

Chapter 9: Conclusions and summary

Improving the prospects for disadvantaged children is not an expense but an excellent investment, one that can be postponed only at much greater cost to society.

Committee for Economic Development, 1987¹

The health of our children is of crucial importance for their own future and that of the nation. It is an essential basis for continuing stability of society within a robust economic framework. Every child born in the UK has an equal right to develop a sense of physical, emotional, intellectual, psychological and spiritual wellbeing, and ensuring child health should be a central objective of public health policy.

The 1999 BMA report, *Growing up in Britain*, recognised the multifactorial nature of child health and identified several areas of inequality in the attainment of health in 0 to five year olds in the UK. These are largely attributable to social determinants; children share the same gradients in health expectation as adults. High-profile reports and policies since that time have recognised, and tried to address, the nature and prevalence of social determinants in the UK and their effect on health. There have been some successes, but the reality is that most of the inequalities identified in 1999 persist, and in many cases the gap between the most privileged and least privileged in our society has widened. This has consequences for the health of our youngest children and their reasonable expectation of leading healthy adult lives.

This report re-examines the factors identified in 1999 and looks at the changes in our society since then, in the context of their effect on the health of our youngest children. It is disappointing to note that much of the evidence presented in this updated report echoes the conclusion of the 1999 report that ‘inequity within the UK is increasing rather than decreasing’.

A specific list of key recommendations for future policy and research is presented at the end of each chapter and these have been collated and presented together in Chapter 10. The aim of this chapter is to present an overview of the present state of children’s health and children’s services in the UK, with general observations on improvements to research, policy and practice that are urgently needed, as well as a vision for children’s health services for the next 10 years.

9.1 Continuing need to reduce health inequalities

As already noted, a combination of social, economic and personal factors influence child health, and a multidisciplinary approach that takes account of the interactions of all these factors is required to reduce the detrimental effects of disadvantage. As Marmot and his team concluded in *Fair Society, Healthy Lives* 'every child should have the best start in life'. Many of the factors involved have an influence before conception and birth and their effect is likely to persist for the whole of an individual's life.

Chapter 3 of this report has identified the main factors that adversely affect child health: broadly, the socioeconomic factors involved are poor housing, low income or lack of a job, family composition and belonging to a black or minority ethnic group. These are likely to be accompanied by a poor environment for making lasting emotional attachments, poor-quality child care, low educational attainment, poor nutrition and lack of exercise. Without intervention, disadvantages persist and poor health and low levels of wellbeing are likely to be lifelong. The effect of poverty underpins almost all disadvantage – it is a factor that contributes to or exacerbates almost all other risk factors. It is also apparent that the effects of socioeconomic disadvantage on child health are not just additive but multiplicative (see **Chapters 3 and 7**).²

In 2003, the DH published ECM, and identified a framework with five important outcomes: being healthy, staying safe, enjoying and achieving, making a positive contribution and economic wellbeing.³ A series of reports since then, from UNICEF, and the OECD amongst others, have shown that the UK is failing to provide these underpinning elements (see **Chapter 2**).⁴ It seems we are failing in every aspect of the ECM framework – children's health and safety; material wellbeing; educational wellbeing; family and peer relationships; behaviour and risks; and subjective wellbeing.

In 2010 the Marmot Review emphasised the importance of investment in children to reduce health inequalities at all ages.⁵ The report unequivocally states that 'Britain is failing its young children on a grand scale'. It stresses that the close links between early disadvantage and poor outcomes over time can only be broken by taking action to reduce health inequalities before birth, and continuing these throughout the life of the child.⁵

As discussed in **Chapter 2**, political solutions to the structural causes of ill health are required, even though the manifestations are seen and measured in the health sector. Early intervention is key to reducing costs further down the line, and the importance of adopting a multidisciplinary approach to child health cannot be overemphasised. As noted in the 1999 BMA report, 'tackling particular factors in isolation will not achieve the desired outcome of reversing the trend in the UK towards an increasingly inequitable society'. Consistent and reliable funding underpins evidence-based and multidisciplinary interventions. Policy makers must produce evidence-based guidance

and policies that reduce the inequalities in health for our youngest children, thereby ensuring the health and wellbeing of the whole population.

