Community Dispatch

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POVERTY REDUCTION SERIES:

SICK AND TIRED: THE FAILING HEALTH OF ONTARIO'S POOR

Members of the Halton community and social agencies have voiced concern over the adequacy of the incomes of their neighbours or clients living on social assistance or falling into the group know as the working poor. In Halton's community conversations on poverty reduction, individuals have simply said that people on these incomes cannot be housed or feed themselves not to mention be actively engaged members of the community. The phrase, "pay the rent or feed the kids", emerged from lived experience. I share in this Community Dispatch the findings of a new report, Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario. Written by the Community Social Planning Council of Toronto, the Wellesley Institute and the research initiative Social Assistance in the New Economy, this study documents the profound impact of poverty incomes on the long term health of low-income people in Ontario. Not only are the lives of individuals diminished but higher morbidity and mortality rates increase costs in our health care system and decrease our economic productivity through absenteeism.

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Context

Sick and Tired is based on an analysis of Statistic Canada's 2005 Canadian Community Health Survey, the most recent and comprehensive survey of health and health care use of Canadians. Analyses are based on data from over 24,000 working-age Ontarians.

The working poor

Some important changes have occurred since 2005 when the survey was conducted. Rising unemployment and full-time job losses have hit Ontario workers hard (Statistics Canada, 2009, January 9). Ontario manufacturers have shed a staggering one in ten jobs between 2003 and 2007, with increased lay-offs into 2008 (Ontario Federation of Labour, 2007; Statistics Canada, 2009, January 9). Early effects of this historical economic crisis are likely to have pushed more people into poverty, further compromising individual health – and it's far from over.

On a positive note, Ontario's minimum wage rate was increased by $1.30 per hour between 2005 and 2008 (Ontario Ministry of Labour, n.d.). While welcome, these recent increases have only helped to make up for lost ground from a rate freeze that extended from 1995 to 2003 under the previous provincial government. At $8.75 per hour, the current rate offers minimum wage earners just about the same purchasing power as their counterparts had in 1995. Today's minimum wage remains a poverty wage, and as such, a health hazard to these low wage workers.

Social assistance recipients

Beginning in 2003 and continuing since 2005, the provincial government introduced periodic 2-3% increases to social assistance rates (National Council of Welfare, 2006; National Council of Welfare, 2008). Prior to these rate increases, social assistance recipients endured a 21.6% cut in 1995 followed by an 8-year

rate freeze under the previous government. While a step in the right direction, the current government's inflation-matching increases have done little to fundamentally change the position of social assistance recipients. In 2007, their incomes remained at 33% to 61% of Statistics Canada's Low Income Cut-Off. Research suggests that these modest increases have contributed little to improving the quality of life or health outcomes for social assistance recipients in Ontario (Lightman et al., 2008a, 2008b, 2005a, 2005b) has not improved since the data was collected in 2005.

Results: The Health of Ontario's Poor

The findings of the report paint a shocking picture of the health of Ontario's poor. Median household income for social assistance recipients was only $13,000 annually, while the working poor had a median household income of just $21,000 a year. The report found that:

- Social Assistance recipients, compared to the non-poor, had significantly higher rates of poor health and chronic conditions on 38 of 39 health measures. In some cases rates 7.2 times higher than those of the non-poor group were reported.
- Social assistance recipients had higher rates of diabetes, hearth disease, chronic bronchitis, arthritis and rheumatism, mood disorders, anxiety disorders and many other conditions.
- One in ten social assistance recipients considered suicide in the 12-month period preceding the study and suicide attempts were 10 times higher for social assistance recipients compared to the non-poor.
- Compared to the non-poor, the working poor had higher rates on a range of chronic conditions including diabetes, heart disease, chronic bronchitis, and migraines, among others.
- Even after taking into account multiple factors associated with ill health, including educational attainment, disability status, smoking and physical activity among others, household income and/or social assistance receipt continued to be strongly associated with most chronic conditions.
- Despite higher rates of unmet health care needs, both poor groups were less likely to have a regular medical practitioner compared to the non-poor group.
- Among individuals with unmet health care needs, one in five respondents from the working poor and social assistance groups cited cost as a factor.
- Rates were especially troubling regarding women's preventative health care where substantial numbers of poor women had never had a Pap smear test, breast exam or mammogram for those over 40 years of age.
- Despite recent increases that keep pace with inflation, rates are so low that half of all respondents from the social assistance group live in food insecure households.
- Coupled with inadequate rates, recipient health is further compromised by their exposure to punitive bureaucracies and social stigma associated with social assistance.

