

## Children, poverty and health promotion in Australia

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For our next term, we are setting achievable new goals for Australia's future in the world. And at the head of those goals is the future of all our children. So we set ourselves this first goal: By 1990 no Australian child will be living in poverty.<sup>1</sup>

This is the well-known and often quoted goal from the election campaign launch of 1987 delivered in the Sydney Opera House by the then Prime Minister Bob Hawke. At the time there were ~580 000 Australian children living in poverty.<sup>2</sup> The most recent data puts the poverty rate for children in 2014 at 17.4%, or 731 000 children.<sup>3</sup> The risk of poverty is much higher in single-parent families, where the rate for children is now 40.6%.<sup>3</sup>

Consider this family from an outer suburb of Perth, described by CB, who saw the family in his capacity as a GP:

A mother in her mid-twenties walked into my surgery complaining that she had a cold. She probably had one, but that paled into insignificance compared with her other problems. Behind her trailed four small children, including a 12-month-old in a stroller pushed by the eldest (6 years). The mother was about 6 months pregnant. Her story tumbled out. She was so happy to be able to tell me about her good fortune. An agency had found a house for her and another group had provided basic furniture. She doesn't have a car and has to walk to the local shop or the doctors' surgery. It emerged that her boyfriend had beaten her up and she had been taken to a refuge. After several months in the refuge the social service agencies had been able to assist.

As in so many similar cases in the outer suburbs of Perth, drugs had been involved in this case, although the woman claimed no use of drugs since she had become pregnant. (A drug screen confirmed that she was clean). She has no close relatives in the state and the most likely scenario is that her children will spend most of their lives in care. She is one of the countless single-parent families in the outer suburbs of Australia, where many children live in poverty. As I spoke to this mother, theories and facts about the 'social determinants of health' and the benefits of health promotion flooded through my mind. What can we as health promotion professionals do? (C. Binns, personal case notes)

In her 1995 Boyer Lectures, Eva Cox discussed the role of civil society in the provision of services in society to care for everyone.<sup>4</sup> Twenty-one years on, our society still needs reminding of how important inequality remains in Australia. In the 2016 Boyer lectures

'Fair Australia: social justice and the health gap', Sir Michael Marmot reminded us of the importance of the social determinants of health.<sup>5</sup> He had no need to remind health promotion and public health workers; every day in our regular work we are reminded of the wide gaps in health across the social spectrum in Australia.

We are told that Australia has outperformed other Organisation for Economic Co-operation and Development (OECD) economies by achieving 25 consecutive years of positive economic growth. This means that someone born in 1991 has, on average, an income of about twice the level it was when they were born, after adjusting for prices increases and population growth. Yet large socioeconomic and educational gaps remain. It is estimated that almost 1 million Australian families are living in housing that may be classified as poor or derelict, and that health in these households is more likely to be rated as fair or poor compared with those living in better quality housing.<sup>6</sup>

The outer suburbs, where the lower quintile socioeconomic status (SES) groups live, are prize locations for large liquor stores, or 'booze barns',<sup>7</sup> which turn over large quantities of cheap alcohol. Research indicates that reducing the density of these packaged liquor outlets may decrease harmful levels of alcohol consumption, especially in socially disadvantaged or lower SES groups and young people.<sup>7</sup> High levels of alcohol consumption increase the health and social risks to children in poor families.<sup>7</sup> But who is listening to the pleas of health promotion workers? The booze barns are not usually located where the politicians live.

Children who live in disadvantaged areas are more likely to be given unhealthy diets and to be overweight or obese.<sup>8</sup> In the areas of greatest relative disadvantage, the rate of child obesity was more than double (28%) the rate of obesity in areas with the lowest relative disadvantage (13%).<sup>9</sup> As well as socioeconomic differences, these children had less attractive options in education, fewer opportunities for physical activity and restricted access to healthy food options. There are many other documented disadvantages of being born poor and living as a child in poverty, including shortened life expectancy and higher rates of chronic diseases later in life.<sup>5</sup>

CB describes another family (parents) coming into his GP surgery:

CB: Don't forget to buy fruit for your children today.

