Richmond Poverty Response Committee

Submission to the BC Government Select Standing Committee on Health
Re: Health Sustainability

December 2014

Background

This submission is made on behalf of the Richmond Poverty Response Committee in response to the request to identify potential strategies to sustain the health care system. Our submission provides information on the effects of poverty on health and addresses sustainable health care through the lens of the social determinants of health.

Since 2000, our coalition has completed several community projects to alleviate the effects of poverty in our community. We also advocate for systemic change that will result in the reduction of poverty among Richmond residents and prepare reports and research to better understand poverty in our community. Our coalition consists of individual members and representatives of faith groups and community agencies that serve low-income residents.

Overview

This is what we know about poverty in Richmond, based on the work we have done within our community and input from our members working with people living in poverty. Note the population of Richmond is about 200,000 residents.

- 22% of population of Richmond are low-income
- 25% of children under 18 live in poverty
- First Call Child Poverty Report Card mapped two Richmond neighbourhoods with over 40% of children living in poverty
- 19% of seniors live in poverty
- Richmond numbers are not available but in BC one third of recent immigrants fall below the poverty line
- First Call Child Poverty Report Card identified a growing level of income inequality with 50% of BC families in low-income receiving 25% of the total income and the richest 10% of families receiving 24% of the total income

The Social Determinants of Health

A 2010 report by Dr. Perry Kendall[1] noted the importance of considering how disease affects an individual's quality of life and thus impacts the larger community. The report points out that health is not only dependent on acute, life-or-death healthcare services but rather on other non-medical and alternative models of healthcare that are integral and essential working parts of the system (such as mental health facilities, community clinics, "better at home" programs). Other key points made in relation to poverty include:

- Risks factors for chronic disease can be exacerbated by stressful or harmful conditions, policies or practices in our homes, schools, workplaces and communities, which shape our ability to make "healthy choices."
- Those with the most resources (highest incomes, most education, good housing, etc) consistently have the best health and live the longest lives. Those with the fewest resources (lowest incomes, poor education, bad housing, cheap food, etc) have the worst health and the shortest lives.
- The effects of low socio-economic status can be generational making it both a cause and an outcome of poor health. Studies show that the lowest socio-economic groups are more often and more seriously sick or injured.
- People of lower socio-economic status groups use approximately twice the amount of health care services as those in the highest income group, their hospitalization rates are higher and health disparities associated with poverty are cost to our economy and the healthcare system and thus for true sustainability, the root causes of these inequities should be addressed.

The report concludes that a system is burdened by poor health outcomes resulting from social inequity is economically and otherwise unsustainable. The mounting evidence is that spending more on health care will not result in significant further improvements in population health. However, "there are strong and growing indications that other factors such as living and working conditions are crucially important for a healthy population."[2]

[1] Dr. Perry Kendall Provincial Health Officer, Investing in Prevention: Improving Health and Creating Sustainability, Sept 2010

[2] Towards a Healthy Future, a Second Report on the Health of Canadians, Public Health Agency of Canada, 1999

The Health Care Gap

Recent reports by the Health Officers' Council of BC and Statistics Canada have shown that health inequities and child poverty in BC have worsened over the past several years.3 Given the elevated risks for those with low income, interventions to prevent or mitigate poverty, particularly among households with children, should be a high priority if the ultimate goal of improving the health of British Columbians is to be achieved, and the goals set out in the 'Guiding Framework for Public Health' are to be met.[4]

In order to build sustainability into the health care system, it is vitally important to address the health inequities that low-income families and individuals face. Current service models are rife with barriers and difficult to access unless a person has the time to spare and the right contacts. Alternate models of delivering health care to underserved populations do exist and it has been shown that these models improve the health of the rest of the population as well.

Removing Barriers to Accessing Health Care

Income Support:

The BC government could bring an evidence-based approach to improving health and wellbeing to the forefront of their decision-making. Numerous analyses have demonstrated that programs to alleviate poverty can pay for themselves through, for example, increased tax revenues, reduced health costs, lower crime, and increased productivity.

"Poverty is a disease and treating poverty works like medicine. In societies with less poverty, and with less inequality, the evidence shows that everyone is healthier, even the well off. Our governments can continue to legislate poverty and ill health, or they can build legislative bridges to a healthier life for everyone. These bridges would include a minimum wage that brings workers above the poverty line, and social assistance rates that enable people to pay the rent and eat a basic healthy diet. They are also made of policies that allow people to participate in society and protect their health, such as affordable childcare and universal pharmacare."[5]

Interdisciplinary Teams:

The fee for service model only allows physicians to bill the government for one ailment at a time. Although this model encourages physicians to provide a high volume of services, fees are not linked to patient outcomes. "This restricts physicians from working in interdisciplinary teams, which have been shown to improve patient satisfaction, access and equity."[6]

"The fee-for-service model is expensive, because it incentivizes illness care rather than prevention. It is also expensive for patients, who bear the burden of having to come back again and again for various issues. But there are better options. In a 2012 research study published in the medical journal Canadian Family Physician, we heard from 133 recently graduated family doctors in B.C. and 71 per cent preferred progressive models of payment as opposed to the one-problem-per-visit style of practice that we buy in fee-for-service."[7]

Health Clinics:

Multi-service health clinics work for people on low-income because they can have a number of ailments treated in one visit and not spend time and travel coming back again and again. The clinic becomes a place where they feel comfortable and can establish good relationships with care providers. "Research increasingly suggests that when nursing and other health-related sciences focus their attentions on the social determinants of health, we will achieve improved health status and greater health equity in the populations we serve."[8] A local story illustrates the success of this model. "As Chair of Basics for Health Society I met with Vancity and the Health

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[3] Health Officers Council of BC http://healthofferscouncil.files.wordpress.com/2012/12/health-inequities-in-bc-april-15-2013

[4] BC Healthy Living Alliance On the Path to Better Health http://www.bchealthyliving.ca/engagereportson-the-path-to-better-health/

[5] Dr. Gary Bloch, St. Michael's Hospital, Toronto, founding member of Health Providers Against Poverty, expert advisor with EvidenceNetwork.ca, Speaker at "Poverty-Health Hazard for All," September 23, 2014.

