Physicians and Health Equity: Lessons from Canada

March 24, 2015

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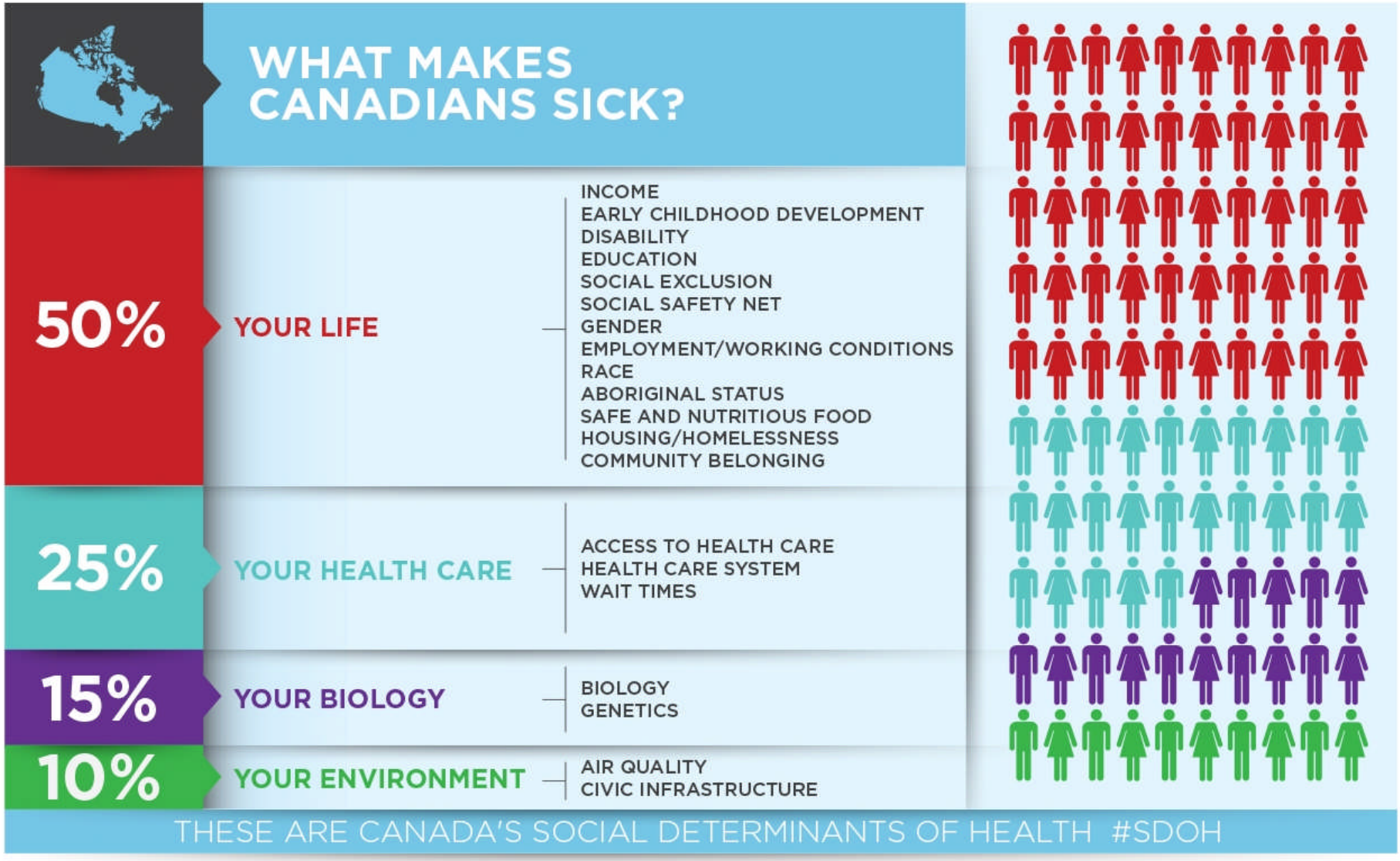
