Health Providers Against Poverty:

Lessons Learned from Nine Years of Education, Engagement, and Political Advocacy

Kathy Hardill, Monika Dutt, Katie Dorman

Prevent More To Treat Less Conference

June 2014

Presenter Disclosures

We approach this work from a privileged position as health care providers. We do *not* speak on behalf of people living in poverty, we speak as allies to these individuals.

Objectives

1. To review the evidence for poverty as a key determinant of health that can be addressed through upstream initiatives, education and policy changes

2. To examine strategies used by a community-based, interdisciplinary, health advocacy organization, with a focus on successes, failures, and future directions

3. To generate new ideas on engaging public health and primary care in advocacy around social determinants of health through an interactive discussion

Outline

Part I: Presentation

- Poverty In Canada
- The Evidence: Income & Health
- Health Providers Against Poverty
  - History
  - Strategies
  - Successes
  - Challenges

40 minutes

Part II: Workshop

- Breakout Sessions
- Report Back
- Consensus

50 minutes

What Is Poverty?

"Poverty Lines" for a Family of Four

Low Income Cut Off (LICO)	$30,945
Market Basket Measure (MBM)	$31,939

Research Paper: Low Income Lines, 2011-2012. *Statistics Canada* 2012.

Poverty in Canada

- 1 in 7 children live in poverty in Canada[1]
- 12% of Ontarians live in poverty[2]
- > 156,000 Ontario households waiting for affordable, rent-geared-to-income housing[3]
- Number of Canadians assisted by food banks increased by 39% between 2002 and 2012[4]

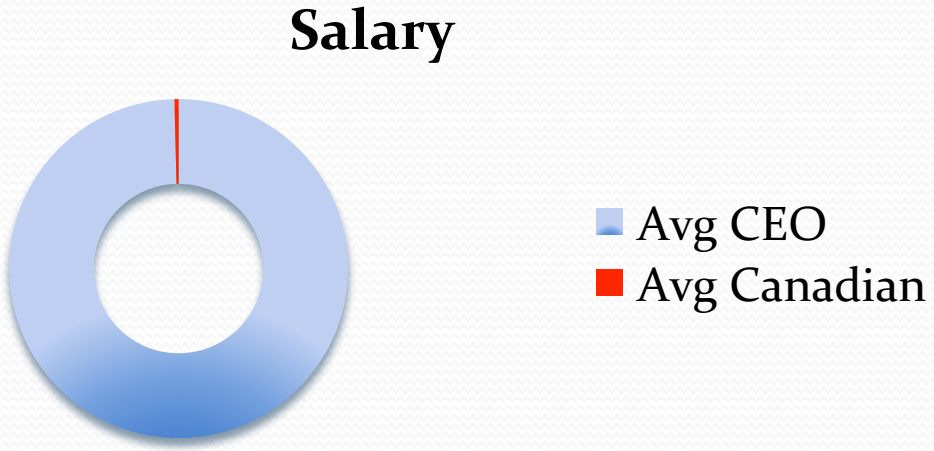
Campaign 2000 Report (2012)

Poverty disproportionately affects children, women, people with disabilities, racialized individuals, and Aboriginal individuals

[1] Innocenti Report Card 10. *UNICEF Innocenti Research Centre.* Florence, Italy: 2012.
[2] CANISM Table 202-0802. *Statistics Canada*. Ottawa, Ontario: 2013.
[3] Ontario Non-Profit Waiting List Survey 2012. Ontario Non-Profit Housing Association, 2012.
[4] Hunger Count 2012. Food Banks Canada. Toronto, Ontario: 2012.

Income Inequality

- Income inequality is growing in Canada
- The average CEO took home 250 times the income of the average Canadian in 2011[1]



[1] McQuaig L, Brooks N. The Trouble With Billionaires. Penguin Canada. Toronto, Ontario: 2012.

Social Assistance In Ontario

- OW recipients report having **less than $1 per day** to spend on food
- ODSP recipients report having **less than $4 per day** to spend on food

