

TACKLING POVERTY THROUGH PRIMARY CARE: EXPERIENCES FROM THE FRONT LINES

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Mac for Medicare: March 16, 2010

OBJECTIVES

- 1) Examine arguments for intervening in poverty in primary care.
- 2) Through the presenter's experiences, examine ways family doctors can intervene in poverty.

⦿ Discussion:

Do you think family doctors have a duty to do what they can do increase their patients' income?

ARGUMENTS FOR ADDRESSING POVERTY IN PRIMARY CARE

ARGUMENT 1: THIS IS
REQUIRED BY THE
PRINCIPLES OF FAMILY
MEDICINE

PRINCIPLES OF FAMILY MEDICINE

- ... a skilled clinician.
 - “... use their understanding of human development and family *and other social systems* to develop a comprehensive approach ...”
- ... a community-based discipline.
 - “... significantly influenced by community factors.”
- ... a resource to a defined practice population.
 - “... responsibility to advocate public policy that promotes their patients’ health.”
- The patient-physician relationship ...
 - “... an understanding and appreciation of the human condition.”

AND BY THE ACADEMY

Future of Medical Education in Canada (2009)

- ◎ Address Individual and Community Needs
 - Social responsibility and accountability are core values ... physicians and faculties must respond to the diverse needs of individuals and communities throughout Canada ...

ARGUMENT 2: POVERTY IS
A MAJOR RISK FACTOR FOR
DISEASE, SO REQUIRES
INTERVENTION

RISK FACTORS FOR DISEASE ROUTINELY ADDRESSED BY FAMILY MEDICINE

- poor diet
- lack of exercise
- alcohol and drug use
- high risk sexual behaviour

- We routinely screen for and intervene in these risky behaviours ...

- Should poverty be treated as an equivalent risk factor, similarly warranting intervention?

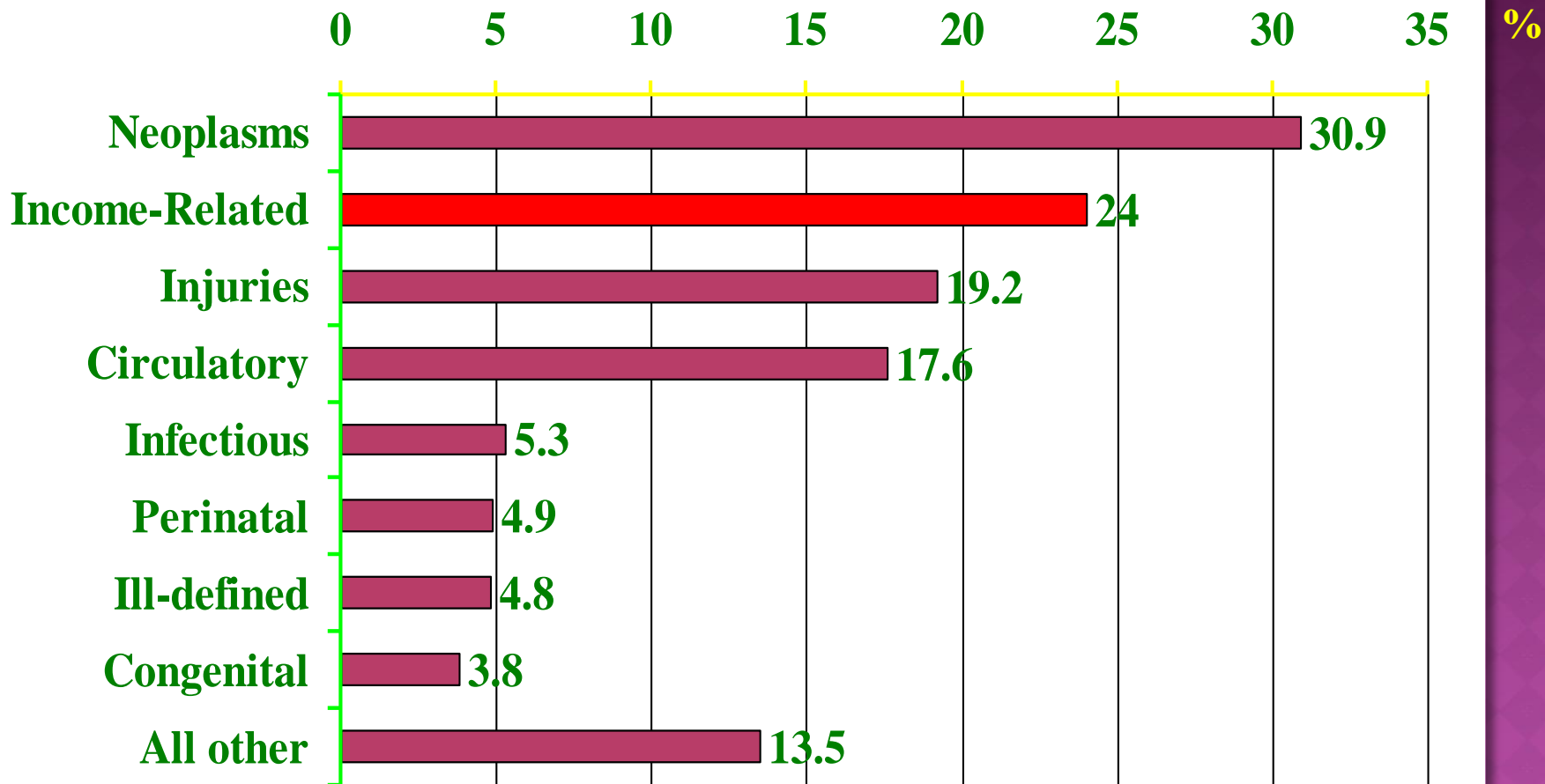
ARGUMENT 3: POVERTY IS
A DISEASE OR ILLNESS OR
DISORDER, AND WARRANTS
TREATMENT LIKE ANY
OTHER

