Poverty and Health

Why poverty makes us sick

physician backgrounder

by The Ontario Physicians Poverty Work Group
(Gary Bloch, MD, Vera Etches, MD, Charles Gardner, MD, Rosana Pellizzari, MD, Michael Rachlis, MD, Fran Scott, MD, Itamar Tamari, MD)

A 57-year-old woman comes into your family practice office, complaining of intermittent chest pain on exertion. She is hypertensive, has type 2 diabetes, and smokes a pack of cigarettes a day. She lives on social assistance benefits of $570 a month (and has been turned down for disability benefits). She has few social supports. She does not take her medication consistently, and is not interested in quitting smoking ("It is one of my few pleasures in life"). She has missed a cardiac stress test twice because, she says, she was looking for housing. Every time she leaves your office, you feel a mixture of frustration and sadness at her situation and her apparent inattention to her health. You have considered discharging her from your practice for noncompliance. What evidence is there for a link between her income status and her health issues? How can we begin to rethink our approach to her situation, taking into account an evidence-based understanding of the link between her income status and her health?

Introduction

Health follows a social gradient: populations occupying a lower position in the social hierarchy experience, as a group, worse health. This holds true whether the outcome is morbidity or mortality. Other social determinants of health, such as education and gender, also have a major impact on health, but income inequality has a powerful influence on health itself and on the other social determinants as well.

Since the 1970s, it has been clear that, in order to effect significant changes to health, we must look beyond focusing on individual risk factors such as smoking, to modifying the social environments within which people make bad choices.

Canada's universally accessible health-care system mitigates some health inequities by providing earlier diagnosis and fewer barriers to treatment and referral.

An international survey found that Canadians are among the least likely to report that they did not seek health care because of concerns about costs.[1]

A recent Canadian-American study concluded that Canada's disadvantaged groups, including the poor, have better access to health care than their American counterparts.[2]

Physicians can make a difference for their individual patients by integrating a "determinants of health" approach into patient care. But individual physicians and the health system alone cannot address most of the upstream causes of poor health. Therefore, physicians must work with others to advance public policy that addresses these determinants, such as poverty.

This is the first in a series of articles written for doctors by doctors on the issue of poverty and health. Each article will introduce readers to real-life individuals and families who can teach us about poverty in Ontario. The articles will also contain practical information that doctors can integrate into their professional practice.

Poverty as a risk factor for ill health: the evidence

Poverty is strongly associated with a higher incidence, prevalence, and severity of chronic illness, acute illness, and injuries.[3] The evidence for the impact of poverty on health has been comprehensively reviewed in other publications.[4]

This section will briefly outline the impact of poverty on population health, chronic illness, and children's health. The evidence is strong enough to conclude that poverty may well be the most powerful determinant of health.[5]

Poverty has been strongly linked to many adverse health outcomes.[6] Life expectancy in the lowest-income quintile neighbourhoods in urban Canada is five years shorter for men, and 1.6 years shorter for women, compared with those who live in the highest-income quintile neighbourhoods.

Infant mortality rates are 61 per cent higher in the poorest areas,[7] and low birthweight rates are 43 per cent higher.[8] Low-income individuals are nearly four times more likely to report poor or fair health status than are high-income individuals.[9]

Perhaps most striking, 24 per cent of all potential years of life lost in Canada in 1996 were estimated to be attributable directly to poverty. This compares with 31 per cent for cancer, and 18 per cent for cardiovascular disease.[10]

Table 1 (see p. 33) shows a much

higher mortality rate from chronic conditions in the poorest urban neighbourhoods in Canada.

Recently, the Institute for Clinical and Evaluative Sciences identified poverty as a risk factor for developing diabetes. Low-income Ontario women are nearly four times more likely to suffer from diabetes than high-income women.[12]

Low income is estimated to be responsible for 25 per cent to 30 per cent of the total mortality from cardiovascular disease. The increased cardiovascular disease burden due to poverty is comparable to that due to smoking and hypertension.[13,14]

A large study showed that each $10,000 increase in neighbourhood income correlated with a 10 per cent decrease in mortality after myocardial infarction.[15] Furthermore, poverty causes barriers to access to some services. Ontarians living in low-income areas have 23 per cent fewer angiograms, and wait 40 per cent longer for these examinations.[15]

The prevalence of depression among low-income individuals is 60 per cent higher than the Canadian average.[16] Studies on individuals with high levels of food insecurity (a good marker of severe poverty) have shown that they have three times the risk of suffering from a major depressive episode.[17] They have a higher risk of isolation and poor social support,[18] and of reporting stressful life circumstances.[19]

Children living in poverty are particularly susceptible to its deleterious effects[20] Canadian children living in poverty are more likely to develop a variety of illnesses and injuries, as well as suffer growth retardation and developmental difficulties.[21] They are also more likely to experience hospitalization, mental health problems, and difficulties in school, such as lower school achievement and early school leaving.[22,23]

Of course, many poor children do better themselves economically as they grow into adults. But to paraphrase an old saying, "While one can take a child out of poverty, one cannot take poverty out of the child."

Table 1
The Increase in Mortality Due to Chronic Conditions in Lowest Compared to Highest Income Quintile Neighbourhoods, 1996[11]

Cause of Death		Increase in mortality in lowest vs. highest income quintile neighbourhoods
All Causes	Both sexes	32%
	Males	43%
	Females	16%
Ischemic Heart Disease	Males	31%
	Females	25%
Cirrhosis	Males	150%
	Females	-5%
Uterine Cancer	Females	50%
Lung Cancer	Males	56%
Mental Disorders	Both sexes	30%
Diabetes	Males	56%
	Females	47%

Table 2
Effect of Living on Social Assistance on Health Status*

Health Condition	Odds ratio for presence of condition among individuals living on welfare compared to individuals not living on welfare (adjusted for age and sex)
Poor/fair self-rated health	3.7
Major Depression	2.0
Poor Social Support	2.9
Heart Disease	3.7
Diabetes	2.5
Hypertension	1.6
Obesity	1.1

** Adapted from Vozoris NT, Tarasuk VS. The health of Canadians on welfare. Can J Public Health. 2004 Mar-Apr;95(2):117.*

Growing up in poverty often leaves lifetime scars. Children in low-income households experience a higher risk of health problems throughout their lifespans, independent of their later socioeconomic status.[24,25]

Those living on social assistance have the lowest incomes of all and have the highest risk for health problems.[26,27,28]

Data from the 1996-1997 National Population Health Survey, summarized in Table 2 (see p. 33), show the impact of living on welfare on the health of social assistance recipients.

