Tackling child poverty is a public health priority. A recent analysis (Cribb et al 2013) showed that, across the UK, absolute and relative income related child poverty is projected to increase between 2010-11 and 2020-21. This would reverse the reduction seen between 2000-01 and 2010-11, and would mean an expected increase of 1.1 million children in the UK in relative income related poverty and 1.4 million in the number of children in poverty according to the absolute low income measure. This equates to around 50,000 more children in poverty in Scotland. The report concludes that the UK government needs to review its policies to meet their legally binding targets or develop objectives that are both desirable and achievable to reduce child poverty and mitigate the impact.

**What is child poverty?**

Poverty is about lack of income. Lister (2004) suggests “One danger of [Governments] downplaying income when defining poverty is that it can be used to justify a policy stance opposed to raising the incomes of those in poverty.” Children in poverty live in households that are in receipt of welfare benefits, living on low wages; have a lone or disabled parent or a parent with a long term limiting illness. Minority ethnic communities are disproportionately affected.

Poverty is also about social exclusion. Townsend (1979) enabled a deeper understanding of poverty by developing a multidimensional definition of child poverty which helps us to better understand the experience of poverty:

> **Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or are at least widely encouraged or approved, in the societies to which they belong. Their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities.**
Townsend’s definition is important in a society defined by abundance rather than scarcity and where poverty is measured in relative terms rather than absolutes. If relative and absolute poverty persist then so will social exclusion and the consequent effects on children and families.

Poverty is emotive. Those better off in society are inclined to see people in poverty as victims of their own fate (The Fabian Society 2006). The Child Poverty Action Group (2009) lists ten reasons why we should be angry about the social injustice of child poverty:

- More than half of the children living in poverty have a parent in employment
- Current benefit and tax credits leave many children living below the poverty line
- The poorest families pay the most for key necessities
- The poorest families pay the highest proportion of their income in tax
- Poor children are more likely to experience unsafe environments
- More affluent and better educated people tend to get the best out of public services
- Poverty is a barrier to educational success
- Children in poverty go without the necessities most of us take for granted
- Poverty damages children’s health
- Parents’ aspirations for their children are high, but their life chances are low

**Why does poverty matter to health?**

Understanding why poverty matters is critical to the effectiveness of anti poverty strategies. Material circumstances and relative income make a difference to health and social problems. Policy needs to address both.

The biggest challenge for Greater Glasgow and Clyde is the variation in health, particularly related to the effects of disadvantage. Using the Strathclyde Passenger Transport map (Figure 1:1) we can see that men living in the affluent west end of Glasgow, for example, can expect to live to 75. It is estimated that 87% of 15 year old boys in Eastwood and Bearsden, will reach their 65th birthday. In the east end of the city, however, life expectancy for men drops by almost two decades. Just 53% of
15 year old boys in Bridgeton and Dennistoun are estimated to reach their 65th birthday. Reducing the extent of income inequality can lead to improvement in health of all groups in the population. In addition to reducing life expectancy, poverty is associated with higher levels of infant mortality and stillbirth (Healthcare Improvement Scotland 2010). Smoking in pregnancy and in the postnatal period is the major modifiable risk factor underpinning the inequality (Allen et al 2009).

Figure 1.1: Glasgow - The Inequality Gap
(Source: GCPH community health and wellbeing profiles (various))

Early years’ experiences are crucial for health throughout life. As Michael Marmot says in his report Fair Society, Healthy Lives (Marmot Review, 2010)

*The foundations for virtually every aspect of human development - physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being*
Child poverty in Greater Glasgow and Clyde

In 2011, there were 270,542 children and young people (0-19) in NHS Greater Glasgow and Clyde (NHSGGC) (making up 22.2% of the population). The total number of children living in NHSGGC under 5 years old in 2011 was just over 67,000. The population of 0-15 year olds is projected to increase by 4% across NHSGGC across the period 2010-2020. This compares with a 5% rise across Scotland for the same period. However, there will be marked variations in change across local areas, with Glasgow City seeing a rise of 11% and East Dunbartonshire seeing a fall of 12% across the same period (National Records of Scotland, 2012). By 2030, it is projected that NHSGGC will have a 1% fall in the 0-15 population based on the 2010 level.