- ⦿ Disease? “An abnormal condition of an organism that impairs bodily function”
- ⦿ Illness? “A person’s experience of their condition”
- ⦿ Disorder? “functional abnormality or disturbance”

WHAT ARE COMPARABLE “DISEASES”?

- Are high blood pressure, diabetes, high cholesterol diseases? Risks for disease?
- These all place people at high risk for disease ... but only *directly* cause illness at extremes
- Is poverty similar? ... Let's look at the evidence

PERSON YEARS OF LIFE LOST



Wilkins R, Berthelot J-M, Ng E. Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996. *Health Reports* (Statistics Canada). 2002;13(Supplement): 10.

Adapted from: Dennis Raphael

INFANT MORTALITY AND LBW

- Poorest vs. richest areas:
 - Low Birth Weight: **40% higher**
 - Infant Mortality: **61% higher**

McKeown et. al., 2009; Wilkins et. al., 2002.

CARDIOVASCULAR DISEASE

- ◉ *Prevalence*: **17% higher** than Canadian average.
- ◉ *Mortality*: If everyone had the mortality rates of the highest income category there would be **21% fewer premature CVD deaths per year** in Toronto.

Lightman, E., Mitchell, A. & Wilson, B. (2008). Poverty is making us sick: A comprehensive survey of income and health in Canada. Wellesley Institute.

City of Toronto. (2008). Unequal City: Income and Health Inequalities in Toronto (http://www.toronto.ca/health/map/pdf/unequalcity_20081016.pdf)

DIABETES

- ◉ *Prevalence*: Lowest income more than **double** highest income (10% vs. 5% men, 8% vs. 3% women).
- ◉ *Mortality*: Women **70% higher** (17 vs. 10/10⁵); Men **58% higher** (27 vs. 17/10⁵).

Bierman, A.S., et. al. (2009). Burden of Illness. In: Bierman, A.S., editor. Project for an Ontario Women's Health Evidence-Based Report: Volume 1: Toronto.

MENTAL ILLNESS

- ◉ **Prevalence: Consistent relationship** between low SES and mental illness.
- ◉ **Depression: Prevalence 58% higher** than Cdn average (14.5% vs. 9.2%).
- ◉ **Suicide: Attempt rate on social assistance 18 times higher** than higher income individuals.

