PERSONAL VIEW

The Acheson report: challenges for the College

N J Spencer

The Acheson report "Inequalities in health: report of an independent inquiry",¹ has been published 18 years after the Black report ("Inequalities in health: report of a research working group").² This 18 year period has seen an increase in income inequality in the UK: 24% of the population had an income below half the average after housing costs in 1995-96 compared with 7% in 1977.³ Families with children have been hardest hit: 31% of children live in households with less than half the average income after housing costs³ and more than one million children live in families without a wage earner.

This article aims to open a debate among paediatricians and within the Royal College of Paediatrics and Child Health. The evidence for the adverse effects of poverty on child health is overwhelming⁴ and the Acheson report, with its explicit focus on maternal and child health, offers an opportunity to use the College's considerable influence to advocate for government policies that reduce poverty among families with children.

The Acheson report's findings and recommendations on maternal and child health

In common with Black, Acheson adopts the socioeconomic model of health and its inequalities, which traces the roots of ill health to such determinants as income, education and employment, as well as the material environment and lifestyle. Three crucial areas are identified:

- all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities
- a high priority should be given to health of families with children
- further steps should be taken to reduce income inequalities and improve the living standards of poor households.

Priority is given to families with children because childhood is seen as a critical and vulnerable stage where poor socioeconomic circumstances have lasting effects. In addition, interventions related to parents, particularly present and future mothers, and children are seen as having the best chance of reducing future inequalities in mental and physical health. Specific recommendations include improved benefit levels for families with children, measures to improve health and nutrition of women and children, promotion of breast feeding, reducing the prevalence of smoking in pregnancy, and social and emotional support of parents.

Some of the report's recommendations have been criticised as "too vague to be useful",⁵ and the inquiry team avoids the key issue of income redistribution through taxation when considering income inequality. Tax changes favouring the rich have contributed strongly to the increase in income inequality since 1979.⁶ Unequal societies are characterised by extremes of wealth and poverty; the rich are as much a "problem" as the poor. Redistributive tax policies underpin the Swedish child health achievements.

The College made a detailed submission to the inquiry. However, despite the priority given in the recommendations to families with children, child health inequalities receive scant attention in the report. The social gradient in birth weight is mentioned briefly (page 69) but the limitations of the Registrar General's social class as a measure of socioeconomic status in relation to pregnancy outcome is not considered. As a consequence, the extent of the social difference in birth weight is almost certainly underestimated.⁷

British governments, including the present one, look to the USA for social policy inspiration. In view of the extent of poverty and its consequences in the USA particularly affecting families and children,⁸ this orientation is bizarre. US child health status measures are among the worst in the developed world with infant mortality rates in inner city areas reaching levels found in developing nations.⁹ The USA leads the developed world in violent crime, adolescent pregnancy, and drug abuse; emulating their policies is unlikely to alleviate similar problems in the UK.

In contrast, Scandinavian countries, although not exempt from social problems and child health inequalities, have some of the best child health status measures in the world, as well as relatively low levels of crime and adolescent pregnancy. For example, lone mothers in Norway receive benefit at 81% of the average income for households with children, lifting most out of poverty, whereas their US and Canadian counterparts receive 52% and 66%, respectively, and most remain locked in poverty.¹⁰ Disappointingly, the report makes little reference to the success of these Scandinavian social policies, further study of which might prove rewarding.

Nonetheless, the report carries a strong message to government and health professionals that poverty and ill health are intimately linked and the health of future generations depends on the extent to which health inequalities are addressed.

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How has the College responded to the increase in child and family poverty in the past two decades?

Before considering the College's response it is worth reviewing how the College, and the British Paediatric Association (BPA) before it, has responded to the increase in child and family poverty in the last two decades. A child advocacy network (CHANT) has been established, mainly through the efforts of members of BACCH (British Association of Community Child Health), which has been endorsed by the College. The College submitted a detailed report on child health inequalities to the inquiry and is planning a conference on child health and poverty.

