

# REDUCING POVERTY IN PRIMARY CARE: WHAT ALL FAMILY DOCTORS CAN DO TO ADDRESS THEIR PATIENTS' POVERTY

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# DISCUSSION

- ◉ Do physicians have a duty to try to decrease their patients' poverty?

# OBJECTIVES

- 1) To learn a simple, three step approach to identifying and reducing patients' poverty
- 2) To examine concrete skills and practice-friendly tools family physicians can use to tackle poverty and its impact on health

# RESEARCH BASE

- This session draws on the following research:
  - 1) A comprehensive review of the evidence linking poverty and health
  - 2) A comprehensive review of the evidence concerning primary care interventions into poverty
  - 3) A qualitative study of expert informants on primary care interventions into poverty in Ontario

# FUNDING AND COLLABORATION



St. Michael's Hospital Family  
Medicine Associates



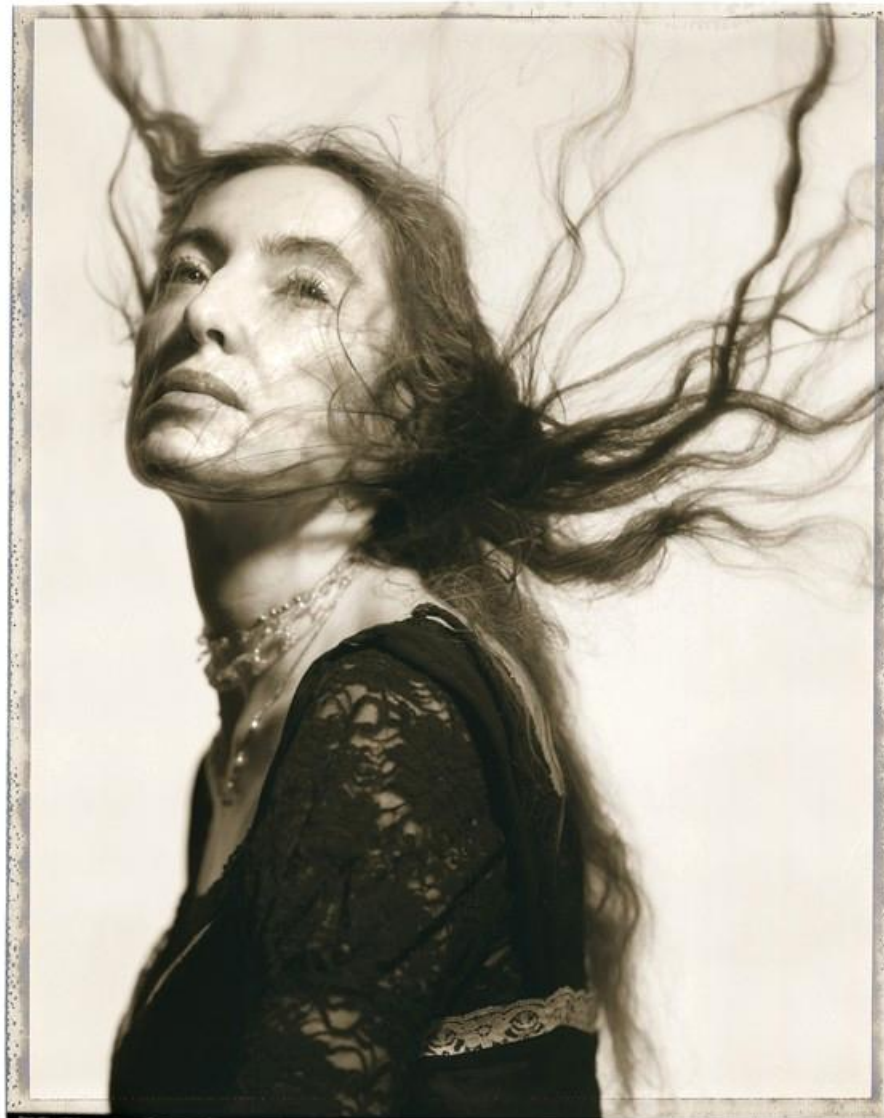
Linda Rozmovits PhD,  
Qualitative Researcher

