Poverty and Health

Strategies for physicians to mitigate the health effects of poverty

by The Ontario Physicians Poverty Work Group
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You are a family physician starting out a new career in Public Health. One day, you receive a call from a former patient. She is a single parent of two boys, ages 8 and 14, whose births you attended. In fact, she first came to you, at age 14, after dropping out of school because she was pregnant. After her marriage and second baby, she disclosed to you that her partner was abusive. She left the marriage and has been raising her boys on her own. She phoned you today to share her good news: she finished high school and has been accepted into a nursing program. But she also needs your advice. She is living on social assistance, can no longer afford to pay her rent and her tuition, and is at risk of losing her apartment. She has also been told recently that she has type 2 diabetes, one of her children is lactose intolerant, and both have multiple dental caries, but she hasn’t had time to fully explore or address these issues. She is starting to feel overwhelmed, and is losing sleep due to anxiety. She doesn’t know who else to call so she is turning to you for help.

Introduction

Most physicians have traditionally viewed attempts to alleviate the health effects of poverty as falling outside the realm of their daily practice. In this series of articles, we have demonstrated that physicians can and should address poverty as a risk factor for ill health, in the same way we target other well-accepted health risks, such as smoking and obesity.

The following article examines some specific, action-oriented strategies physicians can use to mitigate the health effects of poverty. These approaches are intended for implementation with individual patients, communities, and professional organizations.

Addressing poverty as a risk factor for health with individual patients

The approaches to assisting individual patients who live in poverty include:

- Providing patient-centred care.
- Incorporating poverty as a clinical risk factor.
- Assisting patients to access resources.

1. Providing patient-centred care

Patient-centred care has repeatedly been identified as a key element in quality health care.

In its inaugural report in 2006, the Ontario Health Quality Council (OHQC) identified patient-centredness as one of nine attributes of a high performing health system: “Patient-centred care respects the individuality, ethnicity, dignity, privacy and information needs of each patient and the patient’s family. That respect should pervade the health system. Patients should be in control of their own care. Accountability to patients and their families should be high.”

Most physicians witness the health effects of poverty on their patients on a daily basis. Physicians should attempt to approach patients’ situations from patients’ perspectives, walking in their patients’ shoes. Physicians should attempt to incorporate their patients’ values, not their own, into decision-making.

Patients who live in poverty often prioritize shelter, food, and income over lower blood pressure, tight glycemic control, and quitting smoking and physicians should take on this prioritization as their own. Physicians should also empower their patients by assisting them to be strong advocates for themselves within the health system and social services system.

2. Incorporating poverty as a clinical risk factor

Poverty and illness interact in a very complex fashion, often acting in synergy. Figure 1 (see p. 46) illustrates the cycle of poverty and illness. Physicians can integrate an evidence-based understanding of the connection between poverty and ill health into their day-to-day practice.

For example, cumulative patient profiles and periodic health examinations can incorporate this evidence to trigger appropriate investigations and interventions for people living in poverty. Poverty is known to be a strong risk factor for conditions such as cardiovascular disease and diabetes, and income level should be considered in decisions to screen for, and take steps to prevent, these conditions.
Patients can be asked about social determinants of health (e.g., housing, food, income, education) on first assessment and periodically thereafter to determine the contribution of these determinants to their level of risk for health problems. Some sample questions about poverty are provided in Table 1 (see p. 47).

Patient-oriented information on poverty and health should be available in every physician’s office. This could include an overview of the risks posed by poverty to health, information on how to improve income through the social assistance system, and contact information for area resources to aid patients in decreasing their poverty (such as social workers, welfare offices, and legal aid clinics).

3. Assisting patients to access resources

Physicians can take direct, practical steps to help patients to increase their incomes, especially those living on social assistance. For example, physicians can:

- Encourage patients to apply for the Ontario Disability Support Program, and for supplements to welfare income that require approval by a physician, including supplements for special dietary requirements, transportation to health appointments, and extra medical supplies.
- Direct patients to programs that can assist them with their health-care costs (e.g., Trillium Drug Program, low-income dental programs).
- Assist patients with their advocacy with social services. Patients often require strong health-care advocates to support their applications for disability benefits programs, or to get medical exemptions from required employment skills or education programs.
- Prepare form letters to support patients with common difficulties with the social services system, for example, to facilitate access to affordable housing and to appeal rejected income supplement applications.
- Work closely with social service and community agencies to coordinate advocacy efforts for your patients.

Physicians are sometimes torn between being advocates for their patients and being gatekeepers for the social services system. But doctors have a primary therapeutic alliance with their patients, and they should position themselves as patient advocates first. Then, they can act within the realm of current regulations to maximize patients’ access to benefits and decrease their risk of poverty-associated health problems.

Case study follow-up

In consideration of the suggestions outlined above, you take a proactive approach to this patient’s situation.