It is estimated that 30.4% of people in NHSGGC live in the 15% most deprived data zones (SIMD) the range is from 3.1% in East Dunbartonshire to over 50% in North and East Glasgow. Figure 1.2 shows that in Glasgow City 33% of children are estimated to live in relative poverty. In some of our neighbourhoods, such as Glasgow North East, 43% of children are living in relative poverty (see Figure 1.3).
Figure 1.2: Percentage of children living in relative poverty NHSGGC 2013 by Local Authority. (Source: End Child Poverty (2013))

Figure 1.3: Percentage of children living in relative poverty NHSGGC 2013 by Glasgow City. (Source: End Child Poverty (2013))
The 2011 Census reported that there were 88,464 minority ethnic people living in Greater Glasgow and Clyde (7.3% of the total population of the Board area). This varied from 1.4% in Inverclyde to 14.2% Glasgow City CHP’s south sector. This compared with only 4% for Scotland. We know that there have been substantial changes to the minority ethnic populations in Greater Glasgow and Clyde, both in terms of an increase in numbers and in the profile of ethnic backgrounds and nationalities.

**Persistent poverty**

Persistent poverty is defined as children living in households where income is below 60% of the median income in at least three of the last four years. The problem for families who fall into this category is that they are income and benefit dependant. This means that families may have work that is irregular or below the living wage and therefore try to maintain working while they are also dependent on welfare benefits to survive. In the current recession, where families are trapped in low wages with no hope of wage rises, they are also disadvantaged by rapid welfare benefit changes.

The number of children in Scotland in persistent poverty is estimated at around 13% against the UK percentage of 9% as can be seen in Figure 1.4. In Glasgow City the estimate is 19%.
A short spell in poverty is not the same as a lifetime with resources stripped by need (Walker and Ashworth 1994). Time is crucial to health status in relation to life course experience. Long run income (income levels, income changes and experience of poverty) and persistent poverty are key determinants of health in addition short term falls in income can also have a detrimental effect on health (Benzeval and Judge 2001). Benzeval and Judge conclude that two sets of policies need to be considered. Firstly, policy must reduce the risk of persistent poverty. These can be achieved through education and sustainable employment opportunities. Secondly, where people can’t access education and find well paid work, benefits need to provide an adequate standard of living.
The impact of poverty on health

Poverty is associated with worse outcomes for children. The experience and effects of poverty follows children into adulthood. Children growing up in low income households have poorer outcomes including health, emotional and behavioural problems and poorer educational attainment. Children from minority ethnic backgrounds have an increased risk of persistent poverty as do those with mothers who have a disability or long standing illness.

Children born into poverty are more likely than those born into affluent families to:

- die in the first year of life
- be born small, be born early, or both
- be bottle fed
- die from an accident in childhood
- become smokers and have a parent who smokes
- have poor nutrition including being formula and not breast-fed
- become a lone parent
- have or father children at a young age
- suffer from mental health problems (x3)*
- more likely to have a chronic disease
- more likely to live a proportion of their life with a life-limiting illness
- die in an accident (x5)*
- die younger

* More likely than children from affluent families

Figure 1.5 shows the infant mortality rate per 1,000 live births in NHSGGC by SIMD (Scottish Index of Multiple Deprivation) Quintile and illustrates the impact of poverty on infant health.
Figure 1.5: Infant mortality rate per 1000 births by SIMD Quintile NHSGGC, 2009/10 to 2011/12. (Source NRS/SMR02)

Figure 1.6 shows the rates by SIMD Quintile for low birth weight; the percentage of mothers smoking and percentage of mother who breast feed exclusively at 6-8 weeks in NHSGGC.
National Policy

The UK Child Poverty Act 2010 enshrines in law the commitment to eradicate child poverty by 2020. The acts sets out four targets related to relative low income, combined low income and material deprivation, absolute low income and persistent poverty.

At the heart of the Scottish Government’s Early Year’s Framework (2009) is a desire to see investment in early years. This means intervening not only when there is a crisis but working on prevention and early intervention. The framework sits alongside: Achieving Our Potential: A Framework to Tackle Poverty and Income Inequality in Scotland (2008a); and the Equally Well Report on Health Inequalities (2008b). These three social policy strands are central to the Child Poverty Strategy for Scotland.
(Scottish Government 2011b). The strategy is underpinned by the principles of Getting it Right for Every Child (Scottish Government 2012).

The independent review, Joining the Dots (Deacon 2011) states that what we urgently need is to create a “bias for action” and radically shift energy, time and resources from analysis to action and from process to people. She contests that we don’t need more evidence on the importance of investing in early years; we need to ensure that we take action.