Fryers, T., Melzer, D., & Jenkins, R. (2003). Social inequalities and the common mental disorders: a systematic review of the evidence. *Social Psychiatry and Psychiatric Epidemiology*, 38, 229-237.

Smith, et. al., (2007) "Gender, Income and Immigration Differences in Depression in Canadian Urban Centres," *CJPH*, 98(2): 149.

Lightman, E., Mitchell, A. & Wilson, B. (2009). *Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario*. Wellesley Institute.

CANCER

- ◉ **Prevalence: Higher** for lung, oral (OR 2.41), cervical (RR 2.08).
- ◉ **Mortality: Lower 5-year survival rates** for most cancers.
- ◉ **Screening: Low income women are less likely to access mammograms or Paps.**

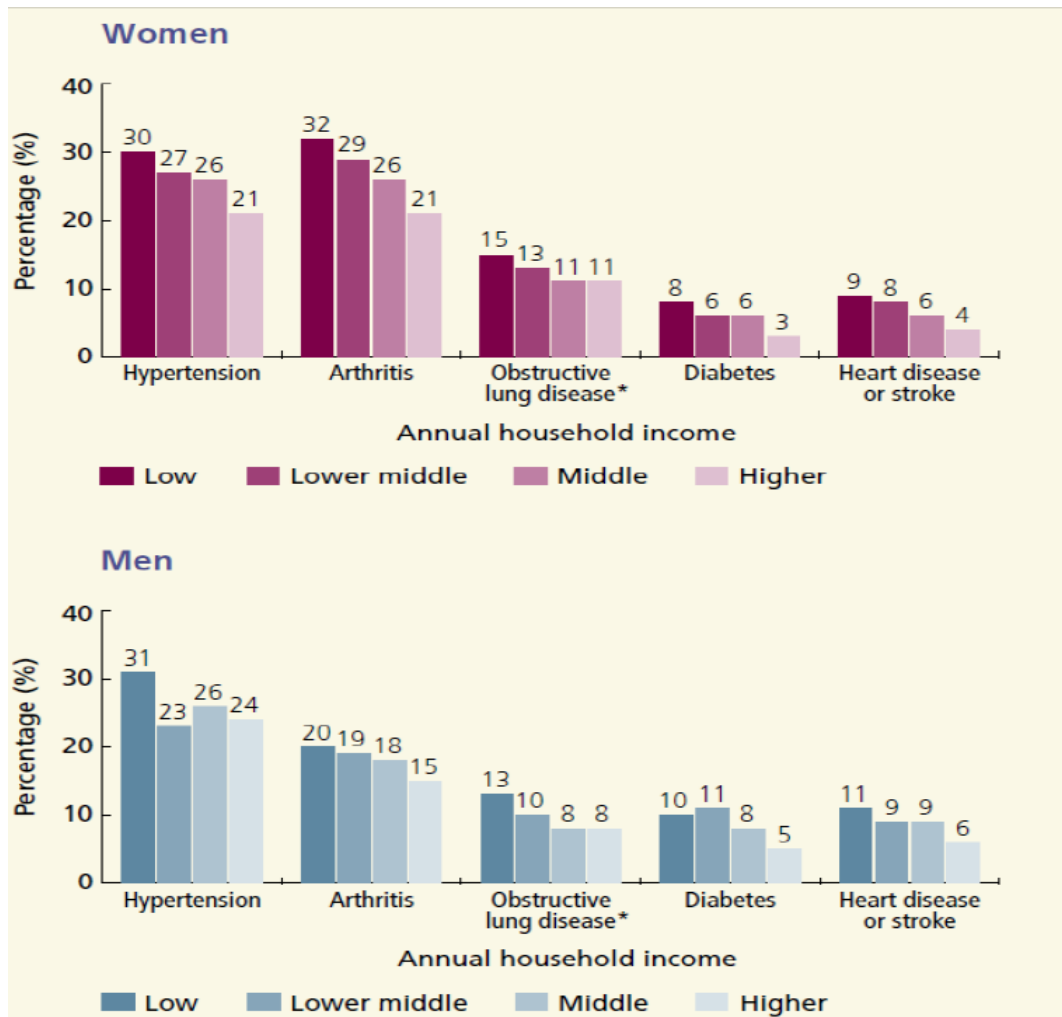
Krzyzanowska, M.K., et. al. (2009). Cancer. In. Bierman, A.S., editor. Project for an Ontario Women's Health Evidence-Based Report: Volume 1: Toronto.

