Family & Community Medicine
UNIVERSITY OF TORONTO

WORKING WITH FAMILIES INSTITUTE

Poverty and Health:

Key Issues in Patient Care

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In today's world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

Goals

The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

How to Use the Modules

The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

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Bill Watson
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CONTENTS

SUMMARY

Poverty is an important determinant of health and illness, which has profound effects throughout the life cycle. Poverty is strongly linked to many adverse health outcomes and associated with a higher incidence, prevalence, and severity of chronic illness, acute illness, and injuries.[1] Physicians can make a difference for individual patients by integrating a "determinants of health" approach into patient-centred care while assisting with access to health care, income supports, and resources. Addressing poverty helps redress inequalities in health—an important ethical concern. An understanding of the facts about poverty in Canada and practical strategies will allow family physicians (FPs) to intervene and care for patients affected by poverty.

OBJECTIVES

After completing this module, you will be able to

1. understand poverty as a significant determinant of health and consider its impact throughout the life cycle.
2. screen for poverty effectively during routine primary care encounters and recognize its impact on health risk.
3. practise using available skills and tools to address poverty and assist with income supports and resources when possible.

Key features:

1. The incidence of poverty is increasing in Canada.
2. Physicians have an important role to play in helping patients access income support and resources.

Core Competencies:

1. Display effective, professional and non-judgmental communication skills.
2. Adopt a patient centred approach.
3. Demonstrate sensitivity to cultural, gender and socioeconomic differences.

CASE STUDIES

Case 1: Ms. Anderson, aged 18

You have met Ms. Anderson at the clinic of a local youth drop-in centre. She has not had a period for four months. Recently she administered a home pregnancy test, the result of which was positive. Although this is an unplanned pregnancy, she discussed it with her boyfriend and tells you "we want to keep it."

- ***What questions might you ask during history-taking to screen for poverty as a risk factor in this patient's pregnancy?***

In childhood, Ms. Anderson was diagnosed with attention deficit hyperactivity disorder (ADHD), for which she is taking no medication. She admits to smoking and drinking alcohol through the beginning of her pregnancy, but she stopped after administering the pregnancy test. She has been living at a women's shelter for the past 12 months, ever since her stepfather "booted her out" of the family home. She finished grade 11 and has been able to find only part-time work at a coffee shop, where she is paid minimum wage and has no benefits. She would like to finish high school but has struggled with school in the past.

- ***How would you begin to address Ms. Anderson's health needs?***

Two years later, you meet Ms. Anderson and her son at a drop-in centre. He is there for an 18-month well-baby visit. Ms. A. now lives in a subsidized apartment and is receiving social assistance. She and the baby's father have separated because he was physically abusive. She has tried to find part-time work, but most jobs do not pay well enough to cover the cost of childcare. She says, "I want my son to have a better chance than I did."

- ***What are your areas of focus during the visit?***
- ***How do you address her concern about her son's future?***

Case 2: Mrs. Jones, aged 60

Mrs. Jones lives alone in an apartment complex on the outskirts of town. She has not been to the clinic since her husband died more than a year ago. Her husband had been receiving a government disability pension, which was discontinued when he died. Mrs. Jones has several medical problems, including diabetes, depression, hypertension, and chronic obstructive pulmonary disease (COPD). She has come in today because she has run out of medication and the pharmacist told her she needs to see her doctor. A neighbour was able to drive her to the clinic, but she is anxious because she has to find a way of getting home.

- ***What are the main issues of concern for Mrs. Jones?***
- ***What elements of her social history are important to gather?***
- ***What are the major factors affecting her health and quality of life?***

Further discussion reveals that Mrs. Jones has been quite isolated socially. Her daughter lives several hours away in another town. Mrs. Jones is surviving on monthly welfare cheques but often runs out of food before the end of the month. She usually buys food from the convenience store in a gas station close to the highway. Neighbours have been helping her and occasionally she walks or hitches a ride to the food bank, but only if the weather is good. She wonders if you can do anything to help her. She says that since her husband died, she just can't make ends meet.