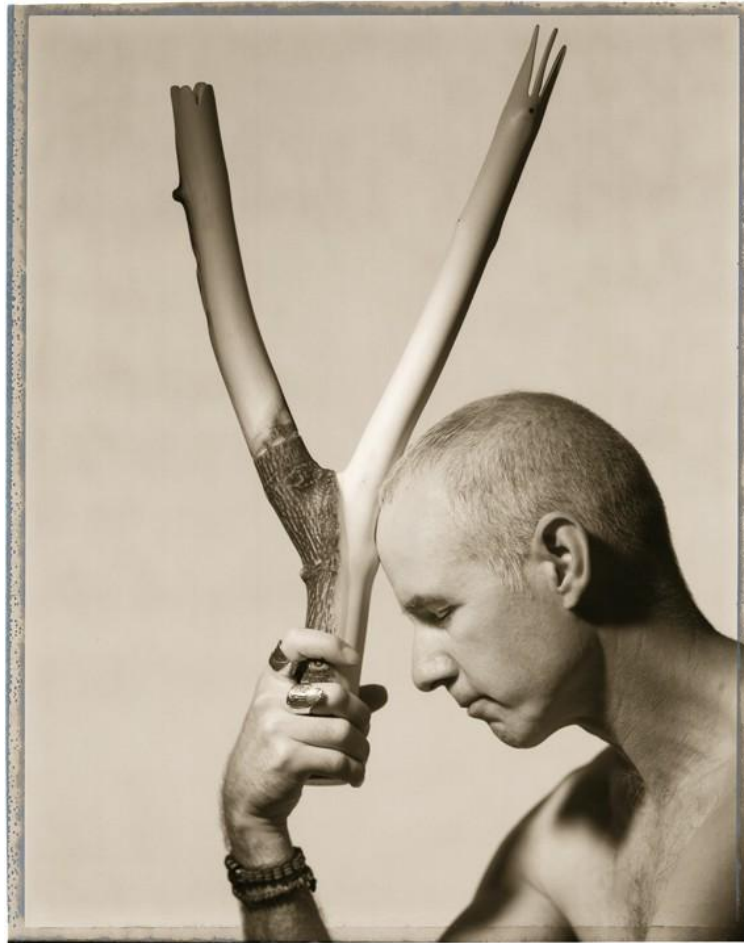
Broden Giambrone MHS,  
Research Assistant

# OUR CASE

- 42yo woman, single mother of a 5 year old.
  - New patient, no previous family MD. Complains of occasional R CP on exertion, occasional SOB, fatigue, generalized muscle aches, vague abdominal discomfort. Non-smoker, no significant FHx.
  - Works part time, earns \$12 500/year. Rents bachelor apartment, \$600/mo.
- 1) What are our priority health issues for this woman?
  - 2) What are you worried about? What investigations are reasonable, based on her history?
  - 3) Can and should we do anything about her poverty?

WHO ARE WE TALKING  
ABOUT TODAY?







# THREE STEPS TO ADDRESSING POVERTY IN PRIMARY CARE

- 1) Screen
- 2) Assess Risk
- 3) Intervene

## STEP 1: SCREEN

*“I suspect that most physicians would be reluctant or it would not be in their consciousness to enquire about people’s economic circumstances, employment, income, debt, nature of their housing ... it’s not in people’s consciousness to look, to gaze beyond the individual patient and try to see what the circumstances of their life are that might be making them sick.”*

*- Family Physician, Inner City Toronto*

# WHY SCREEN

- ◉ Poverty is often hidden ... we can't make assumptions
- ◉ In Toronto: **29%** of families live in Poverty
- ◉ *Poverty affects health on a gradient:* Income negatively affects the health of all but the highest income patients.

United Way (2007).

Wilkinson, R. (2003). Social determinants of health: the solid facts. 2nd edition. World Health Organization Report.

