BC KIDNEY DAYS

Hosted by BC Transplant and the BC Renal Agency

2014

The Face of Poverty in Clinical Care

The Face of Poverty in Clinical Care:
How and Why to Address Inequities in Health Care Settings

BC Kidney Days – October 16, 2014

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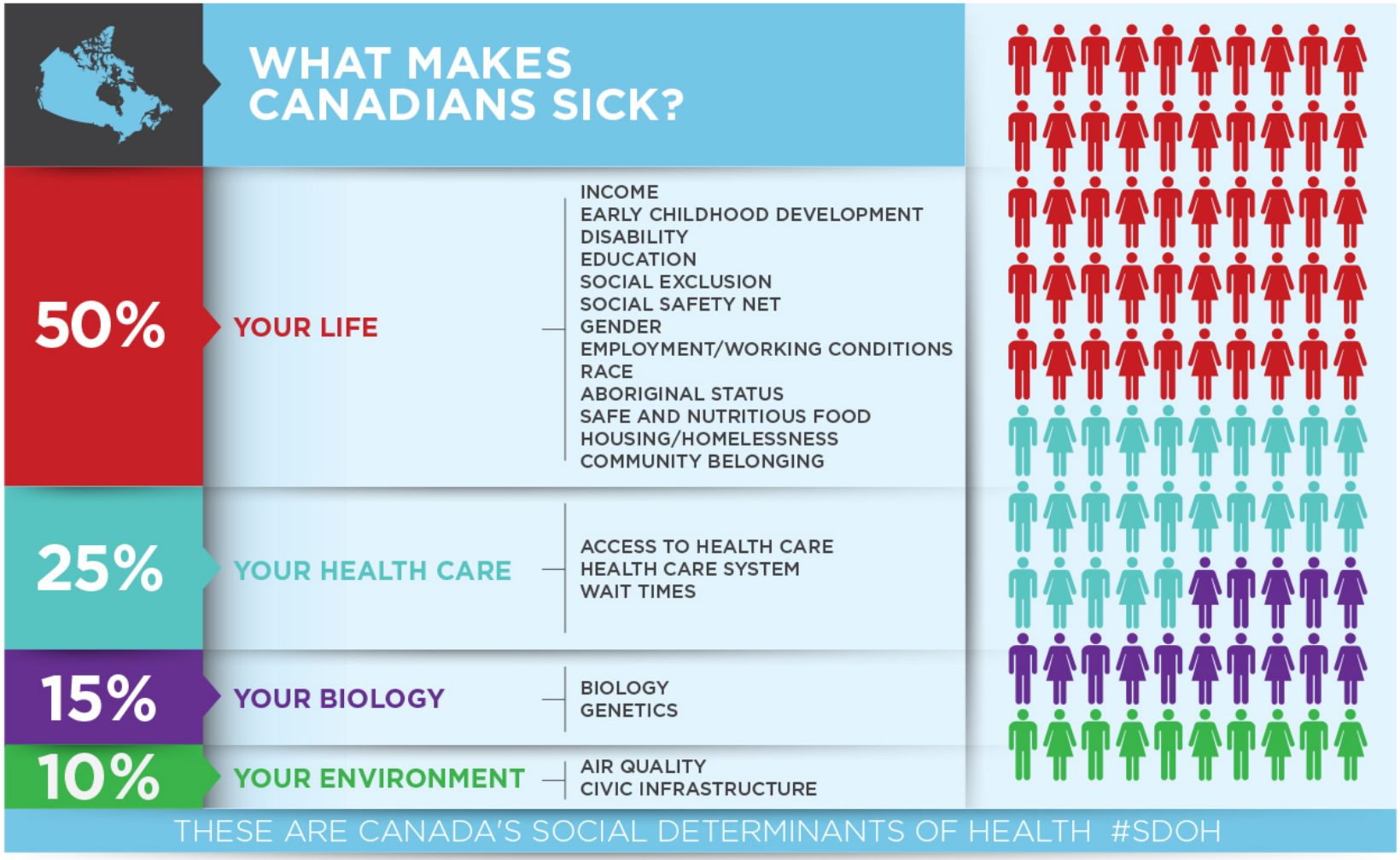
Learning Objectives:

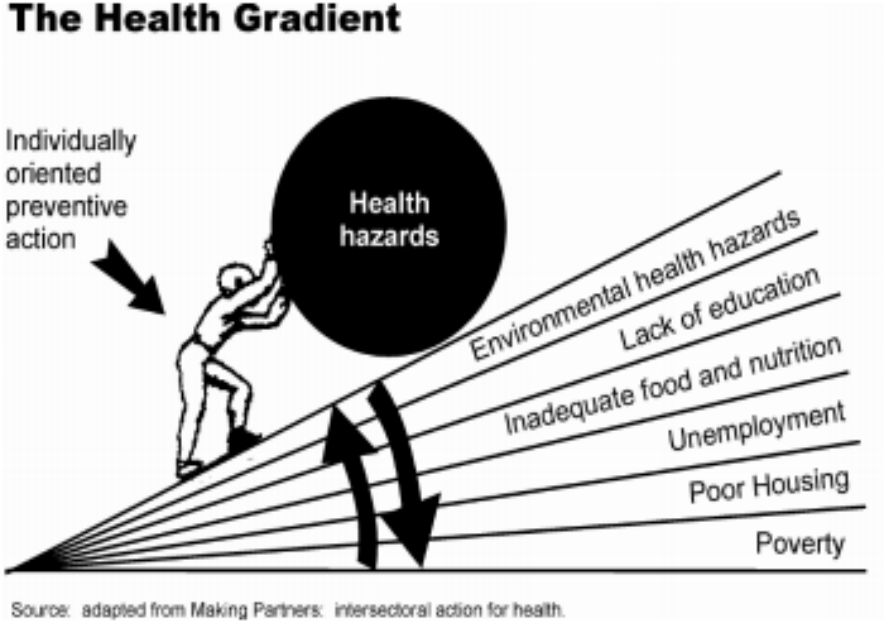
- To gain an understanding of the impact of social determinants of health, including poverty, on health outcomes and patient experiences.
- To gain an understanding of approaches to addressing poverty in clinical settings.

Conflict of Interest:

- None to disclose



Source: Canadian Medical Association



"All [the studies reviewed] conclude that … the main direction of influence is *from* poverty *to* poor(er) health."

Phipps S. *The impact of poverty on health: a scan of the research literature*. Ottawa: CIHI; 2003.

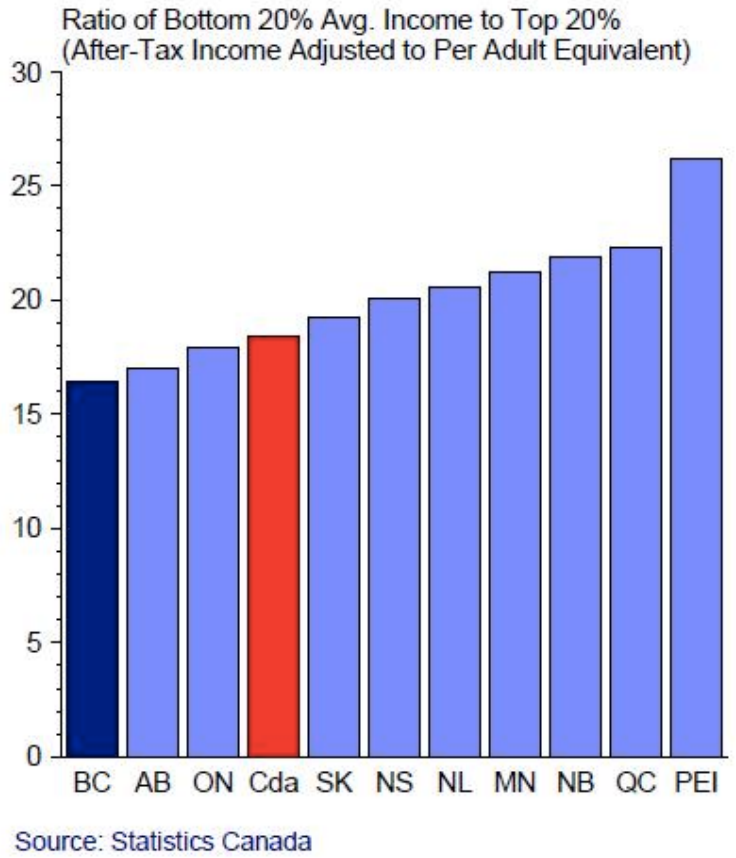
"Lower income ... leads to a significant increase in mortality risk, yet the influence of major health risk behaviors explains only a modest proportion of this relationship."

P. Lantz et al. *SE Factors, Health Behaviors, & Mortality: Results From a Nationally Representative Prospective Study of US Adults*. JAMA. 1998;279(21):1703-1708.