- ***What income support resources are you aware of? What programs could help Mrs. Jones?***
- ***Is the physician's role to intervene when social determinants of health, like poverty, are present?***
- ***What factors will affect your ability to provide care for Mrs. Jones? What feelings does this case evoke in you?***

Case 3: Mr. Dihoud, aged 47

Mr. Dihoud is unmarried and originally from Somalia. He has been living in Canada for the past 17 years. He has no family in the city and has supported himself by picking up intermittent jobs as a general labourer. He has been staying with various friends ("couch surfing") and does not have his own home. He has stayed in shelters when necessary and has occasionally slept outdoors. He has previously been diagnosed with hypertension, high cholesterol levels, and hepatitis C infection, but has never taken any medication because he has not been able to afford it. Recently, he fractured his ankle and injured his back after a fall when he was drinking. He has a lot of pain and requests your help—he says he needs to get back to work.

- ***How will you approach Mr. Dihoud's request for help?***
- ***What factors have prevented Mr. Dihoud from accessing health care?***
- ***What community resources are available to assist Mr. Dihoud?***
- ***How might your priorities as a health care provider differ from Mr. Dihoud's priorities?***
- ***What ideas can you generate for assisting Mr. Dihoud? What will be the most important interventions for Mr. Dihoud's overall health?***

Case 4: Benjamin, aged eight

You are seeing eight-year-old Benjamin Radley, along with his mother Sarah, aged 32, in your evening clinic. Sarah has brought Benjamin to follow up on an asthma exacerbation triggered by a recent respiratory infection. The family has been in your practice for several years, and you also follow her husband Dan and her two other children, Jenny and Billy, aged two and five respectively. Today, Sarah notes that Benjamin's cough seems to be persisting. She is administering his 'rescue' puffer at least a few times a day and he coughs frequently at night. Sarah reveals that they ran out of his steroid puffer a week ago and could not afford to refill the prescription. As well, they are no longer using a spacer with the inhaler as it was lost and it is 'too expensive to buy another one'. Sarah admits the family is struggling and 'it's been a tough few months.'

- ***What are some questions you might ask at this point?***

When probed, Sarah reveals that Dan has not been able to get as many shifts in construction work for the last several months, so she has taken another part-time job cleaning offices overnight. She has been working in a coffee-shop three times a week as well. They don't have extended health insurance for medication purchases. They are 'behind' on a few bills, and Sarah fears she may need to quit her day job as it is hard to pay for babysitting when she and Dan are working. She admits this has led to more stress at home, and she has taken up smoking again, though she tries to smoke outside 'or at least out the window.' She is feeling overwhelmed and at times 'fed up' with Dan, as she feels that he is not helping her with household chores and childcare: 'I'm doing everything I can do and we are just not getting by'.

- ***What elements of this family's situation are contributing to Benjamin's health situation?***
- ***Are there any interventions you are familiar with that could help with the current situation?***
- ***What are the challenges of eliciting information about family functioning during in an acute visit? What questions might help to elicit this type of information?***
- ***How might you approach the relationship tensions Sarah and Dan are facing? What are some steps that you might take to assist the family?***

INFORMATION POINTS

Background: Poverty and Health in Context

1. Determinants of health are factors that contribute to a person's state of biological, behavioural, and social health.[1] For many years, poverty has been widely recognized as one of the strongest determinants of a population's health. Poverty plays a major role in defining equitable access to housing and education, the conditions of early childhood, the nature of employment and working conditions, and access to health care services. As such, poverty is a central factor influencing multiple other social determinants of health. All these determinants together affect individuals' physical, mental, and social well-being.[2]

Poverty

2. Most people conceptualize "poverty" as a state of deprivation. Two major approaches are used to define poverty. With the *absolute* approach, a basket of essential goods and services necessary for physical survival is described (Market Basket Measure) and a poverty line is implied on the basis of the costs of this basket. The second approach is to define poverty in relative terms: someone is "worse off" than average and components of social and psychological deprivation might be included, as well as physical needs.[3] Poverty in Canada has also been described statistically in terms of a 'low income cut-off' (LICO) which refers to an income threshold at which families are likely to spend 20% more than the average family on food, shelter and clothing and is connected to cost of living and size of community.[4] Access to social assistance programs at the federal, provincial, and municipal levels is most often defined according to an absolute definition of poverty (e.g., family annual income level), which may not take into account an individual's actual level of need.[3]

