

# Public health for paediatricians: Fifteen-minute consultation on addressing child poverty in clinical practice

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## ABSTRACT

Paediatricians and other child health professionals have a key role in identifying, preventing or mitigating the impacts of poverty on child health. Approaching a problem as vast and intractable as poverty can seem daunting. This article will outline how social determinants impact child health, and provide practical guidance on how to address this problem through a public health lens. The aim is to give frontline practitioners a straightforward, evidence-based framework and practical solutions for tackling child poverty, across three levels: (1) the clinical consultation; (2) the clinical service for the population of children and young people we serve and (3) with a broader policy and social view.

## INTRODUCTION

Paediatricians and other child health professionals have a key role in identifying, preventing or mitigating the impact of poverty on child health. Approaching a problem as vast and intractable as poverty can seem daunting. This article will outline how social determinants affect child health, and provide practical guidance on how to address this problem through a public health lens. The aim is to give frontline practitioners a straightforward, evidence-based framework and practical solutions for tackling child poverty, across three levels: (1) the clinical consultation; (2) the clinical service for the population of children and young people we serve and (3) with a broader policy and social view.

### Defining the problem: poverty in 21st century Britain

Public perception and media representation of the poverty is often inaccurate, skewed and highly politicised<sup>1</sup> leaving

many doctors surprised and unprepared for the stark realities of clinical practice. Even the definition of poverty itself is disputed. The UK currently does not have an official measurement of poverty.<sup>2</sup> **Table 1** lists some commonly used definitions.

Different measures will paint different pictures about the extent of the problem. Generally, absolute poverty is more useful in assessing poverty in the short-term, whereas relative poverty is better at seeing long-term trends, since it encompasses changes in the wealth of a society over time.<sup>3</sup> It is important to understand that each measure is designed for a specific purpose, and the use of a single figure alone may hide the bigger, more nuanced, picture: one should treat with some scepticism any claim that portrays poverty as a single number or trend. Moreover, poverty is far more complex than simply income or purchasing power; social, cultural and political influences, and how individuals perceive poverty in their context are also essential considerations.<sup>4</sup>

Economic definitions are important from a policy perspective. But for clinicians, who must first focus on how poverty might affect a child's health and well-being, Townsend's framing in **box 1** might be more helpful.

Across a range of the definitions, recent trends suggest that child poverty remains a significant challenge. One estimate suggests that there are now 4.1 million children living in poverty in the UK. This number has risen consistently since 2010; one prediction suggests that child poverty is likely to rise to its highest level in 30 years by 2024.<sup>5</sup> This prediction may have to be revised further upwards in light of the economic impact of the COVID-19 pandemic. Many reasons for the increase

**Table 1** Defining poverty

Term	Meaning
Absolute poverty	<ul style="list-style-type: none"> <li>▶ When a person's income level falls below some minimum level necessary to meet basic needs. In October 2015, the World Bank set a new global poverty line at US\$1.90 a day.</li> <li>▶ 'Living below the UK absolute poverty line' is defined as having a household income below 60% of the UK median (as measured in 2011, adjusted for inflation). Confusingly, although this is known as 'absolute poverty', this is in fact also a 'relative' measure (although relative to a historical population income in 2011)—but is considered 'absolute' because no comparison is made with <i>current</i> income or household costs.</li> </ul>
Relative poverty	<ul style="list-style-type: none"> <li>▶ This considers one's location and what it means to be poor in a particular society. People are in relative poverty if their income falls below the minimum amount needed for them to maintain the average standard of living, in the society in which they live.</li> <li>▶ An example is Households Below Average Income. This survey considers a person in the UK to be living in poverty if their income is &lt;60% of the current median UK household income. In 2016–2017, this was £425 a week after housing costs (£22 100 a year).</li> <li>▶ Relative poverty may also be reported either before or after housing costs are taken into account. Relative income after housing costs is often considered a more meaningful measure of poverty, given that housing costs are a significant (and unavoidable) expenditure.</li> </ul>
Material deprivation	▶ The inability to afford basic resources and services such as sufficient food, heating, clothing and so on.
Proxy measures of poverty	▶ Other proxy measures used to assess poverty include those families in receipt of income-related benefits, or being in receipt of means tested free school meals.

in poverty in the UK have been proposed, from global economic downturn to austerity measures resulting in rising living costs, low wages, and changes to the welfare system.

