dr ern England

Who is the Child of the North today?

The Child of the North has a

2%

chance of living in poverty compared to **20%** in the rest of England.

1%

Child mental wellbeing

The rise in mental health issues in the North over the course of the pandemic is of particular concern. Untreated mental health disorders in children and adolescents are linked to poor academic outcomes and poor health, including drug abuse, self-harm, and suicidal behaviour. They often persist into adulthood and can have substantial socioeconomic consequences.

The mental health of children and adolescents was deteriorating prior to COVID-19, but there was significant deterioration during the pandemic, particularly in the North of England.

There is an urgent need to ensure that schools and services can provide immediate intervention and continued support to children and young people, so that mental health problems do not result in unfortunate consequences, with negative impacts on educational attainment, labour market outcomes, and adult health.

Detailed findings

Data show that children in the North of England were disproportionately a□ected by the consequences of the pandemic, experiencing more mental health di□culties compared to children in the rest of England. In particular, the evidence suggests that the mental health of boys aged 5-10 years in all areas of the North, and girls aged 5-10 years in Yorkshire and Humber, were significantly and negatively a□ected by the COVID-19 pandemic and the associated lockdowns.

Loneliness is directly linked to worse mental health among youth. 23% of parents in the North reported that their child was 'often' lonely compared to 15% of parents in the rest of England.

lfromp10%Vonel6%rest of England.

Detailed findings

NHS England and NHS Improvement and the O□ce for Health Improvement and Disparities should adopt a public mental health approach that includes a focus on mental ill health prevention early in the life-course, recognising the importance of early detection and prompt access to professional treatment.

Government should invest in and develop a place-based monitoring system for understanding the longer-term mental health impacts of COVID-19 pandemic on children and parents. Targeted support should then flow to families where needed, including outreach services more closely tailored to the needs of vulnerable parents.

10 Area-level measures of children's physical and mental health should be developed to better understand place-based inequalities.

11 More NIHR research should be undertaken into the relationship between child health and economic performance, in particular in understanding the likely causal pathways between these in order to identify entry points for policy.

12 Government should reinvest in services that tackle domestic abuse, recognising the part domestic abuse plays, not only in children entering care, but also in high conflict divorce and separation cases, which also feature disproportionately in the North.

13 Address the uneven geographic distribution of children's residential care, including secure provision, in order to reduce the disproportionate burden on the North. An impact assessment of the disproportionate costs to a range of services in the North due to the number of children with complex care and support needs, is needed and long overdue.

14 Embed Equity Impact Assessments in all COVID-19 recovery and other policy processes relating to socioeconomic deprivation at national, regional and local levels.

1 Use Children's Rights Impact Assessments to anticipate and evaluate the specific impact of COVID-19 recovery strategies on children and young people. Collect, disaggregate and publish relevant data so that the impact of the pandemic on children can be routinely evaluated.

1 Promote and expand the Race Disparity Audit, sharpening the focus on children and drawing on disaggregated data by region. Ethnicity should be included in all national public health data collection systems, including child and maternal health datasets.

1 Increase the representation of ethnic minority sta□ within public services and in decision-making processes with specific recruitment targets, recruitment campaigns and greater transparency on the percentage of ethnic minority sta□. This should be particularly in leadership positions, in order to reflect the populations served.

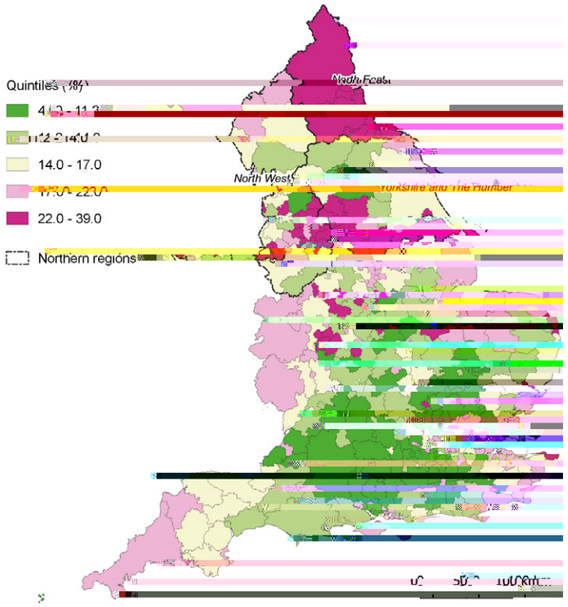
1 Local COVID-19 recovery strategies must be grounded in internationally recognised human ues and pri2 inimpaccula6 matts. Ig7syorafnspal47.3j mut80 7m r tso prcausues ay

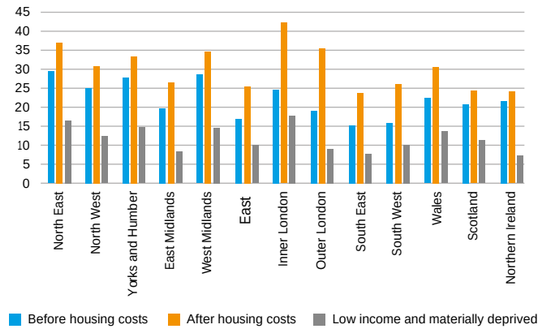
more crowded, noisier, and of lower quality than those of their peers who do not live in poverty.

