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Poverty is an insult to our values

BY MARK CHAMBERLAIN

Mark Chamberlain is president and CEO, Trivaris, and chair, Hamilton Roundtable for Poverty Reduction.

As Canadians we embrace values of shared responsibility and a collective destiny, and yet more than three million of us live in poverty.

A 2008 national poll found that 88 per cent of Canadians say Canada should try to distinguish itself in the world as a country where no person lives in poverty.

We have fallen far short of this goal as evidenced by the deepening economic disparity in many inner-city neighbourhoods.

Over the past 30 years, we as a city, province and country have made only incremental progress on the overall reduction of poverty. Today, one in nine Canadians still lives below the poverty line. This reality exists despite tremendous efforts by exceptional volunteers, charities, not-for-profit organizations, foundations and government partners.

Is poverty not a serious enough problem to merit an immediate solution? Is poverty too expensive to fix? Or is poverty simply too complex for us as a community to find appropriate, sustainable solutions?

To the first question, countless reports, longitudinal studies and investigations written over the past 30 years suggest that poverty is sickening — literally.

The total number of individuals affected by poverty far exceeds the number of individuals affected by SARS, H1N1, C difficile and West Nile virus combined, and has far more serious individual and population health outcomes.

As early as 1967, researchers such as Sir Michael Marmot have repeatedly shown that the higher a person's income or social status, the healthier and longer life that person will enjoy. Reductions in lifespan and other negative health outcomes caused by poverty are catastrophic public health issues.

To the second question, economic cost is an important consideration when mounting a response to a serious health problem; but so is the cost of not mounting an adequate response.

According to a 2008 Ontario Association of Food Banks report, failure to eliminate poverty costs the private and public sectors in Ontario more than $30 billion a year. Put another way, this report states, "In real terms, poverty costs every household in the province from $2,299 to $2,895 each year."

It takes investment to eliminate poverty. Yet continuing to pay for the negative health and social outcome costs are simply unaffordable.

To the third question, it's not poverty that is complex, it's the negative health outcomes caused by poverty that are complex.

The simple steps to reducing the risk of complex personal health issues are being active and eating well. The simple step to reducing the risk of negative health impacts caused by poverty is an adequate income.

With an adequate income, most can afford the necessary healthy food, shelter and discretionary income for their own and their children's participation in their community. And with some control over your own life comes dignity. Income is a simple prerequisite baseline for both personal and population health, similar to exercise and good nutrition.

Poverty is a catastrophic health issue, it costs us more than $30 billion per year in Ontario, and something as simple as an adequate income can significantly reduce its devastating effects. So why does poverty still exist?

The good news is there are solutions that could eliminate poverty in five years.

A solution to poverty, however, is not dependent on new knowledge; rather it is dependent on a fundamental shift in how we view it and the urgency we place on solving it. First, we need to change the conversation about poverty from "charity" to "health," and from "social cost" to "investment in human development."

Second, the urgency must be driven from our personal and our collective values, not our economics.

It's about personal values because although 88 per cent of us have stated we want to eliminate poverty, what percentage of us would agree to pay more for a cup of coffee to ensure those serving us had better health as a result of making a living and just wage? It's about collective values because politics and economics must always have direction, and that direction is set by our collective values.

Do we believe paying individuals a just, living wage for a hard day's work is critical to a person's health? Should we provide a combination of adequate income and supports to those who have a barrier to full employment due to a disability? Do we believe in providing adequate transitional support to help those unfortunate to be between jobs? And are we prepared to look at, and even experiment with, broad solutions such as a Guaranteed Annual Income that would ensure every working-age individual receives a living income thereby ensuring a baseline of personal health?

These are fair, just and simple solutions, but they will require courage driven by our values to enact.

Good values have always led good economics. Good values created the economics for immediate and complete responses to SARS and H1N1. Good values are the reason why child labour and slavery were abolished and universal health care and education introduced.

These value decisions did not destroy the economy, rather they strengthened it. If urgency is value driven, then we must act immediately to reflect our values in our government policies, the wages we pay in our businesses, and how we as individuals act to support an adequate income for everyone.