9.2 The current situation and changes since 1999

As highlighted in **Chapter 3**, the overall health and mortality of children in the UK is improving but health inequalities appear to be widening and the gradient of mortality has become steeper.⁶⁻⁸

The family

The UK ranks twenty-fourth out of 27 European countries in a composite measure of pressure on families and has the highest proportion of children living in a household where no one is employed.⁹ Twelve per cent of British children (aged 11 to 15 years) live in step-families and 16 per cent in single-parent families.¹⁰ These figures are higher than other western European countries, though lower than the USA.

In 2011/12, the highest number of children ever recorded in the UK was referred for out-of-home care.¹¹ Most referrals were because of abuse or neglect and this was an increase of over 10 per cent in one year.¹² More than 64,000 children in the UK live in the care of local authorities rather than with their parents.¹² The evidence presented in **Chapters 2** and **7** shows that cared for children fare poorly in later life so their outlook is poor.¹³ The cost to the state is also enormous: for 2009/10 the average cost per 'looked after' child was estimated to be £37,669 per year.¹⁴

Educational achievement

Pressure on the family and a poor social-emotional environment translate into low achievement for children of disadvantaged families: fewer than two-thirds of five year olds had achieved a good level of development in 2011, measured in terms of ability to concentrate, speak, recognise words and dress themselves. One-third of children in Britain aged between 11 and 16 years do not own a book.

Changes in health conditions

Currently the major cause of child morbidity is no longer infectious diseases. Three-quarters of childhood diseases are attributable to long-term conditions.¹⁵ Many can be linked to socioeconomic disadvantage.

The largest category of non-communicable disease is mental health; unipolar depression is the single most common cause. The majority of young people who die following suicide or substance misuse have not been in contact with mental health service, due in part to the stigma of referral to CAMHS. The DH has recognised the importance of these problems and in 2011 issued a strategy for preventing mental illness and intervening early in childhood.¹⁶

Nutrition, exercise and obesity

While there are still some instances of undernutrition and some vitamin deficiencies are of concern, overnutrition is a more important risk factor for child health. More than 20 per cent of children entering school (age 4+ years) are overweight or obese and are therefore at increased risk of ongoing overweight and obesity and of incurring the physical health problems such as diabetes, CHD, and osteoarthritis in later life.¹⁷ Fewer than half of children aged 11 to 15 years engage in at least one hour per day of moderate to vigorous physical activity, and the rate decreases with age. Tobacco, alcohol, physical inactivity, overweight and lack of fruits and vegetables in the diet are all important risk factors for child health. As discussed in **Chapter 2**, all these risk factors appear to be linked to socioeconomic disadvantage and are amenable to intervention.

Modification of risk factors

Many childhood diseases and deaths are preventable, and it is clear that socioeconomic disadvantage, especially poverty, underpins almost all risk factors for child health in the UK. Many of the risk factors are modifiable. There is a moral obligation on Government to direct policies and resources to addressing the underlying causes of preventable ill health.

In 1999, the BMA report stated that 'The United Nations Development Programme considers that the UK is now one of the most unequal industrialised countries in the world. The relationship between inequality and ill health is therefore more relevant than ever before'. If anything this situation has worsened since then.

9.3 Policies and interventions for prevention of health risk

Effective policies are evidenced-based; the evidence on risk factors and on what works is increasingly available and must form the basis of policies. Health agencies should engage with others to introduce policies that cross health and social divides, are evidence based and intervene as early as possible in the cycle of deprivation and disease.

The country's resources are finite, and choices have to be made about where to direct them. It is imperative to research the evidence about which interventions are most likely to have a lasting impact, and also which are the most cost-effective. Early intervention is always going to be cheaper than interventions to deal with the consequences of deprivation and ill health.