Their neighbourhoods are more dangerous, the air they breathe more polluted. Children growing up in poverty have worse nutrition, are more likely to be hungry, have a less stimulating learning environment, more restricted access to books, computers, and school trips.

We know that poverty impacts family functioning and parental health and behaviour, which, in turn, a□ect child health. A recent study, using data from a nationally representative sample of thousands of children born in 2000, assessed the impact on children's health of childhood adversities that cluster with poverty[9]. The study shows that over 40% of children in

Figure 2.3. **Percentage of children in relative low-income households (<60% median household income), before housing costs, by local authority, 2019/20.**





attempted suicide than their more advantaged counterparts. The proportion experiencing psychological distress was also higher among those from lower income families[25]. Child poverty has a lasting impact on child and adolescent mental health. A single transition into poverty has been linked to child psychological distress, independent of parental employment status.

After accounting for other factors that might influence mental health, research using data from the Millennium Cohort Study found that the odds of poor mental health and wellbeing in children were significantly increased if they transitioned into poverty during their childhood[26].

Another recent study using trajectory modelling found that persistent poverty and/or persistent parental mental ill health affects over four in ten UK children. The combination of both affects one in ten children, increasing the odds of child mental health problems more than sixfold, compared to children with low exposure to poverty and parental mental ill health. In isolation, poverty and parental mental ill health each doubled the odds of child mental health problems[9].

3. Childhood obesity is twice as common in the most deprived areas of England than the least deprived areas, and the prevalence of severe obesity in children in the most deprived 10% of the country is four times as high as in the least deprived 10%[27]. These inequalities have been widening in recent years, and the impacts of the pandemic lockdowns are likely to have exacerbated this (see Chapter 5). A recent study using data from the Millennium Cohort Study reported that when compared with children who had never experienced poverty, those who experienced poverty during childhood – whether transiently or persistently – were more likely to be living with obesity in adolescence[6].

The role of social security and cuts to local authority funding

In 2010, the government introduced an austerity programme with the primary aim of reducing the government's deficit and shrinking the welfare state, predominantly by moving people into work. The past decade has seen the introduction of the benefit cap, the under-occupation penalty (bedroom tax), the abolition of discretionary social funds, the introduction of Universal Credit (in 2013), the benefit freeze (in 2015) and more recently, the introduction of the two-child policy (in 2017). Whilst all have different targets, their intended function has been the same: to reduce welfare spending and move people into work as a route out of poverty. Figure 2.2 shows that prior to 2013 the child poverty rate was falling. However, after the introduction of many of these austerity policies, child poverty started to rise, leading many to infer a causal relationship[28].

Moreover, work has not provided a sure route out of poverty for children. More than 75% of children living in poverty are actually in households where someone is in paid employment[18], and previous research linking child poverty to health outcomes for children found that the relationship was independent of parental employment[29].

Austerity measures have also meant cuts to local authority budgets, leading to substantially reduced public expenditure on services for children, particularly early years expenditure, with the greatest cuts in the most deprived areas with the greatest need (see Chapter 3). Between 2010 and 2018, local authority spending on Sure Start Children's Centres, per eligible child, was cut by 67% in the North, compared to 63% in the rest of England.

Starting from a higher level of spending in the North due to higher need, this equates to much larger cuts in absolute terms in the North: on average, spending was cut by £412 per eligible child in the North, compared to only £283 in the rest of England (or £347 per child across England as a whole). A recent study investigated the impact of cuts to Sure Start children's centres on child obesity between 2010 and 2017.

Sure Start children's centres provide universal services for families with pre-school children, including for child and family health, parenting, money, employment and early learning. Spending on these centres decreased by 53% over the study period, with deeper cuts in more deprived local authorities.