Poverty in BC

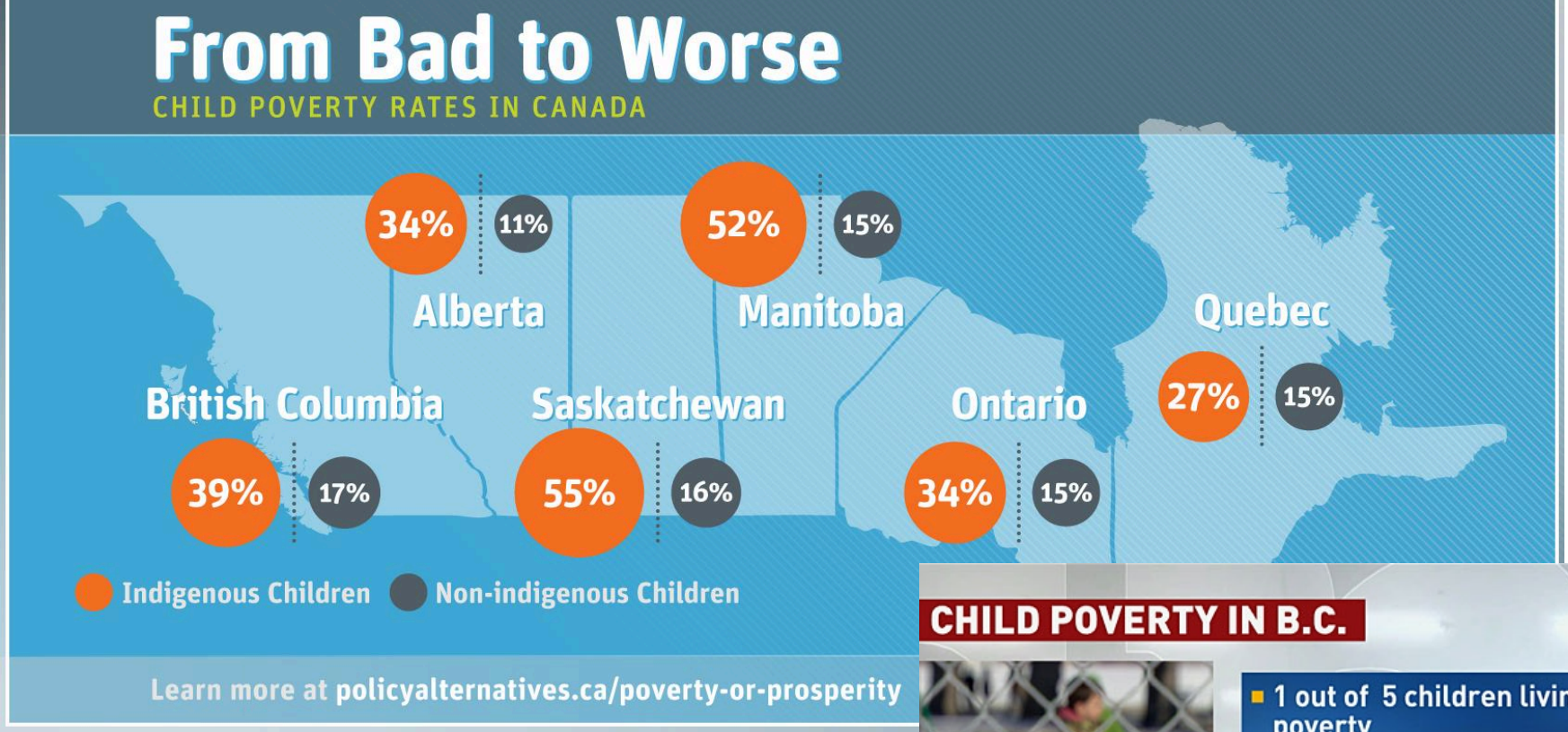
www.worstincanada.org

- Income inequality in BC is growing faster than in other provinces and the USA
- Poverty in BC has an estimated cost of $8-9 billion annually (vs. $3-4 billion for a comprehensive poverty reduction strategy)
- ↑ unemployment; ↓ full-time work
- Unemployment in young people 2x Cdn avg
- Net loss of ~ 665,000 jobs since the 2008 recession
- 2013: BC government announces an additional $130 million in cuts to public services over the next 3 years.



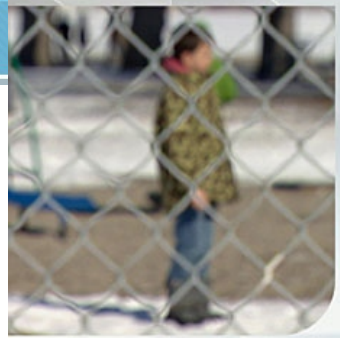
From Bad to Worse

CHILD POVERTY RATES IN CANADA



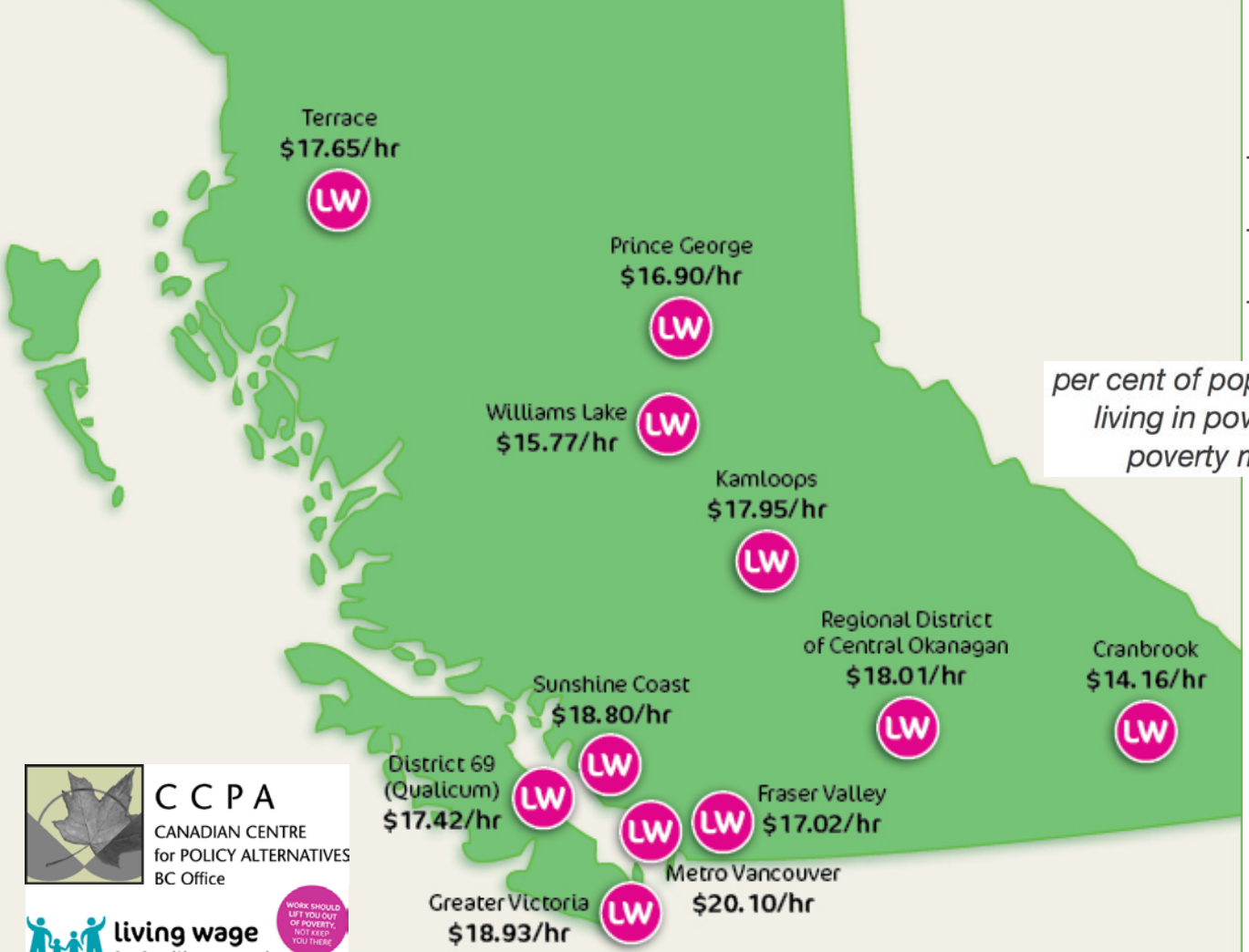
Learn more at policyalternatives.ca/poverty-or-prosperity

CHILD POVERTY IN B.C.