Conway, D.I., et. al. (2009). Significant oral cancer risk associated with low socioeconomic status. *British Dental Journal*, 206(6), 2811-2819.

Shack, L., et. al. (2008). Variation in incidence of breast, lung and cervical cancer and malignant melanoma of skin by socioeconomic group in England. *BMC Cancer*, 8, 271.

Singh, G.K., et. al. (2003). Area Socioeconomic Variations in US Cancer Incidence, Mortality, Stage, Treatment, and Survival, 1975-1999. NCI Cancer Surveillance Monograph Series, No. 4. NIH Publication No. 03-5417. Bethesda, Md: National Cancer Institute.

OTHER CHRONIC CONDITIONS



Bierman et. al. (2009).

CHILDREN

- Growing up in relative poverty associated with **increased adult morbidity and mortality** from:
 - stomach, liver, lung CA; diabetes; CVD; CVA; respiratory diseases; nervous sx conditions; GI disorders; alcoholic cirrhosis; unintentional injuries; and homicide.
- Low income children experience more **disability from their health conditions.**

Currie J, Lin W. (2007). Chipping away at health: more on the relationship between income and child health. *Health Affairs*, 26(2), 331-344.

Lemelin, E.T., et. al. (2009). Life-course socioeconomic positions and subclinical atherosclerosis in the multi-ethnic study of atherosclerosis. *Soc Sci Med.*, 68(3), 444-51.

Emerson, E. (2009). Relative child poverty, income inequality, wealth, and health. *JAMA*, 301(4), 425-6.

ISN'T IT JUST THAT POOR HEALTH CAUSES POVERTY?

- ⦿ “All [the studies reviewed] conclude that ... the main direction of influence is *from* poverty *to* poor(er) health.”

Shelley Phipps, 2003.

ISN'T IT JUST POOR PEOPLE'S UNHEALTHY LIFESTYLES?

- Health inequalities persist even after lifestyle factors are controlled for ...

Marmot MG. *Social Inequalities in Mortality: the social environment*. In: Wilkinson RG. editor. *Class and Health: Research and Longitudinal Data*. London: Tavistock; 1986.

SO IS POVERTY A DISEASE?

- Just like high blood pressure, diabetes, cholesterol:
 - Puts sufferers at risk of high morbidity and mortality through various pathways
 - No other cause accounts for all the elevated risk
 - At extremes it can cause direct harm
 - Groups that move out of poverty experience a decrease in illness
 - The finding is consistent across time, geography, and different population groups ...

WHY INTERVENE IN POVERTY?

- ⦿ A disease? An illness? A risk factor?
- ⦿ On the basis of principles of family medicine?
- ⦿ ***Whichever argument holds, we should be treating poverty ...***
- ⦿ But can we do anything about it???

EXPERIENCES IN TREATING POVERTY

INTERVENTION:
MOBILIZATION AND
ADVOCACY - THE SPECIAL
DIET CAMPAIGN

IT ALL STARTED WITH A DIRECT HEALTH INTERVENTION INTO POVERTY ...



AND IT EVOLVED INTO ...

Lobbying Policymakers



Public awareness raising



Health Organizations



Alliances with
Antipoverty Groups



Legal Challenges



THE PARTNERS

- ◉ **Health providers**
- ◉ **Antipoverty activists**
- ◉ **People living in poverty**
- ◉ **Health professional organizations**
- ◉ **Health provider organizations**
- ◉ **Toronto Public Health & Board of Health**
- ◉ **Other advocacy organizations**

RESULTS

- ◉ Tens (perhaps hundreds) of millions of dollars in the pockets of people living in poverty
- ◉ Media attention to poverty and health
- ◉ Mobilization of health providers
- ◉ Connections with antipoverty groups
- ◉ A world of possibility: a direct health intervention into poverty

LESSONS FROM THE SPECIAL DIET CAMPAIGN

1. Engage in action with real impact
2. Partner with people living in poverty
3. Think long-term
4. Diversify your activities

THIS MATURED INTO:

**HEALTH
PROVIDERS**

**AGAINST
POVERTY**

We'll get back to this ...