We don't need a perfect solution, we simply need a better one.

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Why does it still exist?

Hopeful Hamilton is committed, generous

BY DR. CHRIS MACKIE

Dr. Chris Mackie is one of Hamilton's associate medical officers of health and an assistant professor in McMaster University's Department of Clinical Epidemiology and Biostatistics.

Money can't buy me love — but it can buy health.

It's one of those ugly facts of life. Rich people live longer, healthier lives than the poor.

In public health, it has become a cliché that the lower your income, the more likely you are to get sick – from infectious diseases such as tuberculosis or chronic diseases such as diabetes, heart disease and lung cancer.

Last year's H1N1 pandemic could not have highlighted this more clearly. True, the virus put a strain on the health system here in Hamilton, but fortunately deaths were rare.

By contrast, H1N1 devastated communities that face more severe poverty. On reserves in northern Manitoba, whole communities became ill, and many people died. Mexico, where the swine flu virus originated, was overwhelmed.

Death tolls were much higher than in Canada, owing largely to poor nutrition and housing conditions that made it easy for the flu to spread.

So why is there such a variation in health even here in Canada, where access to health care is free to all?

If we are all using the same health care system, why are our poor so much sicker? The answer is that health care only accounts for about 25 per cent of health, maybe less.

Social and economic factors are far more important. Income is linked to health through access to adequate nutrition, housing, education, child care and personal health behaviours.

My first experience working in a First Nations community was in a nursing station in Lac Brochet, a tiny, remote reserve in northern Manitoba. Most people lived on social assistance of one form or another, well below the poverty line.

While a fortunate few in "Lac" had reasonable housing, many lived in plywood shacks with no running water. With families of eight to 12 crammed into two rooms, viruses and bacteria spread fast.

Milk cost $14 for a two-litre jug, but potato chips were cheap — so adequate nutrition was hard to come by. Less than a quarter of adults had high school diplomas.

It was hard to see people living that way. As a medical student, all I could do was treat the illness that I saw. Throat, skin and lung infections were very common in my patients, and many did not live long enough to experience diseases such as heart disease.

At the time, I didn't know that the community had the highest rate of tuberculosis in the world. TB infection indicates poor overall health and is closely linked to poverty. At over 100 times the Canadian average, TB was more common in Lac Brochet than in the slums of South Africa.

Here in Hamilton, we are a lot more fortunate than the people living in the Third World conditions of Lac Brochet. No one has to live five or six crammed to a room. Virtually everyone has access to clean running water, and healthy food is much more readily available.

But as this Code Red project shows, we still have huge differences in health between neighbourhoods.

This is upsetting, but not surprising. Your neighbourhood is closely linked with your income, so the relationship with health outcomes should be expected. And while income differences within Hamilton are nothing like the differences between Hamilton and Lac Brochet, they are still enough to produce most of the differences in health that we see in Code Red.

Nutrition, child care and education represent some of the pathways linking income and health in Hamilton. Think of how much cheaper sugary, fatty, salty foods are, and what people on low incomes can afford.

Try to find high-quality child care at an affordable rate, and consider how important those early years are for building a strong base of learning and development for a child's future.

University tuition rates have skyrocketed. How hard would it would be for a family living on minimum wage to send their children to McMaster?

While virtually everyone in our city is better off than the majority of people in Lac Brochet, we still have huge gaps in health between our rich and poor for reasons such as these.

Fortunately, there is hope here in Hamilton.

We live in a city where people are willing to put time, effort and money into caring for those who are less fortunate. We have made a collective commitment to make Hamilton the best place to raise a child because we recognize that happy, healthy children are more likely to grow up into happy, healthy adults, and more likely to build a happier, healthier community.

And this commitment is not just on paper. Hamiltonians donated almost $5 million to the United Way last year, and the Hamilton Community Foundation invested another $3.4 million in poverty reduction, strengthening neighbourhoods and protecting our environment.