#### What is the impact of child poverty?

The effect of poverty on a child's health outcomes are pervasive and last through the life course (box 2). This may occur directly as a result of families being unable to afford necessities that contribute to a child's health; or it may come indirectly: the emotional stress of poverty can limit carers' ability to look after the child's needs. There is also an impact on the use of health services. Families living in areas of high deprivation are much more likely to attend A&E, and those with long-term conditions fare worse than their more affluent peers.<sup>6</sup>

#### What does child poverty mean for the clinician?

While most paediatricians have always been sensitive to the wider social factors around a child, research shows that many feel disempowered to be able to address them.<sup>7 8</sup> This has implications for professionals as well as children: healthcare staff burnout is amplified by 'routine moral stress' caused by working in constrained conditions<sup>9</sup>—including having to work without sufficient individual and organisational resources to address patients' social need.<sup>10</sup>

#### Box 1 What poverty means to the clinician

'Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the type of diet, participate in the activities and have the living conditions and the amenities which are customary, or at least widely encouraged or approved in the societies to which they belong. Their resources are so seriously below those commanded by the average family that they are in effect excluded from the ordinary living patterns, customs, and activities'. (Townsend 1979)

The case study in box 3 demonstrates a practical approach that starts from the point of view of the health professional, and considers: how can I help the

#### Box 2 Child poverty is associated with wide-ranging adverse outcomes

##### Physical and mental health:

- ▶ Low birth weight.
- ▶ Infant mortality.
- ▶ Unhealthy behaviours such as smoking, alcohol and substance misuse.
- ▶ Obesity.
- ▶ Unplanned hospital admissions.
- ▶ Poorer outcomes for long-term conditions (such as asthma and diabetes).
- ▶ Accidental and non-accidental injuries.
- ▶ Anxiety, depression and suicide.

##### Educational outcomes:

- ▶ Poorer academic achievement.
- ▶ Higher rates of special educational needs.

##### Behavioural and social outcomes:

- ▶ Poverty is associated with poorer neurocognitive and social development.
- ▶ Children in poverty report increased incidence of: Experience of stigma and bullying from peers. Social stigmatisation, isolation and deprivation.

##### Family:

- ▶ Poverty is associated with disrupted family functioning—in particular communication, behaviour control and family stress—and higher risk of relationship breakdowns.
- ▶ Lone parenthood is associated with higher risk of poverty.

##### Later outcomes into adulthood:

- ▶ Increased lifetime risk of cardiovascular disease and certain cancers.
  - ▶ Lower lifetime earnings.
  - ▶ Higher rate of being Not in Education or Employment Training.
  - ▶ Reduced life expectancy.
- These risks perpetuate beyond the individual and are increased for future generations.

**Box 3 Child poverty case study—Max\***

Max, aged 15 years with type 1 diabetes, presented to accident and emergency in diabetic ketoacidosis. He rarely checks his blood glucose levels and frequently misses insulin doses. He has been unable to attend several appointments to see the diabetes team due to transport costs.

A patient history was taken using the adapted HEADSS framework (see table 2).

**Home:** Max lives in a one-bedroom council flat, with his mother and two siblings (aged 4 and 6 years), which is overcrowded. His parents had recently separated and his father lives 2 hours away.

**Employment/Education:** Max's dad worked full time as a lorry driver and his mother previously worked as a dinner lady. However, Max's mother suffered from depression, which worsened after she separated from Max's father. Max's mother felt immense pressure from caring for her mother (who suffered from a stroke), her three children as a single parent and she is now unemployed. Max had poor school attendance and attainment.

**Activities:** Max does not have any hobbies/after school activities. He was becoming increasingly socially isolated, had worsening low mood and self-esteem following his parents' separation and was being bullied at school. The family had not been on holiday for several years.

