Title: Should we screen for poverty in primary care?

Authors: Dr Dipesh P. Gopal[1#]

Miss Sarah Beardon[2]

Prof Martin Caraher[3]

Dr Charlotte Woodhead[4]

Prof Stephanie J. C. Taylor[1]

1. Wolfson Institute of Population Health, Barts and The London School of Medicine and Dentistry, Yvonne Carter Building, 58 Turner Street, London E1 2AB
2. Institute of Epidemiology & Health Care, Department of Applied Health Research, Gower Street, London WC1E 6BT
3. School of Health Sciences, Division of Health Sciences Research and Management, City University of London, Northampton Square, EC1V OHB
4. ESRC Centre for Society and Mental Health, King's College London, 22 Kingsway WC2B 6NR
5. Wolfson Institute of Population Health, Barts and The London School of Medicine and Dentistry, Yvonne Carter Building, 58 Turner Street, London E1 2AB

Corresponding author. Email address: d.gopal@qmul.ac.uk; Telephone number: +44 (0)20 7882 5882

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Should we screen for poverty in primary care?

This pandemic oversees the worst economic decline for almost 300 years, which will widen existing health inequalities. This has resulted in rising poverty levels and increasing numbers of people claiming state benefits, with probable knock-on effects for food insecurity and fuel poverty. This is on top of ongoing cuts to public services and welfare provisions as well as rising unemployment. Some patient groups are more likely to suffer economic hardship; for example, those living with and beyond cancer are likely to experience 'financial toxicity' - the economic effects of cancer treatment.

Since primary care is community facing, should primary care practitioners screen for poverty during routine interactions with patients. If so, does poverty screening fulfil 'screening criteria'? An updated version[1] of Wilson and Junger's 1968 classic screening criteria provides a basis for debate about screening for poverty in primary care:

- The screening programme should respond to a recognised need.
- The objectives of screening should be defined at the outset.
- There should be a defined target population.
- There should be scientific evidence of screening programme effectiveness.
- The programme should integrate education, testing, clinical services and programme management.
- There should be quality assurance, with mechanisms to minimize potential risks of screening.
- The programme should ensure informed choice, confidentiality and respect for autonomy.
- The programme should promote equity and access to screening for the entire target population.
- Programme evaluation should be planned from the outset.
- The overall benefits of screening should outweigh the harm.

Figure 1: Andermann and colleagues updated screening criteria for the genomic age[1]

The case to screen

There is no doubt that there is a tangible need at a local and population level to reach those who are living in poverty during and after the pandemic. This could link people to available financial assistance to improve their quality of life especially if they have low or unstable incomes. A target population may be anyone that presents to primary care, as poverty may underpin their presentation, such as tension headache due to stress from insecure working conditions. When it comes to screening questions, Brcic and colleagues[2] asked

10 questions and correlated responses with demographic and income data. From 156 responses they identified several questions which can screen for poverty. For example:

- Do you have difficulty making ends meet at the end of the month? (98% sensitivity, 40% specificity),
- Considering your current income, how difficult is it to make ends meet? (78% sensitivity, 73% specificity)
- Do you ever worry about losing your place to live? (86% sensitivity, 62% specificity)

Data [3] from 22 Canadian healthcare professionals has suggested that using the question “Do you have difficulty making ends meet at the end of the month?” is acceptable to 75% of those patients who responded to the questionnaire (n=56, 100% response rate). This question identified some people who healthcare professionals would not suspect to be suffering from poverty. Direction to nearby employment organisations[4], co-located welfare rights advice services[5], advice workers in a Deep End GP scheme[6], peer-to-peer financial support with facilitation by healthcare professionals[7] and social prescribing[8] may all be viable responses. Follow-up questions could focus on use of food banks, living circumstances (housing conditions and tenure), job security, amount of household debt to signpost to appropriate sources of assistance. Education for staff would support implementation of the screening tool, and evaluating its implementation would help identify, for example, how consistently it was administered and its effectiveness.

