

BMA

Health at a price

Reducing the impact of poverty

A briefing from the board of science, June 2017



British Medical Association
bma.org.uk

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Summary

Recent estimates suggest that one in three people in the UK has, at some stage in their life, experienced relative poverty (for definition see **Box 1**). The causes of poverty are complex and intertwined. They include unemployment, low-paid work, inadequate benefit entitlements, and lack of affordable housing. There are also various social risk factors including having a disability, being a carer, and being part of a lone-parent or large family.

Poverty can affect the health of people at all ages. In infancy, it is associated with a low birth weight, shorter life expectancy and a higher risk of death in the first year of life. Children living in poverty are more likely to suffer from chronic diseases and diet-related problems. Twice as many people are obese in the most deprived areas of the UK than in the least deprived areas. Poverty can affect children's cognitive development, and those living in poverty are over three times more likely to suffer from mental health problems. Poverty has long term implications on children's 'life chances' and health in adulthood. Most individual long-term conditions are more than twice as common in adults from lower socio-economic groups, and mental health problems are much more prevalent.

There is much debate about the interactions and relationships between poverty and health. 'Food poverty' has a range of adverse effects on health, as do some types of low-paid employment (such as manual work). Unemployment is associated with poor health behaviours such as smoking and increased alcohol consumption, and poorer mental health. 'Fuel poverty' leads to a higher risk of physical and mental health problems (particularly in older people), as does living in overcrowded homes (also associated with lower school attainment in children). The strong association between poor mental health and poverty may be partly explained by the stresses associated with poverty.

A negative cycle can exist between poverty and health. Unemployment and poverty contribute to poor mental and physical health, which in turn makes it more difficult to find work. Many people living in poverty cannot afford the cost of their care, such as prescription charges, resulting in their conditions worsening over time. This negative cycle can transfer across generations, starting from pre-birth, with impact upon parenting, educational attainment, and employment.

Preventing poverty and reducing its impact is a significant challenge, because of its complexity. Within the healthcare setting, action can be taken in a range of ways to help reduce the impact on health, and doctors can play a key role in supporting action in this area. Some suggested areas for action are summarised below:

Tackling the social determinants of health

- The 2010 Marmot review sets out action, in six broad policy areas, required to tackle the social determinants of health. The BMA believes that a cross-government national action plan is required setting out short, medium and long-term actions against each of these recommendations, which must be implemented within the first year of the new parliament.
- A 'health in all policies' approach is required to ensure that all government policies are focused on the impact they have on people's health.

The role of the NHS

- With increased investment, the NHS can play a stronger role in ameliorating the impacts of poverty; for example by spending more on prevention, and as a major employer by providing greater support for its own employees.
- The NHS should ensure it is fully engaged with other sectors outside of the health system in relation to tackling poverty. This includes the way it integrates with other public services, and the voluntary and community sector.

Doctors as advocates

- Doctors can be strong advocates against the negative effects of poverty on health, for example, by writing to their local councillor or MP, or becoming involved with other professional and health organisations, community projects or school boards.

Supporting patients

- Doctors can support their patients directly, for example, by focusing on their health literacy, and prioritising ill health prevention measures in commissioning.
- Consideration should be given to the role of social prescribing, in signposting patients at risk of poverty to non-medical support services.

Background

Between 2011 and 2014, almost a third (32.5%) of the UK population had experienced relative poverty at least once in their life.¹ People living in poverty have a much lower life expectancy than those who are not,² and doctors witness first-hand the impact this has on their patients' health. Poverty is also costly; the Joseph Rowntree Foundation estimated that £29 billion a year is spent on treating the conditions associated with poverty in the UK (approximately a quarter of all health spending).³

At the BMA's 2016 Annual Representative Meeting, doctors expressed concern about poverty and social inequality, and the negative effect this can have on physical and mental health, and life expectancy. Similar concerns have been highlighted in recent BMA reports. In 2013, the BMA published *Growing up in the UK*,⁴ which outlined the effects of poverty and social inequality on child health and wellbeing in the UK. A follow-up progress report, published in 2016, found little had changed in the years since. The BMA's 2016 briefing, *Health in all policies: health, austerity and welfare reform*,⁵ drew attention to the impact of austerity and welfare reform on health and wellbeing, particularly for the most vulnerable and disadvantaged in society.

