Advancing Health Equity through Benefits Screening

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This article is the sixth in a series on Poverty and Human Rights in Canada.

SUMMARY: This article explores benefits screening, a system of auditing patients to identify those living in poverty and the benefits they may be eligible for, as an innovative step towards realizing the right to health in Canada by advancing health equity.[1] In particular, it assesses one online tool developed by Prosper Canada, the St. Michael's Hospital Academic Family Health Team, Flemingdon Health Centre, and the Inner City Family Health Team. To date, the tool has been piloted in Toronto at health centres with large numbers of low-income patients with complex health needs.

RÉSUMÉ: Cet article explore un système d'évaluation des patients en vue d'identifier ceux qui vivent dans la pauvreté ainsi que les prestations auxquelles ils peuvent être admissibles; cet outil de dépistage est une mesure novatrice ayant pour but de concrétiser le droit à la santé au Canada en faisant la promotion de l'équité en matière de santé. On évalue particulièrement un outil en ligne élaboré par Prospérité Canada en partenariat avec le Academic Family Health Team du St. Michael's Hospital, le Flemingdon Health Centre et le Inner City Family Health Team. À ce jour, dans le cadre d'un projet pilote mené dans des centres de santé de Toronto, l'outil est utilisé avec de nombreux patients à faible revenu ayant des problèmes de santé complexes.

Despite universal healthcare coverage, there is ample evidence that health disparities exist across the country and disproportionately affect vulnerable groups, such as Indigenous people, visible minorities, and people with low incomes. First Nations citizens' life expectancy is between five and seven years less than non-Indigenous Canadians (Assembly of First Nations, 2011). Immigrants from non-European countries, primarily from Asia, are twice as likely to report

declining health as those from European countries (Hyman, 2009).

Meanwhile, in Toronto, when compared with the health status of the highest income group, men in the lowest income group are 50% more likely to die before age 75 and women in the lowest income group are 85% more likely to have diabetes. Additionally, young women aged 15-24 in the lowest income group are twice as likely to be reported with chlamydia infection, and babies in the lowest income group are 40% more likely to have a low birth weight (Toronto Public Health, 2015).

What explains such disparities in a country with universal healthcare? Although Canadians are fortunate to have universal care, research shows poverty is one of the most significant contributors to health disparities (Mariner, 2016; Marmot, 2015). The 2012 Canadian Income Survey indicates that 13.8% of the total Canadian population (or 4.7 million people), and 16% of children, lived in households with low incomes in 2012. Certain groups are more likely to have low incomes: lone parents (especially female-led, lone-parent households); newcomers; people living with disabilities; and Indigenous Canadians.

Poverty is often at the root of poor health and poor access to healthcare. There is evidence that those with higher socio-economic status enjoy more frequent access to almost every available health service than those with lower socio-economic status (Canadian Medical Association, 2012). In addition, disadvantaged groups are less likely to receive appropriate healthcare even if access to the system is available (Dunlop, Coyte, & McIsaac, 2000), and many Canadians with low incomes have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs (Public Health Agency of Canada, 2013). For example, those living on low incomes are three times less likely to fill prescriptions and 60% less able to get access to necessary tests due to cost (Mikkonen & Raphael, 2010).

While access to healthcare is an important determinant of health, there is strong evidence that social and economic factors – such as income and social status, education, and physical environments – have an even stronger influence on health outcomes than healthcare (Canadian Medical Association, 2016; Keon & Pépin, 2008a; Link & Phelan, 1995). Research suggests that biology and genetics determine 15% of a population health, physical environments determine 10%, the health care system is responsible for 25%, and our social and economic environments account for 50% (Keon & Pépin, 2008b). As such, the "conditions by which people are born, grow, live, work and age," also known as the social determinants of health, are the fundamental drivers of population health (World Health Organization).

Many of the behaviours and environments that place an individual at high risk for chronic disease are conditioned by poverty. As health law scholar Wendy K. Mariner observes, "the ability to practice 'good' or healthy behavior is not equally distributed across populations . . . It cannot be assumed that everyone is able to eat well or exercise adequately (Mariner, 2016, p. 296)." Poverty creates a barrier to preventive behaviour and can lead to stress, physical illness and mental illness. A study by the World Health Organization found that unemployment and economic instability cause significant physical and mental health problems for unemployed individuals and their families. In Hamilton, Ontario, the lung cancer mortality rate in the lowest-income neighbourhoods is 15 times higher than in the highest income neighbourhoods (Buist, 2013). Additionally, women and men from the lowest-income areas in Ontario are almost twice as likely to be hospitalized for depression (Lin et al., 2009).