Living on social assistance should be considered, with poverty, to be a major risk factor for ill health.

Why is poverty of such concern "now"?

The House of Commons passed a unanimous resolution in 1989 to end child poverty by the year 2000. Yet, today, a higher proportion of Canada's children live in poverty than in 14 other countries belonging to the Organization for Economic Co-operation and Development (OECD), including Hungary, Greece and the Czech Republic.[29]

Nationally, the 2007 child poverty rate of 11.7 per cent was exactly the same as in 1989 when parliament passed its resolution to end childhood poverty. The rate has moderated since a peak in the 1990s.[30]

However, the situation is different in Ontario, where the child poverty rate is 12.6 per cent, having risen since 2001.[30] Nearly half of all of Canada's poor children live in Ontario.

In Ontario, the median income of many individuals and families dropped sharply in the 1990s due to both an economic recession and deep cuts to the social safety net.

Ontarians living on social assistance have seen their purchasing power decline during this time.[31] Ontario Disability Support rates were not raised from 1993 to 2003, and the increases since have not kept pace with inflation. Similarly, Ontario Works recipients had their rates cut by 22 per cent in 1995, frozen from 1995 to 2003, with only minimal raises since.

In 2005 constant dollars, the income for a family of four receiving social assistance in Ontario dropped from $22,102 in 1986 to $19,302 in 2005.[32]

In November 2007, the United Way of Greater Toronto reported that poverty levels are continuing to climb; that one in five of Toronto's two-parent families were low-income in 2005; and that families are falling behind families in the rest of the country.[33]

Equally disturbing are the trends of growing levels of precarious employment, increasing applications for evictions related to the non-payment of rents, and rising levels of indebtedness.

Some jurisdictions, such as Que-

bec, Newfoundland and Labrador, and Ireland, have made official commitments to poverty reduction. These examples provide us with both inspiration and important lessons for decreasing poverty in Ontario.

Ontario Premier Dalton McGuinty has pledged to develop a comprehensive government strategy to reduce poverty. He has appointed Minister of Children and Youth Services Deb Matthews as Chair of a Cabinet Committee on Poverty. Minister of Health and Long-Term Care George Smitherman is the committee's vice-chair. The committee is to issue its report by the end of 2008.

Upcoming articles

For more than a decade, researchers, physicians, other health professionals, and public health providers have been calling for action on the health problems caused by the province's deepening social inequalities. Ontario's physicians can help to encourage meaningful government action on poverty, at all levels, to build a healthier future for all our patients.

This is the first in a series of articles for physicians on poverty. The second article ("Identifying Poverty in Your Practice and Community," on pages 39-43) addresses issues in the definition and measurement of poverty, and provides doctors with helpful indicators that can be used at the practice level and as population health assessment tools.

The third article ("Strategies for Physicians to Mitigate the Health Effects of Poverty," on pages 45-49) focuses on what doctors can do to effectively respond to and address poverty with their patients, and in their communities.

A fourth article, scheduled to appear next month, will consider high-risk groups in which poverty may be hidden or particularly severe.

The fifth instalment will present the evidence for policies that mitigate and prevent poverty.

The authors hope that the series will enable colleagues to better respond to the individual patient's poverty-

Appendix
Selected major Canadian government reports expressing the need to address poverty as a health issue

- Canada. Parliament. Senate. Special Committee on Poverty. Poverty in Canada. [Chair: D.A. Croll]. Ottawa, ON: Information Canada; 1971.
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related problems and to participate in the current public policy debate about reducing poverty in Ontario.

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Identifying poverty in your practice and community

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You are a new family doctor with a practice in a growing multicultural suburb in the Greater Toronto Area. One of your first patients is Sunil K, who is five-years-old and has a chronic cough. When you make a home visit for Sunil after he has spiked a fever, you are surprised to find an extended family living in the home.

Introduction

Physicians know that their practices include patients living in poverty. Even a practice based in an affluent neighbourhood will have some patients who drift into poverty because of job loss, family break up, illness, or acts of nature.

Because poverty and other determinants of health, like housing, have a major impact on health and health-care programs, it is important to have accurate information about patients who are suffering economic deprivation. Unfortunately, few doctors or health-care facilities keep track of poverty among their patients.

This article discusses how poverty is measured, and how this information can be used for clinical practice and public policy.

The measurement of poverty

Governments and organizations use a variety of different indices to categorize persons as "poor" or "non-poor." In some instances, this has prompted a debate that could be characterized as, "how poor does one have to be, to be poor?"

Of course, this is scientifically inappropriate because the process uses income as a dichotomous variable when, in fact, it is a continuous variable.

For example, air humidity is a continuous variable which measures the saturation of air with water vapour, from zero per cent to 100 per cent. However, it only rains when the air is saturated, at 100 per cent. Measuring the humidity with a rain barrel wouldn't tell us very much.

This situation is similar to that faced by clinical practice guideline committees when they define thresholds of blood pressure as hypertension. Systolic blood pressure levels above 130 mmHg and diastolic levels above 80 mmHg are associated with increased risk of illness, but treatment thresholds for most hypertensives are above this level.

A third-generation mother on social assistance and a third-year engineering student might be defined as poor, but the implications for their health are quite different. They require tailored approaches to their poverty from the health-care delivery system and the policy process.

The faces of poverty are often hidden to physicians. Patients may be ashamed to say they cannot afford their prescriptions or follow other advice.