While this previous work has recognised the link between poverty and social inequality, and poor physical and mental health, the BMA has not focused specifically on this issue. This briefing provides an overview of the impact of poverty on health (including both the physical and mental aspects of health^a); and suggests proposals for action for policymakers and doctors to help prevent and mitigate the adverse impact of poverty on health. It will be used to support the Association's lobbying for action to reduce poverty levels, as well as raising awareness among members of the ways in which they can help.

What is poverty?

There are many ways of measuring or defining poverty (see **Box 1**). Unless otherwise stated, this briefing considers poverty to be where someone's '...resources are so seriously below those commanded by the average individual or family, that they are, in effect, excluded from ordinary living patterns, customs and activities.'⁶

Box 1 – Measures and definitions of poverty

There are various definitions and measures of poverty, and no single definition is universally accepted. Some of the most commonly used include:

- **Absolute poverty** – this generally denotes a poverty level relative to a fixed standard of living, rather than the rest of the population.
- **Relative poverty** – this compares each household's income to the median income of their country, where those with less than 60% of the median income are classified as poor. This 60% poverty line is an agreed international measure and has been used throughout the EU. Using relative poverty, severe poverty is defined as a household income lower than 40% of the median household income.⁷ Persistent poverty is defined as when an individual experiences relative low income in the current year, as well as at least two out of the three preceding years.¹ Relative poverty is the most commonly used approach to defining poverty.
- **Material deprivation** – when an individual is not able to afford certain possessions most people take for granted, or are unable to replace worn out items. This is often combined with low income to provide a wider measure of living standards.⁸
- **Worklessness** – when no one in a household is in work. This has been recently adopted by the UK Government, in combination with other factors such as income, material deprivation and educational attainment at age 16, as part of new measures of child poverty, intended to focus on 'life chances'.⁹

a More information on the BMA's mental health work can be found on the mental health hub page www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/mental-health

The causes of poverty

The causes of poverty are complex and intertwined.¹⁰ The following summarises some of the main social and economic factors which may contribute towards poverty.

Unemployment and low-paid work

Workless households are much more likely to experience poverty than households where at least one adult is in work.⁷ People moving repeatedly between unemployment and work is also an endemic problem in the UK. This has risen by 60% since 2006, mainly as a result of the recession.¹¹

However, people in work can still live in poverty. In 2009/10, 58% of all families living below the poverty line^b in the UK contained a working member.¹⁰ Data from the ONS (Office for National Statistics) in 2014 shows that one in five employees in the UK was low paid.^{c,12} Low-paid work is often concurrent with insecure and part-time work and cycles of unemployment. Those most likely to be low paid are women, those aged 16-24, part-time and temporary employees, those in lower-skilled occupations, and those employed in the hospitality, retail and care sectors.¹³

Inadequate benefits

Benefits and tax credits can form a significant proportion of some households' incomes. Inadequate benefit entitlements may leave families living in poverty. In 2014, the Council of Europe claimed that the minimum level of UK benefits someone might receive was "manifestly inadequate" as it falls below 40% of the median income of European states.¹⁴ The BMA report *Health in all policies: health, austerity and welfare reform*⁵ highlighted that the benefit reforms planned between 2015 and 2019 will have a disproportionate impact on low-income households.

Lack of affordable housing

There is a lack of available social housing in the UK: in 2013 there were 1.8 million households on local authority waiting lists, an increase of 81% since 1997.¹⁵ An inadequate supply of affordable housing can result in people having to spend a disproportionate amount of their income on housing costs, causing them to live in poverty and face material deprivation. In 2010/11, an additional 5% of the UK population experienced poverty^d when taking into account housing costs.¹⁶ Poverty induced by housing costs has increased over the last two decades which is likely due to rising rents and changes to housing benefits.¹⁶

Association between demographic factors and poverty

There are certain risk factors for living in poverty, such as having a disability, being a carer, and being part of a lone-parent family or large family.¹⁷ For example, 41% of children living in lone-parent households live in poverty, compared to 24% of two-parent families.¹⁸ A lack of flexible working options in the job market, low wages, and high childcare costs can affect single parents' ability to work.¹⁹

Thirty five per cent of children living in large families (three children or more) live in poverty compared to 25% of those in families with one or two children.¹⁸ A 2006 study by the Joseph Rowntree Foundation found that children from large families were more likely to have a parent who was unemployed, had their first child at a young age, had a lower level of educational attainment, or was disabled; which are all factors associated with poverty.²⁰ Families with a disabled child or disabled adult have a 39% risk of child poverty, compared to 24% in a family with no disability.¹⁷

