Call for Evidence

Realising potential: Delivering the Child Poverty Strategy

Introduction and Reason for Submitting Evidence

The Faculty of Public Health (FPH) is a public health professional body and registered charity, with a membership of around 6,000 public health professionals across the UK. It is responsible for setting training standards for public health specialists in the UK and its core mission is to improve the health and wellbeing of local communities and national populations.

Tackling poverty is one of the four priorities set out in the Faculty of Public Health's Vision, reflecting its central importance to public health. The Faculty is clear that poverty is a fundamental cause of poor health and health inequity across the UK, and sees addressing poverty as central to ensuring everyone can live a long and healthy life (FPH, undated). Poverty in childhood has lifelong consequences, and should not be seen as separate from family poverty as many health determinants are mediated through parental health and well-being. As an organisation concerned with the health and wellbeing of the population, we are keen to ensure that the Child Poverty Strategy is ambitious, practical and effective.

This response has been prepared on behalf of the Faculty of Public Health by two of its constituent Special Interest Groups (SIGs). The FPH Poverty SIG focuses on the impact of poverty on public health. It contributed evidence to the Child Poverty Taskforce, which led the development of the Child Poverty Strategy, and has published a commentary on the Strategy itself (Clissold et al., 2026). The Children & Young People SIG, in partnership with the British Association for Child and Adolescent Public Health (BACAPH), promotes evidence-based public health programmes for children and young people, recognising the impact of poverty as a key concern.

Our submission responds to each question in the Terms of Reference that falls within our remit as a public health organisation:

(1) Is the Child Poverty Strategy sufficiently ambitious?

The Child Poverty Strategy addresses many of the complex drivers of childhood and family poverty in the UK.

Childhood poverty is a cause of poor health through multiple routes with lifelong consequences. The material (e.g. food poverty, poor housing), economic (e.g. limiting access to opportunities, such as school activities) and psychosocial (e.g. substantial and prolonged stress, stigma) aspects of poverty drive worse health outcomes, while poverty also acts as a barrier to healing and rehabilitation (e.g. through inadequate access to healthcare). Poverty in childhood affects cognitive and behavioural development, educational outcomes, risk of adverse childhood events (ACE) and harmful addictive behaviours.

[For specific sources of evidence, please see the full reference list to Clissold et al. (2026), or visit the FPH Poverty SIG website for further resources: https://www.fph.org.uk/policy-advocacy/special-interest-groups/poverty-sig/]

Reducing poverty should therefore lead to improvements in physical and mental health, for children and young people now and throughout their lives, as well as for their parents or caregivers; in turn leading to healthier working lives, with a positive economic and social impact.

We recognise that some of the proposals in the Child Poverty Strategy which will have particularly significant impacts on reducing child poverty and therefore health, such as the removal of the 'two child limit', required determination in the face of significant opposition. We want to acknowledge the considerable ambition that has already helped to shape the Strategy.

However, we are firmly of the view that even greater ambition, and measurable action supported by sufficient funding, is needed. We are clear about what is at stake in terms of public health. Poverty results in shortened lives (with a loss of more than 10 years in the poorest parts of the UK, compared to the wealthiest), longer periods of poor health (a near 20 year gap in healthy life expectancy, which government has pledged to halve[1]), and more substantial and complex health needs (National Records of Scotland, 2025, 2026; ONS, 2026). Poverty experienced in childhood can have urgent, short-term consequences – lower birthweights, greater acute care admissions, even increased infant mortality (Taylor-Robinson et al., 2019; Dibben et al., 2006) - as well as lifelong effects for health and wellbeing. Poor health, in turn, affects productivity and social connection, making it even harder for individuals and families to change their circumstances.

In public health terms, action on poverty is one of the most important levers for improving health. Failure to do so has an enormous cost at an individual and population level. The government estimates that the Child Poverty Strategy will lift around 450,000 children out of poverty; but this is only a tenth of the 4.5 million children affected by poverty in the UK, including 2 million in deep poverty (unable to afford the basics to meet physical needs). Poverty continues to be unequally distributed, with some households (including those where someone is disabled, single-parent households, and ethnic minority households) at much greater risk: mirroring and amplifying existing patterns of disadvantage. Even with the Strategy, about one third of the UK's children will continue to grow up in poverty: the government must aim much higher.