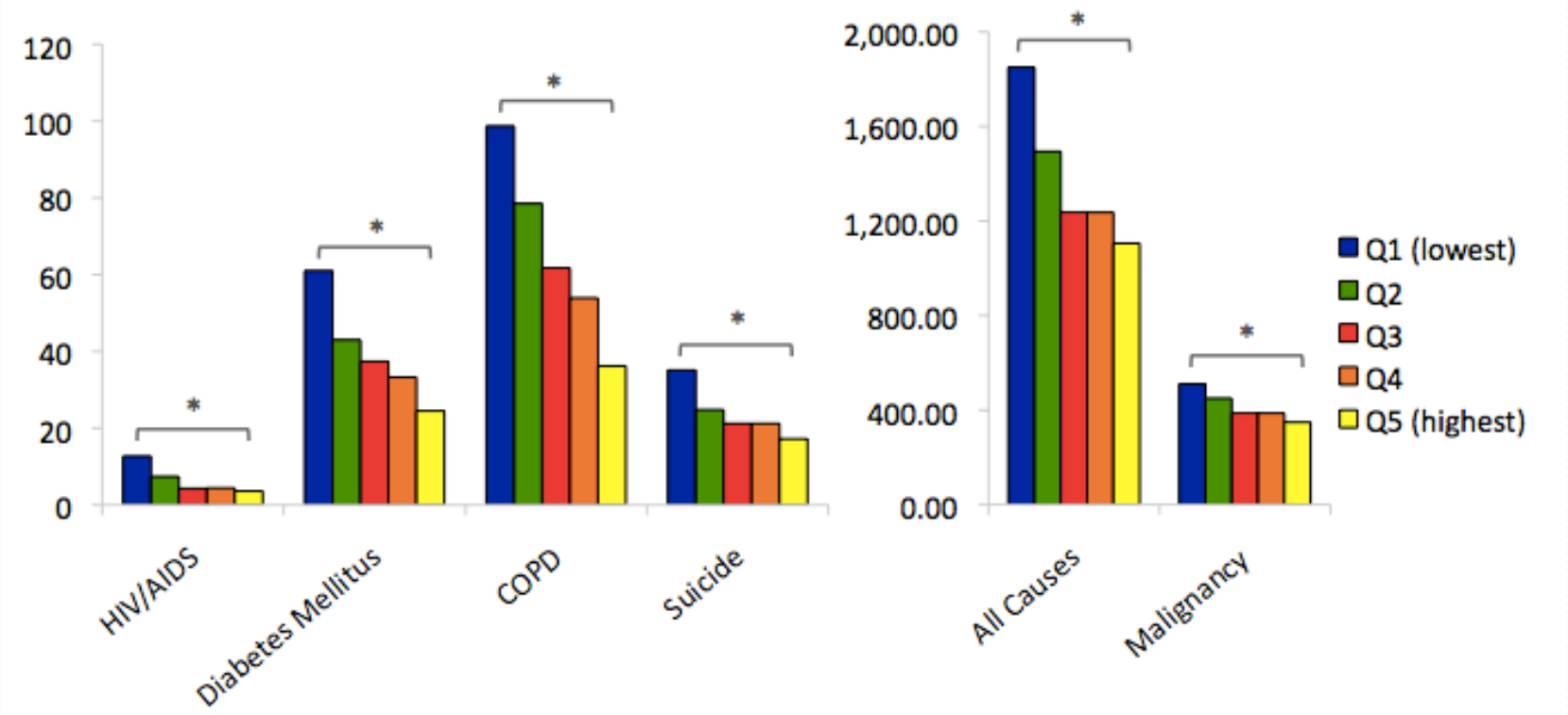
[1] Pinto, A., G. Bloch, J. Polsky, T. Svoboda. Survey. Toronto, Ontario: 2010.

Income and Health

Income is the single most important factor which determines whether someone is healthy or not

- Canadian Population Health Initiative, 2004

Income and Health



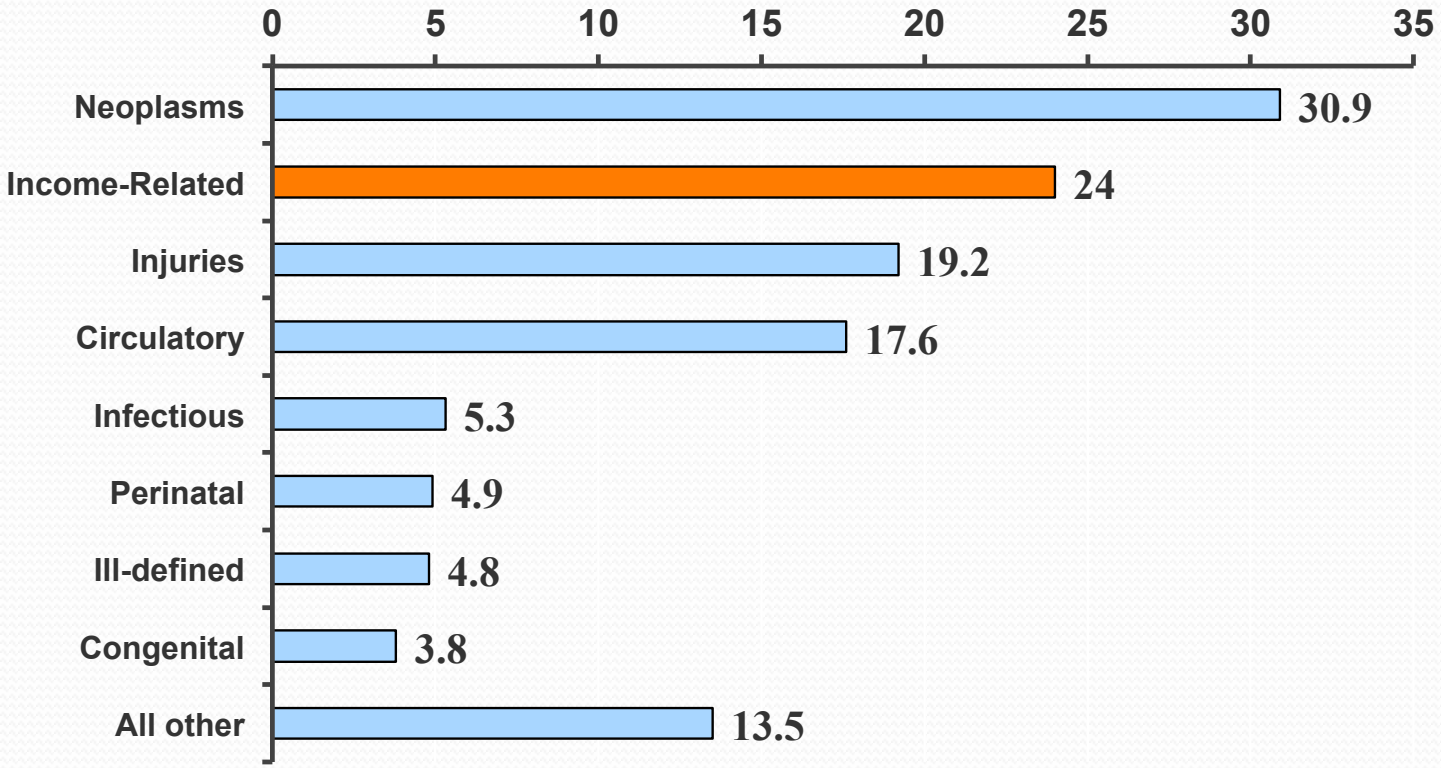
Age-Standardized Mortality Rates For Selected Causes By Income Quintile Q1-Q5