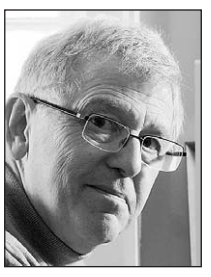
Last year at a Hamilton Timeraiser event, young adults committed more than 3,000 hours of volunteer time — a small fraction of the volunteer work being done in our city, but a big indication of how willing we are to give help when asked.

The municipal, provincial and federal governments are all contributing as well, but they need our help as citizens. Good political leadership doesn't come out of thin air — but it will come when the people demand it. Politicians need us to support their efforts to improve the economic conditions of those less fortunate.

If you care about improving the health of people who are less fortunate, take the time to get involved in the political process by contacting your representative or speaking out in whatever way you can.

Made-in-Hamilton poverty-health solution

BY NEIL JOHNSTON



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Outrage is the word I select to best describe my reaction to this series and what it reveals about our community. That such a waste of human potential and its consequences to our health, justice and education systems can reach the point it has requires radical change.

It is not simply a moral priority. The chasm between neighbourhoods in the downtown core and the suburbs in determinants of health and health-service use is perhaps the most important reason why Hamilton will never be able to regain the prosperity it enjoyed 40 years ago.

No matter what is achieved in attracting business investment to Hamilton, it will have little real value unless we simultaneously invest the same energy to eliminating disparities in the determinants of health in our community. Success in that endeavour will probably take a generation to take full effect.

If I had to pick out one statistic that truly appalled me, it was the percentage of low birth-weight babies born in Hamilton. Fifteen years ago when the Ontario government set out to "restructure" the province's hospitals, I was asked by the Hamilton hospital CEOs of the time to create profiles of health-service use in Hamilton similar to those used for this series. At that time, the low birth-weight percentage was roughly 7 per cent. Two years ago, it was near 8 per cent.

So all of the investment growth in our health-care system that has occurred over that time does not appear to have improved one of the most important determinants of lifetime health.

There are many fine programs aimed at improving pregnancy outcomes and many dedicated people doing what they can, but unless a systemic long-term commitment is made by the province and civic leaders to reduce poor pregnancy outcomes, with very clear accountability for achievement of policy targets, the problem will continue.

We don't have to invent something. There are many good examples of systemic approaches to prenatal care in other countries as well as elsewhere in Canada. Band-Aid programs that sound wonderful in political speeches won't cut it.

We have built a health care system in Hamilton that we can be rightly proud of, one that should be the envy of many communities in Canada. We have access to medical, nursing and therapy specialists without equal, and our hospitals achieve outstanding outcomes.

Given Ontario's current financial situation and the growing proportion of tax revenues spent on health care, it's worth asking if our health system is sustainable as it is. The answer is: probably not.

At the very least, that should provoke some serious questions about how the "health system" currently operates.

Our hospitals and emergency rooms have become the default option for managing problems that are fundamentally social in origin, and in many cases beds are filled by people with no better alternative to meet their needs.

So the most expensive health care resource we have — designed to provide acute care and restore people to health — becomes, in many cases, a nursing home.

In Hamilton, few hospital beds remain empty at any time, and health care professionals are forced to compete for them when they are. Huge advances have been made in surgical and diagnostic procedures such that many patients do not require a hospital bed.

However, the decision to send a patient home should not be influenced by an ongoing lottery for bed access. There is a social component to this as well because those who have family support and are capable of understanding their discharge instructions may run the risk of being discharged too early for their own good.

Our hospitals are not to blame for this situation, they are victims of the complete incoherence of social policy in Ontario; and the fix requires that the health, social welfare, and perhaps justice systems undergo radical change driven by explicit policies and accountabilities. There will be savings if this occurs, but it requires a generational commitment.

One obvious area for innovation is the pathetic track record for adoption of information systems in the health and social welfare systems.

If our banks were run like the health system, they'd be sending runners between branches with transaction slips or perhaps using carrier pigeons. The problem in the health system is that if there is no timely transfer of clinical information between and among health-care providers, people die.

In the absence of coherent provincial leadership, it's worth asking if improvements can be achieved in Hamilton with civic leadership. I believe they can.

The leaders are already here. The motivation should be recognition that Hamilton's future economic success will be fostered by improving the health of our people.

Who will pick up the torch?