Reflexión

HEALTH INITIATIVES AIMED AT JUVENILE PATIENTS FROM LOWER SOCIOECONOMIC STATUS IN UK AND CHILE

INICIATIVAS DE SALUD DIRIGIDAS A PACIENTES JUVENILES DE BAJO NIVEL SOCIOECONÓMICO EN EL REINO UNIDO Y CHILE

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ABSTRACT
While socioeconomic status impacts every individual, the early years of life are crucial in influencing future health and well-being. This paper examines the interplay of socioeconomic status, health education and outcomes for juvenile patients in the United Kingdom and Chile. Despite different healthcare systems, both countries experience health inequalities linked to economic disparities. Government policies in both countries aim to alleviate these issues but challenges include cultural competency gaps, lack of resources and barriers to access. Effective health education initiatives should be culturally sensitive, implemented throughout life and community aimed to close these gaps. Addressing these disparities requires a multi-disciplinary team and collaboration between healthcare providers, government, and educators of all levels. Future research most be directed towards parental involvement, support in communities, and environmental factors to foster development in a way that seeks to inform health policies and practices that are universally inclusive.
Key words: Child, Adolescent, Health education, Patient outcomes, Socioeconomic factors.

RESUMEN
Aunque el estatus socioeconómico afecta a todos, los primeros años de vida son cruciales para influir en la salud y el bienestar futuros. Este artículo examina la interacción entre estatus socioeconómico, educación en salud y resultados de salud de pacientes jóvenes en Reino Unido y Chile. A pesar de diferencias en sus sistemas sanitarios, ambos países experimentan desigualdades en salud relacionadas con disparidades económicas. Sus políticas pretenden paliar estos problemas, pero persisten desafíos en competencias culturales, falta de recursos y barreras de acceso. Las iniciativas de educación en salud deben considerar las diferencias culturales, el ciclo vital y el enfoque comunitario para cerrar brechas. Esto requiere un equipo multidisciplinar, colaboraciones entre equipos de salud, instituciones y educadores de distintos niveles. La investigación futura debe incluir padres y madres, comunidades y considerar factores ambientales para fomentar el desarrollo e informar sobre políticas y prácticas de salud universalmente inclusivas.
Palabras claves: Niño, Adolescentes, Educación en salud, Factores socioeconómicos.

INTRODUCCIÓN

A child's cognitive, physical, mental, and emotional development is formed in their early years of life, directly impacting their future health and well-being[1]. Studies have found that many health challenges and inequalities have foundations set in early childhood, with low Socioeconomic Status (SES), often leading to worse health outcomes and long-term health consequences[2].

In the United Kingdom (UK), as study revealed that children from lower-income households are twice as likely to experience conditions such as childhood obesity, depression and other mental health disorders compared to their peers[2]. In Chile recent research has highlighted nutritional issues facing children, especially those from lower SES and nearly 54% of juveniles are at risk of experiencing malnutrition. Research has shown that health education can empower individuals with the relevant knowledge and skills needed to make informed health decisions, which subsequently leads to better health outcomes[2,3]. However, individuals from lower SES often face barriers to accessing this education, such as limited availability of resources, language barriers, and cultural differences[3]. The UK and Chile present unique perspectives for studying these issues, as they each have distinct healthcare systems and socioeconomic landscapes. These structural differences provide a meaningful framework for exploring how socioeconomic factors shape health outcomes in childhood and how healthcare accessibility and quality can differ based on national policies and economic conditions.

In this context, the aim of the article is to explore the interplay between socioeconomic status, health education and overall outcomes for juvenile patients in the UK and Chile. By comparing these two distinctive health care systems, we can identify both commonalities and unique challenges that arise from socioeconomic disparities and apply this crucial information to modify practices in diverse sectors and enhance patient's overall outcomes. Addressing these challenges can allow healthcare providers to strive for greater equality and improved health

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outcomes in all juvenile patients regardless of SES[4]. This is a crucial aspect of chiropractic care as the aim is to deliver patient centered treatments with a biopsychosocial approach, taking into account all areas that may affect the patient. Within the profession accessibility and equality are of high importance so that all individuals can receive the same standard of care regardless of SES.

DEVELOPMENT

The World Health Organisation (WHO) advises that health is not merely the absence of disease or illness but a state of complete wellness which includes mental, physical, and social well-being with all factors directly influencing one another[5]. The delivery of healthcare has changed in recent years from a biomedical model to now including a biopsychosocial approach especially in childcare, taking into consideration all areas that may initiate or escalate an individual's condition[6].

In the UK the National Health Service (NHS) provides a universal health care model, yet children from deprived areas still experience significant health inequities[2]. In contrast, Chile's health care system is a mixed model with both public and private components. The public system is called Fondo Nacional de Salud (FONASA) and is accessed by around 76,5% of the population while the private system is consisting of various insurance providers such as Instituciones de Salud Previsional (ISAPRE), which covers around 15,4%[7]. Similarly, Chile's access to quality health care often depends on an individual's economic status, leading to pronounced disparities and worse outcomes in deprived areas. More specifically, it was previously reported that children living within England have poorer health outcomes than average across the EU15+ (15 EU countries plus Canada, Australia, and Norway) this included infant mortality, childhood obesity and lower rates of breastfeeding[2].

