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**Practising ‘social paediatrics’: what do the
social determinants of child health mean for
professionalism and practice?**

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Practising ‘social paediatrics’: what do the social determinants of child health mean for professionalism and practice?

Abstract

Paediatrics stands at a turning point: today’s health challenges are chronic, complex and connected, but health services are ill-prepared. Given the well-established epidemiological literature which shows that health status is heavily determined by social factors, the profession is now forced to redefine itself. What role should paediatricians play in the health systems of the future? How might the application of a ‘social lens’ and development of ‘social paediatrics’ help the profession to reconsider its roles and responsibilities?

This paper represents a first attempt to respond to these questions. Using child poverty as an example of how socially conscious practice can broaden paediatric interventions for both the individual patient and wider population, it lays the ground for further work, which is both timely and necessary if practitioners are to be properly empowered and equipped to deal with child health in the 21st century.

Key Words: social determinants of health, social lens, socially-conscious practice, social determinants thesis, social paediatrics, paediatric practice, paediatric professionalism, paediatric role, child health, social medicine, medical education

Practising ‘social paediatrics’: what do the social determinants of child health mean for professionalism and practice?

Introduction

The practice of child health in the 21st century would be unrecognizable to the mid-19th century pioneers who first established paediatrics as a specialized field of medicine. The epidemiological transition for under-5 mortality has meant that as mortality rates have declined, the relative contribution of deaths from congenital anomalies, non-communicable diseases and injuries has increased, while the relative contribution from infectious diseases – previously the biggest killers in children – has progressively decreased. Key advances in public health, the anti-microbial revolution and the ability of paediatric medicine to prolong survival for extremely premature infants and those facing otherwise life-threatening diseases have moved paediatrics from the era of addressing immediate health threats with acute and emergency care, to the era of chronic disease management and secondary prevention. We now live in a world where child health services are overwhelmed by record levels of presentations of a multifactorial nature: 1 in 10 children or young people suffer from mental health problems; almost 1 in 3 are obese; rates of alcohol consumption continue to rise; and adolescent mortality rates have remained stagnant for the last 40 years. Clearly, while more children may be surviving in the UK at the beginning of the 21st century, they are certainly not all thriving.

How can the profession best move beyond helping children to survive to helping them thrive?

Re-imagining paediatrics

The chronic, complex and connected nature of health problems faced by paediatrics today necessitates that child health systems evolve toward a third era; one informed by breakthroughs in life-course health science. Life-course health science explains developmental origins of health and disease patterns by elucidating how environmental exposures and social experiences, including those occurring during sensitive periods of development early in life, are embedded in biological and behavioral systems. It builds on the biomedical and biopsychosocial models of disease causation, using recent breakthroughs in social epidemiology to focus more attention on the upstream social, behavioral, and developmental (that is, earlier in the life course) determinants of health. In so doing, the life-course approach takes the social determinants of health seriously, as described by Dr. Nick Spencer in this issue, and forces paediatricians at the beginning of the 21st century to ask: What is

our purpose? What are the goals of child health professionals? How might our methods change in accordance with that?

This challenge forms our starting point for two reasons. First, how we define paediatrics determines how it regards its mission and how it proceeds to fulfill it. If care is directed solely at the domain of biological dysfunction, death, and dying, then the tools of clinical science are oriented towards that domain. If, however, clinical paediatrics directs itself to health, wellbeing and the whole person - not just to the biology of disease - then these tools must be coupled not only to a humane attitude of care to appropriately respond to the inner worlds of our patients, but also to the understanding that patients do not exist in isolation: each is situated within a particular set of material and social circumstances which are salient for health. Of course, an emphasis on the biomedical makes sense in some situations, for example in medical emergencies, where life-saving and survival are prime. However, the contemporary medical enterprise must also be about helping people to thrive and live well throughout the course of their lives. Second, making the significant shift from a health care system focused on producing *medical care* toward a health system focused on supporting *healthy lives* is unlikely to succeed without buy in from those who work in the system. Part of the work in reimagining what child health in the 21st century will look like needs to come from paediatricians themselves.