# STEP 1: SCREEN

Screen everyone!!!

**“Do you ever have difficulty making ends meet at the end of the month?”**

(Sensitivity 98%, Specificity 64% for living below the poverty line)

Brcic, Vanessa and Caroline Eberdt, “Developing a tool to identify poverty in a family practice setting,” Unpublished. Vancouver, BC: 2009.

# SCREENING TOOLS - CPP



## CUMULATIVE PATIENT PROFILE

DATE:		ACTIVE/ ONGOING MEDICAL
Primary Health Provider:		
<b>SOCIAL HISTORY</b>		
Income: <input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate Source:		
Housing: <input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/> Homeless		
Education (Highest Level):		
Social Supports:		
Drug Plan:	Food Secure: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Immigration Status: <input type="checkbox"/> Cdn Citizen <input type="checkbox"/> Other: _____		
Smoker: <input type="checkbox"/> No <input type="checkbox"/> ___cigs/day	Alcohol: <input type="checkbox"/> No <input type="checkbox"/> ___drinks/wk	
Other Substance Use: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
<b>FAMILY HISTORY/ GENOGRAM</b>		

# SCREENING TOOLS - AHE



## Preventive Care Checklist Form®

For average-risk, routine, female  
health assessments

Based on form developed by: Drs. V. Dubey, R. Mathew, K. Iglar; Revised by HPAP 2008

Name:

Sex:

DOB:

Health Card:

Tel:

Date:

Age:

<p>Current Concerns:</p>	<p><u>Determinants of Health:</u> HOUSING/HOMELESS:</p> <p>INCOME (EMPLOYED/OW/ODSP):</p> <p>WELFARE SUPPLEMENTS (E.G. DIET, TRANSPORTATION, SUPPLIES):</p> <p>FOOD SECURITY:</p> <p>WORK/OCCUP. HEALTH RISKS:</p> <p>SOCIAL SUPPORTS:</p> <p>FAMILY/RELATIONSHIPS: Abuse</p>	<p>DIET:</p> <p>EXERCISE</p> <p>SMOKING:</p> <p>ALCOHOL:</p> <p>DRUGS:</p> <p>SEXUAL HISTORY:</p> <p>FAMILY PLANNING/ CONTRACEPTION</p>
	<p><u>Update Cumulative Patient Profile:</u></p> <p><input type="checkbox"/> Family History                      <input type="checkbox"/> Medications</p> <p><input type="checkbox"/> Hospitalizations/Surgeries        <input type="checkbox"/> Allergies</p>	
Functional Inquiry:	Normal	Remarks

## STEP 2: ASSESS HEALTH RISK

- ◉ If a patient smokes, how does that change your screening and diagnostic decision-making?
- ◉ Should poverty be treated like other risk factors?

