Increasing Equity Through Medicine: An Interview with Dr. Gary Bloch

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Dr. Gary Bloch admits he took an unusual path into medicine. The young Dr. Bloch began his post-secondary education at McGill where he took up a degree in African History. After contemplating the best way he could tackle social justice issues, Dr. Bloch decided on medicine. He returned to his home city of Vancouver where he attended medical school at UBC and then moved to Toronto where he completed his residency in 2004. Dr. Bloch is currently on faculty in the University of Toronto's Department of Family and Community Medicine and works as a family doctor out of St. Michael's Hospital. He spends half of his time in a family practice working with an inner city oriented population. The other half of Dr. Bloch's time is devoted to working with the homeless at Inner City Health Associates, a group of physicians providing care to the homeless across the Greater Toronto Area. Inner City Health Associates has nearly 40 physicians at roughly 25 homeless service sites. These sites are continually adapting and expanding their services. The organization is actively engaged in education, research, and systems-level planning around homeless health. Through Inner City Health Associates, Dr. Bloch works to set up primary care sites and systems around primary care for the homeless. Outside of Canada, Dr. Bloch has traveled to Lesotho in southern Africa to provide help for an HIV assistance project. At the time of this interview, Dr. Bloch returned from six months of paternity leave. He has three children and wanted it to be made explicitly known that doctors can have children and focus on their careers at the same time!

UTMJ: How would you compare the poverty you saw in Lesotho to the poverty you see in Canada?

GB: Poverty is always complicated. There are many different causes and impacts of poverty. The poverty in southern Africa is an economic poverty, but it's also a poverty of state infrastructure, mostly due the history of colonialism that left half-formed states to fend for themselves. Another way to look at the situation is that many of these countries are still young and in the process of figuring out how to transform themselves into viable functioning states. While the economic poverty in southern Africa is very much a fallout of this history, the economic poverty is very real. Many people live on less than a dollar a day. It's poverty beyond anything we see here in Canada.

UTMJ: What factors influence HIV treatment in Africa?

GB: In terms of dealing with the HIV crisis in Lesotho, there's first of all the pure healthcare level. For example, it took ten more years to start widespread rollout of current multi-drug HIV antiretroviral 'cocktails' in Lesotho relative to Canada. That was largely economically related, although other factors like racism certainly played their part. Nurses, hospitals, clinics, and other types of resources are scarce or not in place. That's the big healthcare systems level. But in terms of people's daily lives, in Canada, when I see someone with HIV, it is often the focus of that person's life, and rightly so. It's a huge issue for them and they're able to spend a huge amount of time understanding the disease, figuring out how to treat it, monitoring it, and live with it – which is a huge luxury, believe it or not. It's something that the people living in devastating poverty in Lesotho don't have. For example, many people in Lesotho have to travel five to six hours to get to a clinic. So, there's a major cost for transport, not to mention the cost of tests, the cost of drugs, and the cost of healthcare. The other level to the issue is hopefulness. People in Canada seem to have a stronger sense of hope that there are structures around them that will allow them to deal with their illness. I think people in Lesotho didn't have those structures in place and probably still don't. Hope can be a huge factor in staying well.

UTMJ: Is the link between poverty and health getting much scholarly attention in Canada?

GB: Poverty is the number one determinant of health. We know this from many years of studying poverty. In the Canadian context, there is a strong body of scholarly work looking at the link between poverty and health. There's also a strong academic community looking at this issue as well. What's been shown convincingly when looking at access to healthcare, chronic disease, acute disease, injuries, childhood illness, and mental illness, is that people who live in poverty have higher incidence rates of, and morbidity from, acute and chronic physical and mental health conditions. For a good summary of Canadian- and Ontario-based statistics on poverty and health, I would suggest looking at the first of five articles on poverty and health a group of us put together this year.[1,2,3,4,5] These were published in the May and June issues of the Ontario Medical Review and are freely available at www.oma.org/pcomm/omr.

UTMJ: How will economics impact the health of Canadians, given the current economic crisis?

GB: Well, to gaze into the crystal ball, it doesn't seem like the government is pulling money away from the Canadian healthcare system due to the current economic crisis. In many ways, the healthcare system seems to be a kind of Holy Grail in our society. There

are measures being put in place for hospitals needing to make sure their budgets are balanced, sort of being pinched around the edges, but I don't think the major impact of the economic crisis will be felt at the level of the Canadian healthcare system.

