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The Cost of Living Crisis: What can health professionals do?

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TITLE	The Cost of Living Crisis: What can paediatricians do?
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The Cost of Living Crisis: What can paediatricians do?

Introduction

The UK's 'Cost of Living Crisis' has thrown millions more families into poverty in 2022, delivering an intensifying economic shock that will likely eclipse the financial impact of the pandemic for millions of children, families and communities. But what is the relevance for paediatricians? Written by doctors who spend considerable time confronting social problems from clinical, public health and advocacy perspectives, this article aims to untangle the 'Cost of Living Crisis; (COLC) for those working in child health and seeks to stimulate a meaningful conversation about how we might reimagine paediatrics for life in the 21st century.

Taking the current crisis as our point of departure, we argue that COLC can be best understood as a *crisis of inequality* and that, as such, it is a matter of social justice, with complex origins beyond the shallow media spotlight. We propose that understanding the true 'causes of the causes' of acute social challenges such as COLC is essential for the 21st-century paediatrician, as the impact on child health is deep, wide-ranging and long-lasting. However, the current gap in knowledge and skills in this area leads to disempowerment in the profession.

We end with this provocation: What, after all, does it mean to be a paediatrician in a time of economic crisis? We offer thoughts about how paediatrics might respond to social challenges, such as the COLC, acknowledging that organised and concerted action must be taken both inside and outside of health systems if we are to help bring about the changes that our patients genuinely and urgently need.

What is the "Cost of living crisis" (COLC)?

In the UK, media and public discourse have characterised the cost of living crisis (COLC) as the result of substantial energy price rises and soaring inflation. On 1st October 2022 the cap on household energy bills will be lifted to £3549 per year, up from £1277 just 12 months prior, [1] with inflation now predicted to reach 18% in January 2023 at the time of writing.[2] Both will have devastating implications for the financial security of millions of households and businesses, already reflected in the greatest drop in living standards since records began 60 years ago.[3] The often cited 'heating or eating' dilemma has become an intractable everyday reality for families at the sharp end of

disadvantage; research published this May shows that 2.6 million children report having smaller meals and regularly skip meals altogether.[4]

While the Russian invasion of Ukraine and global supply chain volatility undoubtedly exacerbate economic turmoil, looking beyond the UK shoreline helps to contextualise the issue. While varying degrees of neoliberal economic policy have been adopted the world over, the British public find themselves in an especially precarious situation owing to the extent of deregulation, market and corporate power and ideological stance of the incumbent government. Comparable economies are providing greater stability for households, businesses and communities resulting in little change in living standards in keeping with stronger post-2020 economic recovery. [5,6] Take France for instance, where by August household energy bills had risen by just 4%, compared to 215% across the Channel in the UK, which also, incidenteally, boasts the least energy efficient homes in Western Europe. [7,8]

From this vantage point, demands for lower energy prices are important but simply not enough. Rather, a 'causes of the causes' lens recognises that 40 years of neoliberal political ideology and policy have put profit ahead of people, private wealth ahead of state or common ownership and the class interests of a privileged few ahead of those of wider society. [9] The 'cost of living crisis' has been a chronic lived experience for the poorest long before the media took notice this year. The 'new poor' are being absorbed into the orbit of hardships faced by the 'old poor' and those well accustomed to decades of political dispossession. After all, 4 million children in the UK were already in poverty by 2020 – well before the pandemic and Ukraine war.

Focusing on energy bills and inflation as the drivers of the current crisis is myopic. It turns a blind eye to the converging assault of falling wages, rising rent costs and asset price inflation, growing intergenerational wealth inequality, precarious employment, anti-union laws, cuts to public services, departure from the EU, enclosure of commons and natural resources, and privatisation, deregulation and monopolisation of a fossil-fuel-reliant energy market. [10-17] The true 'causes of the causes' of COLC are not overseas conflict and supply chain disruption, but a history of political choices that reflect an ideology based on social, economic, and environmental injustice.

Thus, the UK's so-called 'cost of living crisis' is really part of a wider social emergency: the 'crisis of inequality'. The resultant outlook for children and the society that surrounds them is bleak, and only rapidly worsens as winter approaches.

What is the impact on child health?

The cost of extreme inequality is paid through countless impacts on child health across the life course. In the context of the COLC, the poorest households are struggling to afford necessities resulting in greater infant mortality, lower birth weights and poorer neurocognitive and social development as well as anxiety, depression and suicide and worse outcomes for those with chronic conditions. Poor health, in turn, impacts the healthcare system. Children from households in areas of greater deprivation are much more likely to attend emergency departments and accrue unplanned hospital admissions. Children experiencing chronic ill health fare worse than those from wealthier backgrounds. [18]

The alarm bells are already ringing as increasing numbers of families find themselves in financial hardship. Research from the Childhood Trust reports a catastrophic picture for children's mental health and wellbeing and a 17% jump in self-harm. [19] Fears of widespread child hunger have sparked calls for universal free school meals as 800,000 children in poverty do not qualify under current benefit regimes. [20]

For health workers in emergency departments, wards and surgeries up and down the country, this crisis of inequality has now become an embedded reality of our daily work; asthma exacerbations owing to damp and unsafe housing, increasing hospital admissions due to malnutrition, and inordinate numbers of young people presenting in acute yet preventable mental health crises.[18] Paediatricians are treating the symptoms of social and economic policy that are fundamentally at odds with the interests of their patients.

The moral and practical considerations for paediatricians addressing inequality

The social, economic and political drivers of inequality remain ascendant, and until there is a significant rethink of the current world order, inequality is here to stay.

Ought doctors to be dealing with economic issues? Economies shape health, and the health of our patients is, after all, the core concern of our profession. That said, a number of cautions deserve serious consideration here.

First, is the contention that doctors should stick to dealing with the medical aspects of patient care. While undergraduate medical training now increasingly makes reference to the social determinants of health, curricula still largely exclude explanations of political economy or critical social science perspectives on health. Moreover, many clinicians may legitimately feel that dealing with social problems is 'not their job'. If medicine's boundaries are to be wider, can they be redrawn without medicine becoming a general

social service for dealing with all the problems people have?

Second, even if there was a legitimate role for doctors on the wider determinants of health, such as economic inequality, many clinicians would argue that there is neither the time nor resource in current health systems to do this role justice. After all, health systems around the world are facing cost crises of their very own; the repeated assaults of the 2008 financial collapse, austerity programmes, and the COVID-19 policy response in the run-up to the current time understandably leads to something of a "crisis fatigue", [21]. Working in these conditions is hard and morale in health services across the world is at an all-time low. [22]

These questions deserve to be - and are being - explored more deeply by the entire profession. In the meantime, we suggest that, regardless of where we are practising, what unites paediatricians globally is that our patients are our first concern. The COLC demonstrates that our patients continue to need us.

We refer you to previous work on medical professionalism and the social determinants for general approaches to this issue. [23, 24] so that we can focus here on the particularities of economic crises. We propose that paediatricians can think of their approach to social problems such as the COLC in two distinct phases, much as they do all medical problems; 'emergency responses' in the acute setting to be accompanied by more slow-burning 'preventive action'. Though by no means exhaustive, Tables 1 and 2 give a flavour of the kinds of action that might result from such an approach.

What does it mean to be a paediatrician in a time of crisis?

'Emergency Responses': From Inside and outside the Clinic

Within healthcare settings, growing interest and energy in healthcare is being directed towards initiatives such as screening for social risk factors, social prescribing and on-site provisioning of resources. [25,26] (See Table 1 for more details.) Taken together, these practices can be understood as medicine's most developed answer to social problems. When handled sensitively, the power of these interventions for bridging sociodemographic divides and empowering patients to better manage their own conditions should not be underestimated. [27]

Health professionals can also take part in emergency responses outside of the clinic. The pandemic response showcased a range of examples such as community mutual aid groups and outreach to improve migrant access to healthcare during the pandemic,

as well as successfully lobbying the government to provide urgent accommodation and support for those experiencing homelessness during COVID-19 lockdown. [28]

As others have argued, "public health problems do not necessarily have effective individual clinical solutions". [29] Attempting to address social problems from the clinic or from a purely acute perspective treats the symptoms but not the underlying cause; these are sticking plaster tools for emergency situations. For more far-reaching and transformational outcomes for child health, a preventive approach is required.