First, you acknowledge her difficult situation, and reinforce your willingness to support her in any way possible to build a foundation for good health.

You also acknowledge that her current health problems may have
been partly caused by living in poverty, and that working to reduce her family’s poverty is essential to improving her health, and her children’s health.

You refer her to a family physician and, in the interim, you offer to meet with her and complete applications for special dietary and transportation income supplements for her and her children. As a result, her income increases by $200 per month and she can now afford more food.

You ensure she has applied for the Child Tax Benefit. You also write a letter to her nursing school supporting her request for accommodation for her health needs and child care requirements. You give her contact information for a local social worker knowledgeable in navigating the social services system.

This approach makes a tangible impact on the depth of her poverty, gives her a little bit of breathing room to address her family’s physical health issues, and lets her know she has a strong ally in her struggle to emerge from poverty.

**Addressing poverty as a risk factor for health in communities**

The connection of physicians to their communities is one of the College of Family Physicians of Canada’s “Principles of Family Medicine.”

This section outlines three community-oriented strategies for physicians to reduce poverty in their communities:

- Planning health services according to community need.
- Disseminating knowledge about health and poverty.
- Advocating for those living in poverty.

1. **Planning health services according to community need**

Planning health services to meet community need is a well-accepted principle of health planning. For physicians, this can take the form of providing focused services to marginalized and underserved groups, including those living in poverty.

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**Table 1**

Sample Routine History Questions Assessing Income as a Determinant of Health

- Are you currently working? How are things at work? On a scale of 1 to 10, how happy are you with your job? On a scale of 1 to 10, how concerned are you about losing your job?
- Do you have a place to live? If you do have a home, on a scale of 1 to 10, how concerned are you about losing your home?
- If you are not working, are you on social assistance?
- If you are on social assistance, have you applied for additional income through supplemental allowances or disability support programs?
- Have you been denied social assistance? If you have been denied, have you appealed this decision? Did you receive appropriate physician input into your appeal?
- Do you ever have difficulty making ends meet at the end of the month? If yes, does this mean that sometimes there is not enough food for your family?

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Examples include working at clinics in homeless shelters, preferentially accepting referrals from organizations that work with people living in poverty, or establishing focused clinics to assess individuals’ eligibility for extra supplements to social assistance income.

Physicians with research expertise can evaluate and review the impact of interventions to combat the health effects of poverty.

2. Dissemination of knowledge about health and poverty
Physicians should use opportunities to present at public events and to speak on panels, or through the media, to discuss poverty as a risk factor for health, and practical steps that can be taken to address this risk. Telling patients’ stories or assisting patients to tell their own stories of the impact of poverty on their health are powerful tools for educating the public on these issues.

Physicians should also educate their colleagues about these issues through personal discussion, presentations, and incorporation into conferences and other continuing education events. This information should be integrated into standard physician training curricula in medical schools.

3. Advocating for those living in poverty
Physicians have a powerful voice to advocate for poverty reduction. They also have the opportunity to speak out about the health effects of poverty. Physicians can advance these issues before key policy-makers and members of government, through individual or small group meetings, legislative committee hearings, and events set up to hear public opinion, such as “town hall meetings.”

Medical organizations like the OMA have played an important role in promoting public education about health risks such as smoking and air pollution.

Physicians should encourage their organizations to take on poverty as a health risk in a similar manner and advocate for its eradication. These organizations can maximize their impact by collaborating with other professional or non-professional organizations around advocacy.

Examples of community-level interventions by health providers
1. *Nutritious Food Baskets*: Public health departments across the province are mandated to calculate and publish an assessment of the base level of income needed to meet essential needs and purchase a basic healthy diet in every community, and compare these to social assistance rates. These documents are useful resources for education and advocacy.

2. *The Raise the Rates Campaign*: Nearly 100 health providers have
been involved in a campaign advocating for an increase in welfare rates as a basic intervention to improve the health of the poorest Ontarians.

3. Street Health Reports: Street Health, an organization of nurses working with the homeless and underhoused, has twice carried out health needs surveys of the most marginalized homeless people in Toronto — people who are not normally captured in censuses or other population-level studies. These reports have educated the general public and policy-makers about the devastating health impact of severe poverty and homelessness.

**Conclusion**

The connection between poverty and health is well established in the medical literature. Less well explored are strategies physicians can employ to address poverty as a health issue.

This series of articles has outlined means through which physicians can address the impact of poverty on the health of their patients, and the communities in which they live and work.

The final two instalments, to be published next month, will identify specific populations at extra risk for poverty and discuss public policy options for reducing poverty in Ontario.

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**Strategies for Physicians**

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**References**


2. Sample periodic health examination and cumulative patient profile forms will be available from: www.healthprovidersagainstpoverty.ca.


