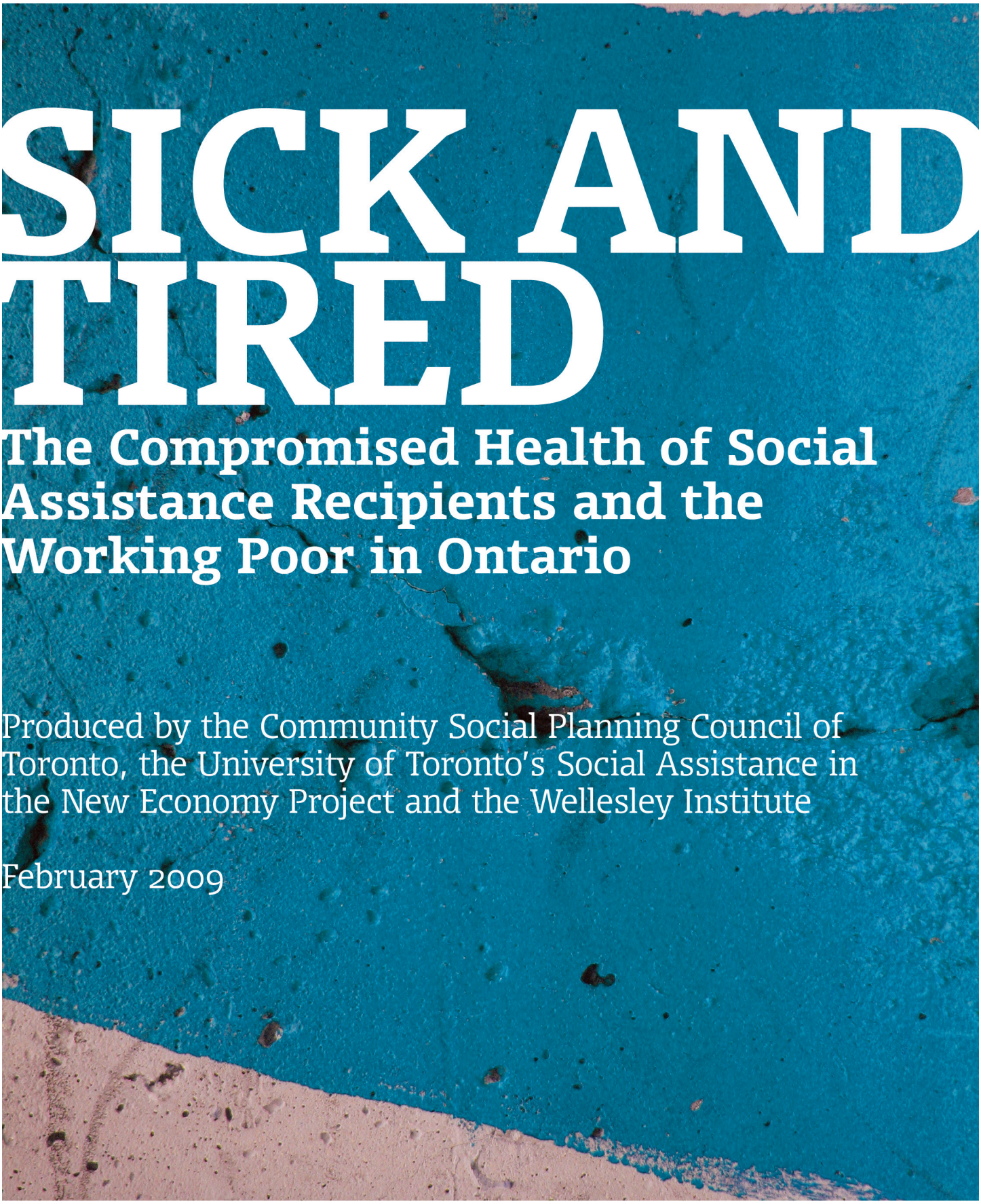


SICK AND TIRED

The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario

Produced by the Community Social Planning Council of Toronto, the University of Toronto's Social Assistance in the New Economy Project and the Wellesley Institute

February 2009

WELLESLEY INSTITUTE
a decade of advancing urban health

COMMUNITY SOCIAL PLANNING COUNCIL OF TORONTO

Social Assistance in the New Economy

Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario

February 2009

ISBN: 978-1-894199-18-6

Produced by the Community Social Planning Council of Toronto (CSPC-T), University of Toronto's Social Assistance in the New Economy Project (SANE) and the Wellesley Institute.

RESEARCH PARTNERS

Wellesley Institute, University of Toronto's Social Assistance in the New Economy Project and the Community Social Planning Council of Toronto

RESEARCH TEAM

Ernie Lightman, Principal Investigator, University of Toronto's Social Assistance in the New Economy Project
Andrew Mitchell, Coordinator, University of Toronto's Social Assistance in the New Economy Project
Beth Wilson, Senior Researcher, Community Social Planning Council of Toronto

REPORT AUTHOR

Beth Wilson, CSPC-T

RESEARCH SUPPORT

Jim Dunn, Centre for Research on Inner City Health
Raluca Fletcher, CSPC-T
Bob Gardner, Wellesley Institute
Esther Guttman, CSPC-T
Dean Herd, SANE
Dianne Patychuk
Michael Shapcott, Wellesley Institute
Zachary Tucker-Abramson, CSPC-T

CSPC-T RESEARCH ADVISORY COMMITTEE

Tam Goossen, Chair
Mario Calla
Celia Denov, ex-officio
Rick Eagan, project advisory committee liaison
Luin Goldring
Mazher Jaffery
John Myles
Rhonda Roffey
Cheryl Teelucksingh
Armine Yalnizyan

REPORT DESIGN

Christopher Wulff, CSPC-T

FUNDING SUPPORT

This project was made possible through the financial support of:

WELLESLEY INSTITUTE
a decade of advancing urban health

United Way Toronto

TORONTO

Social Sciences and Humanities Research Council of Canada

Table of Contents

Acknowledgements

I would like to extend my heartfelt thanks to Ernie Lightman and Andy Mitchell for the wonderful support and thoughtful direction that they provided throughout this project. It has been a priviledge and my pleasure to work with Ernie and Andy – both outstanding researchers, dedicated advocates and keen observers of the political landscape.

Special thanks to Michael Shapcott for his careful review and thoughtful comments on draft reports, continued support and enthusiasm for this project, and his and the Wellesley Institute's ongoing commitment to put research into action for social change.

I would like to extend my appreciation to Bob Gardner, Dianne Patychuk, Dean Herd and Jim Dunn for their helpful advice and assistance with this project. Many thanks to Rick Eagan, CSPC-T research advisory committee member and project advisory liaison for his active engagement and grounded perspective. I would also like to thank CSPC-T research advisory committee members Luin Goldring, Tam Goossen, Rhonda Roffey and Cheryl Teelucksingh who provided important feedback contributing to the development of this report.

Many thanks go to Raluca Fletcher, Esther Guttman and Zak Tucker-Abrahmson for their thorough research assistance.

I would like to acknowledge the vital financial contributions of our project funders, the Wellesley Institute and Social Sciences and Humanities Research Council of Canada, and CSPC-T's core funders, City of Toronto and United Way Toronto.

Many of the 1.3 million Ontarians living in poverty are sick and tired of being sick and tired. This project builds on a strong base of compelling research demonstrating the critical need to invest in the social determinants of health. It's in the interest of individual health, and the fiscal health of our health care system and the economy. It is my hope that this work will help propel our governments forward to take real action on poverty, bad jobs and poor health.

Beth Wilson, *Report Author*

About the partners

Community Social Planning Council of Toronto (CSPC-T) is a non-profit community organization committed to building a civic society in which diversity, equity, social and economic justice, interdependence and active civic participation are central. CSPC-T works with diverse communities, engages in community-based research and conducts policy analysis with an aim of improving the quality of life of all Toronto residents.
www.socialplanningtoronto.org

The **Social Assistance in the New Economy** (SANE) research initiative is a multi-year, multi-disciplinary inquiry into the changing nature of social assistance in Ontario and its relation to precarious employment in a globalizing economy. Funded primarily by the Social Sciences and Humanities Research Council (SSHRC) through four major grants, the research program comprises a number of complementary research projects which are investigating: the welfare and post-welfare experiences of social assistance recipients as well as the labour market experiences of those precariously employed. Our methodologies include primary data collection through qualitative in-depth interviews through to secondary analysis of large data sets such as the SLID and CCHS. Aside from publishing extensively in the academic literature, SANE has advised various non-profit community-based agencies and governments on policies towards income support for those with low incomes.
www.oise.utoronto.ca/fsw/exponent/fsw/fswsupport/sane/

The **Wellesley Institute** is a Toronto-based non-profit and non-partisan research and policy institute. Our focus is on developing research and community-based policy solutions to the problems of urban health and health disparities. We identify and advance practical and achievable policy alternatives and solutions to pressing issues of urban health; fund research on the social determinants of health and health disparities, focusing on the relationships between health and housing, poverty and income distribution, social exclusion and other social and economic inequalities; support community engagement and capacity building; work in numerous collaborations and partnerships locally, nationally and internationally, to support social and policy change to address the impact of the social determinants of health.
www.wellesleyinstitute.com

Executive Summary

Falling on the heels of the release of Ontario's landmark poverty reduction strategy, *Sick and Tired* paints a grim picture of the health of the province's poorest residents. This new report from the Community Social Planning Council of Toronto, University of Toronto's Social Assistance in the New Economy Project and the Wellesley Institute documents the compromised health of social assistance recipients and the working poor in Ontario. Following a discussion of Ontario's health-compromising social assistance system and troubling labour market realities, we offer recommendations to strengthen the Province's poverty reduction plan, address the increased burden of ill health among poor people in Ontario, and promote equitable access to health services in Ontario. In addition to addressing poverty and health equity issues, many of our recommended actions, if enacted, will promote much-needed economic stimulus as an antidote to Ontario's struggling economy and promote cost savings in the health care system.

Context

This report 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.

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.

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).

Today's global economic crisis, coupled with the continued disadvantage of low income Ontarians, offers no reason to imagine that the health prospects of low income working-age Ontarians have improved since our survey data was collected in 2005. In fact, forecasts for a continued steep downturn through 2009 suggest even tougher economic times ahead for growing numbers of Ontarians, and greater risks to individual health.