Despite such strong evidence connecting low income to poor health outcomes, Canada lacks explicit national and provincial strategies to address social determinants to improve health (Raphael & Brassolotto, 2015). While key government actors, such as the Public Health Agency of Canada and the Canadian Senate, have documented the importance of the social determinants of health and have recommended that diverse sectors work together to improve health equity (Keon & Pépin, 2008a), this has yet to become a government priority (Raphael, 2015).

In order for the public health system to improve the health of *everyone*, public health policy needs to address the underlying causes of illness (Kickbush & Gleicher, 2012; Mariner, 2016). Since there is no shortage of evidence that health is intimately related to income, promoting this shift in governance is a largely political endeavour that requires engagement and support from the general public and with researchers and policymakers outside of the health sector (Miele, 2016; Raphael, 2016). Stakeholders must anchor efforts to build broad-based support in a paradigm that positions health as both a social and medical issue. To this end, the right to health provides a framework that brings equity and health together.

Advancing health equity through a human rights framework

The *Universal Declaration of Human Rights* (UDHR) (1948), Article 25, first articulated the idea of a "right to health:"

Everyone has the right to a standard of living adequate for the *health* and wellbeing of himself and of his family, including food, clothing, housing and *medical care* and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

By including health as an entitlement, the UDHR laid the groundwork for the development of subsequent international expectations and commitments with respect to health promotion, protection and care. However, the *International Covenant on Economic, Social and Cultural Right*s (ICESCR) (1966) provides the most comprehensive article on the right to health in international law. Article 12.1 of the covenant recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Article 12.2 enumerates a number of "steps to be taken by the States parties . . . to achieve the full realization of this right." These include "the improvement of all aspects of environmental and industrial hygiene" and the "creation of conditions which would assure to all medical service and medical attention in the event of sickness."

In 2000, the UN Committee on Social, Economic and Cultural Rights issued General Comment 14, which makes clear that the right to health is not an entitlement to being healthy, but rather a right to healthcare and the social determinants of health (Forman, 2015; Forman, Caraoshi, Chapman, & Lamprea, 2016). According to General Comment 14, the right to health covers three broad areas: (1) Healthcare facilities, goods and services (including essential drugs); (2) Social determinants of health (e.g. food, basic shelter, housing, sanitation, and water); and (3) the AAAQ Framework. It states that health services and programs must be: *Available* in sufficient quantities; physically and economically *Accessible* without discrimination; medically, ethically, and culturally *Appropriate*; and good *Quality*. Additionally, General Comment 14 clarifies certain human rights principles, including: non-discrimination, participatory decision-making, and prioritisation of vulnerable or marginalized groups (Backman et al., 2008). Many

other human rights instruments also enshrine the right to health.[2]

The right to health in Canada

In the context of these established and universally supported norms, conventions, and goals with respect to the right to health, do Canadians in fact enjoy an actual right to health?

Although Canada has ratified numerous international treaties that specify the right to health, including the ICESCR, and many Canadians believe that healthcare is a constitutional right, the right to health is not explicitly enshrined in Canadian law (Parliament of Canada, 2002). Nevertheless, the Canada Health Act and sections in the *Charter of Rights and Freedoms* – in particular section 15 (the equality provision) and section 7 (which guarantees the right to life, liberty and security of the person) – are an important source of protection for social and economic rights in the country, including the right to health. Moreover, the Supreme Court of Canada has stated that legislators should interpret the rights in the *Charter* consistently with international human rights (Jackman & Porter, 1999, p. 58). Together, the *Canada Health Act*, the *Charter*, and the Supreme Court of Canada's interpretive presumption regarding international human rights support the foundation of a right to health in Canada and provide a persuasive source for a positive interpretation (Jackman, 2010; Jackman & Porter, forthcoming). Canadian courts, however, have been reluctant to adopt a "more expansive judicial interpretation of existing constitutional rights to include a positive right to health care (Flood & Gross, 2014, p.66)."