Listening to patient stories and/or participating in community initiatives can supplement more formal data, and assist physicians to identify individuals who are at risk for the health impacts of poverty.

Absolute versus relative poverty measurement

The most common indicator used for poverty is the low income cut-off (LICO).[1] Statistics Canada defines those below the LICO as those households who spend more than 20 percent more of their income than average on food, shelter and clothing. The LICO is adjusted for family size and degree of urbanization. LICO is a relative indicator because the poverty rate could go up if the wealthiest got wealthier even if the poorest didn't get poorer.

On the other hand, some recommend using an index that measures more explicit deprivation. There will always be problems associated with choosing thresholds for diagnosis from a continuous variable.

However, the relative approach to poverty measurement, such as LICO, seems to be more consistent with identifying it from a health perspective.

A number of epidemiological studies have concluded that even when people have significantly more than their basic needs met, their relative socio-economic position still confers considerable extra risk. For example, the U.K.'s Whitehall studies investigated cardiovascular risks in men employed by the British civil service, all of whom lived above any level of deprivation.[2] Nonetheless, the men at the lowest level of the civil service had mortality rates that were four times those of the senior administrators.

Poverty measurement in practice

You are an established specialist in obstetrics/gynecology in Scarborough. You have been accepting referrals from Public Health for a number of years and have noticed a recent increase in low pre-pregnancy weights in your patients, and wonder if others are seeing this as well.

Physicians, other health-care providers, public health practitioners, researchers and social policy-makers, use many sources of information to describe, define and compare poverty levels in individuals and groups. Examples include census data, information on social assistance case loads, and health-care utilization data.

Information collected at the local level, through self-report surveys, direct observation, and discussions with local social services personnel, are particularly valuable.

Demographic questionnaires, which are completed when a new patient or family joins a practice and updated routinely, can assist physicians in understanding the economic challenges faced by their patients.

Primary care physicians are particularly interested in collecting, utilizing and updating patient information about determinants of health and risk factors as they change over the life course of their patients.

Ontario's Community Health Centres (CHCs) have provided leadership by including social demographic information in the intake form of new patients. A self-administered questionnaire is used to ask immigration status, ethnic or religious background, income and education level, as well as family composition. Unfortunately, the limits of current electronic systems prevent the full use of this data.

Some individuals and communities are concerned about the collection of data and registration as they fear misuse of this information by government and others. Physicians can discuss these concerns and provide reassurance regarding how this information is collected and used.

Patients who appreciate the health reasons for collecting sensitive information about themselves and their community are more willing to disclose.

Poverty measurement in the community

The Zehr family runs a farm in southwestern Ontario. According to Perth County's report on the cost of healthy eating (Nutritious Food Basket), the family cannot afford to eat well enough at certain times of the year. Their family doctor has not asked them about this, and they feel ashamed to mention it.

At times, poverty may not be easily identified within a practice, but may be seen through local statistics and stories. Information on poverty levels in communities is often analyzed and grouped by geographic area

(neighbourhoods for example), but can also be presented by other common factors, such as age, gender, and ethno-racial identification. Groups such as farmers or Aboriginals are often left out of studies as they are not identified in the collection of information.

Physicians can access this kind of information through their local health unit, social planning council, or municipality. In addition, local media (e.g., newspapers) may present this information. Informed physicians can support families like the Zehrs through local knowledge of families at risk.

Population measures of poverty

There are many reports on population measures of poverty, such as the Poverty by Postal Code report by the United Way of Greater Toronto,[4] and the Institute for Clinical Evaluative Sciences (ICES) report on the geography of diabetes.[5]

Poverty is usually measured by household income levels, either with a relative approach or absolute approach. However, poverty can be measured with other data, such as:

- Housing security (homelessness, shelter use, waiting lists for supported housing).
- Job security (unemployment, access to employment insurance, full-time/part-time, permanent/temporary employment).
- Education (high-school graduation, enrolment, literacy).
- Food security (food bank use, local Public Health's "Cost of a Nutritious Food Basket" calculations).

The cost of poverty to society can also be measured. The Federal/Provincial/Territorial Health Disparities Task Group estimated that health disparities, many due to economic disparities, increased the cost of health care in Canada by 20 per cent,[6] approximately $35 billion.

Poverty measurement provincially, nationally and internationally

The measurement of levels of poverty regionally, nationally, and internationally, is of great interest to policymakers and researchers. This enables them to identify trends and high-risk groups, and assess the impact of interventions (such as taxation, child benefits, etc.) on poverty reduction and health improvement.

Physicians can critically assess poverty statistics by asking themselves how the information is collected and presented:

- Does income include all sources: work, government transfers, etc.?
- Does income include before-tax or after-tax figures?
- Is the unit of analysis individual, household, or economic family?
- Is there any adjustment for expenses: non-discretionary or not?

Historically, Canada has used the low income cut-off (LICO) statistic to measure individuals and families at risk of poverty.[3] LICO levels are updated annually. LICO levels are higher than levels for social assistance or minimum wage.[7] The overall Canadian LICO rate is 10.8 per cent, but certain populations have much higher rates.[8]

Approximately 30 per cent of female, single-parent-led families, and single-person households fall below the LICO. While LICO may be a relative rate, most low-income families have much lower incomes than the LICO threshold. An average low-income family lives approximately $10,000 below LICO.[9]

Other measures used in Canada include the low-income measure (LIM), which is defined as half the median family income (income is adjusted for the family size), and the market basket measure (MBM), which defines a basket of goods and services necessary to live in communities across Canada, and then determines the necessary disposable income to purchase those services.[3]

The Nutritious Food Basket is Ontario's standardized food-costing tool that measures the real cost of healthy eating.[10] Ontario Boards of Health collect data from grocery stores within their health units each year to monitor the cost of eating nutritious food in their communities. This information is used to promote and support the development

of policies to increase access to nutritious food.

Toronto Public Health has posted its reports online. Physicians can access this information from their local public health units.