**Strengthening the NHSGGC response**

Child poverty is an issue for all our partners and therefore needs a co-ordinated response from every Community Planning Partnership that involves a bias for action to mitigate the impact of poverty on children and families. The following examples demonstrate the commitment to mitigate the impact of poverty.

We are working to ensure that equalities legislation drives organisational change to make our services sensitive to the needs of all our users. An inequalities sensitive enquiry approach (NHSGGC 2009) has been adopted by NHSGGC. The approach describes how frontline workers in our services can best respond to the social circumstances which affect patients’ health and wellbeing. Frontline staff are trained to enquire about underlying issues routine in patient care. A key focus for inequality sensitive practice has been the systematic identification of gender based violence. The practice has been extended to include employment, financial inclusion, patient and staff experience of discrimination, and literacy and numeracy.

**Healthy Babies Programme**

The aim of the Healthy Babies programme is to ensure we implement service changes from the Refreshed Framework for Maternity Care in Scotland (Scottish Government 2011c). The programme addresses health inequalities by focussing our activity on early intervention and prevention to target those in need in addition to providing universal services:

- Improving access to antenatal health care services
• Improving the assessment of health and social need
• Improving multidisciplinary and multi-sectoral delivery of care
• Ensuring equity in the quality of care for women and their babies

Components of the Healthy Babies programme include:

• **The Family Nurse Partnership**, a preventative programme which aims to improve outcomes for first time young teenage mothers and their children. This is done through structured home visits delivered by specialist family nurses from pregnancy up to two years of age. The family nurses will work alongside midwives delivering a programme of tailored support. It is hoped to recruit 250 women into this pilot scheme by October 2013 and, subject to evaluation results, roll it out across NHSGGC.

• **The Special Needs in Pregnancy Service** (SNIPS) adopts a multi-agency approach to delivering comprehensive care to women with substance abuse, asylum seekers, refugees, teenagers and homeless families. In Clyde, the SNIPS is an integrated health and social care service, providing care for women with special social and psychological needs. This award winning preventative programme focussed on early intervention to identify potentially vulnerable babies as early as possible. This approach will be integrated across NHSGGC.

• **Parents and Children Together (PACT)** are multi-agency teams who provide support to families in local communities who are expecting a baby or already have children less than five years of age. The principle aim of this service is early intervention. PACT teams work with families on a voluntary, planned and time limited basis to reduce the need for more intrusive and/or statutory measures. The teams help to build resilience in the families they work with and develop sustainable skills to meet a variety of child and parental needs.
Healthy Children Programme

Children and Family Teams are well established across NHSGGC to tackle the intergenerational effects of poverty by supporting vulnerable families to care for children from birth to nineteen years of age. They provide a service for vulnerable children and their families. In line with government policy, we have reviewed the effectiveness of our early years' services. As a result, we are now establishing and implementing our Healthy Children Programme, a planned approach to service provision for our children and families. The programme will implement the National Practice Model for children across NHS services. Getting It Right for Every Child (2012) helps staff to assess consistently children and families for needs against nationally agreed wellbeing indicators: safe, healthy, achieving, nurtured, active, respected, responsible, and included. The model also helps staff to create child-centred action to bring about improved outcomes for children. The programme links closely with local authority partners to ensure a consistent approach for children who need multi agency support.

Components of this Healthy Children programme include:

- The Parenting Support Framework for Glasgow (NHSGGC and Glasgow City 2009) aims to ensure that all parents are able to access a range of parenting interventions based on their specific needs. These programmes can also be accessed through education, housing and third sector organisations. In addition, the roll out of the 30 month assessment will ensure that children who require additional support around communication and behaviour are identified and supported. The framework is now in its third year of implementation and there has been substantial learning. The framework is being revised to ensure dedicated staff time for delivery of parenting interventions and improved co-ordination of attachment interventions, parenting programmes and intensive family support.

- Ready to Learn 30 month health surveillance: The most promising public health interventions available are those which improve parenting capacity and which prepare children for learning. A board-wide needs assessment identified impoverished communication as an important unmet need for the population.
Making contact at 30 months gives health visitors the opportunity to work alongside parents to identify children whose social, emotional and behavioural development puts them at risk of adverse life course outcomes. Once identified, children at risk are supported through appropriate services to give them the best start in education. Ready to Learn offers additional opportunity to engage families with information on nutrition, second hand smoke, play, safety and physical activity.

