Should we screen for poverty in primary care?

During the current pandemic we are likely to encounter the worst economic decline for almost 300 years, which will widen existing health inequalities through direct health and indirect socio-economic effects. The pandemic has resulted in rising poverty levels[1], disproportionately affecting women, racially minoritised and disabled people. There have been increasing numbers of people claiming state benefits, with probable knock-on effects for food insecurity and fuel poverty. This is on a background of cuts to public services and welfare provisions as well as rising employment despite stagnant levels of poverty[2]. Many people throughout society are affected but some patient groups are more likely to suffer economic hardship; for example, those with severe mental illness and living with and beyond cancer (i.e., cancer survivors) are likely to suffer worsening financial toxicity. 'Financial toxicity' is the name first given to the economic effects of cancer treatment.

Since primary care is community facing, questions are raised about what role primary care has in relation to poverty and whether primary care has a duty to screen for poverty. More specifically, should primary care practitioners screen for poverty during routine interactions with patients, and if so, does poverty screening fulfil 'screening criteria'?

Using a reworking of Wilson and Junger's 1968 classic screening criteria, Andermann and colleagues[3] suggest an updated version for the twenty-first century. This could provide a basis for debate about screening for poverty in primary care:

- The screening programme should respond to a recognized 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[3]

The case to screen

There is no doubt that there is a tangible need at a population and local level to reach those who are at risk of poverty during and in the aftermath of the pandemic. This could link people up with available financial assistance to improve their quality of life especially if they have low or unstable incomes. It is difficult to define a target population but arguably it is anyone that presents to primary care as poverty may very well underpin their presentation such as tension headache due to stress from insecure working conditions. When it comes to screening questions, Brcic and colleagues[4] used a list of 10 questions asked via a questionnaire and correlated responses with demographic and income data. From 156 responses they identified a few questions which could be used to screen for poverty:

- 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)

Early data[5] involving 22 Canadian healthcare professionals and 581 patients 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). Whilst asking such a question, many professionals identified people who they would not suspect to be suffering from poverty. Direction to nearby employment organisations[6], co-located welfare services[7], advice workers in a Deep End GP scheme[8], peer-to-peer financial support with facilitation by healthcare professionals[9] and social prescribing[10] may all be viable responses. Follow-up questions could be more specific and focus on use of food banks, living circumstances (private versus rented versus sofa surfing versus homeless), job security, household debt including loans[2] to signpost to appropriate sources of assistance. Education for clinical and non-clinical staff would support implementation of the screening tool, and evaluating of its implementation would help identify, for example, how consistently it was administered, how effective it was and whether improvements could be made.

Patient-level benefits of screening[11] include acknowledgement of socially determined disease risks, adaptation of management plans and appreciation of non-adherence to those plans. Furthermore, the idea of poverty screening is not new. Proactive and opportunistic poverty screening in English[12] and Scottish[13] 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[14] directed at patients suffering with severe symptoms of osteoarthritis and rheumatoid arthritis in hospital and community settings generated over £2100 of annual benefits per claimant at a cost of £59-71 to healthcare in 2002. Cuts in public spending since that time may mean have reduced the relative value of what could be claimed. Despite this, welfare rights advice delivered in primary care can improve the incomes of people who are otherwise living in financial hardship, and have been shown to significantly reduce the experience of financial strain and improve mental wellbeing[7]. Screening with co-located welfare services may have secondary benefits including a subjective decrease in GP workload and consultation time[15,16] and with patients experiencing subjective benefit in the quality of life[17].

On a population level, screening for poverty could identify more systemic problems; for example, the availability of services and adequacy of policies to combat poverty. Solutions to these problems may include more equitable healthcare resource allocation, better integration of health and other sectors, and better-informed public health policies.

The case not to screen

During the pandemic, healthcare services have been struck by absences due to isolation or actual illness as well as escalating burnout and moral injury from high workloads. Primary care has been involved in managing patients who cannot be quickly seen in secondary care as well as in the organisation of COVID-19 vaccinations. Thus, screening may place additional pressure on already overstretched clinical staff. Primary care has been involved in managing patients who cannot be quickly seen in secondary care as well as organisation of COVID-19 vaccinations which presents its own unique challenges. 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. Within this study, a survey revealed that 25% of patients (14 of 56 asked) were not satisfied[5] with the screening question.

Whilst the reasons behind this were unclear, such enquiries may foster patient distrust of healthcare services[18]. Thematic analysis of a focus group with clinicians revealed that asking such a question seemed 'out of place' for well-known patients[5]. There was a fear of helplessness without an adequate intervention to help patients out of poverty. A 2006 systematic review[19] found little 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. A randomized controlled trial[17] comparing people over the age of 60 receiving welfare advice for up to 12 months (n=381) to those who did not (n=374) found no objective improvement in health outcomes at 2 years.

For many clinicians, helping with poverty may seem 'outside their lane' especially when interventions may seem outside the direct reach of healthcare such as housing or money. Perhaps socio-economic problems require socio-economic solutions. For example, a recent systematic review[20] found that supportive housing and income assistance are effective interventions for decreasing homelessness. Yet it could be argued these issues should be addressed by other agencies. 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 access to health. Furthermore, many would argue that many of the proposed downstream solutions are context specific and there is limited evidence from research and implementation science of success in practice, let alone during a pandemic. Such screening would ideally require a measure of effectiveness to see if the benefits outweigh the financial and time costs of implementation.

Conclusion

With the expectations of widening health inequalities during the pandemic, clinicians and non-clinicians (e.g. social prescribers) in primary care may have an important role in identifying poverty and connecting patients with appropriate sources of support. Those who wish to opportunistically screen for poverty during consultations should firstly identify a referral pathway or intervention to tackle poverty. This will be context-dependent and may consist of referral to in-house welfare services such as Citizens' Advice or social prescribing in a Primary Care Network (PCN). 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 may seem out of place

with existing patients but could form part of an existing social history alongside questions about occupation, household 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 and the private sector. The pandemic presents us an opportunity for how we re-organise society to benefit everyone: it is our choice whether we choose to take it. We can start those conversations now in our local areas.

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 services, advice workers 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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