Other measures of poverty include deprivation indices, which have been used to adjust population-based health-care funding in the United Kingdom[11] and Quebec.[12]

Quebec's deprivation index uses six indicators: the proportion of persons who have no high-school diploma; the ratio of employment to population; average income; the proportion of persons who are separated, divorced or widowed; the proportion of single-parent families; and the proportion of people living alone, adjusted according to the age and sex of the population, and combined using a factorial approach.

Because of the challenge to measure poverty accurately, other indicators have been used to measure social inequity.

This permits the assessment of inequality from a variety of perspectives, including income, education, unemployment, housing affordability, crime, single-parent families, and food insecurity.

Table 1 (left) summarizes the indicators used nationally by the Health Indicators framework from Statistics Canada and the Canadian Institute for Health Information, and provincially by the Association of Public Health Epidemiologists in Ontario in the Core Indicator project.

The statistics of health indicators at the community level can also be found on the Statistics Canada website.

A list of useful Web resources for physicians appears in Table 2 (see p. 43).

Table 1
Summary of Social Determinants of Health Indicators

- High school graduates
- Post–secondary graduates
- Adult and youth unemployment rate
- Long–term unemployment rate
- Labour force participation Rate
- Low income rate (income for the year prior to the census)
- Children in low–income families (income for the year prior to the census)
- Average personal income (income for the year prior to the census)
- Median share of income
- Government transfer income
- Income Inequality
- Housing affordability (income for the year prior to the census)
- Single Parent Families
- Living Arrangements for Seniors
- Decision latitude at work
- Crime incidents
- Adults and youth charged
- Food insecurity
- Cost of a nutritious food basket
- Commuting population

Summary

You are an experienced cottage country family doctor nearing retirement who has been asked to join a local anti-poverty coalition. Although you know much from your years of practice, you want to be better informed about the burden of poverty in your community.

Ontario physicians have a unique viewpoint on the province's increasing rates of poverty. Physicians are also uniquely placed to help ameliorate its effects. Practice and population data complement each other to provide a useful base for planning clinical programs and policy advocacy.

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Table 2
Online Poverty Information Resources for Physicians

- *Local Health Integration Networks:* www.lhins.on.ca
- *Social Planning Councils (Social Planning Network of Ontario*): www.spno.ca
- *United Way of Canada:* http://www1.unitedway.ca/sites/PortalEN/default.aspx)
- *Campaign 2000:* http://www.campaign2000.ca/
- Statistics Canada http://www.statcan.ca/menu-en.htm
- *Toronto Public Health reports on Nutritious Food Basket:* http://www.toronto.ca/health/food_basket.htm
- *Association of Local Public Health Agencies:* http://www.alphaweb.org/health_units.asp
- *Canadian Population Health Index with the Canadian Health Information Institute:* http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_e
- *Institute for Clinical Evaluative Sciences:* http://www.ices.on.ca/webpage.cfm
- *Centre for Urban and Community Studies at the University of Toronto:* http://www.urbancentre.utoronto.ca/
- *Health Providers Against Poverty*: www.healthprovidersagainstpoverty.ca

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Poverty and Health

Strategies for physicians to mitigate the health effects of poverty

by The Ontario Physicians Poverty Work Group
(Gary Bloch, MD, Vera Etches, MD, Charles Gardner, MD, Rosana Pellizzari, MD, Michael Rachlis, MD, Fran Scott, MD, Itamar Tamari, MD)

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."[1]

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.

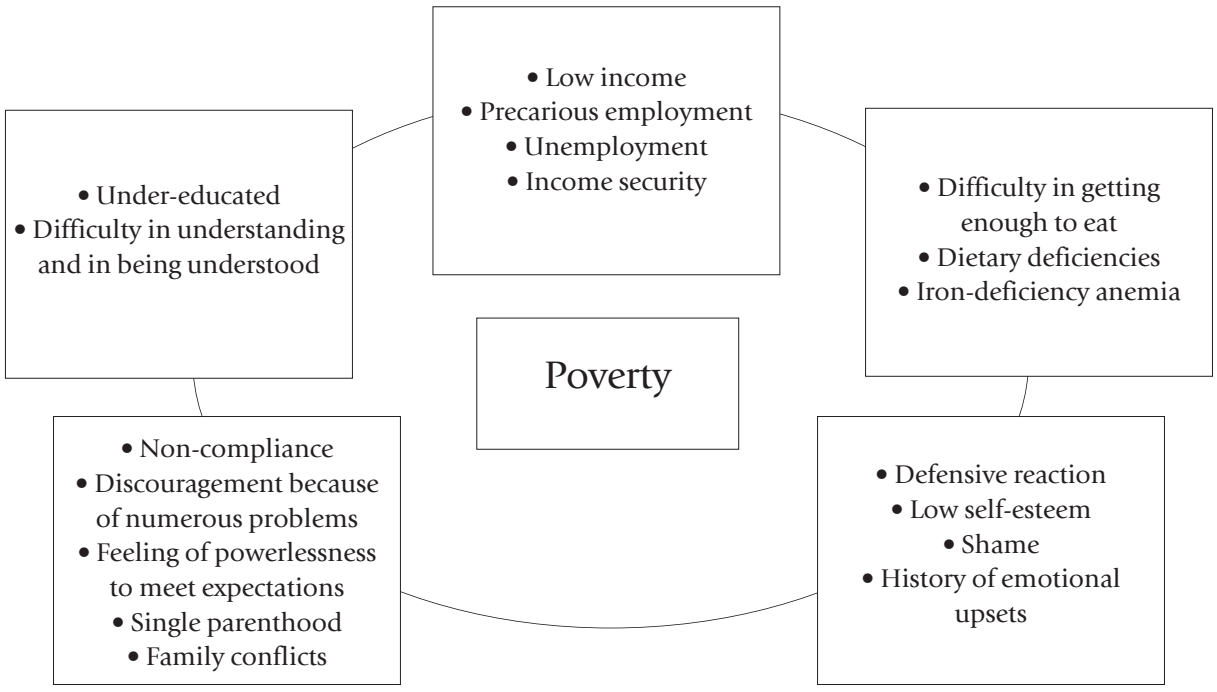
Patients who live in poverty often prioritize shelter, food, and income over lower blood pressure, tight glycemic control, and quitting smoking and physicians should take on this prioritization as their own. Physicians should also empower their patients by assisting them to be strong advocates for themselves 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.[2] 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.