I really think that the impact of the economic crisis will be felt with our individual patients and communities of practice. If more people fall into lower income categories, more people will see their health risks increase due to poverty. I can tell you that, first of all, poverty itself seems to cause poor health. When looking at the evidence, a group of people who have fallen into poverty as a result of poor health can be teased apart from those living in poverty. Despite this, there is a larger group of people who have fallen into ill health after becoming poor. So there seems to be some sort of pathway from poverty to poor health.

There's no definitive answer as to how poverty causes ill health, but there are studies about a link between poverty and poor health. The mechanism of this may be rooted in increased stress hormones that have a wide-ranging impact on the body's ability to function and resist acute and chronic illnesses, but this is just one pathway that's been studied.

Admittedly, it will be very hard to make an absolute link between poverty and ill health. A lot of these determinants of health are long-term. So something that happens now during the economic crisis may only affect someone twenty years on. It might be possible to trace health problems back to the current economic crisis in the years to come. However, in the circumstances that we currently find ourselves in, we have to fall back on the evidence we have. That evidence points to significant health effects from living in poverty.

I think the other area that we'll see an impact of the economic crisis is in the willingness of the government to strengthen programs designed to support people living in poverty. And we're already seeing this. In December 2008, the Ontario government rolled out it's so called 'Breaking the Cycle' poverty reduction strategy. In that plan we saw a pretty clear indication that they were hedging themselves. Plans were given for poverty reduction; however, if the economic downturn is too severe, if our funds fall off too much, the Ontario government was indicating the we had better be ready for them to pull back on some of the key elements of this plan, which was not surprising. It's an easy way out for the government. I would say that this is exactly the time to put significant amounts of money into poverty reduction because we run the risk of having a large number of people sliding into poverty, and the long term impacts of that, economically and health-wise, are potentially huge. However, governments do not tend to think long term in that way and are usually more interested in maintaining their immediate bottom line. So the willingness of the government to strengthen support programs would probably be the biggest immediate impact of the economic crisis and would disproportionately impact those people who are already living on welfare or disability support and are not getting the kind of increased support that they need to survive.

UTMJ: You are involved with 'Health Providers Against Poverty'. Tell us about the organization.

GB: Health Providers Against Poverty (HPAP) formed in 2005 initially out of the special diets campaign. This was an effort started by a group of anti-poverty activists mainly from the Ontario Coalition Against Poverty (OCAP). OCAP realized that there was a provision within welfare legislation that allowed certain health care providers –physicians, nurse practitioners, dieticians, midwives – to approve an extra amount of income for people living on welfare or disability support with special dietary needs for health purposes. This was a very underutilized provision of welfare legislation that allowed for relatively large amounts of extra money to be added to people's welfare cheques, on the order of 40% if a person qualified for the full amount of the special dietary supplement. Initially OCAP and the few health care providers started to organize clinics for people to see if they qualified for the supplement. This really bloomed. Over about six months in 2005, it went from a few clinics doing these assessments to 60-80 health care providers who assessed well over 6000 people, almost all of whom qualified for some portion of the supplement based on how the regulations were written at that time.

At that point there was no formal group of health care providers; however, we recognized that there was a group of us interested in poverty as a health issue. We were all seeing poverty in our daily practices, most of us spent the bulk of our professional lives dealing with people living in poverty, so it was pretty obvious to us that poverty was a significant factor in these people's lives. It made sense for us to form something that was longer lasting and had an organizational structure that could carry forward a project working on the link between poverty and health. So Health Providers Against Poverty was born.

UTMJ: Have the activities of HPAP changed since 2005?

GB: To make a long story of four intense years short, the activities of HPAP have changed significantly. The original special diet campaign no longer exists since the government changed the regulations and thereby restricted people's ability to access the special dietary supplement. We as a group, however, have adopted a more diverse approach to poverty as a health issue. I can give a sampling of the activities we're involved in now. Education has been a major thrust. Not only education of the public, but especially education of health providers. This involves talking about the link between poverty and health, what we as health providers can do to deal with poverty as a health issue, as well as publishing articles. The purpose of this is to raise awareness

about the issue. We are also increasing awareness about HPAP with the hope of increasing the capacity of the group to bring the issue of poverty and health forward.

Research has also been a part of HPAP's recent activities. Research is being conducted on the level of poverty our patients are living in. There are also two systematic reviews in the works. One will be looking at whether changes in welfare regimens can actually impact health. Another review will be looking at whether focused primary care interventions have been done with respect to poverty and health.