Being part of a black or minority ethnic group is also associated with an increased likelihood of experiencing poverty.¹⁷ Within black British households, 47% of children live in low-income households, compared to 24% in white households.¹⁷ Fifty eight per cent of children live in poverty in Pakistani and Bangladeshi households.¹⁷ One key driver for this higher rate is disparity in employment levels. Approximately 60% of working-age adults are in employment from minority ethnic groups compared to 75% for the White ethnic group.²¹ There are also many traditionally white working-class neighbourhoods, which experience some of the highest levels of deprivation found in the UK.²²

b Those living below 60% of the median UK household income.

c Low pay as defined by gross hourly earnings (excluding overtime) that are below two-thirds of the median. This was equivalent to £7.67 an hour in April 2014.

d The Joseph Rowntree Foundation define poverty as "when a person's resources (mainly their material resources) are not sufficient to meet their minimum needs (including social participation)."

Refugees and asylum seekers in the UK are also at great risk of living in poverty. Asylum seekers are restricted in their ability to work whilst their claims are being determined or appealed, and they have to rely on a lower rate of support than UK citizens who are unable to work.²³

Poverty and health outcomes

Poverty can impact on the health of people at all stages of life, in numerous ways, and impacts on overall life expectancy. In England, between 2009 and 2013, the life expectancy for those in the most deprived areas compared to the least deprived areas was 7.9 years higher for men, and 5.9 years higher for women.²⁴ The King's Fund found that, between 1999 and 2010, the majority of areas in England with persistently low life expectancy also had a high proportion of people earning low or no wages; and that the reverse was largely true.²⁵

In Scotland, between 2011 and 2013, the male life expectancy was 7.5 years lower in the most deprived areas compared to the least deprived areas, and 5.4 years lower for women.²⁶ In Wales, between 2010 and 2014, this inequality gap was nine years for men and seven years for women.²⁷ In Northern Ireland, between 2011 and 2013, this gap was 7.5 years for men and 4.3 years for women.²⁸ These inequality gaps are even wider when considering 'healthy life expectancy'; an estimate of how many years people might be expected to live in a 'healthy' state. For example, females living in the least deprived local authorities in England could expect to live 16.8 more years of life in good health, than those living in the most deprived.²⁴

Poverty in childhood

Poverty can have a significant impact on child health, from the point before a child is even born. In a 2017 survey by the Royal College of Paediatrics and Child Health (RCPCH) and Child Poverty Action Group, more than two-thirds of doctors said poverty and low income contribute 'very much' to the ill health of children they work with.²⁹

Babies born in the poorest areas in the UK weigh on average 200 grams less than those born in the richest areas,¹⁰ which may impact on subsequent cognitive development.³⁰ Babies living in poverty are also more likely to die within their first year of life.³¹ After birth, poverty is associated with postnatal depression in the mother and lower rates of breastfeeding.³² The 2012 infant feeding survey reported that breastfeeding rates in the UK increased as the level of deprivation in each geographical area decreased, as measured by income, employment, health and education.³³ Seventy three per cent of women in the most deprived quintile initiated breastfeeding, compared to 89% of the least deprived mothers.³³ Post-natal depression and lack of breastfeeding can impact on babies' physical as well as mental health.^{34,35}

Children born into poverty are more likely to suffer from chronic diseases,² such as asthma,³¹ as well as diet-related problems such as tooth decay, malnutrition, obesity and diabetes.³⁶ A 2016 report by NHS Digital found that children in reception year at school, living in the most deprived areas in England, were more than double as likely to be obese than children living in the least deprived areas (12.5% compared to 5.5%).³⁷ In year six, 26% of children living in the most deprived areas were obese compared with 11.7% in the least deprived areas.³⁷

Poor children also have a higher rate of accidents and accidental death. For example they are 13 times more likely to die from unintentional injury.¹⁵ Even for genetic conditions that have no bias in incidence with respect to socio-economic status, such as cystic fibrosis, poorer children experience worse growth, poorer lung function, higher risk of infection and ultimately poorer survival.³¹

As well as poverty affecting their physical health, children living in low-income households are over three times more likely to suffer from mental health problems compared to their more affluent peers.^{38,39} Increased levels of child poverty can have a direct negative effect on children's social, emotional, developmental and cognitive outcomes,⁴⁰ and poverty can hinder parents from providing a supportive and enriching environment for their children to grow up in.⁴¹ This may be, for example, due to parents undergoing continued stress.⁴²