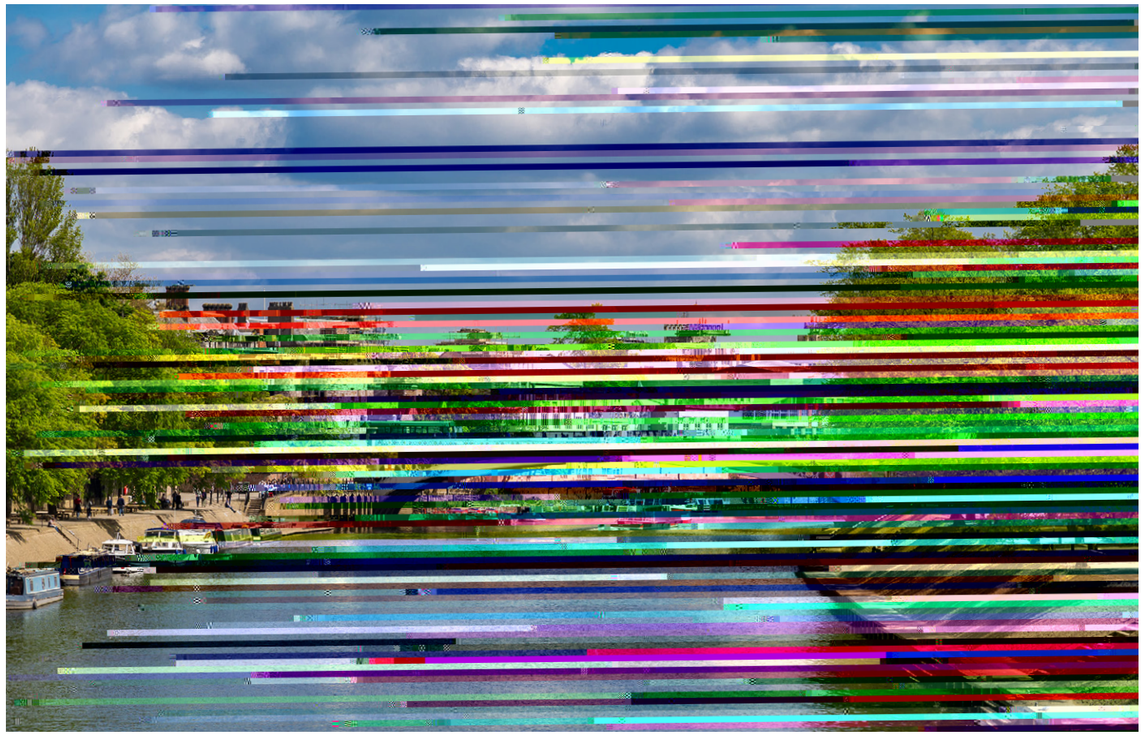
Each 10% cut in spending was associated with an increase in obesity prevalence the following year. This equates to an additional 4,575 obese children (95% CI 1,751 to 7,399), with the number rising to 9,174 if overweight children are included (95% CI 2,689 to 15,660) compared to numbers that would be expected had funding levels for Sure Start children's centres been maintained[30].

Combined, rapid changes to the welfare system and cuts to local authority spending have had directly affected child poverty and subsequent negative health and wellbeing outcomes for children and young people.

COVID-19 and child poverty and inequalities

Whilst there are not yet any official national child poverty indicators covering the period of the COVID-19 pandemic, projections suggest that the impact will be substantial. Both relative and absolute poverty are expected to rise sharply in 2021/22. Illness due to COVID-19 and long COVID and job loss are the primary causes of this projected increase.

Many households have sought support from a welfare system that



A four times greater decrease in spending in the most deprived quintile of Local Authorities compared to the least deprived quintile left the North particularly hard hit (Figure 3.4, and see Chapter 2). The cuts to investment in Sure Start centres are likely to have a□ected progress in school readiness[73] and have been linked to increased obesity prevalence by the time a child starts school[12].

School readiness and COVID-19

more depressed[96]. In the North the figures were substantially higher, at 55% and 45%. In the Born in Bradford study, clinically significant depression among mothers increased from 11% pre-pandemic to 19% during first lockdown; clinically significant anxiety increased from 10% to 16%[58].

In a qualitative study of mental health among parents, children and young people participating in the Born in Bradford study, both parents and children expressed anxiety about COVID-19[97]. Some children were so anxious that they did not leave the house even for permitted activities, and some experienced a worsening of pre-existing symptoms, such as nervous tics and bedwetting.

As well as worrying about their own risk of becoming ill, children worried about their parents, grandparents, and other people close to them. Whilst experiencing anxiety, many children also reported boredom, lethargy, lack of purpose and low mood; many felt disengaged from school and worried about returning. School had been at the centre of most children's social lives and younger children, in particular, struggled to maintain contact with friends. Children also missed seeing their relatives and some had been unable to see their parents at times. Many similar themes emerged in the Teenagers' Experiences of Life in Lockdown (TELL) study[98]. The textbox on the next page assembles some quotes from the TELL study.

Loneliness is directly linked to worse mental health among youth[99]. There was an increase in the prevalence of loneliness during the pandemic, with 43% of children and adolescents in England saying they were 'often' or 'always' lonely during the first lockdown[100] compared to 10% pre-COVID-19[101]. Figure 4.4 shows that there were differences in loneliness between the North and the rest of England,

to 1%, and the proportion of children reporting never feeling sad rose from 20% to 25%[i23].

Children of Pakistani heritage were more likely to report feeling sad less often during the pandemic compared to White British children, whereas boys had a greater likelihood than girls of feeling sad more often. Social relationships – particularly feeling left out by other children before the pandemic – appeared to account for some of these changes in wellbeing. Schools and children's services should consider what learning can be drawn from children's positive experiences of lockdown.