Patient-level benefits of screening[9] include acknowledgement of socially determined disease risks, adaptation of management plans and appreciation of non-adherence to those plans. Proactive and opportunistic poverty screening in English[10] and Scottish[11] GP practices for older adults over 15 years ago generated between £1400 - £3000 in annual unclaimed benefits for patients using the help of an advice worker providing home visits. A similar intervention[12] directed at patients with severe symptoms of osteoarthritis and rheumatoid arthritis in hospital and community settings, cost £59-71 to administer but generated over £2100 of annual benefits per claimant. Whilst benefit levels may have since changed, welfare rights advice delivered in primary care can significantly reduce the experience of financial strain and improve mental wellbeing[5]. Screening with co-located welfare rights advice services may subjectively decrease GP workload and consultation time[13,14] and subjectively improve patient and household quality of life[15].

On a population level, screening for poverty could identify more systemic problems, e.g., the adequacy of policies to combat poverty and stimulate solutions such as better integration of health and other sectors, as well as better-informed public health policies.

The case not to screen

During the pandemic, healthcare services have been struck by absences due to self-isolation or actual illness as well as escalating burnout from high workloads. Primary care has been involved in managing patients who cannot be quickly seen in secondary care as well as organising COVID-19 vaccinations. Thus, screening may place additional pressure on already overstretched clinical staff. The use of the single screening question described above to only those who present to primary care perhaps could be considered as non-equitable since those with the greatest needs may very well not present to primary care. A small proportion of patients were unhappy with the screening question[3] and such enquiries may foster patient distrust of healthcare services. Other research found clinicians felt that asking such a question seemed 'out of place' for well-known patients[3]. There was a fear of helplessness without an adequate intervention to help patients out of poverty. A 2006 systematic review[16] found limited evidence that welfare rights advice in healthcare settings produced health or social benefits at 12 months but this may be due to the lack of high quality studies and inadequate measures.

For clinicians working in deprived areas, screening for poverty may not be helpful especially since many patients may be on low incomes. Furthermore, these clinicians face challenges providing care for patients who have more complex health needs compared to patients for less deprived areas[17] without increased funding and access to other services to meet these needs[18].

For some in primary care, helping with poverty may seem 'outside their lane' especially when interventions may seem beyond the direct reach of healthcare such as housing, jobs or money: medicalising poverty without challenging its root causes. Perhaps socio-economic problems require socio-economic solutions. Co-located welfare services and peer-to-peer support may be difficult to arrange during the pandemic and even online peer support solutions may multiply inequalities in healthcare access. Furthermore, many would argue that many proposed downstream solutions are context-specific and there is limited evidence from research or in practice, let alone during a pandemic.

Conclusion

With anticipated widening health inequalities during the pandemic, primary care staff have an important role in identifying poverty and connecting patients with appropriate sources of support. Those who wish to opportunistically screen for poverty should firstly identify a referral pathway or service to tackle poverty, which may involve services such as employment, social welfare legal advice and debt counselling. Such a screen should consist of at least one question, specifically, “Do you have difficulty making ends meet at the end of the month?” This could form part of an existing social history alongside questions about occupation and smoking status for ‘new’ patients. Finally, there should be an audit system to identify the results of such referral and an anonymous feedback system for both patients and clinicians to review effectiveness.

Highlighting poverty in primary care is looking at the symptoms of the problem. To tackle the root causes of poverty requires cross-sector working with housing, local authorities, third sector and the private sectors. The pandemic presents us an opportunity for how we re-organise society to benefit everyone: it is our choice whether we take it. We can start those conversations now in our local areas, but nationwide action must be supported by an adequately resourced cross-government strategy for the reduction of health inequalities.

Key points

- “Do you have difficulty making ends meet at the end of the month?” is a useful screening question for primary care clinicians to identify poverty in clinical practice.
- Poverty is likely to increase during the pandemic and referral to existing welfare rights advice services and social prescribers after identification can help decrease poverty.
- Benefits of the screening include better clinician understanding of a patients’ circumstances as well as system-level changes such as more equitable healthcare resource allocation.
- Drawbacks include potentially increasing to clinician workload, fostering patient distrust and lack of established referral pathways for poverty may increase clinician helplessness having identified poverty.

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