**Diet:** Max's mother cooks at home and always lets her children eat first, such that she sometimes skipped meals. Max does not always join for meals, preferring to eat snacks and takeaways. He does not undertake some crucial aspects of his diabetes management, such as "counting carbs". They struggle to afford fresh fruit, meat and fish. Their fridge had recently broken, so they were unable to store food or insulin at a suitable temperature.

**Safeguarding/Support:** Max's family is on universal credit and his mother has struggled to budget. They did not have a social worker and are not known to social services.

\*"Max" is a pseudonym - all names and identifying details have been changed to protect the privacy of individuals.

child and family under my care today; how can I help the population of children and young people under my care and what broader action can I take?

**Question 1: How can I help the child and family under my care today?**

The first step in addressing child poverty in clinical settings is identification. However, questions regarding money, housing issues and food insecurity are often not consistently raised, with clinicians citing awkwardness and embarrassment.<sup>11</sup> By contrast, the evidence suggests that most parents are happy to discuss these issues, and want them to be addressed in consultations.<sup>12</sup>

How can I discuss poverty with my patients in a way that sensitively and respectfully but effectively elicits areas of concern?

Active questioning will often be needed as part of routine family and social history taking to elicit risk factors for poverty, such as: large families with three or more young children, single parents, unemployment and/or parents with chronic physical or mental health conditions. One approach adapts the 'HEADSS' tool (originally developed to assist in taking a structured social and contextual history from young people) to co-produce, with the local population, a tailored screening questionnaire for poverty (table 2).<sup>7</sup>

How may problems relating to poverty present to a health professional like me?

Clinicians need to be alert and open-minded regarding the breadth and depth of the potential impact of poverty, and the myriad ways in which that may present to the attention of health professionals. Apart from the direct impact of living in poverty on the child's well-being and health, both physical and mental, there is also an indirect influence through the effect on the family, and the social stigma that results from negative interactions with the child's peers and friends, such as bullying. Symptoms that result from this complex interaction of physical, psychological and social factors are therefore often non-specific, and include many commonly occurring presentations such as headaches, abdominal pain and recurrent respiratory infection.

**Table 2** The adapted 'HEADSS' tool for poverty

Questions	Red flags and cues for poverty
<b>Home:</b> Who lives at home with you? What is your house like?	Chronic physical or mental health problems, >3 young children, single parent. Housing concerns: pests, leaks, mould, cold, overcrowding.
<b>Employment/Education</b> Do you work? What is your job? How is your child doing at school?	▶ Unemployment/Low income, asylum seekers, travellers. ▶ Developmental delay, poor school attainment, poor attendance.
<b>Activities:</b> Do you have any hobbies? Have you been on holiday in the last year?	▶ Lack of disposable income for hobbies, holidays or transport. ▶ Social isolation.
<b>Diet:</b> What did you eat yesterday? In the last year, have you worried that your food would run out before you got money to buy more?	▶ Lack of (healthy) food, unable to afford fresh fruit and vegetables. ▶ Parents missing meals to feed children. ▶ Free school meals. ▶ Foodbank use.
<b>Safeguarding/Support</b> Have you ever had a social worker? Has anyone ever hurt or threatened you?	▶ Reasons for social worker could give insight into current and previous vulnerabilities. Consider what support they already have? Are they receiving benefits? ▶ Physical, emotional, sexual abuse or neglect warrants further investigation and referral as per local pathways.

#### Box 4 What did we do to help Max and his family?

After stabilising Max in acute diabetic ketoacidosis, we referred him to the diabetes multidisciplinary team and arranged follow-up with the diabetes specialist nurses. We also referred to the diabetes psychologist, as the Child and Adolescent Mental Health Service (CAMHS) had rejected the referral made from his GP for low mood. We referred to social services early help for family support, such as aiming to provide a functional fridge.