A life-course approach

The future health and wellbeing of the UK is linked to how successfully we manage the health and wellbeing of today's children. The life-course approach suggests that many of the risk and protective factors that influence health and wellbeing across the lifespan also play an important role in birth outcomes and in health and quality of life beyond

the initial years.¹⁸ The Marmot Review in 2010 identified the need for a 'life-course approach'. Such an approach should combine risk reduction with promotion of health with the aim to influence the whole life-course trajectory.⁵ It requires a variety of interventions across different sectors and involves preconception and pregnancy care, as well as social support and healthcare for the whole of the child's family.

The need for health professionals to work closely together in integrated services to serve the best interests of children and young people has been recognised for more than 30 years. The Court Report in 1976, the NSF for Children in 2004, and the Marmot Review and Kennedy Report in 2010 all emphasise this view.^{5,19-21} It is also recognised that the two most effective types of intervention are educational and family support, which may be interpersonal, emotional, practical or financial.^{22,23}

Family support

Families under stress are ill equipped to provide the social and emotional environment necessary for children to develop in a healthy way. Poverty lies at the root of most inequalities. Support for families should be high priority – to optimise the health and wellbeing of our children. This requires all agencies involved in supporting children and families to work together and communicate with each other. Policies on pay and childcare must provide a living income for all families and high-quality support for their children.

Sure Start Children's Centres are a success story in troubled families as well as an excellent example of multidisciplinary care in action. They can have an enormous positive impact bringing together support agencies from the NHS, social services, education and the voluntary sector. Aimed at pregnant women, they continue supporting them and their children until they reach primary school age. Discussed in more detail in **Chapter 3** – evidence has shown beneficial effects in children and their families in Sure Start areas.

Sure Start Children's Centres are easy to access, usually based in familiar community venues, and serious efforts including home visits are made to reach families that might not otherwise engage with health and social services.²⁴ The services are under one roof and a trusting relationship is built up within the community. The UK coalition agreement 2010 pledged to 'take Sure Start back to its original purpose of early intervention [and] increase its focus on the neediest families',²⁵ and the 2010 Comprehensive Spending Review protected Children's Centre funding in cash terms. Since then local authority budgets have been reduced and services are no longer ring-fenced; some centres have closed or are providing a reduced number of services. Some service users may be referred from a local 'satellite' centre that provide limited services to a larger Children's Centre that may be some distance away. This is no longer a true community service and there may be a reduction in the effectiveness of the centres if access to services becomes more difficult.

Poverty

One of the Marmot Review's key recommendations was 'to develop and implement standards for minimum income for healthy living'.⁵ This should reduce the numbers in persistent and reoccurring (child) poverty, while reducing 'adverse health outcomes attributable to living on low incomes'.⁵ The current economic climate threatens progress in this area.

The Labour Government pledged in 1997 to halve child poverty by 2010, to eradicate it within 20 years, and to reduce health inequalities. A three-strand approach was proposed: universal child care provision, increased financial support for families, and initiatives to make work pay. Child poverty fell steeply in absolute terms between 1999 and 2010 (with a plateau between 2004/5 and 2008),^{26,27} (see **Chapter 5**) but the 2010 target was not met.²⁸ Forecasts produced by the Institute of Fiscal Studies indicate that child poverty will remain broadly constant between 2009/10 and 2012/13, before rising slightly in 2013/14.

In its 2007 study,²⁹ UNICEF ranked the UK as the worst performing of the 21 countries it assessed against various dimensions of children's wellbeing. At the time David Cameron, then in opposition stated 'If today, Britain is the least family-friendly country in the developed world, the aim of the next Conservative Government is to make it the most family-friendly'. To date (see **Chapter 2**) the current administration's policies are unlikely to be described by health policy analysts as family-friendly. Cuts to child benefit, Sure Start centres closures, and regressive tax policies have differentially affected women and children (see **Chapter 7**). The Welfare Reform Act and Health and Social Care Act arguably will have profoundly deleterious effects on the most vulnerable patients.³⁰⁻³² While UNICEF's update to its 2007 study (published in April 2013)³³ found that the UK had seen a modest improvement, this only relates to data up to 2009/10, and does not therefore reflect the Coalition government policies. It is unlikely, given the current economic situation and policy environment, that the trend in improving child wellbeing will continue for the next few years.