   Canadian rates of poverty are difficult to define, as no official definition of poverty exists in Canada.[3] According to a recent report from the Public Health Agency of Canada, an estimated 11% of Canadians live in poverty, although this may be an underestimate. Low incomes disproportionately affect single parents, women, people with disabilities, Aboriginal people, and recent immigrants.[5]

3. Higher proportions of people live in poverty in certain neighbourhoods in Canada's cities. This "concentration of poverty" often leaves neighbourhoods with fewer resources and services, more crime, and less social support, adding to the impact of poverty on individuals.[5] While personal income levels have been on the rise in Canada, the gap between highest and lowest incomes has increased in the past 15 years.[5] Poverty has a different impact on the health of people from different groups, for instance, men and women, people with or without disabilities, immigrants and Canadian-born residents, older and younger people, children and adolescents, gay men/lesbians and heterosexual people.[6]

4. Poverty is an independent risk factor for disease. Higher rates of cardiovascular disease, respiratory disease, malignancy and infectious disease are associated with lower socioeconomic status. [7] A recent Statistics Canada report has clearly shown that health declines as income decreases in Canada. The report found that age-standardized mortality rates (ASMR) are inversely related to income in all causes of mortality studied (i.e. COPD, DM, HIV/AIDS, suicide) except prostate and breast cancer. [8,9]

Poverty and Patient-centred Care

5. In comparison with those in the highest income groups, individuals with chronic disease in the lowest income groups were less likely to report that their primary care physician involved them in clinical decisions or helped them create a treatment plan to manage their conditions.[6]

Child Poverty

6. Child poverty rates in Canada range from 11% to 14%.[5,7] While overall child poverty has decreased in the past decade,[10] rates are still significantly higher than in some other equally developed countries. Canada ranks 24th among 34 industrialized nations.[11] Child poverty rates hover around or are just above overall poverty rates, suggesting that social and tax policies are not doing enough to prioritize this vulnerable group.[11] In contrast, policies to reduce poverty among seniors have enjoyed more success, reducing rates of poverty to the 6% range.[5,10]

Poverty and Health from a Life-course Perspective

7. The strong correlation between income level and health status has long been documented, and the powerful impact of poverty over the life course is gaining recognition. Studies have shown that children who grow up in poverty "sustain higher rates of virtually every form of human malady and developmental hurdles."[11] Socioeconomic status is a potent predictor of morbidity among children, and is correlated with birth weight, infectious disease, dental disease, developmental disorders, and behavioural disorders, among other conditions.[10,11]

8. Poverty plays a role in child health, and early exposure to poverty is also strongly correlated with later health problems. Childhood poverty is linked to later cardiovascular disease (CVD), stroke, respiratory diseases, and a number of adult cancers.[12] These health problems occur because of latent and cumulative effects of exposure to the conditions of poverty. For example, inadequate nutrition in the prenatal period and first year of life is correlated with the risk of developing heart disease and diabetes later in life.[13]

9. Some of the correlation seen between poverty and child health is related to material factors, including nutrition, access to medical care, and the physical environment (e.g., crowded housing, exposure to secondhand smoke). Beyond this, growing evidence shows that early exposure to violence and trauma, more common among children living in low-income homes and neighbourhoods, affects long-term health. In a large southern

California study of 17,000 participants, self-reported exposure to traumatic or abusive events before age 18 was strongly and linearly correlated to a wide range of later physical and mental health problems, including alcoholism, depression, suicide risk, smoking and substance abuse, CVD, chronic lung disease, obesity, and cancer. Exposure had a dose-response relationship: Those exposed to four or more categories of adversity demonstrated a four- to 12-fold greater risk of psychiatric disorders, and a higher number of physical and mental ailments.[11]

Early Adversity

10. Over the past 10 years, a growing body of work has revealed why a correlation exists between early adversity and later health. Studies in neuroscience, genetics, and developmental science show that early adversities play a role in moulding the stress-response system of the young and developing brain. The activation of the stress-response system causes structural and functional changes in the brain and the way it evaluates threat, regulates emotion, and interacts with the peripheral nervous system. These changes influence stress regulation capacity, and have a variety of effects at the physiologic level, influencing, for example, immune function and blood pressure. As such, early adversity may become "biologically embedded," and link childhood stress and adult physical and mental health outcomes.[11] Health and developmental trajectories are set in early life, and may be enhanced by ongoing exposure to stressful events, which creates a "poverty cycle" that is powerfully reinforcing.[11,13]

11. Evidence indicates that several genes play a role in this susceptibility to early stress and its long-term impact. Gene expression is altered in response to environmental experience, and may even be transmitted from generation to generation.[11] Both protective and harmful factors play a role: effective parenting, extended family supports, and even community-level support may protect children from the biological impacts of adversity.[11] As such, supportive programs and health interventions can play a key role in supporting children and families and helping them minimize the long-term impacts of poverty.