'Preventive Action and Addressing Chronic Challenges'

Embedded social challenges such as inequality and the COLC will not be solved by the health system alone. Instead what is required is for society to reorganise itself in ways that genuinely allow people to live happy, healthy lives, and that ultimately requires addressing the social determinants of health through political and societal change. We suggest that medical professionals have a responsibility to support these efforts in two ways: through 'profession building' and 'society building' respectively (see Table 2).

1) ***Profession Building***

We must first set our own house in order before we can put the world to rights. It is our responsibility to demand better, both in terms of our training and our working conditions and resources, to support professional aspirations to truly act in the best and collective interests of our patients. (see Table 2)

2) ***Society Building***

How can paediatricians aid in the process of building a society fit for children and young people to thrive? As individual clinicians, it is easy to feel overwhelmed and insignificant, but for our patients, nothing could be further from the truth. As argued elsewhere, "Doctors carry significant social and cultural capital; our messages are listened to". [24] Paediatricians are uniquely positioned to function as public advocates for child health. Public trust in doctors is very high; to the public, doctors are a credible source of information. [30] Given their social standing, doctors enjoy an unusual degree of access to policymakers, local and national leaders, and citizens; thus, they possess a great deal of leverage in influencing public processes and priorities. Never underestimate the power of the clinician to help shape public discourse around an issue; your voice counts and now is a critical time to use it. Table 2 draws on examples from around the world to help illustrate how doctors can be part of, and help to accelerate, change.

Conclusion

The UK's Cost of Living Crisis has thrown millions more families into poverty overnight, further stripping their lives of dignity and the capabilities to grow and live healthily. While the job of addressing economic crises such as COLC ought not to be left solely to health workers, the paediatric profession must act. For even if policies were introduced to address the high cost of energy bills, what is needed is a deeper, wholesale change in how the economy and society is organised.

While much has been written about how paediatricians might engage with the social determinants of health, we propose that addressing economic crises such as COLC calls for a different approach. Doctors are adept at 'emergency responses', which are available even here. But we propose that realigning paediatric professional roles and our purpose so that they are directed towards addressing both the true 'causes of the causes' - as well as the effects - of the social, economic, political and environmental determinants of health is essential if we are to challenge an economic and professional paradigm that encourages reformist tinkering at the edges when what is needed is something more transformational. [31]

Indeed, what is required is a willingness on the part of the paediatric profession to completely question and re-envision their collective professional roles, both inside and outside of the health system to help address the great challenges of our time. This is a big task and one that needs the whole profession to mobilise and come together. The COLC, and inequality more generally, presents an opportunity to proactively reshape professionalism to better suit 21st-century needs of our patients. If not now, when?

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Table 1: "*Emergency Responses': For Acute Crises of Inequality*

EMERGENCY RESPONSES	**What is it?**	**How to do it**
Screening for social risk factors	The identification of patients who may benefit from greater support in one or more areas, including poverty, food insecurity, violence, unemployment, and housing problems.	Do ask, but ask sensitively. A useful resource of validated and adapted tools for this purpose can be found at: https://www.whamproject.co.uk/ As part of this we advocate gathering data through this process to make visible to local policymakers the need for greater support for children and families.
Social prescribing	Referral for non-medical interventions to address the wider determinants of health identified through screening	Referral pathways may not exist; demand them locally; connect and partner with local third sector organisations for more joined-up care
On-Site Provision	Some health care settings now hold basic provisions, including food, clothing and sanitary products, or access to community-based workers for children and families in desperate situations and without recourse to funds. ED visits can represent a 'cry for help'. For suitable patients presenting in crisis, a referral to other services for follow up can help get support to the young people when it is most needed.	Examples: fresh fruit in clinics; grab bags for vulnerable children; on-site financial advisers or link workers to facilitate access to benefits and local resources including food banks Paediatric ED referral pathways connect medical services with a wider network of support for children and young people in need. E.g OASIS youth violence and harm reduction support

Table 2: *"Preventive Action" for Addressing Chronic Inequality*

PREVENTIVE ACTIONS	Example	Notes
Profession Building	Training	Many paediatricians experience frustration and helplessness in the face of social problems such as the COLC, reporting that their training has ill-equipped them for the world their patients must survive. Despite a year-on-year increase in the incidence of poverty-related disease in UK child health, [32] paediatric training fails to provide clinicians with the specialist skills needed to recognise the signs and symptoms related to deprivation. [24] In addition, a failure to acknowledge the importance of - not to mention provide rigorous structural analysis of - the social determinants of health leads to obvious and glaring gaps in both undergraduate curricula and postgraduate training. As a result, the paediatric workforce must look outside of well-worn paths if they want to make up for the public health, policy or economic understanding that is required. In the UK, the Royal College of Paediatrics and Child Health is the normative and standard-setting body for paediatricians. '*Progress Plus'* is the most recent instantiation of the curriculum that all paediatricians in the UK (and elsewhere in the world) are expected to meet by the end of their training. Whilst we welcome the increased reference to 'public health' competencies, it is noteworthy that the accompanying guidance document to the curriculum, *"Paediatrician of the future: Delivering really good training"*, fails to mention the idea of 'advocacy' for paediatricians even once in all of its fifty pages, and the term 'social determinants' only twice. [33] In some senses, this reflects the long-standing blindness of the modern medical profession in relation to wider conceptions of health and thus the role of doctors in society.

		Education is a political act; by eliding politics, doctors' training is denuded of meaning. [34] The result for ordinary paediatricians who wish to pursue professional commitments to help patients who are suffering under social emergencies such as COLC is that they have little to go on. Holmes and colleagues argue that such a blindspot means that medical care ignores social forces, resulting in 'misdiagnosis, mistreatment and harm'. [35]
	Working Conditions and Culture	Professionalism is much more than narrow competencies and a checklist of skills. It is also an ethical and political orientation about *how* the job is done and how one views one's *role in society*, as well as the *supporting conditions* in which to enact it. [36] In the current climate, even if there were better institutional guidance about addressing social problems such as COLC, paediatricians face other significant obstacles. Rota gaps, heavy workloads, and a culture of training that offer little flexibility or creativity all serve to raise the barrier to entry for clinicians engaging in anything beyond their skeleton job descriptions. What are we doing as a profession to give ourselves the space to make a meaningful difference in children's lives? The RCPCH and medical institutions, in general, have done little to challenge the policies of cuts, closure and commodification that have made working conditions in the NHS increasingly constrained and pressured in recent decades. If we are to be able to act on behalf of our patients, we have to challenge the limits of our workplaces and argue for the time and space to be able to do so safely and effectively, and for a culture that facilitates collective action.
	Health Systems	Children and Young People's Health Partnership

		Lambeth and Southwark - an integrated model of care across primary, secondary and community settings that helps to deliver care to children with the greatest needs in settings more conducive to better outcomes in the longer term by re-thinking how to meet patients and families where they are, closer to home, at schools and in the community. https://arc-sl.nihr.ac.uk/research-and-implementation/our-research-areas/children-and-young-people/children-and-young-peoples
Society Building	Protest/ Direct Action and Raising the Alarm	Doctors and health professionals marching in protest over the privatisation and under-resourcing of the health system Medics, many identifying as gay, supporting the activism of the ACT UP campaign for the research, development and equitable distribution of ART medications during the HIV/AIDS pandemic of the 80s Doctors and health professionals undertake a range of activities including protest and non-violent civil disobedience as well as media work to draw attention to the urgent need to structurally address the climate crisis. Healthcare workers' participation in protest in solidarity with social justice causes relating to fossil fuel extraction and the expansion of fossil fuel infrastructure as well as provision of medical support e.g Mni Wichoni Health Circle and Standing Rock and Standing Rock Resistance Paediatricians cycle to COP26 to raise the alarm of the impact of the climate crisis on child health
	Lobbying and Legal Frameworks	Lobbying for changes to the law - doctors in Manchester lobbied for the introductions of child labour laws and protections to mitigate the worst of exploitative labour practices in cotton factories during the industrial revolution

