Poverty and Chronic Disease: Recommendations for Action

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The Chronic Disease Prevention Alliance of Canada (CDPAC) led this project. Elizabeth Gyorfi-Dyke, a CDPAC consultant, completed the research and writing. This is a collaborative project of the Network of Provincial Territorial Alliances and the Steering Committee organizations of CDPAC. Bonnie Hostrawser facilitated the development and completion of the report.

CDPAC Contact Information
info@cdpac.ca
www.cdpac.ca
Executive Summary

The Chronic Disease Prevention Alliance of Canada (CDPAC) is a national coalition of organizations who share a common vision for an integrated approach to chronic disease prevention in Canada. CDPAC defines its role as a strong national voice of influence and as a facilitator of knowledge exchange.

The CDPAC Network of Provincial/Territorial Alliances has identified collaborative actions to understand and address poverty as a strategy to reduce the burden of chronic diseases. CDPAC has developed a position statement on addressing income-related food security (Chronic Disease Prevention Alliance of Canada, 2007a), as well as a background paper on the status of the National Child Tax Supplement across Canada (Chronic Disease Prevention Alliance of Canada, 2007b). In addition, CPDAC released a call to action following its 2006 Building It Together Conference, calling on Canada to first focus on needs of children in poverty and Aboriginal populations (Chronic Disease Prevention Alliance of Canada, 2006).

The intent of this brief is to outline approved messages to position CDPAC and the participating provincial/territorial alliances with common messaging to reduce poverty in Canada. This brief will first outline the evidence linking poverty and chronic disease, followed by recommendations for action at the federal, provincial/territorial and program levels, as well as for the voluntary sector.

Why is this issue important?

Based on evidence accumulated over time, there is a general acceptance in population health that there is a strong relationship between socio-economic status (SES) and health (Lynch et al., 2001). This relationship is not only seen when comparing the poorest to the richest groups, but there is also a gradient - that is, the richest are more healthy that the next richest, and the middle class are more healthy than the poorer groups (Chandola & Marmot, 2004; Wilkins, 2007; Wilkins et al., 2002) (see Figure 1). This gradient is not limited to income alone – there is a gradient for other determinants (e.g. class/occupation and education) (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004; Marmot et al., 1991).

There is clear evidence linking poverty and health, and poverty and chronic disease. It can be argued that “the most effective way to decrease the negative health consequences of poverty is, first and foremost, to reduce poverty” (Williamson, 2001). Canada has already been successful in reducing poverty amongst seniors through taxes and transfer policy (Osberg, 2001; Wu, 2005). Unfortunately, the same cannot be said for other vulnerable groups, such as children, where taxes and transfers have not substantially decreased poverty rates (Wu, 2005).

What can be done?

There are many areas to advocate for in the area of poverty and chronic disease. It is recognized that the issues of chronic disease and poverty are influenced at multiple levels,
from global policies (e.g. food subsidies and international trade agreements) (Friel et al., 2007) to the local level.

First, previous recommendations from CDPAC’s own work will be outlined. Following this, recommendations based on available evidence and the work of other organizations in this area will be identified, at the federal, provincial/territorial, and program level, as well as for the voluntary sector.

Summary of Key Recommendations

Key Message: It is well-documented that people who live in poverty suffer from a higher incidence of chronic illness including diabetes, heart disease, hypertension and food allergies. It is essential that all sectors take responsibility for reducing poverty in Canada including public policy action at all levels of government.