[1] Dorman, K et al. Ontario Medical Review. October 2013: 15-19.

Statistics Canada (2013), Catalogue No. 82-003-X

Income and Health

Poverty accounts for 24% of person years of life lost in Canada



[1] Wilkins, R, et al. Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996. *Statistics Canada* 2002:13; 10 (supp). Adapted from Dennis Raphael.

Income and Health

- Infants living in poverty have **60% higher mortality** before 1-yr of age[1]
- Children from low-income families are at higher risk of;
  - Low birth weight
  - Learning difficulties and mental health problems
  - Micronutrient deficiencies
  - Asthma
  - Injuries and hospitalization
- Early childhood exposure to poverty leads to adult chronic disease through epigenetic changes, stress hormone deregulation, and altered brain development

[1] Gupta et al. *Pediatr Child Health* 2007; 12(8): 666-72.

Income and Health

- Low income single moms
  - Commonly skip meals to feed their children
  - Calorie deficient
  - Do not meet RDAs for folate, vitamins A, B6, B12, C; iron, zinc, calcium

McIntyre et al. *CMAJ* 2003; 168(6): 686-692.

Income and Health

- Annual increase of $1,000 in income for the poorest twenty percent of Canadians
  - → 10,000 fewer chronic conditions
  - → 6,600 fewer disability days every two weeks

= Extra $20/week

Lightman *et al*. Poverty Is Making Us Sick: A Comprehensive Survey of Income & Health in Canada. 2008.

Health Providers Against Poverty (HPAP)

- Multidisciplinary alliance of health care providers
- Started in 2005 with the “Special Diet Campaign”
- Special Diet clinics Feb to Dec 2005
- Initially Toronto-based, now Canada-wide connections

HEALTH PROVIDERS AGAINST POVERTY

HPAP Mission Statement

Poverty represents a serious but reversible threat to the health of people living in Ontario. As health providers, we enjoy privilege and access to power which many others do not. As a high impact health intervention, we will work to eliminate poverty.

HPAP Objectives

We will work collaboratively to:

1. Ensure income and social security for all;

2. Raise awareness about the health impacts of poverty

3. Engage health providers and people with lived experience of poverty in social and political change

HPAP Membership

- Membership
  - Steering Committee: 15 members
  - E-mail Listserve: 269 members
  - Facebook Group: 223 members
- Monthly meetings attended by ~ 6-8 members and guests
- Decision making by consensus of the steering committee

Strategies

- Direct action
- Political lobbying
- Collaboration
- Public education
- Health provider education

Strategies – Direct Action

- Special Diet Campaign
  - Initiated by Ontario Coalition Against Poverty in Feb 2005
  - Part of the provincial "Raise the Rates" campaign
  - Extra funds available to people on social assistance for nutritious foods if medical conditions verified by health care provider
  - Histories taken by volunteer providers and forms completed
  - > 20 community clinics


Activists trying
o take a bite
ut of hunger

Strategies – Direct Action

- May 2005 - Action at Provincial Minister Sandra Pupatello's office
- Summer 2005 - Opposition to city bureaucratic changes
- September 2005 – T.O. Board of Health
- October 2005 - Massive "hunger clinic" at Queen's Park
  - 40 Health Care Providers
  - 1100 Clients