The social determinants thesis – and the ears of the hippopotamus

If we want to re-imagine paediatrics paying attention to the social determinants of health is a good place to start. Here, “the ears of the hippopotamus”, an aphorism of the global south exchangeable for “the tip of the iceberg”, provides a useful analogy. While surface issues associated with survival and specific disease entities are, much like the ears of the hippopotamus, easy to fixate on, the social determinants thesis - which is based on decades-worth of robust epidemiologic evidence - states that most disease is attributable to the social conditions in which people live and work. As Dr. Spencer lays out in his paper, the social patterning of disease is responsible for substantial mortality and morbidity among children in both poor and rich nations. Acknowledged social determinants of health - including ethnicity, socio-economic class, occupation, and the use of alcohol and tobacco - influence the effectiveness of health care delivery. But other social factors, such as the ability to afford medications, access to transportation, available time, and competing priorities, may influence health outcomes even more. Thus the deeper, more difficult to reach and much more dangerous hidden threats lurking beneath the surface that constitute the bulk of health problems today only come to light when the social dimensions of health and illness are properly considered.

Applying a social scientific perspective - or ‘social lens’ - to medicine orientates patient care towards achieving more sustainable and equitable health outcomes. The practice of “social medicine” elucidates how patients’ environments influence their attitudes and behaviors, and how patients’ agency — the ability to translate their values and choices into action — is constrained by challenging social environments.

Beck (2016) estimates that around 20% of paediatric presentations stem primarily from social problems. Paediatric care is frequently the point of first contact between healthcare services and children and young people with health and social problems. Given that adverse early life environments affect children's later life outcomes, paediatricians are ideally placed to identify those most at risk of later disease and to facilitate interventions for prevention, support and solidarity.

Medical institutions worldwide affirm this view, encouraging all doctors to focus “not only on individual behaviours, but to address the social and economic circumstances that give rise to premature ill health”. The American Academy of Pediatrics recently called for paediatricians to routinely screen for child poverty and address socio-economic deprivation, while paediatric trainees in the UK will know that the curricular requirements of the Royal College of Paediatrics and Child Health (RCPCH) call for a wide range of skills and knowledge around the social and psychological aspects of paediatric care (Table 1). However, research conducted by one of the authors among UK paediatricians reveals that while paediatricians are highly aware of the relevance of social determinants to their work, they feel disempowered to tackle them, and thus unable to meet such recommendations. Instead, they feel conflicted about what they should do and how far this role ought to extend.

Despite the strong case for its existence, the practice of “social paediatrics” is yet to be fully realized. Other than rhetorical support, there has been no clear guidance delimiting new roles for paediatricians, let alone the kinds of tasks such roles would entail, and nor has there been a discussion of the ethical basis and implications of such changes.

What does ‘social paediatrics’ look like?

The implications of the social determinants thesis for paediatric practice and professionalism should be considered as a matter of urgency. It would be easy to see patients with complex social situations as a burden — requiring extra work that is neither rewarded nor central to core clinical expertise. It is also understandable that since the social determinants are distal ‘causes of causes’ acting over the course of individual lives, unseen by the paediatrician and profoundly influenced by social and economic political decisions, they seem beyond the control of individual practitioners.

Rather than despairing at the scale of the challenge, we suggest paediatricians should take inspiration from the social determinants thesis; the proper application of a social lens presents opportunities for alternative avenues for socially conscious paediatric professionalism, opening up action both at the level of the presenting patient *and* at the level of the wider community and population at large.

To consider how a social lens might change paediatric practice we can look to a worked up example for child poverty developed with colleagues at the British Association of Child and Adolescent Health (BACAPH), a membership organization

for those interested in promoting the health and wellbeing of all children and young people (Fig 2a&b).

1. At the level of the individual and interpersonal

Understanding Social History

Obtaining a more appropriate and comprehensive social history enables proper assessment of a child or young person's social environment. Many social barriers exist between patients and health professionals, but deliberate inquiry into the social environment – with careful attention to race, culture, gender and class - allows clinicians to understand behaviors such as non-adherence to treatment plans, missed appointments, or failure to fill prescriptions not as products of ignorance or willful misbehavior but rather as results of the complicated interplay of individual factors with a complex social environment.

