Poverty is a reality for many families living in Canadian inner cities. There is no accepted definition of poverty in Canada. However, it was estimated that 9.6% of Canadians were living on a low income in 2009. This is based on a low-income cutoff defined as the income level at which a family might be in straitened circumstances because it has to spend a greater portion of its income on basics (food, clothing, and shelter) than the average family of similar size does. Previous research has described substantial associations between low socioeconomic status and poor academic performance and psychiatric disorders. While marginalized inner-city families experience the negative downstream effects of poverty on health, they also have the greatest difficulty accessing mainstream health care. The difficulties include lack of transportation, cultural and language barriers, lack of health insurance, discrimination, and stigmatization. Children are particularly vulnerable, as they must rely on others to advocate on their behalf. Further, Canadian children from disadvantaged families are twice as likely to be living in poorly functioning families as children from high-income families are. Children are of particular interest as timely health care access would provide the greatest opportunity for illness prevention. In 2009, nearly 1 in 10 Canadian children were living in low-income households.

School-based health centres
There are several places where marginalized populations in urban areas typically access health care. These include hospital emergency departments, community health centres, and innovative health care delivery initiatives such as those in homeless shelters and youth centres. These services traditionally target marginalized youth and adults. The school system represents an innovative access point for younger children facing barriers to health care. In several regions, schools have evolved into community “hubs” offering services and programs to families within the school community. For marginalized families, schools represent an opportunity to access health care in a convenient and familiar environment.

In particular, the United States has established more than 1900 school-based health centres (SBHCs), with 57% located in urban centres. American research has demonstrated that inner-city children who had access to elementary SBHCs had less difficulty receiving immunizations, physical examinations, and treatment for illnesses and injuries. In addition, rates of enrolment and use of elementary SBHCs are higher among children who traditionally have poorer access to health care. For example, an American study showed that students with either public health insurance or no health insurance were more likely to use their SBHCs and had higher rates of use compared with students who had private health insurance. In 2003, Webber et al reported that access to SBHCs was associated with a substantial reduction in the rate of hospitalization and a gain of 3 days of school for children with chronic illnesses.

Pilot program
How the experience in the United States would translate to the Canadian environment is uncertain, as school-based health care has not previously been evaluated in Canada. The University of Toronto in Ontario, St Michael’s Hospital in Toronto, and the Toronto District School Board have set up a pilot program providing school-based health care to Toronto’s most vulnerable and underserved children living in inner-city communities. The integration of health care provision within the school system is a means of addressing the challenges of delivering accessible health care to children who need it the most.

The Toronto pilot program allows inner-city children to receive health care at a medical clinic within an elementary school staffed by a family physician, a pediatrician, and a developmental pediatrician. Students are referred by parents, teachers, and school support staff for various medical and developmental concerns.

Our initial experience with this program has been rewarding but has also highlighted a number of challenges in bridging the 2 very different publicly funded systems of education and health care. These 2 systems brought different experiences and approaches to school-based health care that required collaboration and mutual understanding. For example, issues of consent, confidentiality, and the role of the health information custodian required special attention, as health care delivery occurred within the school setting.

The realities of a multicultural inner-city population introduce additional challenges such as language and...
cultural barriers; a continually changing immigrant population; and the negative effects of poverty on health.10

The Toronto pilot program is a case example of how the diverse needs of the inner city must be taken into account when developing an effective and accessible health care delivery model. A key step toward addressing these barriers included holding information events for the school communities before implementing the SBHC so that families could learn about the pilot program. In addition, the SBHC was staffed by a multilingual clinic coordinator who could facilitate communication with non–English-speaking families. Further, collaborating with existing school resources such as the school social worker allowed for improved coordination of care for new immigrant and refugee families. Finally, a keen understanding of community resources by the health care team was essential in directing families to access services such as Early Years Centres, pharmacies, and laboratories, as well as coordinating care with their existing family physicians. In addition, for children without primary health care providers, the SBHC served as an opportunity to link families to family physicians in the community.

Canada’s ethnic diversity is both a strength and challenge for health care delivery. Health care providers should be thinking of new and innovative ways to address the health care needs of Canada’s multicultural communities. School-based health care is a model to ensure health care access is equitable for all children living in Canada. However, a successful model of health care delivery to inner-city children will require collaboration among education administrators, health care practitioners, and policy makers.

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Competing Interests
None declared

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