Results

Our analysis revealed that social assistance recipients carry an overwhelmingly high burden of ill health. Compared to the non-poor, they had significantly higher rates of poor health and chronic conditions on 38 of 39 health measures – rates as much as 7.2 times higher than those of the non-poor group. Social assistance recipients had higher rates of diabetes, heart disease, chronic bronchitis, arthritis and rheumatism, mood disorders, anxiety disorders and many other conditions.

Perhaps most distressing, 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.

The median household income for this highly stressed, health compromised and vulnerable group was a mere $13,000 a year.

The health of Ontario's working poor was a more complicated story. 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. They had worse self-reported health and mental health and higher rates of considering and attempting suicide compared to the non-poor group.

Analyses also revealed unexpected findings where the non-poor group had significantly higher rates on some health measures compared to the working poor group. These differences were due, in large part, to a phenomenon called the "healthy immigrant effect" whereby immigrants, and particularly newcomers, enjoy better health compared to their Canadian-born peers. This health benefit diminishes over time. The longer immigrants live in Canada, the more their health levels begin to approximate that of the Canadian-born population. The overall health of the working poor group was better than expected, and on some measures better than the non-poor group, because of the large proportion of the working poor that are immigrants (53%) and their relatively shorter periods of time spent living in Canada.

While faring better than the social assistance group, the working poor had a median household income of just $21,000 a year. This compares to a median household income of $80,000 a year for the non-poor group.

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.

Consistent with their higher rates of ill health, social assistance recipients reported significantly more consultations with medical professionals of all kinds compared to the non-poor group. In contrast, the working poor group had more consultations with general practitioners but fewer consultations with specialists and other medical practitioners compared to the non-poor group. 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.

The working poor group had much lower rates of insurance coverage for vision, dental, prescription medication and hospital care services compared to the non-poor group, and in most cases, the social assistance 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.

The poor groups were also less likely to access preventative health care services. 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.

Lack of access to and use of primary and preventative health care contributes to more serious and costly health problems down the road. Barriers to health care access hurt individuals and families and cost the health care system.

Implications

Study findings raise important questions about Ontario's social assistance system and changing labour market realities. Ontario's social assistance system is the main source of income for the most health compromised group of working-age people in the province. Inadequate Ontario Works (OW) and Ontario Disability Support Program (ODSP) rates leave recipients living in deep poverty. 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. Related research reveals considerable barriers to ODSP for Ontarians with disabilities in financial need (Centre for Addiction and Mental Health, 2003; Income Security Advocacy Centre, 2003; Lightman et al., in press; ODSP Action Coalition, 2008; Social Planning Council of Ottawa, 2001; Street Health, 2006). Coupled with inadequate rates, recipient health is further compromised by their exposure to punitive bureaucracies and social stigma associated with social assistance.

Major labour market restructuring in industrialized countries like Canada has contributed to an expansion of precarious employment characterized by short-term, temporary and contract positions with low wages and few, if any, benefits (Community-University Research Alliance on Precarious Employment, 2005). The working poor in Ontario occupy low wage and precarious positions in a

province with out-dated employment standards' protections and a lack of enforcement. While recent provincial government action offers new hope for exploited workers, this represents only one small step on the path toward ensuring basic rights for all Ontario workers.

Lack of an adequate minimum wage remains an issue for Ontario workers. While the current provincial government has made modest annual increases, today's rate at $8.75 per hour still leaves full-year, full-time workers living in poverty. Lack of access to federal Employment Insurance (EI) benefits further compromises the health of the working poor by leaving them to the inadequacies of social assistance during periods of unemployment – an especially worrisome prospect as the economy continues to plummet.

Recommendations

We offer the following recommendations to support the reduction of poverty in Ontario, to address the increased burden of ill health faced by poor people in Ontario, and to 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 EI 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.

Improving 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.

Sick and Tired is the companion report to *Poverty is Making Us Sick: A Comprehensive Survey of Income and Health in Canada*. Our first report documented the dramatic health inequities among income groups in Canada across a broad range of chronic conditions and health measures, as well as, different patterns of health care use according to income. Both reports are available online at www.socialplanningtoronto.org.

Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario

"Inequity in the conditions of daily lives is shaped by deeper social structures and processes; the inequity is systematic, produced by policies that tolerate or actually enforce unfair distribution of and access to power, wealth, and other necessary social resources."

- World Health Organization, 2008

Introduction

In August 2008, the World Health Organization released a groundbreaking study on the social determinants of health – the political, social and economic forces that shape people's health and people's lives. Closing the Gap in a Generation documents health inequities between and within countries revealing the central role of public policy on individual health. Drawing from a broad base of research, this renowned team of scholars, policy makers and former heads of state and health ministries calls all governments to action on the social determinants of health.

They offer concrete proposals and real world examples that can close the health gap within a generation – from action to ensure fair and decent employment, access to safe and affordable housing, and the provision of quality education and child care to the promotion of gender and racial equity, inclusive social and political decision-making and adequate social protections to ensure healthy living.

As one of the signatory countries to the World Health Organization's Commission on Social Determinants of Health, Canada has made a commitment to advance the social determinants of health domestically and internationally. In December 2008, the Ontario provincial government introduced a poverty reduction strategy to reduce child poverty by 25% in 5 years – a landmark commitment in the history of Ontario (Government of Ontario, 2008). The provincial plan is an important vehicle for reducing poverty, stimulating the economy, and taking action on the social determinants of health.

Many individuals and groups have offered moral and ethical arguments for the need to act on poverty as it relates to ill health. Research also supports the economic benefit of reducing poverty. In a recent study on the economic costs of poverty in Ontario, researchers pegged poverty-induced costs related to provincial health care at $2.9 billion (Laurie, 2008). Real investments to address poverty in Ontario are critical to supporting individual health and safeguarding the fiscal well-being of our health care system and our economy.

In this report, we focus on the health of social assistance recipients and the working poor in Ontario – two groups that should be at the centre of Ontario's poverty reduction plan. We first present results on the health and health care use of these low income Ontarians, and we then offer a series of recommendations to strengthen the provincial government's poverty reduction strategy, to address the disproportionate burden of poor health experienced by low income Ontarians, and to promote health equity within Ontario.

Sick and Tired is the companion piece to *Poverty is Making Us Sick: A Comprehensive Survey of Income and Health in Canada*. In our first report, we examined the health and health care use of the Canadian population by household income quintile. Income quintiles divide the population into five equal groups starting with the bottom 20% of the population with the lowest household incomes, followed by the next 20% and so on, up to the top 20% with the highest household incomes. This report documented dramatic health inequities among income groups across a broad range of chronic conditions and health measures, as well as different patterns of health care use according to income. Not only did the rich have better health outcomes than the poor, health status improved at each successive step up the income ladder. Using multivariate analyses, we found that an increase of $1,000 in household income

for the lowest income Canadians was associated with substantial decreases in rates of many chronic conditions.

Building on our first report, *Sick and Tired* focuses on health equity issues in Ontario. In this document, we focus in particular on recipients of social assistance and on the working poor. Our findings are broadly in line with those of the earlier study, though the differences among groups are often more pronounced in the present report.

Method

This analysis is based on Ontario data from the most recent Canadian Community Health Survey (CCHS) conducted in 2005. Statistics Canada's CCHS is the most comprehensive survey of the health and health care use of Canadians. Health outcome and health care use information for the Ontario population aged 18-64 years was utilized in this analysis. A total of 24,464 Ontario respondents were included. Standard methods were used to weight the data in order to represent the overall population.

We compared the incidence of specific chronic conditions, health-related measures and health care use, adjusted for age, for three groups:

- **Working Poor:** respondents whose main source of household income is from wages, salaries or self-employment and whose household income is at or below the Low Income Measure (LIM)
- **Social Assistance Recipients:** respondents whose main source of household income is from provincial or municipal social assistance or welfare and whose household income is at or below the LIM; this group includes both Ontario Works (OW) and Ontario Disability Support Program (ODSP) recipients
- **Non-Poor:** respondents whose household income is above the LIM

Statistics Canada's LIM was used to categorize respondents as low income or not. The LIM is a widely used measure of low income. LIMs are set at 50% of the median household income for Canada and take into account family size.

The CCHS does not distinguish between OW and ODSP income sources. For this reason, the social assistance group includes both OW and ODSP recipients.

Multivariate analyses were conducted to better understand the multiple factors associated with ill health. These analyses included the following variables: age, gender, racialized status (referred to by Statistics Canada as visible minority), Aboriginal status, educational attainment, participation and activity limitation (used as a proxy for disability), physical activity level, daily smoker status, employment status, adjusted household income, and social assistance receipt (as main source of household income). These analyses allowed us to consider the question: when multiple factors associated with ill health are taken into account, are household income and/or social assistance receipt still significant predictors of ill health? As well, multivariate analyses allowed us to look at the association between social assistance receipt and ill health when disability status (among other factors) is taken into account (i.e. held constant).

A detailed description of the methodology is available online at www.socialplanningtoronto.org.

Context

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 further declines 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 and 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.

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).

Today's global economic crisis, coupled with the continued disadvantage of low income Ontarians, offers no reason to imagine that the health prospects of low income working-age Ontarians have improved since our survey data was collected in 2005. In fact, forecasts for a continued steep downturn through 2009 suggest even tougher economic times ahead for growing numbers of Ontarians, and greater risks to individual health.

Results

Table 1 shows the characteristics of the poverty status groups included in this analysis. Poverty status groups vary substantially on many characteristics. The poor groups have disproportionately larger numbers of women, Aboriginal people, members of racialized groups, and immigrants.

Women comprise nearly two-thirds of the social assistance group compared to 55% of the working poor and just about half of the non-poor group. Nine percent of the social assistance group is Aboriginal compared to just 3% of the working poor and 2% of the non-poor group. Almost half of the working poor are members of racialized groups compared to 40% of the social assistance group and just 20% of the non-poor group. Over one-half of the working poor group are immigrants compared to just over one-third of the social assistance group and 28% of the non-poor group.

The social assistance recipient (40 years) and non-poor (41 years) groups have higher mean ages than the working poor group (37 years).