- Discussion

Did we overstep our bounds in the Special Diet Campaign? Was this appropriate action for health providers?

INTERVENTION:
SPECIALIZED SERVICES -
INNER CITY HEALTH
ASSOCIATES

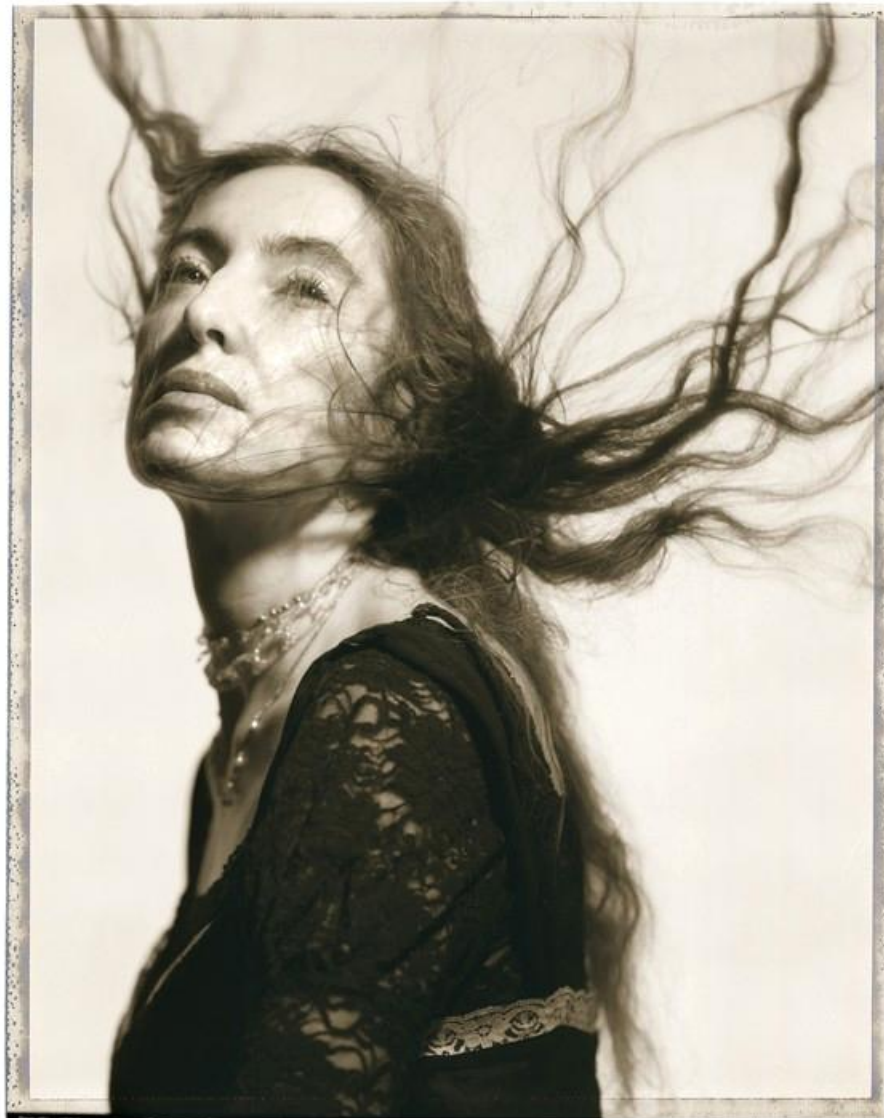
HOMELESS HEALTH

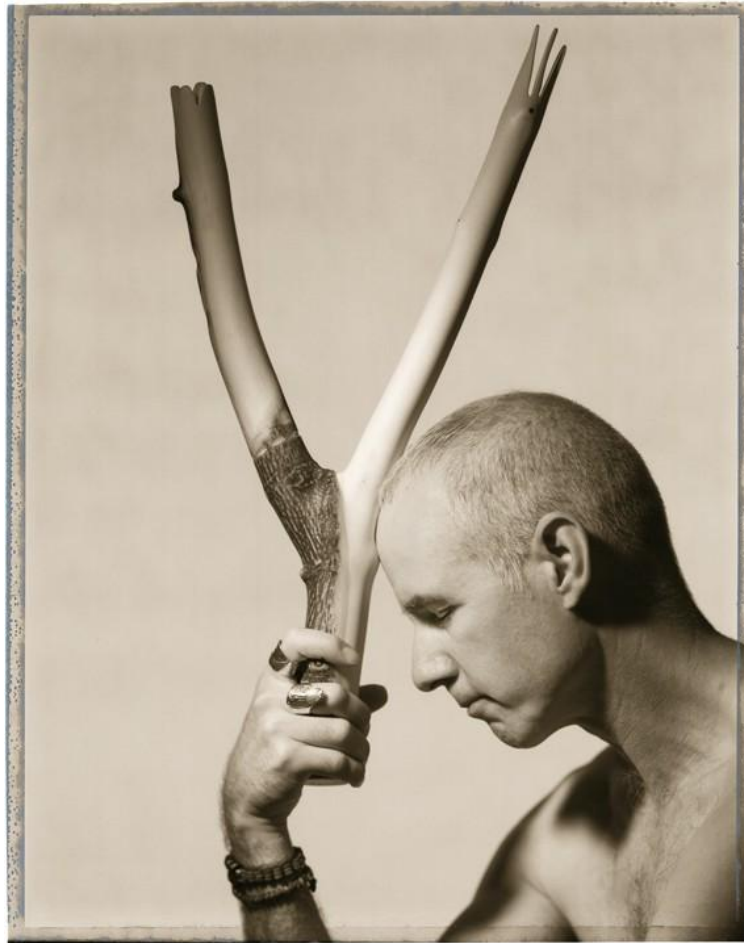
- ⦿ Homeless people in Toronto are:
 - 29 times as likely to have hepatitis C
 - 20 times as likely to have epilepsy
 - 5 times as likely to have heart disease
 - 4 times as likely to have cancer
 - 3 ½ times as likely to have asthma
 - 3 times as likely to have arthritis or rheumatism
 - Twice as likely to have diabetes

Street Health Report 2007

HEALTH ACCESS

- >1/2 have no family doctor
- >1/4 have been refused care d/t lack of ID
- >1/3 have felt disrespected by a health provider







INNER CITY HEALTH ASSOCIATES

- ◎ **4 years ago: 12 physicians at 3 homeless service sites ... then a new payment plan spawned ICHA**
- ◎ **Now: 61 physicians at over 35 homeless service sites across the GTA**

ICHA-Our Approach

Vision

- **To end chronic homelessness related to illness and disability.**

.... a determinants of health-focused medical service!

ICHA- What We Do

Goals/ Strategies

- **Clinical Care**
- **Administration / Program Development**
- **Population level care**
- **Education**
- **Advocacy**

ICHA - REMOVING BARRIERS TO CARE

- ⦿ No ID/Health Card requirements.
- ⦿ Access to MD to sign forms (e.g. disability, welfare)
- ⦿ On-site access to care.
- ⦿ No need for MD referral to access psychiatry.