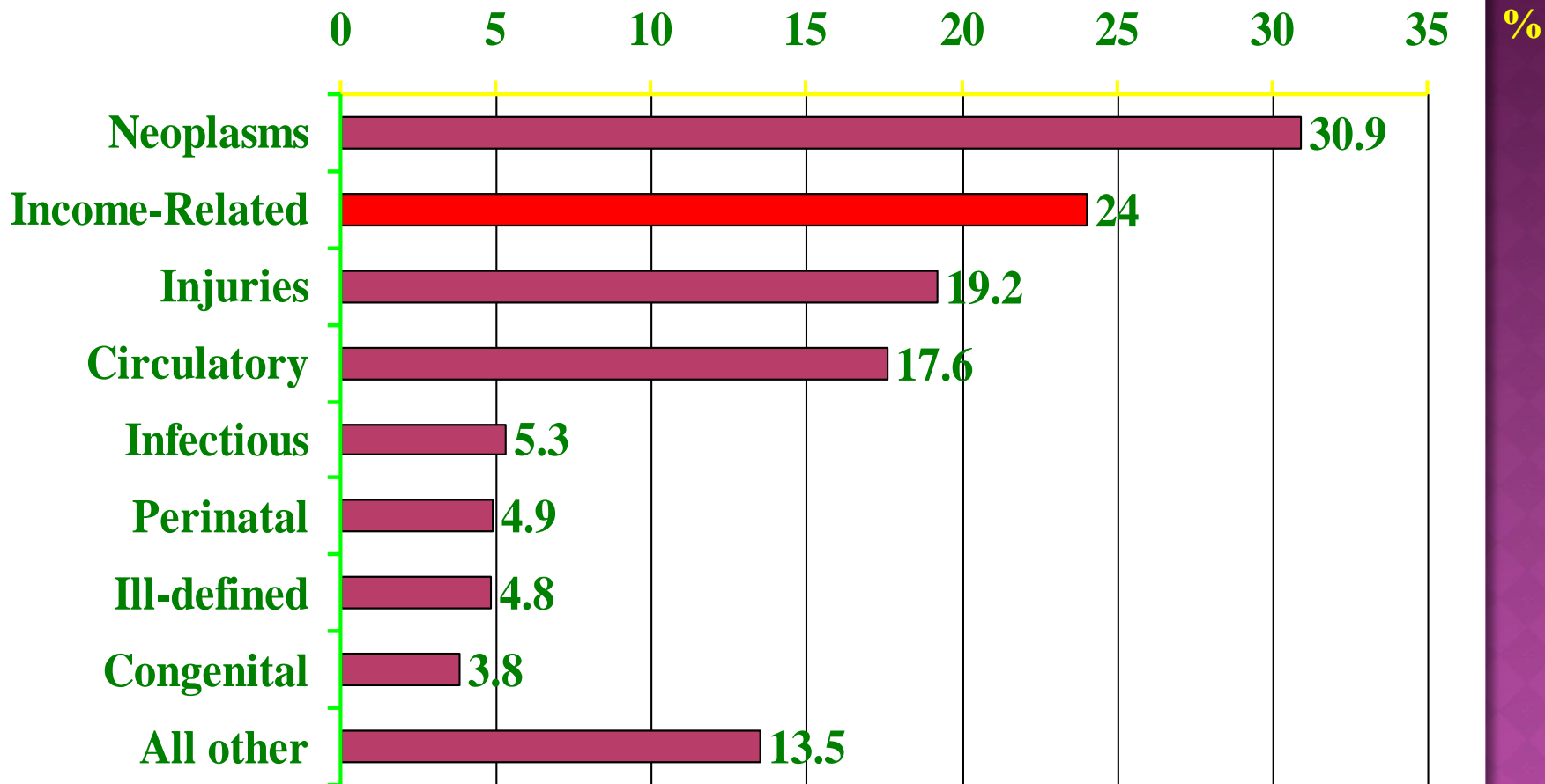
Let's look at the evidence ...

# THE BIG PICTURE

*“There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health.”*

Public Health Agency of Canada, Social Determinants of Health (2004)

# 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*

# 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](http://www.toronto.ca/health/map/pdf/unequalcity_20081016.pdf))

# HOW MUCH OF CARDIOVASCULAR DISEASE MORTALITY IS POVERTY ESTIMATED TO BE RESPONSIBLE FOR?

- A. 1-2%
- B. 5-10%
- C. 15-20%
- D. 25-30%

On par with smoking and hypertension

Peter Tanuseputro, et. al., "Risk Factors for Cardiovascular Disease in Canada," Can J Cardiol 2003; 19(11):1249-1259.

# DIABETES

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

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.