Poverty and Health Equity

12. Health equity is the absence of differences in health between groups. All people should have a fair opportunity to attain their full potential, and no one should be prevented from achieving this potential. Reducing differences is integral to providing equitable health care to all patients.

Gender and Poverty

13. Women's health is affected more negatively by poverty. Women in low-income households have a higher rate of major chronic conditions than do men in most categories, and women with lower incomes face more barriers to screening tests.[10]

Racialized and Immigrant Groups

14. Racialized groups live in the poorest neighbourhoods and have a higher incidence of disease. For example, the areas of Toronto with high rates of poverty have high concentrations of visible minorities. These same areas have been shown to have the highest rates of diabetes.[14] Aboriginal people in Ontario have a life expectancy five to 14 years shorter than the Canadian average.[7] Upon arrival in Canada, new immigrants have better health than Canadian residents do; however, within five years, immigrants' health is worse than long-term residents' health.[15]

Housing and Poverty

15. Among low-income people, access to adequate and affordable housing is another significant determinant of health.[16] Poor housing conditions have been shown to have a direct relationship with poor mental health, developmental delay, and other health problems.[17] Problems with housing exist but differ in urban and rural areas. In rural areas, often fewer housing options are available and services and resources to assist those trying to secure and maintain affordable housing are limited. Difficulties with transportation, increased social isolation, and lack of social services compound health problems in the context of rural poverty.[18]

16. In developed countries, the rate of homelessness is estimated to be 1% of most urban populations.[19] Homelessness can be viewed along a continuum to include those living outdoors, those in shelters, those staying temporarily with friends/family, those who live in substandard housing and are at risk of becoming homeless, and those who spend a large proportion of their monthly income on housing.[20] In Canada, an estimated 150,000 to 300,000 people are homeless; most are in urban centres.[21] Homelessness affects a wide range of people, including families with children, youth, seniors, single men and women, immigrants, refugees, Aboriginal people, and people of all races and ethnicities. Homeless people have a greatly increased risk of illness and premature death and face many barriers in their attempts to access health care.[22] Accessible primary health care is an important factor in improving health outcomes for vulnerable populations. When it is unavailable or inaccessible, people delay seeking help, rely on emergency services, and lose the benefits of continuity of care.[23]

Food Insecurity

17. Poverty, nutrition, and health are inextricably linked. The World Health Organization (WHO) states that food security exists "when all people at all times have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs for an active and healthy life."[2]

    In Canada in 2008, 1.92 million people aged 12 or older lived in food-insecure households, which means household members were uncertain of having or unable to acquire adequate food because they had insufficient money.[24] Groups most vulnerable to food insecurity include social assistance recipients, the working poor, Aboriginal communities and others in remote locations, children and youth, and single-parent families.[24]

Households with food insecurity are significantly more likely to have members with multiple chronic diseases, depression, and poor functional health.[25] Low-income households do not have enough income to pay for the basic fixed costs of living (housing, transportation), and therefore food purchases are items on which these households cut back.[26]

18. Many urban low-income communities are disproportionately underserved by grocery stores, and this creates a "food desert"—an area where people have little or no access to affordable or healthy food. Those without access to transportation may be forced to obtain higher-cost food elsewhere, often at convenience stores.[27] Those in rural or remote locations have limited access to fresh, healthy, and nutritious foods. Healthy foods also tend to cost more than nutrient-poor, energy-dense foods.[28] The use of short-term emergency relief such as food banks has increased dramatically, with approximately 850,000 Canadians relying on food banks each month.[29] In rural Ontario communities, nearly 40% of food bank users are children. When access to community support is limited, access to healthy food in rural and remote communities is a significant concern.[29]

Screening for Poverty

19. Physicians in primary care can address poverty as a risk factor for health with individual patients. Explicitly addressing the social determinants of health is essential to primary health care.[23] Through patient-centred care, the physician recognizes the impact of the patient's social context on health and can integrate into the primary care visit an evidence-based understanding of the connections between poverty and ill health. Recognizing the impact of stigma, social exclusion, and discrimination in relation to poverty is important. During the first assessment, patients can be asked about social determinants of health (housing, food, income, education).[13] During any primary care visit, a physician can screen for poverty by asking "Do you ever have difficulty making ends meet at the end of the month?" The sensitivity of this question is 98% and the specificity is 64% for living below the poverty line.[13, 30] Other questions that assess income as a determinant of health can be incorporated into visits routinely (Table 1).