- 1 out of 5 children living in poverty
- B.C. Child Poverty Rate 18.6%
- National Child Poverty Rate 13.3%

SOURCE: 2013 Child Poverty Report Card



CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
BC Office

living wage
for families campaign

WORK SHOULD LIFT YOU OUT OF POVERTY, NOT KEEP YOU THERE

Vancouver poverty lines (LICO, LIM, MBM)

per cent of population living in poverty, by poverty measure	poverty line, family of four	poverty line, single person
13.6	$36,504	$19,307
15.7	$39,860	$19,930
17.3	$37,663	$18,832

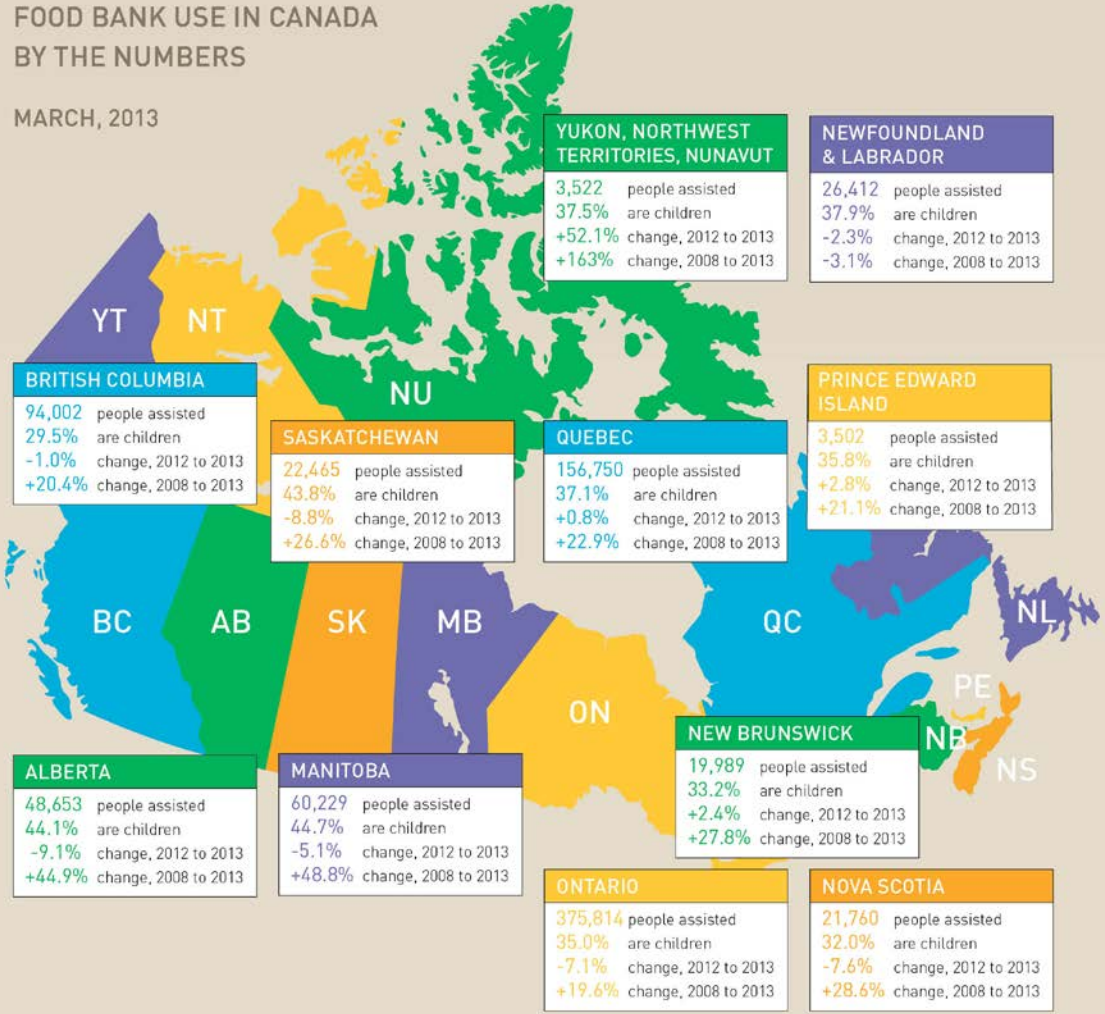
Minimum wage:
$10.25/hr

Welfare rate:
$610/mo

Disability rate:
$905/mo

FOOD BANK USE IN CANADA
BY THE NUMBERS

MARCH, 2013



BRITISH COLUMBIA

94,002 people assisted
29.5% are children
-1.0% change, 2012 to 2013
+20.4% change, 2008 to 2013

Food Banks Canada
Banques alimentaires Canada

Question:

How does poverty (and its impact on health) affect those living above the poverty line?

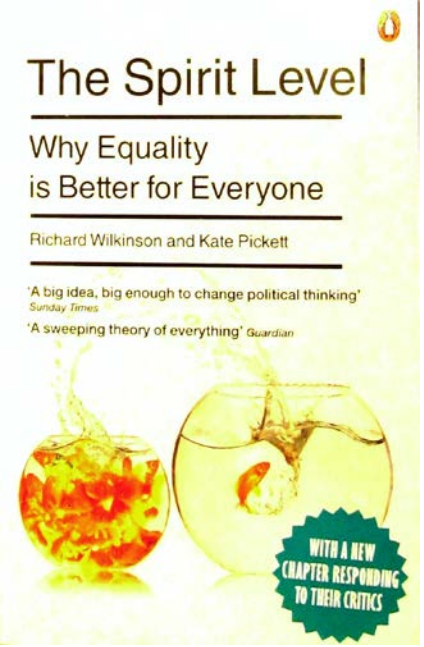
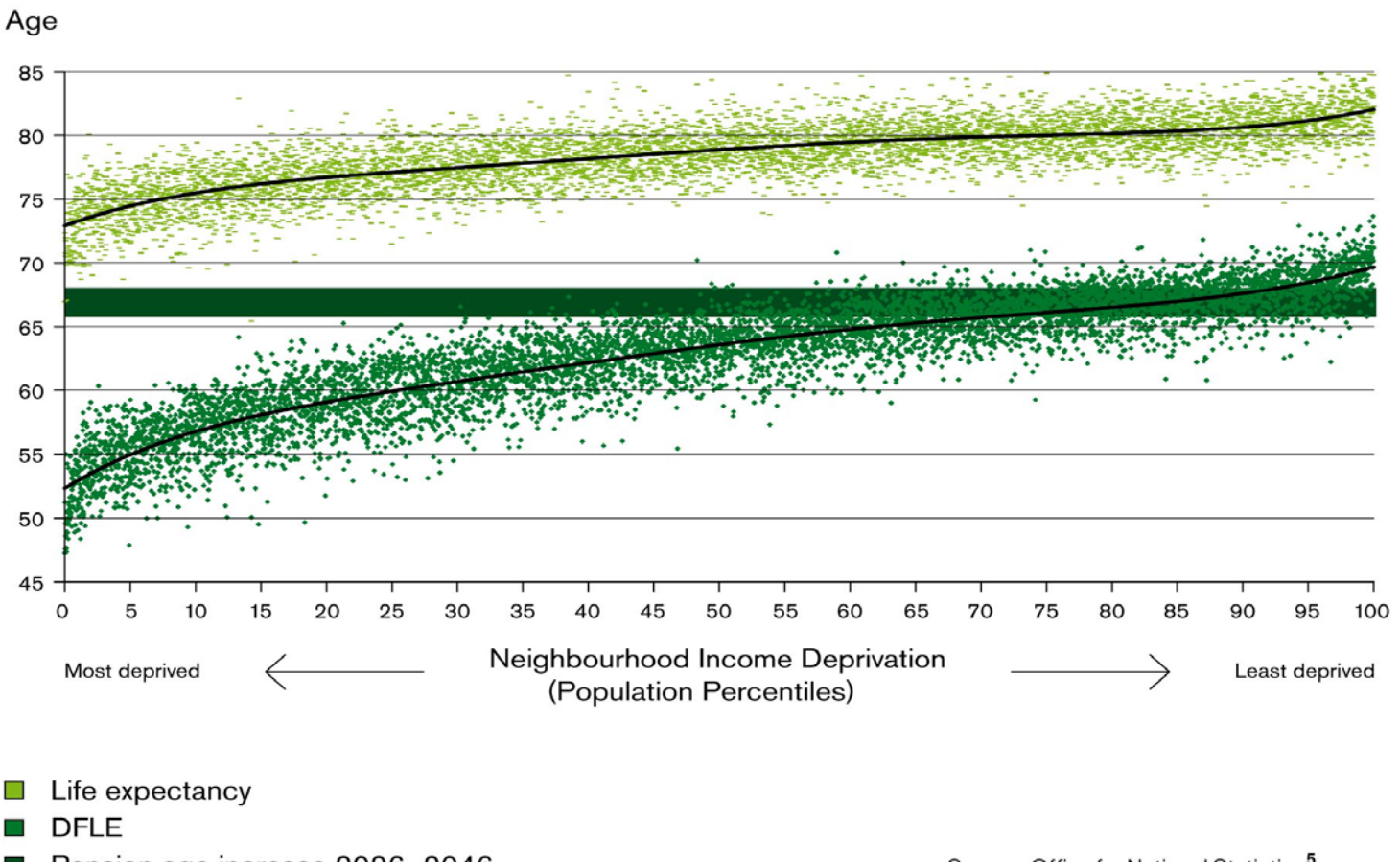
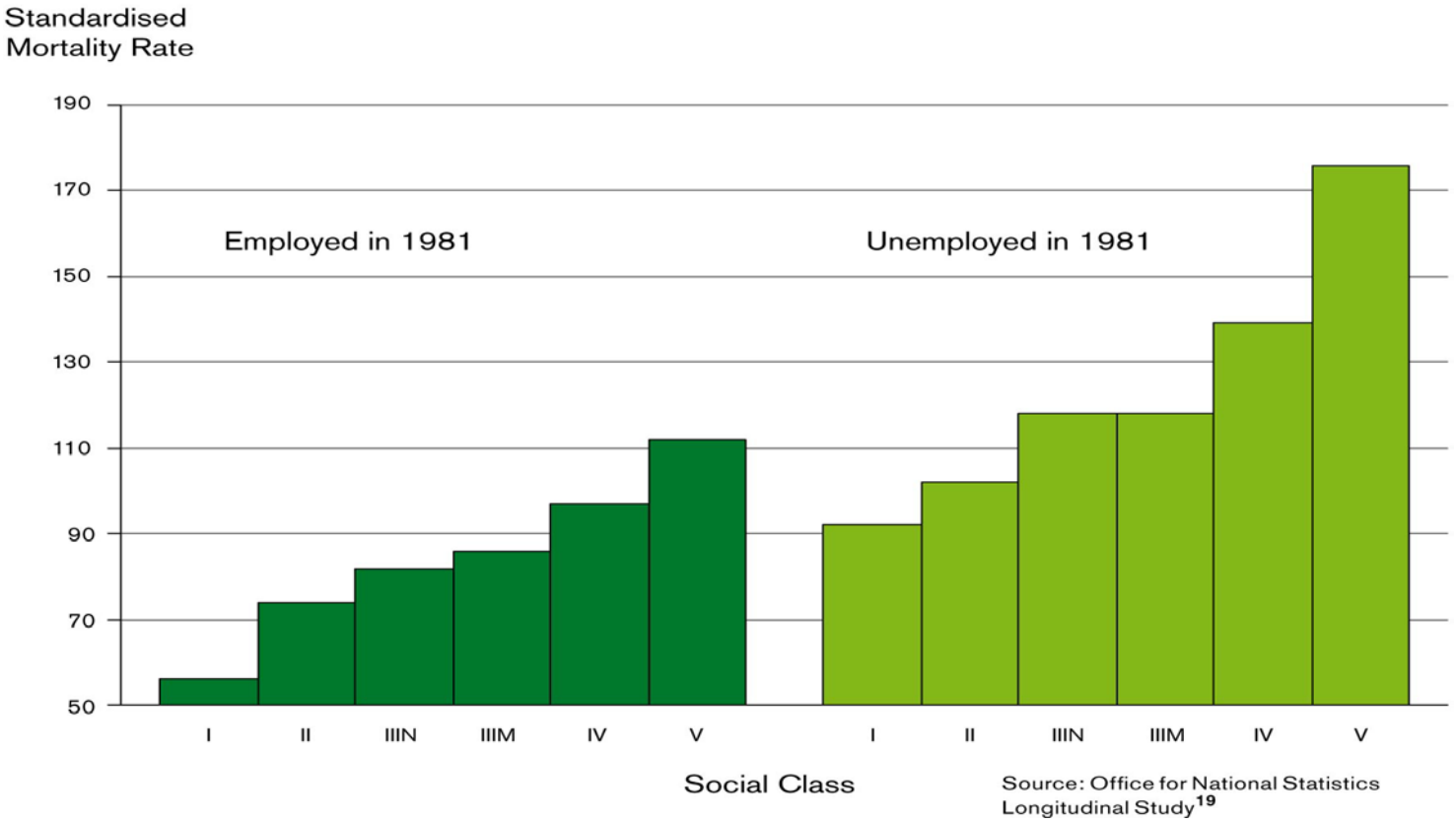


Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[5]

Figure 8 Mortality of men in England and Wales in 1981–92, by social class and employment status at the 1981 Census

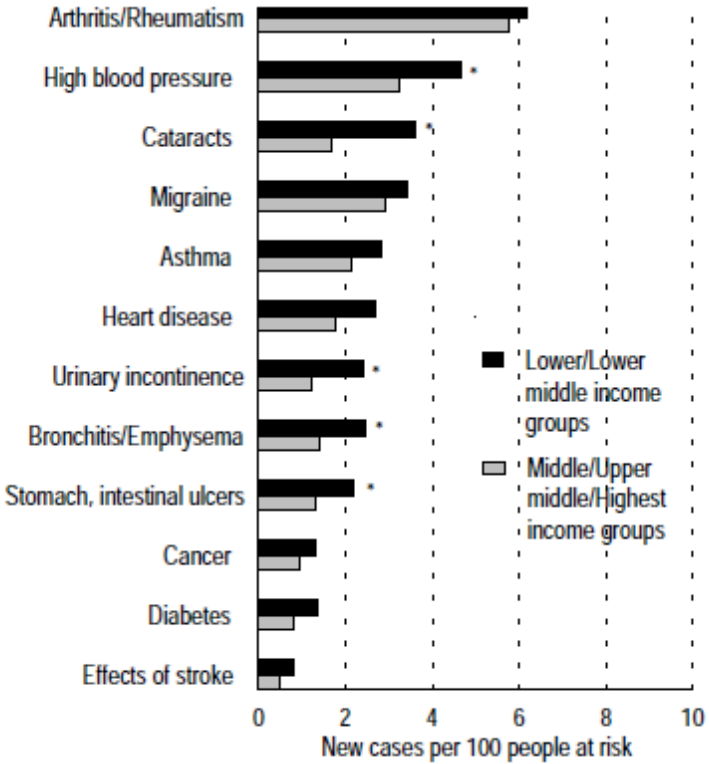


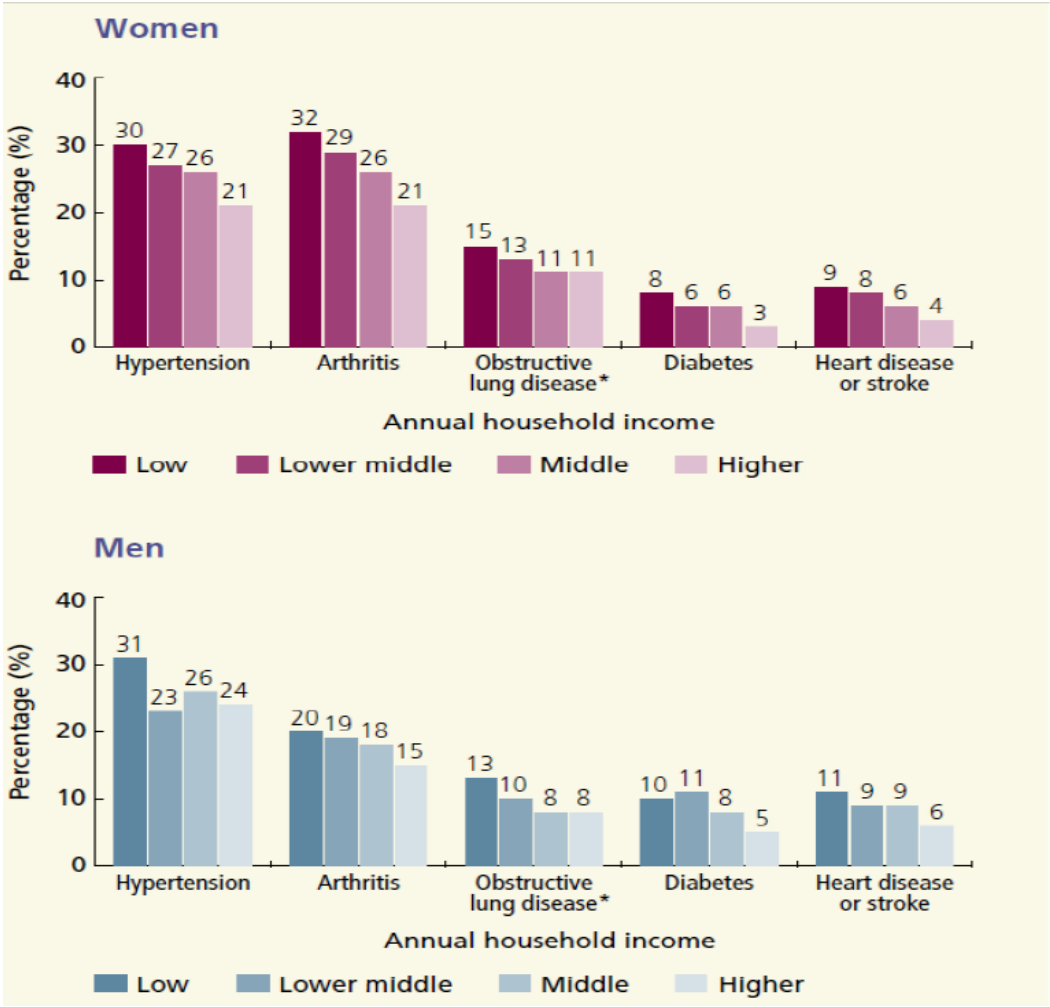
Source: Office for National Statistics Longitudinal Study[19]

Two-year incidence rate of selected chronic diseases, by household income group, population aged 12 and older, Canada excluding Territories, 1994-95 to 1996-97.

Source: National Population Health Survey, Longitudinal Life Cycles 1 & 2.

* Incidence rate significantly higher for lower/lower middle income groups





Sources: NPHS; Bierman, 2009: 63.

Case Study:

Harriett is a 58 yo woman who immigrated to Canada in her 20s from Jamaica. She worked in construction until 15 years ago when a back injury put her out of work. Harriett has an extensive medical history, including diabetes, chronic renal disease, hypertension, depression, and, after an MI, early heart failure. Your team has done its best to optimize her treatment for her physical and mental health conditions. You do not feel Harriett's health has really improved during the time your team has been working her.

Question:

How should you use your time with Harriet today?

Hindawi Publishing Corporation
International Journal of Family Medicine
Volume 2011, Article ID 812182, 7 pages
doi:10.1155/2011/812182

Level 1: Practical ways to address poverty.