If the right to health is not explicitly enshrined in domestic law and the ICESCR is not enforceable by domestic courts, what is the value of the right to health for Canadians? How can we transform it into actual policies, entitlements, and outcomes? Although there remain doubts that the right to health can lead to improved health outcomes, scholars in diverse sectors agree that a great value of a human rights and health approach is its power as a framework (Forman, 2015; Jackman, 2010; Jackman & Porter, 2017; Mann et al., 1994; Tobin, 2012; Vanderplaat & Teles, 2005). For example, although international human rights are not directly enforceable by Canadian courts unless they have been incorporated into domestic law, they are used by courts to interpret the scope and application of domestic law (Jackman & Porter, 1999). As such, the human rights framework could have a powerful impact on court decisions that, in turn, would have important trickledown effects on future policies and programs (Jackman & Porter, forthcoming).

The late Jonathan Mann, the founding chief of the WHO Global Program on AIDS, first put forward the health and human rights discourse. He believed that the promotion of health is inextricably linked to the promotion of human rights (Mann et al., 1994). Mann contended that human rights are a "more useful framework, vocabulary, and template for public efforts to analyze and respond directly to the social determinants of health than any framework inherited from the past biomedical or public health tradition" (1998). A rights-based framework is powerful because it promotes an interdisciplinary conversation that brings "the language of health and medicine face to face with the language of power and social inequality (Vanderplaat & Teles, 2005, p. 34)." Perhaps most importantly, it is both "normative and operational" (Tobin, 2012, p. 1) and, as such, "provides strategies and solutions to address and rectify inequalities, discriminatory practices and unjust power relations (World Health Organization, 2015)."

Pathways to realizing the right to health in Canada

Health and human rights scholar Lisa Forman has identified three mechanisms through which rights-based approaches can cement the right to health: (1) domestic litigation; (2) rights-based advocacy; and (3) rights-based policy and tools. Through these approaches, "actors can access the potential power of the right to health by translating it into tangible outcomes and benefits (Forman, 2015, p. 94)."

Enforcing the right to health through domestic litigation is the most formal mechanism for integrating it into domestic institutions. Although courts have been reluctant to subject health care decisions to *Charter* scrutiny, Martha Jackman has identified judicial review under the *Canadian Charter of Rights and Freedoms* as a promising "avenue of healthcare accountability (2010, p. 2)." She argues that the *Charter* provides "a valuable framework for assessing whether decisions limiting healthcare comply with basic constitutional values (2010, p. 20)." In particular, section 15 of the *Charter* enables courts to examine health claims in light of substantive equality principles. Bruce Porter, Director of the Social Rights Advocacy Centre, has discussed the significance of section 15 and its potential to lead to a "more positive conception of equality (Porter, 2006, p. 34)."

Legislators in parts of Africa and Latin America have successfully harnessed international human rights law to enshrine human rights commitments at the national level. For example in South Africa and Argentina, groups have successfully drawn upon the right to health to realize important gains, such as reproductive rights and penal healthcare.[3] An oft-discussed example is South Africa, where litigants secured access to antiretroviral (ARV) drugs for people with HIV/AIDS through court appeals. In fact, Lisa Forman has observed that a "consistent variable" in successful litigation is that a country has both ratified the ICESCR and included the right to health within its domestic constitution, as this "amplifies" the legal force of treaty ramification (Forman, 2015, p. 94).

Rights-based advocacy is a bottom-up pathway in which change is won through discourse and protest, rather than directly through institutional channels. Social movements have successfully drawn upon the right to health to frame their issue in a universally compelling and comprehensible way. For example, in the HIV/AIDS treatment campaigns of the 2000s, activists challenged the pharmaceutical industry and their host governments to make ARV drugs widely accessible (Forman, 2015). As Sikkink and Risse observe, human rights are powerful norms that help shape a nation's identity and so create pressure to uphold them – "norms become relevant and causally important during the process by which actors define and refine their collective identities and interests (Risse & Sikkink, 1999, p. 13)."