Relevant to child poverty, this might include recording household income. Paediatricians would be better able to: offer health and lifestyle advice suited to a family's budget; identify families for whom prescription charges (or other healthcare-related costs) may represent a challenge to adherence; and ensure patients are accessing community resources that could be helpful to them and state benefits to which they may be entitled. Greater sensitivity towards household income could directly improve the quality of health care received. Instead of adhering to guidelines or protocols unconditionally, a social lens encourages health professionals to balance treatment efficacy with patient preference and feasibility; for the patient, care becomes more humane.

Refocusing research and quality improvement

It is a part of the duty of all health professionals to engage in activities that are not strictly clinical and yet have implications for patient care or service provision. These include participation in research and local quality improvement. While lip service to the social determinants and health inequalities is paid at policy and guideline level, how far does this translate into individual practitioner behaviour? A social lens might help doctors themselves to engage in the kind of service improvement projects that explicitly attend to and address these issues, thus realising aspirations set at higher levels. This includes, for instance, highlighting gaps in service provision and inequities of access to care for certain social groups. For example, a study might find that visits to hospital for medical appointments are prohibitively expensive, preventing some families from receiving optimal care. Collection of local data on key child health indicators not only helps to shape services but also becomes useful for broader advocacy efforts.

Social Prescribing

Social prescribing is a way of linking patients with sources of support within the community. Rather than a prescription for a medication, it provides paediatricians (as well as GPs and nurses) with a non-medical referral option that can operate

alongside existing treatments to improve health and wellbeing. It seeks to address people's needs in a holistic way and to support individuals to take greater control of their own health. For long-lasting success, this model necessitates new roles for social prescribing or wellbeing co-ordinators, whose responsibility it is to help coach patients and families to better health.

Sport, cycling, walking, creative arts, volunteering and dancing are all examples of activities for which a social prescription may be given. Social problems, such as child poverty, however, can preclude the uptake of such activities. Thus, by opening up non-medical interventions to deprived families, social prescribing can help to address child health inequalities. While the evidence base for social prescribing has yet to be established, the potential for cost-effective health benefits and reduction of pressure on existing health systems has meant growing interest from service commissioning bodies.

2. At the level of local service provision

Applying a social lens to paediatrics necessitates a reframing of the relationships, structures and roles of the medical, nursing and allied teams in child health.

The RCPCH curriculum states that a key aspect of the role for paediatricians is to “work in multidisciplinary teams and with colleagues from a wide range of professional groups in hospitals, general practice and in the community, in social services and schools and with the voluntary sector.”

A social lens encourages the removal of barriers to care, greater respect for the autonomy of patients, and the development of more collaborative ways of working for child health professionals. Indeed children and young people's services in the UK are increasingly seeing the introduction of new models of care designed to embody these more socially conscious values. Examples include: locally integrated care models where the boundaries between primary and secondary care are blurred; community empowerment and engagement through the co-creation of health systems; and the reframing of inter-professional relations, for instance in the shifting of traditional tasks and responsibilities from doctors to nurses, or through the creation of child health 'teams' or 'hubs'. For example, having identified the expense and inconvenience of travel to multiple appointments as a potential barrier to those living in poverty, health professionals could approach local organisations and service providers (such as Citizen's Advice, social services and/or allied medical professionals) to develop a formal, streamlined referral system or to establish more accessible, co-located services.

A social perspective can therefore prompt reconsideration of what child health services look like. Insights from the social sciences help us to question traditional hierarchies and power relations within and between health professions. This is vital if, as the RCPCH curriculum suggests, paediatricians are to “take on differing and complementary roles within the different communities of practice within which they work, in hospitals, general practice and in the community, in social services and

schools” and to “be more willing and better able to access multidisciplinary input in a non-hierarchical way, such as psychological help, for patients we might previously have dismissed”. Placing the needs of the child and family at the centre of child health practice means focusing on whether the best care is being delivered by the right combination of people, at the right place and at the right time.

A social lens also helps health professionals to understand themselves as social beings and the effects their own work environments have on their ability to do their jobs and function as healthy persons. Thus, as well as reconfiguring services to benefit patients in a direct way, reconfiguration could be partly aimed at producing a more humane working environment, which thereby better serves patients. For example, recognising the importance of being able to give patients enough time in their consultations to do justice to a social history, health professionals might resist management imperatives to shorter consultation times or rapid turnover by organising collectively at a local or regional level, making the case for different working conditions in the interests both of patient care and health worker wellbeing.

