# Life & Times

# The cost of living crisis:

## how can we tackle fuel poverty and food insecurity in practice?

### BACKGROUND

In the past few months the UK population has experienced compounded cost of living increases among soaring costs and decreases in real income. The current cost of living crisis is making life ever more difficult for families living on the knife edge of poverty, and we know that poverty is bad for your health.[1] The poorer you are, the more likely you are to die from heart disease, lung cancer, and chronic lower respiratory illnesses, as well as suicide.[2] The cost of living crisis is not only making our society poorer but also more systematically unfair. Health inequalities are caused by a wide range of factors, such as income, housing, and transport, which are all being targeted by price rises. This slide into increased poverty and health inequalities is deeply worrying for healthcare professionals who see the direct impact on their patients' lives. I will focus here on just two areas: fuel poverty and food insecurity, as areas where primary care can, and perhaps should, get involved.

### FUEL POVERTY

With spiralling fuel prices and a planned scrapping of the energy price cap in the autumn, industry experts warn that up to 40% of households could fall into fuel poverty.[3] Fuel poverty disproportionately affects older people, among whom colder homes lead to an increased risk of cardiovascular disease, respiratory illnesses, and falls.[4] Home visits are an insightful window into the lives of our patients, and GPs and district nurses are ideally placed to identify people who live in cold or hard to heat homes; especially among vulnerable older people who spend long periods of time at home. National Institute for Health and Care Excellence (NICE) guidance recommends that the heating needs of people should be assessed annually, with referrals to local health and housing services as required.[4]

How does the NICE guidance translate to practice? Back in 2017, the Royal College of General Practitioners ran a fuel poverty pilot in Wiltshire that automatically flagged a patients GP record if they were at risk of deterioration due to a cold home. This flag then prompted primary care practitioners (not just GPs) to speak to patients about heating their home. If the patient needed support, practitioners were directed to an automatic referral to a local warm homes service. Overall, the pilot found that relatively few patients were actually referred, but interestingly, running the pilot led to a culture change within the involved practices, with practitioners beginning to understand their role in addressing cold homes and fuel poverty.[5]

Links between practices, local authorities, and the voluntary sector can take time to develop and evolve. Citizens Advice have developed a toolkit on 'Building cold homes referrals with the health sector'[6] (so that health professionals are able to identify and refer patients who are vulnerable to living in a cold home), which includes information about developing and maintaining local referral pathways. As with any new initiative, building these links requires local champions to identify fuel poverty and energy efficiency programmes to support vulnerable people living in cold homes within their area.

### FOOD INSECURITY

Food prices are increasing rapidly, with grocery price inflation levels above 5% in April.[7] Food insecurity is intrinsically linked to adverse health outcomes, especially among children, with increased risks of chronic disease and mental illness later in life.[8] The first step must be to identify the scale of the problem, and indeed, some posit that doctors have an ethical obligation to ask about food insecurity.[9]

The Hunger Vital Signscreen[10] identifies households at being at risk for food insecurity if they answer that either or both of the following two statements is often true or never true:

*'Within the past 12 months we worried whether our food would run out before we got money to buy more'*

*'Within the past 12 months the food we bought just didn't last and we didn't have money to get more'*[11]

You could make it simpler than this to screen for poverty — and just ask, *'Do you (ever) have difficulty making ends meet at the end of the month?'*[12] Being armoured with this information, however, is only half the battle. As Knight and Fritz write, *'doctors may feel impotent to deal with food insecurity, even if they are empowered to unearth it.'*[9] As with fuel poverty, acting

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upon food insecurity requires local solutions such as knowledge of food banks, which can be challenging. Directing patients to Citizens Advice[13] is a good first step, as advisers can signpost and refer to food banks as required.

## WE NEED TO ASK PATIENTS

The questions we ask or don't ask our patients at a micro-level can affect macro-level debate and discussion. As Andrew Moscrop and colleagues note:

*'By not asking patients about their social circumstances or recording socioeconomic data, doctors help to conceal these problems from public view and from the political agenda.'*[14]

Especially in the cases of fuel and food poverty, it is up to practices and primary care networks to identify, record, and refer to local services. It seems that for the foreseeable future, households in the UK are going to feel the squeeze of higher inflation and the corresponding impact on health. And as GPs, we are well placed to understand the social context of physical and mental health illnesses, and the complex cycles that trap our patients in poverty and ill health.

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