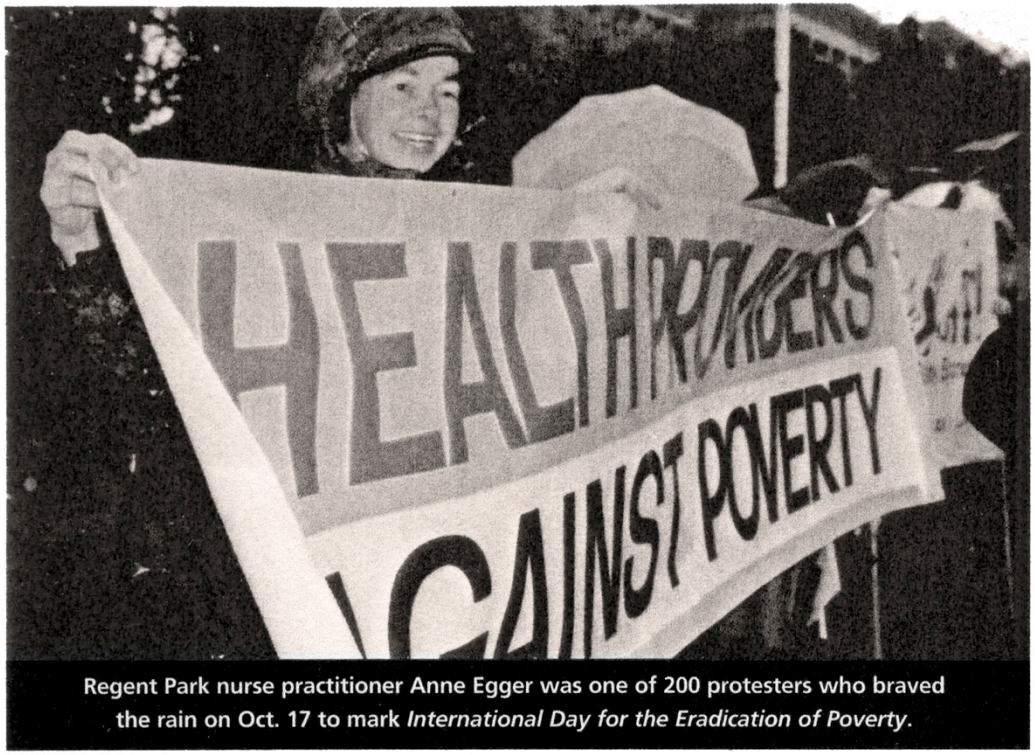
Strategies – Direct Action

Strategies – Direct Action

- Repeated attempts to meet Minister rebuffed
- Joint actions with Raise the Rates group and unions around increasing social assistance rates in provincial budget
- Hunger March
- Submissions on Ontario Poverty Reduction Strategy consultation

Strategies – Direct Action

- October ?– Anti-Poverty Rally (Toronto, ON)



Regent Park nurse practitioner Anne Egger was one of 200 protesters who braved the rain on Oct. 17 to mark *International Day for the Eradication of Poverty*.

Strategies – Direct Action

- March 2012 – March Against Austerity (Toronto, ON)

Strategies – Direct Action

- June 2012 –National Day of Action against federal cuts to refugee health care coverage (Hamilton, ON)

Strategies – Direct Action

- Oct 2012 – Anti-Poverty March (Hamilton, ON)

Strategies – Direct Action

- Feb 2013 – "Emergency Shelter" at City Hall (Toronto, ON)

Strategies – Direct Action

- Sept 2013 – OCAP Rally For Housing and Shelter (Toronto, ON)

Strategies – Political Lobbying

- Letters to government representatives
- Pre-budget submissions
- Government consultations

Strategies – Political Lobbying

Poverty Reduction Strategy Consultation

Poverty and Inequality – Blueprint For A Sicker Ontario?

Submission by Health Providers Against Poverty (HPAP) – Oct 2013

Key Messages:

- Poverty and income inequality are key determinants of health. For individuals to attain good health, they require adequate income as well as safe and secure housing.
- Ontario's Poverty Reduction Strategy (PRS) has achieved some noteworthy milestones, with expansion of the Child Tax Benefit. However, **these efforts have failed to adequately address income inequality in Ontario** and are dampened by the increasing costs of living and losses of social supports in the province.
- Adults do not appear a significant focus of the PRS. In fact, the co-occurring erosion of the Community Start Up and Maintenance Benefit and the promotion of substandard social assistance rates ensures that many more will be hoisted into and trapped in the cycle of poverty. Many of these adults are parents who are now less able to provide what their children need.
- In order to adequately reduce poverty in Ontario, activities must be directed to equitable social assistance rates, increased minimum wage, more affordable housing, and restoration of essential benefit programs. Provincial investment in these areas will save health care costs and improve health.
- In order to fund necessary social programs and reverse the erosion of social assistance, the government must explore and implement constructive solutions such as progressive taxation of the highest income earners.
- Provincial health care must evolve to reduce health disparities among low-income Ontarians. Requisite changes include expansion of equity-based health care models such as Community Health Centres and the introduction of Universal Pharmacare.

Strategies - Collaboration

- Ontario Coalition Against Poverty (OCAP)
- Put Food in the Budget (PFIB)
- 25 in 5 Network
- Raise the Rates
- Hamilton Roundtable for Poverty Reduction
- Health For All
- YWCA Hamilton

Strategies – Public Education

- Opinion Editorials

THE HAMILTON SPECTATOR December 10, 2014

The province's sickening decision

It's not a frill: The elimination of the Community Start-Up Benefit poses real health risks

THE GLOBE & MAIL MARCH 20, 2014

As a doctor, here's why I'm prescribing tax returns. Seriously.

Strategies – Public Education

- Media Coverage
- Press Releases
- Lectures
- Blogs
- Interviews

MICHAEL STUPARYK/TORONTO STAR

Volunteer Paul Johnson, left, Zephie James, centre, and volunteer Tony Gallant dish out lasagna, salad and garlic bread at the Parkdale Activity-Recreation Centre on Queen St. W. The centre served 108,000 meals last year; it's not unusual to have 400 people at Friday lunch. Many people bring containers to take home any leftovers.

Trying to eat on 35¢ a day

Food banks, churches, agencies see demand skyrocketing

'Hunger March' today to call for 40% raise in welfare rates

SCOTT SIMMIE
FEATURE WRITER

It's 6:30 a.m., freezing, at the corner of Sherbourne and Dundas Sts.