Poverty underlies almost all child health inequalities and alleviation of poverty should be a Government priority. As discussed in **Chapter 3**, it is essential that all families have a minimum living income, set at a realistic level and constantly updated. A recent report from KPMG (2012), claiming that one in five workers in the UK earns less than a living wage, is not encouraging.³⁴ A 2012 research report from Action for Children, The Children's Society and the NSPCC has estimated that between 2008 and 2015 there will be an increase of just over 14 per cent in the number of families living with five or more vulnerabilities and that 'changes to the tax and benefits system will, on average, have a negative impact on every type of vulnerable household [they] analysed. Tax and benefit changes will disproportionately hit the most vulnerable and their negative effect on family income will increase, the more vulnerable you are'.³⁵

Child care

While material wealth is important, so is the quality of a child's social and emotional environment. Policies that ensure optimal child care are essential, recognising that factors such as poverty, mental health problems, unemployment or homelessness can affect the child by the overall reduction in parental capacity to meet their own, and their children's, emotional needs. The 2012 *Social Justice: transforming lives* strategy allocates the extension of free nursery places for all children and to targeted interventions to help families identified as vulnerable. Although this is encouraging, optimal child care also requires support of families where most children spend most of their time, so this needs to be understood within the context of other cuts and changes to tax and benefits and the forecasts of net disadvantage to families.²⁷

Healthy foods and exercise

The rapid increase in the number of obese people in the UK represents a major public health challenge that requires urgent action. The DH Change4Life campaign introduced in 2009 aims to inspire a societal movement in which everyone who has an interest in preventing obesity, including government, business, healthcare professionals, schools, families, and individuals can play a part.³⁶ Free child care in the early years setting also offers an opportunity to develop good nutrition habits.

Advice and education have limited effectiveness and it is likely that legislation and tax changes will be needed to make any major change to people's habits. The food industry has a powerful voice and a conflict of interest with Government attempts to reduce overconsumption. Sponsorship of schools and sporting events by companies that sell unhealthy foods or drinks is not helpful alongside attempts to encourage healthy eating. Rules on television advertising to children have limited effectiveness, as many children watch programmes outside the times when advertising is not allowed.

As discussed in **Chapter 4**, it is essential that Government moves away from partnership with industry and looks at effective alternatives to self-regulation to ensure that there is a transparent and effective policy development process.

The poor level of exercise in children is another area that should be amenable to intervention and education. If facilities for exercise or sport are difficult to access or too expensive they will not be used. Investment in open spaces, leisure centres, sports facilities and exercise equipment in parks would help to increase engagement in activity and reduce health problems resulting from a sedentary life. Selling off school playing fields may raise money for local authorities in the short term, but the loss of open space is likely to have a long-term effect on children's health. One example of an initiative that works to increase exercise is the charity Living Streets' Walk to School campaign, which reaches more than 1.9 million children each year.³⁷

Health services

As discussed in **Chapter 1**, although the past decade has seen some improvements in children, young people and families' health services, the care provided by UK child health services is inferior in many regards to that in comparable European countries.

As stated in **Chapter 2**, prevention of chronic disease, addressing risk factors for ill health and improving life chances are priorities for the entire health system, and the greatest gains will accrue from starting at the earliest stage of life. Despite the shift from acute to chronic and long-term illnesses in children, child health care in the UK is still delivered in a hospital-centric manner. A different model of care that focuses on prevention and integrated services is required.³⁸ This requires a re-examination of curricula for training health professionals and those in other integrated professions.³⁹

Whole-population approaches

Whole-population approaches in the form of education or advertising campaigns can have a significant effect on public awareness and behaviour. Examples are education about nutrition (eg the five-a-day message) or exercise. As discussed in **Chapter 5**, these can have the effect of 'shifting the risk curve' so that individuals who might otherwise have been at risk are moved out of a risk group, and those at high risk are moved to lower risk.

