# PCRS Position Statement

## Respiratory health inequality - Poverty

January 2024

Tackling smoking, reducing air pollution, improving access to healthcare for those experiencing health inequality and an improved focus on research and development to fit the needs of people experiencing health inequality should be the priorities for systems wanting to make respiratory health outcomes equal. Whilst primary care is in an ideal position to screen for, recognise, and treat the effects of poverty on respiratory health, the evidence for prevention interventions that have a direct effect on poverty are limited and do not have strong evidence to support them. Respiratory health integration intentions must go beyond health service systems to also include social and voluntary sectors to impact on the drivers of poverty related poor respiratory health.

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## Background

A patient survey by Asthma + Lung UK (ALUK) in 2022 showed that 1 in 5 people with asthma reported experiencing asthma attacks because of a need to ration their medicines, heating and food.[1] 50% of people with COPD and bronchiectasis were also reporting worsening of symptoms for the same reasons.

The survey was carried out at a time when the UK was experiencing the peak of a cost of living crisis with record high levels of inflation and fuel costs.[2] In 2022 the office for national statistics (ONS) calculated that there was a worsening of income inequality using the Gini coefficient,[3] a measure that allows comparison between countries. The UK in 2021 was already one of the worst performing countries for this measure.[4] The data to show the presence of and impacts caused by health inequality is not new. The Black Report (1980),[5] Acheson Report (1988),[6] Marmot Report (2010)[7] and Marmot Report "revisited" (2020)[8] have all clearly highlighted this with the latest Marmot report showing that health inequalities are widening rather than narrowing.

The ALUK survey made the link between poor respiratory outcomes and the cost of living crisis due to the content of the narrative responses they received and because the charity's helpline had seen an 89% increase in those needing advice for help with their finances or benefits. Actions taken by patients included:

- 63% buying and eating less food
- 15% trying to make their preventer inhaler last longer
- 5% borrowing medicines
- 6% not getting their prescriptions
- 10% using electric devices such as nebulisers and oxygen concentrators were using them less
- 74% planning to heat their homes less

The survey's findings followed ALUK's report earlier that same year highlighting key factors, amenable to intervention, that needed to be attended to by policy makers in order to tackle inequalities that result in worse respiratory outcomes9. These were:

- Smoking
- Air pollution
- Inequitable access to diagnosis and treatment
- Respiratory research and development that excludes or fails to focus on people and groups experiencing health inequality

Poverty is linked to poor respiratory outcomes. As highlighted by ALUK, key factors include:

- Tobacco smoking, which is more common in people with lower incomes and the cost of smoking makes households poorer.[10,11]
- Air pollution, where indoors, there is more of a problem in poor homes and low-income households, and also outdoors because, on the whole, poor housing tends to be located nearer to heavier traffic flows that are the main source of environmental pollutants that affect respiratory health.[12–14]
- Poverty being associated with problems accessing the right, i.e. planned, health care appointments for diagnosis and treatment.[15]

A more in-depth description of these and other factors is available at the PCRS Health Inequalities resources webpage, with material that includes a review of homelessness, poverty and poor housing and their impacts on respiratory health.[16] The material also explores further, the evidence that demonstrates why tragic child deaths occur more in certain ethnic groups such as in the case of Ella Kissi-Debrah and Awaab Ishak.

## Children and young people (CYP), asthma and poverty

Inequality is a problem facing CYP as well as adults, and poverty affects CYP's lung health. Asthma is the most prevalent long-term condition in CYP, with worse outcomes and subsequent later life impacts seen as a result of inequalities. For children of all ages, higher socioeconomic deprivation is significantly associated with having an exacerbation.[17] In 2020, the Royal College of Paediatrics and Child Health (RCPCH) report on the state of child health in the UK, made reducing child health inequalities one of its three key priorities. There are a number of inequalities that children can experience but poverty is likely to be the most significant and the RCPCH report highlighted that in a typical UK classroom 30% of children live in poverty.[18] They suggest that tobacco smoke exposure, including starting smoking at a younger age, and environmental pollution are likely to be significant contributors

## Poor housing

It is hard to isolate poverty and poor housing from each other when analysing their respective effects on respiratory health. There is much overlap, with the consequences for respiratory health arising from cold homes, buildings that overheat, mould, indoor pollution and overcrowding.