Table 1

Examples of Social History Questions Using "ITHELLPS" Mnemonic to Address Basic Needs

Domain/Area	Examples of Questions
Income and Food Security	
General	Do you ever have trouble making ends meet?
Food income	Within the past 12 months, did you worry whether your food would run out before you got money to buy more?
	Within the past 12 months, did the food you buy last and did you have money to get more?
Transportation	
Public transportation	Do you have trouble paying for public transportation?
Long distance travels	Are you able to access basic needs from your home (i.e. food, health services, job, school) in manageable time?
Housing	
Housing	Is your housing ever a problem for you?
Utilities	Do you ever have trouble paying your electric/heat/telephone bill?
Education	
Appropriate education Placement	How is your child doing in school? Is he/she getting the help to learn what he/she needs? Are you able to speak to the teacher and go to parent-teacher meetings? Does your child have access to school breakfast and after-school programs?
Early childhood program	Do you go to the Early Years/Best Start Child and Family Centres?
	Does your child go to other preschool or early childhood activities?
Legal Status	
Immigration	Do you have questions about your immigration status?
	Do you need help accessing benefits or services for your family?

Literacy	
Child literacy	Do you read to your child or tell stories around pictures in the book every night? Are you able to sing and speak with your child as much as possible?
Parent literacy	How happy are you with how you read?
Personal Safety	
Domestic violence	Have you ever taken out a restraining order? Do you feel safe in your relationship?
General Safety	Do you feel safe in your home? In your neighbourhood?
Support	
Personal	Do you have a close network of supportive family and friends?
Support Services	Are you aware of social programs available to you? Do you use them?

Adapted from Kenyon C, Sandel M, Silverstein M, Shakir A, Zuckerman B: Revisiting the social history for child health.Pediatrics 2007;120:e734-8 and Hager ER, Quigg AM, Black MM, et al Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity Pediatrics 2010;126;e26-e32.

Clinical Tools

20. Strategies and tools that help physicians and patients explore how to improve individual patients' incomes and other social determinants can be used and adapted. Clinical tools have been developed to assist physicians in patient assessment and treatment.[13,31] Because poverty is a strong risk factor for cardiovascular disease, diabetes, cancer, mental illness, and other chronic conditions such as COPD, arthritis, and asthma, the use of adapted cumulative patient profiles and periodic health examinations can trigger appropriate investigations and interventions for those living in poverty.[13,32] In the United States, the Health Leads program (www.healthleadsusa.org) promotes and facilitates physicians' "prescription" of social determinants of health such as food, housing, health insurance, job training, or other important resources, just as medication would be prescribed.[33]

Clinical Interventions

21. Working with patients in a health advocacy role, physicians can facilitate access to social housing, food, clothing, and income resources, and can support efforts to find employment.[23] Physicians can help empower patients to advocate for themselves within the health and social services systems. Physicians can take practical steps to help patients access income supports

and health resources, such as disability supports, dietary supplements, transportation funding, and low-cost dental care, as well as government prescription-funding programs. A thorough understanding of resources available at the municipal, provincial, and federal levels is highly useful. In addition, physicians can provide health-care advocacy for housing and employment through timely letters, medical reports, and phone assistance.

