

Poverty and Health

Why poverty makes us sick

physician backgrounder

by The Ontario Physicians Poverty Work Group

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A 57-year-old woman comes into your family practice office, complaining of intermittent chest pain on exertion. She is hypertensive, has type 2 diabetes, and smokes a pack of cigarettes a day. She lives on social assistance benefits of \$570 a month (and has been turned down for disability benefits). She has few social supports. She does not take her medication consistently, and is not interested in quitting smoking ("It is one of my few pleasures in life"). She has missed a cardiac stress test twice because, she says, she was looking for housing. Every time she leaves your office, you feel a mixture of frustration and sadness at her situation and her apparent inattention to her health. You have considered discharging her from your practice for noncompliance. What evidence is there for a link between her income status and her health issues? How can we begin to rethink our approach to her situation, taking into account an evidence-based understanding of the link between her income status and her health?

Introduction

Health follows a social gradient: populations occupying a lower position in the social hierarchy experience, as a group, worse health. This holds true whether the outcome is morbidity or mortality. Other social determinants of health, such as education and gender, also have a major impact on health, but income inequality has a powerful influence on health itself and on the other social determinants as well.

Since the 1970s, it has been clear that, in order to effect significant changes to health, we must look beyond focusing on individual risk factors such as smoking, to modifying the social environments within which people make bad choices.

Canada's universally accessible health-care system mitigates some health inequities by providing earlier diagnosis and fewer barriers to treatment and referral.

An international survey found that Canadians are among the least likely

to report that they did not seek health care because of concerns about costs.¹

A recent Canadian-American study concluded that Canada's disadvantaged groups, including the poor, have better access to health care than their American counterparts.²

Physicians can make a difference for their individual patients by integrating a "determinants of health" approach into patient care. But individual physicians and the health system alone cannot address most of the upstream causes of poor health. Therefore, physicians must work with others to advance public policy that addresses these determinants, such as poverty.

This is the first in a series of articles written for doctors by doctors on the issue of poverty and health. Each article will introduce readers to real-life individuals and families who can teach us about poverty in Ontario. The articles will also contain practical information that doctors can integrate into their professional practice.

Poverty as a risk factor for ill health: the evidence

Poverty is strongly associated with a higher incidence, prevalence, and severity of chronic illness, acute illness, and injuries.³ The evidence for the impact of poverty on health has been comprehensively reviewed in other publications.⁴

This section will briefly outline the impact of poverty on population health, chronic illness, and children's health. The evidence is strong enough to conclude that poverty may well be the most powerful determinant of health.⁵

Poverty has been strongly linked to many adverse health outcomes.⁶ Life expectancy in the lowest-income quintile neighbourhoods in urban Canada is five years shorter for men, and 1.6 years shorter for women, compared with those who live in the highest-income quintile neighbourhoods.

Infant mortality rates are 61 per cent higher in the poorest areas,⁷ and low birthweight rates are 43 per cent higher.⁸ Low-income individuals are nearly four times more likely to report poor or fair health status than are high-income individuals.⁹

Perhaps most striking, 24 per cent of all potential years of life lost in Canada in 1996 were estimated to be attributable directly to poverty. This compares with 31 per cent for cancer, and 18 per cent for cardiovascular disease.¹⁰

Table 1 (see p. 33) shows a much

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higher mortality rate from chronic conditions in the poorest urban neighbourhoods in Canada.

Recently, the Institute for Clinical and Evaluative Sciences identified poverty as a risk factor for developing diabetes. Low-income Ontario women are nearly four times more likely to suffer from diabetes than high-income women.¹²

Low income is estimated to be responsible for 25 per cent to 30 per cent of the total mortality from cardiovascular disease. The increased cardiovascular disease burden due to poverty is comparable to that due to smoking and hypertension.^{13,14}

A large study showed that each \$10,000 increase in neighbourhood income correlated with a 10 per cent decrease in mortality after myocardial infarction.¹⁵ Furthermore, poverty causes barriers to access to some services. Ontarians living in low-income areas have 23 per cent fewer angiograms, and wait 40 per cent longer for these examinations.¹⁵

The prevalence of depression among low-income individuals is 60 per cent higher than the Canadian average.¹⁶ Studies on individuals with high levels of food insecurity (a good marker of severe poverty) have shown that they have three times the risk of suffering from a major depressive episode.¹⁷ They have a higher risk of isolation and poor social support,¹⁸ and of reporting stressful life circumstances.¹⁹

Children living in poverty are particularly susceptible to its deleterious effects²⁰ Canadian children living in poverty are more likely to develop a variety of illnesses and injuries, as well as suffer growth retardation and developmental difficulties.²¹ They are also more likely to experience hospitalization, mental health problems, and difficulties in school, such as lower school achievement and early school leaving.^{22,23}

Of course, many poor children do better themselves economically as they grow into adults. But to paraphrase an old saying, "While one can take a child out of poverty, one cannot take poverty out of the child."