		Paediatricians lobby RCPCH to end receipt of funding from formula milk companies Doctors taking the government to court over government failure to meet climate and emissions targets RCPCH lobbying the government to end NHS charging
	Industrial Action	Under-resourced health systems are an economic justice and health justice issue. Supporting workers in securing decent pay that meets needs and living costs. On our doorstep; nurses, allied health professionals and colleagues who have seen their contracts outsourced to profit making companies e.g 2022 GOSH security guards strike. Beyond this HCWs must show solidarity with fellow workers especially during 'hot strike summer' where workers from a range of sectors (transport, communications, postal etc) are on strike action to demand pay that can keep up with inflation as well as better conditions Berlin - an inclusive hospital movement 'krankenhausbewegung' aimed at securing better working for conditions for all led to a 1 month health system general strike Nurses in Minnesota, USA, are going on strike this September due to insecure work, poor conditions and pay that is not meeting basic needs, all of which are contributing towards workforce depletion with likely impacts on patient care
	Solidarity/ Mutual Aid and Collaborative Work	Feeding into the work of third sector organisations, either developing the connections between child poverty and ill health to build the evidence base and shape policy or through campaigning and building power in communities. Local: Home-Start, Children North East, Everyone's Children Glasgow

		National: End Child Poverty Coalition, CPAG, Trussell Trust, The Childhood Trust, The Children's Society, Action for Children, Child of the North, Save the Children, UNICEF UK, APPG Poverty International: ISSOP, International Pediatrics Association, UNICEF, Medact,, Save the Children, MSF, Joseph Rowntree Foundation, Lancet Migration, CHIFA, Doctors of the World. Example of a collaboration: RCPCH and CPAG surveying the experiences of frontline paediatricians concerning poverty, the impact on child health and use of health systems
	Political Education	Medact - doctors, healthcare workers and researchers produced a range of resources for political education for fellow health workers on the economic determinants of health. 3 zines covered, liveable incomes, secure housing and tax justice as three areas of political education and campaigning Patient's Not Passports produced an advocacy toolkit for health workers and community members to support those facing NHS charging as well as immigration checks Political education, political change and the electorate - health workers providing political education on health justice at national political events, engaging the public in a radical re-imagining of health and abolishing systems and structures of sickness and using health as a means of building power
	Changing the culture	Using our social and cultural capital to speak out about economic inequality in newspapers, on the radio, television and social media.
	Voting	Political choice is exercised by the indiivdual as much as by policy makers; what we do in the voting booth counts. We ought to choose candidates who hold poicies that will support child health and ideals for social justice at the centre of their work. In addition, as paediatricians, we can help young people to use their voice. We can support young

		people to vote, help to lower voting age to 16 in England, and defend their political rights.

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TITLE	The Cost of Living Crisis: What can paediatricians do? A UK crisis with global implications
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The Cost of Living Crisis: What can paediatricians do? A UK crisis with global implications

Abstract

The UK's 'Cost of Living Crisis' has thrown millions of families into poverty in 2022, delivering an intensifying economic shock that will likely eclipse the financial impact of the global coronavirus pandemic for children, families and communities alike. But what is the relevance for paediatricians? Written by doctors who spend considerable time confronting social problems from clinical, public health and advocacy perspectives, this article aims to untangle the 'Cost of Living Crisis' (COLC) for those working in child health and seeks to stimulate a meaningful conversation about how we might reimagine paediatrics for life in the 21st century.

Taking the current crisis as our point of departure, we argue that the UK's COLC can be best understood as a *crisis of inequality* which has been created through social, economic and political processes that were not inevitable. The health impacts, then, are a matter of health equity and social justice. While the acuity of the crisis unfolding in the UK garners much attention, the implications are global with lessons for paediatricians everywhere. We propose that using a *'social lens'* for understanding the true 'causes of the causes' of complex challenges such as COLC is essential for the 21st-century paediatrician, as the consequences for child health is deep, wide-ranging and long-lasting. However, the current gap in knowledge, skills and infrastructure in this area leads to disempowerment in the profession.

We end with this provocation: What, after all, does it mean to be a paediatrician in a time of economic crisis? We offer thoughts about how paediatrics might respond to social challenges, such as the COLC, acknowledging that organised and concerted action must be taken both inside and outside of health systems if we are to help bring about the changes that our patients and their surrounding communities urgently need.

What is the "Cost of living crisis" (COLC)?

In the UK, media and public discourse have characterised the 'cost of living crisis' (COLC) as the result of substantial energy price rises and soaring inflation. Both are already having devastating implications for the financial security of millions of households and businesses reflected in the greatest drop in living

standards since records began 60 years ago.[1] The often cited 'heating or eating' dilemma has become an intractable everyday reality for families at the sharp end of disadvantage; research published in May 2022 shows that 2.6 million children report having smaller meals and regularly skip meals altogether.[2]

The UK's so-called 'cost of living crisis' is really part of a wider social, economic and political emergency: what we are calling a *crisis of inequality'*. The arising differences in health, wealth and power are not simply an imbalance, or result of a passive natural process, but instead are the result of unjust and unfair political and social processes. Health inequalities result from political and social *inequities*.[3] The resultant outlook for children and the society that surrounds them is bleak and will only rapidly worsen as winter approaches.

The Russian invasion of Ukraine and global supply chain volatility undoubtedly exacerbates economic turmoil, but looking beyond the UK shoreline helps to contextualise the issue. While varying degrees of neoliberal economic policy have been adopted the world over, the British public find themselves in an especially precarious situation owing to the extent of deregulation, market and corporate power and ideological stance of recent governments.[4] Comparable economies are providing greater stability for households, businesses and communities resulting in little change in living standards in keeping with stronger post-2020 economic recovery. [5,6]

Rising energy bills will still drag many households into extremely difficult circumstances this winter despite the government's intervention on energy price caps which will see average dual energy bills increase by 96% compared to last winter, not to mention the downstream impact of borrowing on the taxpayer. French household energy bill rises on the other hand are capped at just 4%.[7] This is a far cry from households in the UK which also incidentally boast the least energy efficient homes in Western Europe.[8]

From this vantage point, demands for lower energy prices are important but simply not enough. Rather, a 'causes of the causes' lens recognises that 40 years of neoliberal political ideology and policy have put profit ahead of people, private wealth ahead of state or common ownership and the class interests of a privileged few ahead of those of wider society. [9] The 'cost of living crisis' has been a chronic lived experience for the poorest long before the media took notice this year. The 'new poor' are being absorbed into the orbit of hardships faced by the 'old poor' and those well accustomed to decades of political

dispossession. After all, 4 million children in the UK were already in poverty by 2020 – well before the pandemic and Russian invasion of Ukraine.

Focusing on energy bills and price inflation as the drivers of the current crisis is myopic. It turns a blind eye to the converging assault of falling wages, rising rent costs and asset inflation, growing intergenerational wealth inequality, precarious employment, anti-union laws, austerity and cuts to public services, departure from the EU, enclosure of commons and natural resources, and the privatisation and deregulation of a fossil-fuel-reliant energy market. [10-17] The true 'causes of the causes' of COLC are not overseas conflict and supply chain disruption, but a history of political choices that reflect an ideology based on social, economic, and environmental injustice and concentration of power and wealth in the hands of a small minority (see Table 1).

What is the impact on child health?