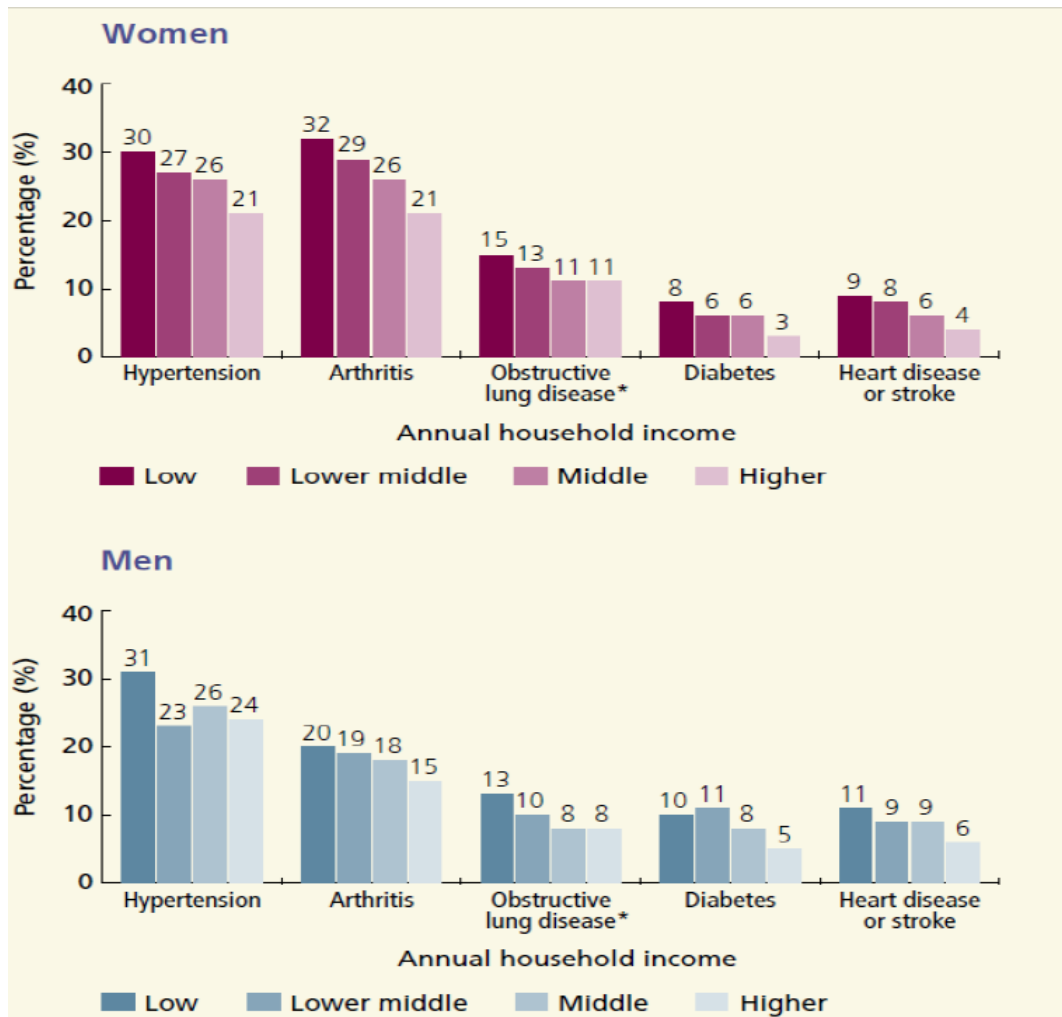
# PREGNANCY

- ◉ *Prevalence of Low Birth Weight: 43% higher*
- ◉ *If all babies in Toronto were born with the LBW rate of the highest income categories there would be 1,300 or 20% fewer singleton LBW babies per year.*

Wilkins et. al. (2002)

City of Toronto. (2008). Unequal City: Income and Health Inequalities in Toronto

# 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.

# STEP 2: ASSESS HEALTH RISK

## DISCUSSION:

In consideration of this evidence, should we alter our clinical decision-making for low income patients?

E.g.: 1) Is poverty another major risk factor for CVD?

2) Should we routinely screen low income patients for diabetes? or depression?

# OUR CASE (DOES THIS EVIDENCE CHANGE YOUR APPROACH?)

- 42yo woman, single mother of a 5 year old.
  - New patient, no previous family MD. Complains of occasional R CP on exertion, occasional SOB, fatigue, generalized muscle aches, vague abdominal discomfort. Non-smoker, no significant FHx.
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- 
- 1) What are our priority health issues for this woman?
  - 2) What investigations are reasonable, based on her history?
  - 3) Can we do anything about her poverty? What?