As most in the GTA are about to wake and prepare breakfast, a steady stream of defeated-looking people snakes in the door of the Toronto Friendship Centre. Many of them have their shoulders hunched in protection from the cold. But their posture also seems indicative of something else: hunger.

They come here, at this early hour, for whatever they can get to fill their stomachs. At the moment, it's donated pizza from Second Harvest. About 30 people are eating slices of pepperoni off sheets of brown paper towel. They wash it down with coffee.

Some are homeless and living in shelters that they must leave first thing in the morning. Others have their own small apartments or rooms but come here because they have no food in their fridge — or no fridge at all. Most at this drop-in are men (though women will soon start filtering in at a women's drop-in up the street). And the vast majority are here because they're trying — and failing — to get by on social assistance.

"You can't live on $520 a month when a room costs $450," says The Colonel — a fixture on the Sherbourne-Dundas scene and a man who knows the streets because he lives them. "Anyone who tells you there are no hungry people in Canada — they're insane."

There's stark evidence of that this morning. When the man distributing the food shouts: *"Fish and chicken up!"* there's an immediate, almost panicked, scramble to form a line to the counter. The sight is reminiscent of a refugee camp, and it's by no means uncommon.

"When I first started here 17 years ago we gave out 500 cups of soup a week," says Dawn Dowling, executive director of the Friendship Centre. "Now we distribute probably 7,500 pounds of food a week."

For many years, advocates, churches, social drop-in agencies, food banks and health-care providers in Toronto have watched the rise of a disturbing phenomenon: ever-increasing numbers of people on social assistance who cannot afford to adequately feed themselves. And they're not just single men.

"One-third of the women we see are seniors," says Bonnie Wakely, drop-in services manager at Sistering. "They're relying on us for their main meal of the day."

Part of the problem, say advocates, is the erosion of affordable housing. Supply is down and prices are up. But an even bigger factor is that welfare rates, slashed 21.6 per cent and frozen by the Mike Harris government in 1995, have increased by just 3 per cent since the Liberals came to power. Right now, a single person on Ontario Works receives a maximum of $536 per month, while a single parent with two children aged 0-12 receives $1,119 monthly.

"In the city of Toronto, you can't be on welfare and pay rent and buy food. They need to raise the rates about 40 per cent," says Brian Buckle, drop-in coordinator at the All Saints Church. He, too, has watched the phenomenon grow during the 15 years he's been working there.

"As soon as Harris got in, our numbers tripled," he says. "And it just continues to snowball and snowball."

There was high-profile advocacy to tackle the hunger issue last year, when a series of clinics managed to get more than 6,000 poor people onto the province's Special Diet program. The program allows a supplement of up to $250 for people on social assistance who have special food needs — and many sympathetic healthcare providers believed a balanced diet that included fresh fruit and vegetables qualified as a special food need.

> ***'Anyone who tells you there are no hungry people in Canada — they're insane.'***
>
> **The Colonel**, who eats at the Toronto Friendship Centre

The province, however, said some people were exploiting the system (including families where several members were receiving the benefit). And last fall, it tightened the language so that only people with certain explicit diagnoses can qualify for the supplement. Many who were receiving the extra money have since seen it cut from their welfare cheques.

Those supplying healthcare to the city's most impoverished say they've seen the physical and mental health of their clients suffer due to inadequate or insufficient diets.

"The moms here in Regent Park routinely don't eat during the last few days of the month so their kids can eat," says Kathy Hardill, an outreach nurse practitioner at the Regent Park Community Health Centre.

In addition to her medical supplies, the cupboard in Hardill's office/examining room contains Campbell's Chunky Soup and instant noodles. For the past two years, Hardill has kept it stocked to give to her patients. Deficient in calories, micronutrients and minerals, she says many — especially children — will be more likely than someone eating balanced meals to develop diabetes, heart disease and a host of other ailments in later life.

"That early experience of deprivation creates risk that does not go away," she says.

Hardill has more than anecdotal evidence of the problem. During those Special Diet clinics, her centre surveyed some 350 families on social assistance representing 1,270 individuals. It found that after paying rent, phone and utilities, the average amount left for food was 35 cents per person per day.

With a provincial budget coming up March 23, a number of groups have mobilized to organize a "Hunger March" that takes place today. Several hundred people are expected at noon at the Metropolitan Church Park at Queen and Church Sts. to call for a raise of 40 per cent to the welfare rates.

"My rent is going up $13 a month," says Michael Fitzgerald, a full-time volunteer at the Parkdale Activity-Recreation Centre. "And while that might not sound like a lot to you, that means $13 less in food I can buy."

That drop-in centre served 108,000 meals last year — including thousands to people who are not members. The demand has grown so much that it's now not unusual for 400 people to attend Friday lunch. Many, in fact, bring containers to take home seconds or to scrape in anything left on their plate.

"When I first came to this drop-in, it wasn't all about the food," says Jean, who's worked in PARC's kitchen for 15 years. "People would come in, play cards, talk to staff. That's gone. If the government would give people the money to actually live on, you could get the drop-in back to what it's actually supposed to be."

The Ministry of Community and Social Services says it cannot comment on whether a boost to welfare rates is being considered. But the spokesperson for Sandra Pupatello says the minister is aware of the difficulties many face.