The social assistance group includes disproportionate numbers of single people (32%) and lone parent families (31%). In contrast, single people make up 17% of the working poor and 13% of the non-poor, and lone parent families comprise 13% of the working poor and just 6% of the non-poor. Households with children make up a full 60% of the working poor compared to 45% of social assistance recipients and 43% of the non-poor.

At 84%, the non-poor rate for post-secondary graduate attainment is twice that of the social assistance group (42%). Almost 7 in 10 of the working poor completed post-secondary studies. In contrast, the social assistance group (29%) has 10 times the rate of not completing high school compared to the non-poor group (2.7%). At 6.1%, the working poor group had more than two times the rate of not completing high school compared to the non-poor.

More than four out of five of the non-poor have current jobs compared to nearly three-quarters of the working poor and just 14% of the social assistance group. All of the working poor and almost all of the non-poor reported household income from wages, salaries or self-employment. Although considerably lower than the working poor and non-poor, still more than one-quarter of the social assistance group reported some household income from wages, salaries or self-employment.

Median household incomes varied considerably with the non-poor reporting $80,000, compared to just $21,000 for the working poor and a meagre $13,000 for social assistance recipient households.

Table 1. Characteristics of poverty status groups (percent unless otherwise noted)

	Non-poor (unweighted n=22,127)	Working poor (unweighted n=1,612)	Social assistance (unweighted n=725)
Gender			
Male	51.5	44.6	38.5
Female	48.5	55.4	61.5
Age			
Mean age	40.6	36.6	40.1
18-24	12.6	22.5	15.5
25-34	20.9	21.3	17.3
35-44	27.0	27.9	28.8
45-54	23.4	18.8	21.4
55-64	16.1	9.4	16.9
Ethnoracial/cultural group			
Aboriginal person	1.5	2.6	8.9
Member of racialized group	20.4	47.8	39.5
Immigrant status			
Immigrant (born outside of Canada)	28.1	53.3	36.6
Household composition			
Single person	12.6	16.5	31.6
Couple with child/children	51.9	52.0	21.0
Lone parent with child/children	5.7	12.8	31.2
Couple without children	21.8	8.6	10.7
Other family composition	8.1	10.1	5.6
Households with children	43.2	60.0	45.1
Educational attainment			
Less than secondary school	2.7	6.1	29.0
Secondary school graduate	8.9	15.4	17.7
Some post-secondary	4.7	9.4	11.6
Post-secondary graduate	83.8	69.1	41.8
Employment status, income and income source			
Has current job	83.3	74.4[1]	13.8
Has household income for 12-month period preceding interview from wages, salaries or self employment	96.7	100.0	27.6
Median household income for 12-month period preceding interview	$80,000	$21,000	$13,000

Health and Health-Related Measures

In almost every instance, the social assistance group had dramatically higher rates of health problems and chronic conditions across a broad range of measures compared to the working poor and the non-poor groups. Strong statistically significant differences were found between the social assistance group and the other two groups.

The working poor had significantly worse health than the non-poor on several measures. Unexpectedly, the non-poor were found to have higher rates on some health outcomes compared to the working poor. This latter finding was largely a product of the 'healthy immigrant effect', a phenomenon discussed below in the Implications section.

This section focuses on selected major findings from the analyses. Full results are provided in the Appendix.

Self-rated health - Respondents were asked to rate their health as excellent, very good, good, fair or poor. Self-rated health is a valid and reliable measure, strongly correlated with objective measures of health including physicians' ratings (see Shields & Shooshtari, 2001 for review).

On average, Ontarians rate their health highly. However these ratings differ significantly between poverty status groups. As shown in figure 1 (shown below), the social assistance group had significantly higher rates of poor or fair health compared to the working poor and non-poor groups – more than 3 to 5 times higher. The working poor had significantly higher rates than the non-poor group as well.

Disability - Respondents were asked about participation and activity limitations that affected their daily lives at work, school, home and in other settings. The social assistance group had significantly higher rates of participation and activity limitations – 3.5 to 4 times higher than that of the other two groups.

Respondents reported the number of days during the two-week period preceding their interview that they spent all or most of the day in bed because of illness or injury. Again the social assistance group had significantly higher rates at 2.8 days compared to .8 days for the other two groups.

Stress - The social assistance group had significantly higher rates of high stress compared to the other two groups. Over one-third of the social assistance group reported feeling quite a bit or extremely stressful most days compared to around one-quarter of respondents from the other two groups.

Suicide[2] - Particularly disturbing results emerged in analyses pertaining to suicide. As shown in figure 2 (on the following page), the social assistance group had significantly higher rates of considering suicide and attempting suicide than the other two groups. In the 12-month period preceding their interview, one in ten respondents from the social assistance group considered suicide and 2% attempted suicide – rates that are 10 times higher than the non-poor group.

The working poor also had significantly higher rates of considering and attempting suicide than the non-poor group. The working poor group was twice as likely to attempt suicide in the 12-month period preceding their interview compared to the non-poor group.

FIGURE 1

'Poor' or 'Fair' Self-Reported Health
Age-Adjusted Rates per Thousand Population by Poverty Status

Ontario, Population 18-64, 2005

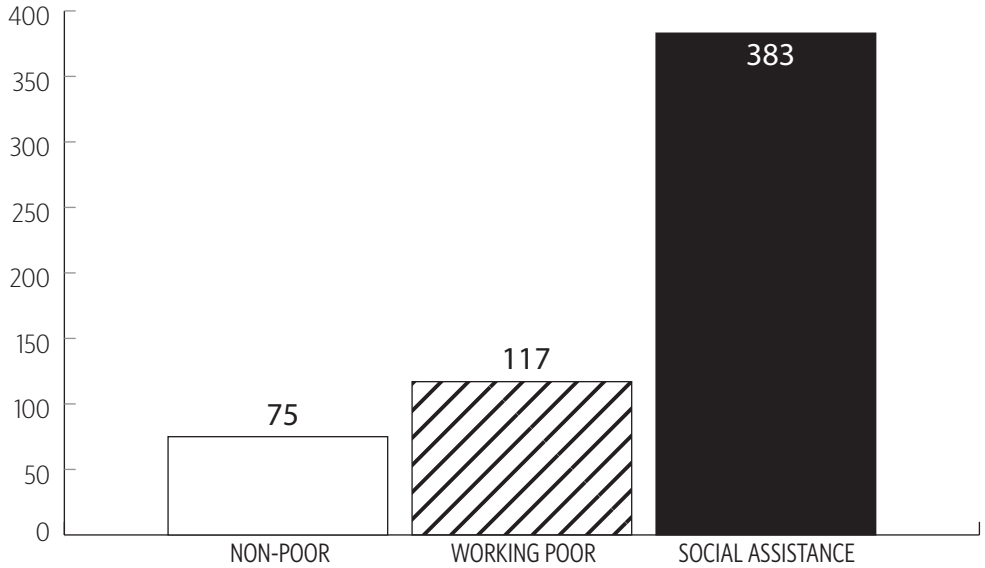
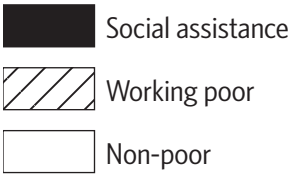


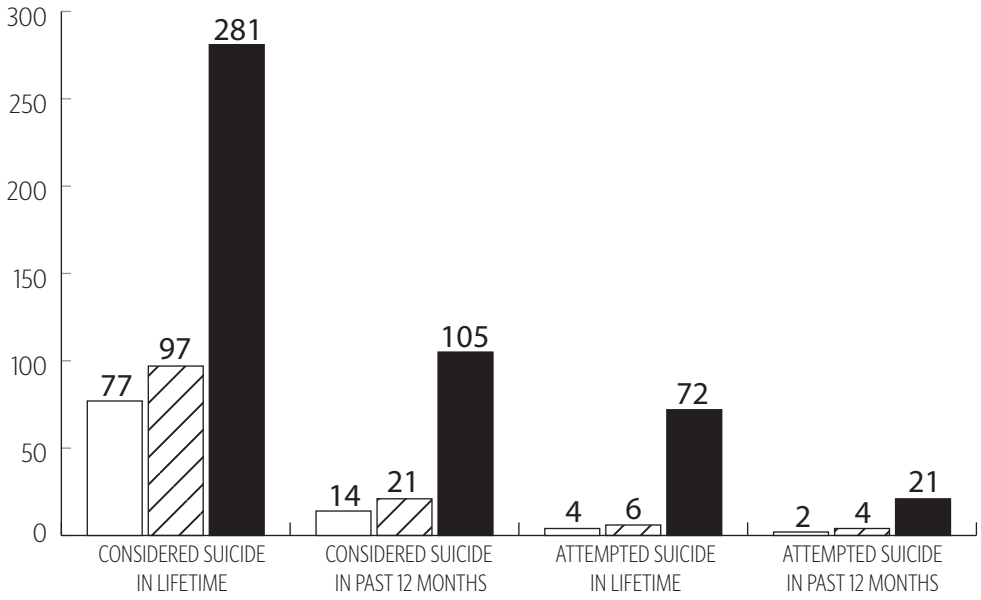
FIGURE 2

Considered and Attempted Suicide

Age-Adjusted Rates per Thousand Population by Poverty Status

Ontario, Population 18-64, 2005





Chronic conditions - Respondents were asked whether a medical practitioner had diagnosed them with various chronic conditions. The presence of at least one chronic condition is quite common among working-age Ontarians. However rates vary widely by poverty status.

The social assistance group had significantly higher rates of chronic conditions, multiple conditions and total number of conditions compared to the other two groups. A total of 85% of social assistance recipients had a chronic condition compared to 69% of the non-poor and 63% of the working poor. The non-poor had significantly higher rates of having at least one chronic condition compared to the working poor. However, the working poor had significantly higher rates of multiple chronic conditions compared to the non-poor.

Diabetes - As shown in figure 3 below, social assistance recipients had a significantly higher rate of diabetes compared to the other two groups. With more than one in ten individuals affected, the diabetes rate was 2.1 to 3.6 times higher in the social assistance group compared to the other two groups. The working poor also had significantly higher rates compared to the non-poor – 1.7 times higher.

Heart disease - Social assistance recipients had significantly higher rates of heart disease compared to the other two groups. At 8%, the rate was more than 2 to 3 times higher among social assistance recipients compared to the other two groups. The working poor also had significantly higher rates at more than 1.3 times that of the non-poor group.

