

Disproportionate disadvantage of the young: Britain, the Unicef report on child well-being, and political choices

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Unicef Innocenti's latest comparative overview of child well-being in rich countries looks like good news for the UK. We have risen up the ranks, now reaching 16th place among 29 countries.¹ This mediocre position is worthy of celebration because Unicef's previous report in 2007 was shocking: our overall position was lowest among 21 rich countries.² We shared this lamentable place with the USA. Indeed many newspaper headlines reflected the recent progress, albeit with one or two examples of scepticism about the notion of measuring child well-being. Children's health policy and systems research has not yet proven its worth to all in the health community, which is trained to believe that the randomised controlled trial is the gold standard of evidence. So it is good to see arguments around this new and important research field, still defining new methods and standards, reaching beyond medical journals to the mainstream press.³

Although ranking countries by health system performance, or any other outcome, can be controversial and often stimulates heated arguments, it effectively focuses attention onto important issues. Indeed the 2007 report provoked debate

about important problems for children and families, and crucially prompted investment and research. Unicef UK, for example, enquired further into why children in this country experience such strikingly low well-being, while some children from countries with less economic security have a greater sense of well-being.⁴ One explanation to this finding lies in the damaging effects of inequality.⁵ Governments can act to reduce poverty and inequalities directly through redistributive fiscal policy, benefitting those who are most at-risk. However, there is even more that could be done to help children. The harsh effects of poverty can be softened through social protection. For example, Sweden has lower child deprivation rates than other countries of similar wealth (as measured by per capita income) for example Germany, because of their different approaches to supporting vulnerable families, such as those with single parents.⁶ The UK historically also had fairly good results in poverty reduction and social protection, providing cash and public services to families in need. This has meant that up to 2009, the UK would have had three times the child poverty rate were it not for Government policy on cash transfers, tax credits and public services for children.⁷ The investment in improving child health and life circumstances paid off and is reflected in the results published in the 2013 report which show modest improvement to the UK's position. Indeed we are now mid-

range in the overall ranking, as shown in table 1.¹ An important caveat: the data in the report is from 2009–2010, just after the economic crisis began to hit, and when the Coalition government gained power. Any inferences about policy must be confined to the period ending 2010.

A few specific aspects of the report stand out and need urgent attention. First, progress had been made in improving overall child well-being, and in tackling poverty and deprivation, the fundamental social determinants of health. Unfortunately many of these gains will now be reversed as a result of falling incomes, austerity economic policies and cuts to social support. A 2012 report by the Family and Parenting Institute together with the Institute of Fiscal Studies projected that relative child poverty is predicted to increase by 400 000 children between 2010–2011 and 2015–2016 and that half a million children in the UK will live in absolute poverty, as defined by the 2010 Child Poverty Act, within the same period.⁸ Progress in improving well-being is also likely to reverse.

Second, we should seriously be concerned about how many of our young people are not in education, employment or training. We risk a lost generation of young people growing up at increased risk of mental health problems, substance misuse, crime and long-term unemployment with all the health risks that are associated with these problems. An effective and sustained policy response to this problem is required.

Third, small progress in reducing the percentage of children and young people who are overweight must not breed complacency. Obesity continues to be a major and growing health emergency. We could do better, as shown by detailed information in the report about important proximal determinants of obesity such as food, nutrition and exercise. It is welcome news that the Faculty of Public Health has

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Table 1 A summary of the Unicef 2013 report

