The Healthy Child Programme: how did we get here and where should we go?

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Abstract

A Child Health Promotion programme has developed over the last century. Its remit and content has been revised and updated over the last 50 years. The current programme, the Healthy Child Programme, enshrined in law, offers a comprehensive schedule of checks, reviews and support from pregnancy to 19 years of age. This is the first nationally agreed programme, and yet we are not clear whether it is achieving what it sets out to do. We review the aims of the HCP and ask whether it is doing too little or too much? We explore the outcomes that matter and assert that we often don't have the data to make this judgement. We call for more data and argue for the importance of getting to know your local data, in advocating for children and young people. We ask paediatricians to step up and take a role in the promotion of health and wellbeing of families in their care: child public health is everybody's business.

Keywords Child Health Promotion Programme; child public health; Children and Young People's Outcomes Framework; health outcomes; health promotion; Healthy Child Programme; screening; well-child care

Origins

The origins of child public health in the UK can be traced back to activities such as Edward Jenner's discovery of the smallpox vaccine, legislation including the 1832 Factory Act which stopped children under the age of ten working in factories and John Snow's reducing cholera in the water supply by removing the pump handle in Broad Street. Most of these changes came about from recognition of the role that social and environmental conditions play in the health of children rather than the application of direct medical interventions. A Child Health Promotion Programme (CHP) as such did not really develop until the end of the nineteenth/beginning of the twentieth century, and began within the education system.

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The 1876 Education Act made elementary education compulsory and children were brought together for the first time as a population in schools. Recognizing the poor health of many children once they were within schools, and the similar poor health of many recruits for the Boer War, in 1907, the school boards came under a legal obligation to consider (with little ability to *address*) the health needs of all children. Subsequent legislation set out to improve children's health including the 1918 Maternal and Child Health Welfare Act which established health visitors and medical officers in infant welfare centres, both organized by the local authority. Provision of services varied around the country with little uniformity.

Their focus in the first half of the 20th century was largely nutrition and prevention of infectious disease through appropriate sanitation, good quality food and clean water supplies. These services were distinct from hospital and General Practice (GP) services and it was not until 1974, that these doctors and nurses working in this service were brought within the NHS in an attempt to more closely align preventive and curative services.

Around this time, the government commissioned the Report on the Committee of Child Health Services, to look at what was going on around the country (both within acute, community and public health settings) and make some recommendations for best practice. This report, the 1976 Court Report, marked a cultural shift in out of hospital care, and preventative services. It started with the premise that the burden of disease had shifted from nutritional and infectious causes to developmental and behavioural problems. In addition to various other suggestions, such as the development of Community Paediatrics, and the GP Paediatrician, the report recommended a full programme of health surveillance including monitoring of health, growth and developmental progress of *all* children, an immunization programme, support and advice for parents and parental health education and training. It advocated that the GP and health visitor should lead these activities. This marked the beginning of a more formal CHP.

The changing focus of CHP — evidence based medicine

Over the last 40 years the content of this programme has changed, to reflect a changing focus from an active "seek and treat" paradigm to one of "protect and promote" — explore risk factors and health education and support. This represents both the development of an evidence base and, arguably, a political change in terms of the role of the state.

The Court Report set out a "best-buy" programme of surveillance involving seven examinations between birth and school entry. The Royal College of General Practitioners also produced a document outlining recommended reviews. Despite this, practice varied across the country greatly at this time, both in terms of *what* reviews and surveillance were being done, and *who* was undertaking these activities.

At this time Professor David Hall was invited to lead a multidisciplinary working group for the then British Paediatric Association (the forerunner of the Royal College of Paediatrics and Child Health) to assess the efficacy of the multitude of routine examinations of infants and children. His review of the evidence base, the first Health for All Children Report (HFAC) (1989), was critical that many of the components of the CHP had little evidence to support their use. As a result a more limited programme was recommended.

Subsequent HFAC Reports have continued to appraise the evidence base for our CHP. The Third HFAC Report in 1996 marked a further shift in direction: it placed more of an emphasis on health promotion and focused on the role of parents through parental health education. It moved away from routine surveillance and screening and promoted opportunistic and targeted examinations.

