



## Widening the lens on child health

Robin Kearns, Shanthi Ameratunga, Pat Neuwelt

In this issue of the *Journal*, Shaw, Blakely, Crampton, and Atkinson<sup>1</sup> provide stark evidence of inequalities in child mortality across a range of causes. Their findings provide another sobering reminder that the cliché of New Zealand being ‘a great place to bring up kids’ holds true for some, but it cannot be presumed to be the case for all.

The authors admit that theirs is an analysis focussing on ‘proximal risk factors’ such as acquisition of diseases and the experience of severe injuries. The results bear further witness to the gradients of life chances experienced across Western countries. The steepest gradients in the Shaw paper belong to ‘non road traffic injury’ and ‘other’. These categories carry the potential to apportion blame through the so-called ‘accident’ of a child acting, or being acted upon, in a certain way.<sup>2</sup>

Wisely, however, the authors point to ‘distal mechanisms’ such as policies on transport, income, and food as having ultimate influence over the grim occurrences that precipitate child deaths. Elsewhere, researchers have grappled with untangling these complex distal relations between human development and what Hertzman<sup>3</sup> terms ‘the social/economic/psychosocial conjunction’. Clearly, a study reliant on census and mortality records cannot examine the relative importance of ‘distal’ determinants. What, then, can such work suggest to members of the health professions and research communities?

First, given their rigorous methodologies and convincing conclusions, perhaps it is now time to hold back from searching for more evidence of (and mechanisms for) inequalities, and instead divert energy towards influencing policy. The ‘distal’ determinants discussed in this study, range well beyond conventional domains of health and healthcare. It therefore behoves all involved in healthcare and research to convey health-promoting options to those crafting policy in cognate fields.

Transport planners, for instance, invariably design roads with cars and drivers pre-eminently in mind.<sup>4</sup> The needs of other legitimate road users such as child pedestrians are seldom at the forefront of design briefs. How often have communities had to lobby for safe pedestrian crossings? While it should not necessarily be the case, it is arguably health professionals and public health researchers who are most appraised of the vulnerabilities of especially the young and old. It is incumbent on us to make a case for those whose voices are least heard.

Second, there is a need to complement quantitative analyses of *indicators* (such as that by Shaw et al) with indepth explorations of *experience*. Experience can be accessed through encountering others and observing their environments *in situ*. With their retreat from home visiting, members of the medical profession increasingly encounter people only within clinical and institutional settings. Healthcare interventions will always be a necessary (but not sufficient) ingredient in addressing inequalities in child health. While processes and places of everyday life most accurately reveal exposure to the distal determinants of health, the synergies between diverse domains of human experience have only recently been considered in policy.<sup>5</sup>

A critical awareness of *processes* such as mobility, and *places* such as housing and streets, can be gained by health professionals through more sustained dialogue with social scientists as well as developing a heightened awareness of what is happening in their own neighbourhoods. Both sources of critical awareness warrant comment.

Encounters in both general practice and the so-called ‘qualitative turn’ in social science are founded on *narrative*. In a clinical encounter as well as in an in-depth interview, the opening query invariably begins with the three words “Tell me about..”. Away from a clinical setting, this can be the invitation to articulate richly described commentaries that may not be so easily appropriated as enumerated variables. Through analysis of the ensuing narratives, we can begin to discern relations between the domains of disadvantage that converge within everyday life.

To take one example, housing need and food poverty are invariably treated as separate welfare issues. Food banks and social housing are even operated by different sectors of society. Yet, as Cheer et al<sup>6</sup> demonstrated through the stories of Otara families, levels of rent were strongly influencing the ‘discounting’ of health through compromised food purchasing. Perhaps the relative lack of interest in such matters provides evidence of what Eyles and Woods<sup>7</sup> termed the ‘inverse interest law’—that the more commonplace the problem and the more people affected, the less will be the medical interest.

The study by Shaw et al demonstrates that children are differentially at risk of premature death according to social class in New Zealand. However, there is a danger of under-estimating the ways in which children at large are disadvantaged in terms of health-promoting opportunities *vis a vis* adults. Granted, children of the affluent are generally better fed, clothed, and housed than many poorer adults. But, as a demographic cohort, we rarely acknowledge the ways that children’s freedoms are curtailed with ‘downstream’ health implications.

For instance, in our risk averse society, many children’s recreation is corralled within playgrounds, limiting their sense of adventure. Few are asked what sort of city they would prefer. Such observations reflect a society that sees children as inherently vulnerable, rather than regarding adult-installed infrastructure such as roads as inherently dangerous. The gradients of child mortality will only decrease in slope when children are seen as already *being* citizens rather than mere youngsters on the way to *becoming* adults.