Dimension and components (number of indicators)	UK rank (of 29 countries)	Top 5 countries	Notable points and possible policy lessons for the UK
Material well-being ► Monetary deprivation (2) ► Material deprivation (2)	14	Netherlands Finland Norway Iceland Sweden	The UK child deprivation rate fell in the decade from 2000 to 2010. The child poverty rate is predicted from 2010 onwards to rise substantially
Health and safety ► Health at birth (2) ► Preventive health services (1) ► Child and youth mortality (1)	16	Iceland Sweden Finland Luxembourg Netherlands	Infant mortality rate has declined; however, the UK is in the lowest 1/3 along with the USA
Educational well-being ► Participation (3) ► Achievement (1)	24	Netherlands Belgium Germany Finland Slovenia	The UK ranks in the lowest third for participation by 15–19-year olds in higher education. A high level of youth not in education, employment or training (NEET) is associated with mental health problems, crime, drug misuse, long-term unemployment. The UK ranks in the top third for preschool enrolment, but in the midrange for educational achievement by 15 years. Finland is a notable outlier in high performance in educational achievement at 15 years. Equally notably they invest far above the OECD average on early years care and education. They require exceptionally high minimum standards of qualification for preschool staff and have the highest standards of staff to child ratios (1:4 for children under 3 years and 1:7 for children 4–6 years)
Behaviours and risks ► Health behaviours (4) ► Risk behaviours (4) ► Exposure to violence (2)	15	Netherlands Denmark Iceland Norway Sweden	The UK is in the top third for young people who smoke at least once per week. Since most smokers begin their habit in adolescence, this is the ideal window of opportunity to reduce the rate still further. The recently announced pause in progress to introduce standard packaging of tobacco is lamentable and has been raised as a child protection concern by respiratory physicians. The teenage fertility rate in the UK is in the worst third performing countries and is three from the absolute bottom of the list. The Netherlands however, has among the lowest rates. There is a statutory duty to reduce sexually transmitted infections (therefore to provide services tailored for adolescents). There is commonly access to services through schools or the universal youth health service
Housing and environment ► Housing (2) ► Environmental safety (2)	10	Switzerland Ireland Norway Netherlands Luxembourg	
Overall (composite of the five rows above)	16	Netherlands Norway Iceland Finland Sweden	In the early 2000s, the UK ranked joint 20th (with the USA) out of 21 countries, by the late 2000s, the UK had moved up 4 places to 16th, of a larger sample of 29 countries. The UK has remained in the bottom third throughout the decade
Children's life satisfaction (self-reported, for 11, 13, 15 years old) (1)	14	Netherlands Iceland Spain Finland Greece	
Children's relationships with parents and peers (3)	17	Netherlands Iceland Sweden Denmark Romania	Relationships are one of the most important aspects of a child's well-being
Trends over 10 years from early 2000s to late 2000s	The UK position has improved up until 2010 ► Percentage of children reporting low family affluence ► Infant mortality rate ► Percentage of people aged 15–19 years remaining in education ► Percentage of young people aged 11, 13, 15 years who are overweight ► Percentage of young people aged 11, 13, 15 years who report smoking at least once a week		The UK position has worsened up till 2010 ► Teenage fertility rate

Continued

Table 1 Continued

Dimension and components (number of indicators)	UK rank (of 29 countries)	Top 5 countries	Notable points and possible policy lessons for the UK
	▶ Percentage of young people aged 11, 13, 15 years who report having been drunk on more than two occasions ▶ Percentage of young people aged 11, 13, 15 years who report having used cannabis in the last year ▶ Percentage of young people aged 11, 13, 15 years who report having been involved in fighting at least once in the past year ▶ Percentage of young people aged 11, 13, 15 years who report having been bullied at least once in the past couple of months ▶ Percentage of young people aged 11, 13, 15 years who report satisfaction with life		

OECD, Organisation for Economic Co-operation and Development.

withdrawn support from the so-called Responsibility Deals with food industry, and that the Academy of Medical Royal Colleges has issued a 10-point action plan which includes a 20% tax on sugary soft drinks and fewer fast food outlets near schools.

Finally, teenage pregnancy continues to be an enormous problem. Parenthood too early in life risks perpetuating cycles of deprivation and disadvantage to subsequent generations. Despite increased effort over recent years, we still lag far behind other countries. We need a fundamental shift in our approach regarding the sexual and reproductive health of young people.

So, what are the main messages of the 2013 Unicef report? In a nutshell: progress has been made, but there remains so much more that could be done, and many of the gains made are now likely to be lost.