Poverty can have long-term implications on an individual's health as well as their general 'life chances'³⁶ (ie their opportunities to improve their socio-economic status and quality of life). Those growing up in poverty as children are more likely to suffer poor physical and mental health in adulthood, and are at increased risk of severe, long-term and life-limiting illnesses.⁴³ Longitudinal studies have shown that children growing up in poverty have a higher risk of death as adults. This has been studied across almost all conditions including for example, stomach cancer, lung cancer, haemorrhagic stroke, coronary heart disease, respiratory diseases and alcohol-related death.³¹

Poverty in adult life

Most long-term conditions are more common in adults from lower socio-economic groups,⁴⁴ including the working poor, such as diabetes, chronic obstructive pulmonary disease, arthritis and hypertension. For example, two-fifths of adults in England aged 45 to 64 with below-average incomes have a limiting long-term illness, more than twice the rate of adults of the same age with above-average incomes.⁴⁵ Multi-morbidity is also more common among deprived populations.⁴⁴

A 2017 report by the Mental Health Foundation found that three in four people living in the lowest household income bracket report having experienced a mental health problem, compared to six in ten of the highest household income bracket.⁴⁶ Poverty, unemployment and social isolation are associated with higher prevalence of schizophrenia, and rates of admission to specialist psychiatric care.⁴⁷

Poverty in later life

As highlighted in the BMA's report *Growing older in the UK*,⁴⁸ older people^e from lower socio-economic groups are more likely to experience worse health than those from higher socio-economic groups; and poor health will begin earlier in life.⁴⁹ Data indicates that older people who have experienced disadvantage throughout their adult lives are at greater risk of reporting ill health and long-term illness.^{50,51} In the over-65 age group, high levels of deprivation are increasingly being recognised as detrimental to emotional wellbeing and mental health.⁵²

e There are many different ways of defining 'older people'. For example, the ONS commonly quote data on individuals aged over 65, and those aged over 85 have been described as the 'oldest old'. The WHO (World Health Organization) define an 'older person' as someone 'whose age has passed the median life expectancy at birth', which in the UK is currently 81.2 for men and women combined.

How can poverty impact on health?

There are many underlying factors that can contribute to the complex relationship between poverty and poor health, and there is debate about the interactions between them.⁵³ This section explores some of the factors which may contribute to this relationship.

Income and food poverty

As highlighted in the BMA's 2015 report, *Food for thought: promoting healthy diets among children and young people*,⁵⁴ income can influence the ability of individuals and households to obtain a healthy diet; with those on low incomes at risk of suffering from 'food poverty'.^{f,55} Data from the National Diet and Nutrition survey (between 2008/09 and 2011/12) show that the lowest income group generally consume less protein, iron, fruit and vegetables, vitamin C, calcium, fish and folate.⁵⁶ One explanation for this is that nutrient-dense foods such as lean meat, fish, fruit and vegetables are more expensive than low-nutrient foods.⁵⁷ People on low incomes also eat more processed foods, which are high in saturated fats and salt, and consume more added sugars.^{g,55}

'I have many concerns about the impact of poverty on the ability of patients to eat healthily. This is compounded by a lack of education and cookery skills. It is possible to eat well on a budget but becomes harder if you've never been taught to cook basic ingredients and harder still if you have very limited cooking facilities and no fridge, let alone a freezer.'

Undernutrition caused by food poverty can have a range of adverse health effects, including on the muscular system, the immune system and psycho-social function.⁵⁸ A case-control study across 52 countries found that food poverty has been estimated to contribute to 50% of all coronary heart disease deaths.⁵⁹ Food poverty has also been associated with increased falls and fractures in older people, low birth weight and increased childhood mortality, and increased dental caries in children.⁶⁰

Working conditions

Some types of low-paid employment are associated with poorer health outcomes. Data from the General Household Survey in 2011 show that 37% of those in manual occupations in Great Britain had a long-standing illness compared to 29% of those from professional occupations.⁶¹ Death rates for cancer and heart disease – the two biggest causes of death for under 65s – are about twice as high for people employed in manual compared to non-manual work.⁴⁵ As highlighted in the BMA's *Growing older in the UK*,⁴⁸ poorer working conditions and exposure to hazards carries a high risk of poor mental and physical health, including musculoskeletal problems, increased rates of long-term illness, increased medication use, and lower recovery from illness.⁴⁸ For example, it is estimated that one in ten cases of asthma in adults in the UK is caused by work-related factors, through exposure to irritants or allergens.⁶²

f The Department of Health (England) recognises food poverty as 'the inability to afford, or to have access to, food to make up a healthy diet.'

g Added sugars are 'free sugars' which comprises all monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus sugars naturally present in honey, syrups and unsweetened fruit juices. Under this definition lactose (the sugar in milk) when naturally present in milk and milk products and the sugars contained within the cellular structure of foods (particularly fruits and vegetables) are excluded.

