IMPROVING THE HEALTH OF CHILDREN IN NSW: A VIEW FROM THE UNITED KINGDOM

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I am honoured and delighted to be asked to comment on a series of articles published in the *NSW Public Health Bulletin* during 1998, as part of its child health series. I must confess, however, to a feeling of acute embarrassment engendered by the contrast between the advanced theoretical and practical approach to child health service planning represented by the series, and the current primitive state of child health planning across the United Kingdom, and in my own service. Any criticisms that I make are offered with due humility and in the knowledge that they will be given careful consideration consistent with the approach underpinning the series.

CHILD PUBLIC HEALTH IN PRACTICE

The articles in the Bulletin's child health series are an example of how the ideas of child public health can systematically be used to address the health of a child population. In the United Kingdom there are many examples of population-level interventions using child public health methods to address specific problems, for example the 'Back to sleep campaign',[1] but there are few published examples of the systematic application of child public health principles to maximise health gain across a whole child population.

The significance of this pioneering initiative in NSW, which incorporates the concepts of evidence-based child health and an explicit scientifically-based method of prioritisation of health issues, should not be underestimated. Paediatric practice, and the research which informs it, remains locked in the acute illness, hospital-based paradigm. Paediatricians deliver a reactive service focused mainly on the disease process in the individual child and, increasingly, the disease process in the individual organ. Lip service is paid to 'holistic practice', but the reality of super-specialisation—with its narrow focus on 'interesting' and rare conditions—is quite different. Paediatrics practised in this way can have, at best, a marginal effect on child health at the population level; and, at worst, can have a negative effect resulting from the diversion of scarce resources to expensive interventions that, while innovative and heroic, have minimal health benefit.

Health gains are rarely, if ever, achieved at the individual level. The health gains associated with advances in neonatal care have not been achieved solely as a result of the skill of individual neonatologists. They are underpinned by the improvements in living standards, sanitation and nutrition that have been responsible for the dramatic fall in maternal and infant mortality in developed countries, allowing doctors to focus on the survival of preterm babies. Where such advances at the societal level have not been made, 'state of the art' neonatology is an expensive luxury diverting resources from more pressing priorities. Child public health—that is, caring for the health of child populations in a wider economic, social and political context—offers the greatest chance of future health gain.

THE CHILD PUBLIC HEALTH VISION

There is a child public health vision running throughout the Bulletin's child health series which is derived from key principles of planned population health interventions. This is epitomised by the strategic plan for child and youth health gain in the Central Sydney Area Health Service (CSAHS) described by Alperstein and Nossar (Volume 9, Number 10). The CSAHS plan combines the best traditions of the 'old' public health with the best features of the 'new' public health, including consultation with agencies and departments besides health, and consultation with the community.

The influence of the child public health vision can also be seen in the report from the Area Health Promotion Units (Volume 9, Number 10). Health promotion has tended to focus on the individual in the belief that simply telling people what is good for them will induce behavioural change. The examples of state-wide programs in NSW show a refreshing commitment to change at the level of organisations such as schools rather than solely at the individual level.

While applauding the clarity and precision of the vision running through this series, it is important to enter a few notes of caution. These are programs driven by health services, based on national health goals and targets. Health services have relatively little influence on health. This applies particularly to traditional reactive models of health care delivery but may also be true of innovative approaches such as those outlined in this series. The reason, as Rose points out,[2] is that despite major advances in medical treatment, the primary determinants of health remain stubbornly related to social, environmental and economic factors over which health services have limited influence. This paradox is well illustrated by Pope and Raphael's article (Volume 9, Number 10) on mental health issues for

children. Almost all the risk factors, including IQ and academic failure, listed in Table 2 (p.115) are closely correlated with adverse environmental, social and economic conditions beyond the control of the individual. Even the protective factors listed are likely to be integrally linked with adverse social factors; and those families in which protective factors are not operating are likely to be more materially and socially disadvantaged than those families in which protective factors do operate. Against the sheer weight of adverse social and environmental factors acting throughout the lives of the most disadvantaged groups, the effects of Positive Parenting Programs and medication for maternal depression are likely to be marginal.

In an effort to address the effects of disadvantage more directly, health-related programs based on targeting high-risk groups and areas have been adopted. The renewed interest in the relationship between relative poverty and health since the election of the new Labour government in the United Kingdom in 1997 has been accompanied by a plethora of programs (for example: Health Action Zones, Sure Start, etc) aimed at socially deprived areas. Areas vie with each other to be recognised as more deprived in order to 'win' in the bidding process set up to control the spending on these initiatives. As has been pointed out, these programs are flawed for a range of reasons.[3] They label individuals and areas. They assume, wrongly, that those living in disadvantaged areas are universally 'at risk' and are all disadvantaged (the ecological fallacy). They commit health and other agencies to an unseemly process of bidding against other areas with similar needs for resources which should be universally available if their effectiveness has been proven. The UK experience should act as a caution against the temptation to solve funding difficulties by a spurious process of targeting and competition.

