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# Inequities in Child Health

Position Statement

May 2018



# Acknowledgements

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This Position Statement was produced by a working group of the RACP's Paediatric Policy and Advocacy Committee, comprised of:

Professor Sharon Goldfeld (co-chair)  
Associate Professor Susan Woolfenden (co-chair)  
Professor Innes Asher  
Dr Paul Bauert  
Dr Danny De Lore  
Professor Elizabeth Elliott  
Adjunct Clinical Associate Professor Bret Hart  
Dr Victoria Matheson  
Professor Victor Nossar  
Dr Robert Roseby  
Professor Andrew Scott

Research, policy and editorial assistance:

Mr Alex Lynch  
Ms Louise Hardy

# Executive Summary

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All children, no matter where they live or who they are, should have the same opportunity to fulfil their potential. Child health inequities are differential outcomes in children's health, development and well-being that are unjust, unnecessary, systematic and preventable.<sup>1</sup> Many inequities start early in childhood and increase along a clear social gradient.<sup>2</sup> This means the greater a child's disadvantage, the worse their health, development and well-being. These gaps widen as children progress across the life trajectory resulting in adverse adult health, educational and vocational outcomes, with increased subsequent premature mortality and morbidity. This can have an intergenerational effect with inequity passed on to the next generation.<sup>3</sup>

In Australia and New Zealand a large number of children are currently missing out on the benefits of social and economic progress.<sup>4, 5</sup> They will not have the same health, wellbeing and developmental outcomes of their more socially advantaged peers. There are groups of children who are particularly at increased risk of experiencing health inequities that are beyond socio-economic disadvantage. These include:

- Aboriginal and Torres Strait Islander and Māori children;
- Children of refugee and asylum seeker families;
- Children from culturally and linguistically diverse (CALD) backgrounds, including Pacific Islander children in New Zealand;
- Children living in rural and remote communities;
- Children living in out of home care;
- Children born in to poverty;
- Incarcerated children and young people; and
- Children with disabilities.

Many children who experience inequities in health are also disadvantaged in accessing health care.<sup>6, 7</sup> Their access to quality health care (especially specialist care) is adversely affected by social determinants of health such as geography (including living in rural and remote areas), ethnicity and socioeconomic status despite increased clinical need.

Inequities in health have high costs to society. In New Zealand, they're estimated to cost up to \$6 billion per year.<sup>8</sup> The cost of inaction on the social determinants of health on productivity and expenditure in Australia has been estimated to be as high as \$14 billion per year.<sup>9</sup> By tackling health inequities, societies achieve better health overall and the social gradient flattens with a "spill over" effect on non-health outcomes such as social, educational and workforce inclusion and crime reduction. Significant economic benefits flow from providing strong and truly universal child health and education services that are proportionate to a population group's needs, with those children most at need having the greatest access to quality services.<sup>10</sup>

The Convention on the Rights of the Child (1990), ratified by Australia in 1990 and New Zealand in 1993<sup>11</sup> states that children must be free from discrimination, have an adequate standard of living for development, and should be provided appropriate support programmes, particularly with regard to nutrition, clothing, housing and health care. Governments, policy makers and health professionals must work together to reduce these inequities.

# Recommendations

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*The RACP recommends that all National, State and Territory Governments in Australia and the New Zealand government:*

1. Increase accountability for improving child health equity by:
  - Making directors-general/secretaries and chief executives of all relevant Government departments accountable for the achievement of equity-based key performance indicators that promote the health, development and well-being of all children;
  - Requiring health services to develop and regularly review their own plans to address child health inequity in their local areas, tailored to the demographics of the population they serve;
  - Appointing a national chief paediatrician with a mandate to advocate for improving child health equity;
  - Adopting targets to close the equity gap in health, well-being and educational outcomes across the social gradient; and
  - Enhancing the reporting and measurement of key performance indicators through better integrated data and reporting systems.
2. Improve legislation and policies that impact child health equity by:
  - Conducting health equity impact assessments on policies and significant legislation with a focus on children's health;
  - Establishing accountability mechanisms that evaluate and lead to the modification or removal of existing policy and legislation that perpetuate child health inequities; and
  - Immediately re-establishing the Australian Health Ministers' Advisory Council (AHMAC) subcommittee on child and youth health.
3. Improve service capacity by:
  - Providing strong and truly universal child health and education services that deliver the right care to children for their health, development and well-being regardless of their family circumstances, socioeconomic status, ethnicity, geography or other social determinants;
  - Funding to establish and maintain an *Inequities in Child Health Research Alliance*, in conjunction with leading Australian universities, non-governmental organisations or health services;
  - Funding services to ensure they have the reach and intensity necessary to tackle inequities – and therefore are in accordance with the principles of 'proportionate universalism;' and
  - Improve funding to health services so they can better engage groups facing additional challenges including Aboriginal and Torres Strait Islander, Māori and Pacific Islander children, children living with disabilities, children in detention and children from culturally and linguistically diverse backgrounds to address health equity.
4. Ensure services that impact children take an evidence-based approach to addressing child health inequity through:
  - Use of programs that have been proven to be effective by high quality research;