Key Recommendations for Public Policy: This can be achieved by:

- Increasing (and indexing) income transfers and income generally. Details include:
  - “reassessing and reforming the Employment Insurance program to ensure that eligibility requirements and payment levels actually provide an acceptable living wage” (Chronic Disease Prevention Alliance of Canada, 2007a, p. 2)
  - ensuring a “full indexation of social assistance rates in all provinces starting in 2008 (and) annual increases to social assistance rates of 3% or more above inflation also starting in 2008” (Novisk, 2007, p. 37)
  - increasing the child benefit to $5,100 a year while ensuring that this money is not clawed back (or social assistance rates lowered as a result)
  - increasing and indexing the minimum wage to a minimum $10 an hour
- Ensuring adequate housing. Details include:
  - “Reinstat(ing) the federal Social Housing Program and increase funding to the Affordable Housing Initiative to ensure low income wage earners and those on social assistance have safe and affordable housing alternatives” (Chronic Disease Prevention Alliance of Canada, 2007a, p. 2)
- Ensuring that the people who are in the most need benefit first (Chronic Disease Prevention Alliance of Canada, 2006). Details include:
  - Advocating for groups who are more vulnerable to poverty, including children, lone parents, people who are single, recent immigrants, and Aboriginal Peoples

There are many key opportunities for CPDAC and its network to advocate for poverty reduction, given the link to chronic disease. Specifically, with the large number of reports being released this year that deal with this topic, CDPAC and its network should respond to each report as it is released.

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1 Recommendations at a global level are beyond the scope of this briefing.
Table of Contents

1 Introduction ...................................................................................................................................................... 1
2 The Link Between Chronic Disease and Poverty......................................................................................... 1
  2.1 Vulnerable Populations ................................................................................................................................. 4
  2.2 Rationale for Addressing Poverty ................................................................................................................ 4
3 Recommendations ........................................................................................................................................... 5
  3.1 Previous CDPAC Recommendations .......................................................................................................... 5
  3.2 Potential Federal Recommendations .......................................................................................................... 6
  3.3 Potential Provincial/Territorial Recommendations ....................................................................................... 7
  3.4 Potential Program-level Recommendations ............................................................................................... 8
  3.5 Potential Voluntary Sector Recommendations ............................................................................................ 8
  3.6 Other Recommendations ............................................................................................................................ 9
  3.7 Summary: Key Recommendations ............................................................................................................ 10
4 Next Steps ...................................................................................................................................................... 11
5 References ..................................................................................................................................................... 13
I Introduction

One researcher asks, “Why is it that the health sector so rarely employs political strategies to address poverty, despite contentions by policy-influencing bodies and growing numbers of scholars that the health of individual Canadians in poverty and society as a whole will not be enhanced without concentrated efforts to alter the fundamental structural conditions contributing to poverty?” (Williamson, 2001, p. 182). CDPAC and its networks have an opportunity to demonstrate this leadership by advocating for changes to address poverty.

The Chronic Disease Prevention Alliance of Canada (CDPAC) is a national coalition of organizations who share a common vision for an integrated approach to chronic disease prevention in Canada. Our mission is to lead and promote Canada-wide efforts towards systems changes that will reduce the prevalence of chronic diseases and improve the health of Canadians. CDPAC defines its role as a strong national voice of influence and as a facilitator of knowledge exchange.

The CDPAC Network of Provincial/Territorial Alliances has identified collaborative actions to understand and address poverty as a strategy to reduce the burden of chronic diseases. CDPAC has developed a position statement on addressing income-related food security (Chronic Disease Prevention Alliance of Canada, 2007a), as well as a background paper on the status of the National Child Tax Supplement across Canada (Chronic Disease Prevention Alliance of Canada, 2007b). In addition, CDPAC released a call to action following its 2006 Building It Together Conference, calling on Canada to first focus on needs of children in poverty and Aboriginal populations (Chronic Disease Prevention Alliance of Canada, 2006).

There are many opportunities in 2008 for CDPAC and its network to call for action on poverty. Numerous reports on inequalities in health will be released in 2008, including reports from the Senate Subcommittee on Population Health, the Chief Public Health Officer’s annual report, the World Health Organization (WHO) Commission on the Social Determinants of Health, and a report on urban health and socioeconomic status from the Canadian Population Health Initiative (CPHI). Key events, including the Canadian Public Health Association conference in June 2008, will also focus on inequalities in health.

The intent of this brief is to outline approved messages to position CDPAC and the participating provincial/territorial alliances with common messaging for when these various reports are released. This brief will first outline the evidence linking poverty and chronic disease, followed by recommendations for action at the federal, provincial/territorial and program levels, as well as for the voluntary sector.