3. At the level of national policy and advocacy

The safeguarding of children must also include protecting children from the adverse effects of social disadvantage. The RCPCH states that, “Paediatricians are committed to a policy of advocacy for a healthy lifestyle in children and young people and for the protection of their rights.” To fully realize this goal, paediatricians need to “understand how local and national policy initiatives impact on medical practice and social health and wellbeing”. For this, the profession must advocate first for their own education and training to reflect the social nature of health problems, if they are to be able to respond appropriately. Currently, training and experience is largely directed towards diagnosing and managing medical conditions in individual patients; limited emphasis is given to how health is generated at societal and population level. For social paediatrics to become the norm, a broadening of medical education is needed that incorporates the diverse capabilities necessary for professionals to competently manage this element of their job – drawing on knowledge of political economy, public health, and the humanities and social sciences.

Armed with this knowledge, paediatricians will be in a better position to advocate for children and their families at both local and national levels. For instance, the strategic collection and deployment of key statistics can help guide not only the commissioning of local services, but also the implementation of national health and social policy. This enables us to appeal to local MPs, and to organise with fellow paediatricians collectively to make the case for improvements in health care and social conditions for patients. The joint child poverty campaign between BACAPH, the RCPCH and the Child Poverty Action Group (CPAG), for example, demonstrates how working across sectors and at different levels within child health can be effective.

The challenges of 'socially-conscious practice'

While adopting a social lens presents opportunities to develop more responsive, integrated and outward looking child health, realising social paediatrics in practice will often mean confronting significant political and ethical challenges.

A key element of a social paediatrics is its potential to usher in new roles for professionals, patients and stakeholders, creating fresh possibilities for their identities and relationships. Models of care involving integration and co-creation, for instance, could therefore disrupt and potentially transform the professional role of doctors by challenging them to continuously attend to, and negotiate, diverse interests and perspectives with respect to concerns both within and beyond the clinical terrain.

One can expect that expanding the role of paediatricians will introduce tensions of various types. For instance, professionals will need to reconsider how far their practice is oriented towards the patient in front of them or the population at large. What harms could increasingly socially oriented medicine do to the doctor-patient relationship or to the broader relationships of trust between doctors and communities? Would individual patients feel short changed by socially conscious doctors who, whilst fostering patient-centred care on the one hand, were also seeking to consider the interests of the wider population on the other? Similarly, could information elicited from social histories such as income level or migration status be seen as unreasonably intrusive, or appropriated for less benign purposes such as to check up on entitlements to state benefits or the right to remain?

Another set of potential challenges is more pragmatic in nature. It may be that a more social role would place such heavy burdens on practitioners with regard to time and volume of work, that while desirable in an ideal situation, it could be practically untenable. Indeed, for socially conscious practice to succeed, there need to be system-level policies that assist, validate and reward professionals for attempting to fully realise these professional obligations. As this is far from a given, it is something that paediatricians would have to insist on alongside fleshing out socially conscious practice.

The reality of broadening and deepening the paediatric role has yet to be worked out. This paper merely seeks to introduce areas of critical reflection about some of the related opportunities and challenges. Research about the impact of evolving roles of paediatricians in proposed new models of care is lacking, and yet is clearly necessary if professional practice is to be able to keep pace with pressures on health systems.

Conclusion

Social problems affect children and young people's health and the effectiveness of their treatment: we simply cannot afford to ignore them in assessments and treatment plans if we hope to improve outcomes, reduce costs, and improve patient satisfaction. A clinician's acknowledgment of social forces can strengthen their therapeutic alliance with patients. Patients and families know paediatricians cannot alleviate their poverty, obesity, or mental health burdens, but empathy and concern shown by a clinician who explicitly addresses them constitute powerful medicine. Crucially, a social lens enables paediatricians to see beyond and stretch the limits of their clinical roles to consider alternative avenues for fully realizing their professional obligations to uphold and promote child health.