Research Article

Development of a Tool to Identify Poverty in a Family Practice Setting: A Pilot Study

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Objective. The goal of this pilot study was to develop and field-test questions for use as a poverty case-finding tool to assist primary care providers in identifying poverty in clinical practice. *Methods*. 156 questionnaires were completed by a convenience sample of urban and rural primary care patients presenting to four family practices in British Columbia, Canada. Univariate and multivariate logistic regression analyses compared questionnaire responses with low-income cut-off (LICO) levels calculated for each respondent. *Results*. 35% of respondents were below the "poverty line" (LICO). The question "Do you (ever) have difficulty making ends meet at the end of the month?" was identified as a good predictor of poverty (sensitivity 98%; specificity 60%; OR 32.3, 95% CI 5.4–191.5). Multivariate analysis identified a 3-item case-finding tool including 2 additional questions about food and housing security (sensitivity 64.3%; specificity 94.4%; OR 30.2, 95% CI 10.3–88.1). 85% of below-LICO respondents felt that poverty screening was important and 67% felt comfortable speaking to their family physician about poverty. *Conclusions*. Asking patients directly about poverty may help identify patients with increased needs in primary care.

Screen:

- *“Do you ever have difficulty making ends meet at the end of the month?”*
- Sensitivity 98%, Specificity 60%; OR 32.3 (95% CI 5.4–191.5)
- Or, *“Do you have enough money for food after paying your monthly bills?”*
- Income should be part of a patient’s social history.

Intervene:

- *“Have you filed your tax return? Do you need help doing that?”*

Three ways to address poverty in primary care: 123

Poverty is not always apparent...
we can't make assumptions

Poverty is everywhere ... In Ontario 20% of families live in Poverty.[3]

Poverty affects health on a gradient: There is no health poverty line. Income negatively affects the health of all but the highest income patients.[4]

13,14,15

ONTARIO COLLEGE OF FAMILY PHYSICIANS

Family & Community Medicine
UNIVERSITY OF TORONTO

HEALTH PROVIDERS AGAINST POVERTY

The CLEAR toolkit

Helping health workers tackle the social causes of poor health

Version 1.0

Improving health and making a difference in people's lives

Frontline health workers can prevent illness by fighting poverty, social exclusion and injustice

"We have to understand the situation, what is going on, what the patient needs, and try to solve the problem"

Helping disadvantaged patients	&	Improving population health

• BE RESPECTFUL
• ASK ABOUT SOCIAL PROBLEMS
• UNDERSTAND THE ISSUES
• PROBLEM SOLVE TOGETHER
  ○ COUNSEL AND ADVISE
  ○ HELP TO ACCESS BENEFITS
  ○ MAKE A SOCIAL PRESCRIPTION
  ○ REFER TO LOCAL SUPPORT
  ○ ADVOCATE FOR YOUR PATIENT
  ○ COORDINATE AND FOLLOW UP
• REACH OUT
• BUILD TRUST
• DOCUMENT HARMS
		• BE A LEADER
		  ○ RAISE AWARENESS
		  ○ BUILD PARTNERSHIPS
		  ○ IDENTIFY LOCAL CHAMPIONS
		  ○ START A SOCIAL MOVEMENT
		• WORK INTERSECTORALLY
		• ADVOCATE FOR A STRONGER AND HEALTHIER COMMUNITY
		• RESEARCH TO GUIDE ACTION
		• EVALUATE IMPACT
		• TRAIN MORE LEADERS

Become your own expert in your community to find the support you need

There are many free programs and services in the Lower Mainland that can help you access housing, government benefits, health services, legal information and more.

RICHMOND

Volunteer Richmond – Seniors information & Referral Program Services for ages 55 and older, on-site (by appointment) or by phone.
604-279-7020 www.volunteerrichmond.ca

CHIMO – Outreach & Advocacy Multilingual services, on-site (by appointment).
604-247-1175 www.chimocrisis.com

VANCOUVER

411 Seniors Centre Society – Information & Referral and Outreach Services Multilingual services for seniors, on-site (walk in) or at your home in Vancouver.
604-684-8171 411seniors.bc.ca

BC Coalition of People with Disabilities – Advocacy Access Program Assistance with disability benefits, on-site (by appointment).
604-872-1278 www.bccpd.bc.ca

St. Paul's Anglican Church – Advocacy Office
Services on-site. 604-683-4287
stpaulsanglican.bc.ca

NORTH SHORE

North Shore Community Resources – Legal Information & Advocacy *and* Seniors' One Stop Information Program Services for North Shore residents, on-site (walk-in or appointment) or by phone. All people 604-985-7138; Seniors 604-983-3303
www.nscr.bc.ca

Have you filed your tax return?

Even if you made no money, file a return each year so that you can get many government benefits, such as:

GST/HST Credit: The Government pays you back some of the sales tax you paid.
www.cra-arc.gc.ca/tx/bsnss/tpcs/gst-tps/menu-eng.html

Working Income Tax Benefits: This is a tax credit for working people with low incomes.
www.cra-arc.gc.ca/bnfts/wtb/menu-eng.html

Child Benefits: These payments help you support your children.
www.cra-arc.gc.ca/bnfts/cctb/menu-eng.html

If you do not have permanent resident status yet, you can still file a tax return. You may be able to get some of these benefits.

Get advice at a free income tax clinic: To find one where you live, contact bc211.

Adapted with permission from Christine Herrera, MD Candidate, and Dr. Gary Bloch, MD CCFP.

Money Matters!

Financial benefits and resources for residents in Richmond, Vancouver and the North Shore

A better income can improve your health.

Vancouver Coastal Health

dren.

If you do not have your resident status yet, you can still file a tax return.

Poverty Intervention Tool

Put patient poverty on your radar...

"There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health."

– **Public Health Agency of Canada**[1]

Four reasons to address poverty

1. Poverty affects health on a gradient: there is not just one health poverty line.[3]
2. Poverty is not always apparent. We need to be pro-active.
3. According to Stats Canada, poverty is pervasive. B.C. has the highest poverty (15.3%) and child poverty (18.6%) rates.[2]
4. People with low socio-economic status are more likely to be hospitalized for conditions where hospitalization could be avoided with early disease management.[4]

Three steps to address poverty

1. **Inquire about poverty when screening all patients.**
2. **Include poverty as a health risk factor.**
3. **Intervene to address poverty-related issues.**

Despite B.C. citizens having better health behaviours than others, a recent Canadian Institute for Health Information report found a higher prevalence of illnesses among those with low incomes.[4]

There are tangible things you can do to address the impacts of poverty and manage other social determinants of health.

- If your otherwise healthy 35-year-old patient with no diabetes risk factors is living in poverty, consider ordering a screening test for diabetes and providing contact details for community nutrition services.
- If your low-risk patient presents with chest pain and lives in poverty, this elevates pre-test probability of a cardiac source. Let this determine how aggressive you are in ordering investigations.

Read on for more ways to make your practice poverty-sensitive.

www.divisionsbc.ca/kb/povertyintervention

...or google "Kootenay Boundary Division Poverty Intervention tool"

Divisions of Family Practice
A GPSC initiative

Three steps to address poverty

Poverty requires intervention like other major health risks.

Step 1: Inquire about poverty – integrate it into your screening.

Screen everyone – regardless of age, ethnicity or medical status – by asking:

Do you have enough money for food after paying your monthly bills?

(Sensitivity, 98%. Specificity, 64% for those living below the poverty line).[5]

Step 2: Include poverty on your risk list. Make it a key risk factor.

The health risks associated with poverty are equivalent to hypertension, high cholesterol and smoking.[6]

Let the evidence speak.

"By tolerating poverty, we end up spending more on treating preventable and avoidable illness." [7]

Cancer:

- **Prevalence:** Higher for lung, oral and cervical for lower income population.
- **Screening:** Low income women are less likely to access mammograms or Pap tests.[8,9]
- **Mortality:** Lower five-year survival rates for most cancers.

Cardiovascular disease:

- **Prevalence:** B.C. has a 17% higher rate of circulatory conditions among the lowest income 20%, than the Canadian average. [10]
- **Mortality:** There would be 21% fewer premature deaths per year due to CVD [11], if everyone had the premature mortality rates of the highest income quintile.[6]

Diabetes:

- **Prevalence:** Lowest income 20% has more than double the rate of diabetes, compared to the highest income. (10% vs. 5% in men, 8% vs. 3% in women).[12]
- **Mortality:** Women–70% higher (17 vs. 10/105). Men–58% higher (27 vs. 17/105).

Mental illness:

- **Prevalence:** Consistent relationship between low SES and mental illness. Depression is 58% higher below the poverty line, than the Canadian average. [13,14]
- **Suicide:** The suicide attempt rate for people on social assistance is 18 times greater than higher income individuals.