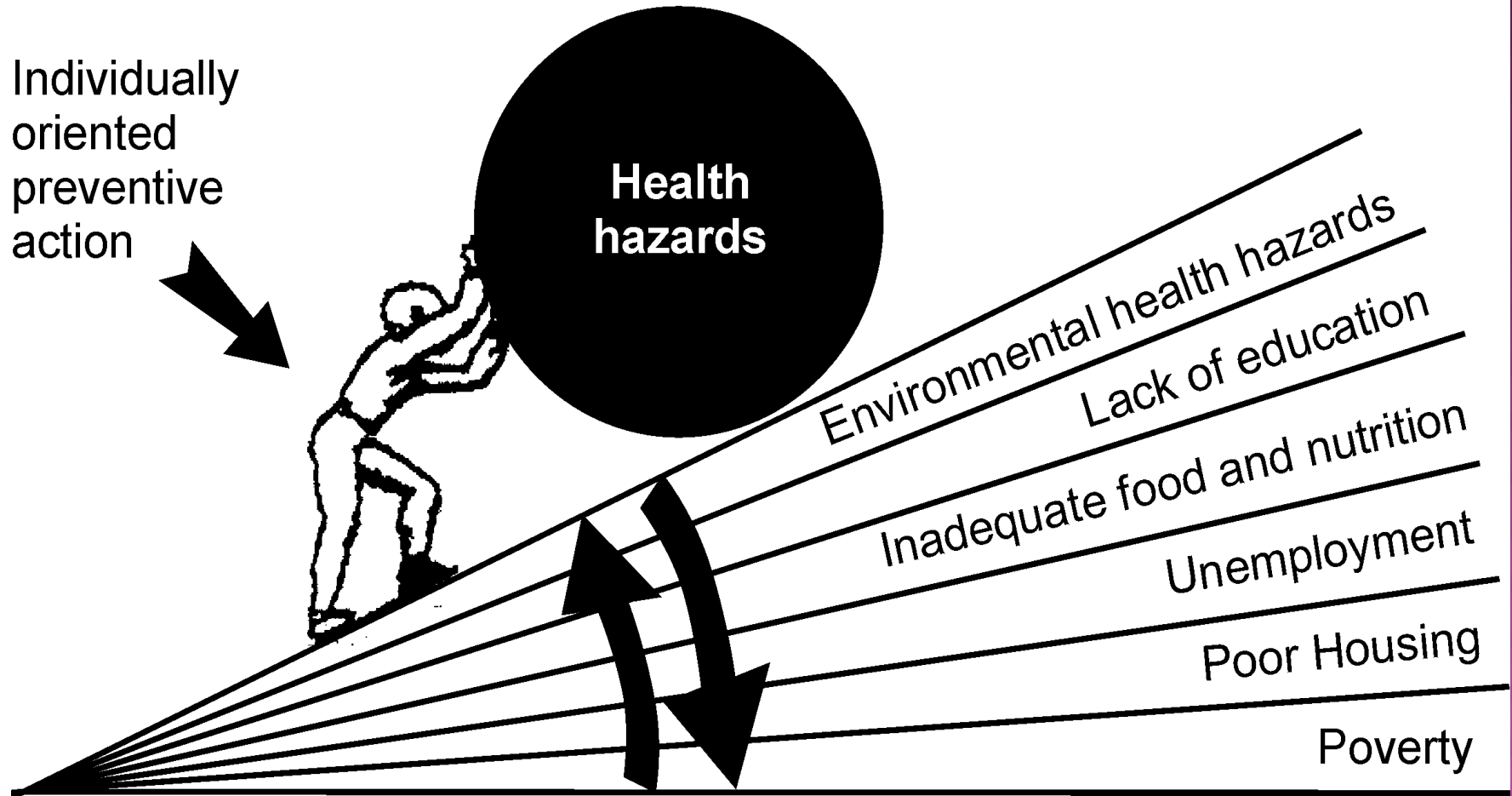
INTERVENTION: WITH INDIVIDUAL PATIENTS

UNDERSTAND THE REALITY!!!

“[Family doctors] might see [poverty] ... in terms of a theoretical academic construct but I don’t think they’d actually understand the real reality of it in terms of what it actually means for a person to get X amount of dollars and be forced to try to live on those dollars.”

-- Community Worker, Low income Drop-in Centre, Toronto

The Health Gradient



Source: adapted from Making Partners: intersectoral action for health.

WHAT IS THE AVERAGE MONTHLY
INCOME FOR A SINGLE INDIVIDUAL ON
OW?