The cost of extreme inequality is paid through the impact on child health across the life course. In the context of the COLC, the poorest households are struggling to afford necessities which historical evidence tells us results in greater infant mortality, lower birth weights and poorer neurocognitive and social development as well as anxiety, depression and suicide and worse outcomes for those with chronic conditions.[18] Poor health, in turn, impacts the healthcare system. Children from households in areas of greater deprivation are much more likely to attend emergency departments and accrue unplanned hospital admissions. Children experiencing chronic ill health fare worse than those from wealthier backgrounds.[19]

The alarm bells are already ringing as increasing numbers of families find themselves in financial hardship. Research from the Childhood Trust reports a catastrophic picture for children's mental health and wellbeing and a 17% jump in self-harm. [20] Fears of widespread child hunger have sparked calls for universal free school meals as 800,000 children in poverty do not qualify under current benefit regimes. [21]

For health workers in emergency departments, wards and surgeries up and down the country, this crisis of inequality has now become an embedded reality of our daily work; asthma exacerbations owing to

damp and unsafe housing, increasing hospital admissions due to undernutrition, and inordinate numbers of young people presenting in acute yet preventable mental health crises.[19] Paediatricians are treating the symptoms of social and economic policy that are fundamentally at odds with the interests of their patients.

The moral and practical considerations for paediatricians addressing inequality

Ought doctors to be dealing with economic issues? Economies shape health, and the health of patients is, after all, the core concern of the medical profession. The social, economic and political drivers of inequality remain ascendant, and until there is a significant rethink of the current world order, inequality is here to stay. That said, a number of cautions deserve serious consideration here.

First, is the contention that doctors should stick to dealing with the medical aspects of patient care. While undergraduate medical training now increasingly makes reference to the social determinants of health, curricula still largely exclude explanations of political economy or critical social science perspectives on health. Moreover, many clinicians may legitimately feel that dealing with social problems is “not their job”. If medicine's boundaries are to be wider, can they be redrawn without medicine becoming a general social service for dealing with all the problems people have?

Second, even if there is a legitimate role for doctors on the determinants of health, such as economic inequality, many clinicians would argue that there is neither the time nor resource in current health systems to do this role justice. After all, health systems around the world are facing cost crises of their own; the repeated assaults of the 2008 financial collapse, austerity programmes, and the COVID-19 policy response in the run-up to the current time understandably leads to something of a “crisis fatigue”, [22]. Working in these conditions is hard and morale in health services across the world is at an all-time low. [23]

These questions deserve to be - and are being - explored more deeply by the entire profession. In the meantime, we suggest that, regardless of where in the world we are practising, what unites paediatricians globally is that our patients are our first concern.

What does it mean to be a paediatrician in a time of crisis?

Building on previous work on medical professionalism and health determinants, we propose that paediatricians approach complex, social problems by applying what is called a '*social lens'* to their work: thinking outside the confines of their clinical roles to instead see their ethical responsibilities extending beyond the clinician-patient relationship. [24-26.] We suggest this can best be done by thinking of action in two distinct spaces: *inside* and *outside* of health systems. By no means exhaustive, and seen rather as a stimulus for creative thinking, Tables 2 and 3 give a flavour of the kinds of responses that might result from such an approach, focussing here on economic crises.

Addressing inequality from within health systems (Table 2)

Within healthcare settings, growing interest and energy in healthcare is being directed towards initiatives such as screening for social risk factors, social prescribing and on-site provisioning of resources. [27,28] (See Table 2 for more details.) Taken together, these practices can be understood as medicine's most developed answer to social problems. When handled sensitively, the power of these interventions for bridging sociodemographic divides and empowering patients to better manage their own conditions should not be underestimated. [29]

However, as others have argued, "public health problems do not necessarily have effective individual clinical solutions". [30] Attempting to address social problems from the clinic or from a purely individualistic acute perspective treats the symptoms but not the underlying cause; these are sticking plaster tools for emergency situations. For more far-reaching and transformational outcomes for child health, a more systemic, connected and preventive approach is required.

In the longer term, clinicians have the duty and power to help shape clinical services to better deal with and mitigate the effects of social inequality. At the level of local service provision, 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, and often it has been the efforts of ordinary clincians using tools such as research and quality improvement to conscientiously address the issues that matter most to them. [31]

Addressing inequality from outside the health system (Table 3)

Embedded social challenges such as inequality and the COLC will not be solved by the health system alone. Instead, what is required is for society to reorganise itself in ways that genuinely allow people to live happy, healthy lives, and that ultimately requires addressing the political and social determinants of health through political and societal change. We suggest that medical professionals have a responsibility to support these efforts in two ways: through 'profession building' and 'society building' respectively.

1) Profession Building

We must first set our own house in order before we can put the world to rights.

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.

It is our responsibility to demand better to support professional aspirations to truly act in the best and collective interests of our patients. We discuss two particular aspects of this in more detail now.

Training

Many paediatricians experience frustration and helplessness in the face of social problems such as the COLC, reporting that their training has ill-equipped them for the world their patients must survive. Despite a year-on-year increase in the incidence of poverty-related disease in UK child health, [32] paediatric training fails to provide clinicians with the specialist skills needed to recognise the signs and symptoms related to deprivation. [33] In addition, a failure to acknowledge the importance of - not to mention provide rigorous structural analysis of - the social determinants of health leads to obvious and glaring gaps in both undergraduate curricula and postgraduate

training. As a result, the paediatric workforce must look outside of well-worn paths if they want to make up for the public health, policy or economic understanding that is required.

In the UK, the Royal College of Paediatrics and Child Health is the normative and standard-setting body for paediatricians. 'Progress Plus' is the most recent instantiation of the curriculum that all paediatricians in the UK (and elsewhere in the world) are expected to meet by the end of their training. Whilst we welcome the increased reference to 'public health' competencies, it is noteworthy that the accompanying curricular guidance document, "Paediatrician of the future: Delivering really good training", fails to mention the idea of 'advocacy' for paediatricians even once in all of its fifty pages, and the term 'social determinants' only twice. [34] This is striking given the now explicit emphasis of 'population health management for clinicians' in the NHS Long term Plan. [35] In some senses, what we see in paediatrics merely reflects the long-standing, and admittedly even more pronounced, blindness of the entire modern medical profession in relation to wider conceptions of health and thus the role of doctors in society.

Education is a political act; by eliding politics, doctors' training is denuded of meaning. [36] The result for ordinary paediatricians who wish to pursue professional commitments to help patients who are suffering under social emergencies such as COLC is that they have little to go on. Holmes and colleagues argue that such a blindspot means that medical care ignores social forces, resulting in 'misdiagnosis, mistreatment and harm'. [37]

Working Conditions and Culture

Professionalism is much more than narrow competencies and a checklist of skills. It is also an ethical and political orientation about how the job is done and how one views one's role in society, as well as the supporting conditions in which to enact it. [38] In the current climate, even if there were better institutional guidance about addressing social problems such as COLC and inequality, paediatricians face other significant obstacles. Rota gaps, heavy workloads, and a culture of training that offer little flexibility or creativity all serve to raise the barrier to entry for clinicians engaging in anything beyond their skeleton job descriptions.

What are we doing as a profession to give ourselves the space to make a meaningful difference in children's lives? Medical institutions, including the RCPCH, have in general, done little to

challenge the policies of cuts, closure and commodification that have made working conditions in the NHS increasingly constrained and pressured in recent decades. If we are to be able to act on behalf of our patients, we must challenge the limits of our workplaces,andargue for the time and space to be able to do so safely and effectively.

But the onus also falls on us as ordinary clinicians. Neoliberalism has not only created an unequal world through economic policy but has also reinforced a popular culture in which collective action, agency and empowerment are minimised in favour of a rhetoric of individual responsiblity and sef-interest. [39] We argue that paediatrcians must fight against this mentality - even in the face of burnout and resource constraint - if we are to fully realise the potential of our role as advocates.

How can we make addressing the social determinants of health easier for ordinary clinicians? What can we do to create the spaces for mobilising and organising outside of the formal setting? If we, as a profession, want to move beyond rhetoric and platitude toward action, then we must take the responsibility for developing the tools and approaches we need ourselves.