- Regular evaluation of services to ensure that program implementation is of high quality and appropriately targeted, and also results in increased access, quality and affordability; and
  - Providing adequate funding for high-quality evaluations of the evidence used to design service provision.
5. Recognise and reinforce the broad array of policy areas that impact on child health inequity, by:
- Developing and implementing equitable health, education, employment, housing, early childhood and welfare policies, which ensure that all children have the best possible outcomes no matter who they are born to or where they live.

*On behalf of its Member paediatricians and physicians, the RACP will:*

1. Advocate for the need to address child health inequities across Australian and New Zealand by:
  - Considering child health equity in future policy documents relating to children; and
  - Working with all levels of government, national and state children’s commissioners, other colleges and relevant organisations to promote evidence-based policy change that addresses inequity.
2. Provide material to assist our members to address child health inequities by:
  - Disseminating information on existing and future reports on child health indicators;
  - Identifying useful sources of data on child health inequities and highlighting them for our Members to inform their practice; and
  - Identify and disseminate tools for paediatricians to sensitively seek information on the social determinants of health from their patient’s families.
3. Educate the next generation of paediatricians using child health inequity principles, including:
  - Equity principles, awareness, and practical ways to address child health inequities at an individual, community and service level, and in the continuing education of paediatricians;
  - Encouraging our partner organisations to address inequities in child health;
  - Prioritising cultural competency in the training of physicians and in the continuing professional development of Fellows; and
  - Supporting the development of a culturally diverse paediatric workforce that more closely mirrors the population.

*Paediatricians and other health professionals can help address child health inequity by:*

1. Powerfully advocating for their patients through:
  - Sensitively seeking information from families about their social determinants of health such as food insecurity, housing, economic hardship and other psychosocial stressors;
  - Working within their networks to identify services that can assist children and their families who are experiencing health inequity, and advocating for better services for disadvantaged children; and
  - Recognising socioeconomic disadvantage and social adversity as factors in management of childhood illness and in all clinical decision making.
2. Advocating for all children in their geographical area and networks by:

- Ensuring their clinical settings take into account the impact of psychosocial and socioeconomic adversity on children's health, development and well-being, and creating opportunities to build on local strengths;
- Lobbying the health services they work in to develop an explicit plan of action to reduce child health inequities for the populations they serve and in the services they work;
- Engaging with their local community to better understand the needs, resources & possibilities for improving child health equity; and
- Encouraging the health services that they work in to regularly evaluate their progress towards elimination of inequity in local service delivery through data collection and monitoring. This includes the collection of patient reported experience and impact measures as a measure of the quality of care; and monitoring their own practice data to examine whether they are addressing inequity in the services they provide.

# Identifying mechanisms to reduce child health inequity

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## **POLICY DEVELOPMENT AND IMPLEMENTATION**

*All policy and service delivery must support health equity for children, families and their communities*

Despite Australia and New Zealand's relatively robust health, education and welfare sectors, inequities in child health remain starkly evident, and are increasing.<sup>12, 13, 14</sup> Health inequities are unjust, unnecessary, systematic and preventable and they are also modifiable, an important implication for policy and service delivery. Legislation and related government regulation and policy should set the standard for addressing child health inequities throughout Australia and New Zealand.

Child-centred policies should optimise platforms of high quality health care at the primary, secondary and tertiary level. A comprehensive policy response needs to truly commit to implementation and evaluation on a large scale. Given the central impact of multiple areas of government on the social determinants of health it makes no sense to develop these services streams separately from each other. A coordinated policy approach to reduce child health inequity is critical.