It is important to note that the information on the working poor includes immigrants, who represent 53% of the working poor group. Surprisingly, immigrants exhibited better health than that of the rest of the working poor group or the social assistance recipient group. The report cites that this can be attributed to the "*healthy immigrant effect*" whereby immigrants, especially newcomers, have better health than their Canadian-born peers. However, this advantage diminishes over time as the longer an immigrant lives in Canada,

the more their health becomes comparable to that the Canadian-born population.

Recommendations

The following recommendations support the reduction of poverty in Ontario and address the increased burden of ill health faced by poor people in Ontario, and promote equitable access to health services in Ontario. These recommendations are based on the results of this study and supported by related research.

Improving the Provincial Poverty Reduction Strategy

Recommendation 1: The provincial government establish an independent panel to set Ontario Works and Ontario Disability Support Program rates, through an evidence-based process, to reflect the actual cost of living in Ontario communities. The basic needs and shelter portions of social assistance should reflect the actual costs of meeting basic needs, including health-related needs, and maintaining decent housing. Rates should take into account regional differences in the cost of living. The Canada Mortgage and Housing Corporation rental housing survey and local nutritious food basket measures can assist in this regard. Once established, rates should be fully indexed to inflation.

Recommendation 2: The federal and provincial government take immediate action to bring Canada into compliance with its commitment to the human right to food under various international treaties. Local nutritious food basket measures assess the cost of a nutritious diet in specific communities. These are useful tools to guide government action on the right to food.

Recommendation 3: The provincial government undertake a review of ODSP, including a broad-based community consultation, to identify barriers to access and implement changes to ensure that people with disabilities in financial need have timely access to this essential program.

Recommendation 4: The provincial government report transparently on its efforts to protect temp agency workers and enforce employment standards. We also recommend that the provincial government update labour standards' legislation to protect the rights of workers engaged in other forms of precarious employment. These workers include those deemed self-employed by employers seeking to offload employee-related responsibilities and expenses. Finally, we recommend that the provincial government set minimum wage rates to ensure that no full-time, full-year worker in Ontario lives in poverty.

Recommendation 5: The provincial government expand its existing target to reduce poverty by 25% in 5 years for all Ontarians. In addition to recognizing the full face of poverty in Ontario, an inclusive goal will also reflect the fact that poor children live in poor families and that child poverty cannot be addressed without a simultaneous focus on family and adult poverty.

Taking Action on the Federal Level

Recommendation 6: The federal government introduce a national poverty reduction strategy with concrete targets and timelines, and that it monitor and provide regular public updates on the progress of this plan.

Recommendation 7: The federal government restore Employment Insurance as a universal social program by expanding the eligibility criteria to address the needs of workers in the precarious labour force, ensuring equal access to benefits regardless of residence, improving benefit levels and increasing coverage periods. Rather than divert El contributions to

cover federal deficits and pay down debt, as has been government practice for the last decade, these funds should be used for their intended purpose, to support unemployed workers.

Health Care Access, Promoting Health Equity

Recommendation 8: The provincial government take action to ensure equitable access to health care services irrespective of income and poverty status, and reduce the ability to pay as a factor in accessing health care in Ontario. Expansion of and increased funding to community health centres (which focus on the health needs of marginalized communities), expansion of dental, vision, prescription drug and hospital care coverage, and expansion of the Ontario Trillium Drug Plan are key areas for action. Language interpreter services and health ambassadors (non-professionals within communities that can provide information and referrals) are critical supports to promote preventative health care and deliver culturally appropriate health services.

Improving Research Tools, Focusing on Equity-Seeking Groups

Recommendation 9: Statistics Canada revise future versions of the Canadian Community Health Survey to allow for the collection of income data that distinguishes between general social assistance (short-term assistance) programs and disability support programs (long-term) in each province.

Recommendation 10: Additional research be conducted to better understand the effects of income inequality, poverty, social assistance and labour market conditions on the health and health care use of women, racialized groups, Aboriginal people, immigrants and people with disabilities. We also recommend that analyses be conducted to better understand how place of residence, such as neighbourhood or region, may relate to poor health.

See full report for citations. *Sick and Tired* is available online at www.socialplanningtoronto.org

Support poverty reduction and sign the petition to *Put Food in the Budget*, found online at www.povertywatchontario.ca

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