2) Society Building

How can paediatricians aid in the process of building a society fit for children and young people to thrive? As individual clinicians, it is easy to feel overwhelmed and insignificant, but for our patients, nothing could be further from the truth. As argued elsewhere, “Doctors carry significant social and cultural capital; our messages are listened to“. [25] Paediatricians are uniquely positioned to function as public advocates for child health. Public trust in doctors is very high; to the public, doctors are a credible source of information. [40] Given their social standing, doctors enjoy an unusual degree of access to policymakers, local and national leaders, and citizens; thus, they possess a great deal of leverage in influencing public processes and priorities. Never underestimate the power of the clinician to help shape public discourse around an issue; your voice counts and now is a critical time to use it. Table 3 draws on examples from around the world to help illustrate how doctors can be part of, and moreover help to accelerate, change.

Conclusion

The UK's Cost of Living Crisis pushes millions more families into poverty, further stripping their lives of dignity and the capabilities to grow and live healthily. While the job of addressing economic crises such as COLC ought not to be left solely to health workers, the paediatric profession must act. For even though policies have been introduced to address the high cost of energy bills, what is needed is a deeper, wholesale change in how the economy and society is organised.

While much has been written about how paediatricians might engage with the determinants of health, we propose that addressing economic crises such as COLC calls for a different approach.

We propose that applying a 'social lens' will help to realign paediatric professional roles and our purpose so that they are directed towards addressing both the true 'causes of the causes' - as well as the effects - of the social, economic, political and environmental determinants of health. This is essential if we are to challenge an economic and professional paradigm that encourages reformist tinkering at the edges over something more transformational. [31]

A willingness on the part of the paediatric profession to completely question and re-envision their collective professional roles to help address the great challenges of our time - both inside and outside of the health system - is urgent and necessary. It is time to ask for more: changes to medical education and training to empower practising paediatricians to meaningfully engage in economic justice; an overhaul of outdated workforce plans which only perpetuate inequalities through disparities in structured and protected opportunities to tackle inequality in policy and clinical settings; and a cultural shift wherein advocacy is seen as something which occurs on both a collective and population level as well as just between the doctor and the patient, for, ultimately, inequality is everyone's responsibility.

This is a big task and one that needs the whole profession to mobilise and come together. The COLC, and inequality more generally, presents an opportunity to proactively reshape professionalism to better suit 21st-century needs of our patients. If not now, when?

Key Messages

a) Seen through a 'social lens' the UK's Cost of Living Crisis can be understood as a symptom of a much deeper, worldwide disease, the 'Crisis of Inequality'.

b) Given that the social, economic and political processes that created the Crisis of Inequality were not inevitable, doctors can see the resulting impacts on health as a matter of health equity and thus social justice.

c) Doctors can conceive of their role in attending to social justice as occurring both inside and outside of health systems.

d) Inside health systems, doctors can change how they conduct clinical encounters, the shape service user pathways and the orientation of research and improvement to deliver more equitably outcomes.

e) The deeper transformation of both the medical profession and society that is needed to act effectively outside of health systems to address social justice invites an expansion and reimagining of what it means to be a doctor in the 21st century.

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Table 1 - Examples of increasing inequality between rich and poor and its impact on children

The income inequality gap as measured by the Gini coefficient has steadily increased to 36.3% in January 2022 which was the highest level of income inequality since 2010. [a]
The number of people in in-work poverty has increased by 2 million since [the government] came to power in 2010. It's now at a record high, as is the number of children in poverty living in a house where at least one adult is in work. [b]
The UK is fifth from bottom among 27 European countries for infant mortality. Since 2010 there has been a rise in infant mortality rates for the poorest children, compared to falling rates for more advantaged infants [c]

Sources:

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Table 2: Addressing inequality from within health systems

Proposed Action	What is it?	How to do it

Screening for social risk factors	The identification of patients who may benefit from greater support in one or more areas, including poverty, food insecurity, violence, unemployment, and housing problems.	Do ask, but ask sensitively. A useful resource of validated and adapted tools for this purpose can be found at: https://www.whamproject.co.uk/ As part of this we advocate gathering data through this process to make visible to local policymakers the need for greater support for children and families.
Social prescribing	Referral for non-medical interventions to address the wider determinants of health identified through screening	Referral pathways may not exist; demand them locally; connect and partner with local third sector organisations for more joined-up care
On-Site Provision	Some health care settings now hold basic provisions, including food, clothing and sanitary products, or access to community-based workers for children and families in desperate situations and without recourse to funds. ED visits can represent a 'cry for help'. For suitable patients presenting in crisis, a referral to other services for follow up can help get support to the young people when it is most needed.	Examples: fresh fruit in clinics; grab bags for vulnerable children; on-site financial advisers or link workers to facilitate access to benefits and local resources including food banks Paediatric ED referral pathways connect medical services with a wider network of support for children and young people in need. E.g OASIS youth violence and harm reduction support

Refocusing local service provision	How can local research and QI efforts be conducted in ways that matter to both service users and health professionals so as to have the best chance to do good?	Examples: Addressing poverty in clinical practice. Based on the initial work of trainee paediatricians in a London district general hospital to develop clinical surveillance tools and advice for the emergency department, there is now a growing network of clinicians using QI methodology to tackle inequality within health systems. For more, see: https://www.whamproject.co.uk/ and https://qicentral.rcpch.ac.uk/whamportal/
	Whole-system change	An example of how to reorient whole systems to serve Communities and Child Health is the Children and Young People's Health Partnership Lambeth and Southwark. CYPHP is an integrated model of care across primary, secondary and community settings that helps to deliver care to children with the greatest needs in settings more conducive to better outcomes in the longer term by re-thinking how to meet patients and families where they are, closer to

		home, at schools and in the community.

Table 3: Addressing inequality from outside the health system

PROFESSION BUILDING	
Lobby medical institutions	The Royal College of Paediatrics and Child Health is set up as a membership organisation with members' interests at the forefront. We are entitled to ask what is being done about addressing the gaping holes in our training in relation to health inequality, and what action the College is taking to safeguard our ability as clinicians to meaningfully deal with these issues as clinicians, researchers and advocates.
Self-organise	Based on the idea that we can all come up with news ways of practising, whether it is how we conduct consultations, deciding who our pathways reach, or the kinds of questions we focus on in research, the Wellbeing and Health Action Movement (https://www.whamproject.co.uk/) arose to fill a perceived gap for paediatricians who care about health inequality. But so much more is needed and so much more is possible. We urge creativity and innovation at the margins here. Don't wait for those in power to show the way.
SOCIETY BUILDING	
Raising the alarm by:	

Protest	Doctors and all health professionals have a responsibility and obligation to engage in all kinds of non-violent social protest. This can take the form of marching in protest over the privatisation and under-resourcing of the health system and in defence of a universal and publicly owned NHS, as well as the health impacts of the economic crisis and wealth inequality.
Shining the media spotlight	Media, including television, radio and social media shape public discourse, spotlighting matters in the public interest in ways that can lead to political and social change. Health professionals have a role to play in informing these narratives, bearing witness, linking health, illness and inequalities with their determinants and speaking out on the injustices faced by patients and communities in order to demand better for our collective health.
Engaging with civil society	Health professionals also play a vital role in demanding better from civic institutions, using research and evidence to build pressure and support more equitable policy and position. Medical and public health bodies also have a role in advocating for such changes, using their institutional voices to inform policy demands as well as facilitate cultural changes among members. Royal College of Physicians public polling on the link between the economic crisis and self-reported impacts on health has been featured in national news.
Supporting social justice through:	
Solidarity & Allyship	Clinicians can help the third sector by connecting child poverty and ill health, building the evidence base and shaping policy. We can help by adding the power of the medical voice; this requires us to deconstruct silos and working collaboratively across sectors to strengthen networks. Some examples of organisations to get involved with:

	• Local: Home-Start, Children North East, Everyone's Children Glasgow • National: End Child Poverty Coalition, CPAG, Trussell Trust, The Childhood Trust, The Children's Society, Action for Children, Child of the North, Save the Children, UNICEF UK, APPG Poverty • International: ISSOP, International Pediatrics Association, UNICEF, Medact, Save the Children, MSF, Joseph Rowntree Foundation, Lancet Migration, CHIFA, Doctors of the World.
Lobbying and Legal Frameworks	Health professionals have played a historic role in lobbying for changes to the law. Doctors in Manchester lobbied for the introduction of child labour laws and protections to mitigate the worst of exploitative labour practices in cotton factories during the industrial revolution. Child health professionals have called out the dangers of the abolition of child poverty targets in the Child Poverty Act 2010 which was replaced by the Welfare Reform and Work 2016. Doctors have also taken the government to court over the failure to meet climate and emissions targets and RCPCH is lobbying the government to end NHS charging. More recently, child health professionals have played a role in submitting evidence and oral testimony to the legal frameworks surrounding child poverty and its accountability mechanisms.
Industrial Action and Collective Organising	Health system workers who have had contracts outsourced to profit making companies have experienced a fall in real terms wages whilst navigating increasing employment insecurity.