Unemployment

Unemployment, besides from being an underlying cause of poverty, can have a significant direct impact on physical and mental health, as noted in the Marmot Review.² The Review also highlighted that unemployment is consistently associated with an increase in overall mortality and increased medication use.² Unemployment can impact on health behaviours, such as smoking, increased alcohol consumption and decreased physical exercise.² Data from the ONS in 2012 shows that unemployed people in the UK are twice as likely to smoke as employed people.⁶³ Data from NESARC (National Epidemiologic Survey on Alcohol and Related Conditions) suggest that job loss in the previous year corresponds to increased alcohol consumption, possibly due to mental factors such as strain, and financial pressure.⁶⁴ There is evidence that unemployment can contribute to distress, anxiety, depression and suicide,^{2,65} with people who move into work tending to report substantial improvements in their mental health.⁶⁶ The health and social effects resulting from a long period of unemployment can last for years.⁶⁷

Education

In households without children, those living in poverty are more likely to have no qualifications,⁶⁸ which is likely to impact on employability and income. The 2007 (most recent) Low Income Diet and Nutrition Survey shows that those with no educational qualifications were less likely to eat fruit and vegetables and were more likely to eat energy-dense foods than those with educational qualifications.⁶⁹ Higher educational attainment is also associated with reduced smoking and increased physical activity.⁷⁰

Fuel poverty and poor housing

Many individuals on low incomes face 'fuel poverty'; meaning that given their income, they cannot afford to keep their home adequately warm. Living in a cold, damp home leads to a higher risk of poor health outcomes, as well as increased morbidity and mortality.⁷¹ This includes, among all age groups, cardiovascular and respiratory diseases and mental health problems, as well as increased minor illnesses and exacerbation of existing conditions such as arthritis and rheumatism.⁷¹

Children living in cold homes are more than twice as likely to suffer from a range of respiratory problems compared to those living in warm homes.⁷¹ Cold housing has also been identified as having indirect, negative effects on children's educational attainment, emotional wellbeing and resilience.⁷¹ More than one in four adolescents living in cold homes is at risk of multiple mental health problems, compared to one in 20 living in warm housing.⁷² Older people are particularly vulnerable to higher mortality risk, and physical health and mental health problems, due to living in a cold home.⁷¹

Families on low incomes are more likely to live in overcrowded homes.⁷³ Overcrowding is four times as prevalent in social-rented housing compared to owner occupation.⁷³ Rates of respiratory disease, tuberculosis, meningitis and gastric conditions are higher in overcrowded homes, and they can also have a negative effect on mental health.⁷⁴ Furthermore, concerns about housing – such as living in a poorly maintained, unsafe or temporary home – can place considerable stress on families and prevent parents from providing practical and emotional support to children.⁷⁵

Those who are homeless experience health problems at a rate significantly higher than the general population; their average age at death is 43 for women and 47 for men.⁷⁶ Multiple and co-occurring physical and mental health problems alongside substance use amongst the homeless are common.⁷⁷

Mental health

The strong association between poverty and poor emotional wellbeing may be partly explained by the stresses associated with poverty.⁵² This includes struggling to make ends meet, the impact of problem debt in attempting to cope with poverty; poor housing conditions and wider physical environment; fear of crime; and relatively poor physical health.⁵² A 2003 systematic review of social inequalities and common mental disorders found that the most consistent associations of common mental illnesses were with unemployment, education, income, and material standard of living,⁷⁸ though the causal relationship between these factors is complex.