One reflection of their presumed vulnerability is that our cities are increasingly populated with children who are driven to and from school. This chauffeuring is frequently claimed to be in children’s interests, yet children who are driven often express a clear preference for walking.<sup>8</sup> More recent work has confirmed that children have well-formed understandings of the broad benefits of walking.<sup>9</sup> The questions informing this type of qualitative research can be applied in everyday life. How often do we ask children what makes them feel safe, healthy, and hopeful? How often do we walk with our children to school, observing what interests them, as well as the behaviour of drivers?

A recent study gave children in primary schools cameras and asked them to photograph whatever they perceived as dangerous in their neighbourhood. The results were revealing. Many impediments to children’s security might pass unnoticed by adults but not by children: broken glass on the pavement, cars parked near pedestrian

crossings, dogs that bark aggressively behind fences.<sup>10</sup> The message is we need to find new ways to listen to children. This requires us to slow down—not just on the roads, but in general so as to create space for children to be included in a broader spectrum of social life.

We are not alone in having researchers reveal dire trends in the lives and deaths of children.<sup>11</sup> Indeed, the title of a recent book describes Australia as having ‘turned its back on children’. Significantly, however, the same volume complements grim statistical findings with chapters such as *How do children flourish?* and *Creating a civil society*.<sup>12</sup> To this extent, we can learn from these Australian colleagues. For while Shaw et al serve us well in presenting a rigorous analysis of the evidence, we cannot stop at recognising gradients.

We must also ask ourselves (as well as our politicians, policymakers, and children themselves) ‘what would make all New Zealand children thrive and flourish’ and then, with courage and conviction, set about promoting and implementing policies that would create a truly civil society.

**Author information:** Robin A. Kearns, Associate Professor, School of Geography and Environmental Science, The University of Auckland, Auckland; Shanthi Ameratunga, Director, Injury Prevention Research Centre, School of Population Health, The University of Auckland, Auckland; Pat Neuwelt, Public Health Medicine Registrar, Auckland Regional Public Health Service, Auckland.

**Correspondence:** Associate Professor Robin Kearns, School of Geography and Environmental Science, The University of Auckland, Private Bag 92019, Auckland. Fax: (09) 373 7434; email: [r.kearns@auckland.ac.nz](mailto:r.kearns@auckland.ac.nz)

#### References:

1. Shaw C, Blakely T, Crampton P, Atkinson, J. The contribution of causes of death to socioeconomic inequalities in child mortality: New Zealand 1981–1999. *N Z Med J*. 2005;118(1227). URL: <http://www.nzma.org.nz/journal/118-1227/1779>
2. Roberts I, Coggan C. Blaming children for child pedestrian injury. *Social Science and Medicine*. 1994;38:749–53.
3. Hertzman C. Population health and human development. In: DP Keating and C Hertzman (eds.) *Developmental Health and the Wealth of Nations: Social, Biological and Educational Dynamics*. New York: Guildford Press; 1999, p21–40.
4. Ameratunga S, Hajar M, Norton R. Road traffic injuries: confronting disparities to address a global health problem. *Lancet* (in press).
5. Clinton J, McDuff I, Bullen C, Kearns RA, Mahony F. *The Healthy Housing Programme: Final Report of the Qualitative Outcomes Evaluation*. Auckland: Uniservices Ltd; 2005.
6. Cheer T, Kearns RA, Murphy L. Housing policy, poverty and culture: ‘discounting’ decisions among Pacific peoples in Auckland, New Zealand. *Environment and Planning C: Government and Policy*. 2002;20:497–516.
7. Eyles J, Woods K. Who care what care? An inverse interest law? *Social Science and Medicine*. 1986;23:1087–92.
8. Collins DCA, Kearns RA. The safe journeys of an enterprising school: Negotiating landscapes of opportunity and risk. *Health & Place*. 2001;7:293–306.
9. Neuwelt, P. “Walking is Good for my Health!”: Report of a pilot study on the perceived health benefits to children of Walking School Buses in the Auckland region. Report for the

Auckland Regional Transport Authority, Auckland, Health Promotion Forum of New Zealand; 2005.

10. Mitchell H. Through the Children's Eyes: (Re)interpreting the Freedom, and Use, of Public Space From Children's Perspectives. Unpublished MSc Thesis, School of Geography and Environmental Science, The University of Auckland; 2005.
11. Oliver LN, Hayes MV Neighbourhood socio-economic status and the prevalence of overweight Canadian children and youth. *Canadian Journal of Public Health*. 2005;96:415–20.
12. Stanley F, Richardson S, Prior M. Children of the Lucky Country? How Australian Society has Turned its back on Children and Why Children Matter. Sydney: Macmillan; 2005.