	Doctors helped support cleaners, porters and domestic staff at Barts Health NHS trust win their struggle for pay and conditions and were brought back into NHS employment in March 2022 Security guards based at Great Ormond Street Hospital have been on strike this year and fellow health professionals have shown solidarity through enhancing their voice, spreading their message and contributing to strike funds. Workers from a range of public sectors have undertaken strike action during 2022 to demand pay that can keep up with inflation as well as better working conditions.
Political Education	Healthcare and public health professionals and researchers have produced a range of resources for political education for fellow health workers on the economic determinants of health. These zines cover, liveable incomes, secure housing and tax justice as three key areas for political education and campaigning for a just economy. Patient's Not Passports produced an advocacy toolkit for health workers and community members to support those facing NHS charging as well as immigration checks Health professionals also use their testimony and understanding of the means required towards collective flourishing to provide political education on health justice at national political events, engaging the public in a radical re-imagining of health, through abolishing systems of violence and oppression, using health as a means of building power.
Voting	Political choice is exercised by the individual as much as by policy makers; what we do in the voting booth counts. We ought to choose candidates who hold policies that will support child public health and ideals for social justice at the centre of their work.

	In addition, as paediatricians, we can help young people to use their voice. We can support young people to vote, help to lower voting age to 16 in England, and defend their political rights.

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The Cost of Living Crisis: A UK crisis with global implications. A call to action for paediatricians

Abstract

The UK's 'Cost of Living Crisis' has thrown millions of families into poverty in 2022, delivering an intensifying economic shock that will likely eclipse the financial impact of the global coronavirus pandemic for children, families and communities alike. But what is the relevance for paediatricians? Written by doctors who spend considerable time confronting social problems from clinical, public health and advocacy perspectives, this article aims to untangle the 'Cost of Living Crisis' (COLC) for those working in child health and seeks to stimulate a meaningful conversation about how we might reimagine paediatrics for life in the 21st century.

Taking the current crisis as our point of departure, we argue that the UK's COLC can be best understood as a *crisis of inequality* which has been created through social, economic and political processes that were not inevitable. The health impacts, then, are a matter of health equity and social justice. While the acuity of the crisis unfolding in the UK garners much attention, the implications are global with lessons for paediatricians everywhere. We propose that using a *'social lens'* for understanding the true 'causes of the causes' of complex challenges such as COLC is essential for the 21st-century paediatrician, as the consequences for child health is deep, wide-ranging and long-lasting. However, the current gap in knowledge, skills and infrastructure in this area leads to disempowerment in the profession.

We end with this provocation: What, after all, does it mean to be a paediatrician in a time of economic crisis? We offer thoughts about how paediatrics might respond to social challenges, such as the COLC, acknowledging that organised and concerted action must be taken both inside and outside of health systems if we are to help bring about the changes that our patients and their surrounding communities urgently need.

What is the "Cost of living crisis" (COLC)?

In the UK, media and public discourse have characterised the 'cost of living crisis' (COLC) as the result of substantial energy price rises and soaring inflation. Both are already having devastating implications for the financial security of millions of households and businesses reflected in the greatest drop in living standards since records began 60 years ago.[1] The often cited 'heating or eating' dilemma has become an intractable everyday reality for families at the sharp end of disadvantage; research published in May 2022 shows that 2.6 million children report having smaller meals and regularly skip meals altogether.[2]

The UK's so-called 'cost of living crisis' is really part of a wider social, economic and political emergency: what we are calling a *crisis of inequality'*. The arising differences in health, wealth and power are not simply an imbalance, or result of a passive natural process, but instead are the result of unjust and unfair political and social processes. Health inequalities result from political and social *inequities*.[3] The resultant outlook for children and the society that surrounds them is bleak and will only rapidly worsen as winter approaches.

The Russian invasion of Ukraine and global supply chain volatility undoubtedly exacerbates economic turmoil, but looking beyond the UK shoreline helps to contextualise the issue. While varying degrees of neoliberal economic policy have been adopted the world over, the British public find themselves in an especially precarious situation owing to the extent of deregulation, market and corporate power and ideological stance of recent governments.[4] Comparable economies are providing greater stability for households, businesses and communities resulting in little change in living standards in keeping with stronger post-2020 economic recovery. [5,6]

Rising energy bills will still drag many households into extremely difficult circumstances this winter despite the government's intervention on energy price caps which will see average dual energy bills increase by 96% compared to last winter, not to mention the downstream impact of borrowing on the taxpayer. French household energy bill rises on the other hand are capped at just 4%.[7] This is a far cry from households in the UK which also incidentally boast the least energy efficient homes in Western Europe.[8]

From this vantage point, demands for lower energy prices are important but simply not enough. Rather, a 'causes of the causes' lens recognises that 40 years of neoliberal political ideology and policy have put profit ahead of people, private wealth ahead of state or common ownership and the class interests of a

privileged few ahead of those of wider society. [9] The 'cost of living crisis' has been a chronic lived experience for the poorest long before the media took notice this year. The 'new poor' are being absorbed into the orbit of hardships faced by the 'old poor' and those well accustomed to decades of political dispossession. After all, 4 million children in the UK were already in poverty by 2020 – well before the pandemic and Russian invasion of Ukraine.

Focusing on energy bills and price inflation as the drivers of the current crisis is myopic. It turns a blind eye to the converging assault of falling wages, rising rent costs and asset inflation, growing intergenerational wealth inequality, precarious employment, anti-union laws, austerity and cuts to public services, departure from the EU, enclosure of commons and natural resources, and the privatisation and deregulation of a fossil-fuel-reliant energy market. [10] The true 'causes of the causes' of COLC are not overseas conflict and supply chain disruption, but a history of political choices that reflect an ideology based on social, economic, and environmental injustice and concentration of power and wealth in the hands of a small minority (see Table 1). [11-13]

What is the impact on child health?

In light of alarming increases in poverty and inequality, the UN Special Rapporteur on poverty found the UK government in breach of its human rights obligations to children in 2019, [14] The cost of extreme inequality is paid through the impact on child health across the life course. In the context of the COLC, the poorest households are struggling to afford necessities which historical evidence tells us results in greater infant mortality, lower birth weights and poorer neurocognitive and social development as well as anxiety, depression and suicide and worse outcomes for those with chronic conditions.[15] Poor health, in turn, impacts the healthcare system. Children from households in areas of greater deprivation are much more likely to attend emergency departments and accrue unplanned hospital admissions. Children experiencing chronic ill health fare worse than those from wealthier backgrounds.[16]

The alarm bells are already ringing as increasing numbers of families find themselves in financial hardship. Research from the Childhood Trust reports a catastrophic picture for children's mental health

and wellbeing and a 17% jump in self-harm. [17] Fears of widespread child hunger have sparked calls for universal free school meals as 800,000 children in poverty do not qualify under current benefit regimes. [18]

For health workers in emergency departments, wards and surgeries up and down the country, this crisis of inequality has now become an embedded reality of our daily work; asthma exacerbations owing to damp and unsafe housing, increasing hospital admissions due to undernutrition, and inordinate numbers of young people presenting in acute yet preventable mental health crises.[16] Paediatricians are treating the symptoms of social and economic policy that are fundamentally at odds with the interests of their patients.