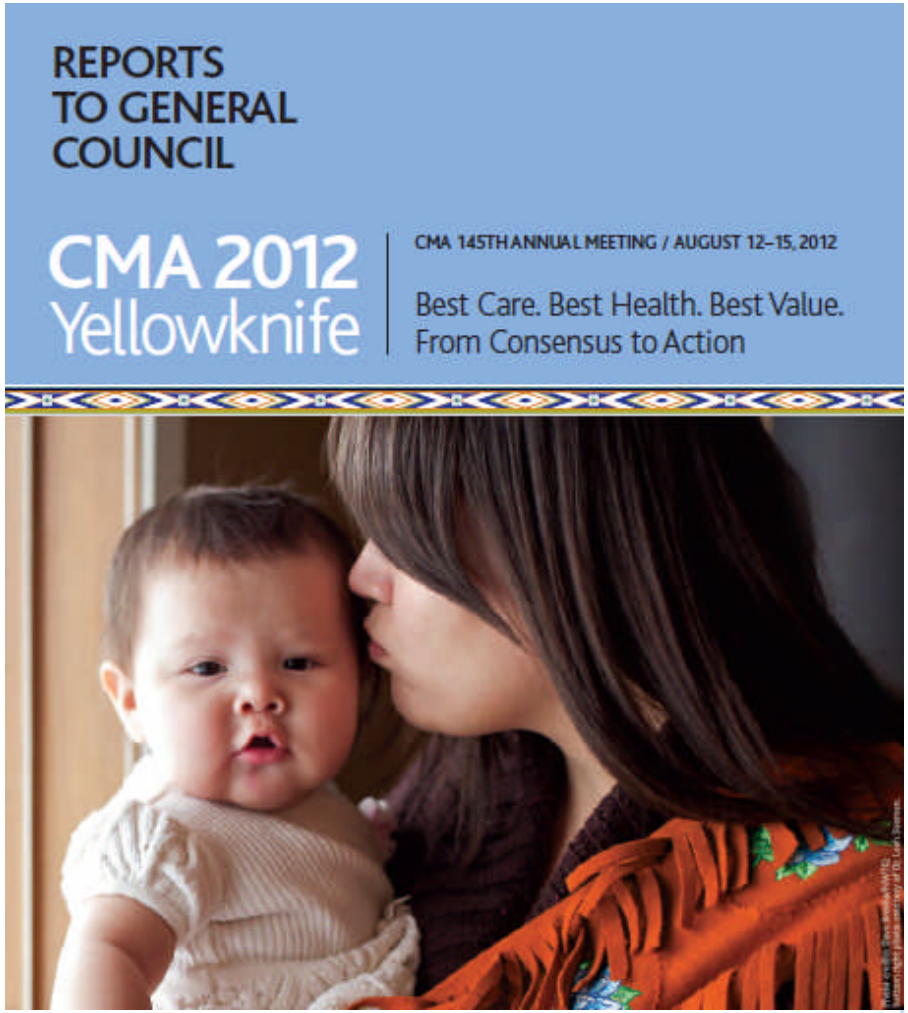
Symposium: Role of Physicians and National Medical Associations in Addressing the Social Determinants of Health and Health Equity