Right-to-health tools are perhaps the most hands-on mechanism, as they translate human rights norms into tangible instruments. A major goal of a human rights-based approach to health is that all health policies, strategies and programs are designed with the goal of improving the right to health for all people (World Health Organization, 2015). Rights-based tools integrate core human rights principles – such as non-discrimination and a focus on poor and marginalized groups – into public health planning, policies and programs, and provide a foundation for action. For example, new research on indicators measuring the right to health can help policymakers determine whether they have an equitable health system (Backman et al., 2008). Health in All Policies (HiAP) is a cross-sector public-policy approach that emphasizes the impact of public policies on the social determinants of health (WHO). In Canada, the *Upstream* movement led by Ryan Miele seeks to reframe public discourse around the social determinants of health and to explore the impact of diverse policies on population health in Canada.[4] In Ontario, the Health

Equity Impact Assessment (HEIA) is a tool developed by the Ministry of Health and Long-Term Care that helps assess how specific programs or policies will impact the health and health disparity of diverse population groups.

The Benefits Screening Tool as a rights-based tool

This article proposes that screening for income and benefits is a seminal rights-based tool that can advance health equity in Canada. Doctors working with patients living on low incomes have long been familiar with the negative impact of poverty on health, but struggled with how they, as healthcare providers, can intervene effectively to address the poverty of their patients. According to Gary Bloch, a family physician at St. Michael's hospital, "there is a powerful connection between peoples' level of income and their health . . . we [health sector] offer a gateway . . . everyone comes into contact with a health sector person (Bloch, 2016)." After learning that many people with low incomes have not been fully accessing income benefits for which they are eligible, a pioneering group of Toronto health professionals, led by Bloch, developed a paper-based clinical tool for doctors. It enables them to screen patients for low income; adjust the patient's health risk assessment accordingly; identify income benefits the patient is likely eligible for, but may not be getting; and provide information on how to access these benefits through tax filing or other means.[5]

This process is an important health and poverty reduction intervention that promotes health equity by helping vulnerable and marginalized individuals boost their incomes. Many individuals living on low income do not file taxes and so miss substantial income available through tax benefits. In Ontario alone, people with low income can access 41 potential federal and provincial income benefit programs directly or indirectly through tax filing. These include important supports for individuals and families with low incomes like the Canada Child Benefit, Old Age Security, Guaranteed Income Supplement, Working Income Tax Benefit and the GST/HST credit. It also includes tax credits like the Disability Tax Credit, or Caregiver Tax Credit, as well as a range of provincial programs aimed at supplementing federal benefits or helping low-income households to offset expenses for things like medicine and home heating.

Estimates from the Ontario Ministry of Community and Social Services (2012) indicate that tax benefits can represent up to 40% of income for families on social assistance with children, while seniors with low incomes can receive up to $700 in additional income per month through the Guaranteed Income Supplement. Failing to file taxes can also mean some miss government grants and matched savings programs, such as the Canada Disability Savings Bond.

Research has shown that tax benefits and refunds can significantly improve the lives of recipients (Prosper Canada, 2015). It was discovered that the use of the Canadian Child Tax Benefit (CCTB) led to improved outcomes for children and their families. A study of families receiving the CCTB found that they decrease their consumption of alcohol and tobacco use and increase spending on food, childcare and transportation (Jones, Milligan, & Stabile, 2015). Children of families receiving the CCTB demonstrated improvements in educational outcomes, as well as physical and mental health (Milligan & Stabile, 2011). Moreover, researchers found that single mothers who received the National Child Benefit Supplement showed improved workforce participation (Milligan & Stabile, 2007).

The online Benefits Screening Tool

Building on the innovative benefit screening tool developed by Gary Bloch and his colleagues, Prosper Canada has been working with the St. Michael's Hospital Academic Family Health Team, Flemingdon Health Centre, and the Inner City Family Health Team in Toronto to develop an online Benefits Screening Tool. It can be updated centrally (a key challenge with any paper-based tool), made available to health practitioners across Canada more cost-effectively, and continuously capture user analytics and feedback to support ongoing improvements.

With funding from Intuit, a prototype, online Benefits Screening Tool was developed, populated with federal and Ontario benefits, and pilot tested on a small scale in each of the three settings, which serve large numbers of patients with complex health needs:

- **Flemingdon Health Centre** is a community health centre in east Toronto that provides comprehensive primary care services to patients using the frameworks of the social determinants of health and community engagement. The Centre serves a diverse population made up of many new immigrants and refugees.
- **Michael's Hospital Academic Family Health Team** serves more than 35,000 patients at six clinics in downtown Toronto, its newest site having opened in summer 2016. It is one of the largest academic Family Health Teams in the province and focuses on serving marginalized populations. In 2010, researchers found more than 30% of patients at three of five clinic sites (St. Jamestown, 410 Sherbourne and 80 Bond) to be in the lowest income quintile, and more than 50% in the lowest two income quintiles.
- **Inner City Family Health Team** is a new Family Health Team that predominantly serves current and former clients of Seaton House, Toronto's largest men's shelter. The Family Health Team focuses on addressing the social determinants of patient health. It has strong links with community service agencies in downtown Toronto.