The moral and practical considerations for paediatricians addressing inequality

Ought doctors to be dealing with economic issues? Economies shape health, and the health of patients is, after all, the core concern of the medical profession. The social, economic and political drivers of inequality remain ascendant, and until there is a significant rethink of the current world order, inequality is here to stay. That said, a number of cautions deserve serious consideration here.

First, is the contention that doctors should stick to dealing with the medical aspects of patient care. While undergraduate medical training now increasingly makes reference to the social determinants of health, curricula still largely exclude explanations of political economy or critical social science perspectives on health. Moreover, many clinicians may legitimately feel that dealing with social problems is “not their job”. If medicine's boundaries are to be wider, can they be redrawn without medicine becoming a general social service for dealing with all the problems people have?

Second, even if there is a legitimate role for doctors on the determinants of health, such as economic inequality, many clinicians would argue that there is neither the time nor resource in current health systems to do this role justice. After all, health systems around the world are facing cost crises of their own; the repeated assaults of the 2008 financial collapse, austerity programmes, and the COVID-19 policy response in the run-up to the current time understandably leads to something of a “crisis fatigue”, [19]. Working in these conditions is hard and morale in health services across the world is at an all-time low. [20]

These questions deserve to be - and are being - explored more deeply by the entire profession. In the meantime, we suggest that, regardless of where in the world we are practising, what unites paediatricians globally is that our patients are our first concern.

What does it mean to be a paediatrician in a time of crisis?

Building on previous work on medical professionalism and health determinants, we propose that paediatricians approach complex, social problems by applying what is called a '*social lens'* to their work: thinking outside the confines of their clinical roles to instead see their ethical responsibilities extending beyond the clinician-patient relationship. [21-23.] We suggest this can best be done by thinking of action in two distinct spaces: *inside* and *outside* of health systems. By no means exhaustive, and seen rather as a stimulus for creative thinking, Tables 2 and 3 give a flavour of the kinds of responses that might result from such an approach, focussing here on economic crises.

Addressing inequality from within health systems (Table 2)

Within healthcare settings, growing interest and energy in healthcare is being directed towards initiatives such as screening for social risk factors, social prescribing and on-site provisioning of resources. [24,25] (See Table 2 for more details.) Taken together, these practices can be understood as medicine's most developed answer to social problems. When handled sensitively, the power of these interventions for bridging sociodemographic divides and empowering patients to better manage their own conditions should not be underestimated. [26]

However, as others have argued, "public health problems do not necessarily have effective individual clinical solutions". [27] Attempting to address social problems from the clinic or from a purely individualistic acute perspective treats the symptoms but not the underlying cause; these are sticking plaster tools for

emergency situations. For more far-reaching and transformational outcomes for child health, a more systemic, connected and preventive approach is required.

In the longer term, clinicians have the duty and power to help shape clinical services to better deal with and mitigate the effects of social inequality. At the level of local service provision, 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, and often it has been the efforts of ordinary clinicians using tools such as research and quality improvement to conscientiously address the issues that matter most to them. [28]

Addressing inequality from outside the health system (Table 3)

Embedded social challenges such as inequality and the COLC will not be solved by the health system alone. Instead, what is required is for society to reorganise itself in ways that genuinely allow people to live happy, healthy lives, and that ultimately requires addressing the political and social determinants of health through political and societal change. We suggest that medical professionals have a responsibility to support these efforts in two ways: through 'profession building' and 'society building' respectively.

1) Profession Building

We must first set our own house in order before we can put the world to rights.

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.

It is our responsibility to demand better to support professional aspirations to truly act in the best and collective interests of our patients. We discuss two particular aspects of this in more detail now.

Training

Many paediatricians experience frustration and helplessness in the face of social problems such as the COLC, reporting that their training has ill-equipped them for the world their patients must survive. Despite a year-on-year increase in the incidence of poverty-related disease in UK child health, [29] paediatric training fails to provide clinicians with the specialist skills needed to recognise the signs and symptoms related to deprivation. [30] In addition, a failure to acknowledge the importance of - not to mention provide rigorous structural analysis of - the social determinants of health leads to obvious and glaring gaps in both undergraduate curricula and postgraduate training. As a result, the paediatric workforce must look outside of well-worn paths if they want to make up for the public health, policy or economic understanding that is required.

In the UK, the Royal College of Paediatrics and Child Health is the normative and standard-setting body for paediatricians. 'Progress Plus' is the most recent instantiation of the curriculum that all paediatricians in the UK (and elsewhere in the world) are expected to meet by the end of their training. Whilst we welcome the increased reference to 'public health' competencies, it is noteworthy that the accompanying curricular guidance document, "Paediatrician of the future: Delivering really good training", fails to mention the idea of 'advocacy' for paediatricians even once in all of its fifty pages, and the term 'social determinants' only twice. [31] This is striking given the now explicit emphasis of 'population health management for clinicians' in the NHS Long term Plan. [32] In some senses, what we see in paediatrics merely reflects the long-standing, and admittedly even more pronounced, blindness of the entire modern medical profession in relation to wider conceptions of health and thus the role of doctors in society. To its credit, the RCPCH finally responded to calls for more with a statement acknowledging the role of paediatricians in addressing inequality in late 2022. [33]

Education is a political act; by eliding politics, doctors' training is denuded of meaning. [34] The result for ordinary paediatricians who wish to pursue professional commitments to help patients who are suffering under social emergencies such as COLC is that they have little to go on. Holmes and colleagues argue that such a blind spot means that medical care ignores social forces, resulting in 'misdiagnosis, mistreatment and harm'. [35]

Working Conditions and Culture

Professionalism is much more than narrow competencies and a checklist of skills. It is also an ethical and political orientation about how the job is done and how one views one's role in society, as well as the supporting conditions in which to enact it. [36] In the current climate, even if there were better institutional guidance about addressing social problems such as COLC and inequality, paediatricians face other significant obstacles. Rota gaps, heavy workloads, and a culture of training that offer little flexibility or creativity all serve to raise the barrier to entry for clinicians engaging in anything beyond their skeleton job descriptions.

What are we doing as a profession to give ourselves the space to make a meaningful difference in children's lives? Medical institutions, including the RCPCH, have in general, not done enough to challenge the policies of cuts, closure and commodification that have made working conditions in the NHS increasingly constrained and pressured in recent decades. If we are to be able to act on behalf of our patients, we must challenge the limits of our workplaces, and argue for the time and space to be able to do so safely and effectively.

But the onus also falls on us as ordinary clinicians. Neoliberalism has not only created an unequal world through economic policy but has also reinforced a popular culture in which collective action, agency and empowerment are minimised in favour of a rhetoric of individual responsibility and self-interest. [37] We argue that paediatricians must fight against this mentality - even in the face of burnout and resource constraint - if we are to fully realise the potential of our role as advocates.

How can we make addressing the social determinants of health easier for ordinary clinicians? What can we do to create the spaces for mobilising and organising outside of the formal setting? If we, as a profession, want to move beyond rhetoric and platitude toward action, then we must take the responsibility for developing the tools and approaches we need ourselves.

2) Society Building

How can paediatricians aid in the process of building a society fit for children and young people to thrive? As individual clinicians, it is easy to feel overwhelmed and insignificant, but for our patients, nothing could be further from the truth. As argued elsewhere, "Doctors carry significant social and cultural capital; our messages are listened to". [22] Paediatricians are uniquely

positioned to function as public advocates for child health. Public trust in doctors is very high; to the public, doctors are a credible source of information. [38] Given their social standing, doctors enjoy an unusual degree of access to policymakers, local and national leaders, and citizens; thus, they possess a great deal of leverage in influencing public processes and priorities. Never underestimate the power of the clinician to help shape public discourse around an issue; your voice counts and now is a critical time to use it. Table 3 draws on examples from around the world to help illustrate how doctors can be part of, and moreover help to accelerate, change.