Association Médicale Canadienne
Canadian Medical Association


WHAT MAKES CANADIANS SICK?
50%
YOUR LIFE
INCOME
EARLY CHILDHOOD DEVELOPMENT
DISABILITY
EDUCATION
SOCIAL EXCLUSION
SOCIAL SAFETY NET
GENDER
EMPLOYMENT/WORKING CONDITIONS
RACE
ABORIGINAL STATUS
SAFE AND NUTRITIOUS FOOD
HOUSING/HOMELESSNESS
COMMUNITY BELONGING
25%
YOUR HEALTH CARE
ACCESS TO HEALTH CARE
HEALTH CARE SYSTEM
WAIT TIMES
15%
YOUR BIOLOGY
BIOLOGY
GENETICS
10%
YOUR ENVIRONMENT
AIR QUALITY
CIVIC INFRASTRUCTURE
THESE ARE CANADA'S SOCIAL DETERMINANTS OF HEALTH #SDOH

HEALTH CARE TRANSFORMATION IN CANADA



Winnipeg – Hamilton – Charlottetown – Calgary – Montreal – St. John's

Key Themes

- Poverty
- Early childhood education
- Food security
- Social Housing
- Mental Health
- Clear roles for governments, citizens and health care providers

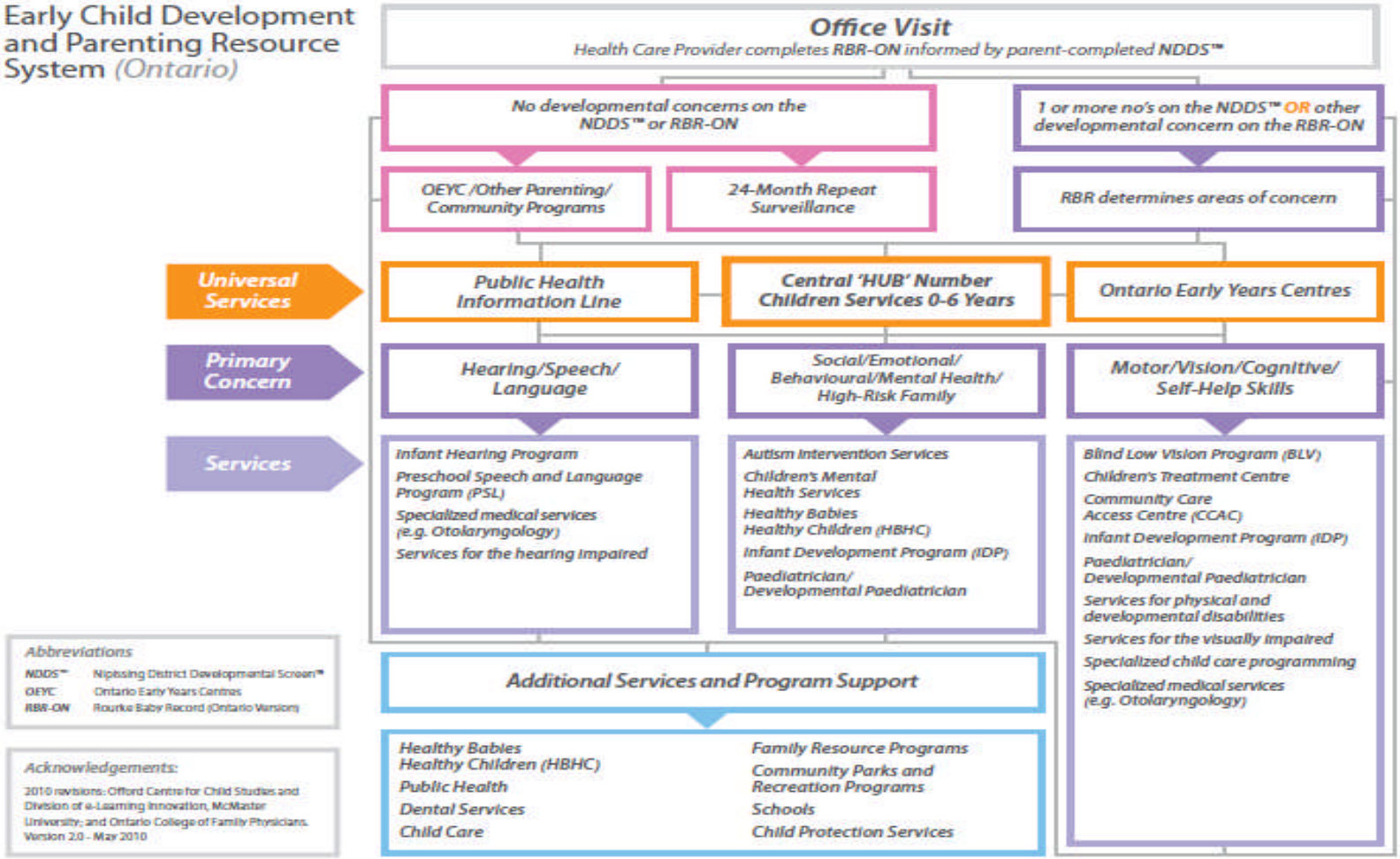
The Physician and Health Equity: Opportunities in Practice

- Between February and April 2012, interviews were conducted with 30 additional physicians. 29 sites in total spanning 8 provinces and 2 territories.

- Predominately family physicians but ER physicians, pediatricians, psychiatrists, public health, and hospital based practitioners were interviewed as well.

- Practice populations included rural and urban, inner city, Aboriginal, child and youth, mental health, women's health and northern health.

1. Linking patients with supportive community programs and services



2. Asking questions about a patient's social and economic circumstances

Three ways to address poverty in primary care: 123

1. SCREEN

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

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

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

Screen everyone!!!

"Do you ever have difficulty making ends meet at the end of the month?"

(Sensitivity 98%, Specificity 64% for living below the poverty line)

2. ADJUST RISK

Factor poverty into clinical decision-making like other risk factors. Consider the evidence:

Cardiovascular disease:
- Prevalence: **17% higher** rate of circulatory conditions among lowest income quintile than Canadian average.
- Mortality: If everyone had the premature mortality rates of the highest income quintile there would be **21%** fewer premature deaths per year due to CVD.

Diabetes:
- Prevalence: Lowest income quintile **more than double** highest income (10% vs. 5% in men, 8% vs. 3% in women).
- 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, e.g. depression **58% higher** below the poverty line than the Canadian average.
- Suicide: Attempt rate of people on social assistance is **18 times higher** than higher income individuals.