The Institute of Health Equity 2022 report focused on cold homes and child health,[19] with Michael Marmot and paediatrician Ian Sinha stating:

"A child's lungs play a crucial role in determining his or her health and life expectancy. There is a window of opportunity in childhood for optimal respiratory maturation. This is impaired by problems associated with cold, substandard, or overcrowded housing such as viruses, dust, mould, and pollution. When we add in factors such as cutting back on food to pay the gas bills, and the mental health and educational impact of cold houses, the picture is bleaker still. Without meaningful and swift action cold housing will have dangerous consequences for many children now, and through their life-course".

### Poor nutrition

Diet and nutrition are modifiable contributors to chronic respiratory disease development and progression. Evidence suggests that dietary intake impacts on obstructive lung diseases including asthma and COPD starting from early life and resulting from maternal nutrition factors.[20]

Evidence consistently reports that households experiencing poverty find themselves unable to afford enough food, and the food that they can afford is often poor quality, energy dense and low in nutrients. However, the relationship between diet, poverty and health is complex and there are factors beyond income that create this association. It is increasingly apparent that 'uncertainty' is one of those aspects and this arises from energy costs, cost of living pressures and change in policy on social and financial benefits to those with low income. With heightened uncertainty, all aspects of household food provisioning – including budgeting, shopping, storage, meal planning and cooking – are more difficult and sometimes impossible. Experiences of prolonged uncertainty shape dietary practices and impact health and well-being.[21]

### Primary care interventions to mitigate the effects of financial poverty

Social policies such as a universal basic income may improve health at a population level and there is in addition, a debate, about whether healthcare has a responsibility to also intervene to manage the negative health outcomes from poverty. It is also of no surprise that within the wider healthcare system, it would be considered within the remit of general practice to deliver these interventions. However, there are risks of using a healthcare system to attend to such a deep social problem as those at greatest need may be least able to access healthcare and therefore a health approach could widen the inequality gap.[22] Screening for poverty in primary care has some evidence base but the outcomes are mixed.

A set of recommendations for primary care from a UK based group[23] about screening poverty recommends:

- First identify a pathway or service that could tackle the problem whether it be employment, welfare payments, legal advice, money advice.
- They recommend the screening question - 'Do you have difficulty making ends meet at the end of the month?'
- The screening question could be asked at registration in the same way as for example smoking history is.
- Due to current lack of evidence to specifically support primary care interventions, local audit of impact should be performed.

The NICE guideline[24] on health risks of cold homes, a secondary effect of poverty, has recommendations that apply to health systems but also some actions that can be taken by individual practitioners or local networks of primary and community care:

- Recognise those most at risk from cold homes i.e. those at risk of fuel poverty and those whose illnesses worsen with a cold home.
- Train people who see people in their homes to recognise housing problems that affect health, provide practical advice and refer.

### PCRS position

- PCRS supports the Asthma and Lung UK 'levelling-up' priorities of tackling smoking, reducing air pollution, improving access to healthcare for those experiencing health inequality and an improved focus on research and development to fit the needs of people experiencing health inequality including financial poverty.
- PCRS recognises that primary and community care workers are in an ideal position to screen for poverty and recognise and treat the effects of poverty on respiratory health. However, evidence for prevention interventions that have a direct effect on poverty are limited and do not have strong evidence to support them.
- Improving equitable access to planned respiratory care for those identified as living in poverty is a quality improvement activity that PCRS would encourage practices to prioritise.

- PCRS supports integration of respiratory health care that goes beyond health service integration to also include social and voluntary sectors to impact on the drivers of poverty related poor respiratory health, including amongst others, preventing and stopping smoking, ensuring warm and dry homes, avoiding overcrowding, ensuring access to good nutrition and improving air quality.

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