Conclusion

The UK's Cost of Living Crisis pushes millions more families into poverty, further stripping their lives of dignity and the capabilities to grow and live healthily. While the job of addressing economic crises such as COLC ought not to be left solely to health workers, the paediatric profession must act. For even though policies have been introduced to address the high cost of energy bills, what is needed is a deeper, wholesale change in how the economy and society is organised.

While much has been written about how paediatricians might engage with the determinants of health, we propose that addressing economic crises such as COLC calls for a different approach.

We propose that applying a 'social lens' will help to realign paediatric professional roles and our purpose so that they are directed towards addressing both the true 'causes of the causes' - as well as the effects - of the social, economic, political and environmental determinants of health. This is essential if we are to challenge an economic and professional paradigm that encourages reformist tinkering at the edges over something more transformational. [28]

A willingness on the part of the paediatric profession to completely question and re-envision their collective professional roles to help address the great challenges of our time - both inside and outside of the health system - is urgent and necessary. It is time to ask for more: changes to medical education and training to empower practising paediatricians to meaningfully engage in economic justice; an overhaul of outdated workforce plans which only perpetuate inequalities through disparities in structured and protected opportunities to tackle inequality in policy and clinical settings; and a cultural shift wherein

advocacy is seen as something which occurs on both a collective and population level as well as just between the doctor and the patient, for, ultimately, inequality is everyone's responsibility.

This is a big task and one that needs the whole profession to mobilise and come together. The COLC, and inequality more generally, presents an opportunity to proactively reshape professionalism to better suit 21st-century needs of our patients. If not now, when?

Key Messages

a) Seen through a 'social lens' the UK's Cost of Living Crisis can be understood as a symptom of a much deeper, worldwide disease, the 'Crisis of Inequality'.
b) Given that the social, economic and political processes that created the Crisis of Inequality were not inevitable, doctors can see the resulting impacts on health as a matter of health equity and thus social justice.
c) Doctors can conceive of their role in attending to social justice as occurring both inside and outside of health systems.
d) Inside health systems, doctors can change how they conduct clinical encounters, the shape service user pathways and the orientation of research and improvement to deliver more equitable outcomes.
e) The medical profession needs to be actively involved in promoting social justice. This invites deep professional transformation with an expansion and reimagining of what it means to be a doctor in the 21st century.

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Table 1 - Examples of increasing inequality between rich and poor and its impact on children

In the UK, wealth is even more unevenly shared than household income; by 2022 the wealthiest 10% of households held 43% of all the wealth. In contrast the bottom 50% held only 9% of all wealth.[11]
The number of people in in-work poverty has increased by 2 million since [the government] came to power in 2010. It's now at a record high, as is the number of children in poverty living in a house where at least one adult is in work. [12]
The UK is fifth from bottom among 27 European countries for infant mortality. Since 2010 there has been a rise in infant mortality rates for the poorest children, compared to falling rates for more advantaged infants [13]

Table 2: Addressing inequality from within health systems

Proposed Action	What is it?	How to do it
Screening for social risk factors	The identification of patients who may benefit from greater support in one or more areas, including poverty, food insecurity, violence, unemployment, and housing problems.	Do ask, but ask sensitively. A useful resource of validated and adapted tools for this purpose can be found at: https://www.whamproject.co.uk/ As part of this we advocate gathering data through this process to make visible to local policymakers the need for greater support for children and families.

Social prescribing	Referral for non-medical interventions to address the wider determinants of health identified through screening	Referral pathways may not exist; demand them locally; connect and partner with local third sector organisations for more joined-up care
On-Site Provision: **a) In the Clinic**	Some health care settings now hold basic provisions, including food, clothing and sanitary products, or access to community-based workers for children and families in desperate situations and without recourse to funds.	Examples: fresh fruit in clinics; grab bags for vulnerable children; on-site financial advisers or link workers to facilitate access to benefits and local resources including food banks
b) In the Emergency Department	ED attendances can be a 'cry for help' and present opportunities to engage a wider range of support and follow up to meet the needs of vulnerable children.	Examples include OASIS youth violence and harm reduction support.
Refocusing local service provision	How can local research and QI efforts be conducted in ways that matter to both service users and health professionals so as to have the best chance to do good?	Examples: Addressing poverty in clinical practice. Based on the initial work of trainee paediatricians in a London district general hospital to develop clinical surveillance tools and advice for the emergency department, there is now a growing network of clinicians using QI methodology to tackle inequality within health systems.

		For more, see: https://www.whamproject.co.uk/ and https://qicentral.rcpch.ac.uk/whamportal/
	Whole-system change	Children and Young People's Health Partnership is an integrated model of primary, secondary and community care that improves outcomes for children with the greatest need by meeting children and families where they are.

Table 3: Addressing inequality from outside the health system

PROFESSION BUILDING	
Lobby medical institutions	The Royal College of Paediatrics and Child Health is set up as a membership organisation with members' interests at the forefront. We are entitled to ask what is being done about addressing the gaping holes in our training in relation to health inequality, and what action the College is taking to safeguard our ability as clinicians to meaningfully deal with these issues as clinicians, researchers and advocates.

Self-organise	Based on the idea that we can all come up with news ways of practising, whether it is how we conduct consultations, deciding who our pathways reach, or the kinds of questions we focus on in research, the Wellbeing and Health Action Movement (https://www.whamproject.co.uk/) arose to fill a perceived gap for paediatricians who care about health inequality. But so much more is needed and so much more is possible. We urge creativity and innovation at the margins here. Don't wait for those in power to show the way.
SOCIETY BUILDING	
Raising the alarm by:	
Protest	Health workers have a responsibility to engage in all kinds of non-violent social protest. Examples include marching in protest over NHS privatisation, the health impacts of economic inequality and the climate crisis.
Shining the media spotlight	Media shapes public discourse, with the potential to highlight issues in ways conducive to political and social change. Health workers can bear witness, inform debate and speak out on injustice on behalf of children and communities.
Engaging with civil society	Health workers and their representative institutions have powerful advocacy voices which can be harnessed to demand better from civic and political institutions and build pressure for more equitable policy for children and young people.
Supporting social justice through:	
Solidarity & Allyship	Health workers can engage the third sector by linking child poverty and ill health with broader social movements, requiring us

	to deconstruct siloes, work collaboratively across sectors and build meaningful solidarity. Some examples of organisations to get involved with: • Local: Home-Start, Children North East, Everyone's Children Glasgow • National: End Child Poverty Coalition, CPAG, Trussell Trust, The Childhood Trust, The Children's Society, Action for Children, Child of the North, Save the Children, UNICEF UK, APPG Poverty • International: ISSOP, International Pediatrics Association, UNICEF, Medact, Save the Children, MSF, Joseph Rowntree Foundation, Lancet Migration, CHIFA, Doctors of the World.
Lobbying and Legal Frameworks	Health workers advocated for the introduction of child labour laws. Today's child health professionals have provided oral testimony and submitted evidence to parliamentary groups concerning the accountability frameworks surrounding child poverty and health.
Industrial Action and Collective Organising	Health workers helped support cleaners, porters and domestic staff at Barts Health NHS trust win their struggle for pay and conditions and were brought back into NHS employment in March 2022
Political Education: **a) For Health Workers** **b) For The Public**	Health workers at Medact have produced resources for political education for fellow workers concerning economic determinants of health. They cover liveable incomes, secure housing and tax justice as topics essential for a just economy and better child health

	Health workers have provided political education on health justice at national political events, engaging the public in a radical re-imagining of health, through abolishing systems of violence and oppression, using health as a means of building collective power.
Voting: **a) By the Profession** **b) By Young People**	What we do in the voting booth counts. We ought to choose candidates who hold policies that will support child public health and ideals for social justice at the centre of their work. We can also help young people to use their voice, supporting them to vote by helping to lower voting age to 16 in England, and defend their political rights.