"The minister has always said she knows it's a challenge for people to live on the rates now. So she's recognized that," said Sara Best. "And we are doing what we can, not only in the area of rates, but in improving the way Ontario Works and the Ontario Disability Support Program work ... to move people off welfare and into work. We're doing what we can, as quickly as we can."

For a Mexican woman who wants to be known as Araceli, relief can't come soon enough. Sidelined by surgery that prevents her from working as a housekeeper, she now relies on meals at the Sistering drop-in. Asked about the psychological impact of going from work to relying on free meals, she simply weeps.

TORONTO STAR March 15, 2006

Health Providers Call For ‘Livable’ Minimum Wage

Press Conference – January 14, 2014

http://www.chch.com/health-providers-call-livable-minimum-wage/

TEDx Talk: If You Want To Help Me, Prescribe Me Money

Gary Bloch – July 2014

https://www.youtube.com/watch?v=FLRTobvaz98

Strategies – Provider Education

- Educational initiatives for health care providers, medical students, and nursing students

  i.e. Invited Talk For RNAO Board of Directors

  Guest lectures for NP students

  U of T Medical Student Workshops

  Conference Presentations

- Ontario Medical Review Series: 2008, 2013

- Poverty Clinical Tool For Primary Care

Strategies – Provider Education

FEATURE

Part 1

Why poverty is a medical problem

by Katie Dorman, MD, MSc
Rosana Pellizzari, MD, MSc, CCFP, FRCPC
Michael Rachlis, MD, FRCPC, LLD
Samantha Green, MD, CCFP

LINDA IS A 58-YEAR-OLD WOMAN WHO PRESENTS TO YOUR OFFICE WITH CHEST PAIN ON EXERTION. SHE HAS HYPERTENSION, TYPE 2 DIABETES AND OSTEOARTHRITIS IN HER KNEES. HER ONLY SOCIAL SUPPORT IS HER DAUGHTER, WHO WORKS MOST EVENINGS AT A GROCERY STORE. LINDA WORKS PART-TIME IN RETAIL BUT HAS HAD DIFFICULTY MAKING IT TO WORK LATELY DUE TO SEVERE KNEE PAIN THAT LIMITS HER MOBILITY.

Her average annual before tax income is $16,600. Efforts to control Linda's hypertension and diabetes have been met with great difficulty. She does not take her medications regularly because she cannot afford them. She tells you that she relies on a food bank and that in between visits she buys food from the convenience store next to her apartment building. She is tearful at this visit and tells you that she has not been sleeping because she is worried about eviction and how to pay her bills. You feel frustrated because it seems impossible to address Linda's health issues without addressing her financial stress — but you're a physician, what can you do to help?

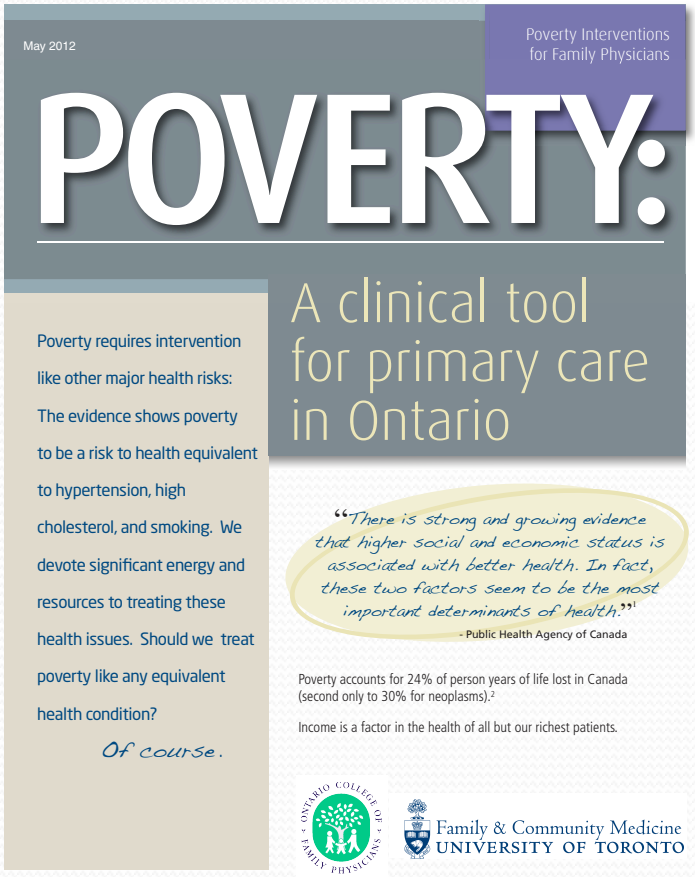
Introduction

Health follows an income gradient; individuals at the lowest income level have the poorest health. Poverty is an independent risk factor for disease, on par with traditional risk factors such as smoking or hypertension. Physicians can feel overwhelmed by the prospect of addressing this important risk factor, since the etiologies of poverty are complex and interventions for poverty are not typically taught during medical training.