2 The Link Between Chronic Disease and Poverty

Based on evidence accumulated over time, there is a general acceptance in population health that there is a strong relationship between socio-economic status (SES) and health (Lynch et al., 2001). This relationship is not only seen when comparing the poorest to the richest groups, but there is also a gradient - that is, the richest are more healthy than the next richest, and the middle class are more healthy than the poorer groups (Chandola & Marmot, 2004; Wilkins, 2007; Wilkins et al., 2002) (see Figure 1). This gradient is not limited to income alone – there is a gradient for other determinants (e.g. class/occupation and education)
Why does poverty matter to chronic disease advocates? Chronic disease prevention advocates care about poverty and health inequities because there is also a strong link between socio-economic status and chronic disease (World Health Organization and the Public Health Agency of Canada, 2005). There is a gradient for many chronic diseases (Adler et al., 1994; Rabi et al., 2006; Wilkins, 2007; Wilkins et al., 2002), such as heart disease, mental disorders, certain cancers, hypertension, and diabetes (see Figure 2 as an example). As the Heart and Stroke Foundation of Canada notes “social inequality, whether measured at the population or individual level, is the single leading condition for poor health, including cardiovascular diseases and related risk factors” (Heart and Stroke Foundation of Canada, 2006, p. 11). While much work has been done to try to change lifestyle risk behaviours, these can actually result in increased inequities (Hayward & Colman, 2003). If we want to decrease chronic diseases in Canada, we need to look at the key roles that poverty and inequity play and focus on these root causes.
Childhood poverty and chronic disease in adulthood

Research has also shown that poverty in childhood is linked to chronic disease later on in life (Cohen & Reutter, 2007; Galobardes et al., 2004; Poulton et al., 2002). In fact, the gradient of health “actually emerges in childhood”, regardless of one’s socioeconomic status in adulthood (Poulton et al., 2002, p. 1644). This is likely due to many complex factors, including, but not limited to, poor nutrition as a result of lack of money (Power, 2002).

Compared to other OECD countries, Canada ranks as having the 8th highest child poverty rate (14.9%), ahead of only Mexico, the U.S., Italy, New Zealand, Ireland, Portugal and the UK (UNICEF Innocenti Research Centre, 2005, p. 4). Hence, “given this link between early childhood experiences and later health status, the persistent high levels of children living in poverty in Canada (and elsewhere) should be of particular concern to the health sector” (Cohen & Reutter, 2007, p. 97), and of particular concern to those working in chronic disease.

Why does this gradient occur? Single explanations (e.g. lifestyle risk factors like smoking) alone do not explain these inequities (Marmot et al., 1991). There are numerous pathways and explanations for the gradient in health, including differences in health behaviours, material structural explanations, and psychosocial mechanisms, among others (Dahlgren & Whitehead, 2006; Hayward & Colman, 2003; Orpana & Lemyre, 2004; World Health Organization and the Public Health Agency of Canada, 2005). We know that these are
complex pathways (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005), and that “no single mechanism accounts for the SES-health gradient” (Adler & Conner Snibbe, 2003, p. 120).

2.1 Vulnerable Populations

Certain groups are more likely to be at risk for poverty, including children, lone parents, people who are single, Aboriginal Peoples (Canadian Population Health Initiative, 2004b; Canadian Population Health Initiative, 2004a), and recent immigrants (Picot et al., 2007). Some groups also advocate for a focus on pregnant women (Women’s Budget Group, 2005).

2.2 Rationale for Addressing Poverty

There are numerous reasons why it is important to address the issue of poverty (and the gradient), given the connection with chronic disease. These rationales may also vary depending on the audience. Two main arguments focus on social justice and cost.

Wilkins (2007) argues that the “elimination of remaining disparities would result in gains in potential years of life equivalent to eradicating one of the three leading causes of death”. These inequities in health are unjust and unfair and can be changed (Whitehead & Dahlgren, 2006). Hence, one argument is that of social justice. This argument focuses on the values we place as Canadians on health, fairness, and equality. One Federal/Provincial/Territorial report states that “health disparities are inconsistent with Canadian values” (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005, p. vi). This is a key reason for action.