Advocacy and direct action remain the core of the group's work. Our initial advocacy work centered on visiting policy makers at all levels of government to talk about poverty as a health issue. We've now shifted over mostly to supporting coalition work on these issues. There are some pretty exciting and strong coalitions that represent the issue of poverty in Ontario, the biggest one being the 25 in 5 Coalition (www.25in5.ca). This coalition is pushing for a 25% reduction in poverty in 5 years. We've put most of our lobbying efforts into bringing a health perspective to that coalition, mostly because we recognize that we're not broad social policy experts, we're health experts. We're probably most effective by adding our expertise to the expertise of everyone else that comes to the coalition from other backgrounds.

By direct action I mean direct ways to decrease the poverty of our patients. The first iteration of this was the special diet clinics. We are now developing and hoping to pilot a much broader multidisciplinary anti-poverty clinic. There is strong interest in this initiative from many different parties including community health centres, social service agencies, legal clinics, and advocacy organizations. The idea here is that there would be health providers but also social workers, legal experts, income experts, housing experts, and other people that deal with different social determinants of health, all within one place. A patient would walk in the door, have an assessment, and then be directed to a tailored set of experts, which is pretty exciting!

UTMJ: Is it possible to make a distinction between child and adult poverty?

GB: I'm wary of making too much of a distinction between child and adult poverty. It's a very popular way to go though, but I'm hesitant on several levels. First of all, I don't think you can deal with child poverty without dealing with the adults around them. I think you need to deal with overall poverty in order to deal with child poverty properly. Second, I think the tendency to emphasize child poverty over adult poverty comes from a place that blames people for their poverty. In other words, there is a sense that adults who live in poverty should have got themselves out of poverty by now, and if they have not they are lazy, they are not trying hard enough, they are not smart enough to figure out what the ways out are, and that overall they are to blame for the situation they are living in. Whereas children are, of course, not to blame for the situation they are living in, they are vulnerable, they have not had the ability to make the same life choices, hence people do not get the same sense of discomfort in dealing with child poverty. I do not completely subscribe to that view. I think adults living in poverty in most cases are people who have ended up there because of circumstances beyond their control. Whatever the circumstances may be, and whether these were circumstances that they grew up in or circumstances they fell into later in life, I have yet to come across someone who really wants to be living in poverty and who would not choose to get themselves out of poverty if they had that choice.

UTMJ: How can medical students get involved in fighting poverty?

GB: I think there is a lot that can be done in medical school. First and foremost, I think that poverty and other social determinants of health need to be given a more prominent place in the curriculum. In my ideal world, I would like to see social determinants of health placed on the same level as other health issues that medical students learn about. By this I mean that instead of shifting poverty over into the social issue courses like Determinants of Community Health we would actually throw poverty into the mainstream curriculum. It is hard for me to believe that people have to sit and memorize a list of risk factors for diabetes when poverty is not on that list. This when there is evidence to show that the impact of poverty on diabetes is at least as high as diet or exercise. In clerkship, and there perhaps more than anywhere, medical students need to be guided through understanding how to incorporate the socio-economic situations of their patients into their day to day practice. The classic example is that of a disadvantaged patient who comes to a hospital and tends to have their biomedical issues dealt with beautifully and then gets booted back onto the street when their housing and income issues have not even been touched, which is ridiculous. Housing and income issues are as prominent health factors as the physical problems that tend to get dealt with.

Beyond medical school, I think there are a number of ways to get involved. Anyone can go to the Health Providers Against Poverty website (www.healthprovidersagainstpoverty.ca), see what is happening, and get our contact information (hpagainstpoverty@gmail.com). There is a fairly broad range of areas to get involved in, from education, to advocacy, to research, to whatever people's interests are. Speaking more generically, I think people should be seeking out experiences that give them exposure to both communities living in poverty and organizations dealing with poverty. There are fantastic health organizations out there – Regent Park Community Health Centre, Parkdale Community Health Centre, Street Health,

Sherbourne Health Centre, Anishinabe Health – and many other organizations that deal with the health impacts of poverty. I think that everyone going through medical school should gain some exposure to what those organizations are doing, to what their approaches are, and what their experiences are in dealing with these issues. At a minimum, read. Take the time to recognize poverty as an important health issue and start exploring it. Dennis Raphael has a fabulous book called 'Social Determinants of Health: Canadian Perspectives' and another book called 'Poverty and Policy in Canada: Implications for Health and Quality of Life'. Just grabbing those books and browsing through them over the year will significantly shift people's perspective and transform their way of practicing medicine.

References

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