A recent *BMJ* editorial questions whether target setting actually makes any difference to health.[4] The authors conclude that 'it depends'. A health policy model which takes account of the political, practical and technical constraints faced by each country and region 'can provide a more rational basis for health policy and begin to address problems that might otherwise be ignored'.[4] The programs described in the Bulletin's child health series seem to be embedded in the needs of the children and youth of NSW, and are likely to fulfil these criteria. It is essential, however, that continued adherence to these criteria is closely monitored throughout the life of each program.

The above cautionary notes are not intended to undermine the programs outlined in the child health series. As I have already stated, child public health programs are likely to be the most important contribution that child health services can make to future child health gain. However, these programs alone cannot address the underlying social determinants of health. Their potential lies in promoting health gain at a population level and influencing social, political and economic policy so as to modify the main social determinants of health.[5]

MONITORING CHILD HEALTH

Continuous monitoring of child health using routine and occasional survey data is essential to the success of the programs outlined in the series. Routine health service data have been process-focused and, with few exceptions, are of poor quality.

The articles in the June–July 1998 issue (Volume 9, Numbers 6–7) of the Bulletin indicate how some of these problems may be overcome. The focus is on health outcomes, as well as some of the social, environmental and economic mediators of these outcomes. However, some of the health status measures put forward in this issue, such as hospital admissions and separations, need to be treated with caution. As equity is one of the main principles on which the programs are based, differences between social groups need to be continuously monitored. In the United Kingdom this can be done using postcodes aggregated and ranked according to an ecological measure of material deprivation.[6]

The articles in the October issue (Volume 9, Number 10) of the Bulletin refer to cross-sectional surveys as a means of supplementing routine child health data. A further approach which might be considered is the use of longitudinal studies and cohort data sets. In the United Kingdom we have been fortunate to have three national cohort studies providing vital child health data. The Scandinavian medical birth register,[7] based on a unique personal identification number issued at birth, provides opportunities for record linkage and monitoring of cohort effects not currently available in the UK. Consideration might be given to the development of a medical birth register for NSW.

EVIDENCE-BASED CHILD HEALTH

The high level of importance given to an evidence-based approach to child health in the series is appropriate. However, as Alperstein and Nossar acknowledge in the article on the efficacy of child health interventions

(Volume 9, Number 10), not all interventions lend themselves to evidence-based or randomised control trial (RCT) evaluation. Their caution echoes that expressed by Davey Smith and Gordon,[3] who point out that, when arguing for measures of health burdens such as poverty and inequity, it is not valid to demand an RCT-informed evidence base. The efficacy of health interventions at the individual level is appropriately addressed using RCTs, but the same is not true of population level policy measures. Evidence related to different national policy approaches exists, which supports the view that social and economic policies resulting in increased income inequalities are associated with poorer health outcomes.[8,9] To dismiss this on the basis of the lack of supportive RCTs would be foolish.

CONCLUSION

It has been a privilege to be asked to comment on the Bulletin's child health series. The series demonstrates a child public health approach which is innovative, systematic, evidence-based, and sensitive to social and political contexts. I am sure that those involved in planning and executing these programs are acutely aware of some of the limitations and potential pitfalls I have considered. If linked with effective advocacy at local, state and national level, I am confident that these child health programs outlined in the series will contribute positively to the health of children in NSW. I am equally sure that the model for these programs will be invaluable to those who, like myself, are attempting to introduce a child public health agenda locally, nationally and internationally.

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CHILD HEALTH POLICY IN NSW: BUILDING ON A CENTURY OF CARE

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The NSW child health policy framework is informed by a long and successful history of providing health services to children and their families, as well as recent policy developments at the national level. This article describes the background to the development of the NSW child health policy, *The Start of Good Health: Improving the Health of Children in NSW*,[1] and provides information on NSW Health policy directions for child health.

COMMUNITY CHILD HEALTH SERVICES IN NSW: A HISTORY

The origin of community child health services in NSW is found in the infant welfare movement at the beginning of the 20th century. This movement was one of the most significant and successful public health initiatives, stemming from an awareness that children's health and welfare represented a particularly sensitive index of the wellbeing and progress of our society. At that time the issues were the high infant mortality rate associated with infectious disease and poor nutrition, and advocacy from mothers and grandmothers seeking support for the physical and nutritional needs of children. There was also recognition that poorer families could not afford medical advice for their children except in an emergency. The infant welfare movement played a major role in reducing the infant mortality rate, and led to the establishment of baby health services, which were the forerunner of our current child and family health services.

Early innovations in care

A study of these early services revealed considerable innovation in delivering flexible and responsive services