## STEP 3: INTERVENE

- ◎ **Individual patients** (Today's focus)
- ◎ Changes to our practices
- ◎ Our communities

# 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

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 WITH INDIVIDUALS

○ See situation from client's perspective

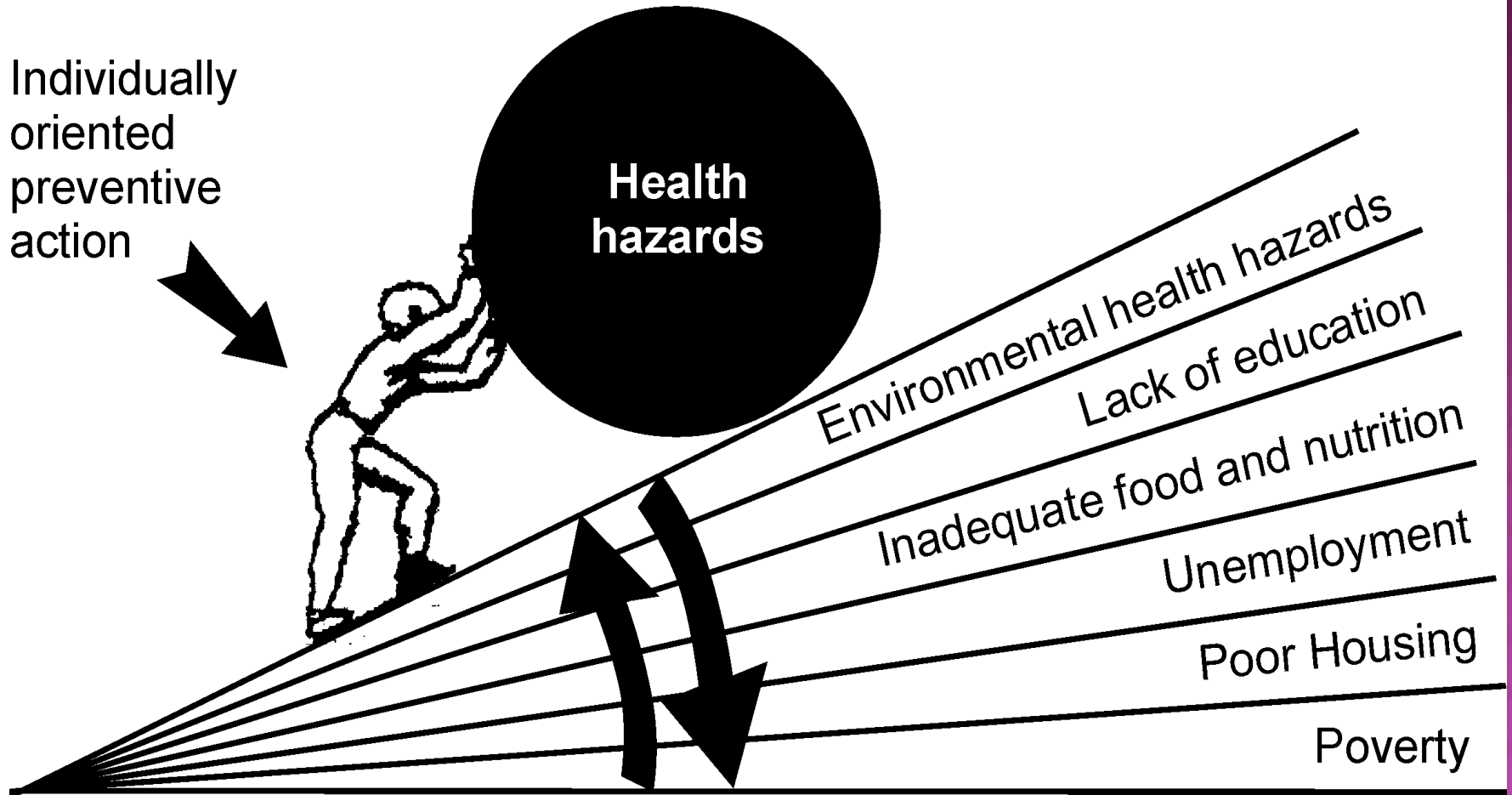
- Legitimize

- Reprioritize

# TAILOR CARE PLANS TO POVERTY

- Don't judge patients, understand their circumstances
- Treat the cause
  - e.g. move out of the mouldy basement, instead of prescribing inhaled steroids
- Prescribe drugs that are covered or cheap
- Consider dosing, storage, other demands on time

# The Health Gradient



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

BUT CAN WE HELP PEOPLE  
INCREASE THEIR INCOME?

# 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 20<sup>th</sup> 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

# HOW DO BENEFITS ADD UP? THE NEW SINGLE MOTHER

Child Benefits and other benefits in Ontario that are paid when you fill in a few forms  
Lone Parent mother with one child - recently given birth - earns \$12,500 a year - pays rent \$700 a month

What causes the benefit to be paid?	What program is it?	How much per year for a first child?
Federal Child Benefit Application and filing (filling out and mailing) a tax return	Child Tax Benefit (CTB)	\$1,340
	National Child Benefit Supplement (NCBS)	\$2,076
	Universal Child Care Benefit (UCCB)	\$1,200
	Ontario Child Benefit	\$1,100
Filing (filling out and mailing) a tax return	Goods and Services Tax Credits (GSTC)	\$ 626
	Working Income Tax benefit	\$1,044
	Special HST Credits (2010)	\$ 600
	Property and Sales Tax Credits	\$ 348
<b>Total</b>	<b>All Credits</b>	<b>\$8,334</b>
Above + Birth Certificate, Child SIN, RESP Registration	Canada Learning Bond in first year	\$ 500