In "A Vision for the Public's Health" (https://www.fph.org.uk/policy-advocacy/what-we-think/a-vision-for-the-publics-health), the Faculty of Public Health calls for the UK Government to introduce a Child Poverty Act, with an urgent and legally-binding commitment to ending child poverty. We remain of the view that this level of ambition is essential. This will substantially benefit the health and wellbeing of the UK; and, given the bi-directional relationship between poverty and health, thereby enhance its social and economic flourishing (Alston, 2019).

(2) Are the drivers and outcomes that the Government has set out in the Strategy the right ones?

(3) Are there any policies and initiatives that could strengthen the outcomes in: (i) boosting families' incomes; (ii) saving families' money; (iii) securing families' finances; and (iv) strengthening local support, that were not included in the Child Poverty Strategy?

[1] Labour Party Manifesto 2024: p103 (https://labour.org.uk/wp-content/uploads/2024/06/Labour-Party-manifesto-2024.pdf)

We have answered Questions 2 and 3 together. We consider that the elements of the Strategy are all positive, but they do not go far enough, given the scale and urgency of the challenge. Policies and initiatives that could further strengthen the Strategy include:

i) and ii)

Prioritising further action on key drivers such as **social protection**, in order to ensure that benefit rates ensure an adequate standard of living, rather than leaving some households unable to afford the essentials (JRF, 2026); and **decent, affordable housing**, with much faster progress on delivering sufficient, healthy and climate-friendly social housing.

ii) iii) and iv)

Health is a key driver of poverty, and vice versa. Given this close, bi-directional relationship, there are clear opportunities to improve outcomes and productivity through action on both. Recognition and adequate resourcing of the role of public health and prevention is essential in breaking this link. This should be led by adequately resourced local government public health teams (i.e. by real terms restoration of the public health grant), together with national leadership; alongside investment in public services and the voluntary and community sector, in ways that rebalance the sustained under-investment in the UK's poorest communities. Sufficient, high-quality **early years provision** is also essential to improve school readiness and subsequent school outcomes.

Commercial interests can play a significant role in shaping the health of the public (we refer to these as 'commercial determinants of health'). These are important but under-recognised drivers of poor health and poverty. In the context of poverty reduction and protecting health, particular concerns include the marketing of health-harming industries (such as gambling or unhealthy food) towards lower-income groups, and the impact of harmful practices within the financial services sector, such as predatory lending and debt (Gilmore et al., 2023). Addressing this would have a beneficial impact on households' financial security, but it is an area of policy development which is largely absent from the Strategy, even though it is an area where national leadership is essential.

Furthermore, adequately resourced **research** including monitoring and evaluation, with lived experience at the centre, is essential to ensuring interventions are evidence-informed, effective and acceptable. Public health and health equity research is essential to better understand the impacts of poverty and its reduction, and effective interventions for those living in poverty in the UK.

(4) What will the distributional impacts of the Strategy be, including across the regions and nations of the UK and among different groups of children and families with protected characteristics?

While some aspects of the Strategy will have a beneficial impact UK-wide, many others (e.g. policies on free school meals, skills support, access to childcare, and investment in building new homes) are specific to England. This is not necessarily problematic: these are devolved powers in the other UK nations, and each national government has developed their own policies accordingly. This has led to examples of good practice in each nation – Scotland, in particular, has made real efforts to address child poverty through policy and legislation, which appears to be leading to some meaningful progress on reducing child poverty rates (Scottish Government, 2025). The Strategy would be significantly strengthened if it included mechanisms for the four national governments to

collaborate and share learning and good practice; as well as greater support for collaboration at all levels of government and across all policy sectors.

As discussed above (end of Q1), poverty also mirrors and amplifies other forms of disadvantage, such as discrimination on the basis of various protected characteristics, again with detrimental consequences for health and wellbeing. To address poverty and its consequences effectively, the Strategy needs to be responsive to different experiences of compound disadvantage, and commit to co-producing holistic, contextualised approaches for the most vulnerable groups.

(5) What impact might the Strategy have on children who experience other specific barriers, for example, children with experience of the care system; children at risk of criminal exploitation; and children at risk of entering the criminal justice system?

The Strategy is a necessary, but not a sufficient, step towards improving outcomes for children who experience additional disadvantage. Children who live in households affected by poverty are more likely to be taken into care (Bennett et al., 2022); in turn, facing a much higher risk of negative health outcomes throughout their lives (Murray et al., 2020). Targeted support as well as universal policies are essential to improve their circumstances and outcomes.

