Public Health and Poverty

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Montreal, the poverty capital of Canada! For decades, Montreal has held this sad distinction, as year in year out, one third of its population falls below the Statistics Canada low-income cutoff. Moreover, many problems related to social inequalities are concentrated in the densely populated neighbourhoods in the city centre and the north-south corridor, thus forming a geographic “T” of poverty which successive censuses confirm with discouraging consistency. Unemployment, social assistance and a low percentage of higher education round out the picture of economic poverty. That was the situation in the city when the Direction de santé publique (DSP) de Montréal was created in 1992.

Through its programs and interventions on public policies, can public health help reduce poverty in a population? Can poverty’s impact on the poor be reduced or can poverty even be prevented? This was the challenge the DSP set for itself from the outset and which has appeared one way or another in its policies and programs ever since.

The DSP’s concerns are not new. Considering the history of public health in Montreal,1 one sees that around 1850 there were already concerns for women and young children in underprivileged environments. Young women there were dying of postpartum fever and children were dying of various infections, especially respiratory. Over time, the causes of death change but the disparities in the face of disease and death remain.

In fact, the DSP has no choice but to intervene regarding poverty and social inequality if it truly intends to improve the population’s state of health. With the great physicians of the 19th century (Chadwick, Virchow) having shown the way, modern scientific literature – of which the Black report2 is a fine example – confirms the significance of the problem in terms of higher rates of incidence, prevalence and severity of disease and mortality. Whether cancer or any other chronic disease, trauma, infections or mental health, the disadvantaged almost systematically experience poorer health, and in the rare circumstances for which their health indicators appear better – as for instance with breast cancer incidence in Montreal – these do not translate into lower mortality rates. In addition, the Whitehall studies3 also showed that health inequities were graded across the various social classes categories. Social inequalities were not only determinants of poverty but also determinants of the health of populations.

The first DSP annual report was published in 1998.4 Entitled “Social Inequalities of Health”, it reported specifically on the work of the knowledge and surveillance team which, having studied health statistics on a geographic basis, discovered a 10-year difference in life expectancy between upper-class neighbourhoods and the others, with these differences being still more striking with regard to life expectancy in good health. On the Island of Montreal, some areas compare favourably with the most advanced societies with regard to health, whereas others rank with middle-income countries. The segments of the population that are most severely impacted are single-parent families, single people, and certain ethnic groups of which more than 50% of members were living below the Statistics Canada low-income cutoff in 1996. The report also confirmed that disparities existed for an entire range of health problems. This work received a great deal of attention from Montreal decision-makers and was the starting point for the creation of a partnership framework for city-wide social development efforts.

The description of social and health inequalities provoked as much interest as it did questions on interventions likely to reduce them. The model adopted by the national program in the Netherlands5,6 for assessing interventions illustrates that socio-economic status influences various mediating determinants leading to poor health, which in turn can result in a deterioration of social conditions. Public health programs and interventions are therefore called upon, which could paradoxically result in increasing the gaps in health if particular attention is not given to reaching the most underprivileged segments of the population. A case in point is tobacco-use control programs, which are less readily taken up in low socio-economic settings.

Although specific programs are implemented by the DSP, the impact of low income is more pronounced in some critical aspects of people’s health. For example, because housing costs cannot be reduced, the poor balance their budgets by cutting their spending on food. The DSP is aware of the importance of food insecurity and devotes a portion of its resources to addressing this issue.7

The concern with reducing social inequalities in health remains constant in all programs. In one annual report after another, various public health interventions are addressed. The challenges of aging,8 organizing the care system for improving the population’s health,9 and mental health10 were addressed taking social disparities and the most vulnerable populations into account. In 2002, the annual report on urban health11 again took stock of the inequalities by comparing Montreal to the other major cities in Canada. Although a noticeable improvement could be observed over time, the persistence of socio-economic and geographic disparities, as well as a lag compared to the other cities in Canada, were still noted.

The DSP units and their city partners are now implementing new interventions in the built environment and public transport areas, as shown in the most recent annual report.11 These new areas present the same challenges: understanding the impact on the health of the most vulnerable and, above all, working to reduce this impact.

Beyond its specific programs and actions, the Montreal DSP has attempted to be a driver of social change by publicly taking posi-

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tions that foster the protection of the poorest people’s health. Based on rigorous scientific data, the DSP produced scientific reports on public policy proposals which could not be ignored but which occasionally produced fairly strong reactions on the part of social and economic stakeholders who had little inclination to see public health go beyond matters pertaining strictly to immediate health protection. For example, a development project involving the installation of a significant number of video poker terminals near a low socio-economic neighbourhood was thus called into question by the DSP, to the great displeasure of the development’s promoters. More recently, the various highway development projects within the city have been called into question, specifically due to studies produced by the Direction de santé publique, showing a possible deterioration in the respiratory health of individuals living near major highway corridors, many of whom would find it difficult financially to relocate.

Conscious of the major impact socio-economic status has on a multitude of health problems, the DSP has made an investment in the future, creating an observatory of social inequalities in health and subsequently lending its support to a research team which was active in the development of the Quebec law “An Act to combat poverty and social exclusion”, R.S.Q. c. L-7 (Law 112), which was unanimously adopted by the Quebec National Assembly in December 2002.

That which is measured improves. With a view to throwing light on its work and assisting its partners in mobilization, the DSP now aims to expand its observatory on social inequalities in health in the various locations where the inequalities are experienced. Working closely with the ministère de la Santé et des Services sociaux du Québec [translation: Quebec ministry of health and social services] and the 12 local Centres de santé et de services sociaux [translation: health and social services centres] in the Montreal area, the DSP is supporting local health and social workers by providing information systems and other tools they need. Whether by evaluating immunization coverage in underprivileged areas, calculating trauma from motor vehicle accidents involving pedestrians in downtown neighbourhoods, or measuring accessibility to primary health care services, the information produced or collated by the DSP should allow an ongoing assessment of public health interventions, an integrated approach by the various local actors, as well as the documentation necessary for advocacy work with the various levels of government.

Finally, although this phenomenon is adequately understood to justify action, the DSP has been encouraging research on social inequalities of health by housing a CIHR research development centre dedicated to this field, the Centre Léa Roback, since 2002. The Centre involves researchers from Montreal’s four universities as well as from public health institutions.

Reducing poverty and its impacts on health is obviously a social and public policy issue which goes beyond the mandate of a regional public health department. But health (40% of the province’s budget) is a priority for the population and its leaders and if our role is to protect and improve health, we must join with other government, community and philanthropic partners to not only promote the value of health but to make it accessible to the greatest number of people, especially the most vulnerable.

Since we know that education and income are the most significant factors for improving health, and that for decades the poorest have had poor health from one generation to the next, public health needs to move beyond the comfort of the disease paradigm. Examining long-term solutions like early childhood development and academic success in underprivileged neighbourhoods become strategies that are just as necessary as those that target the prevention of obesity or cardiovascular diseases.

However, recognition of the legitimacy of our involvement in social and economic policies having an impact on health will only come from fully assuming our responsibilities for health protection. Health is our only justification, but what better justification could there be?

References

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