FIGURE 3

Diabetes

Age-Adjusted Rates per Thousand Population by Poverty Status

Ontario, Population 18-64, 2005

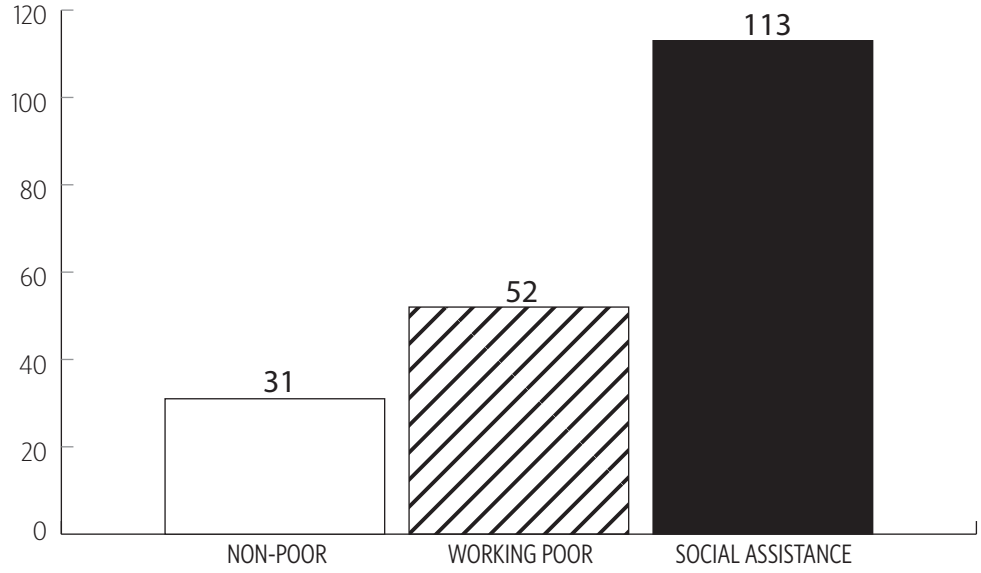
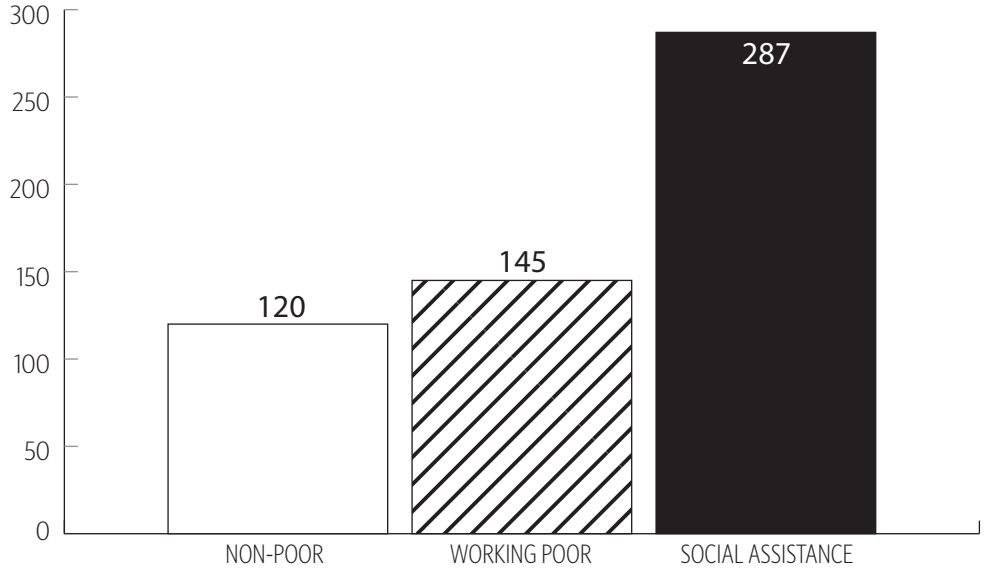


FIGURE 4

Migraines
Age-Adjusted Rates per Thousand Population by Poverty Status

Ontario, Population 18-64, 2005



Migraines - As shown in figure 4 above, the social assistance group had significantly higher rates of migraines at nearly double to over 2.3 times the rates of the other two groups. The working poor group also had significantly higher rates than the non-poor group.

Chronic bronchitis - Again the social assistance group had significantly higher rates of chronic bronchitis at 2.8 and 4.6 times that of the other two groups. Rates were significantly higher among the working poor compared to the non-poor as well.

Asthma - At 16%, the asthma rate among social assistance recipients was double that of the other two groups.

Arthritis and rheumatism - Figure 5 below shows the elevated rates of arthritis and rheumatism among social assistance recipients compared to the other two groups. The social assistance group had rates more than double that of the working poor and non-poor.

Mood disorders - As shown in figure 6 (on the following page), the social assistance group had significantly higher rates of mood disorders at nearly four times that of the other two groups.

Health Care Service Use

The social assistance and working poor groups were significantly more likely to report not having a doctor (13-15%) compared to the non-poor group (10%).

Despite being less likely to have a regular medical doctor, social assistance recipients reported significantly more consultations with all medical professionals, general

FIGURE 5

Arthritis or Rheumatism
Age-Adjusted Rates per Thousand Population by Poverty Status

Ontario, Population 18-64, 2005

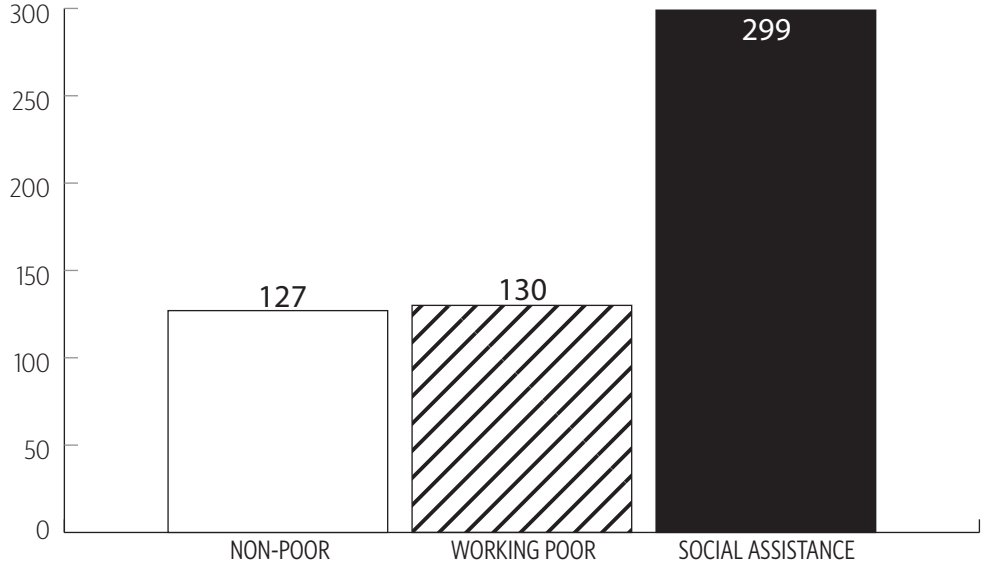
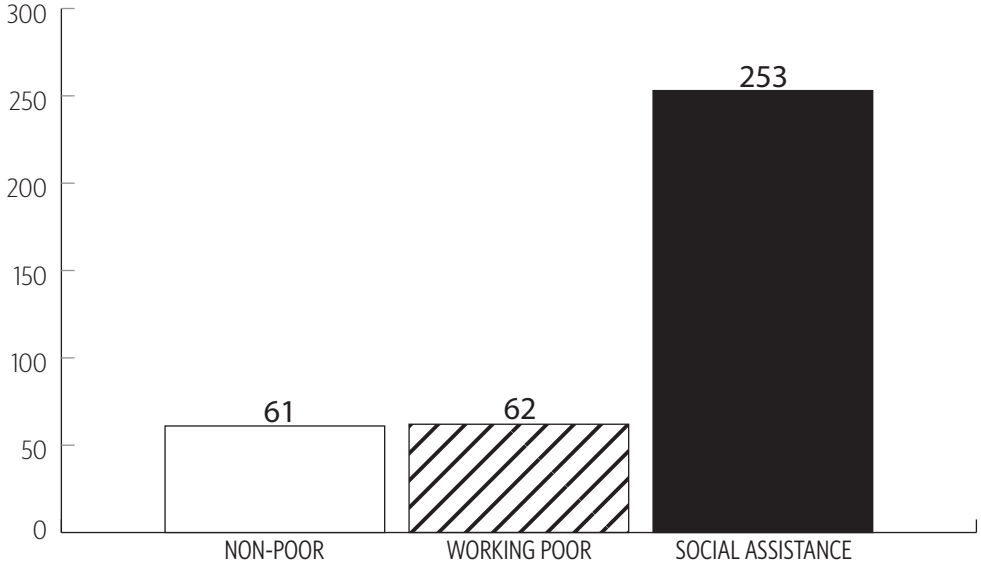


FIGURE 6

Mood Disorder
Age-Adjusted Rates per Thousand Population by Poverty Status

Ontario, Population 18-64, 2005



practitioners, specialists, and other medical practitioners compared to the non-poor and working poor groups.

The non-poor group had significantly more consultations with all medical practitioners, specialists, and other medical practitioners compared to the working poor group. In contrast, the working poor group had significantly more consultations with general practitioners than the non-poor group.

Figure 7 below shows the differences in consultations with medical practitioners among poverty status groups.
The social assistance group had a significantly higher number of nights spent in a hospital, nursing home or convalescent home compared to the other two groups.

Preventative Health Care Service Use

In general, the working poor and social assistance groups were less likely to have accessed various preventative health measures than the non-poor group. In some cases, the working poor group had lower rates than the social assistance group.