Figure 1
The Cycle of Poverty and Illness



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).[3,4,5]

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."[6]

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.[7] For physicians, this can take the form of providing focused services to marginalized and underserved groups, including those living in poverty.

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?

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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Poverty and Health

The many faces of poverty in Ontario

by The Ontario Physicians Poverty Work Group
(Gary Bloch, MD, Vera Etches, MD, Charles Gardner, MD, Rosana Pellizzari, MD, Michael Rachlis, MD, Fran Scott, MD, Itamar Tamari, MD)

Last month, the *Ontario Medical Review* introduced a five-part series on the topic of poverty and health. Three feature articles provided physicians with an overview of current issues related to poverty and health, indicators and resources that can be used in practice, and strategies to help mitigate the health effects of poverty in individual patients and communities.* The fourth instalment, below, describes the many faces of poverty in Ontario. The fifth and final article explores potential policy options to help reduce poverty (see p. 42).

Poverty is arguably the most important determinant of illness and early mortality.[1,2,3]

According to Statistics Canada, 10.8 per cent of Canadians, or one in 13, live below the low income cut-off (LICO) rate.[4] But certain populations have much higher rates. For example, approximately 30 per cent of female single parent-led families, and single-person households, fall below the LICO.

The following article looks at the many faces of poverty, with a particular focus on how poverty clusters in certain high-risk groups.

Who is at risk – and why?

Case example

You are a general internist, working in a medium-sized town in northern Ontario. You have been asked to consult on a recently hospitalized patient. She is a 34-year-old woman who emigrated from Burundi 18 months ago. She knew she was HIV-positive before her arrival in Canada, but has just been diagnosed with active TB during a work-up for a worsening cough. She begs you to allow her to leave hospital because she was just about to start work as a nursing home assistant. She has two children and a husband at home, and they have been living on social assistance since their arrival in Canada. She and her husband owned a successful clothing factory in Burundi, and their children went to an exclusive private school.

The clustering of poverty reflects its underlying causal dynamics. Specifically, poverty is caused by social and political dynamics and policies that result in some groups experiencing social exclusion.

These groups have reduced access to higher education, work training, meaningful and gainful employment, inclusion in mutually supportive social networks, and financial resources necessary for optimal health.

In turn, these deprivations often arise due to illness, linguistic or cultural barriers, reduced levels of education, physical isolation in sparsely populated regions, and racial and cultural discrimination.[5]

In Canada, poverty is much more common in the following groups:

- Aboriginal populations
- Northern populations
- Recent immigrants and people of colour
- Impoverished urban neighbourhoods
- Children
- Single parent families, particularly female-headed families
- People with disabilities

The particular situations facing each of these groups are described on the following pages.

Aboriginal populations

Aboriginal populations (First Nations) consist of registered and non-status Indians (as defined under the Indian Act), Inuit and Métis.[7] More than one-million Canadians (almost four per cent of the overall population) consider themselves to be Aboriginal, with more than 70 per cent living off of First Nations reserves.[8,9]

Aboriginals and the majority of First Nations communities are considerably poorer than the Canadian average. The per capita income of registered Indians in 2001 was $10,094 compared to $22,489 for other Canadians.[5] As a result, nearly one-third of registered Indians live in poverty, more than two-and-a-half times the national average.[5]

In 2001, 17 per cent of off-reserve Aboriginal people, and 53 per cent of urban Inuit, lived in overcrowded housing, compared to seven per cent of the overall Canadian population.[6]

At least partly because of their economic deprivation, the health status of Aboriginal populations is worse than for other Canadians. In 2001, the overall life expectancy for registered Indians was 72.9 years, and 67.1 years for Inuit, compared to 78.7 years for the overall Canadian population. Infant mortality rates are 1.5 times that of the Canadian average. Injuries, suicides, and diabetes rates are three to five times the Canada average. Obesity and tuberculosis are eight to 10 times the Canadian average.[6]

Northern populations

Most First Nations communities are located in remote and northern areas. Such areas themselves have higher rates of poverty related to decreased access to economic and educational opportunities. This economic disparity is reflected in the dramatic disparities in health status and life expectancy.

In 1996, the life expectancy in Northwestern Region in Ontario was 76.3 years compared to 80.3 years in the regions of Halton and Peel.[10] Similarly, more than 12.3 per cent of the population in the Northern Planning Region had long-term disabilities compared to 7.3 per cent of the Toronto population.

Recent immigrants and racialized populations

Some 220,000 to 240,000 immigrants enter Canada each year.[11] Immigrants usually have better health than non-immigrants.[12] First, they must be healthy to contemplate uprooting themselves and moving to a new country. Second, they are screened during the immigration process to ensure they are healthy. This is often referred to as the "healthy immigrant effect."

Compared with previous generations, Canada's recent immigrants have higher rates of poverty after landing.[12]

In general, immigrants are more likely to work in low-paying jobs, less likely to be employed, and more likely to live in poverty.[13]

Immigrants are very well educated but have difficulty establishing themselves in jobs commensurate with their training.[14]

There is also a growing racial face to poverty in Toronto. From 1981 to 2001, the poverty rate in Toronto increased by 362 per cent in visible minority families.[17] As a result, in 2001, while only 10 per cent of Torontonians of European heritage were poor, 40 per cent of those claiming African origin, and 30 per cent of Arabs and West Asians, were poor.[13,16,17]

Many immigrants face health challenges from their reduced socioeconomic status, the challenges inherent to the resettlement process, and the gradual adoption of less healthy Canadian lifestyles.[11]

There have been major changes in the composition of Canada's immigrants during the past 30 years, with a large majority coming from non-European countries.[18] Recent European immigrants are healthier than Canadian-born citizens, but non-European immigrants are twice as likely as those Canadian-born to report that their health has deteriorated after coming to Canada.[12]

Impoverished urban neighbourhoods

Neighbourhoods with concentrations of poverty have particular problems and require comprehensive solutions.