The teams tailored the Benefits Screening Tool to fit into the routine workflow of a clinical setting. It provides healthcare professionals with a short quiz of 13 questions that they administer to a patient during an appointment. Experts designed the questions to assess income insecurity and benefits eligibility. They include questions on age, employment status and annual income. The tool then acts like an expert, assessing options to provide the patient with tailored information on benefits they may be eligible for, but may not be receiving. The patient receives a personalized plan, including information on relevant benefits.

In the pilot, healthcare providers used the tool with 127 patients. They discovered that, although all patients were receiving some benefits, many were eligible for, but not collecting, additional benefits like the GST/HST Tax Credit and the Special Diet Allowance. They also alerted participating physicians about some of the obstacles that prevent disadvantaged groups from accessing benefits. While patients tended to be aware of certain benefits, they often did not apply because complex application processes deterred them or because they believed they were ineligible.

This initial pilot demonstrated the feasibility of deploying the tool in frontline healthcare settings, and the strong support of participating physicians, but it also revealed the challenges involved with integrating a new tool into the everyday workflow of a clinical setting, such as the time involved in administering the tool during an appointment. The next phase of this initiative, funded by Maytree, will address these. It will add Manitoba benefits to the tool, develop additional user guidance for those who administer it, and address the need for healthcare providers to build effective referral networks for patients who need help to file their taxes or

apply for benefits. With these improvements, stakeholders will pilot the tool more broadly in Ontario and Manitoba.

In addition, an active group of policy, research and practice experts have been planning to expand the benefits/income screening initiative through electronic medical record links, the medical training curriculum and a comprehensive approach for evaluating impact.

Conclusion

By promoting greater equity in access to benefits through the health sector, the Benefits Screening Tool integrates core human rights principles – such as a focus on poor and marginalized groups – and the social determinants of health into frontline healthcare delivery. Screening for poverty and benefits empowers healthcare providers to take practical action to improve the incomes and health of vulnerable patients and to reduce health disparities in the communities they serve. Benefits screening also empowers and supports people with low incomes to take action themselves to realize their rights and legal entitlements – to income as well as better health.

In addition to improving patient health by boosting incomes, benefits screening promotes the right to health by addressing participation, equity, and non-discrimination in several ways. It helps ensure that all Canadians may actually access the benefits to which they are legally entitled, by removing barriers typically faced by vulnerable and excluded groups. Further, it actively engages vulnerable and marginalized groups through physician outreach in low-income health settings. We are unlikely to see reduction in disparities in accessing benefits without active outreach and support to the most disadvantaged groups. To date, the tool prioritizes engagement of groups that frequently face neglect or discrimination. Finally, benefits screening reduces income gaps that drive disparities in health between populations.

Policies to address poverty and other upstream determinants of health may always be politically challenged to compete with the demands of Canada's acute healthcare system. However, benefits screening offers an important opportunity to close the gap between traditional medical care and solutions that address upstream determinants of health (like income) and fundamental questions of equity in income and health.

By appealing to Canadians' strong belief in the right of everyone to health and healthcare, we can hopefully open the door to more opportunities to mobilize our healthcare system to help cure societal ills, like poverty and inequality, as well as our individual infirmities, recognizing that these are, and always will be, inextricably linked.

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[1] We define "inequity" as *avoidable* health inequalities that arise because of the circumstances in which people grow, live, work and age, as well as the nature of the systems currently in place to deal with illness.

[2] See John Tobin, The Right to Health in International Law, (provides fulsome discussion of the history and evolution of the right to health).

[3] See Lisa Forman, *Decoding the Right to Health*, (provides detailed discussion of successful rights-based litigation)

[4] Refer to thinkupstream.net

[5] The paper-based tool can be accessed at: http://ocfp.on.ca/cpd/povertytool