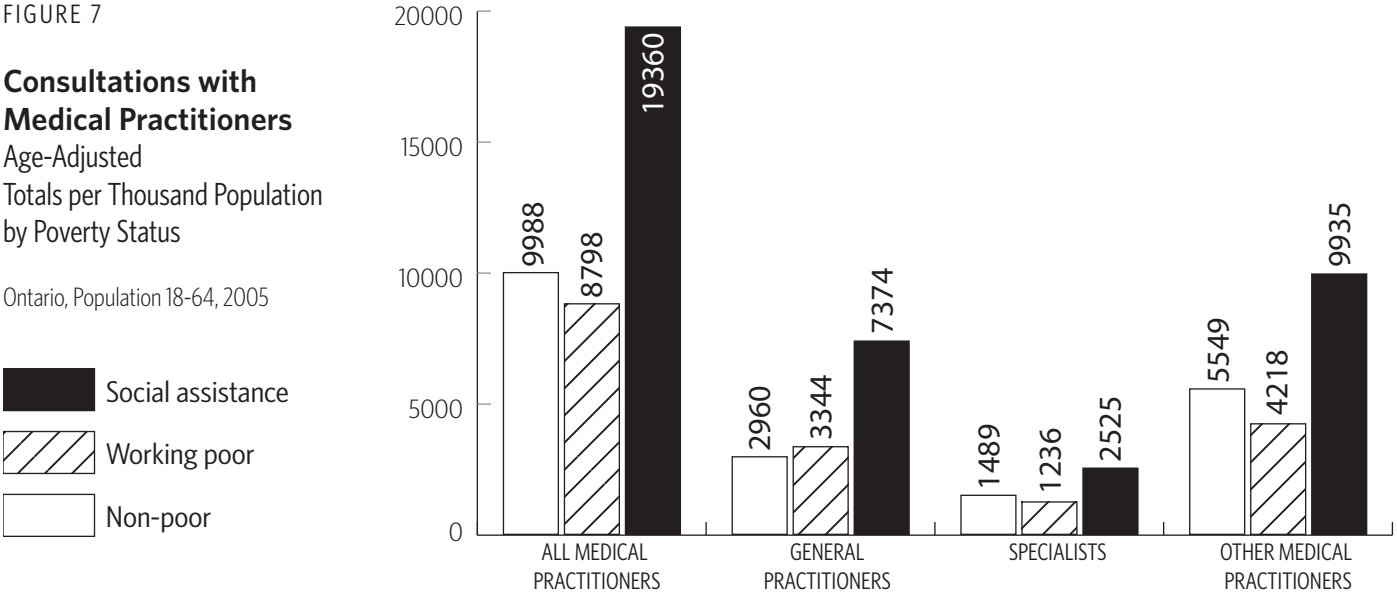
Most working-age Ontarians have had an eye exam and visited a dentist in the past. However important differences emerged for poverty status groups.

The working poor were significantly more likely to report never having an eye exam compared to the non-poor

FIGURE 7

Consultations with Medical Practitioners
Age-Adjusted
Totals per Thousand Population by Poverty Status

Ontario, Population 18-64, 2005



group. The non-poor group was significantly more likely to report having a recent eye exam compared to the poor groups.

The working poor group was significantly more likely to report never having visited a dentist compared to the other two groups. Again, the non-poor group was significantly more likely to report having a recent visit to a dentist compared to the poor groups.

With regard to women's health, the working poor and social assistance groups were significantly more likely to report never having had a breast exam, a mammogram among women 40-64 years of age, or a pap smear test compared to the non-poor group.

Among 40-64 year olds, the working poor group was significantly more likely to report never having had a colorectal cancer screening test compared to the non-poor and social assistance groups.

Unmet Health Care Needs

Social assistance recipients reported significantly higher rates of unmet health care needs compared to the other two groups. Over one-quarter reported unmet health care needs compared to 13-15% of the working poor and non-poor groups.

Respondents from the poor groups were significantly more likely to report cost (20-22%) as a reason for not receiving care compared to the non-poor group (9%). Poor respondents (4-7%) were also significantly more likely to report transportation problems compared to non-poor respondents (1%).

Access to Health Insurance

Strong significant differences were found among poverty status groups on access to health insurance. About four out of five respondents from the non-poor and social assistance groups had health insurance for prescription medications compared to just over two out of five respondents from the working poor group. Similarly, about 70% of respondents from the non-poor and social assistance groups had insurance for eyeglasses and contact lenses compared to 29% of the working poor group.

A different pattern emerged for dental care coverage and hospital charges. Non-poor respondents (78%) had the highest rate of dental care coverage, followed by the social assistance group (66%) and then the working poor group (39%)[3]. Significant differences were found between all three groups. Almost three out of four non-poor respondents have insurance to cover hospital charges compared to 24-28% of the social assistance and working poor groups.

Food Insecurity

The rate of household food insecurity among social assistance recipients was 15 times higher than that of the non-poor group, and almost 3 times higher than the working poor group. Almost half of all respondents from the social assistance group were in food insecure households compared to 17% of the working poor and 3% of the non-poor. These differences were highly significant.

Chronic Conditions: Examining Multiple Factors

We conducted a series of multivariate analyses to test for associations between household income and ill health, and social assistance receipt and ill health, when other factors related to ill health are taken into account (see Table F in the Appendix). These control variables included: age, gender, racialized status, Aboriginal status, educational attainment, participation and activity limitation (a proxy for disability status), physical activity level, daily smoker status and employment status.

After taking into account all of these factors, household income and/or social assistance receipt continued to be significantly associated with 6 out of 8 chronic condition categories, and 15 out of 21 specific chronic conditions.

It is important to stress that these associations are statistically significant after taking into account (i.e. holding constant) the effects of demographic, educational, employment, health behaviour factors and disability status.

Implications

Social Assistance and Sickness

Results of this study paint a grim picture of the health of social assistance recipients in Ontario. Social assistance recipients have significantly higher rates of poor health and chronic conditions on 38 of 39 health measures compared to the non-poor, and 37 of 39 health measures compared to the working poor. Their rates on conditions such as diabetes, heart disease, chronic bronchitis, arthritis

and rheumatism, mood disorders and anxiety disorders are 2.4 to 4.6 times higher than that of the non-poor. Not surprisingly, over one-third report high stress levels. Forty percent of the social assistance group often experience participation and activity limitations that interfere with their everyday lives.

Perhaps most distressing, over one-quarter of social assistance recipients considered suicide in their lifetime and one in ten in the 12-month period preceding their interview. The social assistance group reported attempting suicide at rates that were 5 to 18 times higher than the non-poor and working poor groups.

Multivariate analyses resulted in powerful findings linking household income and social assistance receipt to a broad range of chronic conditions, even when other factors, including disability status and health behaviour factors such as smoking and physical activity, were taken into account.

The median annual household income for this highly stressed, health compromised and vulnerable group was a mere $13,000.

While data from this study cannot directly address the causal relationship between income and health, researchers that have explored this question have found that while poor health affects income by diminishing a person's ability to engage in paid employment, the strongest causal influence shows low income leading to poor health (Phipps, 2003). Regardless of whether individuals initially experience falling incomes as a result of ill health or declining health as a result of low income, the fact remains that poverty further compromises health and undermines a person's ability to cope with chronic health problems and to get well.

An Illness Producing System

Our analysis raises important questions about Ontario's social assistance system – a system that leaves the most health compromised group of working-age people in the province to subsist on meagre income assistance. In fact, rates are so low that almost half of all recipients live in food insecure households.

Ontario's social assistance system includes two main programs: Ontario Works (OW) and the Ontario Disability Support Program (ODSP). OW is intended as the short-term income assistance program of last resort, providing financial and employment assistance to recipients. ODSP provides longer-term income and employment assistance to Ontarians with disabilities.

OW and ODSP rates are abysmally low. In 2005 when our data was collected, estimated annual incomes[4] for OW recipients were $7,007 for a single person, $14,451 for a lone parent with one child and $19,302 for a couple with two children (National Council of Welfare, 2006). A person with a disability receiving ODSP had an estimated annual income of $12,057. These incomes were between 34% and 58% of the poverty line[5], with single OW recipients at the lowest level.

Comparing Ontario inflation-adjusted social assistance incomes between 1986 and 2005, the National Council of Welfare (2006) found the lowest incomes for three out of four family types occurred in 2005. The lowest social assistance income for a couple with two children occurred in 2003. By 2005, the annual income for this family type had increased by $75, about $6 more per month.

While the provincial government has made modest 2-3% periodic increases to social assistance rates in recent years, these rates remain troublingly low (National Council of Welfare, 2006; National Council of Welfare, 2008). Social assistance income statistics for 2007 reveal further declines for a single employable person and a person with a disability, when inflation is taken into account (National Council of Welfare, 2008). Since 2005, families with children fared better with an increase in social assistance incomes of 9.1% for a lone parent with one child and 4.7% for a couple with two children. However, estimated annual social assistance incomes remained at 33% to 61% of the poverty line in 2007, with single individuals receiving OW continuing to be the worst off. Inflation-matching increases alone have not changed the woeful inadequacy of Ontario's social assistance rates.

While disability assistance rates are well below the poverty line, ODSP provides higher levels of income assistance to recipients compared to OW. With their increased burden of compromised health and corresponding health care expenses, access to ODSP is vital to people with disabilities in financial need. We found very high rates of chronic conditions and ill health among social assistance recipients in general. While it was not possible to distinguish between OW and ODSP recipients in the dataset, these alarming rates, coupled with very low incomes, raise questions about the extent to which people with disabilities are gaining access to ODSP.

Several studies have documented the considerable barriers that Ontarians with disabilities face in accessing ODSP (Centre for Addiction and Mental Health, 2003; Income Security Advocacy Centre, 2003; ODSP Action Coalition, 2008; Social Planning Council of Ottawa, 2001; Street Health, 2006). While some improvements have been made since the program's inception in 1998 (Ombudsman Ontario, 2006), advocates continue to raise serious concerns about access to ODSP. Lack of access leaves people with disabilities either with no income or struggling to survive on OW (Ombudsman Ontario, 2006).

Social assistance recipients in Ontario live in grinding poverty. For the large numbers struggling with ill health, poverty further undermines their ability to cope with health problems and to improve their health. In addition, social assistance recipients have the extra burden of dealing with Ontario's social assistance system – a complex and punitive bureaucracy that promotes stress, anxiety, depression and self-blame (Community Social Planning Council of Toronto & Family Service Association of Toronto, 2004; Herd et al., 2005; Herd & Mitchell, 2002; Lightman et al., 2003a; Lightman et al., 2003b). As well, social assistance recipients are confronted with societal judgment and social exclusion associated with being 'on welfare' (Power, 2005; Reid & Tom, 2006; Swanson, 2001). Rather than a source of support in hard times, the system and the societal baggage associated with it further undermine the health of social assistance recipients.