In Toronto, poverty has become concentrated within so-called "inner suburbs," while downtown neighbourhoods have been "gentrified." As a result, the proportion of city neighbourhoods measured as "middle class" has fallen from 66 per cent to 32 per cent.[19] These inner suburban neighbourhoods have decreased access to public transportation, fewer retail outlets with healthy food, fewer parks and recreational facilities, and fewer medical and community services.[20]

This deprivation further exacerbates the impact of poverty on these vulnerable populations. For example, diabetes rates have been found to be elevated in poorer neighbourhoods in Toronto.[21] Other reports have linked these deprived urban neighbourhoods with trauma and homicide.[22]

Children

Children are especially vulnerable to poverty's impact. Children growing up in low-income households experience a higher risk of health problems throughout their lifespans, independent of their later socioeconomic status.[23,24]

Poor children are twice as likely to die in their first year of life.[25] After the first year, they are more likely to die from respiratory infections, asthma, injuries, and violence. They also suffer from more behavioural problems. Children living in poverty have reduced access to safe play spaces, and more commonly experience food insecurity, and even homelessness.

In 2007, the Canadian child poverty rate was 11.7 per cent, exactly the same as in 1989, when parliament passed its resolution to end childhood poverty. The rate has moderated since a peak in the 1990s.[26]

According to the United Nations International Children's Fund's (UNICEF) most recent international report card on child poverty in rich countries, Canada rated 19 out of 26 countries. Denmark, Finland, Norway, and Sweden all had rates less than one-third that in Canada.[27]

Of course, child poverty is much more common in the children of high-risk groups. According to the 2001 Census, 47 per cent of Ontario children in new immigrant families, and 32 per cent of children in families of visible minorities, were poor. One-third of off-reserve Aboriginal children, and 26 per cent of children with disabilities, lived in poverty.[26]

Single-parent families, particularly female lone-parent families

One of the reasons why children are a high-risk group is that single-parent families, especially those led by women, are at exceptionally high risk for poverty.[26]

Ontario Single-parent women-led families had a poverty rate of 49 per cent in 2007. Male-led single-parent families had incomes 50 per cent higher than those headed by women.

People with disabilities

Those with reduced access to gainful employment are at risk of impoverishment. Fifty-two per cent of Canadians with disabilities are unemployed.[5]

The monthly support for an individual on Ontario Disability Support Program (about $1,000 per month) leaves recipients living well below the poverty line.

Medical care for the many faces of poverty

There are specific approaches physicians can take with high-risk groups in their practice:

- Be aware of which patients are at risk of poverty by flagging risk factors (such as Aboriginal status, recent immigration, single-parent status, etc.). Become aware of the high-risk populations prevalent in your community of practice. Obtain social, economic and demographic information on your community through easily accessible Internet-based resources, such as your local health unit and Local Health Integration Network (LHIN).
- Adjust your practice location, hours and on-site supports to optimize access for populations at risk in your community. This may include the establishment of clinics in, or specific outreach to, underserviced communities. It may also include ensuring your clinic is accessible to the disabled, and for those arriving by public or active transportation.[28]

Physicians can also help high-risk groups by making specific services and resources easily available, and linking these with their medical practices. For example:

- Establish partnership arrangements with community services

such as social workers, Early Years Centres, and public health departments/units.
- Educate patients and the public about the health impacts of poverty, and the importance of addressing the underlying determinants of poverty.

Case follow-up

You provide suggestions for addressing this patient's obvious physical health issues, but take some extra time in your consult note to discuss an approach to her social determinants of health. You suggest she apply to the Ontario Disability Support Program, and you ask a social worker and occupational therapist to meet with her to optimize her chances of obtaining and maintaining employment after her convalescence. You connect her with a support group for central Africans with HIV that can resource tutors for her children, and social supports for her family. You also connect her with an HIV advocacy organization that provides cheap meals and free home support services. Finally, you note, in conversation with your local medical officer of health, that there is a growing community of recent African immigrants in your town, and you suggest that they may benefit from resources to create targeted services for their health and social needs.

Conclusion

Poverty has many faces in the form of high-risk populations. It is as important for physicians to be aware of these high-risk groups as it is to be aware of other risk factors for disease.

Physicians can display leadership to ensure that the health-care system is accessible and provides high-quality care to those populations at high risk of poverty.

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* Poverty articles posted on OMA website

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Poverty and Health

Poverty reduction: policy options and perspectives

by The Ontario Physicians Poverty Work Group
(Gary Bloch, MD, Vera Etches, MD, Charles Gardner, MD, Rosana Pellizzari, MD, Michael Rachlis, MD, Fran Scott, MD, Itamar Tamari, MD)

The following article describes policy initiatives that have proven to be effective at alleviating poverty in Ontario, as well as other Canadian and international jurisdictions.

The health-care system has a vital role to play in this endeavour, however, substantial poverty reduction requires action in many other sectors.

To be effective partners and advocates, Ontario physicians should have an appreciation of the multiple strategies required to address poverty reduction, and an understanding of which interventions actually work.

Poverty can be beaten

Some Canadians tend to think that the "poor will always be with us." However, many other countries have much lower poverty rates than Canada, and some provinces have lower rates than others.

The 2000 Canadian general poverty rate of 10 per cent, and childhood poverty rate of 14 per cent, were in the middle range for wealthy countries.[1] The United States' general poverty rate of 17 per cent, and childhood rate of 22 per cent, were much higher than Canada's, while most northern European countries had general poverty rates of five per cent, and child poverty rates of three per cent.

The United States has a greater gross domestic product per capita than all but two European countries that are members of the Organization of Economic Co-operation and Development (OECD), and yet it has higher poverty rates than all of them.[1] Clearly, poverty reduction is much more about policy choices than overall economic performance.