**Employability**

NHSGGC supports employability action in an attempt to address health inequality arising from unemployment and resulting poverty. Particular groups face significant barriers to work which are caused by their health issues and often compounded by prejudice and discrimination. The majority of people on incapacity benefit (70%), for example, have mental health related difficulties. They may or may not be accessing support from their GP and are unlikely to be accessing support from Primary Care Mental Health Teams or from secondary care. The role of the CH(C)P is to offer social interventions which can help people to join or re-join the employability pathway. The vast majority of people who have experienced a mental health problem continue to work successfully. The greatest barrier people with mental health problems face is being given the chance to prove their ability to work. Research indicates that once given this chance, they have lower sick leave than average and demonstrate strong loyalty towards their employer. NHSGGC commissions and supports employability services for people with mental health problems.

People who have had addictions problems also face considerable barriers to employment. Community Addiction Teams have worked to ensure that employability is discussed as part of people’s care plans. Local bridging services are then able to support people to access employability advice.

The recession in 2009, combined with welfare reform and austerity have had an impact on unemployment. While job loss was greater for men than women in the initial stages of the recession, the EHRC (Hogarth et al 2009) identified the following issues for women: women are less likely to register as unemployed and are less
likely to be able to claim benefits; where women are in work they earn less than men, tend to work in low status jobs and continue to carry the majority of childcare and domestic responsibilities; women were already in a more vulnerable position in the labour market and more likely to be in part-time work although there is some evidence that men are moving to part-time work and in jobs traditionally taken up by women as a result of the recession; there are some indirect consequences of the recession which may affect women more than men, for example, increased gender based violence, relationship breakdown, debt and associated concerns over child wellbeing.

These labour market and recession issues all have a major impact on lone parents, 90% of whom are women. Lone parents whose children are five now claim job seekers allowance which means they are required to undertake job related activity. Lone parents could be at risk of losing family benefit as sanctions if they fail to meet the Department of Work and Pension requirements.

One Parent Families Scotland, an organisation which supports lone parents, believes that many families have to make difficult choices and a combination of the increased cost of living, benefit changes and sanctions are making these choices even harder. Many families on low incomes live well below the poverty line and nearly a quarter of the poorest families can’t even afford to warm their homes (Consumer Focus 2012). While work can be a route out of poverty, this is challenging for lone parents because they need to find work which is flexible enough to meet their childcare responsibilities and is well paid enough to bring them above the poverty line.

**Healthier Wealthier Children**

Healthier Wealthier Children is a children and families financial inclusion project. It is part of NHSGGC’s aim to prioritise routine enquiry on social issues including money worries. In just over two years, the project received 4,844 referrals, with a £4,358,672 gain to households. 38% of the referrals to the service were lone parent women — who we know are at higher risk of poverty. Outcomes have included reduced stress, improved budgeting skills and better access to crisis loans e.g. for cookers or
washing machines. The project has been mainstreamed across NHSGGC. Plans are being developed for innovative work which involves money advice services in antenatal education for pregnant women and outreach money advice clinics for pregnant women with complex needs.

Healthier Wealthier Children has been recognised as a model of good practice in the Equally Well Review (Scottish Government 2010), National Money Advice Service Good Practice Guide and at the Scottish Health Awards.

**What more can the NHS do to tackle child poverty?**

As no one agency alone can address the issue, community planning offers a collaborative route to identify resources that will mitigate the impact of child poverty at a local level. The NHS is a key partner in community planning partnerships.

The Director of Public Health for NHSGGC and Glasgow has prioritised child poverty for public health action and has adopted an influencing role at both national and local level towards a bias for action.

A key principle in work on poverty has been to ensure that we stay engaged with communities and families. This has been achieved through the Poverty Truth Commission where the maxim “nothing without us is about us” has been upheld. Glasgow City community planning partners, with expert advice and input from the Child Poverty Action Group and One Parent Families Scotland, have developed a Child Poverty Action Plan. The plan was recently tested with families and communities supported by the expertise of the Poverty Alliance. Glasgow’s Action Plan for Change (2013) is now part of the work of the Poverty Panel led by the leader of Glasgow City Council.

Community Planning Partnerships must work to reduce the impact of poverty on health, and some of the initiatives suggest that NHS staff can also support families to access better financial support. However, it should be remembered that the greatest proportion of children in poverty are living in absolute or material poverty, which can
be addressed by measures to increase the income of households containing children.