Poor Health and The Working Poor

The health of the working poor is a more complicated story. The working poor have higher rates of diabetes, heart disease, chronic bronchitis, migraines, multiple chemical sensitivities and learning disabilities compared to the non-poor group. They have lower self-reported health and mental health, a higher rate of household food insecurity and are more likely to report multiple chronic conditions compared to the non-poor group.

Compared to the non-poor, the working poor were more likely to consider suicide in their lifetime and in the 12-month period preceding their interview. They were twice as likely as the non-poor group to attempt suicide in the year prior to their interview.

While the working poor group had higher rates on a number of health problems, they did not differ from the non-poor group in the average number of days spent in bed due to illness or injury. This is likely related to working conditions in the precarious labour market that generally provide low wages with no benefits. While the working poor may need time to recover, and their health may be further compromised by continuing to work through illness and injury, taking time off may be a luxury that they simply cannot afford. In contrast, the non-poor group was more likely to enjoy both higher wages that would allow them to take time off, and benefits such as sick days and long-term disability plans that prevent or reduce losses of wages related to illness and injury.

The Working Poor and the Healthy Immigrant Effect

While the working poor have compromised health outcomes on a number of measures, the whole story of their health is more complex. The non-poor, compared to the working poor, were more likely to report having at least one chronic condition, and had higher rates of endocrine and metabolic conditions, circulatory system conditions, musculoskeletal conditions, miscellaneous conditions, allergies other than food allergies, high blood pressure, urinary incontinence, bowel disorder and other chronic conditions.

These differences can be explained, in large part, by a phenomenon called the "healthy immigrant effect". National data strongly support the existence of the healthy immigrant effect, whereby immigrants and particularly newcomers to Canada enjoy better health, including lower rates of chronic conditions, than their Canadian-born counterparts overall (Newbold, 2006; Ng et al., 2005). Researchers have found that this health benefit diminishes over time until immigrant health levels begin to approximate that of their Canadian-born counterparts, and is particularly evident among non-European immigrants.

Researchers have explored this issue in some depth. They point to the impact of immigration policies that exclude immigrants with 'medically inadmissible' conditions as a reason for newcomers' superior health relative to their Canadian-born peers and barriers to health care services that result in lower rates of medical diagnoses (Newbold, 2006). The declining health of immigrant groups over time has been attributed to the impact of disproportionate rates of poverty, poor working conditions and the lack of recognition of internationally-acquired credentials.

In our sample, over half of the working poor are immigrants compared to 28% of the non-poor group. Despite their income levels, it is not surprising to find better than

expected health outcomes for the working poor as a result of the healthy immigrant effect. We conducted additional analyses showing that immigrants in the working poor group had been living in Canada an average of 12 years compared to 22 years in the non-poor group. This data further suggested that the healthy immigrant effect was at work.

Additional analyses revealed that the healthy immigrant effect was a significant factor in explaining the contrary results between the working poor and non-poor groups. We conducted separate analyses for the Canadian-born and immigrant populations in Ontario for the ten health outcomes where the non-poor group had higher rates than the working poor group.[6]

In analyses of the Canadian-born population controlling for age, the results either reversed themselves, where the working poor had higher rates of ill health than the non-poor or no differences were found between groups.

In analyses of the immigrant population controlling for age and length of residency in Canada, we found either no significant differences between the working poor and non-poor groups, or a significant but diminished difference between groups where the non-poor continued to have higher rates for some health problems compared to the working poor group. After taking into account age and length of residency in Canada, the non-poor immigrant group had significantly higher rates of the following chronic conditions/categories compared to the working poor immigrant group: having at least one chronic condition, musculoskeletal conditions, miscellaneous conditions, allergies other than food allergies, high blood pressure and bowel disorder. Differences in experiences with the health care system may also explain some of these findings. Additional research is needed to further unpack these results.

Low Wages, Precarious Work and Compromised Health

Labour markets in industrialized countries like Canada have undergone major restructuring over the past 30 years, resulting in an expansion of precarious employment. In Canada, 37% of jobs are part-time, temporary or self-employed positions (Community-University Research Alliance on Precarious Employment, 2005). In 2005, 22.5% of Canadians, aged 25-64 years, working full-year full-week had an annual income of less than $30,000, up from 21.1% in 2000 (Statistics Canada, 2008). Among women, aged 25-64 years, working full-year full-week, 23.5% had an annual income below $30,000 compared to 21.7% of men. Almost one-quarter of all jobs in Ontario pay less than $10 an hour (Workers' Action Centre, 2007a). Studies show that women, immigrants, and workers of colour are over-represented in the ranks of Ontario's working poor (Campaign 2000, Citizens for Public Justice & Workers' Action Centre, 2006).

The working poor in our study had a median annual income of $21,000 and low rates of insurance coverage for dental, vision, prescription drug and hospital expenses. Nearly half were members of racialized groups. More than half were immigrants, and more than half were women.

The working poor group is likely employed in low wage and precarious positions. These jobs typically include short-term, temporary and contract work with low pay and few, if any, benefits. Part-time employment is also a feature of precarious work. While some workers may desire part-time employment, many part-time workers seek and require full-time jobs to make ends meet. Workers in the precarious labour market may also juggle multiple jobs, are vulnerable to exploitive employers and generally lack access to collective representation.

In Toronto, the Workers' Action Centre (2007b) has documented widespread employment standards' violations, the complete exclusion of many workers from employment standards' protections, and a lack of enforcement of standards for workers who are covered by the provincial Employment Standards Act (an issue that the Province is beginning to address through its poverty reduction strategy). This research links poor working conditions from precarious employment to increased stress resulting in poor physical and mental health.

Due to restructuring of the Employment Insurance (EI) system (formerly Unemployment Insurance) in the mid-1990s, many workers with precarious employment are now ineligible for federal Employment Insurance (EI) benefits when laid off. This is particularly pronounced in Ontario, compared to the rest of Canada, and in the big urban centres such as Toronto. Drastic changes to the program rendered many workers with short-term and/or part-time positions – particularly women – ineligible due to inadequate insurable hours (Canadian Labour Congress, 1999). When short-term jobs end, these workers must scramble for other employment or turn to the social assistance system with its considerably lower benefit levels.

Lack of an adequate minimum wage has long been an issue for low wage workers in Ontario. The former Conservative provincial government froze the minimum wage at $6.85 per hour during both of its terms in office from 1995 to 2003 (Ontario Ministry of Labour, 2003). While the Liberal provincial government elected in 2003 began making modest annual increases to the minimum wage, these increases have not been sufficient to pull minimum wage earners out of poverty.

In recent years, workers, community groups and labour organizations mounted a vigorous campaign calling on the provincial government to raise the minimum wage to $10 per hour immediately. The provincial government responded by slating annual increases to bring the minimum wage up to $10.25 per hour in 2010 (Ontario Ministry of Labour, n.d.). Despite these advances, the current rate at $8.75 per hour still leaves minimum wage workers in poverty. Economists from the Canadian Centre for Policy Alternatives peg a living wage for Toronto at $16.60, nearly double the current rate (Mackenzie & Stanford, 2008).

Low wage and precarious employment contributes to the compromised health of the working poor. Lack of access to EI benefits puts short-term contract workers further at risk by leaving them to the inadequacies of the social assistance system when their employment ends. On a bright note, recent provincial actions promise to improve the position of some vulnerable workers in Ontario. In response to workers' advocacy efforts, the Ontario provincial government recently adopted legislation to extend protections for temp agency workers, arguably some of the most vulnerable workers in the province (Ontario Ministry of Labour, 2008). This legislation represents a first step toward improving protections for temporary workers in Ontario.

Health Care Inequities

Not surprisingly, the social assistance group with its much higher rates of chronic conditions and poor health reported significantly more consultations with medical practitioners of all kinds. These results are also expected given the requirements of ODSP applicants and recipients to provide detailed documentation from medical doctors to access and maintain benefits. Despite their frequent consultations with various medical professionals, the social assistance group was less likely to have a regular medical doctor compared to the non-poor group. While the working poor group reported more visits to general practitioners compared to the non-poor group, they were also less likely to have a regular medical doctor compared to the non-poor group.

In a 25-year review of health care utilization in Canada, Curtis and MacMinn (2008) report some parallel findings. This study showed that people in Canada with lower socioeconomic status (SES) were less likely to visit a physician compared to other residents. This inequity appears to be growing more prevalent over time. However, these researchers also found that once initial contact was made with a physician, residents with lower SES consulted with physicians more frequently than others. Similarly, we found both poor groups had more consultations with general practitioners compared to the non-poor group but were less likely to have a regular medical doctor.

Similar to our results with the working poor, these researchers found people in Canada with lower SES were less likely to see a specialist. Once initial contact was made with a specialist, these researchers found that income was no longer a factor in the number of specialist consultations between groups. While the working poor in our study had fewer consultations with specialists than the non-poor group, social assistance recipients had more consultations with specialists compared to the non-poor and working poor groups. This latter finding demonstrates that important differences exist within the lower SES group.

In addition, our data showed lower rates of preventative health care utilization among poor groups compared to the non-poor group. Rates were especially troubling regarding women's preventative health care where substantial numbers of women in the poor groups had never had a pap smear test, breast exam or mammogram for those over 40 years of age.

As well, the working poor were much less likely to have insurance to cover additional health services compared to the non-poor group. Social assistance recipients reported lower rates for dental care and hospital expense coverage compared to the non-poor. Although social assistance recipients had higher rates for dental coverage than the working poor, their government-provided coverage is limited to emergency services only.

In Ontario, delisting of some health care services has forced Ontarians without insurance to pay for additional services out of pocket (Browne, n.d.). Data from our study suggest that poor Ontarians are forgoing some health services due to cost. We found higher rates of unmet health

care need among the poor groups compared to the non-poor group, and cost cited as a factor for one in five poor respondents with unmet health care needs.

Our data and related studies reveal troubling inequities regarding health care service utilization (Curtis & MacMinn, 2008; Steele et al., 2002; Street Health, 2007). With regard to physicians and specialists, Curtis and MacMinn (2008) found that the largest inequities exist at the point of first contact. Their work documents a growing gap in the amount of health care received between the rich and the poor, Canadian-born and immigrant populations, and residents with lower levels of education compared to more highly educated residents. These trends have important implications for Ontario's working poor and social assistance recipients.