In Canada, those aged 65 or older had poverty rates above 20 per cent until the 1970s. But the implementation of the guaranteed annual supplement to the old-age pension reduced these rates to four per cent by 2000. This compares with a poverty rate among the elderly of 25 per cent in the United States.

The dramatic poverty reduction among Canadian elderly in response to specific policy initiatives highlights how poverty can be ameliorated by concerted government action.

Policies that can remedy poverty

Addressing poverty starts with a commitment to action, and setting measurable objectives with targets.

The United Kingdom established targets to reduce childhood poverty in the late 1990s, and has since seen the fastest drop in childhood poverty of any European country.[2]

In 2002, the province of Quebec introduced an action plan for poverty reduction.[3] Quebec's performance on childhood poverty reduction stands in contrast to that of Ontario. In 1998, the Quebec childhood poverty rate was 23.8 per cent, compared with 17.5 per cent in Ontario.[4] By 2005, the Ontario rate had fallen to 12.6 per cent (a 29 per cent relative reduction), but the Quebec rate had plunged to 9.6 per cent (a 60 per cent relative reduction).[5]

In 2006, the Newfoundland and Labrador government announced that it would reduce poverty in that province. On May 30, 2007, the Newfoundland and Labrador House of Assembly passed a resolution committing the province to having the lowest Canadian poverty rate by 2017.

Campaign 2000, a Canadian coalition to eliminate child and family poverty, has highlighted the following four categories of policies that could significantly reduce overall Canadian poverty levels.[6]

The principle of sustaining employment

There should be an assurance that any adult working full time (at least 30 or more hours per week, or 1,500 hours per year) will not live in poverty.

Little empirical evidence exists to gauge the complex impact of minimum wage alone on poverty, as many other market and supply-and-demand factors influence employment of low-wage workers.[7] However, public policies to increase the minimum wage have been implemented in many jurisdictions with the intent to reduce poverty. Once minimum wages are set to lift working families above the poverty level, the wage must be indexed to ensure it rises with inflation.

Income-tax deductions, by definition, do not benefit those too poor to pay income tax. Alternatively, tax credits which are refundable ensure that those low-income workers who do not otherwise earn enough to benefit from tax deductions will still receive some money back from the government.[8]

In 2006, women made up 47 per cent of the Canadian workforce. Three-quarters of employed women have young children.[9] Universal, affordable, high-quality child care can lift many young families out of poverty through two actions: first, child care allows women to work and earn income; second, reducing the costs of child care would free up income to be used on housing and food.

Canada has the dubious distinction of ranking at the bottom of 14 OECD countries on public spending on early learning and child care.[10]

The principle of a basic income system for persons with disabilities

Canadians with disabilities are more likely to live in poverty than any other Canadians.[11] Families with disabled children are more likely to live on social assistance. Disability benefits could provide disabled Canadians with a guaranteed and adequate income, similar to that received by seniors.

The principle of transitional support with dignity

Transitional support with dignity should be provided for individuals and families when adults are unavailable for employment due to temporary or extended problems.

When employment insurance (EI) was originally designed, the vast majority of workers benefited from it. However, currently, only 27 per cent of unemployed persons in Ontario are eligible for EI. In Toronto and Ottawa, this rate falls to just above 20 per cent.[12] This situation could be addressed by implementing a uniform EI entrance requirement, increasing benefits so that they represent at least 60 per cent of earnings, and eliminating the two-week waiting period so that families are not thrown into a crisis.

In the past, welfare programs divided people into so-called "deserving" and "undeserving" poor. We are still treating those on social assistance with a harsher hand.

Social assistance rates have fallen by 40 per cent in spending power since just prior to the mid-1990s. This leaves the rate at 40 per cent to 65 per cent below the poverty line (depending on family type).[13]

Ontario Works (the base welfare program) is the final safety net for low-income persons in Ontario, and often is the source of income for unemployed people who do not qualify for EI, disabled people who have not applied or qualified for the Ontario Disability Support Program (ODSP), single mothers who cannot afford child care, and other highly disadvantaged groups.

The policy sentiment behind lowering welfare rates and restricting access to benefits — that people need to be pushed back into the workforce — does not take into account powerful extenuating circumstances that prevent many of these individuals from working.

The principle of available and essential resources

We should ensure that individuals and families have the available and necessary resources to promote equal opportunities for all Canadians.

Prescription medicines cost Canadians $27 billion in 2007, and the growth rate is escalating rapidly.[14] People with lower incomes are more likely to be prescribed medications because they are sicker.[15] Yet, low-

income persons who are not on social assistance are the least likely to have prescription drug benefits.

The same pattern exists for dental care: low-income persons have more dental disease but are the least likely to have dental insurance.[16] Increasing coverage for drug and dental costs, such as an extension of the principle of equal access in the Canada Health Act to include these areas, is one strategy to remedy this situation.

Housing costs consume the largest part of the monthly budget for many people, so that improving housing affordability enables households to have more money for food and other essentials.[17]

Housing policy strategies may include greater provincial support for housing programs, provincial investments to maintain aging public housing, rent supplements for low-income renters, and construction of rental units geared to income and supportive housing.[18]

Canada is the only wealthy country without a national housing policy.[19] A recent study based on 2007 data concluded that since a 2001 federal-provincial agreement which promised $1 billion for housing, net spending on housing had only increased by $24 million. Ontario actually cut its spending by $732 million during the period.[20] This shortfall was only partly ameliorated by the 2008 Ontario budget, which promised $100 million for new social housing.[21]

Early childhood development is a well-established determinant of health. Full-day junior and senior kindergarten, as well as universally subsidized day care, supports early childhood development while enabling parents to remain in the workforce, as described above.