9.4 Funding and the focus of services

Under coalition policy, there has been a move to focus services on the sharper end of social welfare need and there have been cuts to resources needed to offer preventive services (see **Chapter 5**).⁴⁰ It is shortsighted to remove funding from prevention; early intervention costs much less than dealing with the consequences later in a child's life.⁴¹ As the Rt Hon Eric Pickles MP, Secretary of State for Communities and Local Government, said in his 2010 speech to the Conservative Party conference: 'council spending on early intervention for children and families can deliver £10 of savings for every pound spent. Investing money to address the causes of social breakdown is far more effective than subsidising the symptoms'.⁴¹

Current spending on early intervention is low: national estimates have put prevention spending at 4 per cent of total health spending.⁴² The OECD reports that for every £100 spent on early childhood (0 to five years) in the UK, £135 is spent on middle childhood (6 to 11 years) and £148 is spent on late childhood (12 to 17 years).⁴³

It is not easy to measure the cost savings of any intervention, because early intervention is multidisciplinary and good outcomes are reflected in the absence of problems, and reduction in costs to society, in later life.⁴⁴ A common calculation is the 'social return on investment'. Calculations invariably show impressive ratios between initial outlay and later savings. For example, a study of family support interventions in children's centres

by Barnardo's showed that family support workers generated £4.50 social return on investment for every £1 spent.⁴⁴

Identification of children in need of intervention

Early intervention requires early identification of children at risk and that information from professionals who identify early problems is acted on promptly. Evidence presented in this report suggests that this does not always run as smoothly as it should (see **Chapter 5**).

Primary care is well placed to spot signs, recent high-profile cases of child maltreatment have reinforced the forensic role of paediatricians and their part in judicial proceedings, with much less attention to preventive roles. As discussed in **Chapter 5**, there are numerous reports of lack of feedback from social services to GPs or schools, so that families have to tell the same story to different agencies, which do not communicate with each other. Schools are also well placed to intervene before small problems become larger. In many situations scope for early intervention is largely limited to referral to social services, which has a very high threshold for acceptance of cases. A similar scenario is reported for referrals to CAMHS (see **Chapter 5**).

The Munro review of child protection in 2011 reiterated the importance of a preventive, proactive approach, targeted at vulnerable families and recognised the importance of other public services, schools, primary care and adult mental health services to aid social care in their proactive, preventive approach. Other public services could also intervene early in response to concerns about child maltreatment. Specific policies and guidelines are urgently needed to address this matter.

9.5 The importance of research to improve the evidence base for interventions

Money spent on interventions must achieve maximum benefits; outcomes should be measured preferably in longitudinal and randomised controlled population-based trials.

A comprehensive childhood disease incidence and prevalence databases – with indicators of wellbeing, development, and risk profiles, all linked to demographic information – is essential for health planning but does not currently exist (see **Chapter 2**). The Child and Maternal Health Observatory is helpful but will only ever be as good as the data available, which remain insufficient.⁴⁵

Many interventions to reduce ill health and reduce inequity are short term and do not allow sufficient time for gathering of robust evidence from longitudinal studies, and less than 10 per cent of over 150 known approaches currently used in England have good evidence of effectiveness.⁴⁶ Future policy should concentrate on this area in order that limited resources can be focused on interventions with proven effectiveness. The use of HPSR must allow for recommendations on the basis of 'best available knowledge rather

than the most desirable evidence' in order to help us understand how well systems work, and what should be done differently to strengthen child health system performance.

Research on effectiveness requires documentation of measurable outcomes. It is easy to measure levels of income, joblessness or inadequate housing, but outcomes should also include subjective measures of wellbeing or the absence of difficulties years or decades later. Outcomes will also be reflected in reduced costs for health and social care; these are hard to measure and may not be apparent for many years. Government terms of five years or less, lead to a temptation to record and publish only short-term outcomes. It is essential in the context of child health that the whole life-course trajectory is examined and long-term studies must be conducted.