There are significant costs to the health-care system attributable to poverty. As a means of determining these costs it was estimated that in 2007, increasing the income of people in the lowest income quintile in Ontario to a level comparable to those in the second quintile would reduce health-care expenditures by $2.9 billion provincially and $7.6 billion federally.[1]

In response to growing physician concerns over the impact of social determinants on their patients' health, the Canadian Medical Association (CMA) held a series of six town hall meetings throughout the past year to

Strategies – Provider Education



Successes

- Special Diet Campaign
  - Millions of dollars directly into low income pockets
    - → Effects profound at the individual level
  - Widespread awareness of the special diet allowance
    - → Although eligibility became stricter, awareness grew
  - Galvanized health provider focus on poverty and health
    - → Transformative change in the way some of us saw poverty and health; more than an intellectual construct

Successes

- Increases in Social Assistance Rates

Year	Increase	Inflation	
2005	3%	2.2%	↑
2006	2%	2.0%	
2007	2%	2.2%	↓
2008	2%	2.3%	↓
2009	2%	0.3%	↑
2010	1%	1.8%	↓
2011	1%	2.9%	↓
2012	1%	1.5%	↓
2013	1% (3%)	0.9%	↑

Successes

- Increased Recognition of Link Between Poverty & Health
  - CMA Report *What Makes Us Sick* (July 2013)
    "Poverty is the most important factor and must be addressed"
  - Ontario Medical Review (October 2013)
    "It is clear poverty represents a serious but modifiable threat to health"
  - RNAO Newsroom (August 2013)
    "Poverty reduction is one of our biggest priorities"
  - Canadian Family Physician (June 2012)

    "Further research into how primary care teams can screen for and intervene in our patients' poverty is necessary to understand how best to improve health outcomes."

Successes

- Expansion of Network

INSERT MAP

Success / Challenge

Challenges

- Loss of focus after special diet clinics
- Few clear direct action possibilities
- Limited organizational capacity

Challenges

- College of Physicians and Surgeons of Ontario disciplinary hearing for Dr. Roland Wong
  - Then Toronto mayoral candidate Rob Ford

    "A doctor is there to be a doctor, not to advocate for the poor, or to be the official opposition in government through taxpayer's money"

    - CMAJ, April 2010
  - Lodged the complaint with CPSO
  - Fined $35K; license suspended for 6 months

    "Failed to maintain the standard of practice of the profession"

http://www.cpso.on.ca/Whatsnew/News-Releases/2014/2014-01-28-Discipline-Committee-Decisions

Challenges

"Advocacy for a patient … should not trump one's professional integrity"

- CPSO

- No patient was harmed - harsh penalty
- Dr. Philip Berger, Chief of DFCM, St. Michael's Hospital

  "The College is also sending a message …do not bother coming to us if you're poor or on welfare. We're not going to help you. We're just going to punish your doctors who are trying to help you."

- Political analysis – Dr. Wong was attacked for confronting the austerity agenda

Note: Dr. Wong is an anti-poverty ally, but not a member of Health Providers Against Poverty