From a cost point of view, chronic diseases cost billions of dollars (Patra et al., 2007), and inequities in health are costly to the health system. Poorer Canadians use more health services than the richest Canadians (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005). Reducing these inequities and improving health will ultimately lead to increased productivity (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005).

Can We Make Ends Meet This Month?
The reality of living without enough income is quite stark when you put yourself in the shoes of a family who is trying to make ends meet (Atlantic Health Promotion Research Centre et al., 2004; Kerstetter & Goldberg, 2007). For instance, in British Columbia, a Provincial Health Services Authority report shows that a family with two parents and two children, with one income earner making $11 an hour ($22,880 annually), is able to afford food for the month, yet would be short $453.40 in their other expenses (Kerstetter & Goldberg, 2007, p. 46). (See Appendix A for more details).
3 Recommendations

There is clear evidence linking poverty and health, and poverty and chronic disease. It can be argued that “the most effective way to decrease the negative health consequences of poverty is, first and foremost, to reduce poverty” (Williamson, 2001). Canada has already been successful in reducing poverty amongst seniors through taxes and transfer policy (Osberg, 2001; Wu, 2005). Unfortunately, the same cannot be said for other vulnerable groups, such as children, where taxes and transfers have not substantially decreased poverty rates (Wu, 2005).

There are many areas to advocate for in the area of poverty and chronic disease. It is recognized that the issues of chronic disease and poverty are influenced at multiple levels, from global policies\(^2\) (e.g. food subsidies and international trade agreements) (Friel et al., 2007) to the local level.

First, previous recommendations from CDPAC’s own work will be outlined. Following this, recommendations based on available evidence and the work of other organizations in this area will be identified, at the federal, provincial/territorial, and program level, as well as for the voluntary sector. Finally, more general recommendations that apply across these groups will be summarized.

3.1 Previous CDPAC Recommendations

A number of CDPAC position papers related to poverty have already been developed based on the available evidence, and it will be important to continue to build upon these key messages. CDPAC has released a position statement on addressing income-related food security with support from the Dietitians of Canada (Chronic Disease Prevention Alliance of Canada, 2007a), as well as a background paper on the status of the National Child Tax Supplement across Canada (Chronic Disease Prevention Alliance of Canada, 2007b). In addition, CDPAC released a call to action following its 2006 Building It Together Conference, calling on Canada to first focus on needs of children in poverty and Aboriginal populations (Chronic Disease Prevention Alliance of Canada, 2006).

The following are key recommendations from these documents related to the issue of poverty.


In this brief, the strategy focusing on poverty is to “Address the root cause of individual and household food insecurity – poverty – through improvements to social safety net programs, ensuring that individuals and families have sufficient financial resources to meet basic needs for food, clothing and shelter” (p. 1). Hence a number of actions are suggested that fall under federal jurisdiction:

- “Eliminate the current option by the federal government for provinces and territories to claw back the National Child Benefit Supplement” (p. 2)

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\(^2\) Recommendations at a global level are beyond the scope of this briefing.
• “Reassess and reform the Employment Insurance program to ensure that eligibility requirements and payment levels actually provide an acceptable living wage” (p. 2)
• “Reinstate the federal Social Housing Program and increase funding to the Affordable Housing Initiative to ensure low income wage earners and those on social assistance have safe and affordable housing alternatives” (p. 2)
• “Long term sustained financial support to programs targeting low income pregnant women that use a community development model, focusing on healthy eating, promotion of breast feeding, building of social networks, harm reduction (smoking, drugs, alcohol) and physical activity” (p. 1)

The Status and Impact of Provincial/Territorial Recoveries of the National Child Benefit Supplement (2007) (Chronic Disease Prevention Alliance of Canada, 2007b)