[6] Russ Jones, MBA, CA, BC Government Auditor General, Oversight of Physician Services report: "An audit to determine whether the Ministry of Health, health authorities, and the Medical Services Commission are ensuring that British Columbians receive value for money for physician services" February 2014.

[7] Dr. Vanessa Brcic, Vancouver family physician, clinician scholar Department of Family Practice UBC, The Tyee, Feb 21, 2014.

[8] Upstream Nursing Practice, Evans, T., Whitehead, M., Diderichsen, F., Bhuiya, A., & Wirth, M. (2001). Challenging inequalities in health: From ethics to action. Retrieved May 22, 2004 from http://www.rockfound.org/

Connection clinic in North Vancouver, a grassroots health clinic for homeless and marginalized patients. Their stats dropped my jaw to the floor: In the 9 months since the clinic had been open, hospital admissions from the ER dropped by over 50%. The average inpatient stay of Health Connection patients dropped from 12 days to 4 days. The number of ALC days in hospital (days that patients were sleeping in a hospital bed simply because they didn't have anywhere else to go), dropped to zero. Patients said they felt safe, respected and validated at the clinic. This is the stuff of gold standard primary care."[9]

Integrating Seniors Care:

Nineteen percent of Richmond seniors live in poverty and many are new immigrants. Lack of transportation, language difficulties and the need for others to help them navigate the system are barriers to equitable access to health care. Seniors health care is divided into departmental and ministry silos depending on how chronic or acute their health condition.

In a 2011 paper, health policy researchers Dr. Neena Chappell[10] and Dr. Marcus Hollander[11] called for an integrated system of continuing care delivery instead of the disconnected web of services we currently have. An integrated system would provide lower cost, seamless care for seniors across a wide range of health and supportive services, community services, long-term care facilities, specialized geriatric assessment and treatment units in hospitals. All services would be in one system, with one overall budget, and care would be coordinated by professional case managers who can assess needs, develop customized care plans, and authorize access to any of the services in the integrated system or in acute care hospitals.[12]

Universal Pharmacare:

Canada remains the only industrialized country with universal health insurance but no national pharmacare policy for its citizens. Just as access to a family doctor or emergency department is crucial, access to drugs is essential for a truly responsive and sustainable health care system. In addition to the economic benefits, the social benefits of pharmacare would be to ensure access to essential prescribed medications, particularly for those who are most in need and least able to pay.

We pay around $5 billion out of our own pockets for prescription drugs every year. The result: one in 10 Canadians cannot afford their prescription drugs, and others are facing grim trade-offs between buying their needed prescription drugs, and food or rent.[13] A recently released report notes that universal, publicly funded pharmacare is the dominant standard in most OECD countries. The report calculates savings of up to $11.4 billion a year if Canada had national universal pharmacare. Countries with integrated pharmaceutical coverage achieve better access to medicines and greater financial protection for the ill at significantly lower costs than any Canadian provinces can achieve.[14]

Addiction and Mental Health Services:

Those with the few resources in the social determinants of health make up the majority of people suffering with addiction and mental illness. Improving services to these individuals improves their health and their ability to form social connections.

A blue ribbon panel on crime reduction appointed by BC Justice Minister Suzanne Anton made recommendations to expand drug treatment and services for the mentally ill and to provide more wraparound services to recidivist offenders. The report cites estimates that every dollar spent curing addiction cuts drug-related crime and justice costs by up to $7, and $12 if health care costs are counted. The panel report said lack of access for drug and alcohol addiction treatment was a major issue across the province.[15]

Recommendations:

The Richmond Poverty Response Committee urges the Standing Committee on Health Sustainability to recommend to the BCC

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[9] Dr. Vanessa Brcic , CCPA Policy Note October 21, 2014 http://www.policynote.ca/category/health-care/

[10] Neena Chappell, Canada Research Chair in Social Gerontology, Professor, Centre on Aging & Dept. of Sociology, University of Victoria

[11] Marcus Hollander, Hollander Analytical Services Ltd, Victoria, An Evidence-Based Policy Prescription for an Aging Population 2011

[12] ibid http://www.longwoods.com/content/22246

[13] Michael Law, Associate Professor, Centre for Health Services/Policy Research, School of Population/Public Health at UBC and expert advisor Evidence Network, Toronto Start, Sept. 27, 2014

[14] A Roadmap to a Rational Pharmacare Policy in Canada, Marc-André Gagnon, PhD School of Public Policy & Administration Carleton University, June 2014

[15] Jeff Nagel, Richmond Review, December 4, 2014

government the following strategies to sustain the health care system.

- Establish a BC poverty reduction strategy with targets and timelines
- Raise income assistance rates and index them to inflation
- Increase the minimum wage and index it to inflation
- Address the structural barriers faced by marginalized groups
- Re-commit to building more social housing units
- Establish pilot studies of interdisciplinary health teams in clinic settings
- Integrate seniors care into a continuum of care with one system and one budget
- Establish a BC Universal Pharmacare Plan
- Lobby the Federal government to establish a Universal Pharmacare plan for all Canadians
- Provide more services and facilities for people with addictions or mental illness

Respectfully submitted for the Richmond Poverty Response Committee on December 31, 2014 by:

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