Cancer:
- Prevalence: **Higher** for lung, oral (OR 2.41), cervical (RR 2.08).
- Mortality: **Lower 5-year survival** rates for most cancers.
- Screening: Low income women are **less likely to access** mammograms or Paps.

Other chronic conditions:
- Prevalence: **Higher** for hypertension, arthritis, COPD, asthma, higher risk of having multiple chronic conditions.
- Mortality: **Increased** for COPD.

Infants:
- Infant mortality: **60% higher** in lowest income quintile neighbourhoods
- Low birth weight: If all babies in Toronto were born with the low birth weight rate of the highest income quintile there would be **1,300** or **20%** fewer singleton LBW babies born per year.

Highest risk groups:
Women, First Nations, people of colour, LGBT.

Growing up in Poverty:

We must intervene to improve income early.

Growing up in poverty has been associated with increased adult morbidity and mortality resulting from: stomach, liver, and lung cancer; diabetes; cardiovascular disease; stroke; respiratory diseases; nervous system conditions; diseases of the digestive system; alcoholic cirrhosis; unintentional injuries; and homicide.

Some examples of how the evidence might change your practice:

1. If an otherwise healthy 35 year old comes to your office, without risk factors for diabetes other than living in poverty, you consider ordering a screening test for diabetes.
2. If an otherwise low risk patient who lives in poverty presents with chest pain, this elevates your pre-test probability of a cardiac source and helps determine how aggressive you are in ordering investigations

3. INTERVENE

7 simple questions to help patients living in poverty

FOR EVERYBODY:

Have you filled out and mailed in your tax forms?
- Tax returns are essential to access many income security benefits e.g. GST / HST credits, Child Benefits, working income tax benefits, and property tax credits.
- Even people without official residency status can file returns.
- **Drug Coverage:** Extended Health Benefits or Trillium for those without Ontario Drug Benefits.

See **www.drugcoverage.ca** for a guide to federal and provincial drug insurance programs.

For seniors living in poverty:

Do you receive Old Age Security and Guaranteed Income Supplement?
- Most people over age 65 who live in poverty should receive at least **$1400/month** in income through OAS, GIS and grants from filing a tax return.

For families with children:

Do you receive the Child Benefit on the 20th of every month?
- This can get some low income single parents over **$8000 more per year**, and can lead to a number of other income supports.

For people with disabilities:

Do you receive payments for Disability?
- Eight major disability programs: ODSP, CPP Disability, EI, Disability Tax Credit (DTC), Veterans benefits, WSIB, Employers' long term protection, Registered Disability Savings Plan (RDSP).
- The DTC requires a health provider to complete the application form. It provides **up to $1100 per year** in tax savings (plus retroactive payments), and is required to receive other benefits including the RDSP.
- RDSP: **Up to 300%** matching funds. Or disability bonds **up to $20 000** for those without resources to save money.

For First Nations:

Are you Status Indian?
- 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

For social assistance recipients:

Have you applied for extra income supplements?
- Mandatory Special Necessities Benefits (MDs bill K054 for $25):
  - Medical supplies and health-related transportation (includes e.g. AA, psychotherapy).
- Limitation to Participation (MDs bill K053 for $15): Disability can exclude a recipient from mandatory job search and training programs.
- Special Diet Allowance (MDs bill K055 for $20): some health conditions will qualify a recipient for extra income.
- Other benefits available: Employment supports, Drug & Dental, Vision, Hearing, ADP Co-payment, Community Start Up & Maintenance, Women in Transition/Interval Houses, Advanced age allowance, Community Participation ($100 per month extra for volunteering). "Discretionary Benefits".

Applications and benefits available through a patient's OW/ODSP worker

If you might qualify, have you applied for ODSP?
- ODSP application (MDs bill K050 for $100): provide as much information as possible, including about the impact of a person's disability on their lives.
  - Include all collateral, expedite necessary referrals, and write a detailed narrative on the last page. Consider obtaining a detailed functional assessment, and having an allied health provider assist with filling in details.
- If denied, refer to nearest legal clinic – acceptance rates on appeal are very high.

www.clso.on.ca/english/pub/onpub/PDF/socialAsst/ods-prof.pdf for a good ODSP tip sheet for health professionals.

Remember:

Health providers are not the gatekeepers for income security programs. Our job is to provide complete and detailed information that accurately portrays our patients' health status and disability.