This brief focuses on the research and evidence behind the clawing back of the National Child Benefit supplement (NCBS), including evidence to support calling for a stop to the clawing back of the NCBS. Other factors that are discussed in the brief include:

- Increasing income transfers generally (e.g. social assistance, child benefits)
- Increasing minimum wage
- Increasing nutrition allowances

National Child Benefit Clawback

Not all provinces claw back the National Child Benefit. New Brunswick demonstrated this leadership by stating “one of the key objectives of the National Child Benefit is to close the gap between low income working Canadians and Canadians on social assistance. In New Brunswick, this gap is still quite large in comparison with other provinces. As such, the province will make no adjustments in social assistance benefits” (Department of Social Development - New Brunswick Government, n.d.). Research done comparing New Brunswick and Nova Scotia (Nova Scotia at the time had a clawback) illustrated that New Brunswick families headed by lone mothers reported less food insecurity than Nova Scotia families headed by lone mothers, and that New Brunswick’s policy of not clawing back the National Child Benefit may have played a key role in this difference (McIntyre et al., 2002).

3.2 Potential Federal Recommendations

Based on the evidence and advocacy documents from other organizations working in poverty reduction, the following is recommended at the federal level:

- **Increase the Child Tax Benefit:** The recommendation from many organizations is that the child benefit be increased. Campaign 2000 (Novisk, 2007) is calling for an increase to $5,100 a year and The Caledon Institute (Battle et al., 2007) is calling for an increase to $5,000 per year (2007 dollars). Part of this recommendation is the understanding that money would not be clawed back, or result in lower social assistance rates (Novisk, 2007).

- **Improve Employment Insurance (EI):** This recommendation reflects one already made in previous CDPAC documents (Chronic Disease Prevention Alliance of Canada, 2007a). EI improvements include examining the number of hours required, levels of benefits, and earning calculation (Novisk, 2007).
• **Invest in social housing**: This is a recommendation that applies at the provincial/territorial and federal levels. Housing and health are strongly linked, and many Canadians are in core housing need (Canadian Population Health Initiative, 2006; Novisk, 2007).

• **Invest in early learning and child care**: Ensuring “universal access to opportunities for high quality learning and care for all children during the early years” (Novisk, 2007, p. 36) is another recommendation that has implications at the federal and provincial/territorial levels. This recommendation includes the need for “high-quality affordable child care” (Battle et al., 2007).

• **Provide adequate funding for people with disabilities**: Canada has been successful in decreasing poverty for its seniors via guaranteed income (Wu, 2005). Building on this success, a recommendation is to provide people with disabilities with a minimum income at a similar level to seniors (Battle et al., 2007; Novisk, 2007).

Various countries (e.g. Sweden, United Kingdom, Netherlands, Northern Ireland) (National Collaborating Centre for the Social Determinants of Health, 2006) have country-wide strategies to decrease health inequities, with many initiatives similar to those listed above. These strategies should continue to be monitored for best practices that may be applicable to Canada.

### 3.3 Potential Provincial/Territorial Recommendations

Based on previous work of CDPAC, as well as other organizations, advocacy for the following is recommended at a provincial/territorial level:

- **Increase and index minimum wage**: This recommendation calls on provinces to increase the minimum wage to provide adequate income (Novisk, 2007), to a minimum of $10 an hour.

- **Increase and index social assistance rates**: Building on previous CDPAC recommendations, it is recommended that there be a “full indexation of social assistance rates in all provinces starting in 2008 (and) annual increases to social assistance rates of 3% or more above inflation also starting in 2008” (Novisk, 2007, p. 37).

- **Increase funding for affordable housing**: As identified in the federal recommendations, housing is critical. This recommendation calls for more investments to ensure affordable housing.

- **Increase medical and dental coverage**: The recommendation includes ensuring drug and dental coverage for workers (Novisk, 2007).

- **Invest in early learning and child care programs**: As identified in the federal recommendations, early learning and child care programs are critical to health.

