

FEATURE



A prescription for poverty

Jane Parry reports on a family physician run project in Canada that aims to treat social problems as well as medical ones

Jane Parry *freelance journalist, Hong Kong*

It's a predicament familiar to any doctor with patients who are living in poverty: you can treat a patient's medical condition but the underlying reasons why the patient has poor health—low paid work, poor housing, low literacy—are beyond the scope of the prescription pad.

Gary Bloch, a family physician at a St Michael's Hospital clinic situated in a socially deprived area of downtown Toronto, Canada, wanted to do more than just feel powerless about his patients' situation. So he decided to learn about the effect of poverty on health and equip himself and his colleagues with the tools to do something about it.

In 2005 he took part in an eight month series of clinics organised by the Ontario Coalition Against Poverty. Bloch was one of 40 health practitioners at the organisation's "hunger clinic," held in front of the provincial legislature, who helped 1000 people living on welfare obtain a special diet supplement of up to \$C250 (£134; €170; \$190) a month.¹ He was, in effect, prescribing them money to treat their food insecurity. The province tightened the criteria for the allowance soon afterwards, but it showed Bloch that doctors could take action to tackle poverty and gave him a taste for more.

New tools

In 2010 Bloch created a clinical tool on poverty for primary care physicians, a three step process that fits easily into existing doctor visits. The tool prompts doctors to ask patients if they have trouble making ends meet and tells them about the risk factors associated with poverty they should consider, such as cardiovascular disease and diabetes. It then provides guidance on interventions doctors can make, such as ensuring patients complete tax forms or are receiving the benefits they are entitled to.

This has since been widely distributed across Ontario and has been adopted by the Ontario College of Family Physicians in doctors' education.² "It reframes poverty as a medical concern that can be addressed. It leaps the barrier of 'I'm a doctor, I can't do anything beyond treating their diseases,'" Bloch says.

Building on the interaction between individual patients and providers, the team at St Michael's, a hospital keen to support efforts to address the social determinants of health, constructed a novel approach that starts in the clinic waiting area. When any of the 40 000 patients attend the six St Michael's family

medicine clinics, they complete a tablet based questionnaire to collect routine sociodemographic data, including income, housing, home language, immigration status, and literacy level. The information feeds directly into the patient's electronic medical record and is immediately accessible during the consultation.

Practical support

St Michael's family health team also includes non-medical staff who work with patients to help increase their income—for example, by ensuring they are receiving the benefits they are entitled to and helping them to reduce expenses and improve their financial literacy.

"The biggest stressors are often financial," says Gordon Soplet, one of the support staff. "They are often at the whim of debt collectors, and they're completely disempowered. We help them with letters to debt collection companies, help them fill in forms for benefits, and ensure they know what's available to them. We try to be preventive, helping them prioritize and make good decisions with the money they have."

Patients also present with legal problems. In partnership with the ARCH Disability Law Centre, they can get free legal services directly from the health centre under the health justice initiative. "How they come to me is different to other legal services," explains lawyer Johanna MacDonald. "They are referred because of their health. The grinding legal issues they face are across the board, including housing, abuse, and matters relating to being refugees."

Housing accounts for 15-25% of problems, she says, citing chronic health problems caused by disrepair and environmental health hazards and also accommodation discrimination because housing is inaccessible to a person with disability. "We also have cases where people with mental health problems and disability are at high risk of eviction. Our job is to play more of a preventive role—that is, we can prevent an ongoing issue of eviction rather than it getting to an eviction hearing.

"A number of people have disclosed sexual, physical, or emotional abuse for the first time, and only disclosed it because they were talking to a healthcare provider. This gives us important access, and even if you are only providing legal advice that helps them to understand their options."

Michael Marmot, director of the University College London Institute of Health Equity, who was in Toronto recently and met with Bloch and his team, says he was inspired by what he saw: “I’m very excited that a group of clinicians are taking seriously what I’ve been arguing about the social determinants of health, which at first glance sound like they have not much to do with doctors.

“Gary and his team recognise that they have a mixed population in that part of Toronto, and that the hospital has a community it serves. It’s important to get the evidence to see what works and what doesn’t, but I was very impressed with what they’re trying to do.”

Thinking bigger

The next steps of the programme are to evaluate its effect and to promote it throughout the rest of the city and the state of Ontario, where 38% of Canada’s population live. The patient led sociodemographic data tool is already in use in hospitals and clinics under the Toronto Central Local Health Integration Network, the body responsible for planning, funding, and integration of local health services for 1.2 million of the city’s population of 2.86 million. Bloch and his colleagues also plan to use every opportunity to use the evidence they generate from their work to advocate for a change in provincial and national policy.

Bloch observes that one of the criticisms of his team’s approach is that higher level intervention is needed rather than incremental, individual input. “First we have to bring health providers (especially doctors) into taking regular action on the social determinants of health, and I think this requires getting them to take part in smaller level actions first, and hopefully we will see a trickle up to higher level action.

“My ultimate goal is for health teams and the medical world at large to act as advocates for policy change. This is being done to some extent, but I would like to see poverty addressed in the medical community like smoking and obesity—to see it within the medical mind—and here in Ontario we’re slowly moving towards that.”

Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

- 1 Ontario Coalition Against Poverty. Short history of OCAP. <http://ocap.ca/files/history%20of%20ocap.pdf>
- 2 Centre for Effective Practice. Poverty: a clinical tool for primary care providers. http://thewellhealth.ca/wp-content/uploads/2016/05/Poverty_-_A_Clinical_Tool_for_Primary_Care_ProvidersMay-1.pdf

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