Curtis and MacMinn offer some recommendations to address Canada's growing health care inequities. They suggest an increased focus on language and cultural issues with regard to health care service provision, improved access to pharmaceuticals for residents who are unable to pay, increased access to physicians in poor areas, training of more physicians from diverse communities, public education, including development of multilingual materials, to promote use of preventative health care services, and development of clinical guidelines for physicians regarding appropriate referrals to specialists. These authors point out that improved access to primary care including medications may lessen the burden on emergency services and hospitals.

Human Costs, Health Care Costs

The increased burden of compromised health among social assistance recipients and the working poor undermines the quality of life of poor Ontarians and results in increased costs to the health care system. In a study of the impact of chronic conditions, Schultz and Kopec (2003) found moderate to severe quality of life impacts for people with Alzheimer's disease, urinary incontinence, effects of a stroke, arthritis and rheumatism, bowel disorders, chronic bronchitis and emphysema, back problems, epilepsy, heart disease and cataracts. Several of these conditions were more common among the poor groups in our study, particularly for social assistance recipients.

Individuals living with health problems and in poverty face difficult challenges. As supported by our research and others, they may lack the funds to pay for a nutritious diet which is critical to good health (Sieppert et al., 2004). The stress of living in poverty, unable to pay the bills and cover basic needs, including health-related needs, further exacerbates ill health. People living with ill health and in poverty are also disadvantaged by the lack of affordable housing and problems of substandard housing in Ontario. For social assistance recipients, the ongoing surveillance, and arbitrary and punitive nature of the system contributes to poor health (Community Social Planning Council of Toronto & Family Service Association of Toronto, 2004; Herd et al., 2005; Lightman et al., 2003a; 2003b; Baker Collins, 2005).

Both social assistance recipients and the working poor are engaged in systems that reduce their sense of control over their lives – whether as a result of interactions with the social assistance system or within precarious labour markets where workers have little control over their work environments. The loss of personal control, characteristic of social assistance systems and precarious work environments, has important implications for individual health.

Poverty also affects people's relationships and connections to community. It can limit a person's ability to participate in the broader community which may already be hindered by illness, contributing to social isolation which further undermines health. Material deprivation can erode relationships among family members (Hamelin et al., 2002). Worried parents sacrifice their own material needs to provide for their children in an attempt to spare them from the impact of poverty. For families living in poverty, a parent or family member's illness adds additional strain to an already difficult situation.

In addition to the human costs, poverty also contributes to added financial costs to the health care system. Our study found longer in-patient stays for social assistance recipients compared to the working poor and non-poor groups. In Canada, total acute care inpatient costs were $17,046.6 million for 2004-05, representing over 37% of overall public health expenditures (Canadian Institute for Health Information, 2008a). Diseases of the respiratory and circulatory systems – conditions disproportionately present among the social assistance group and in some cases, the working poor group – account for 28.8% of all acute care inpatient costs. In a recent study on the economic costs of poverty in Ontario, researchers pegged poverty-induced costs related to provincial health care at $2.9 billion (Laurie, 2008).

The human and financial costs associated with poverty and ill health are considerable. Whether on moral or economic grounds, the need for bold action is clear.

Recommendations

We offer the following recommendations to support the reduction of poverty in Ontario, to address the increased burden of ill health faced by poor people in Ontario, and to 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 Province's poverty reduction strategy includes a plan to review social assistance with an aim of "removing barriers and increasing opportunities". The proposed review is focused on improving rules to better facilitate movement of people from social assistance to work. Re-evaluating complex and contradictory social assistance rules is an important undertaking, however the strategy does not acknowledge one of the fundamental problems with social assistance – inadequate benefit levels that leave people living in deep poverty that compromises individual health and undermines the ability of people to move from social assistance to work. In addition to reviewing social assistance rules, we recommend that:

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

As a signatory country on the United Nations International Covenant on Economic, Social and Cultural Rights and the Rome Declaration on World Food Security, Canada has recognized the human right to food and has committed to take action domestically and abroad. However our data show that half of all social assistance recipients and 17% of the working poor live in food insecure households. In March 2008, a total of 314,258 Ontarians received food from a food bank (Ontario Association of Food Banks, 2008). Between September 2007 and September 2008, food banks in Ontario reported an average increase of 13% in the number of people receiving food. Social assistance recipients, the working poor and people with disabilities rank high among food bank recipients. Access to a nutritious diet is vital to individual health. It is unacceptable that there are Ontarians going hungry because of poverty, that mothers are sacrificing meals to feed their children, and that residents are filling up on water and rationing bread slices to make it through the month (Community Social Planning Council of Toronto & Family Service Association of Toronto, 2004; Daily Bread Food Bank, 2008; Human Resources and Social Development Canada, 1999; Smilek et al., 2000). Therefore, we recommend that:

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

Social assistance recipients in our study had much higher rates of ill health, chronic conditions and activity limitations compared to others, and reported very low household incomes. These findings raise questions about Ontarians with disabilities and their access to ODSP. Related literature and advocate accounts reveal considerable barriers to ODSP for people with disabilities (Centre for Addiction and Mental Health, 2003; Income Security Advocacy Centre, 2003; Lightman et al., in press; ODSP Action Coalition, 2008; Social Planning Council of Ottawa, 2001; Street Health, 2006). Access to ODSP is vital to the health of Ontarians with disabilities in financial need. Therefore, we recommend that:

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

Low wage work and poor working conditions in the precarious labour market impact on the health of the working poor. Recent provincial action to introduce protections for temp agency workers is an important first step in improving the working conditions and by extension, health and well-being of Ontario workers. The provincial government's commitment to increase funding for employment standards' enforcement is also a promising move. Following from these steps, we recommend that:

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 Province's poverty reduction strategy sets a goal of reducing child poverty by 25% in 5 years. While an important and laudable goal, the strategy sets no target for reducing adult poverty. In particular, adults without children are not a focus of the plan. According to data from our study, over half of social assistance recipient households and 40% of working poor households do not include children. Therefore, we recommend that:

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

Countries such as the United Kingdom and Ireland have adopted national poverty reduction strategies. In Canada, provincial governments in Ontario, Quebec and Newfoundland and Labrador have taken the lead in developing their own plans. Ontario's poverty reduction strategy recognizes the role of the federal government in reducing poverty. In the last federal election, all major political parties with the notable exception of the Conservative Party made a commitment to introduce a federal poverty reduction strategy. Poverty reduction is critical to promoting the health of Ontarians and Canadians alike. Therefore, we recommend that:

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

Dramatic reforms to the Unemployment Insurance system (now named Employment Insurance) have left the majority of unemployed workers in Ontario and across Canada without access to the benefits that they pay for. Women, youth, immigrants and big city dwellers were most affected by program reforms, showing the lowest rates of access to EI (Black & Shillington, 2005; Canadian Labour Congress, 1999; Townson & Hayes, 2007). Lack of access to EI benefits leaves unemployed workers to the health-compromising inadequacies of provincial social assistance. Rather than the income assistance program of last resort, Ontario Works has become the only option for tens of thousands of unemployed workers in Ontario. It is simply a matter of fairness that workers during periods of job loss, and particularly during these tough economic times, should have access to the benefits that they pay for. Therefore, we recommend that:

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 EI 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.

Improving Health Care Access, Promoting Health Equity

Recommendation 8

Our data and related studies reveal troubling inequities regarding health care service access and utilization. Social assistance recipients and the working poor in our study had higher rates of unmet health care needs compared to the non-poor group. One in five people from the poor groups with unmet health care needs cited cost as a factor in his/her inability to get needed care. Individuals from poor groups were less likely to have a regular medical doctor and had lower rates of various preventative health care services. The working poor also had lower rates of insurance coverage for vision, dental, prescription medication and hospital care compared to the non-poor group, and in most cases, social assistance recipients. In related studies, researchers have documented a growing gap in the amount of health care received between the rich and the poor, Canadian-born and immigrant populations, and residents with lower levels of education compared to more highly educated residents, and more out of pocket health care expenses related to the delisting of health services in Ontario (Browne, n.d.; Curtis & MacMinn, 2008).

These inequities were present and growing during prosperous economic times. In light of the current economic crisis, they are likely to widen and affect increasing numbers of people caught in the downturn. Therefore, we recommend that:

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

To better understand the health and health care use of Canadians receiving income from different types of social assistance programs, we recommend that:

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

The focus of this research has been primarily on the connections between ill health and different forms of poverty status. We have included analyses examining factors such as gender, ethnoracial status, Aboriginal identity, immigration status and disability status. However additional work is needed to examine the specific health outcomes of particular groups. As well, this study is limited to a province-wide analysis for Ontario and does not incorporate other geographic levels including urban, rural and neighbourhood-level analysis. Therefore, we recommend that:

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.

References and Related Literature

Baker Collins, S. (2005). An understanding of poverty from those who are poor. Action Research, 3(1): 9-31.

Black, J. & Shillington, R. (2005). Ontarians can no longer count on Employment Insurance to provide temporary income between jobs. Toronto, Ontario: MISWAA.

Browne, P.L. (n.d.). Public pain, private gain: The privatization of health care in Ontario. Ottawa, Ontario: Canadian Centre for Policy Alternatives.

Campaign 2000, Citizens for Public Justice & Workers' Action Centre (2006). Working, yet poor in Ontario. Toronto, Ontario.

Canadian Institute for Health Information (2008a). The cost of acute care hospital stays by medical condition in Canada, 2004-2005. Ottawa, Ontario.

Canadian Institute for Health Information (2008b). Reducing gaps in health: A focus on socio-economic status in urban Canada. Ottawa, Ontario.

Canadian Labour Congress (1999). Left out in the cold: The end of UI for Canadian workers. Ottawa, Ontario.

Centre for Addiction and Mental Health (2003). Barriers to ODSP: Experiences of people with mental health and addictions. Toronto, Ontario.

Community Social Planning Council of Toronto & Family Service Association of Toronto (2004). Community voices: Young parents in Toronto speak out about work, community services and family life. Toronto, Ontario.

Community-University Research Alliance on Precarious Employment (2005). Ten ways of seeing precarious employment. Toronto, Ontario: Toronto Training Board.