In addition, a number of provinces (e.g. Quebec and Newfoundland) (National Council of Welfare, 2007) have instituted anti-poverty initiatives. These initiatives should be monitored for success, and used as models in other provinces and territories as applicable.
Housing Affordability
We know that housing and health are strongly linked (Canadian Population Health Initiative, 2006). Not surprisingly, finding affordable housing can be a challenge for people with lower incomes. Work done by the Canadian Population Health Initiative (Canadian Population Health Initiative, 2006, p. 75) shows that people who make $30,000-$39,999 would be spending more than 30% of their annual income on rent for a two-bedroom apartment in Vancouver or Toronto. Those making less than $10,000 a year would not be able to find affordable housing (30% of annual income) in Vancouver, Calgary, Toronto, Montreal, or Halifax.

3.4 Potential Program-level Recommendations

There is also a role to play for those developing and implementing chronic disease programs and initiatives at a program level. Recommendations include to:

- **Build equity into initiatives from the start**: Considering poverty when developing initiatives is critical. This may include conducting a health equity audit (Health Development Agency, 2006). It is important to examine the available data from an equity perspective (e.g. smoking rates by income quintile), if this data is available. This data should then be monitored over the period of the initiative, to ensure that inequities are not increasing as a result of the initiative. This may also include targeting vulnerable populations (e.g. low income people) as well as aiming to reduce the gradient and increase the health of the overall population (Whitehead & Dahlgren, 2006).

- **Look upstream**: Focusing on lifestyle behaviours without regard for equity issues may inadvertently result in an increase in health inequities (Hill et al., 2005). Hence, initiatives should look upstream to structural factors that may play a role, such as “social and economic environments” (Dahlgren & Whitehead, 2006, p. 79). This recommendation can include using existing tools that provide ideas on how to work on chronic disease using a determinants of health lens (Ontario Chronic Disease Prevention Alliance, Ontario Prevention Clearinghouse and Canadian Cancer Society-ON Division, 2007).

3.5 Potential Voluntary Sector Recommendations

The voluntary sector plays a key role in advocating for the elimination of poverty. Recommendations include the need to:

- **Conduct health impact assessments in program and policy planning and evaluation**: This includes using a poverty lens when developing policy statements or programs. As above, one tool that may be used is a health equity audit (Health Development Agency, 2006).

- **Play a strong advocacy role**: Health charities and other voluntary sector organizations are well positioned to move the issue of poverty forward. All voluntary sector organizations need to take responsibility for the issue of poverty, given the strong link to chronic disease.
3.6 Other Recommendations

In addition to the recommendations above at the various jurisdictional levels, as well as the important role of the voluntary sector, there are a number of more generic recommendations where everyone has a key role to play. These include recommendations to:

- **Make addressing health inequities a priority:** This recommendation was also identified in the Federal/Provincial/Territorial report on health disparities (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005), including the need to ensure that the “reduction of health disparities … is a key measure of overall government performance” (p. 21). The following two recommendations offer concrete ways to ensure poverty is on the agenda in Canada.

- **Develop a national anti-poverty strategy:** Linked to the need to make addressing health inequities a priority is the recommendation for the development of a national anti-poverty strategy (National Anti-Poverty Organization, 2007; National Council of Welfare, 2007). This strategy would need to be adequately resourced, and would require coordination between the various government levels (National Council of Welfare, 2007).

- **Set measurable targets for reduction in poverty rates:** The setting of targets, and resulting accountabilities, is another way to encourage action in this area. Other countries have set targets for poverty reduction. For example, the United Kingdom is looking to “halve the number of children in relative low income households between 1998-99 and 2010-11, on the way to eradicating child poverty by 2020” (Government of the United Kingdom, 2006, p. 11). Campaign 2000 calls for a minimum target of “25% reduction in child poverty rate over the next 5 years, and a 50% reduction over 10 years” (Decter et al., 2008, p. 2).

- **Increase evaluation of what works and what doesn’t work in poverty and health:** While the relationship between poverty and health is well documented, less is known about what interventions are needed to make a difference (Frankish et al., 2007; Lavis, 2002; Mackenbach, 2003). More work needs to be done in this area (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005; O’Hara, 2005), including continuing to examine what other countries have done (Hayward & Colman, 2003).