Parent A: Sorry, no money left and white bread is on special at \$1 per loaf.

Parent B: The community health nurse advised me to use Gold Pro baby milk, but they don't know that the new supermarket has a new cheap brand.

And so, in two more families the children begin a rapid downhill slide into obesity and midlife chronic disease. It is all so obvious, so why are more resources not made available to health promotion services to get alongside and support these families?

There is a lack of access to health promotion services in the poorer suburbs. The use of drugs (in particular, methyl amphetamine and cannabis) is widespread. Treatment services in the poorer outer suburbs, if they exist at all, are overwhelmed. The first question the psychiatric services ask of the referring health professional is, 'Are drugs involved?' At the first hint of drugs, the referral is rejected and the client is instructed to contact the government drug referral service, which is 40 km away. The fresh food outlets in the outer suburbs have largely closed. The supermarkets and pharmacies compete to promote cheap brands of high-protein infant formula that are more likely to cause obesity than other types of formula.<sup>10</sup> This is a challenge that health promotion professionals have faced for years, but it is getting worse and resources are more stretched than ever.

### **What can health promotion do?**

Child poverty has multiple consequences for health outcomes requiring multiple solutions. Many of the solutions lie within our existing health and welfare programs and services, but others require more drastic action. While not forgetting to retain cultural sensitivities, we cannot afford to be constrained by inappropriate political correctness or 'nanny state' critics. Some of our actions on poverty may require more direct approaches that may offend some of those divorced from the reality of pragmatic interventions. Lack of concerted actions now by health professionals and politicians will implicate them in the future growth of child poverty and its consequences in this country.

Many risk factors that come with poverty can be modified and life outcomes improved. However, this requires considerable effort by the families, health promotion and all aspects of our civil society. We must continue to look for comprehensive approaches that support health-enhancing lifestyle choices.

It is the role of the *Health Promotion Journal of Australia* to continue to document these health and social disparities, to publish potential solutions and to advocate for change. Some potential solutions include:

- continuing to resist the cutback in health promotion and other preventive services. In particular, we need to reverse the trend to centralise services, and to maintain or expand services to the outer suburbs, and remote and rural areas. Health promotion is needed where the people live;

- continuing to build the evidence base about what works and adequately invest in tackling health inequities;
- ongoing advocacy to support health policies that provide 'passive' health protection (e.g. vaccination, fluoridated water, food fortification with thiamine and iodine, the goods and services tax (GST) concession on healthy foods);<sup>11</sup>
- ongoing advocacy for health policies that provide 'active' health protection by making healthy choices, such as diets, easier (e.g. advertising restrictions on unhealthy products and services like junk foods, tobacco, alcohol, and gambling; subsidised fruit and vegetables in remote communities; and family planning services).<sup>12</sup>

There is increasing evidence on the importance of nutrition, health and social development in the first years of life, as this year determines the trajectory of an individual's health, through physical and psychological programming.<sup>13,14</sup> Lack of access to optimum nutrition and an environment supportive of development is closely related to child poverty. Investment in health, now and in the future, should be government's top priority. Reducing child poverty and making health promotion services available to and usable by all is a crucial component of this.

This is the last issue of the *Health Promotion Journal of Australia* for the year. The journal has improved its rankings and we trust is making an impact on health disparities in our region. We thank our authors for contributing quality manuscripts. We thank all those who have voluntarily helped to review articles throughout 2016 and we hope that you will continue to assist in maintaining our standards in 2017. We thank our editorial board for their support, and we especially thank our guest editors for this special issue on 'Advancing evaluation practice' – Associate Professor Ben Smith, Professor Chris Rissel, Professor Adrian Bauman and Mr Trevor Shilton.

### **Conflicts of interest**

CB is a public health academic who has also worked part-time in general practice throughout his professional career. PH is a health promotion professional with extensive experience living and working in disadvantaged communities. JJ is a health promotion academic with extensive experience in the practical evaluation of health promotion programs. JS is an experienced health promotion professional who has worked in Indigenous health and education contexts for the past decade.

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