Mental health support for children and adolescents during the COVID-19 pandemic

Demand for mental health support fluctuated during the COVID-19 pandemic. Child and Adolescent Mental Health Services reported reduced referrals during lockdown, but there was a rapid surge when schools re-opened in September 2020. That increase has continued,

children during the pandemic compared to their ethnic minority counterparts[i30]

Figure 5.5. Proportion of households experiencing food insecurity by region.

Tracking food insecurity through the pandemic in Bradford.

Families participating in the Born in Bradford study reported an increase in food insecurity from 14% pre-COVID-19 to 20% in the first wave (April - June 2020)[58].

This remained high well into the pandemic (October - December 2020), with 17% of families reporting that food did not last and that they had no money to buy more[147].

In addition to the likely impact on physical health, there was a clear relationship between food insecurity and mental health, with mothers more than three times as likely to have depression or anxiety if they were food insecure[64].

As in many areas, emergency food aid provision was increased at this time: 59 new services were set up across the region within the first few months of the pandemic[148].

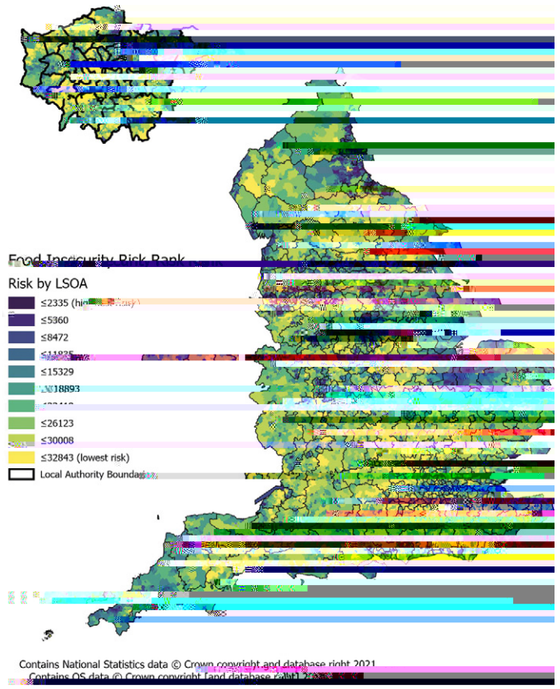
Educational institutions played a key role in this and 42% of the new services that were set up in response to COVID-19 were school-based. Services reported increased demand for culturally acceptable foods (including Halal foods), indicating a shift towards greater demand across all ethnic groups; however, many services also reported limited opportunities for providing such foods, given that most were dependent on donations.

weeks of lockdown, in March 2020, 21% of households with children under 18 years old reported experiencing food insecurity (see Figure 5.4), while in May 2020, in a nationally representative survey, 12% of parents reported that their children had directly experienced food insecurity[139]. These effects persisted despite the easing of national restrictions in the summer of 2020.

In January 2021, an estimated 2.3 million children were living in households that experienced food insecurity in the last six months. Government, private and voluntary sectors responded in a variety of ways, including alternative school food provision[143].

Evidence suggesting that Free School Meal vouchers and furlough may have prevented a much worse situation led to calls for the expansion of Free School Meals eligibility[139], the extension of the holiday food programme across England, and an increase in the value of Healthy Start Vouchers. But despite recent government investment in the Healthy Start scheme, over 250,000 children under five who are food insecure are still ineligible. There are also concerns

Figure 5.6. Risk of food insecurity by Lower Super Output Area, England.



Source: https://www.mylocalmap.org.uk/iaahealth/

that current plans to digitalise Healthy Start vouchers from October 2021 risk excluding even more families.

"I work full-time. It's been very difficult. I was previously receiving benefits and receiving Free School Meals. But I decided to go full-time and be a role model for my children. My monthly salary just about pays off all my bills and just a bit more for food. We try and get the basics that will carry us over to next month to get the things we need and cover us. The last 4 or 5 months when the kids were off school, I had to rely on food banks and donations to get through. Without that, I wouldn't have put food on the table."

Marni, a single mum of four girls between the ages of 6 and 16.

Source: quote reproduced from the Food Foundation, 2021[139]

Food insecurity and ethnicity

The Trussell Trust's State of Hunger report found that people of Black ethnic background were over-represented among those referred to a food bank[144], and a recent analysis of the Family Resources Survey data shows that households where the head was Black were most likely to be food insecure[140]. In 2018/19, the highest percentages of Free School Meal eligibility (a measure of income that does not capture all those who are food insecure) was seen in White minority groups — 56% among Traveller of Irish Heritage pupils, and 39% among Gypsy/Roma pupils. This was followed by Bangladeshi and Pakistani pupils[145].

