Social, Economic, and Political Determinants of Child Health

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ABSTRACT. The Issue. This article presents a brief overview of the effects of social, economic, and political factors on child health. It starts by highlighting child poverty in rich nations, in particular the United Kingdom and the United States, and identifies the economic and political factors underlying this phenomenon. The evidence linking socioeconomic status and child health is briefly reviewed with particular attention to birth weight and child mental health—2 of the most important public health challenges in the 21st century. The implications for pediatricians of high levels of child poverty and the effect that these have on children are discussed. Pediatr ics 2003;112:704–706; social, economic, political, child poverty, advocacy.

ABBREVIATION. OECD, Organization of Economic Cooperation and Development.

CHILD POVERTY IN RICH NATIONS

Child poverty levels (as measured by percentage of children in households with <50% of the national median income) in the United Kingdom (19.4%) and the United States (22.4%) are among the highest in the Organization of Economic Cooperation and Development (OECD) countries.1 This is in sharp contrast to countries such as Sweden, Norway, and Belgium that have child poverty rates below 5%.1 For example, Sweden reduces “market child poverty” (the child poverty level before tax and credit transfers) by as much as 20%, whereas the United States, starting from higher market child poverty, reduces it by as little as 5%.

There has been a sharp increase in child poverty rates in the United Kingdom since 1979. The 1980s also saw a rise in child poverty rates in the United States. These increases in child poverty were accompanied by an increase in income inequalities, a phenomenon noted in many industrial countries during the past 20 years. Children are now the largest single group living in poverty in many countries. There also has been a “feminization” of poverty—lone female parents have very high rates of poverty in all OECD countries, as well as in the United States. Across the OECD countries, children in lone-parent households are 4 times more likely to be living in poverty.1

Child poverty rates are strongly correlated (positive) with the proportion of households in which no adult is employed and the proportion of full-time workers earning less than two thirds of the national median wage. This suggests that countries with high levels of unemployment among families with children and low-wage economies are likely to have the highest rates of child poverty. The United Kingdom, which has experienced very high levels of unemployment in the past 20 years, had 19% of children living in households with no adult employed in 1999.2 It is important to note that high child poverty rates are not inevitable. They result from deliberate political decisions, usually related to economic and social welfare policies.

SOCIOECONOMIC STATUS AND CHILD HEALTH

Globally and historically, socioeconomic status is among the most important health determinants throughout the life course.3 Young children seem to be particularly vulnerable to the effects of adverse socioeconomic status and poverty. Poverty and low socioeconomic status are associated with higher risk of death in infancy and childhood, chronic childhood illness, and many acute illnesses.3 They are also closely linked with birth weight and child mental health problems.

However, increased risk of some adverse health outcomes is not confined to the extremes of poverty and low socioeconomic status. Many child health outcomes show a social gradient, although the gradient varies by exposure and outcome.4 For some outcomes, the longer the child is exposed to adverse social conditions and the worse the social conditions, the greater the effect.5 Birth weight shows a marked social gradient (Table 1). This has profound effects not only in infancy and childhood but also into adult life.6

Studies show a graded reduction in mean birth weight as the areas of residence become more deprived, as measured by the Townsend Deprivation Index.9 It is not only the most deprived fifth of the infant population that is disadvantaged in terms of birth weight compared with the most privileged—the effect is finely graded by socioeconomic status. These findings contribute to our understanding of the social gradients that are noted across the life course.10

Mental health problems in children also have profound effects across the life course. Figure 1 shows the graded relationship between household income and emotional and behavioral problems in childhood in a recent UK study.11 Again, the effects of income

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are not confined to the poorest group but have a finely graded distribution across the income range. Cumulative and additive risk exposures over time and between generations may contribute to an understanding of these gradients. Health behaviors, such as smoking, and concepts such as “good enough” parenting must be seen within their social, economic, and political context. They are risk factors for adverse outcomes but exert their effects as part of complex pathways working over time, across generations, and at the societal as well as individual level. In addition to recognizing the effects of socioeconomic status on child health, recent studies have demonstrated that socioeconomic status in early childhood has a significant impact on a range of adult health outcomes.

**IMPLICATIONS FOR PEDIATRICIANS**

Pediatricians must develop an awareness and understanding of the social determinants of health if they are to contribute fully to improved child health outcomes. These determinants have been forgotten in medical education and understated in the contemporary climate of biomedical and technologic responses to child illness. I am not suggesting that we should abandon biomedical and technologic advances. However, we need to see health within its social context to understand the impact of social factors on children and on their access and response to biomedical and technologic advances in treatment.