Equity is considered an important policy issue by paediatric colleges around the world. For example, the Royal College of Paediatrics and Child Health and the American Association of Pediatrics have both launched equity projects with a focus on member education and training, practice and advocacy to eliminate child health inequity.<sup>15, 16</sup>

Children and young people's voices are often left out of the policy making process. The advantage of including children in the policy making process is that they can provide a unique perspective which is often not heard in the traditional consultation process.<sup>17</sup>

## **EARLY INTERVENTION**

*Use evidence based interventions through existing service platforms*

There is strong evidence that investment in the early years of children's health development and well-being is the most cost effective step to tackle adult health inequity.<sup>18</sup> This is because it offers the possibility of shifting child and adult trajectories and disrupting inter-generational cycles of disadvantage. Population level early interventions aimed at children and their families such as high quality antenatal care, and high quality early childhood education reduce inequities in child health, well-being and development, particularly for disadvantaged children.<sup>19 20</sup> Targeted nurse home visiting and parenting programs have similar effects.<sup>21</sup> Long term and collectively these interventions have been shown to reduce adult morbidity and mortality, high school drop-out rates and criminal behaviour, increase employment, and delay child-bearing.

Australia and New Zealand need comprehensive implementation of universal high quality evidence based early childhood health and education programs that reach all children and their families. This

would provide opportunities for positive impacts on the child's developing brain, generating long lasting benefits. To address inequity, health, welfare and education systems not only need to deliver these evidence-based interventions, they need to ensure that through implementation these interventions maintain their level of quality, effectiveness and reach at a population level, especially hard to reach populations.<sup>22</sup>

## SERVICE DELIVERY

### *Use the principles of proportionate universalism to deliver equitable services to children and their families*

We know that health care inequities are magnified where there is unequal access to services (including their utilisation, quality and distribution). These are often related to demographic differences, such as ethnicity and socioeconomic status rather than need. Tudor Hart referred to this as the 'Inverse Care Law': "*the availability of good (medical) care tends to vary inversely with the need for it in the population served.*"<sup>23</sup> Although much of what impacts on health occurs outside the health system, inequitable access to health care is still a significant contributor that compounds and magnifies existing inequities. Individuals with equal need should be given equal treatment regardless of ability to pay or other sociodemographic differences.<sup>24</sup> To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called 'proportionate universalism.'<sup>25 26</sup>

Aside from being high quality, services need to be accessible, culturally safe and welcoming. They need to reach out and be available for those children and their families who struggle to access our current system. It is important that families continue to have choices in how they engage with health services, which should use innovative methods to connect parents and services. This requires a shift from the presumption that it is the family's responsibility to present to services and negotiate the system. Rather it is the services' responsibility to ensure family's needs are met. This is true for primary care, hospitals and specialists. It is also true in rural and remote communities, where accessing health services can be significantly more challenging with poorer outcomes.<sup>27</sup> People who are already disadvantaged by their geographical location should not be further disadvantaged by poor access to health care.

Poverty rates among Aboriginal and Torres Strait Islander peoples living in rural and remote areas have increased in recent years, despite a fall in the Australia-wide rate.<sup>28</sup> Although a social gradient remains, Aboriginal and Torres Strait Islander peoples with higher incomes experience better health than those on lower incomes.<sup>29</sup>

Paediatricians see the impact of inequities in child health and health care daily in their clinical practice. It impacts on their ability to effectively promote and support child wellbeing, and manage paediatric illness and problems with growth, behaviour and development. Paediatricians have a significant and powerful role in advocating to reduce inequities in their local environments (including their own practices), and to promote equity for all children at family, community, neighbourhood and health service levels. Paediatricians can collaborate on innovative models of health care service delivery with education services and community groups. Working with children, young people and their families when co-designing these models is also essential to make it more effective, accessible

and appropriate.

## **ACCOUNTABILITY**

### *Measure the equity in our systems*

There is a limited understanding about whether our health and education systems are available for children and delivered according to need. Mechanisms are needed to monitor the consistency, utilisation and quality of services with routinely collected data that can be easily accessed by service providers. These data need to disaggregate child health condition prevalence and relevant clinical outcomes by locality, ethnicity and socioeconomic status. For example, if a minimum routine data set was in place that encompassed all health care service providers (primary, secondary and tertiary), and included quality, utilisation and diagnostic information, these data could be used to plan allocation of education and health services in geographic locations where need and potential to benefit is likely greatest and could ensure that quality was highest where needed most.

## **CONCLUSION**

To give children the best start to life and optimise their health, development and well-being; we must eliminate (or at least reduce) health inequities across their life trajectory. The existence of child health inequities in Australia and New Zealand means that not all children get a “fair go.” To ensure that Australia and New Zealand are truly the just countries they aspire to be, the RACP calls on government, policy makers and practitioners to join in efforts that implement these recommendations to urgently tackle children’s inequitable health, development and wellbeing.

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