The proportion of children in England eligible for Free School Meals has increased during the COVID-19 pandemic: from 15.4% in January 2019e) 9 6 -2.471 Td992nd jusgesTJ0 -1.235 Td7hat, ids I Meal 62997 -1.27months N8h1ously receiving

neighbourhoods in the North, we see higher rates of childhood obesity where the relative size of the ethnic minority population is higher (Figure 5.9).

In the North, BMI was the highest in the third of neighbourhoods that were the most ethnically diverse and the most deprived, with BMI being on average 3 points higher (26.2) in the most ethnically diverse third of neighbourhoods than it was in the least ethnically diverse third of neighbourhoods with equivalent deprivation (23.2). In the rest of the country, the difference was 2.4 points.

However, there were fewer inequalities between ethnically diverse and homogeneously white neighbourhoods in less deprived areas in the North than there were in less deprived neighbourhoods in the rest of the country (Figure 5.9).

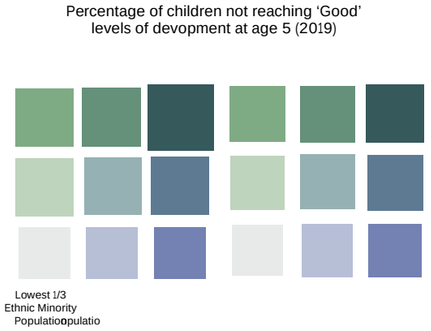
The National Child Measurement Programme was paused during the COVID-19 pandemic due to school closures. As such, there are no data yet available to assess whether the pandemic has affected child weight. Nevertheless, rising socioeconomic deprivation due to the pandemic is cause for serious concern about likely widening inequalities in over- and under-weight among children.

Policy response and the need for whole system actions

The North-South variation in the prevalence of childhood obesity in England is certainly fuelled by poverty. Policies that aim to reduce food poverty and food insecurity, as outlined above, and investment in early years services (see Chapter 2) are key to realising the Government's ambition to halve the prevalence of childhood obesity by 2030, whilst also reducing health inequalities. It isn't that the existing Government Obesity Plan is wrong – all of the strategies within it are sensible, evidence-based, and theoretically effective. However, they rely on an individual's ability and will to make healthier lifestyle choices – including what food and drink they buy and consume – and on their access to appropriate health services in their local area. A recent study sampling local authority obesity programmes found that the overwhelming focus was on changing individual behaviours rather than changing the environments in which people live. Alone, therefore, the Obesity Plan is likely to have limited impact[154].

The research suggests that reducing child poverty is a pre-requisite to reversing and reducing the overall prevalence of, and inequalities in, childhood obesity across England[155]. Beyond this, we need a whole system approach, with a broader set of initiatives targeting, in particular, educational settings, town planning and industry. Strategies must ensure access to health services according to need, with an appropriate balance of prevention and management of childhood obesity within emerging integrated care systems.

The elephant in the room is what this would cost. In the challenges of operating in a pandemic-recovery economy, will local authorities



to reducing children's consumption of unhealthy food and drink. By April 2022, planned legislation will ban in-store promotion of unhealthy food by end-of-aisle and checkout placement and multi-buy promotions. The UK Government intends to introduce a 9pm watershed on advertising foods high in fat and sugar to children, with

wellbeing (see Chapter 4 and earlier NHSA COVID-19 report[165]). These factors all a□ect children and young people's education, increasing the probability that they have experienced bereavement, and creating serious challenges in the home learning environment. From attendance data, it is clear that urban schools and colleges serving the most deprived communities had the most interrupted in-school learning time[166], and the most limited resources for delivering in-school and online teaching during the pandemic[167].

Consequently, schools in the most deprived areas within the UK, many of which are in the North of England, have borne a larger share of the burden in supporting children and young people through the pandemic. They now face a steeper uphill battle in working to mitigate the negative consequences of the lock

The compounding costs are particularly challenging for areas in the North of England, where numbers of looked after children are very high.

A North-South divide in the provision of children's homes

mental ill health and domestic abuse, and provision of treatment and support.

Taken together, the evidence on adverse trends in family adversities and increasingly overwhelmed services does not suggest that the numbers of children in care are likely to fall in the North in the near future. In particular, local authorities in the North will struggle to refocus services on prevention, because they cannot avoid the huge costs associated with children who are already in their care.

Recommendations

There is an urgent need to address the greater risk for children in the North of becoming involved with statutory Children's Services and the care system. A range of prevention strategies can be deployed to reduce this risk, focussed on: strengthening economic support for families; promoting social norms that protect against violence and adversity; identifying family adversity and providing appropriate support and treatment; and making sure that children get the best possible start in life. The Independent Review of Children's Social Care seeks to align services far more closely to family need, and this is very welcome[196]. However, as short-term crisis funding to public services is withdrawn, public services face a cli edge, at a time when need is at an all-time high[193].

Priorities include:

Implementing policies to reduce child poverty, including improvements in the real value of the National Living Wage, and increases in child benefit, the child element of Universal Credit, and child tax credits (see Chapter 2).

