between an individualist approach, which some have characterized as victim blaming, and a centralized responsibility ethic, which at the other extreme is seen as the "nanny state."

However, explicit recognition by government of the societal causes of inequalities in health sometimes seems to be more difficult in practice than in theory. In 1997 and 1998, the 4 health departments in the United Kingdom (there are separate departments for England, Wales, Scotland, and Northern Ireland) issued consultation documents about their developing health policies. Table 1 is reproduced from Working Together for a Healthier Scotland, explicit commitments to tackling inequalities in health were a welcome development in this and other consultation documents, as was the acknowledgment of the societal as well as individual causes of inequalities. In Table 1, the diseases of inequality are set out, together with the individual actions that might prevent them. However, when considering the critical issue of life circumstances, the societal influences that we know are major determinants of inequalities in health—poverty, poor education, unemployment—are relegated to examples in a footnote, without any statement of what should be done (eg, less poverty, better education).

Given the prerequisites for health, it follows that public policy in many areas (eg, housing, transportation, the environment) will affect health. However, popular and political opinion often equate health policy with policy under the remit of the health departments or, even more narrow, with health service policy. Health services and health departments have an important role to play, but policies for health need to encompass wider issues. One of the challenges for child health professionals is how we can influence those wider health policies as well as the health services in which we have a more obvious role.

The current UK government has shown some support for the concept of wide-ranging policy for health, as part of its general strategy for “joined-up government.” Ministers from 10 government departments signed the government’s health strategy, Saving Lives: Our Healthier Nation. Health impact assessment on all policies that might affect health is government policy, but it is in its infancy (health inequalities impact assessment, even more so). But recent announcements of health policy have been put out under the cover of “the National Health Service Plan,” although some of the measures seem to have little to do with the National Health Service (eg, setting targets for inequalities in health, providing free fruit at school). Apparently, there is a natural tendency for government health policy to become policy for health services.

For all policies, the needs of and consequences for children are nobody’s responsibility. Calls continue for a children’s commissioner or ombudsman who would monitor and represent the interests of all UK children across government. Although the recent appointment of a national director for children’s health care services is welcome, a broader role is needed to truly promote children’s health and well-being.

WHAT DETERMINES POLICY? Although it sounds trite to say that policy is determined by political will, the will of political parties and individuals encompasses a range of motivations, constraints, and opportunities, not all of which are typified by the caricature of a cynical politician. For example, politicians may have deeply held moral
convictions (abortion or capital punishment) and have to take into account formidable institutional barriers (eg, in the United Kingdom, the European Union Common Agricultural Policy; in the United States, the options for handgun legislation) and the state of the economy (taxation and welfare policy), but policy also can be affected by evidence, and evidence-based policy has become a Holy Grail. Some advocates cite a sizable body of evidence and press for randomized controlled trials of public health interventions. Others argue that the evidence base in public health is so insubstantial that evidence-based policy is not yet possible. They also press for a wide range of methodologies and approaches.8,9 In the midst of this debate, there have been a number of attempts by academics and government to assess the evidence on reducing inequalities in health with a view to making evidence-based policy. These include 2 government-commissioned reports, from Black (1980), which was buried by the government in power10 and Acheson (1998),11 which has elicited a government response.12 Both of these reports put the reduction of inequalities in child and family health at the forefront of their recommendations. However, the evidence base in these (and most other) areas is suboptimal, particularly for describing precisely what interventions are useful. Also, evidence is not a pure and absolute entity—beliefs and values of researchers and policy makers color the research and its interpretation.

**IS CURRENT POLICY EVIDENCE-BASED?**

The previous UK government tended to focus on changing the behavior of individuals directly. In contrast, the current government favors area-based initiatives—Health Action Zones,13 Education Action Zones,14 Sure Start,15 and so on. However, basing policy on statistics collected at area level risks incurring the ecologic fallacy: associations between variables at an aggregate level do not necessarily mean that the associations exist at the individual level. Furthermore, area-based approaches reach only a minority of people who are poor, most of whom do not live in areas that are poor, and benefit people who are not poor but who live in areas that are.16

The government is also advancing individual-level policies, albeit not to the extent favored by some. It has declared that it will enact a 20-year program to eradicate child poverty. In practice, the main plank of its strategy to increase family income is to encourage age 1 or both parents to go to work. What evidence do we have that this will improve child health? As we do not know the mechanism whereby poverty is associated with disease, we do not know whether raising household income will improve child health. We are applying an unevaluated intervention (raising family income by parents’ working) without knowing whether either the primary intervention (raised income) or the associated interventions (absence of parents, increased workload of parents, provision of child care) will affect the desired outcome (child health and/or poverty). There is evidence on the effect of center-based child care, for instance. Indeed, there is a systematic review of randomized controlled trials at the top of the evidence hierarchy,17 but all the trials were conducted in the United States, so we do not know whether they are applicable in the UK setting. The interventions also contained a number of components. Which was effective within the black box of center-based child care? Will non–center-based child care, which is an important component of the government’s national child care strategy,18 work as well?

Policy for health is not only made at the national level. Local policy making is important in translating national policy to practice and in developing policies that might become or influence national policy. Arguably, local policy making is more amenable to advocacy by local health professionals. Sure Start and Health Action Zones are national programs that rely on local policy making for their implementation, as the form that they take depends on local collaboration between policy makers and services. These programs are or should be based on evidence (at least on principles of what works, eg, community participation and plurality of approach). Their evaluation should add to the evidence base.

**CONCLUSIONS**

Among health professions, there sometimes is a tendency to stick to familiar territory—the health services. After all, that is what we know, but we also know about health and what is associated with ill health. I suggest that we can use that knowledge in the following 2 ways: 1) to develop the evidence base and use it in practice (eg, taking part in or facilitating research, acting on research results, translating them in the context of our working environment) and 2) to advocate for children at any level possible.

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**TABLE 1. Scotland’s Health: National Priorities**

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<th>Improved Life Circumstances*</th>
<th>Lifestyles</th>
<th>Health Topics</th>
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<tr>
<td>Less smoking and drug and alcohol misuse</td>
<td>Child health</td>
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<td>A healthier diet</td>
<td>Dental and oral treatment</td>
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<td>More physical activity</td>
<td>Sexual health, including teenage pregnancies and sexually transmitted diseases</td>
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<td>Coronary heart disease (and stroke)</td>
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<td>Accidents and safety</td>
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*Life circumstances include unemployment, poverty, poor housing, limited educational achievement, the general environment, and all other forms of social exclusion.
REFERENCES

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