Based on the 1-2-3 resources framework (figure 1), resources Max's family could access in addition to help from our referrals include:

1. Increase income
  - a. We signposted to Citizen's Advice and Money Advice Services to ensure the family are on all the benefits that they are entitled to.
  - b. We also discussed some of the services Christians Against Poverty offered, such as their Job Club when Max and/or his mother are ready to enter employment and their money and/or life skills courses to help with budgeting, healthy eating and living.
2. Provide essentials
  - a. We discussed healthy eating in the context of poverty and signposted to local community fridges and Healthy Start.
  - b. We signposted to Shelter for concerns regarding their overcrowded housing.
3. Join in and thrive
  - a. We discussed accessing Relate for family counselling services in light of working through complex emotions from parental separation and [www.kooth.com](http://www.kooth.com) for online mental health support.
  - b. We signposted to local communities like YMCA to increase community participation, engage in more exercise, aiming to help Max value and take ownership of his own health.
  - c. We also signposted Max to 'The Mix' (free, online, confidential advice and helpline for young people aged under 25. This is accessible via phone, text or online messaging on money, sex, relationships, school, bullying, online safety and mental health).

Max's mother's feedback on the resources offered was: "Thank you so much for considering these parts of our lives too, this will be really useful for Max and all of us".

Four months later, Max had made much progress: he had a family support worker, was attending counselling (Relate), had improved school attendance, was studying for school qualifications (box 1) and played football regularly with some friends. He was also checking his blood glucose levels more regularly, resulting in improved haemoglobin A1c levels. Although Max's family were still struggling with poverty in many areas, it was clear that Max now valued his health, well-being and education more highly than before, and they were all feeling more empowered and positive about the future.

The same underlying issue may present in different ways. For example, food poverty (low income which affects the ability to have a healthy diet) may present with either obesity (due to a cheaper, predominantly

processed, high-fat, high-sugar diet), or being underweight and/or nutritional deficiency.

Income poverty, especially in-work poverty, may also result in being 'time-poor', and suboptimal adherence to medical treatment may be a symptom of an underlying inability to manage the demands and needs of the whole family. Similarly, these families may find it difficult to engage smoothly with healthcare systems (such as missing appointments or friction with staff over visiting times) and are often labelled as being 'difficult' for their apparent reluctance to comply with healthcare norms.

Another important concept is that of 'digital poverty'. Over the past few years, it has become increasingly difficult to maintain the position that reliable internet access is a luxury, rather than a necessity of modern life. The COVID-19 pandemic and ensuing social isolation measures has thrown digital inequality into sharp relief, as children from poorer backgrounds struggle with access to online education. As health services rush to implement virtual healthcare consultations wholesale, there is a risk of reduced healthcare access for poorer children who can afford neither internet access nor reliable devices to access it.

## 1-2-3 family wellbeing

Here's a selection of national resources that are available across the UK to help your family with money, essentials like healthy eating and enjoying your local activities ☺

**1 Increase income:**

- [www.moneyadviceservice.org.uk](http://www.moneyadviceservice.org.uk)
- [www.billhelp.uk](http://www.billhelp.uk)
- [www.citizensadvice.org.uk](http://www.citizensadvice.org.uk)
- [www.capuk.org](http://www.capuk.org)
- [www.nationaldebtlne.co.uk](http://www.nationaldebtlne.co.uk)
- [www.buttleuk.org](http://www.buttleuk.org)