The cycle of poverty and health

The relationship between poverty and ill health is bidirectional.⁵³ Unemployment and poverty can contribute to poor health, such as chronic diseases and poor mental health. But poor physical and mental health also increases the likelihood of unemployment;⁷⁹ and the two can become mutually reinforcing.² Many people living in poverty cannot afford the cost of their prescription medicines to treat their conditions, resulting in their condition worsening over time.⁸⁰

'I saw a patient recently in her late 50s (still paying for prescriptions), who needed an alternative prescription for her UTI, which had turned out to be resistant to Trimethoprim. She apparently faced a financial dilemma: if she *bought* the new prescription immediately she would have no spare money left for at least two days, even for food. If she did not change the treatment immediately and get started, she felt she might get so poorly, that she may get a warning or be sacked from her low-paid job. A kind of a Catch 22. Furthermore, she was anxious, if the suggested treatment was really guaranteed to solve the medical problem. I suggested to her to speak to the pharmacist to allow payment for the script with a few days delay. She apparently had to pretend to everybody around her, that she was a *normal* person and that she was generally doing okay, but is, apparently, really rather vulnerable – pretty shocking, at her age, and in a generally quite affluent area (City of York).'

In older people, a qualitative study found that poor health added to material deprivation, by increasing some of the additional cost associated with managing health conditions, such as occasional or costly day-to-day support.⁸¹ Additional costs associated with being disabled can further add to the poverty that disabled people may face, such as extra transport costs or the cost of a wheelchair or stair lift.⁸² A 2014 study by the charity Scope found that disability-related expenses cost on average £550 a month.⁸³

Some families on low incomes may find it harder to access or manage family planning;⁸⁴ which can result in families becoming larger and more expensive; pushing them further into poverty. Many people living with HIV in the UK face financial disadvantage,⁸⁵ particularly among Black African men and women.^{86,87} For some, this initial disadvantage can deteriorate into poverty, due to stress, health problems and the social impact of the condition (making employment more difficult).⁸⁵ A similar cycle is endured by those living in deprived communities with tuberculosis⁸⁸ (of which the rates are seven times higher than for those not living in deprived communities).⁸⁹

The negative cycle between poverty and health can also occur across generations, starting from pre-birth. Women from low-income households are less likely to book antenatal checks and are more likely to smoke and drink alcohol during pregnancy and have a poor diet.² This can affect the fetal development and birthweight of a child, which can in turn affect their neurodevelopmental growth and long-term health and cognitive outcomes.⁹⁰ This can cause children not to be school ready by age five, and affect their educational attainment. Children growing up in poverty are less likely to do well at school.² Having poorer health and educational outcomes can affect an individual's potential to overcome poverty in the future. Lower educational attainment is also associated with riskier health behaviours and poorer health outcomes.⁹¹

Although the teenage pregnancy rate is continuing to fall in the UK, this transgenerational cycle can be exacerbated by teenage pregnancies, which have been more prevalent in lower socio-economic groups.⁹² Teenage pregnancies are more likely to result in lower birth weight babies, higher infant and child mortality, hospital admissions of children, postnatal depression and lower rates of breastfeeding.⁹² Teenage mothers are less likely to complete their education and be in employment, and are more likely to live in poverty.⁹² The children of teenage mothers are more likely to experience these disadvantages and are twice as likely to become teenage parents themselves.⁹³

Addressing the impact of poverty on health

Preventing poverty, and reducing its impact, is a significant challenge because of the complex interplay of factors that cause poverty, and the scale of action needed at a national, regional and local level. The following identifies key policy actions to tackle the social determinants of health, and considers the role that the NHS and doctors can play.

Tackling the social determinants of health

Actions to prevent and reduce poverty align with action to address the social determinants of health (ie the social and economic factors that determine an individual's health, such as education, occupation and income). Many of these areas lie outside the remit of the health system, and require activities and interventions across sectors. This has been comprehensively considered in the 2010 Marmot Review, and the BMA supports the six broad policy objectives identified by the Review.² The Marmot Review sets out a comprehensive range of recommendations for each of these six policy objectives.² The following outlines some examples of the type of action required.

Give every child the best start in life

- Adequately fund early intervention and children's centres, including programmes which target children and families experiencing poverty, to support improved parenting and mitigate the psychological impact of poverty.

Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Extend the role of schools in taking a 'whole child' approach to education, supporting both the physical and mental health of children who might be living in poverty.
- Provide support and advice for 16-25 year olds on life skills and employment opportunities, particularly to those in deprived areas.

Create fair employment and good work for all

- Improve access to good jobs for those in deprived areas.
- Ensure all employers use preventative measures to mitigate mental and physical problems at work, particularly in manual work.
- Provide flexible working options to ensure those with responsibilities at home (such as single parents) can also work, giving them a route out of poverty.

Ensure a healthy standard of living for all

- Recognise and protect a minimum income required for a healthy standard of living, including through reducing the 'cliff-edges' between benefits and work.