All the reviews into child protection and welfare services conducted by the government, except the Munro review, have been in response to a child death.⁴⁰ Government reports and policy place too much emphasis on media reports and high-profile cases. As evidenced in **Chapter 5**, inquiries into individual deaths and national reviews of the 100 or so serious case reviews each year (death or serious injury where maltreatment was a factor) have had a significant impact on policy, while scant attention has been paid to population-based research.⁴⁵

Examples of effective evidence-based interventions

There is strong evidence that intervention during a child's early years improve the health and cognitive development of the child.⁴⁸ The HCP⁴⁹ and FNP Programme focus on at-risk families; early evaluation of the FNP programme has been positive⁵⁰ with a full report due in 2013 and plans to increase capacity from 6,000 to 13,000 by 2015.

Sure Start has reported success.^{51,52} No longitudinal evaluation has yet been possible but it may be more effective for moderately disadvantaged than severely disadvantaged families.^{51,52} A similar programme in the USA running since 1962 has been shown to be very successful in improving social outcomes.⁵³

A good example of evidence-based interventions to improve nutrition and prevent obesity in young children is HENRY, a national organisation that works with health trusts, local authorities and voluntary organisations to provide tailored packages according to local need, using evidence-based methods to provide early interventions. There is evidence that its interventions produce positive and lasting lifestyle effects.⁵⁴

9.6 Vision for the future

'Britain is failing its young children on a grand scale' and compares poorly to other western countries.⁵ This is not acceptable. It is time to reverse the trend and move towards a more equitable society.

The complex social and economic determinants of chronic ill health and of unfulfilled lives cannot be tackled by focusing, in isolation, on the duties of individual professional bodies or on short-term programmes with little evidence for their effectiveness. A multidimensional policy response is required to tackle the multiple factors involved, from preconception onwards.

There will never be enough money to address all the needs of society. It is essential to focus resources on where they have most effect, and where they are most needed. Without presenting specific recommendations, as these are given in the next chapter, the following summarises our view of the revised thinking needed to generate the best policy approaches to reducing inequalities and improving child health.

- Policies aimed at single issues have their place but a joined-up approach is essential, and a whole environment that values and supports family life is the single most important issue.
- The effect of poverty underscores almost all socioeconomic disadvantage and the burden of the financial crisis appears to be falling disproportionately on the poor. Urgent Government intervention is needed to ensure a realistic minimum wage and threshold for payment of income tax.
- Many interventions are short term and not based on evidence of what works. There is no place for short-term and 'knee-jerk' responses, such as those generated by high-profile child protection cases. All policies and interventions should be based on the best evidence available and outcome indicators should be built into the design of all new interventions.
- Gathering evidence requires that the views of parents and children are listened to and acted on. Specific projects can be run with specific groups in mind. Assessments should carefully monitor whether services offered are actually reaching the intended groups. Evidence of the effectiveness of interventions should be gathered in long-term, population-based studies that also document the response of the parents and children involved.
- Whether or not they are directly concerned with the needs of children, all Government policies and programmes should consider their effect on children. As noted in the 1999 BMA report, policies, such as those relevant to transport, housing, environment, employment, and fiscal/welfare, will have effects on children, but these are often overlooked.
- There has been a trend in recent years towards PbR. It should be recognised that, while this can be helpful in some settings, such as acute or preventive medicine, not

all of the desired results are readily measurable. Reducing interventions to results that can be recorded by ticking a box is not helpful in addressing the complexity of general child health and wellbeing, not least because many outcomes are not short-term ones and are only realised by an absence of problems later in life. There is no escape from the need for long-term population based studies to gain real evidence of effectiveness.