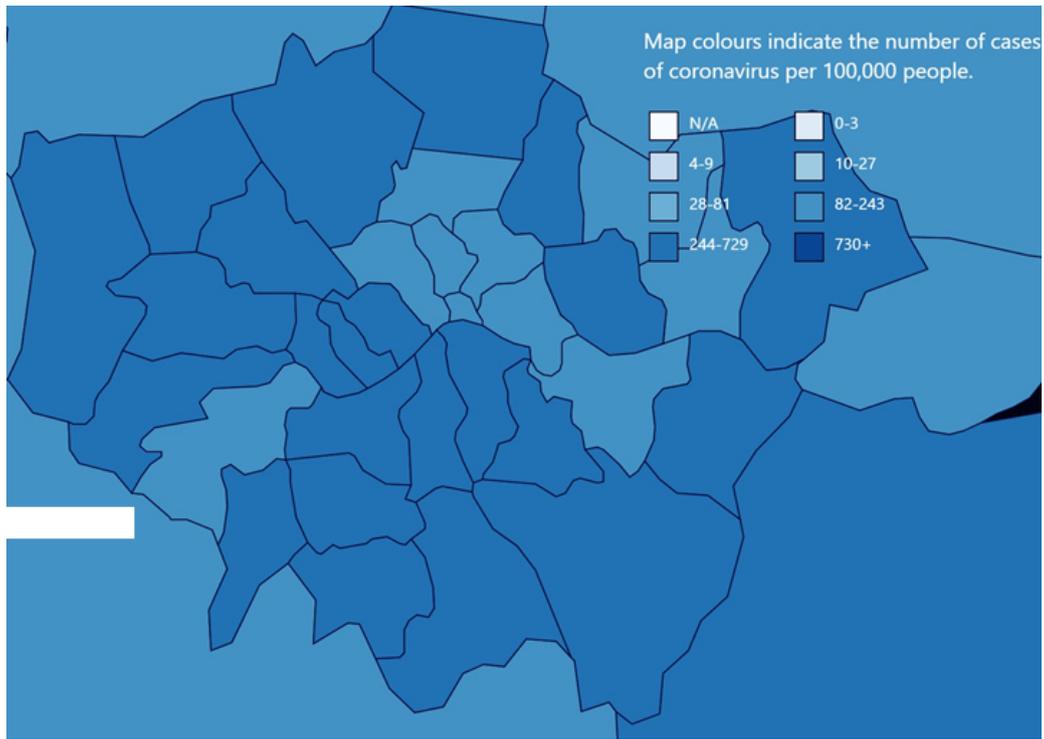
**2 Provide essentials:**

- [www.care4me.org.uk](http://www.care4me.org.uk)
- [www.communityfridge.org](http://www.communityfridge.org)
- [www.shelter.org.uk](http://www.shelter.org.uk)
- [www.healthystart.nhs.uk](http://www.healthystart.nhs.uk)
- [www.trusselltrust.org](http://www.trusselltrust.org)

**3 Join in and thrive:**

- [www.ymca.org.uk](http://www.ymca.org.uk)
- [www.themix.org](http://www.themix.org)
- [www.home-start.org.uk](http://www.home-start.org.uk)
- [www.surestart.org.uk](http://www.surestart.org.uk)
- [www.kooth.com](http://www.kooth.com)

Figure 1 1-2-3 resources leaflet. Resources that can help families in poverty (1) support income, (2) provide essentials and (3) join in and thrive.<sup>7</sup>



London boroughs with highest number of COVID-19 cases per 100,000 and % children in poverty	London boroughs with lowest number of COVID-19 cases per 100,000 and % children in poverty
Brent (421 cases/100,000, 43% poverty)	Islington (179 cases/100,000, 47% poverty)
Southwark (386 cases/100,000, 40% poverty)	City of London (184 cases/100,000, 30% poverty)
Harrow (386 cases/100,000, 37% poverty)	Tower Hamlets (192 cases/100,000, 57% poverty)
Croydon (374 cases/100,000, 30% poverty)	Richmond (198 cases/100,000, 21% poverty)
Lambeth (357 cases/100,000, 43% poverty)	Haringey (208 cases/100,000, 40% poverty)

**Figure 2** COVID-19 cumulative incidence and area deprivation across London (COVID-19 data from gov.uk, gov.scot, nhs.wales, nhs.uk, last updated 8 May 2020 and child poverty data from Trust for London, last updated April 2020).

How can I help the child in poverty and their family?

In many circumstances, understanding of the family’s social and financial situation, and empathetically managing a child’s healthcare with that context in mind, is sufficient to transform the quality of the child’s care. But there are other specific actions (box 4).

Social prescribing—signposting to services that focus on the social determinants of health—is already a common concept among primary care practitioners, and an increasingly important skill for other health professionals. This may involve directing them to sources of financial support, both from the state (such as statutory benefits and social security entitlements) and third sector organisations; local food banks;

childcare support and other practical services. A useful repository of information to help families navigate available services can be found through UK Bill Help (www.billhelp.uk). Figure 1 is an example of an information leaflet which can be adapted for local use.<sup>7</sup>

The way in which we frame the approach to helping a family in poverty is also important. Much of what we have highlighted here relates to ‘deficits’—what a child or their family lacks as a result of their social and financial circumstances. It is also important to explore—and from there, enhance—the strengths of the child and their family. These assets may be at the individual level (personal resilience, knowledge and

skills) or community level (family and social networks, schools and clubs and third sector organisations). An asset-based approach encourages the child and family to develop those assets to improve their health, engendering a sense of agency and purpose.