Other chronic conditions:

- **Prevalence:** Higher for hypertension, arthritis, COPD, asthma. Higher risk of having multiple chronic conditions. [12,10]
- **Mortality:** Increased for COPD. [12]

Infants:

- **Low birth weight:** B.C.'s low birth weight rates increased gradually from 46.9 per 1,000 live births in 1986, to 56.1 in 2011. The rate in older mothers increased more sharply, from 44.9 to 70.8 in 2011. [15]
- **Infant mortality:** 60% higher in lowest income neighbourhoods.[16]

Step 3: Intervene: 8 simple questions to ask your patients living in poverty

Ask every patient:

1. How easy is it for you to access health care – medical visits, medications and health providers?

Poverty levels are rising for Canadian seniors, particularly elderly, divorced or separated women.[15]

2. Have you completed and sent in your tax forms to be considered for benefits?

- Tax returns: Essential to access many income security benefits: GST/HST credits, child benefits, working income tax benefits, and property tax credits. Even people without official residency status can file returns.

  Canada Revenue Agency
  www.cra-arc.gc.ca/individuals/

  Canada Benefits – www.canadabenefits.gc.ca
- Drug Coverage: Find out what coverage is available federally and provincially. www.drugcoverage.ca

Ask seniors living in poverty:

3. Do you receive seniors' benefits like Old Age Security (OAS) and Guaranteed Income Supplement (GIS)?

- Most people over age 65 who live in poverty should receive about $1,400 per month through OAS, GIS and grants from filing a tax return.
- Recommend renters get in touch with BC Housing's SAFER program to see if they qualify for rent support.

Ask families with children:

4. Do you receive the Child Tax Benefit on the 20th of every month?

- This can get some low-income single parents up to $8000 or more per year, and can lead to a number of other income supports.

  Parent Support Services Society of BC
  www.parentsupportbc.ca
  1-877-345-9777.

  Canada Child Tax Benefit (CCTB)
  www.cra-arc.gc.ca/bnfts/cctb/menu-eng.html

  BC Benefits - Family Bonus and BC Low Income Climate Action Tax Credit
  www.cra-arc.gc.ca/bnfts/rltd_prgrms/bc-eng.html

Ask First Nations patients:

5. Are you eligible for First Nations Health Benefits?

- First Nations with the Status designation may qualify for non-insured health benefits through the federal government. These pay for drugs and other extended health benefits not covered by provincial plans. Non-status First Nations, Inuit and Metis can also seek out a variety of community resources.

The Provincial Health Officers (PHO) 2009 study noted that, compared to all groups including visible minorities, Aboriginal people are the most disadvantaged when it comes to employment and income. Inequity in employment affects individuals' social status and self-esteem.[27]

Aboriginal, Inuit, and Metis seniors struggle with poor mental and physical health. Jurisdictional and organizational barriers prevent them from having the same health care access as other Canadian seniors. [21]

B.C. First Nations Health Authority
www.fnha.ca

Aboriginal Patient Health Navigators
Castlegar 250-304-1254
www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/APN.aspx

Circle of Indigenous Nations Society
coinations@gmail.com 250-231-4968

Ask people with disabilities:

6. Do you receive payments for disability?

- There are nine different disability programs patients may qualify for: Persons With Disabilities (PWD); Persons with Persistent Multiple Barriers (PPMB); CPP Disability; Employment Insurance (EI); Disability Tax Credit (DTC); Veterans benefits; Worker's Compensation; Employers' long term protection; Registered Disability Savings Plan (RDSP).
- The DTC is a prerequisite for some other benefits. DTC requires a health provider to complete the application form. Patients may get up to $1100 per year in tax savings (plus retroactive payments).
- RDSP: Up to 300% matching funds. Or, disability bonds up to $20 000 to help people without resources to save money.

  BC Coalition of People with Disabilities website www.bccpd.bc.ca/programs/advocacy.htm

Ask social assistance recipients these two questions:

7. Have you applied for Persons with Disabilities (PWD) Assistance?

- PWD application: Provide as much information as possible. This application is about whether the patient's disability has a severe impact on their ability to perform daily living activities. It is not about whether they are able to work.
- Include as much detail as possible in comments section. Include details about the frequency and duration of any periodic limitations or conditions.
- Expedite necessary referrals. Write a detailed narrative on the last page. An allied health provider can complete the Assessment part of the application.
- If denied, refer patient to nearest legal clinic advocate for possible appeal.

  Clicklaw has a PWD application guide for patients.

  B.C. Coalition of People with Disabilities
  www.BCcpd.BC.ca

8. Have you applied for extra income supplements?

There is evidence that income and socioeconomic status influences access to health care services, even under our universal public health care system. [22]

- The application process for income assistance and PWD designation can be complicated. Advocates can be found at www.povnet.org and in Helpful Links.
- Those already on Income Assistance may have access to supplementary benefits for treatments such as: optical, dental, special diet/nutritional supplements, pre-natal/natal care, alcohol or drug support. (See Helpful Links)
- Other available B.C. benefits: Family Bonus, Healthy Kids, Employment Program, Senior's Supplement, Special Transportation Subsidy, and other programs.

  The B.C. Legal Services Society publishes a guide "Your Welfare Rights" about social assistance applications. (See Helpful Links)

  B.C. Ministry of Social Development and Social Innovation
  www.hsd.gov.bc.ca

  Employment and Assistance Application
  www.hsd.gov.bc.ca/bcea.htm

  Self Assessment and Application
  www.iaselfserve.gov.bc.ca/HomePage.aspx

  Canadian Pension Plan Disability Benefit
  www.servicecanada.gc.ca/eng/services/pensions/cpp/disability/benefit/index.shtml

Your knowledge of your patient's health status makes a difference.

Health providers are not poverty gatekeepers - but you can play an important role in helping patients overcome barriers. You can successfully advocate and improve access for your patients by simply providing accurate, detailed and complete information on their health and disabilities.

www.divisionsbc.ca/kb/povertyintervention

…or google "Kootenay Boundary Division Poverty Intervention tool"

Wages	Income after tax benefits	Income after child benefits
$12,500	$15,184	$20,899
15,000	17,391	23,107
17,500	19,299	25,015
20,000	21,136	26,851
22,500	22,894	28,495
25,000	24,723	30,124
27,500	26,513	31,409
30,000	28,164	32,555
32,500	29,841	33,727
35,000	31,455	34,840
37,500	32,874	35,954

*Based on single mother and infant, no union or benefits, $8,400 rent, $400 medical expenses, $1,452 transit passes

Source: Toronto Star

How to Address Poverty?

Kootenay Boundary Division Poverty Tool
www.divisionsbc.ca/kb/povertyintervention

OCFP Poverty Tool
http://ocfp.on.ca/cme/povertytool

CLEAR Collaboration Toolkit
http://www.mcgill.ca/clear/

https://www.cma.ca/En/Pages/social-determinants-of-health.aspx

Abstract
The aim of this CME module is to raise the awareness of Canadian physicians, that poverty is a risk to the health of individual patients. It also seeks to provide physicians with practical interventions for their practice.

We know that individual health is influenced by a complex inter-play between different factors such as:
•human biology including genetic predispositions;
•the consequences of personal behaviors like smoking or a sedentary lifestyle; and
•access to, and the design of, the health care system.

But health – both individual and collective – is also profoundly influenced by social factors. These factors lead to differences in health at the individual level as well. It is those individuals, in their role as patients, on which most physicians focus their attention.

For the purposes of this CME we will focus on one social determinant, income. Early childhood development will be explored in another CME that is in development. One reason that income is so critical to individual health is its link to the other determinants.

Question:

What else can we do in our professional cultures and practice environments to address poverty?

How to address poverty in primary care?

Given the role of physician as advocate, and the goal of providing appropriate, patient-centered care for patients of lower SES:

1. **What is the role of primary care providers in addressing the health needs of patients living in poverty?**
2. **What barriers and enabling factors are associated with addressing determinants of health, including poverty, in primary care?**

A qualitative, heterogeneous focus group study involving:

- 15 patients (7 male, 9 female, many on disability)
- 7 community advocates (Homeless shelter, food bank, MOA, mental health worker, patient advocates, patient service centre Director)
- 19 health providers (GPs, RNs, pediatrician, MHO, counselor, dietician, parametic, DM educator, medical and nursing students)

Theme : Shame and Power

Patient stories:

"The class thing, resentments maybe; here I am struggling to feed myself and here's this person who makes a hundred and fifty thousand dollars who is supposed to give me the answer in fifteen minutes about a life that she can't understand."

"The doctor thinks they can read your mind, but unfortunately they cannot. But it is hard trying to admit that being embarrassed knowing that we're a lot lower than everyone else." (Pt.V.211)

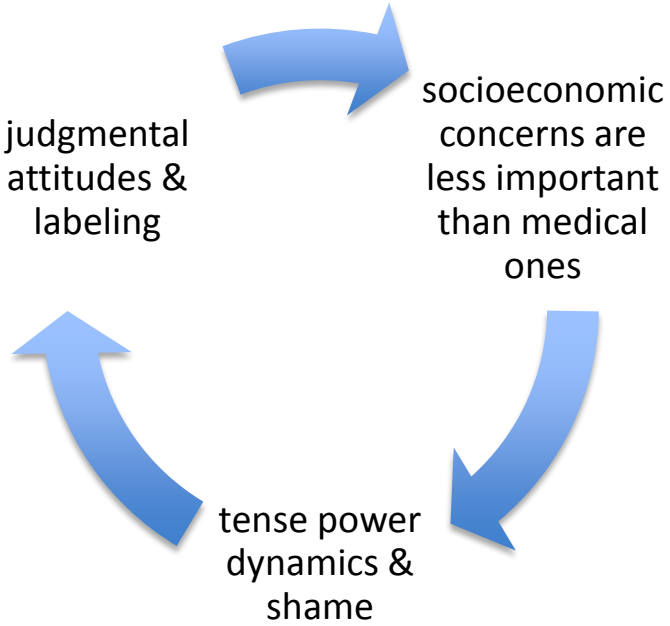
Physician stories:

Patients in one focus group expressed shock when a physician expressed that doctors too can feel *"powerless, if they can't fix the problem."*

Cycle of neglect of SDOH

Don't ask-Don't tell: *"It would open up a whole can of worms and then you'd end up sitting for a half an hour with the person when you've got a full waiting area of people that want to see you."*

"The doctors don't want to say 'Oh you shouldn't delist physiotherapy' or 'You shouldn't delist something else' because, well, that's less money for us. It just creates an adversarial approach between the different disciplines that really should be working together. Like, if we give more money to the nurses that is less money for doctors and vice versa."