Despite the positive rhetoric, truly socially conscious medical practice is currently far from mainstream. While it may be a discomfiting prospect to many, discomfort is poor justification for dismissing the case for evolving paediatricians' roles. If we continue to avoid truths about the extent of health inequalities in the UK, close our eyes to the burden of disease caused by lives blighted from underlying social inequities, and fail to deliver appropriate clinical, professional and public health responses, the future – and patients - will not judge us well.

Paediatrics has a track-record for transforming the medical profession: the primacy of patient rights and the patient-centred care movement result from reform originating in paediatrics. By tackling 21st century health challenges with a social lens, paediatrics could be poised once more to lead professional change.

PRACTICE POINTS

- Around 20% of paediatric presentations stem primarily from social problems; we simply cannot afford to ignore the social dimensions of children and young people's health.
- Social paediatrics is the application of a social scientific perspective - or a 'social lens' - to paediatric medicine, orientating patient care towards achieving more sustainable and equitable health outcomes.
- Social paediatrics would have implications across all levels of practice and professionalism: 1) At the level of the individual and interpersonal; 2) At the level of local service provision; and 3) At the level of national policy and advocacy.
- Realising social paediatrics in practice will often mean confronting significant political and ethical challenges - but as yet, there has been no clear guidance delimiting what social paediatrics might mean in terms of new roles for paediatricians. This gap threatens the ability of the profession to keep pace with health system reform in the 21st century, and needs to be filled as a matter of urgency.

Further Reading

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Online Resources:

British Association for Child and Adolescent Public Health - Child poverty campaign:
<http://www.bacaph.org.uk/advocacy/child-poverty-introduction>

FIGURES AND TABLES

Table 1: Paediatric competencies relating directly to the social dimensions of health and illness extracted from RCPCH Curriculum (2010)

	LEVEL 1 (ST 1-3)	LEVEL 2 (ST 4-6)	LEVEL 3 (ST 6-8)
DUTIES OF A DOCTOR	Understand the responsibility of paediatricians to consider all aspects of a child's well-being including biological, psychological and social factors	Consider all aspects of a child's well-being including biological, psychological and social factors	Understand the duty of all professionals working with children to report concerns about child protection issues to Social Services
GOOD CLINICAL CARE	Be able to take a history accurately and sensitively that routinely includes biological, psychological, educational and social factors in the child and family	Understand the possible medical and psychosocial reasons which might lie behind a patient's difficult behaviour	Know when to gather information from other professionals e.g. those working in education, social work or from others who see the child in a variety of settings
MAINTAINING GOOD MEDICAL PRACTICE	<ul style="list-style-type: none"> Understand the variations in relationship between physical, emotional, intellectual and social factors and their influence on development and health Be aware of the indices of social deprivation 	<ul style="list-style-type: none"> Be able to write reports that explain the condition of a child or young person to non-health personnel working in the Courts, social services or education Know how healthcare services relate to national and local education and social services 	<ul style="list-style-type: none"> Be able to assess the effects of recurrent or chronic illness and its treatment on growth, psycho-social, emotional, physical and sexual development and have strategies to minimise adverse effects Be able to discuss an assessment of the psychosocial health of a child or young person with the multi-disciplinary team while respecting patient confidentiality
TEACHING, TRAINING, ASSESSING, APPRAISING		Contribute to the training of medical students and other professionals, e.g. nurses, physiotherapists, dieticians and others outside their specialty such as teachers and social workers	Take responsibility for the training, supervision and assessment of medical students other professionals e.g. nurses, physiotherapists, dieticians and others outside their specialty such as teachers and social workers
WORKING WITH COLLEAGUES	<ul style="list-style-type: none"> Be able to take on differing and complementary roles within different communities of practice Understand how national and local policy initiatives impact on medical practice and social health and well being 	Have experience of working with multi-agency teams, e.g. social workers and teachers and have developed an awareness of their own role within the team and of the skills and expertise of others	<ul style="list-style-type: none"> Be able to work effectively in multi-agency teams, for example, with social workers and teachers and have developed an awareness of their role within the team and of the skills and expertise of others Understand the relationship between local health, educational and social service provision

Fig. 2a: Local actions for paediatricians to tackle poverty by the British Association of Child and Adolescent Health (BACAPH) (with permission from Dr. Caoimhe McKenna & Dr. Guddi Singh)

WHAT CAN HEALTH PROFESSIONALS DO LOCALLY TO TACKLE CHILD POVERTY?