	Canada Education Savings Grants based on \$2,500 parental contribution	\$ 600
<b>Grand Total</b>		<b>\$9,434</b>

Courtesy of John Stapleton

# FOR PEOPLE ON SOCIAL ASSISTANCE

- 1) Have you applied for extra income supplements?
  - Special Diet, Transportation, Medical Supplies, Volunteering, Many others
  
- 2) If you might qualify, have you applied for ODSP?

# INTERVENTIONS REQUIRING DIRECT PHYSICIAN INPUT

- ◉ *Disability applications:* ODSP, CPP-D, WSIB
- ◉ *Welfare supplements:* Special Diet, Transportation, Medical Supplies
- ◉ *Disability Tax Credit* application
- ◉ *Housing:* some prioritization and transfers, e.g. for palliative patients, medical conditions; Air conditioners
  
- ◉ *But good advice and resources are as powerful as your signature*

# KNOW WHO TO REFER TO

- ◉ Work in a team, or network into the community - think of how we approach diabetics
- ◉ Have resources at your fingertips

# BARRIERS TO INDIVIDUAL INTERVENTIONS

## ⦿ **Brainstorm**

- ⦿ Time pressure
- ⦿ Financial disincentives
- ⦿ Confrontational relationship caused by prior negative experiences
- ⦿ Inadequate knowledge of community resources
- ⦿ Inadequate knowledge of social system

# PRACTICE-LEVEL INTERVENTIONS

- ◉ Work in a Team and Know Your Resources
- ◉ Be flexible with missed appointments
- ◉ Book longer appointments
- ◉ Find alternatives to Fee for Service

# COMMUNITY INTERVENTIONS

“The public’s beliefs about the relationship between poverty and health influences its support for poverty-related policies”

CJPH 93(4), 2002: 297.

# COMMUNITY-LEVEL INTERVENTIONS

- ⦿ Reorganize health services
- ⦿ Disseminate knowledge
- ⦿ Support
- ⦿ Meet
- ⦿ Lobby
- ⦿ Research
- ⦿ Protest

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# CONTACT AND FURTHER INFO

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