The UK government have created various health initiatives to attempt to combat these issues, for example All Our Health and Healthy Child Programme, which aim to take an ecological approach to improve outcomes for children and address the child as an individual within the context of their family, community and living environment. These guides are aimed at health professionals and provide a framework and supports multi-disciplinary care to improve health outcomes in response to local needs and adapt to any level. The goal of the programmes is to provide families with screening, immunisations, prevention strategies, health and development reviews and early effective interventions[2,5]. One of the issues identified with these models is that they fail to account for interventions that support parents with substance abuse which can be common in lower income households[4]. Healthcare sectors within the NHS usually adapt a biomedical model which can sometimes overlook these impacting factors. Alternatively, the biopsychosocial model, a framework emphasised within Complementary and Alternative Medicine (CAM) education models such as chiropractic as it aims to promote comprehensive patient care by addressing physical, psychological, and social dimensions of health. Chiropractic education, particularly, instils the importance of early interventions and tailored healthcare for juvenile patients, especially those from lower SES, to help mitigate health disparities and promote well-rounded development.

The Chilean government has a similar model Chile Crece Contigo (CCC) which aims to support early year development with a multidimensional approach offering education, health, social and community services to help children and families[8]. Mothers enter the programme at their first prenatal checkup and are expected to engage with the system throughout their pregnancy with personalised care offered based on their needs, i.e. breastfeeding education, nutritional advice and child development advice. Children are then enrolled and have access to healthcare and free pre-school education. If any vulnerabilities are detected in the parents or child, i.e. postnatal depression, abuse, or developmental delays than the necessary services intervene[8]. This model does have limitations as it is only aimed at children under 9 years old, currently there is not a dedicated government programme aimed at adolescents, but their hope is to change this in the future[9]. The CCC has also faced some criticism from both users and officials as they state the model can be too rigid and sometimes penalises the parents for following their own cultural practices additionally there are access barriers as not all users are able to interact with the programme due to lack of funds, travelling issues or safety concerns[9].

Both the UK and Chile have diverse populations with an array of different cultures and communities, recent research has questioned the ethics of delivering effective interventions when there is a universal lack of cultural competency within healthcare[3]. Most of the information known in mainstream healthcare is based on constructed "social norms" and can struggle to have universal validity[2,3]. Therefore, implementing health education can be challenging as healthcare professionals can be unaware or don't know enough about what an individual may need to survive and thrive while maintaining their cultural practices. For health education to be effective and permanent it has been argued that strategies should not just be provided during school years but should be systematically planned and implanted throughout juveniles lives regularly[5,3,9]. Examining the similarities between the UK and Chile reveals that both countries face challenges in providing equitable health education and care that considers all socioeconomic groups[1,3,7]. However, the differences in their healthcare systems

also highlight unique obstacles and potential areas for improvement. For instance, while the UK's NHS provides a more uniform approach to healthcare access, there is a need for targeted health education programs that address the specific needs of lower-income families. These programs could focus on providing families with practical strategies for healthy living within constrained budgets and emphasise the importance of mental health support[2,4]. In Chile, efforts could be directed towards improving the public healthcare infrastructure and ensuring that health education initiatives reach all segments of the population[9,10]. Collaborations between public and private sectors with integration from a variety of multi-modal teams may also offer innovative solutions to bridge inequities in care and education[5,6].

CONCLUSION

In conclusion, while the interplay between SES, health education and patient outcomes is evident, research has shown that these obstacles can be overcome through early intervention, effective personalised health education, and comprehensive policies[1,5,6]. The healthcare sector can work towards a future where each person has the opportunity to achieve optimal health. Examples of how to achieve this include encouraging community engagement and utilising various delivery methods which can start to bridge the gaps that currently exist[2,5]. Reflection within healthcare is essential to analyse and identify areas for improvement which can directly enhance clinical skills and patient care. Understanding the relationship between SES, health education and outcomes in juvenile patients is crucial for medical students, it provides insights into the factors that influence patient health and underlines the importance of addressing these disparities early in medical practice by adopting a biopsychosocial approach[4,6]. Within chiropractic education this is a topic that is taught throughout the academic journey as early integration can lead to greater understanding and allows these essential skills to become standard and foundational.

The subject of how SES effects health education and outcomes in juveniles presents opportunities for future research, including the analyses of parental involvement and the impact of community support systems. With the aim of examining how consistent support at home influences long-term health behaviours and outcomes in children[5,10]. Another area of interest might involve evaluating the impact of community support systems, such as local clinics and youth centers, which can reinforce health education and provide safe spaces for physical and mental well-being. Additional research could also investigate how SES directly impacts the availability to nutritious and varied food, safe green spaces, and quality healthcare all of which are crucial for a child's healthy development[1,5,10]. By exploring these areas, researchers can contribute to developing comprehensive policies promoting education to all juveniles regardless of SES. Programs and resources employed in different sectors, that promote health literacy, alongside accessible healthcare services, are essential in empowering individuals to take account of their own well-being[1,2,5,9]. Collaboration between healthcare providers, educators, and government is critical for creating an environment that supports health equity for everybody and not just does of a higher economic status[2-4]. Ultimately, it is our collective responsibility to advocate for and implement strategies that ensure everyone, regardless of their SES can lead healthy and fulfilling lives[2,5,8].

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