Increasing funding for preventative services (health visiting, children's centres, family hubs, early help) – proportional to need, and accounting adequately for area-level deprivation.

Addressing the long-standing deficits in mental health provision for parents, including outreach services more closely tailored to the needs of vulnerable parents.

Reinvesting in services that tackle domestic abuse, and recognising the part that domestic abuse plays – not only in children entering care, but also in high conflict divorce and separation cases, which also feature disproportionately in the North.

Local authorities in the North will struggle to re-direct funds to early family help, because of the costs already tied to a large population of children in their care. The marketisation of children's residential care has added to the strain on the North. A far greater number of children with the most complex di culties are placed in the North West in particular, where there is a greater availability of residential beds.

Priorities include:

Additional targeted investment in the North to ensure su cient provision of preventative services to stem the flow of new children entering care.

Addressing the uneven geographic distribution of children's residential care, including secure provision, to reduce the disproportionate burden on the North. A recognition of the disproportionate costs to a range of services in the North, due to the number of children with complex di culties in care, is long overdue.

The end to COVID-19 restrictions requires a major reset of services that have been delivered entirely remotely – early help and statutory children's social care as well as services provided by the courts.

Priorities include:

Challenging continued remote [only] delivery, which may be seen as cost-saving, particularly in the family courts, which were overwhelmed pre-pandemic. Although remote ways of working have value, the mode of delivery must not compromise the support and protection of children.

Addressing the backlog of cases in the family courts to ensure timely permanency decisions, including the reunification of children to parents or kin.

Finally, the short-term and lifelong impacts of the pandemic on children must be addressed. Vulnerable children were already su ering developmental disadvantage pre-pandemic, and the impacts are likely to have been exacerbated over the last 18 months.

Priorities include:

Providing resources and services to support 'catch up' in all facets of children's development.

Addressing the long-standing deficits in mental health provision for children and adolescents – including children at risk of acute mental health crisis, and including funding for appropriate places of safety.

Ultimately, however, there is a need for an overarching, long-term, equitable plan for children in the North, to address their disproportionate pre- and post-pandemic exposure to health damaging poverty and adversities, and to address the disproportionate underfunding and fragility in the health, social care and criminal justice systems that have a duty of care for these children. This plan must tackle the growing divide between the North and the South, and ensure a sustainable fina55.23.ulties in care, is long overdue.

CHAPTER 8

Ethnic minority children and young people: health and wellbeing

Authors: Sarah Salway, Stephanie Ejegi-Memeh, Calum Webb, Ghazala Mir, Rizwana Lala, Nazmy Villarroel-Williams

Context

The children of the North of England are increasingly ethnically diverse. In an average local authority in the North of England, 21% of school aged pupils now identify as being from an ethnic minority background, and this figure ranges from 6% to 66%. In 2020/21, 27% of school children in Yorkshire and Humber identified as being from an ethnic minority background. This figure was 25% in the North West, and 12% in the North East[215].

All Northern regions include local authorities where ethnic minority children make up a high proportion of the local population, including Bradford (58%), Manchester (64%) and Newcastle upon Tyne (34%) (Figure 8.1).

Other chapters in this report present useful data on child poverty (Chapter 2), perinatal and infant mortality (see Chapter 3), mental health (see Chapter 4), physical activity, obesity and food security (see Chapter 5) and educational inequalities (see Chapter 6), by ethnicity. However, a focused chapter is warranted given the persistent role of interpersonal, cultural and structural racism in shaping the lives of ethnic minority children and young people.

While material deprivation is a key driver of poor health for these groups, this is itself rooted in systemic racism. Furthermore, socioeconomic disadvantage is not the whole picture, and the needs and experiences of ethnic minority children and young people cannot be understood and addressed without attention to racism, in its many forms.

A large and growing body of evidence demonstrates that the COVID-19 pandemic has exacerbated pre-existing ethnic inequalities. However, rather than policy responding to this worsening situation, there is a concern that the push for quick pandemic recovery solutions will result in the further dilution of attention to ethnic diversity, disadvantage and discrimination. Moreover, the current national government has repeatedly denied the role of structural and institutional racism in shaping the lives of the UK's ethnic minority people[216,217], and has promoted a narrative that undermines a sense of belonging and being a valued member of society[218–220].

As such, while we should highlight shared experiences that can unite diverse communities and challenge the health-damaging socioeconomic circumstances a□icting large numbers of children across the country, it is also imperative that intersectional inequalities are understood, and racism tackled.

Here, we identify four broad, inter-linked areas for urgent attention. We need to:

Increase understanding about ethnic minority children and young people, their experiences and needs

Address socioeconomic deprivation

Tackle racism at interpersonal, cultural and structural levels

Make health and well-being policies and services work for ethnic minorities.

Promising practice: Leeds City Council Needs Assessment

In 2019, Leeds City Council undertook a focused needs assessment to paint a detailed picture of mental health and service access in the city, to better understand the needs of ethnic minority children and young people and identify gaps in local provision.