A further HFAC Report in 2006 became the basis for our current CHP — the Healthy Child Programme (HCP) — and was further strengthened by the National Service Framework (NSF) which recommended high quality standards for maternal and child health promotion as a cornerstone of support for women and children. This is the first national programme of CHP, set out in Government legislation.

The Healthy Child Programme — aims and content

Our current incarnation of the HCP was launched in 2009. It encompasses pregnancy, infancy, childhood and early adulthood. In addition to the evidence base set out in HFAC4 it also draws upon guidance from NICE, and a review of health-led parenting programmes conducted by the University of Warwick. It sets out to offer every family:

> "…a programme of screening tests, immunizations, developmental reviews, and information and guidance to supporting parents and healthy choices…that families need to receive if they are to achieve their optimum health and wellbeing."

The overall aims of the programme are listed in Box 1.

There are several themes which are new or changed:

- A major emphasis is placed on parenting support, recognizing the integral role that parents play in the development of emotional health and behaviour.
- It reflects changed public health priorities such as increasing breastfeeding rates and a focus on prevention and early intervention of obesity.
- It places an emphasis on integrated services with HV as the lead.
- There is an increased focus on vulnerable families with the adoption of a model of progressive universalism — a concept similar to Marmot's "proportionate universalism", referring to specific tailoring of the programme to the needs of individual families. This acknowledges that an "all or nothing" approach is too simple and there are many different levels of need.

One of the key changes has been to introduce a comprehensive two year review. This was identified as a key time to review development, transition and behaviour. As we write, the intention is that this review will be integrated with a review of child development as part of the Department for Education's Early Years Foundation Stage requirements.

Figure 1 below shows the programme contents for 2013.

Overall aims of Healthy Child Programme

- strong parent-child attachment and positive parenting
- care that keeps children healthy and safe
- prevention of serious infectious diseases through immunization
- good breastfeeding rates
- readiness for school and improved learning
- early recognition of growth disorders including obesity
- early detection of and action on developmental delay and ill health
- identification of factors that could influence health and well-being in families
- better outcomes for children at risk of social exclusion

Box 1

What are other countries doing?

Our current model of CHP has been noted to be "light touch" compared to other countries and has a different emphasis and focus. In the UK growth monitoring and child health reviews are only formally done at the 6—8 week check, and the 2-year review, and then as required. In Australia, Canada, the USA and Sweden these are carried out at every contact, and there are many more contacts in the first 2 years: on average 9 in Australia, 9—10 in Canada, 14 in the US and 18 in Sweden. Sweden, in particular places an emphasis on children's development at all points of contact.

Whilst specialist nurses deliver the majority of the reviews in Australia and Sweden, (equivalent to our HVs in the UK) in North America the lead provider is mainly GPs (Canada) and Primary Care Paediatricians (US). In addition to child health reviews, the screening programmes in all the other countries studied are also more extensive, but, interestingly, with the exception of Sweden, vaccination coverage is much lower that the UK. It is clear that despite a similar worldwide evidence base, traditional and political considerations have shaped any one particular country's preferred programme.

So, are we doing too much or too little?

In an NHS climate with immense pressure to cost-save and an increased emphasis on outcomes, the scope and reach of the HCP is continually being debated. Several commentators suggest that we have gone too far in pulling back the remit of the HCP. Bellman and Vijeratnam cite several pieces of evidence supporting the assertion that many conditions cannot be detected by a process of selected screening. They lament the fall in HV numbers and the diminished formal training that GPs receive around CHP. The recent call to action to increase health visitor numbers and HCP e-learning curriculum may go some way to ameliorate this but they are concerned that the current delivery model based on progressive universalism is simply not reaching all those that need it, and indeed there *is* evidence that this is the case in Scotland.

Others question whether the CHP is doing too much. Without good enough evidence for interventions, should we be doing any of it? A recent article from the US suggests that traditional paediatric preventive services — well-child care (WCC) — may be largely ineffective in addressing the outcomes that really matter, such as obesity and heart disease.

There is a real need to look at how the whole programme can be delivered effectively as opposed to its individual parts. How