Create and develop healthy and sustainable places and communities

- Ensure there is a sufficient supply of affordable housing.
- Take actions to reduce fuel poverty and help people improve the energy efficiency of their homes.
- Help to fund voluntary sector services that are vital to supporting those in poverty.

Strengthen the role and impact of ill health prevention

- Prioritise funding for prevention and early intervention activities that are effective across the social gradient in health.
- Promote public mental health and invest in initiatives that foster wellbeing.

The BMA believes that a cross-government national action plan is required setting out short, medium and long-term actions against each of these recommendations.² This should incorporate a framework of monitoring and reviewing progress, be led by the respective UK health departments, and should be published within the first year of the new UK parliament.

The BMA also strongly supports a 'health in all policies' approach to ensure that all services and policies are focused on their impact on health. This can be done by making the HIA (Health Impact Assessment) a mandatory requirement for all government departments and public bodies, meaning they have to undertake a health impact assessment of all new policies and policy changes. This is discussed in more detail in the 2016 board of science briefing, *Health in all policies: health, austerity and welfare reform*.

The role of the NHS

While the NHS can play a vital role in ameliorating the impacts of poverty, this is being limited by the high level of demand for services, financial constraints on its resources, and workload pressures on doctors. As the BMA has repeatedly highlighted, there is a need for greater overall investment in the NHS. For example, there needs to be adequate resourcing for general practice to ensure GPs – who are a key point of contact for all NHS patients and the gateway to other health services – have sufficient consultation time to support the health needs of any patients living in poverty. An overall increase in investment will also support a greater focus on prevention. This should be targeted at areas with higher levels of poverty, and include a focus on extending health literacy programmes, increasing the uptake of health screenings, and programmes which support patients in managing their long-term conditions.

Beyond increased investment, the following outlines some ways in which the NHS can become more focused on tackling poverty:

- The NHS needs to develop and publish a strategy, within the next year, for its role in tackling poverty. This should include, for example, an awareness of its existing impact on poverty, how service provision relates to poverty reduction, the role of primary care in proactively changing the wider determinants of health, and how it is accountable for supporting people living in poverty.
- There should be a greater focus on increasing registration rates with those who have low access to health care and might be suffering from poverty, such as homeless people, sex workers and vulnerable migrants.
- As the largest employer in the UK, the NHS should ensure that all its employees are paid the national living wage. It should also ensure all staff have access to comprehensive occupational health services, acting as an exemplar of good practice for other employers.
- The NHS needs to ensure that its priorities are strongly aligned and engaged with other sectors outside of the health system in relation to tackling poverty. This includes the way it integrates with other public services, and the voluntary and community sector. For example, the NHS should work in partnership with:
 - other employers – to ensure that there is a strong focus on occupational health, so that the health of those in employment, especially those in manual work is protected
 - local schools – targeting deprived communities where there are high rates of young people aged 16-24 not in education, employment or training (NEETs), to run work experience programmes alongside other employers, to develop young people's skills and experience for careers within or outside the health service
 - local authorities - to support stronger links between health and social care services, including integrated mental health services
 - the voluntary sector – to ensure patients are aware of the non-medical support services that are available in their local area.

The role of doctors as advocates

Doctors can have a particularly strong voice in advocating for the health needs of their patients and wider population. They are trusted members of society,⁹⁴ who understand the relationship between poverty and health. The following are some potential ways in which doctors can act as advocates, on a local and national scale. This is not meant to be an exhaustive list, or be prescriptive about what should be done, but provides examples of the type of activities doctors can undertake. Equally, the intention is not to replace or counter ongoing relevant projects or work programmes. So for many, **finding out what is already happening and getting involved in existing initiatives** is likely to be the best approach.

- Consider what health-based arguments should be made to those responsible for planning and commissioning of health services, in order to represent the best interests of patients and the health of the public.
- Consider how you can directly influence decisions (eg standing for election as a local councillor, getting involved in a local strategic partnership or acting as a school governor).
- Write to your local councillor or MP highlighting your concerns about the impact of poverty on your patients' health.
- Become involved with the advocacy work of professional organisations and bodies, including the BMA and medical royal colleges.
- As a GP, get involved with your local medical committee to shape the way it represents GPs in the local area on this matter.
- Become involved with the work of health organisations and charities, such as the Institute of Health Equity, to voice your experience of the impact of poverty on health.
- Lobby healthcare organisations and the local authority to assess how their policy and planning decisions can support action to reduce poverty.
- Become involved with a local community project, to influence local policy decisions and voice the need to address the impact of poverty.