- **Increase awareness about the link between poverty and health:** There is an opportunity to increase awareness of the link between poverty and health amongst governments, the general public, and the media (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005; O’Hara, 2005). Research has shown that, while many federal and provincial departments outside of health are aware of the determinants of health, this is not the case with finance departments (Lavis et al., 2003). In addition, public opinion surveys of the general public show that only one in three Canadians report that income, housing, and/or education influence health (Canadian Population Health Initiative, 2005). Finally, there is very limited coverage about poverty and the health gradient in the media in Canada (Hayes et al., 2007).

- **Work intersectorally:** Many potential strategies on the determinants of health, including poverty, fall outside of the health domain. Hence, it is critical that the health sector work with people in other sectors, including the social sector.
(Federal/Provincial/Territorial Advisory Committee on Population Health, 1999; O'Hara, 2005; World Health Organization, 1997). This is important at all levels, and amongst all groups, including at the local program level (Hofrichter, 2006). In addition, many organizations (e.g. National Council of Welfare, Campaign 2000) have been working on the issue of poverty for many years, and can be important allies.

3.7 Summary: Key Recommendations

As outlined above, there are numerous recommendations at various levels that CDPAC members can draw on to prepare briefing material, position statements and other public statements. Below is the a menu of policies that CDPAC and its member organizations can draw on:

Potential Key Message: It is well-documented that people who live in poverty suffer from a higher incidence of chronic illness including diabetes, heart disease, hypertension and food allergies. It is essential that all sectors take responsibility for reducing poverty in Canada including public policy action at all levels of government.

Potential Key Recommendations: This can be achieved by:

- Increasing (and indexing) income transfers and income generally
  - More details include:
    - “reassessing and reforming the Employment Insurance program to ensure that eligibility requirements and payment levels actually provide an acceptable living wage” (Chronic Disease Prevention Alliance of Canada, 2007a, p. 2)
    - ensuring a “full indexation of social assistance rates in all provinces starting in 2008 (and) annual increases to social assistance rates of 3% or more above inflation also starting in 2008” (Novisk, 2007, p. 37)
    - increasing the child benefit to $5,100 a year while ensuring that this money is not clawed back (or social assistance rates lowered as a result)
    - increasing and indexing the minimum wage to a minimum $10 an hour

- Ensuring adequate housing
  - More details include:
    - “Reinstit(ing) the federal Social Housing Program and increase funding to the Affordable Housing Initiative to ensure low income wage earners and those on social assistance have safe and affordable housing alternatives” (Chronic Disease Prevention Alliance of Canada, 2007a, p. 2)

- Ensuring that the people who are in the most need benefit first (Chronic Disease Prevention Alliance of Canada, 2006)
  - More details include:
Advocating for groups who are more vulnerable to poverty, including children, lone parents, people who are single, recent immigrants, and Aboriginal Peoples

While speaking to politicians and others, the question of cost will likely arise – namely, where will the funds come from to pay for these changes (e.g. increases in social assistance)? Campaign 2000 suggests that “all federal savings from lower public debt charges from now to 2012 be directed towards investments in poverty reduction and other national priorities” (Novisk, 2007, p. 37). In addition, as identified earlier in Section 2, long-term cost savings and resulting increased productivity can be emphasized.

4 Next Steps

As identified in the introduction, there are many key opportunities for CPDAC and its network to advocate for poverty reduction, given the link to chronic disease. Specifically, with the large number of reports being released this year that deal with this topic, CPDAC and its network should respond to each report as it is released. Each report will likely vary in its conclusions (including whether or not recommendations are provided), and CPDAC and its network may choose to dovetail the response to a specific report’s findings, while continuing an overall message of the importance of poverty reduction to chronic disease.