However, during the years when government were actively denying the links between poverty and poor health and were pursuing policies deliberately designed to increase income inequalities, the BPA remained silent. As far as I am aware, no public statement was made questioning the wisdom of pushing more families into poverty. The BPA did not ally itself with those, such as Professor Peter Townsend and Richard Wilkinson, who stood against the political consensus and insisted on the adverse health effects of increasing poverty and income inequality.

The reluctance of the BPA, and the College, to engage in the political arena on behalf of families and children in part reflects the tendency among paediatricians to accept the political status quo and to see their professional function as non-political. The paediatric research agenda has remained dominated by the investigation and management of rare and "interesting" diseases. Where the influence of socioeconomic factors on child health has been considered, parental behaviour such as smoking has been said to account for social differences in adverse outcomes¹¹ or socioeconomic factors have been characterised as unmodifiable.¹² The former shifts the responsibility on to the individual parent while the latter absolves the paediatrician of any responsibility for social and political change.

How should the College respond to the Acheson report's recommendations?

The College must publicly and unequivocally align itself with the conclusions of the report, which are broadly in line with the College's submission to the inquiry. In the longer term, the following suggestions would enable the College to use its considerable influence to minimise health inequalities affecting families and children.

ESTABLISH A STANDING GROUP ON CHILD HEALTH INEQUALITIES WITH A REMIT TO:

- ensure that the place of health inequalities is recognised and taken into account in all College activities
- develop College policy on child health inequalities for dissemination, discussion, and publication
- advise the College on data collection and the development of a child health inequalities database

- advise the College on representation to, and links with, government
- advise on the development of innovative clinical services aimed at reducing child health inequalities based on national and international experience.

ESTABLISH A DATABASE AND MONITORING OF TRENDS

The College, through the standing group, should establish a database that might include the following elements:

- published studies addressing child health inequalities in the UK and elsewhere
- a dataset of agreed child health outcomes in different social groups (for example, mean height attained and birth weight) from the Office of National Statistics and district health authorities allowing social trends to be monitored
- database of research in progress with particular focus on interventions to reduce the effects of disadvantage.

ADOPTION OF AN EXPLICIT ADVOCACY AND POLITICAL ROLE FOR THE COLLEGE IN RELATION TO CHILD HEALTH INEQUALITIES

The College has endorsed the development of Child Advocacy International. Similar attention should be given to the problems of children in the UK especially those in poor families. The College should develop formal links with government, such as a direct link to the Social Exclusion Unit, to ensure that children are given priority. Within the College we have a wealth of expertise that could be put at the disposal of a government determined to tackle these key social issues.

INSTITUTE A WIDE RANGING DEBATE ON THE REPORT AND ITS IMPLICATIONS FOR THE COLLEGE
This is a report of critical importance for child health in this country. A debate should be initiated at the College's annual meeting. Subsequently, a programme of national and regional meetings should be organised to discuss the report. Relevant government ministers should be invited to the national meetings. The College should publish a synthesis of this debate.

ADVOCACY AT GOVERNMENT LEVEL FOR A FUNDED RESEARCH PROGRAMME INTO CHILD HEALTH INEQUALITIES

Compared with biomedical research into the cause and management of relatively rare conditions, research in the area of child health inequalities has been underfunded and given low priority. The College should seek to influence government to establish an adequately funded national research programme addressing the mechanisms by which low socioeconomic status affects the health of children, including bio-psycho-social pathways and effective interventions at a social and individual level that reduce or minimise the worst effects of social deprivation on families and children.

ENCOURAGE INNOVATIVE WAYS OF WORKING WITH POOR FAMILIES AND CHILDREN

Many paediatricians already work in innovative and sensitive ways with poor families and

children. While recognising that work with individual families may have little impact on the adverse outcomes associated with poverty, marginal gain of importance to individual families can be achieved, which may assist individual families avoid the worst effects of social exclusion and ensure that their children are not discriminated against. The College should encourage the dissemination of good practice in the paediatric management of children and families living in poor areas. Good practice should be incorporated into local and national standards for working with poor families and their children.