Table 1
The Increase in Mortality Due to Chronic Conditions in Lowest Compared to Highest Income Quintile Neighbourhoods, 1996¹¹

Cause of Death		Increase in mortality in lowest vs. highest income quintile neighbourhoods
All Causes	Both sexes	32%
	Males	43%
	Females	16%
Ischemic Heart Disease	Males	31%
	Females	25%
Cirrhosis	Males	150%
	Females	-5%
Uterine Cancer	Females	50%
Lung Cancer	Males	56%
Mental Disorders	Both sexes	30%
Diabetes	Males	56%
	Females	47%

Table 2
Effect of Living on Social Assistance on Health Status*

Health Condition	Odds ratio for presence of condition among individuals living on welfare compared to individuals not living on welfare (adjusted for age and sex)
Poor/fair self-rated health	3.7
Major Depression	2.0
Poor Social Support	2.9
Heart Disease	3.7
Diabetes	2.5
Hypertension	1.6
Obesity	1.1

* Adapted from Vozoris NT, Tarasuk VS. *The health of Canadians on welfare. Can J Public Health. 2004 Mar-Apr;95(2):117.*

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Growing up in poverty often leaves lifetime scars. Children in low-income households experience a higher risk of health problems throughout their lifespans, independent of their later socioeconomic status.^{24,25}

Those living on social assistance have the lowest incomes of all and have the highest risk for health problems.^{26,27,28}

Data from the 1996-1997 National Population Health Survey, summarized in Table 2 (see p. 33), show the impact of living on welfare on the health of social assistance recipients.

Living on social assistance should be considered, with poverty, to be a major risk factor for ill health.

Why is poverty of such concern "now"?

The House of Commons passed a

unanimous resolution in 1989 to end child poverty by the year 2000. Yet, today, a higher proportion of Canada's children live in poverty than in 14 other countries belonging to the Organization for Economic Co-operation and Development (OECD), including Hungary, Greece and the Czech Republic.²⁹

Nationally, the 2007 child poverty rate of 11.7 per cent was exactly the same as in 1989 when parliament passed its resolution to end childhood poverty. The rate has moderated since a peak in the 1990s.³⁰

However, the situation is different in Ontario, where the child poverty rate is 12.6 per cent, having risen since 2001.³⁰ Nearly half of all of Canada's poor children live in Ontario.

In Ontario, the median income of many individuals and families dropped sharply in the 1990s due to both an economic recession and deep cuts to the social safety net.

Ontarians living on social assistance have seen their purchasing power decline during this time.³¹ Ontario Disability Support rates were not raised from 1993 to 2003, and the increases since have not kept pace with inflation. Similarly, Ontario Works recipients had their rates cut by 22 per cent in 1995, frozen from 1995 to 2003, with only minimal raises since.

In 2005 constant dollars, the income for a family of four receiving social assistance in Ontario dropped from \$22,102 in 1986 to \$19,302 in 2005.³²

In November 2007, the United Way of Greater Toronto reported that poverty levels are continuing to climb; that one in five of Toronto's two-parent families were low-income in 2005; and that families are falling behind families in the rest of the country.³³

Equally disturbing are the trends of growing levels of precarious employment, increasing applications for evictions related to the non-payment of rents, and rising levels of indebtedness.

Some jurisdictions, such as Que-



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bec, Newfoundland and Labrador, and Ireland, have made official commitments to poverty reduction. These examples provide us with both inspiration and important lessons for decreasing poverty in Ontario.

Ontario Premier Dalton McGuinty has pledged to develop a comprehensive government strategy to reduce poverty. He has appointed Minister of Children and Youth Services Deb Matthews as Chair of a Cabinet Committee on Poverty. Minister of Health and Long-Term Care George Smitherman is the committee's vice-chair. The committee is to issue its report by the end of 2008.

Upcoming articles

For more than a decade, researchers, physicians, other health professionals, and public health providers have been calling for action on the health problems caused by the province's deepening social inequalities. Ontario's physicians can help to encourage meaningful government action on poverty, at all levels, to build a healthier future for all our patients.

This is the first in a series of articles for physicians on poverty. The second article ("Identifying Poverty in Your Practice and Community," on pages 39-43) addresses issues in the definition and measurement of poverty, and provides doctors with helpful indicators that can be used at the practice level and as population health assessment tools.

The third article ("Strategies for Physicians to Mitigate the Health Effects of Poverty," on pages 45-49) focuses on what doctors can do to effectively respond to and address poverty with their patients, and in their communities.

A fourth article, scheduled to appear next month, will consider high-risk groups in which poverty may be hidden or particularly severe.

The fifth instalment will present the evidence for policies that mitigate and prevent poverty.

The authors hope that the series will enable colleagues to better respond to the individual patient's poverty-

Appendix

Selected major Canadian government reports expressing the need to address poverty as a health issue

- Canada. Parliament. Senate. Special Committee on Poverty. Poverty in Canada. [Chair: D.A. Croll]. Ottawa, ON: Information Canada; 1971.
- Ontario. Social Assistance Review Committee. Transitions: report of the Social Assistance Review Committee. [Chair: G. Thomson]. Toronto, ON: Queen's Printer for Ontario; 1988.
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- Canada. National Council of Welfare. Solving poverty: four cornerstones of a workable national strategy for Canada. Ottawa, ON: National Council of Welfare; 2007 Winter. [National Council of Welfare Reports, v. 126]. Available from: <http://www.ncwcnbes.net/documents/researchpublications/ResearchProjects/NationalAntiPovertyStrategy/2007Report-SolvingPoverty/ReportENG.pdf>. Accessed: 2008 Apr 25.

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related problems and to participate in the current public policy debate about reducing poverty in Ontario.

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