- A. \$ 585
- B. \$ 735
- C. \$ 925
- D. \$1,125

WHAT DOES THAT TRANSLATE TO FOR A DAILY BUDGET?

- **OW recipients report having less than \$1 per day to spend on food.**
- **ODSP recipients report having less than \$4/day..**



Pinto, A., G. Bloch, J. Polsky, T. Svoboda. "Paying for food after other expenses: social assistance recipients in Ontario," Submitted for publication. Toronto, ON: 2010.

INTERVENTIONS REQUIRING DIRECT PHYSICIAN INPUT

- ◉ *Disability applications: ODSP, CPP-D, WSIB*
- ◉ *Welfare supplements: Special Diet, Transportation, Medical Supplies*
- ◉ *Disability Tax Credit application*

- ◉ *But good advice and resources are as powerful as a signature*

A FEW QUESTIONS WITH BIG IMPACT

- 1) ***For everybody:*** Have you filled out and mailed your income tax forms???
- 2) ***For Low Income Seniors:*** Do you receive at least \$1400 in monthly benefits?
- 3) ***For Families with Children:*** Do you receive the Child Benefit on the 20th of every month?
- 4) ***For people with Disabilities:*** Do you receive Disability Benefits?

FILING A TAX RETURN ... THE KEY TO INCOME SUPPORTS

Wages	Income after tax benefits	Income after child benefits
\$12,500	\$15,184	\$20,899
15,000	17,391	23,107
17,500	19,299	25,015
20,000	21,136	26,851
22,500	22,894	28,495
25,000	24,723	30,124
27,500	26,513	31,409
30,000	28,164	32,555
32,500	29,841	33,727
35,000	31,455	34,840
37,500	32,874	35,954

*Based on single mother and infant, no union or benefits, \$8,400 rent, \$400 medical expenses, \$1,452 transit pass

OTHER TOOLS FOR FAMILY PRACTICE

- ◉ Screening aids: We should be screening everyone for poverty!
- ◉ Evidence-Based Risk Assessments
- ◉ Resource and referral lists

WHY FOCUS ON INDIVIDUAL INTERVENTIONS

- ◉ Bring poverty into the mainstream of medical practice
- ◉ Raise awareness amongst doctors of their patients' poverty
- ◉ Hopefully mobilize doctors to lobby, speak and advocate publicly

THE NEXT FRONTIERS:
WHAT HPAP IS DOING NOW
(AND WHY)

WHAT HPAP IS DOING NOW:

1) EDUCATION

- ◉ Translating poverty into the language of Providers ... evidence, evidence, evidence
- ◉ Funding: DFCM, CEP, SMH Foundation
- ◉ *Rationale:*
 - Change for people living in poverty
 - Building Capacity

2) ADVOCACY

- ⊙ Government

- Coalitions

- ⊙ Professional Organizations

- ⊙ *Rationale:*

- Add health expertise to others' expertise
- Systems-level change ... power in numbers

3) RESEARCH

- ⊙ Systematic Reviews

- Welfare changes and health
- Primary care interventions

- ⊙ Quantifying the effects of poverty

- Welfare recipient study

- ⊙ Evaluating Interventions

- Interviewing expert informants, family docs, people living in poverty
- Interventions trials - the next frontier

- ⊙ *Rationale:*

- The power of good evidence

4) DIRECT ACTION



- ◉ Special Diet Campaign
- ◉ Multidisciplinary anti-poverty clinics
- ◉ Individual provider tools/actions
- ◉ *Rationale:*
 - We can make real change for people living in poverty now
 - Basis for advocacy

A RADICAL SHIFT?

- A radical shift is necessary: how we see our roles as health professionals and what we define as disease
- **Necessary components:**
 - Changes in medical education
 - Changes in discourse in academia and in practice
 - Move to a broader view of health and a broader understanding of disease
 - Move to broader solutions
 - Change in research priorities
 - Development of practice-focused tools
 - Changes in accountability: negligent for *not* addressing diseases like poverty

◉ Discussion

What do you think health providers can and should do to address poverty?

CONTACTS AND FURTHER INFO

www.healthprovidersagainstpoverty.ca

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