KNOWLEDGE

- ROUTINELY ASK ABOUT IT**

In our social history we routinely ask about risk factors for child ill-health, such as smoking & housing conditions. Health professionals should consider expanding their social history to include financial difficulties and access to welfare. As well as helping to develop a holistic understanding of the child's clinical presentation, this information may identify parents who are unaware of their entitlement to financial support.

QUESTIONS YOU MIGHT ASK:

 - Do you have trouble making ends meet?
 - Do you have trouble feeding your family / heating your home?
 - Do you receive any welfare or benefits?
 - Do you have a safe and clean place to live?
- EDUCATE YOURSELF ABOUT WELFARE ENTITLEMENT**

Health professionals should be aware of the basic welfare and benefit allowances which may apply to their patients, or be capable of directing parents to a service which can provide this information (e.g. Citizen's Advice). A comprehensive list of benefit allowances, which apply to children and families, are available online (<https://www.gov.uk/browse/benefits/families>).
- FIND OUT ABOUT LOCAL SERVICES THAT CAN HELP FAMILIES**



Health professionals should aim to build and maintain an up-to-date and comprehensive list of local services which support families. This should be readily available in all clinical areas and accessible to parents. Support services may include organisations which provide free legal, debt or housing advice; local foodbanks; children's centres and other community groups.
- CONTRIBUTE TO THE EDUCATION OF TRAINEES AND COLLEAGUES**

It is vital that health professionals, at all levels, are aware of the impact of child poverty on health. Health professionals should seize opportunities to educate and raise awareness among their juniors and colleagues. This should include practical advice on what health professionals can do to tackle child poverty and its consequences.
- LEARN ABOUT THE POPULATION IN YOUR AREA**

There are several useful resources online which can assist you in learning about the population of children in your local area. ChiMat (<http://atlas.chimat.org.uk/IAS/>) provides easily accessible statistics summarising key child health indicators, including child poverty, according to area. This information can be very useful when educating your colleagues or 'building a case' to discuss with your MP (see below).



Fig 2b: Wider scale actions for paediatricians to tackle poverty by the British Association of Child and Adolescent Health (BACAPH) (with permission from Dr. Caoimhe McKenna & Dr. Guddi Singh)

MULTI-AGENCY WORKING

- CO-LOCATION OF HEALTH AND ADVICE SERVICES**

Health services across the UK have successfully collaborated with external organisations to provide advice and support services alongside standard health services. Health professionals may wish to approach local organisations, such as the Citizen's Advice, to establish co-located services or to develop a formal referral system.
- CREATING A MULTIAGENCY NETWORK**

There are likely to be many organisations in your local area who are also trying to tackle child poverty and its consequences (e.g. health visitors, schools, social workers, local charities). Health professionals may benefit from 'joining forces' with these organisations to create a collaborative network. This may simply be an open forum for communication, or perhaps a more formal partnership with regular meetings, to share information and discuss strategies to tackle child poverty in your area.



ADVOCACY

- WORKING WITH COMMISSIONERS**

Among local commissioning groups, health professionals should advocate for those services which are known to help negate the negative consequences of child poverty; for example, high-quality care for women during pregnancy, investment in the early years and high-quality home visiting services.
- WORKING WITH POLICY MAKERS**

Reducing child poverty will ultimately require action at a national level. Health professionals have a duty to advocate for their patients. At a local level, health professionals can share concerns with their MP, either by writing a letter or by meeting with their representative in person.



- RAISING AWARENESS IN YOUR AREA**

Health professionals can also use their voice to raise awareness of child poverty on multiple platforms. This might include writing a letter to your local newspaper or presenting in a variety of community forums (e.g. schools, church groups, constituency party member meetings, other community gatherings). Not only will this help to raise awareness of child poverty in your area, it may also initiate a dialogue on what can be done to tackle the issue.
- SHARE YOUR EXPERIENCE WITH OTHER ADVOCATES**

Organisations such as the Royal College of Paediatrics and Child Health, BACAPH and the Faculty of Public Health have extensive experience in advocating for children and established channels of influence. Health professionals may wish to establish links with these organisations to share your local experience and support relevant campaigns.

