Screening for poverty in family practice

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I recently completed a death certificate for Marie. She was 42 years old. I listed the cause of death as *cancer of the cervix, metastatic*. But I think I erred in completing the certificate. I really believe Marie died of her poverty.

Marie was a single mom of 2 children, raising them alone after separating from her abusive male partner following the birth of her second child. She struggled on social assistance, then later at cleaning and dishwashing jobs for minimum wage, trying to support her young family as her grade 8 education limited her vocational options. Her long work hours and child care responsibilities made visiting a family doctor a rare, episodic occurrence. Nor did she understand the importance of a Papanicolaou smear.

So although she technically died of cancer, her poverty and social circumstances were more than just a risk factor for cervical cancer, a preventable and treatable disease when caught early. Why didn't I write *poverty* as a cause of her death? What is it about my attitude and training that told me poverty wasn't an acceptable reason or important contributing factor to her demise?

I do know that the most important social determinant of health is income.[1] Poverty accounts for 24% of person-years of life lost in Canada (second only to 31% for neoplasms).[2] Growing up in poverty is associated with increased adult morbidity and mortality from causes including diabetes, mental illness, stroke, cardiovascular disease, gastrointestinal disease, central nervous system disease, cirrhosis, injuries, and homicide.[2] In the well-resourced city of Toronto, Ont, infant mortality is 60% higher in lower-income neighbourhoods.[2] I know too that First Nations people, people of colour, women of all backgrounds, and members of the lesbian, gay, bisexual, and transgendered community are at the greatest risk.[3]

We all regularly screen for diabetes, hyperlipidemia, cancer when the evidence exists, hypertension, depression, smoking, and addiction, yet how many of us screen for the overarching condition of poverty—one of the most important risk factors for ill health and death?

Most of us believe there is little we as family doctors can do with respect to poverty in a systematic way.[4] Indeed, it would be unethical to screen for a disease or condition for which no intervention could be offered. But more evidence is emerging that supports screening, which should raise our awareness of the need to address this issue to improve health outcomes.[3,5]

Family doctors and their primary care teams, as front-line health care providers, are in the ideal position to screen for and address poverty when possible.[5] As supporting evidence becomes stronger, screening for poverty needs to become integrated into our everyday practice, similar to screening for smoking. Thirty years ago, routine screening for smoking was not common. Can you imagine not asking about smoking today or not offering intervention to those interested in quitting? Changing the culture of practice can take years. This is a medical issue, not just a moral or charitable one. Family physicians and the CFPC must raise awareness to perceive poverty as a preventable and treatable condition. Advocacy for our patients, on individual and organizational bases, is one of our critical and important CanMEDS–Family Medicine roles and responsibilities.[6]

To assist in screening for poverty, family physicians have created a validated, evidence-based clinical poverty screening tool.[5] Poverty exists everywhere in Canada and is not always apparent. We cannot make assumptions based on the way patients are dressed or the job that they have. We need to screen everyone.[3,5] Asking "Do you ever have difficulty making ends meet at the end of the month?" (sensitivity of 98% and specificity of 60% for living below the poverty line[5]) is all that it takes. The tool provides several suggestions for addressing poverty (eg, obtaining tax credits and extra income supplements, assisting with disability applications), all of which can be adapted to the local jurisdiction.[3]

Further research into how primary care teams can screen for and intervene in our patients' poverty is necessary to understand how best to improve health outcomes. Can we develop health equity quality indicators and incorporate these into everyday practice? By identifying patients and families experiencing poverty (especially the "not-so-obvious" ones) and by labeling poverty in the clinical practice setting (not just as an underlying social determinant of health), we can maximize the medical and social interventions that might save the lives of our patients. My wish for the future of health care in Canada? I naïvely hope to never have to write *poverty* as a contributing cause of death, ever.

Cet article se trouve aussi en français à la **page 710.**

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