Solutions: Cultural and Attitudinal Shifts

“One of my old family doctors before, they could see when I was starting to slide before I slid… because they deal with you on an ongoing basis.”

Said one participant to another who described feeling welcoming *“vibes”* in his family doctor’s office (Pt.N1.806): *“It sounds like he valued you and he respected you and he liked you.”*

Regarding poverty: *“Be upfront and honest with me rather than beat around the bush and not ask the direct question.”*

Level 2: Address Underlying Issues.

Pairs of young, well-groomed, well-spoken college men with identical resumes apply for 350 advertised entry-level jobs in Milwaukee, Wisconsin. Two teams were black and two were white. In each team, one said that he had served an 18-month prison sentence for cocaine possession.

% of Job Applicants Receiving a Callback:

Criminal Record	White	Black
No	34%	14%
Yes	17%	5%

Devah Pager; Am J Sociology, 2004

Every Day Discrimination

In your day-to-day life how often have any of the following things happened to you?

- You are treated with less courtesy than other people.
- You are treated with less respect than other people.
- You receive poorer service than other people at restaurants or stores.
- People act as if they think you are not smart.
- People act as if they are afraid of you.
- People act as if they think you are dishonest.
- People act as if they’re better than you are.
- You are called names or insulted.
- You are threatened or harassed.

Discrimination & Health: Tene Lewis et al

Everyday Discrimination: positively associated with:

- **Coronary artery calcification** (Lewis et al., Psy Med, 2006)
- **C-reactive protein** (Lewis et al., Brain Beh Immunity, 2010)
- **Blood pressure** (Lewis et al., J Gerontology: Bio Sci & Med Sci 2009)
- **Lower birth weight** (Earnshaw et al., Ann Beh Med, 2013)
- **Cognitive impairment** (Barnes et al., J Intl Neuro Psy Soc, 2012)
- **Poor sleep** [objective & subjective] (Lewis et al, Hlth Psy, 2012)
- **Mortality** (Barnes et al., J Gerontology: Bio Sci & Med Sci, 2008).
- **Visceral fat** (Lewis et al., Am J Epidemiology, 2011)

The effect of SES on access to care:

Olah et all. CMAJ. Feb 23, 2013

Abstract

Background: Health care office staff and providers may discriminate against people of low socioeconomic status, even in the absence of economic incentives to do so. We sought to determine whether socioeconomic status affects the response a patient receives when seeking a primary care appointment.

Methods: In a single unannounced telephone call to a random sample of family physicians and general practices (n = 375) in Toronto, Ontario, a male and a female researcher each played the role of a patient seeking a primary care physician. Callers followed a script suggesting either high (i.e., bank employee transferred to the city) or low (i.e., recipient of social assistance) socioeconomic status, and either the presence or absence of chronic health conditions (diabetes and low back pain). We randomized the characteristics of the caller for each office. Our primary outcome was whether the caller was offered an appointment.

Results: The proportion of calls resulting in an appointment being offered was significantly higher when the callers presented themselves as having high socioeconomic status than when they presented as having low socioeconomic status (22.6% v.14.3%, p = 0.04) and when the callers stated the presence of chronic health conditions than when they did not (23.5% v. 12.8%, p = 0.008). In a model adjusted for all independent variables significant at a p value of 0.10 or less (presence of chronic health conditions, time since graduation from medical school and membership in the College of Family Physicians of Canada), high socioeconomic status was associated with an odds ratio of 1.78 (95% confidence interval 1.02–3.08) for the offer of an appointment. Socioeconomic status and chronic health conditions had independent effects on the likelihood of obtaining an appointment.

Interpretation: Within a universal health insurance system in which physician reimbursement is unaffected by patients' socioeconomic status, people presenting themselves as having high socioeconomic status received preferential access to primary care over those presenting themselves as having low socioeconomic status.

- Researchers played roles of high & low income patients with & without a chronic health condition, seeking a GP
- 22.6% of high SES patients were offered appointments vs. 14.3% of low income patients ✗
- 23.5% of patients with chronic health conditions were offered appointments vs. 12.8% of those without ✔
- Adjusting for significant variables, odds of being offered an appointment for a high SES patient were 1.78 times that for a low SES patient
- ***High SES patients received preferential access to care.***

"But I'm non-judgmental: I know I don't stereotype"

- When one holds a negative stereotype about a group and meets someone who fits the stereotype s/he will discriminate
- Conclusive evidence demonstrates that stereotypes are activated automatically (without intent).
- Individuals frequently are not aware of activation nor impact on their perceptions, emotions and behavior.
- *They are activated more quickly and effortlessly than conscious cognition.*
- Many cognitive processes result in confirmation of expectations (we process information in ways that support our beliefs).

Van Ryn, 2003

Important conclusions:

- By overvaluing biomedical needs over social needs, we can cause harm to patients.
- If we do not create space in medical encounters for addressing the biggest contributors to a patient health, we can cause shame by delegitimizing the day-to-day struggles of patients.
- Often we are simply adding to their problem list by piling biomedical problems onto existing socio-economic ones.
- We must think of the implications of labeling patients as “difficult” and “non-compliant”.
- Whether we see patients in acute or community settings, we can identify appropriate action plans for both acute and chronic risk factors and needs, including needs related to SDOH.

Service Delivery and Social Context

244 low-income hypertensive patients, 80% black (matched on age, race, gender, and blood pressure history) were randomly assigned to:

- Routine Care: Routine hypertensive care from a physician.
- Health Education Intervention: Routine care, plus weekly clinic meetings for 12 weeks run by a health professional.
- Outreach Intervention: Routine care, plus home visits by lay health workers*. Provided info on hypertension, discussed family difficulties, financial strain, employment; as appropriate, provided support, advice, referral, and direct assistance.
- Recruited from the local community, one month of training to address social and medical needs of persons with hypertension.

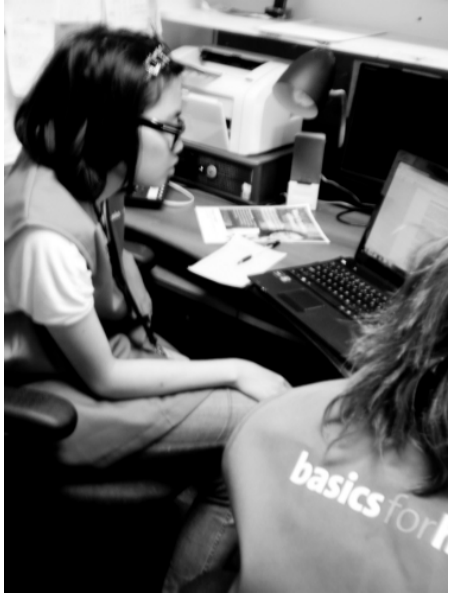
Syme et al. 1978

Service Delivery and Social Context: Results

After 7 months of follow-up, patients in the outreach group:

1. Were more likely to have their blood pressure controlled than patients in the other two groups.
2. Knew twice as much about blood pressure as patients in the other two groups. Those in the outreach group with more knowledge were more successful in blood pressure control.
3. Were more compliant with taking their hypertensive meds than patients in the health education intervention group. Moreover, good compliers in outreach group were twice as successful at controlling their blood pressure as good compliers in health education group.

Syme et al. 1978



basicsforhealth

Basics for Health Society is committed to an equitable health care system that recognizes basic socio-economic needs as an essential component of health care delivery.

We are committed to strengthening the primary health care system through partnership and leadership on the social determinants of health

Our Mission:

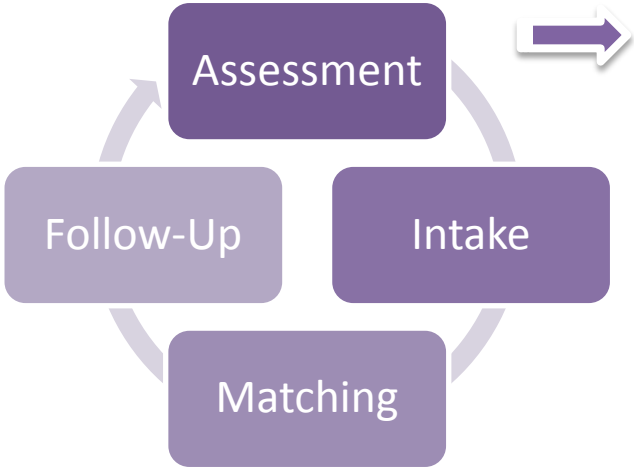
1. To provide individuals and families with connections, and facilitate access, to the resources they need to be healthy.
2. To partner with health care providers in addressing SDOH in clinical practice.
3. To foster the development of a more integrated understanding of health among the next generation of health care providers and leaders.

www.basicsforhealthsociety.ca

History:

2012:
ImpactBC pilot funding
2012-2013:
Operation at REACH CHC
April 2014:
Basics for Health Society incorporated
July 2014:
Transition to Navigator program at REACH
October 2014:
PainBC partnership; program adapted province-wide

How does the Basics for Health Program Work?