A range of approaches was employed to draw in statistical evidence and firsthand accounts from ethnic minority young people. This has informed subsequent action, with work underway to develop city-wide initiatives that reduce the risk of mental health problems, and improve equitable access to mental health services.

More information: https://forumcentral.org.uk/mental-health-inequalities-experienced-by-young-people-from-minority-ethnic-groups/

Know your population

Those charged with developing strategies and services aiming to promote children's health and wellbeing have been slow to recognize and respond to ethnic diversity. Even basic, up-to-date demographic information is lacking. Nationally reported statistics on children's health and wellbeing, including Public Health Profiles[23] frequently overlook ethnic make-up, and national surveys, including the UK Household Longitudinal Study[221], do not support analyses by ethnic group and region due to inadequate sample sizes. It is very rare to find data disaggregated by ethnicity and geography – yet we know that experiences and opportunities among ethnic minority children vary geographically.

The Race Disparity Audit is a useful initiative, but draws on primary sources that often employ very broad ethnic categories[222]. At the local level, Joint Strategic Needs Assessments lack health-related information on ethnic minority children and young people, and pay almost no attention to racism as a determinant of poor health[223].

This absence of data and analysis hides local patterns, renders some groups completely invisible, and precludes investigation of the key drivers of health disadvantage. Promising work that gives greater attention to understanding the needs of ethnic minority children – such as work conducted in Leeds (see textbox on this page) – should be emulated.

Understand and address socioeconomic deprivation

Pre-COVID-19, important ethnic inequalities in socioeconomic adversity were well documented at a national level. Unemployment[224,225], precarious employment and low paid work[226] are all more common among ethnic minority people than the majority White. Furthermore, welfare benefit changes over the last decade have reduced the safety net for low earning households[227,228], with ethnic minority families further disadvantaged by obstacles to benefit uptake[229,230] and entitlement rules, notably the benefit cap[231–233] and two-child limit on Universal Credit[234]vsThe Race Ans local pay

country. In the North, 'low' deprivation neighbourhoods are twice as likely to have relatively high White, than relatively high non-White, child populations (22% versus 9%).

Children from ethnic minority populations are far more likely to be living in particularly adverse socioeconomic conditions at this neighbourhood level. Further, this breakdown suggests that the scale of the inequality is greater in the North of England than it is in the rest of the country.

Post-pandemic, we can expect these ethnic inequalities to be further exacerbated[237]. Recessions a□ect ethnic groups di□erentially, with unemployment rising more sharply among ethnic minority groups than majority White[224,225]. Employment disadvantage will impact both younger children via diminished household income, and those aged 16 and over who need to enter the labour market. Indeed, ethnic minority young adults face the intersection of racial and age-related labour market disadvantage[238]. Preliminary data from the Department of Work and Pensions plotted in Figure 8.4 show a concerning rise in unemployment among the non-White population.

been referred to as the ‘weaponization of schools’ against Black and Muslim youth[285].

Significant Northern community-led responses, including the ‘No Police in Schools’ Manchester campaign led by Kids of Colour and the

CHAPTER 9

The economic impacts of child health

Authors: Rose Atkins, Luke Munford, Clare Bambra

Regional differences in economic performance pre-COVID-19
There is a well-known 'productivity gap' between the North and the rest of England. It has been estimated that productivity within the Northern regions is £4 per-person per-hour lower than in the rest of the country[309]. This productivity gap costs the UK economy around £44bn a year. Figure 9.1 plots the average productivity – measured by Gross Value Added – for the North and the rest of England from 2010 to 2018, with linear prediction up to 2025.

Productivity in the North is consistently well below the rest of England, and this 'productivity gap' is predicted to grow, rather than shrink. In this chapter we outline how the productivity gap has its origins in the relatively poor health of children in the North. Socioeconomic conditions for families have a profound impact on child health and development, impacting children's ability to grow up to be healthy, productive adults in the future.

In a 2018 'Health for Wealth' report, the Northern Health Science Alliance found that improving health in the Northern regions would reduce the regional gap in productivity by 30%, or £1.20 per person per hour, generating an additional £13.2 billion in UK Gross Domestic Product. In this chapter we outline the relationship between the health of children and economic productivity in adulthood[310].

Regional differences in economic performance during COVID-19
Two more recent reports by the Northern Health Science Alliance showed that these regional inequalities grew during the pandemic, with the North experiencing higher unemployment rates (Figure 9.2) and a reduction in wages (Figure 9.3)[15,62].

Previous chapters in this report have demonstrated the relationship between family socioeconomic circumstances and various aspects of child health (see Chapter 2), and how rising unemployment and family poverty are damaging to child health, particularly mental health (see Chapter 4).