For references, please visit
www.ocfp.on.ca/cme/povertytool

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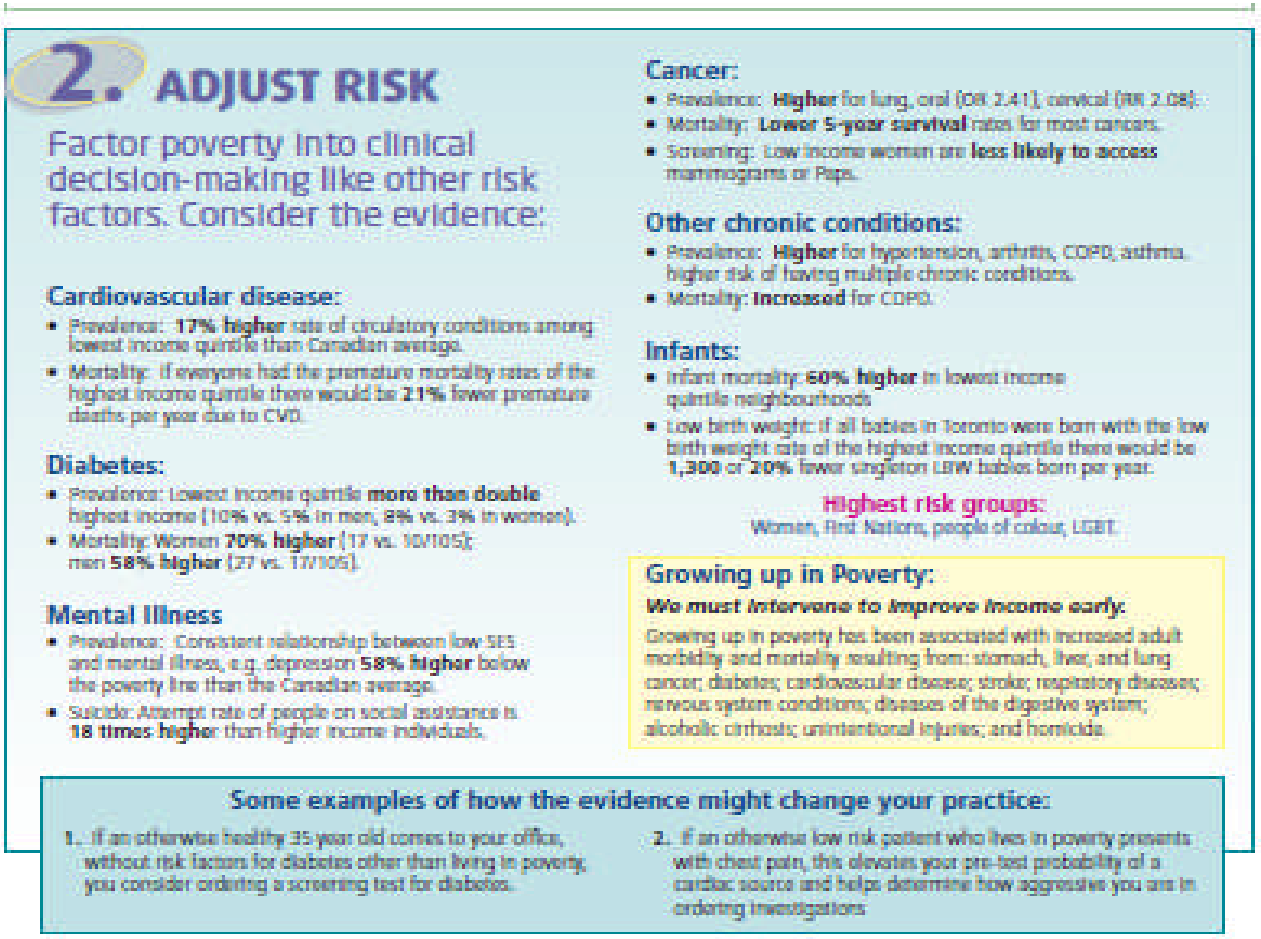
3. Integrating considerations of social and economic conditions into treatment planning



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4. Advocating for changes to improve the social and economic circumstances of the community

upstream

5. Undertaking advocacy on behalf of individual patients

6. Adopting equitable practice design

7. Help patients access existing government programs

Lessons Learned

- Public engagement will drive interest among patients as well as physicians and other stakeholders.
- Need to focus on what social and economic deficits mean for health and the health care system.
- Identify what you can support as a medical association and what you can actually do.
  - Advocacy vs. direct action

Lessons Learned (Cont'd)

- Show a direct line between the theory and what it means to physicians in practice.
  - Best practice examples
  - Tools and resources
  - Training and education
- Physician champions are key to moving the agenda forward.

Questions?


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