Conclusions

It is hoped that the publication of the Acheson report will initiate a long overdue debate in the College on child health inequalities. This paper is written as an initial contribution to such a debate. The College's reluctance to engage in political debate has led, in my view, to silence in the face of social policies, which have devastated the lives of many families adversely affecting the health of their children. The Acheson report provides an opportunity for the College to use its influence and expertise to ensure that government policies, research, and child health services are directed to reducing the extra burden of ill health and death imposed on children as a result of family poverty.

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- 3 Department of Social Security. *Households below average income 1979–1996/7*. London: HMSO, 1998.
- 4 Spencer NJ. *Poverty and child health*. Oxford: Radcliffe Medical Press, 1996.
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- 6 McLoone P, Boddy FA. Deprivation and mortality in Scotland, 1981 and 1991. *BMJ* 1994;**309**:1465–70.
- 7 Spencer NJ, Bambang S, Logan S, Gill L. Socioeconomic status and birth weight: comparison of an area-based measure with the Registrar General's social class. *Journal of Epidemiology and Community Health*. [In press.]
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- 12 Blair PS, Fleming PJ, Bacon C, et al. Smoking and the sudden infant death syndrome: results from 1993–5 case-control study for confidential enquiry into stillbirths and sudden deaths in infancy. *BMJ* 1996;**313**:195–9.

Commentary

I share Professor Spencer's dismay at the prevalence and degree of poverty affecting the UK's children: more than one million children living in families without a wage earner, impoverished materially, emotionally, spiritually with blighted expectations of health. The Acheson report does indeed offer an unrivalled opportunity on which to build a College strategy to address child health inequalities. This we are doing and I openly invite Professor Spencer to join us in this endeavour.

I cannot agree with him that the College has not and is not engaged in the political arena, addressing the inequalities that afflict children

and their families. Let me cite a few recent examples of College initiatives:

- a substantial contribution to the Acheson inquiry was made by the College, much of which is presented in the report and in its major recommendations for action
- an Advocacy Committee has been established with Margaret Lynch in the chair, predominantly concerned with matters of inequality in this country, for example:
 - promoting and protecting breast feeding, particularly among the poorest families
 - contributing to an Intercollegiate Forum on Poverty and Health
 - hosting a meeting with the WHO on "Poverty and health of youth"
 - playing a leading role in campaigning for a national Children's Rights Commissioner to address the sociopolitical origins of poverty and health disadvantage.

To add professionalism to this work, the Advocacy Committee has co-opted to its membership a seasoned and highly skilled political lobbyist.

- in keeping with Professor Spencer's proposals, we have completed a document entitled *The health of the nation's children and young people*, bringing together national information on indices of children's health with the particular purpose of illustrating the socioeconomic chasm. This publication, edited by Aidan Macfarlane, is designed to follow the style of UNICEF's trailblazing publication *The state of the world's children*, with similar aspirations for an annual publication to influence health and social policy.

In all these matters the College's thinking exactly parallels Professor Spencer's. Indeed, in the College strategy, which was published and sent to all members in September 1998, strategy point 5 illustrates our commitment to advocacy and equality, addressing the poverty trap with its consequent inequalities for health opportunities for this country's children. Nevertheless, I can understand his displeasure that our progress has been slow and its impact limited. By way of an excuse I can only offer the fact that in taking on the statutory responsibilities of a medical Royal College—standard setting, education and training, examinations, continuing professional development, and our new roles in clinical governance and revalidation—other elements of our work that we might passionately wish to progress, have not always remained at the top of our agenda. To return to Professor Spencer's challenge: Yes, let us use the Acheson report, and indeed this publication in the *Archives*, as a springboard from which to develop a broad strategy on child health inequalities, for discussion, publication, dissemination, and action. Our Advocacy Committee already stands as the group to bring this into focus and I hope that Professor Spencer will agree to work with us.

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