The tentative dates for these upcoming reports are:

- **February - April 2008**: Senate Subcommittee on Population Health interim reports (reports on other countries’ work will be released in February; Federal/Provincial/Territorial paper as well as issues and options paper in April)
- **Spring 2008**: Chief Public Health Officer (CPHO) Report – includes a focus on inequalities
- **September 2008**: WHO Commission on the Social Determinants of Health final report
- **November 2008**: CPHI Pan-Canadian Report on SES/Urban Health
- **December 2008**: Senate Subcommittee on Population Health final report

In addition, there may be an opportunity to link with the release of various disease strategy releases, given their focus on inequities, including the Heart Health strategy release in the fall. Other potential opportunities include the:

- Senate Standing Committee on Agriculture and Forestry’s work on rural poverty, and Senator Hugh Segal’s call for a guaranteed annual income,
- ongoing work by the Expert Group on Population Health Promotion on disparity indicators, and
- Reducing the Gaps in Health group – of which CPAC is a member (an informal group of organizations who are involved in many of the report releases this year)

Other key upcoming events include:

- **June 2008**: CPHA Conference (on Inequalities)
- **November 2008**: CPAC Conference
Given the strong link between poverty and chronic disease, CDPAC and its networks have a key role to play to advocate for change. 2008 is a key year to make a difference on this issue.
## Appendix A: Scenario for Family of Four – Boy 13 and Girl 7

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<thead>
<tr>
<th>Baseline 2005</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
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<tbody>
<tr>
<td></td>
<td>Raise Wages by $2/hour</td>
<td>Raise Child Benefits to $5,000/child</td>
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<tr>
<td><strong>$11 x 40 x 52</strong></td>
<td>Increase</td>
<td>Increase</td>
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<td><strong>Annual</strong></td>
<td><strong>Monthly</strong></td>
<td><strong>Annual</strong></td>
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<td><strong>Payroll Deductions:</strong></td>
<td><strong>2,440.39</strong></td>
<td><strong>203.37</strong></td>
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<tr>
<td>Federal Tax</td>
<td>822.38</td>
<td>68.53</td>
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<tr>
<td>BC Tax</td>
<td>212.54</td>
<td>17.71</td>
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<tr>
<td>CPP</td>
<td>959.31</td>
<td>79.94</td>
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<tr>
<td>EI</td>
<td>446.16</td>
<td>37.18</td>
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<tr>
<td><strong>Disposable Income</strong></td>
<td><strong>26,979.84</strong></td>
<td><strong>22,449.32</strong></td>
</tr>
<tr>
<td><strong>Fixed Expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent - Three Bedrooms</td>
<td>875.00</td>
<td>654.46</td>
</tr>
<tr>
<td>Hydro/Phone</td>
<td>59.41</td>
<td>59.41</td>
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<tr>
<td>MSP Premiums</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td><strong>Income after Fixed Expenses</strong></td>
<td><strong>1,313.91</strong></td>
<td><strong>1,431.33</strong></td>
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<tr>
<td>Food</td>
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<td><strong>Income after Food</strong></td>
<td><strong>659.45</strong></td>
<td><strong>776.87</strong></td>
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<td>Other Expenses:</td>
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<td>Clothing</td>
<td>233.72</td>
<td>1,112.85</td>
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<td>Household Supplies</td>
<td>51.12</td>
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<tr>
<td>Personal Care</td>
<td>69.57</td>
<td>69.57</td>
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<tr>
<td>Transit</td>
<td>209.00</td>
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<tr>
<td>Other Costs of Daily Living</td>
<td>549.44</td>
<td>549.44</td>
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<tr>
<td><strong>Income after Other Expenses</strong></td>
<td><strong>-459.40</strong></td>
<td><strong>-335.98</strong></td>
</tr>
<tr>
<td><strong>Net Change from Baseline</strong></td>
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</tbody>
</table>

6 References


Chronic Disease Prevention Alliance of Canada. (2006). *Canada Cannot Cope Now With Chronic Disease and is Not Ready for the Tidal Wave in the Next Decade: Call to Action Says Help the Worst, First*. Ottawa, ON: Chronic Disease Prevention Alliance of Canada.


