Health Policy in Relation to Improving Equity in Child Health

David Gordon, PhD

ABSTRACT. The Issue. A major independent inquiry into inequalities in health—and policies that would reduce them—was published in December 1998.1 It identified >40 recommendations designed to reduce inequalities in health. Lifting children out of poverty is among the most important strategies to improve child health. If we want to change policies on health and poverty, then we have to consider the broad political context within which our health systems work. In the United Kingdom, we have a welfare state that sends checks and cash income to 85% of households every month. Many people pay into the welfare state, many people get money back, and everybody receives services.2 In the United States, the situation is different. There, many people pay into the state, but only the poor and corporations actually receive a check. I leave you to decide who gets the most out of these respective systems. We also have fundamental differences in our health systems. In the United Kingdom, 97% of expenditures on health are made by the state; there is virtually no private spending. In the United States, only 44% of health expenditures are made by the state. The limited amount of private health expenditures in the United Kingdom will be reduced further as the National Health Service provides more dentistry in the future. In terms of the amount of resources, the United States spends 14% of its gross domestic product on health, compared with 6% in the United Kingdom. The United States spent $3700 per person on health care in 1997. In the United Kingdom, we spent less than one third of that. Pediatrics 2003;112:725–726; health care in the United States and the United Kingdom, health systems in the United States and the United Kingdom, child health inequality, poverty and child health.

HOW EFFECTIVE ARE OUR HEALTH SYSTEMS?

In the United Kingdom, failures of the health service are to a large extent because of lack of spending. The resource problems are not necessarily because of a lack of political will. In the United States, resources are not the issue. Failures in the health system are because of a lack of political will to distribute resources and services to meet the needs of the entire population. Although it is difficult to compare health outcomes among countries, the World Health Organization has attempted to do this. The United Kingdom is ranked 9th and the United States 15th with respect to outcome of their health systems. So for 3 times the expenditure per person, the United States is ranked 7 places lower than the United Kingdom in terms of overall health system attainment,3,4 and that is despite that the US system is the most responsive in the world by far. If you have the money, then you can get the health service you want, when you want, and how you want in the United States. You cannot necessarily get that in the United Kingdom. However, the converse of this is also true: if you do not have the income in the United States, then you cannot necessarily get the health service that you require. You can in the United Kingdom.

There also is a fundamental difference in the way public health issues are debated in the United States and the United Kingdom. In the United States, public health debates often focus on the behavior of individuals as the primary purveyor of national health outcomes. In the United Kingdom, at least in part, we discuss the health of populations as well. This distinction is important, as the health of populations is not primarily the responsibility of individuals or a health service; it is the responsibility of politicians. If you want to improve health outcomes for populations, then you have to influence politicians. We have similar laws in the United Kingdom and the United States regulating the extent to which charitable non-profit organizations can lobby politicians. We cannot engage in politics, but we can educate politicians. Much of the analysis we do on inequalities in health in the United Kingdom is directed at political constituencies at all levels of government. One of the most effective ways of improving public policy is to tell politicians that their voters are dying faster than their opponents’ and/or how much sicker their constituents are compared with the other guy’s.

We maintain many health statistics in the United Kingdom and have known for a long time that the poor have worse health than the rich. In the mid-18th century, the children of dukes were noted to be much more likely to survive than the children of peasants. The children of richer peasants were also known to survive longer than poorer peasants’ children.

We have therefore known for centuries that poverty is a primary cause of ill health. The British government has committed to end child poverty forever, within a generation, by 2020.5 We hope that this policy also will reduce inequalities in health.1,6,7 We know that during the 1980s and 1990s in the United Kingdom and the United States, despite that the population as a whole got richer, poverty increased rapidly. Using a definition of poverty that includes low income and low standards of living (eg, the inability to afford food, buy adequate clothing, sup-
ply required heat in living quarters), in the United Kingdom, poverty increased from 14% of households in 1983 to 21% in 1990 and 24% in 1999. To put that in perspective, poverty increased by 1% per year during the 1980s. That is the equivalent of a city the size of Liverpool or Sheffield becoming poor each year. In the 1990s, it increased by approximately 0.3% per year. That is the equivalent of a city the size of Brighton or Milton Keynes becoming poor each year. That is a very rapid increase in poverty.

This rapid increase in poverty has led to a widening of the health gap between the people at the top of society and the bottom—between the rich and the poor. The health of the population as a whole got better, but the gap between the top and the bottom widened. When we look at the evidence for the effects of low income and deprivation on child health, it clearly demonstrates a gradient of health as a function of a gradient of income.

**CONCLUSIONS**

There is a direct relationship between poverty and ill health in childhood in the United Kingdom and the United States. A vast range of research evidence has demonstrated that this relationship is causal, i.e., poverty causes ill health. One of the most cost-effective ways of improving the health of children is to reduce the amount of child poverty. This joint American Academy of Pediatrics-Royal College of Paediatrics and Child Health initiative could focus its efforts on developing research initiatives to document the impact of poverty on child health and evaluating programs meant to improve child health outcomes and decrease child health inequalities through increasing real income to families and income redistribution.

**REFERENCES**


**SUGGESTED READING**


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