Figure 9.4. shows the percentage change in gross weekly pay between 2019 and 2020. Throughout large areas of the North, pay reduced considerably. Table 9.1 displays the percentage change in gross weekly pay at regional level. Males living in the North of England saw large percentage reductions in pay, with males living in the North East seeing average pay fall by 3.3%. In the North West, the average pay of males fell by 1.9%, and in Yorkshire and Humber, the average pay of males fell by 2.4%. Females living in all three Northern regions saw a slight increase in pay between 2019 and 2020 – though there was considerable heterogeneity at local authority level.

Early-life skills development and their impact on labour market outcomes
Child health can shape and influence the economic performance of future generations. Today's children are the workers of tomorrow. Cognitive ability, non-cognitive skills and health in children act alongside one another to determine wellbeing across the whole lifecourse[311].

The development of these three capabilities early in life helps shape important life outcomes, such as educational attainment, labour market outcomes and adult health[312–314]. Dynamic, multi-period models

Given population estimates of children aged 5 to 16, this is equivalent to £24.6 billion in lost wages in the North (£14.4 billion for males and £10.2 billion for females).

Preliminary figures on the attainment gap for the whole of England for the spring term suggest a further widening of the attainment gap resulting from the 2021 lockdown. This suggests that the above figures may be an underestimate of the true impact of the COVID-19 pandemic on future labour market outcomes.

Mental health

There is strong evidence that poor child and adolescent mental health in particular is linked with poorer subsequent academic and labour market outcomes[334]. Chapter 4 outlines the inequalities in children's mental health outcomes between the North and the rest of England, as well as the considerable and unequal rise in mental ill health as a consequence of the COVID-19 pandemic.

Given the evidence presented in that chapter and other evidence indicating that a 13% increase in depressive symptoms is associated with 2.4 fewer months of education[342], we estimate that the worsening of mental health during the pandemic will result in an average of 0.9 fewer months of education for boys in the North of England and 0.6 fewer months of education for boys in the rest of England.

For girls, we estimate that in the absence of intervention, those in the North will complete on average 2.5 fewer months of education, compared to 0.9 months in the rest of England. This equates to a wage decrease of 0.5%-0.7% for males in the North of England and 0.4%-0.5% for males in the rest of England. This increases to 1.9%-2.3% for females in the North of England and 0.7%-0.8% for females in the rest of England.

We can apply the same methods outlined above to calculate a conservative estimate of the potential loss of lifetime earnings (Figure 9.9). As children grow into adulthood, males in the North will lose 33% more in lifetime earnings than males living in the rest of England (£3,856 compared to £2,892). Females living in the North will lose 180% more than females living in the rest of England (£7,996 compared to £2,856). Given population estimates of children aged 5 to 16, this is equivalent to £13.2 billion in lost wages in the North (£4.4 billion for males and £8.8 billion for females).

Chapter 4 presents trends in the average Strengths and Difficulties Questionnaire score, a commonly used measure of children's mental health and wellbeing. Higher scores indicate more mental health problems. The chapter reports a sharp, notable reduction in these scores when schools reopen following a lockdown, and an increase when they close in January 2021.

A Strengths and Difficulties Questionnaire score greater than 17 indicates 'socioemotional behavioural problems' which suggests the presence of a mental health problem[343]. Between March 2020 and May 2021, the proportion of children reporting a score greater than 17 increased by 0.8 percentage points for boys in the North of England and 1.0 percentage points for boys in the rest of England. For girls these increases are much greater, with an increase of 6.1 percentage points in the North of England and 4.3 percentage points in the rest of England.

The lifetime costs of childhood mental health conditions are estimated to amount to around £220,000 in lost family income[344]. In the absence of intervention, we estimate that the average male in the North of England will lose £1,760 in lifetime family income, and the average male in the rest of England will lose £2,200. For females, we estimate an average lifetime loss of £13,420 in family income for those in the North of England and an average lifetime loss of £9,460 for those in the rest of England.

Implications for regional inequalities

Given that economic performance and wages in the North are already lower than in the rest of the country, the findings outlined in this chapter are worrying. Yet again, it appears that the North of England will take the largest financial hit, both now and well into the future. The estimates in this chapter suggest that wages in the North will fall further behind those in the rest of the county, for both males and females. Urgent intervention is needed to prevent these regional inequalities widening even further.

Policy recommendations

To mitigate the negative impacts of the COVID-19 pandemic on economic productivity, and address the wide and growing inequalities between the North and the rest of England, we have the following policy recommendations:

Increase investment in the systems that support the health of children, particularly those living in deprived areas and those most affected by the COVID-19 pandemic across welfare systems, health and social care.

Offer greater support for children's educational development in the post-pandemic years to 'make-up' for lost development of cognitive

UNCRC into domestic law in di□erent parts of the UK, including Wales and, more recently, Scotland, it remains largely absent and distant from English law and policy.

The panel ‘The Child friendly Cities Programme’ above illustrates how, notwithstanding any legal incorporation of the UNCRC into English law, the0 .rxo8orabovw ansuccessful p Programs for groutandint

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