Referral by patients & health providers

Assessment
- Health care provider screens patient for resource needs at point of care

Intake
- Patient accesses volunteer desk to address identified resource needs

Matching
- Volunteer connects patient to appropriate community resource

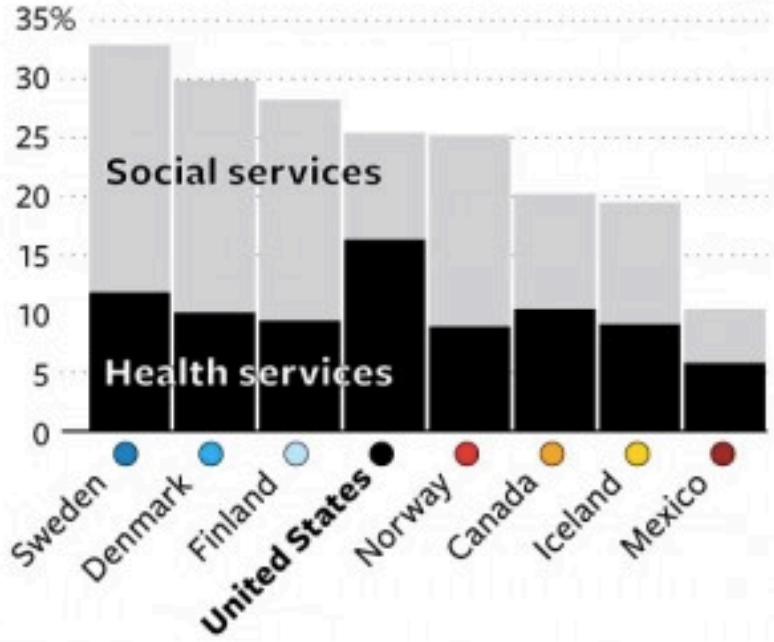
Follow-up
- Volunteer follow up with patient to ensure resource need is met and informs the provider of patient's status

basicsforhealth

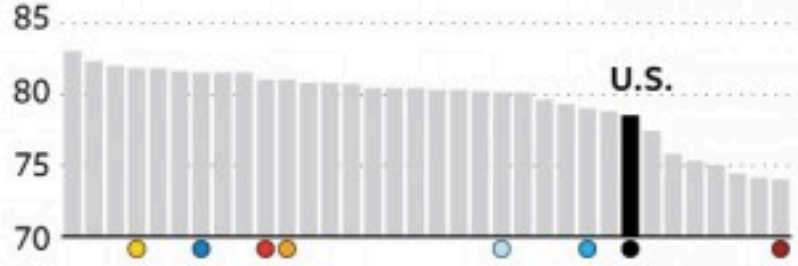
Spending More, But Getting Less

Despite spending more on health care than its peers, the United States compares poorly on measures such as life expectancy and infant mortality. The countries that rank better tend to weight their spending toward social programs rather than medical treatment, as the United States does.

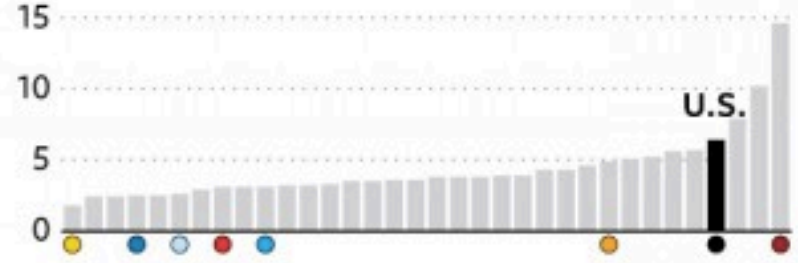
Total health services and social services spending as a percentage of GDP



Life expectancy at birth, in years (OECD countries)



Infant mortality per 1,000 births (OECD countries)



Source: OECD (2009)

A POVERTY REDUCTION PLAN FOR...

HEALTHY PEOPLE AND HEALTHY COMMUNITIES

HIGHER WAGES

Most people living in poverty have a job, and almost half the poor children in BC live in families with at least one parent working full-time.

Increase the minimum wage and index it to inflation, and encourage employers to adopt the Living Wage.

WELFARE

Welfare and disability benefits are far too low at $610 for a single person and $906 for a person with a disability.

Significantly increase welfare and disability rates, and index them to inflation.

HOUSING

BC has the worst record of housing affordability in Canada and increasing numbers of homeless and under-housed people.

Re-commit to building thousands of new social housing units per year.

CHILD CARE

The high cost of child care is a huge burden for many families and makes it completely inaccessible to others.

Adopt the $10/day child care plan.

HEALTH

Poverty is a fundamental determinant of health, and the health care costs of poverty add up to $1.2 billion/year.

Expand essential health services, like dental and optical, and enhance community health care for seniors and people with disabilities.

EDUCATION

Without meaningful, long-term training and education, people cannot access stable, well-paying jobs.

Adequately fund schools and make post-secondary education and training more accessible.

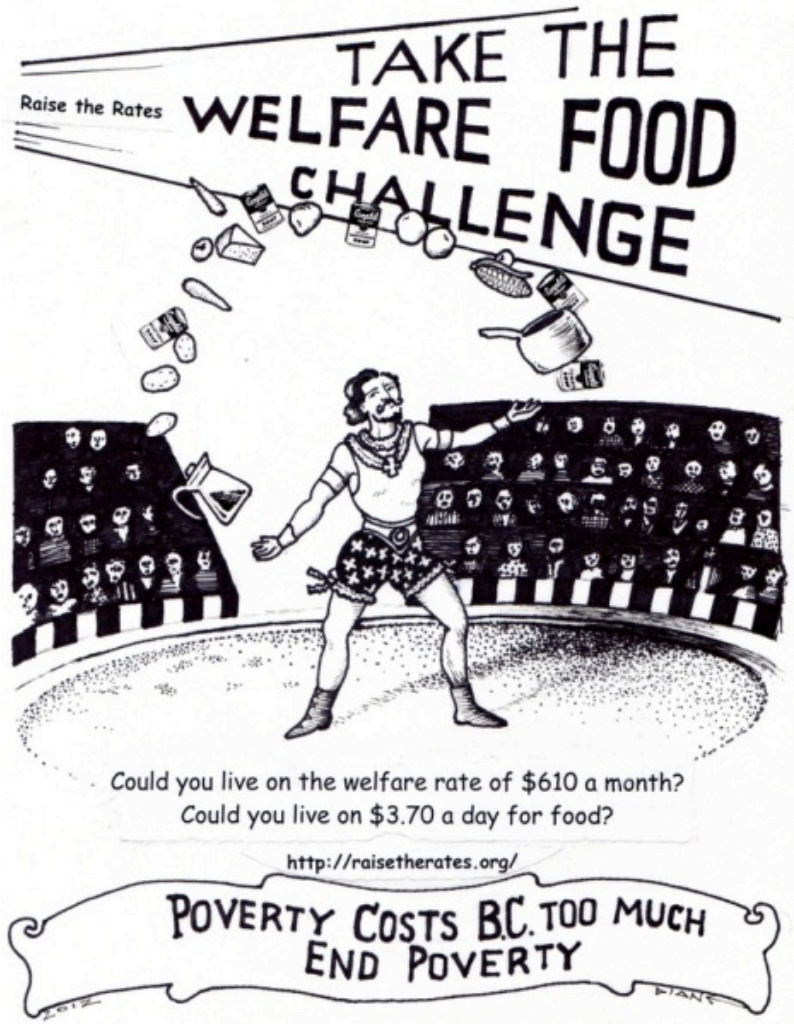
FOCUS ON MARGINALIZED PEOPLE

Aboriginal people, immigrants and refugees, people with disabilities, single mothers and single senior women have high poverty rates.

Focus on the structural barriers faced by each group.

ILLUSTRATION BY SAM BRADD

BC has the highest poverty rate in Canada, but is one of the last provinces left without a poverty reduction plan.



www.welfarefoodchallenge.org
www.chewonthis.ca

- 833,000 Canadians use food banks monthly
- 1 in 3 people helped by food banks are children
- 1 in 8 Canadians experience food insecurity

Question:

Who will join me in the Welfare Food Challenge, to eat for one week on only $21 starting today (or tomorrow)?

Who will sign the petition calling for welfare, disability, and minimum wage increases that allow dignity and the ability to meet basic needs?

www.welfarefoodchallenge.org

Acknowledgments for contributions to this presentation:

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Canadian Centre for Policy Alternatives, BC Office
BC Poverty Reduction Coalition

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BC KIDNEY DAYS 2014
Hosted by BC Transplant and the BC Renal Agency