Resources

22. Fostering connections through interdisciplinary care and collaboration with community resources will also help in the coordination of advocacy efforts for patients living in poverty. Having patient information resources in the office is useful; these resources could include information on topics such as the impact of poverty on health, programs for income and social assistance, and contacts for area resources to help decrease poverty (social workers, housing organizations, legal aid, welfare offices).[13]

Community Level Interventions

23. The WHO has stated that one of the most efficient ways to decrease inequities within a population is to address the health and health care needs of those most disadvantaged.[2] For FPs, understanding issues of poverty and health at the community level can help in the development of strategies to improve health and reduce poverty for individuals and the larger community. Physicians can educate themselves about poverty in their community by accessing statistics and demographics via the local health unit, social planning council, or municipality.[33] Physicians can develop leadership strategies to help influence policy and practices that affect population health, as well as participate in planning health services according to community need.[13,34] The Institute of Health Equity in the United Kingdom advocates that health care providers should have knowledge, skills, and ongoing professional development in population health issues, social determinants of health, and interventions that affect health equity.[35] Physicians are uniquely positioned to provide education on the health effects of poverty and advocate for changes and choices in public policy that promote health and well-being and reduce poverty. Physicians can encourage their own professional organizations to recognize poverty as a health risk and to address the social determinants of health.[33,36] For example, the College of Family Physicians of Canada has adopted a vision of family medicine through its publication *A Vision for Canada: The Patient's Medical Home*, which highlights the importance of recognizing and ameliorating the effects of social determinants such as poverty on health.[37]

Case 1: Ms. Anderson, aged 18

Ms. Anderson presents with her first pregnancy in her late teens, and taking a routine social history will highlight that she is living in poverty. Asking broad questions about financial security and "making ends meet at the end of the month" may not be necessary once you have explored her living situation and personal background. Currently she is facing several challenges that will affect the health of her pregnancy as well as her long-term health. These include poverty, unemployment, housing insecurity, a low level of education, and a notable lack of social supports. At this first visit, you could inquire about her relationship with her partner and ask open-ended questions about supports she might draw on during her pregnancy. In this situation, a key goal is helping Ms. Anderson access community resources, including housing resources, for young pregnant women. Knowledge of the resources in your area is crucial if you are to help her manage the situation with maximal supports.

At the second visit, because you know that Ms. Anderson lives in poverty, you might focus part of the 18-month visit on screening for food security. For example, you could ask about difficulty buying groceries at the end of the month, and about nutritional intake (e.g., of iron-rich foods, calcium). You could also spend part of the visit exploring Ms. Anderson's parenting style, screening for exposure to violence and substance abuse, and screening for caregiver burnout. Ms. Anderson's question about her son shows her desire to provide a safe and nurturing environment for him; supports might include helping her access parenting classes, single mothers' support groups, quality daycare, etc. Additionally, educating Ms. Anderson about the impact of stress on child development might provide her with some direction in her quest to provide the best for her child. While not all stressors are likely to be avoidable, Ms. Anderson can be given information that may help her make healthy choices for her family. For example, in the context of her question, you might provide supportive feedback on her decision to end the abusive relationship with her son's father.

Case 2: Mrs. Jones, aged 60

Mrs. Jones has recently gone through a major life change with the death of her husband. She has a history of depression and is still grieving. Her health has deteriorated. You explore her current concerns in a sensitive way. Further questioning reveals that since her husband died, her only source of income has been social assistance. She used to work in retail sales, but hasn't done so for more than 20 years. Her income has decreased significantly and she can barely pay her monthly rent. Her access to quality food is poor. She does not have money for transportation and thus poverty has further increased her social isolation and made accessing health care more difficult. You have an opportunity to explore income support resources that could improve her situation. Because she is not yet 65, she does not qualify for an old age security pension, but she could apply for provincial disability benefits. She also could qualify for a dietary income supplement because she has both diabetes and hypertension. An advocacy letter to social services or a transportation form

could be submitted to cover the costs of transportation to medical appointments, which is especially relevant in the rural context. She may be eligible to apply for subsidized housing.

Collaborating with other health care team members, such as social workers, nurses, and dietitians, could expand the menu of resources available to Mrs. Jones. It could also decrease her sense of frustration and hopelessness.

Case 3: Mr. Dihoud, aged 47

Mr. Dihoud is presenting with an acute problem heightened by his desperation because of insecure employment and income. At first, he might seem to be seeking narcotics, but an unravelling of his history clearly reveals that his concern is meeting his basic needs for food, shelter, and the ability to work. Acknowledging his priorities and immediate needs will help to engage him in care and allow the therapeutic relationship to develop. Encouraging him to access income supports, such as social assistance, will enable him to obtain prescription medication and a source of income until he is able to work again. He has been homeless for many years and may be eligible for several programs that help people with a history of homelessness find housing. He came to Canada as a refugee fleeing war and, over time, underlying post-traumatic stress disorder may become evident. Culturally specific and sensitive services may be available in the community and help decrease his isolation. Once his basic survival needs have been met, you and Mr. Dihoud may be able to focus on other health conditions that require treatment.