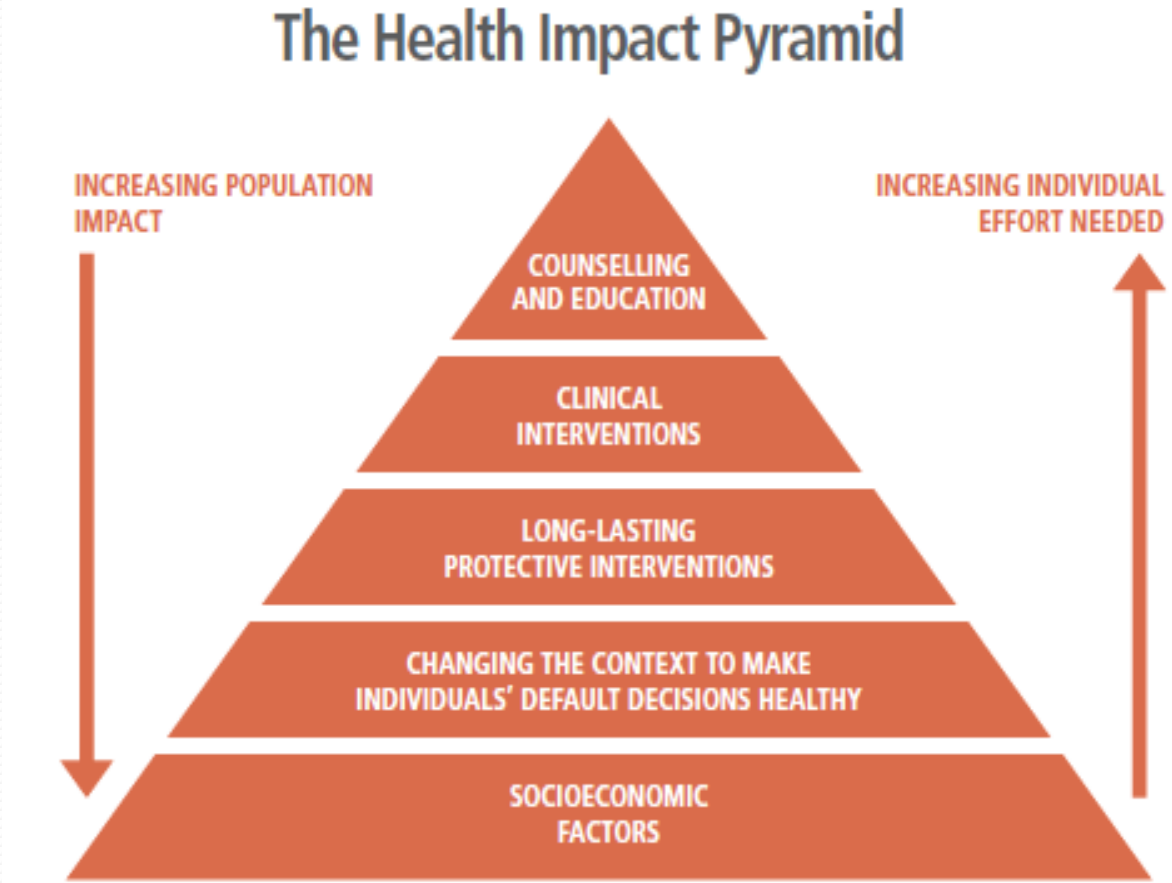
Challenges

- How to get media attention?
- How to identify, agree on, and disseminate timely media responses to ad hoc issues?

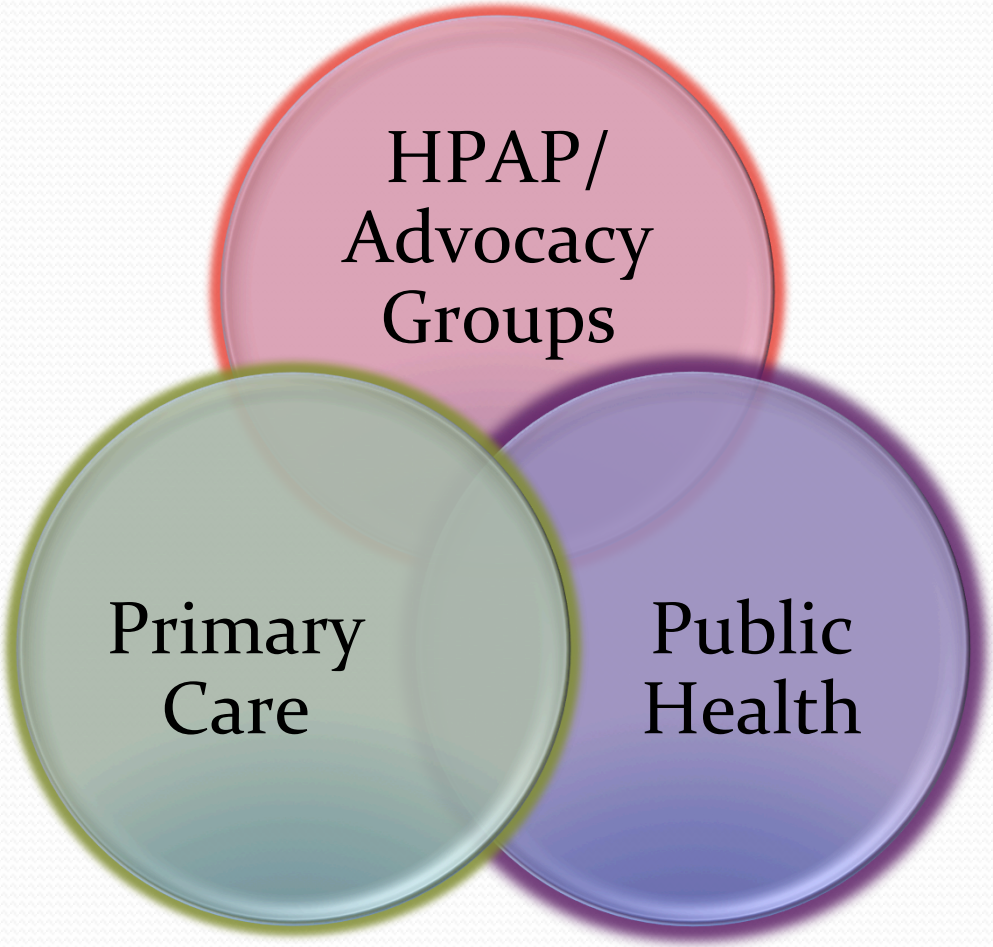
- How do we create a credible, interdisciplinary advocacy group?
- How do we move beyond the silos of our respective disciplines?

Connection: Primary Care & Public Health

- HPAP consists of and creates links between primary care & public health
- HPAP's actions span all levels of the pyramid



Building partnerships



Break Out Sessions

- Brainstorming - Current work
  - List poverty-related priorities for your practice/organization (real or an ideal!)
  - Note areas of potential overlap in your individual/ organizational poverty-related work

Break Out Sessions

- Brainstorming - Future directions
  - List poverty-related priorities as a collective
  - List potential activities under each priority that would involve collaboration between primary care, public health, and advocacy groups

Break Out Sessions

- Charter
  - Write a purpose statement for a team involving primary care, public health and advocacy groups look like
  - Include:
    - What is the value of bringing these groups together?
    - What problem is being faced?
    - What is the desired outcome?

Discussion

Consensus

- Shared priorities
- Purpose of collaboration

Objectives

1. To review the evidence for poverty as a key determinant of health that can be addressed through upstream initiatives, education and policy changes

2. To examine strategies used by a community-based, interdisciplinary, health advocacy organization, with a focus on successes, failures, and future directions

3. To generate new ideas on engaging public health and primary care in advocacy around social determinants of health through an interactive discussion

Join HPAP

- To join the HPAP e-mail listserve, sign up on the sheets provided or e-mail hpagainstpoverty@gmail.com