- While the introduction of PbR for CAMHS planned for 2014 may help to encourage clarity about the focus of mental health interventions for young people, it is important that the requirement to fill in forms and tick boxes does not interfere with the development of relationships between families and professionals.
- There is little doubt that early intervention and family support are effective, but involvement has to be voluntary; in order to engage those who are most at risk, services need to be easily accessible and provided in an advisory and non-stigmatising, non-threatening way. Sure Start is a good model for this and this approach could be extended to other situations and age groups, such as schools and workplaces.
- Those most in need of support are likely to be those that are hardest to reach – for example, no one can be forced to attend a Sure Start Children’s Centre. Seemingly unrelated community activities such as a special interest group, a mother and toddler group or a family fun day may enable professionals to reach stressed families they would not otherwise make contact with.
- Since it is impossible to measure the cost-effectiveness of such support, in the current financial climate these types of activities are in the front line for cuts. In our view, this is short-sighted.
- Building communities in this way is also likely to develop support within the community and eventually reduce the need for costly professional input. Investing in, and supporting, community groups to help them get started is likely to pay off in the long term.
- When money is short, there is a tendency to remove funding from prevention and deal only with more major problems, which are often the outcome of failure to intervene early. Given the very favourable ratios of money saved to money invested in early intervention, this is also rather short sighted.
- Not all those children at risk will be discovered by Sure Start. If more serious problems develop, perhaps at school, the threshold for referral to Social Services or CAMHS is currently very high. Integrated systems to involve a range of professions to avert serious problems are not in place and individuals experience many problems navigating the system. One way to alleviate this is to assign a key support worker to individuals identified to support their needs and help them access all the services required. Development of effective integrated multiprofessional systems would be a major improvement to the current situation.
- Long-term and chronic medical conditions, which are increasing in prevalence, have an effect on many aspects of an individual’s life and require a different approach to medical care. A reduced requirement for acute care should allow an increased emphasis

on preventive and social care. The need to deal with acute social problems reflects a failure to intervene early in a multidisciplinary and holistic way. Both situations point to a need to rethink the way services are run.

- One of the successes of Sure Start has been the result of a common funding source for health and social care services under one roof and this is a model that could be examined for all health and social care in the future.
- Finally, and very importantly, a vision for radical change to the way health and social care is delivered as the 21st century progresses will require a re-examination of the way in which professionals involved in multidisciplinary and cross-professional care are trained. It is essential that all professions involved develop the skills necessary for collaborative teamwork and communication across disciplines and to assimilate the complex needs of individual service users.³⁹

Summary: four key messages

1. Poverty lies at the root of most health disadvantages and must be reduced.
2. Early intervention, with family support and education is cost effective and essential to optimise the life chances for those experiencing socioeconomic disadvantage.
3. Interventions should be evidence based.
4. Integrated and coordinated multiprofessional care is essential for optimal health and social care.

Chapter 10: Recommendations for childhood health: a life- course approach

Successful improvement of health at key life stages requires a continuum of interventions across the life-course, combined with efforts to strengthen health delivery systems and address the broader social and economic determinants of health.

Zsuzsanna Jakab, WHO Regional Director for Europe¹

The future health and wellbeing of the UK is linked to how successfully we manage the health and wellbeing of today's children. We must value children for who they are at the moment, as well as who they will become. Children's services, and the processes and structures that enable them, should be coordinated in the interests of children and families. This will require financial and organisational coordination, supportive local and national policy, and adequate resources invested for sufficient time to enable improvement. The life-course approach suggests that many of the risk and protective factors that influence health and wellbeing across the lifespan also play an important role in birth outcomes and in health and quality of life beyond the initial years.² It is clear that conditions early in life have long-term effects on adult health. Because of this, inequalities in children's socioeconomic circumstances contribute to inequalities in health in adulthood.

A life course perspective offers a more joined up approach with implications for long-term health gain and places emphasis on education and early intervention. It approaches health as an integrated continuum rather than as disconnected and unrelated stages. It puts forward a complex interplay of social and environmental factors mixed with biological, behavioural, and psychological issues that help to define health outcomes across the course of a person's life. In this perspective, each life stage exerts influence on the next stage; social, economic, and physical environments also have influence throughout the life course.

The following sets out the recommendations put forward in this report and incorporated into a life-course approach.