Case 4: Benjamin Radley, aged 8

Benjamin presents with poorly controlled childhood asthma, a situation that may be persisting in part due to the family's current financial constraints and stresses in the home. When Sarah mentions the family's difficulty affording a new spacer, this would be a key moment to ask a few questions about their financial circumstances. You might specifically ask about income sources for the family, as well as their ability to pay bills, buy food and afford medications. While it is unlikely that all issues can be addressed in this acute visit, spending a few extra moments exploring the family's circumstances will give you a better understanding of the whole picture of Benjamin's condition. Acknowledging the difficulty openly and establishing a viable plan to stabilize Benjamin's asthma is an important immediate intervention. Using available resources and programs to assist with obtaining necessary medication will enable further options to be explored.

Open-ended questions such as 'how are you and your husband coping with these stresses?' might help Sarah to discuss the tensions they are facing and how the family is managing. Her resilience and resourcefulness can be highlighted and reinforced. Certainly, following up with Sarah at a future visit focused on exploring what medication access programs, income supports and child supports they might access would be helpful in this circumstance. Offering a follow-up visit with Dan and Sarah might also be appropriate, to explore ways to support the couple.

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RESOURCES

Websites

Association of Local Public Health Agencies: http://www.alphaweb.org/health_units.asp

Campaign 2000: http://www.campaign2000.ca/

Canada Benefits: www.canadabenefits.gc.ca

Canadian Medical Association: http://www.cma.ca/advocacy/what-makes-us-sick

Canadian Population Health Index with the Canadian Health Information Institute: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_e

Centre for Urban and Community Studies at the University of Toronto: http://www.urbancentre.utoronto.ca/

Centers for Disease Control and Prevention: http://www.cdc.gov/

Food Insecurity Report: http://www.nutrionalsciences.lamp.utoronto.ca

Health Equity Clicks: http://www.healthequityclicks.ca/

Health Leads USA: www.healthleadsusa.org

Health Providers Against Poverty: http://www.healthprovidersagainstpoverty.ca/

Institute for Clinical Evaluative Sciences: http://www.ices.on.ca/webpage.cfm

Local Health Integration Networks: http://www.lhins.on.ca

Ontario College of Family Physicians Patient Income Brochure: http://ocfp.on.ca/docs/default-source/poverty-tool/patient-brochure-on-income-supports.pdf

People's Health Movement: http://www.phmovement.org/

Public Health Agency of Canada (PHAC): http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/

Service Canada: www.servicecanada.ca

Social Planning Councils (Social Planning Network of Ontario): http://www.spno.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

United Way of Canada: http://www1.unitedway.ca/sites/PortalEN/default.aspx)

World Health Organization (WHO) Global Health Observatory: http://www.Who.int/gho/en

2. Clinical Tools

(available at http://www.healthprovidersagainstpoverty.ca/)

Child Poverty: Practical Tool for Primary Care

Patient Brochure on Income Supports

Poverty: Clinical Tool for Primary Care

3. Video

TED Talk [Internet]. Rebecca Onie: What if our healthcare system kept us healthy? Online video file. 2012 Jun [cited 2013 Jun 2]. Available from: http://www.ted.com/talks/rebecca_onie_what_if_our_healthcare_system_kept_us_healthy.html.

TED X Talk [Internet]. Gary Bloch: If you want to help me, prescribe me money. Online video file. 2013 [cited 2013 Nov 21] Available from: http://tedxtalks.ted.com/video/If-You-Want-to-Help-Me-Prescrib;search%3Atag%3A%22tedxstouffville%22.

4. Other Resources

Canadian Medical Association. Health care in Canada: what makes us sick? http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/HCT/What-makes-us-sick_en.pdf.

Ontario Medical Review 2008. Poverty Series. Available at: https://www.oma.org/Resources/Documents/OMRpovertyseries2008.pdf

Ontario Medical Review 2013. Why Poverty is a Medical Problem Series. Available at: https://www.oma.org/Resources/Documents/Oct13_OMR_Poverty1.pdf.