How doctors can support patients within the healthcare setting

Doctors also have a unique role within the healthcare setting, in their direct relationship with patients whose health might be affected by living in poverty, or through their commissioning responsibilities.

The following provides some examples of the type of activities doctors can undertake to support their patients:

- Take a proactive approach to improving patients' health literacy, by emphasising (when clinically appropriate) the importance of positive health behaviours, such as a healthy diet and physical exercise as well as the impact of unhealthy behaviours, such as smoking and consuming too much alcohol.
- Consider the role of social prescribing, in signposting patients to non-medical support services. This may include welfare advice (eg their local Welfare Assistance Team or Citizen's Advice Bureau), financial advice services, food banks, or community projects.
- For those with commissioning responsibilities, prioritise commissioning ill health prevention measures, and develop integrated services across health, public health and social care. If not actively involved in commissioning, encourage local planners or commissioners to take a more holistic approach to commissioning and public service policy development.
- Consider undergoing additional training in occupational health, in order to support patients in maximising their health, in a way that means they can participate in employment or return to work following sickness absence.
- Work collaboratively with other health and social care professionals, and the voluntary sector, to provide integrated care to people facing poverty. There are a number of initiatives across the UK, which aim to support the health of individuals living in poverty. Examples of such programmes are summarised in **Box 2**.

Box 2 – Approaches to support the health of individuals living in poverty

GPs at the Deep End⁹⁵

GPs at the Deep End is a network of GP practices which serve the 100 most socio-economically deprived practice populations in Scotland. It was developed by the RCGP Scotland working group on Health Inequalities to allow GPs to share experiences of the challenges they face in dealing with some of the most deprived parts of society. The Deep End project has received funding and administrative support from the Scottish Government's Health Department, the RCGP, and General Practice and Primary Care at the University of Glasgow. Inspired by the Scottish example, General Practice at the Deep End Yorkshire and Humber aims to bring together healthcare professionals working in the region's most socio-economically deprived areas to tackle health inequalities.⁹⁶

Hope Citadel's Focused Care scheme in Manchester⁹⁷

'Hope Citadel' is a not-for-profit scheme commissioned by local CCGs to provide NHS services to the most deprived families across four Greater Manchester GP practices, by filling the gaps between health and social care. Each practice employs a 'Focused Care Practitioner' to help those needing extra support. People can be referred to Focused Care by health staff, social care workers or even police. In each case a patient or family is seen, problems are identified and a care plan drawn up, tackling anything from help with immigration, to parenting and dealing with benefit problems. They are then supported on an ongoing basis. Audits of the 160 families receiving Focused Care over the four surgeries show that they visited A&E 57% less in the year following intervention. Cervical screening rates over the four practices also increased from around 40% to 94%, while at one surgery, 91% of over 65s had their flu vaccine, outstripping the national target of 80%.

Doncaster social prescribing service⁹⁸

The Doncaster Social Prescribing Service is commissioned by the CCG and Council through the Better Care Fund. It is targeted at vulnerable adults; those with poor mental wellbeing affected by social circumstances, with mild to moderate depression or anxiety; those who are frequent attenders at primary or secondary care; and those with long term physical/mental health conditions. It gives GPs, pharmacists and community nurses the option to refer vulnerable patients to non-medical services such as housing or debt advice. Patients referred to the project are visited at home by a specialist adviser who matches them to services available within the community and voluntary sector. High proportions of those who have used the service have reported feeling more confident in managing their health conditions, more connected to the community and more independent.⁹⁸ A recent review found that 68% of clients reported a reduction in the number of GP appointments following referral to the social prescribing scheme.

One GP practice in Doncaster with links to the social prescribing scheme is developing a project 'focus patient' aimed at addressing the health needs of those in poverty. The project identifies those living in areas of socio-economic deprivation within the practice population, allowing targeted support for patients at risk of poverty.

Conclusion

Poverty can have a harmful and wide-reaching impact on health, and the reasons for this are complex. Many individuals facing poverty can end up in a negative cycle, where the harmful impacts further prevent them from overcoming poverty. Actions to tackle poverty and to mitigate its impact, focused on addressing the social determinants of health, are vital to improving health outcomes in the UK and reducing demand on the NHS. With increased investment now, there are ways that the NHS can play a stronger role in tackling poverty and save money later, including working with other sectors to tackle poverty. Doctors can also act as advocates for the negative effect of poverty on health, and there are ways they can support their patients who might be living in poverty.

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BMA 20170523