It also is important that pediatricians be aware of the life course implications of early childhood effects of adverse social circumstances and how these stretch into adult life. Addressing chronic illness in adult life is likely to require social and political interventions that reduce the adverse effects of social disadvantage in childhood. It is equally likely that interventions at this level will be required to reduce the prevalence of low birth weight and mental health problems in children.

Practice and service structures must seek to overcome the “inverse care law,” which states that those most at risk and most in need of services are the least likely to access them. This is a particularly pressing issue in the United States, where many children of families with low income have limited access to child health services, but it is also a problem in the United Kingdom despite the universal availability of high-quality pediatric services. Pediatricians have a special responsibility for ensuring that children of families that are poor or have low income have services that are of equal quality to their more privileged peers. Although this may have only a marginal effect on health outcomes, it can be a vital contribution to ensuring that the disadvantage that these children already experience is not exacerbated by lack of access to services.

Child poverty is not an “unmodifiable” variable. The situation of families with children can be improved, but this will require political and economic policies that are, in essence, redistributive. Higher taxes and/or the redistribution of funds to ensure that all families with children have an adequate income will be necessary to ensure improvements in child health (Figs 2 and 3). Given the profound effects of poverty and low income on health in childhood and across the life course, pediatricians and their organizations (local and national) have a critical

<table>
<thead>
<tr>
<th>Enumeration District Quintiles by Townsend Deprivation Index</th>
<th>Mean Birth Weight (All Live) W Midlands 1991–1993</th>
<th>Mean Birth Weight (Singleton Only) Sheffield 1991–1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (least deprived)</td>
<td>3393 g (3386, 3400)</td>
<td>3408 g (3376, 3440)</td>
</tr>
<tr>
<td></td>
<td>([n = 33 513])</td>
<td>([n = 3466])</td>
</tr>
<tr>
<td>2</td>
<td>3380 g (3372, 3388)</td>
<td>3374 g (3340, 3408)</td>
</tr>
<tr>
<td></td>
<td>([n = 31 146])</td>
<td>([n = 3430])</td>
</tr>
<tr>
<td>3</td>
<td>3344 g (3337, 3351)</td>
<td>3319 g (3287, 3351)</td>
</tr>
<tr>
<td></td>
<td>([n = 36 542])</td>
<td>([n = 3372])</td>
</tr>
<tr>
<td>4</td>
<td>3293 g (3287, 3299)</td>
<td>3282 g (3248, 3316)</td>
</tr>
<tr>
<td></td>
<td>([n = 44 757])</td>
<td>([n = 3721])</td>
</tr>
<tr>
<td>5 (most deprived)</td>
<td>3219 g (3213, 3226)</td>
<td>3225 g (3190, 3260)</td>
</tr>
<tr>
<td></td>
<td>([n = 64 073])</td>
<td>([n = 3733])</td>
</tr>
</tbody>
</table>

**TABLE 1.** Social Gradient in Birth Weight in 2 UK Studies7,8

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**Fig 1.** Social gradient in emotional and behavioral problems by annual household income.
role to play in advocating for policies that protect children from a life in poverty. Advocacy can be at an individual, local, national, or international level.15

Pediatricians also have a responsibility to address the inverse care law as it applies to research. The weight of funding and interest in research is concentrated on rare conditions and their cure, while the social determinants of health, a major cause of ill health, receive limited research funding or attention. In conducting sociomedical research, we should bear in mind that social factors exert their effects through complex pathways. The “single cause” fetishism that arises from the germ theory of disease is inadequate to explain many of the adverse health outcomes associated with social inequality. Child health research must pay more attention to socioeconomic status and improve the measures used to study its effects.

CONCLUSIONS

Child poverty is increasing in the United Kingdom and the United States. Given the known impact of social, economic, environmental, and other nonmedical determinants on child health, an impact that continues through adulthood, it is incumbent on pediatrics and pediatricians to focus their efforts on dealing with the root causes of these social injustices. The Royal College of Pediatrics and Child Health and the American Academy of Pediatrics, through this joint Equity Project, should establish the education, practice, and research framework to integrate these issues into the corpus of pediatrics. Much is available to be learned from our mutual experience but also from the efforts of other countries. Advocacy and political resolve will be necessary for success.

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