POLITICAL CHOICES

What should be done now? How politicians value children is reflected in the choices they make. International comparisons are an important means to raise awareness,

stimulate research and drive investment. The Unicef report has important messages for us: until 2010 we were making progress in improving child health and well-being. As child poverty rises and disinvestment in social protection continues, we risk reversing recent gains in well-being.

This need not be inevitable. Politicians have choices. Social protection can save lives. Children are especially vulnerable to the effects of poverty, but countries differ starkly in the protection they give, even in the face of severely challenging economic circumstances. Indeed the equity of distribution of disadvantage in countries might indicate the relative importance they place on the early years. The evidence suggests that the UK disproportionately disadvantages its children and young people. A greater proportion of children, relative to other age groups, is at risk of poverty or social exclusion than adults or the elderly in the UK compared with Sweden for example, as shown in table 2.⁹

The policy choices that countries make are reflected in the performance of their health systems. For example, poverty,

social protection, and generosity of family policies correlate with infant and child mortality, and the UK's low relative position for family policy generosity may partly explain our relatively poor outcome for mortality, among the higher rates in Europe.^{9–11} By contrast, the UK in common with the Nordic countries has achieved tremendous success in reducing deaths from road traffic through a comprehensive range of enforced policies including legislation, regulation and education, to reduce the morbidity and mortality associated with road traffic.¹² Economic, social, and family policy should equally be seen as an essential component to protecting children's lives.

CHILD RIGHTS: A FOUNDATION FOR CHILD HEALTH AND WELL-BEING

What can we do, as children's health professionals? A rights-led approach is a neat way of bringing social justice to the forefront of our efforts to improve child health. The United Nations Convention on the Rights of the Child (UNCRC) describes rights to the highest attainable state of health.¹³ Although the UK is a signatory of the UNCRC, we have yet to live up to our commitment by incorporating the Convention comprehensively into domestic legislation; doing so would be an important step towards enabling legal challenges to rights abuses. Here is an example of how this could help in practice: nutritional and physical activity environments correlate with child obesity rates,—this is what is meant by the term 'obesogenic environment'. So when governments, national and local, enable obesogenic environments, this represents a failure to secure children's rights to health.¹⁴ We can, and should, advocate

Table 2 At risk of poverty or social exclusion (2011)

Country	Total (%)	Children age 0–17 years (%)	Adults age 18–64 years (%)	Age 65 and over (%)
Austria	16.9	19.2	16.2	17.1
Denmark	18.9	16	20.5	16.6
Finland	17.9	16.1	18	19.8
France	19.3	23	20.1	11.5
Germany	19.9	19.9	21.3	15.3
Italy	28.2	32.3	28.4	24.2
Netherlands	15.7	18	17	6.9
Spain	27	30.6	27.2	22.3
Sweden	16.1	15.9	15.4	18.6
United Kingdom	22.7	26.9	21.4	22.7

for children's rights through meaningful implementation of the UNCRC.

The Unicef report makes an important contribution by deepening our insight into children's lives and their prospects for growing up. We can see the impact that policy made on children's lives through the first decade of the 21st century. We know that progress is possible. Alas, a great deal has changed since then. Anita Tiessen, deputy executive director of Unicef UK, said: "There is no doubt that the situation for children and young people has deteriorated in the last 3 years, with the government making policy choices that risk setting children back in their most crucial stages of development."¹⁵

We are at a pivotal moment in UK child health, when recent gains are likely to be lost. The Unicef report strikes right to the heart of a defining question for our times: what is the duty of the State in protecting and providing the best conditions for nurturing our children? Government policy can foster or hinder children's health, development and well-being. Will we rally behind Professor Marmot's calls for progressive social policies?¹⁶ As child health advocates, we should use a rights-based approach to hold the State to account for the policies that shape our children's lives.

Competing interests None.

Provenance and peer review Commissioned; externally peer reviewed.

To cite Wolfe I. *Arch Dis Child* 2014;**99**:6–9.

Received 16 July 2013

Revised 14 September 2013

Accepted 18 September 2013

Published Online First 25 October 2013

Arch Dis Child 2014;**99**:6–9.

doi:10.1136/archdischild-2013-304437

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