(6) How well does the Child Poverty Strategy link to the Government's work on social mobility? Are there any further strategic ambitions or outcomes that the Government should focus on to support social mobility? For example, relating to closing the educational attainment gap and supporting high aspirations among children and young people.

Education policy is largely outside our scope. However, we note that anti-poverty policies help to improve the conditions in which children are born and grow up. These have a direct positive effect on children's health and wellbeing, better supporting their ability to play, grow and learn, and their development throughout the life course.

(7) Should the Child Poverty Strategy include measurable targets and interim targets? If so, what should they be?

Yes. The Faculty of Public Health continues to call for the UK Government to introduce a Child Poverty Act with an urgent and legally-binding commitment to end child poverty in the UK.

It should be noted that the true impacts on health may not be seen for many years, although measures such as infant mortality can often reflect shorter term changes and could be considered as part of a robust evaluation of effects.

(8) How should the Government work with the devolved nations on setting targets, and monitoring and evaluating progress on delivering the Strategy?

See answer to Q4. In working together with the devolved nations, and at local and regional levels, the government should also ensure that targets or commitments are developed which engage partners at all levels in addressing poverty and reducing poverty-related harms within their sphere of responsibility. This would build on the collaborative approach involved in developing the Child Poverty Strategy.

(9) What is your view of the Government's proposed 'Monitoring and Evaluation Framework' for the Child Poverty Strategy? How could it be improved?

The Framework seems to propose a reasonable approach to measuring the extent and distribution of poverty in the UK. This may be all that is feasible, especially in the early years of the Strategy. But in order to understand the impact of the Strategy in the long term, it is also vital to monitor outcomes in other domains that have a close link to poverty – such as overall health outcomes and inequalities in health across the population.

(10) What should be included in the Government's baseline report this summer?

The government has undertaken to provide more details on its monitoring and evaluation approach in the baseline report this summer, and then to produce an annual progress report against this baseline. We believe that clear, binding and rights-based targets are also essential. As these were not included in the Strategy, the baseline report provides a great opportunity to introduce these targets, and to use them to support ongoing monitoring.

(11) How should the Government support the monitoring and evaluation of actions to reduce child poverty at the local level, and across different protected characteristics? And what data is either available or necessary to achieve this?

(12) What data is available and necessary to monitor child poverty and the impact of interventions, across protected characteristics, at the local level?

Q11 and Q12 – there are numerous examples of good practice at local level, and we encourage the government to work closely with local authorities (and their representative organisations), local and regional public health teams, and local anti-poverty community organisations to develop their approach to monitoring and evaluation in this area.

Under the previous Child Poverty Act, there was a duty on local authorities to have their own child poverty strategy. A similar commitment to developing and implementing action plans on child poverty would support local-level monitoring and evaluation of progress.

(13) Are there any international comparators the Government should learn from, in relation to how it sets targets, and how it monitors and evaluates progress on action to reduce child poverty?

The EU Alliance for Investing in Children has produced a report on “A Europe that protects every child: Aligning EU’s policies and budget to eradicate child poverty” - available at: https://eurohealthnet.eu/wp-content/uploads/publications/2025/250409_statement_eualliance4children_recommendations-for-aligning-eus-policies-and-budget-to-eradicate-child-poverty.pdf.

This includes recommendations for policies, supported by sufficient investment, to tackle child poverty across the EU. The annex to the report (p13 onwards) also includes examples of country-

level initiatives relevant to addressing childhood poverty and its consequences, in relevant comparator countries.

(14) What will be necessary to secure the longevity of the Child Poverty Strategy?

The Child Poverty Strategy has a ten-year horizon, so building cross-party consensus and public support for action on childhood poverty will be essential to ensure that it survives beyond the term of the current government. The government's commitments need to be matched by sufficient and long-term investment in policies that reduce poverty, ensuring incentives are in place for the cross-department, long-term working that is required. We are of the view that a legally binding commitment, in the form of a Child Poverty Act, would strengthen the Strategy and enable the government and its successors to be held to account for meaningful progress. Finally, ensuring that policy development, monitoring and action on child poverty is rights-based, and is co-produced with people who have relevant lived experience, will help to ensure that the Strategy's commitments survive, and result in meaningful progress, over the long term.

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