**Challenges for NHSGGC and partners**

- **Measuring child poverty.** Indicators for children’s health and wellbeing are being developed by the Glasgow Centre for Population Health and Glasgow City Council to support strategic planning and monitoring for child poverty.

- **Mainstream services** are a valuable resource for parents and children. They should be delivered in a way which is sensitive to the needs of parents and children living in poverty and understanding of the inequality they face.

- **Gender issues:** Women are more likely to experience poverty than men. A gendered analysis is essential to ensure that women and their children are not further disadvantaged particularly by the recession and public sector cuts. Service providers need to address the stigma women and children often experience as a result of their experience of poverty (Women’s Budget Group 2008).

- **Child Care:** Accessible, affordable, quality child care is essential. It should be flexible enough to enable parents to gain employment and access training opportunities.

- **Employment and financial inclusion** are important to reducing the extent and incidence of child poverty. Changes to welfare reform are already impacting on parents and they will continue to be directly affected by changes in policy. We need to be able to inform our clinicians and practitioners of these changes and make them aware of the impact on households to ensure appropriate service responses.
Priorities for Action:

Priority 1: Fully support those at the front line of service delivery

We need to:
- Improve engagement with frontline staff in delivering inequalities sensitive services.
- Fully support staff to build supportive, non-judgemental relationships with families.
- Support those working with families with very young children to engage in professional reflective supervision and development, in recognition of the emotionally demanding nature of their work.

Priority 2: Strengthen involvement of senior leaders in advocacy and influence

We need to:
- Provide effective leadership and accountability in Community Planning Partnerships, promoting a bias for action on child poverty including action to improve health of pregnant mothers and employment opportunities for parents across government, public services, employers and the voluntary sector.
- Assess the Clinical Services Review, forthcoming strategic plans of new integration bodies and other major strategies for their impact on child poverty.
- Advocate for a comprehensive early education and child care strategy for Scotland.

Priority 3: Improve mutual clarity of partnership roles in effective delivery

We need to:
- Influence Community Planning Partnerships to define the degree of local autonomy for alleviation of child poverty, for example by adopting the living wage across all sectors and through procurement policies.
Priority 4: Strengthen evaluation, innovation and improvement activities

We need to:

- Improve the involvement of families in development of plans and services to ensure they reflect their experience of poverty and their needs.
- Ensure training, support and development of staff in reducing stigma and discrimination against those living in poverty.
- Encourage creative ways of organising mutual child care.
- Review and revise NHSGGC’s Parenting Framework to reflect experience to date.
- Work with Community Planning Partnerships to plan an extension of the Healthier Wealthier Children model.
- Improve support for vulnerable families and fully engage with Triple P parenting programmes.
### Glossary of Terms

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<th>Term</th>
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<tr>
<td><strong>Community Health Partnership (CHP) and Community Health and Care Partnership (CH(C)P)</strong></td>
<td>Community Health Partnerships are organisations that have been developed across Scotland to manage a wide range of community based health services. In some parts of NHS Greater Glasgow and Clyde, these new partnerships will also be responsible for many local social care services and are called Community Health and Care Partnerships, CH(C)Ps</td>
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<tr>
<td><strong>Community Planning Partnership</strong></td>
<td>A range of partners in the public and voluntary sectors working together to better plan, resource and deliver quality services that meet the needs of local people</td>
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<td><strong>Data zones</strong></td>
<td>Data zones are aggregates of unit postcodes and census output areas and nest within Local Authority boundaries. They are the building blocks of the Scottish Neighbourhood Statistics programme which is intended to make available small area data of many different kinds across Scotland</td>
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Deprivation Quintiles | Deprivation quintiles divide areas in fifths according to some measure of deprivation, and can be used to analyse variations in health between the most and the least deprived sections of the population regardless of where they live

EHRC | Equality and Human Rights Commission

GCPH | Glasgow Centre for Population Health

GP | General Practitioner

SIMD | Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland in a fair way. It provides a wealth of information to help improve the understanding about the outcomes and circumstances of people living in the most deprived areas in Scotland
## Acknowledgements

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Scottish Government (2009). *The Early Year’s Framework: A Framework to give all our children the best start in life and the steps the Scottish Government, local partners and practitioners in early years services need to take to start us on that journey* [Online], Scottish Government: Edinburgh. Available at: http://www.scotland.gov.uk/Publications/2009/01/13095148/0 [Accessed 3 December 2013]