**Question 2: How can I help the population (of children and young people) under my care?**

The poverty and deprivation characteristics of any local area and population can be found on the End Child Poverty website (<http://www.endchildpoverty.org.uk/poverty-in-your-area-2019/>), and its public health effects can be correlated with the Public Health England Fingertips Tool (<https://fingertips.phe.org.uk/>).

A current example of how poverty affects the population can be seen in the wake of the global pandemic of COVID-19. Figure 2 illustrates the correlation between COVID-19 cases (as of 8 May 2020) and area deprivation. It is also important to consider that families living in poverty are more likely to be members of overcrowded intergenerational households, and are likely to under-report cases due to difficulties with healthcare access, language and information. This knowledge should inform the reallocation of healthcare staff and essential resources to deal with the current pandemic, prioritising areas of high deprivation.

These principles are not specific to pandemic management and can be applied to the care of any childhood condition. Indeed, health inequality impact assessments should be a routine part of any service planning and commissioning process. For clinicians, quality improvement opens a way of linking local population level data with tangible change on the ground, for example, addressing child poverty locally by equipping paediatricians with ways to both inquire about poverty and to intervene.<sup>7</sup>

**Question 3: What broader action can I take?**

Beyond the clinical and public health reasons outlined above, perhaps the strongest case for health professionals tackling poverty is a moral one. While it is not possible to lay out the ethical justification in full here, philosophical arguments underline the role of health professionals as ‘physician-citizens’ and ‘health advocates’.<sup>13</sup>

This is important to acknowledge, since acting on the wider determinants of health can raise some challenges and uncertainty, such as the emotional toll on health professionals and reservations about how far our remit should extend when it comes to helping families living in poverty. Faced with these challenges, paediatricians may feel conflicted and disempowered.<sup>8</sup> However, given the social status and power of health professionals, we urge clinicians to think outside of their clinical practice, and work with others in society to tackle the root causes of poverty (box 5).

**Box 5 Wider action for health professionals**

**Stay informed and share learning:**

- ▶ ‘nd Child Health has information about child poverty news, and aims for reducing child poverty nationally (<https://www.rcpch.ac.uk/key-topics/child-poverty>). Its State of Child Health report also provides up-to-date data on the impact of poverty and inequality on child health outcomes (<https://stateofchildhealth.rcpch.ac.uk/>).
- ▶ Attend events such as the RSM Child Health Festival to bridge gaps in knowledge: <https://www.rsm.ac.uk/events/paediatrics-and-child-health/2019-20/pdn16/>

**Local support:**

- ▶ There are many opportunities to get involved in your local area. This could be supporting charities like food banks (<https://www.trusselltrust.org/>), homelessness charities (<https://www.homeless.org.uk/>) and Christians Against Poverty (<https://capuk.org/>). Many of these local charities offer debt counselling, job clubs, life skills help with living on a low income, money management courses and fresh start clubs that help with overcoming addiction.

**Campaigning:**

There are also opportunities to campaign for wider government level changes, by writing to your local MP or partnering with organisations such as:

- ▶ Medact: <https://www.medact.org/>
- ▶ Child Poverty Action Group: <https://cpag.org.uk/>
- ▶ British Association for Child and Adolescent Public Health: <https://www.bacaph.org.uk/>

**CONCLUSION**

Child poverty has detrimental effects on all aspects of child health and well-being. Paediatricians need to be able to identify families living in poverty, and to understand the impact on their clinical presentation and quality of life as a whole. Being familiar with local and national resources, and being equipped to signpost families to them, provides practical and tangible help in the clinical setting. Quality improvement and public health principles can improve care and reduce health inequality across the population we serve. In the long-term, paediatricians must harness their collective voice as a profession in order to influence local and national policy to address child poverty, and transform the lives of vulnerable children and young people. In the words of Michael Marmot, ‘Why treat children only to send them back to the conditions that made them sick?’

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