Dr. Fraser Mustard and Margaret McCain reviewed the evidence on this issue in their 1999 report entitled, "Early Years: Reversing the Real Brain Drain."[22] They recommended a variety of policies to reduce poverty and level the playing field for disadvantaged Ontario children. However, little has been done to implement their recommendations.[23]

While changes in old-age pensions in the 1970s dramatically reduced poverty among seniors, the implementation of the federal government's child tax benefits resulted in more moderate improvements. Part of the explanation is that several governments have "clawed back" some of the money from families on social assistance.[24]

In July 2007, the Ontario government announced the implementation of the Ontario Child Benefit.[25] However, families on social assistance will have some of the benefit clawed back. While the maximum benefit will rise to $92 per month per child by 2011, families on social assistance will only receive $50 per month per child.

Policies that Address High-Risk Groups

Indigenous populations

As noted in article four of this series (pp. 31-36), Canadian Aboriginals have the highest poverty rates and the poorest health.

The Royal Commission on Aboriginal Peoples noted that bands with land claims settlements have improved their economic and health status,[26] and the speedy resolution of these claims must be central to a health improvement strategy for this group.

Targeting policies to support preschool and school-age children to achieve such outcomes as improved school attainment and, ultimately, better employment, are also critical for this population.[27]

Northern populations

Strategies that aim to foster diversification of employment in the North may address the increased burden of poverty in the North. Support for transportation to access work and services over larger geographic distances, and improved access to education and training, are also important for northern populations seeking to reduce poverty.[28]

Tax deductions for residents living in the North are another public policy that has gained some support recently, though those with the lowest incomes would not benefit as they do not pay income tax.[29]

Racialized groups and recent immigrants

Systemic racial discrimination persists in Canadian society and acts as a barrier to both opportunity and livelihood for many Canadians. Meaningful action to address racism requires a commitment from all levels of government, as well as society's major institutions.[30]

Barriers experienced by new immigrants to Canada include inequality in access to professions and trades. Presently, many competent and well-trained immigrants are denied jobs because of the rigidity of many professional associations, and unrealistic demands for Canadian experience.[31]

Impoverished urban neighbourhoods

Geographically concentrated racialized poverty is found in inner-city neighbourhoods in many Canadian cities, such as Winnipeg, Vancouver, Saskatoon and Toronto. These conditions require general policies to improve social determinants of health, including poverty, physical and infrastructure improvements to inner-city neighbourhoods, and targeted community capacity building.[32] The case example of Regent Park's Pathways to Education, described on page 46, is an excellent example of the latter strategy.[33]

The Ontario government is developing an approach to poverty

In 2007, Ontario Premier Dalton McGuinty appointed Deb Matthews, Minister of Children and Youth Services, to chair a cabinet committee on poverty reduction.

The government has committed to developing a poverty-reduction strategy that will contain specific indicators and targets by the end of 2008. Leading up to the release of the

2008 budget, and in the budget itself, the government announced a series of initiatives to deal with poverty, including a low-income children's dental program, expanded student nutrition programs, new textbook and technology grants, new social housing expenditures, and a variety of other programs. The province raised the minimum wage to $8.75 in 2007, and plans to have it rise to $10.25 by 2010.

Changes in public health mandate will lead to increased focus on social issues like poverty

The mandate for the province's public health units is changing to include a stronger emphasis on the determinants of health.

The proposed Ontario Public Health Standards establish new requirements for fundamental health programs and services provided by medical officers of health and other health unit staff.

The standards integrate the determinants of health into key public health functions, such as surveillance and population health assessment, health protection, and health promotion at the local level.

Physicians can expect to receive information on the links between poverty and health status from their local board of health. Physicians may find that more public health services and programs are targeted at low-income and other vulnerable patients within their practices.

Physicians may also be called upon by their public health colleagues to collaborate and advocate on local issues, such as hunger, homelessness, and poverty.

Developing a comprehensive anti-poverty strategy in Ontario

While there are better opportunities than ever to develop a comprehensive plan to reduce poverty in Ontario, there are challenges as well.

The Canadian economy is slowing, a recession in the United States will likely be announced shortly,[34] and Ontario's economy is not performing as well as the economies of other provinces.[35] These slowdowns will reduce the growth of government revenues.

The government of Ontario and the federal government have made deep tax cuts over the past 10 years.[36] Since 1993, spending by Canadian senior levels of government has fallen from 45 per cent of the country's economy to less than one-third.[37] The current Ontario government has pledged to not raise taxes or run a deficit,[38] and the federal government has announced further tax cuts.[39]

The United Nations International Children's Fund (UNICEF) noted that the higher the proportion of a country's overall economy devoted to social transfers (such as the child tax credit), the lower the rate of poverty. This trend has been most

effectively demonstrated in European countries, including the United Kingdom and Sweden.[40]

Case example

Pathways to Education™, an intervention aimed at reducing school drop-out rates, started in 2001 in an inner-city neighbourhood in Toronto when the board and staff of a community health centre (CHC), Regent Park, committed to a vision of local children running the CHC when they grew up. The aim was to assist the children to reach their full potential, and address two powerful social determinants of health — education and income — by supporting them to become the next generation of doctors, nurses, dentists, social workers and administrative staff. Since 2001, funders, parents, schools, the CHC, and other community groups have used academic, social, and financial supports to reduce the drop-out rate in their community from 56 per cent to only 10 per cent. Pathways to Education™ has proven how inner-city neighbourhoods can be incubators of innovative solutions, when the infrastructure and funding exists to empower communities. It has also become a showcase to demonstrate both the link between education and employment opportunities, and the importance of using a comprehensive approach to meet targets.

Conclusion

This article concludes a five-part series on poverty and health written by physicians for physicians.

Poverty is a serious problem in Ontario, and especially in Toronto. For more than a decade, researchers, physicians, and public health providers have been calling for action on the health problems caused by the province's deepening social inequalities. Ontario's physicians can help to advocate for meaningful government action on poverty, at all levels, to build a healthier future for our patients.

Physicians will have many opportunities to influence Ontario's poverty-reduction program as the provincial government develops its plan this year.

The authors hope that this series will enable colleagues to better respond to individual patients' poverty-related problems, and to participate in the current public policy debate about reducing poverty in Ontario.

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