Curtis, L.J. & MacMinn, W.J. (2008). Health care utilization in Canada: Twenty-five years of evidence. Canadian Public Policy, 34(1): 65-87.

Daily Bread Food Bank (2008). Who's hungry: 2008 profile of hunger in the GTA. Toronto, Ontario.

Galabuzi, G.E. (2001). Canada's creeping economic apartheid: The economic segregation and economic marginalisation of racialised groups. Toronto, Ontario: CSJ Foundation for Research and Education.

Government of Ontario (2008). Breaking the cycle: Ontario's poverty reduction strategy. Toronto, Ontario.

Hamelin, A.M., Beaudry, M. & Habicht, J.P. (2002). Characterization of household food insecurity in Quebec: Food and feelings. Social Science & Medicine, 54(1): 119-132.

Herd, D. & Mitchell, A. (2002). Discouraged, diverted and disentitled: Ontario Works new service delivery model. Toronto, Ontario: Community Social Planning Council of Toronto.

Herd, D., Mitchell, A. & Lightman, E. (2005). Rituals of degredation: Administration as policy in the Ontario Works program. Journal of Social Policy and Administration, 39(1): 65-79.

Human Resources and Social Development Canada (1999). Coping with child hunger: Mothers do without. Ottawa, Ontario.

Income Security Advocacy Centre (2003). Denial by design ... The Ontario Disability Support Program. Toronto, Ontario.

Laurie, N. (2008). The cost of poverty: An analysis of the economic cost of poverty in Ontario. Toronto, Ontario: Ontario Association of Food Banks.

Lightman, E., Herd, D. & Mitchell, A. (2008a). Percarious lives: Health, hunger and welfare in Toronto. Journal of Policy Practice, 7(4): 242-259.

Lightman, E., Mitchell, A. & Herd, D. (2008b). Globalization, precarious work and the food bank. Journal of Sociology and Social Welfare, XXXV(2): 9-28.

Lightman, Mitchell, A. & Herd, D. (2005a). One year on: Tracking the experiences of current and former welfare recipients in Toronto. Journal of Poverty: Innovations on Social, Political and Economic Inequalities, 9(4): 5-26.

Lightman, E., Mitchell, A. & Herd, D. (2005b). Welfare to what? After Ontario Works in Toronto. International Social Security Review, 58(4): 95-106.

Lightman, E., Mitchell, A. & Herd, D. (2003a). Struggling to survive: Ontario Works recipients talk about life on welfare. Toronto, Ontario: Social Assistance in the New Economy Project.

Lightman, E., Mitchell, A. & Herd, D. (2003b). Suspicion and surveillance: Navigating welfare's bureaucratic maze. Toronto, Ontario: Social Assistance in the New Economy Project.

Lightman, E., Mitchell, A. & Wilson, B. (2008). Poverty is making us sick: A comprehensive survey of income and health in Canada. Toronto, Ontario.

Lightman, E., Vick, A., Herd, D. & Mitchell, A. (in press). Not disabled enough: Episodic disabilities and the Ontario Disability Support Program. Disability Studies Quarterly.

Mackenzie, H. & Stanford, J. (2008). A living wage for Toronto. Ottawa, Ontario: Canadian Centre for Policy Alternatives.

METRAC & WACT (2008). No cherries grow on our trees. Toronto, Ontario.

National Council of Welfare (2006). Welfare incomes 2005. Ottawa, Ontario.

National Council of Welfare (2008). Welfare incomes, 2006 and 2007. Ottawa, Ontario.

Newbold, K.B. (2006). Chronic conditions and the healthy immigrant effect: Evidence from Canadian immigrants. Journal of Ethnic and Migration Studies, 32(5): 765-784.

Ng, E., Wilkins, R., Gendron, F. & Berthelot, J.M. (2005). The changing health of immigrants. Canadian Social Trends. Statistics Canada Catalogue No. 11-008.

ODSP Action Coaliton (2008). Accessibility survey – Canvassing the views of ODSP recipients. Toronto, Ontario.

Ombudsman Ontario (2006). Losing the waiting game. Ombudsman report. Toronto, Ontario.

Ontario Association of Food Banks (2008). Ontario hunger report 2008: The leading edge of the storm. Toronto, Ontario.

Ontario Federation of Labour (2007). Provincial election 2007: Manufacturing job loss. Toronto, Ontario.

Ontario Ministry of Labour (n.d.). Minimum wage. www.labour.gov.on.ca/english/es/guide/guide_4.html

Ontario Ministry of Labour (2003). Ontario's minimum wage increase.
www.labour.gov.on.ca/english/news/2003/03-65f.html

Ontario Ministry of Labour (2008). Fairness for temporary help agency employees. Backgrounder. www.labour.gov.on.ca/english/news/2008/08-119b.html

Ornstein, M. (2006). Ethno-racial groups in Toronto, 1971-2001: A demographic and socio-economic profile. Toronto, Ontario: York University, Institute for Social Research.

Phipps, S. (2003). The impact of poverty on health: A scan of research literature. Ottawa, Ontario: Canadian Population Health Initiative and Canadian Institute for Health Information.

Power, E. (2005). The unfreedom of being other: Canadian lone mothers' experiences of poverty and 'life on the cheque'. Sociology, 39(4): 643-660.

Reid, C. & Tom, A. (2006). Poor women's discourses of legitimacy, poverty, and health. Gender & Society, 20(3): 402-421.

Schultz, S.E. & Kopec, J.A. (2003). Impact of chronic conditions. Health Reports, 14(4): 41-53.

Shields, M. and Shooshtari,S. (2001). Determinants of self-perceived health. Health Reports, 13(1): 35-52.

Sieppert, J., Linde, J.T. & Rutherford, G. (2004). Poverty as a determinant of health: Capturing the voices of low-income Calgarians. Canadian Review of Social Policy, 53: 122-139.

Smilek, S.M., Bidgood, B.A., Parent, M. & Thompson, J. (2000). When the fridge is bare: Challenges to food security in Waterloo Region. Waterloo, Ontario: The Food Bank of Waterloo Region.

Social Planning Council of Ottawa (2001). The experience of people with disabilities in Ottawa and the Ontario Disability Support Program. Ottawa, Ontario.

Statistics Canada (2009, January 9). Labour force information. Ottawa, Ontario.

Statistics Canada (2008). Income table. Catalogue no. 97-563-XCB2006026. Ottawa.

Steele, L.S., Lemieux-Charles, L., Clark, J.P. & Glazier, R.H. (2002). The impact of policy changes on the health of recent immigrants and refugees in the inner city: A qualitative study of service providers' perspectives. Canadian Journal of Public Health, 93(2): 118-122.

Street Health (2006). Failing the homeless: Barriers in the Ontario Disability Support Program for homeless people with disabilities. Toronto, Ontario.

Street Health (2007). The street health report 2007. Toronto, Ontario.

Swanson, J. (2001). Poor-bashing: The politics of exclusion. Toronto, Ontario: Between the Lines.

Toronto Public Health (2008). The unequal city: Income and health inequalities in Toronto. Toronto, Ontario

Townson, M. & Hayes, K. (2007). Women and the Employment Insurance program. Toronto, Ontario: Canadian Council for Policy Alternatives.

Workers' Action Centre (2007a). Poverty is on the rise in Ontario and low wages are a big reason why. Toronto, Ontario.

Workers' Action Centre (2007b). Working on the edge. Toronto, Ontario.

World Health Organization (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva, Switzerland.

Endnotes

1. 74.4% of the working poor respondents reported having a job at the time of their interview. Why don't all of the working poor have current jobs if they are the 'working poor'? The working poor group is comprised of respondents who reported that the main source of their household income over the 12-month period preceding the interview came from salaries, wages or self-employment, and reported household incomes below the Low Income Measure. Respondents may have gotten most of their income from work in the past 12 months but were not working at the time of their interview. It is also possible that other members of the household were working, contributing to the main source of household income, but the respondent did not have a current job.
2. Due to a flaw in the CCHS questionnaire, lifetime attempted suicide rates included in this report are likely lower than in actual fact. Respondents who had considered suicide in their lifetime but not in the 12-month period preceding the interview were not asked about lifetime suicide attempts.
3. Social assistance recipients have limited dental coverage for emergency services only.
4. National Council of Welfare provides estimated annual welfare incomes for four family types. These incomes include basic social assistance, additional benefits, federal child benefits, provincial/territorial child benefits, federal GST credit and provincial/territorial tax credits, where applicable.
5. While Canada has no official poverty line, Statistics Canada's Low Income Cut-Off is commonly used to assess low income in Canada. Note that the working poor and social assistance groups utilized in our study are constructed using Statistics Canada's Low Income Measure (LIM) which is another widely used instrument. For further details, please see the extended method section available at www.socialplanningtoronto.org
6. We used the GEN MOD procedure in SAS to conduct these analyses. The sample was split into two groups: Canadian-born and immigrant. In the analyses with the Canadian-born group, age and poverty status were included in the model predicting various chronic conditions. In the analyses with the immigrant group, age, poverty status and length of time residing in Canada were included in the model. Results are described in the text ($p<.05$ was used to assess statistical significance).

APPENDIX

Table A

Overview of Health Indicators: Age-Adjusted Rates per Thousand Population

Ontario, Population 18-64 Years, 2005

	Non-Poor	Working Poor	Social Assistance
Self-rated health			
Self-rated health (poor or fair vs. good, very good or excellent)	75****	117****	383****
Self-rated mental health (poor or fair vs. good, very good or excellent)	43****	66****	198****
Disability			
Often has a participation or activity limitation	100*	113****	395****
Number of disability days (over previous two weeks)	830	802****	2832****
Stress			
Stress (most days quite a bit or extremely stressful vs. not at all, not very, a bit stressful)	253*	268****	361****
Suicide			
Considered suicide in lifetime	77***	97****	281****
Considered suicide in past 12 months	14**	21****	105****
Attempted suicide in lifetime	4	6****	72****
Attempted suicide in past 12 months	2**	4****	21****

Statistical significance levels: * p<.05 ** p<.01 *** p<.001 **** p<.0001; significance levels in the non-poor and working poor columns refer to comparisons with the group in the column to the right; significance levels in the social assistance column refer to comparisons with the non-poor group.

Table B

Chronic Conditions: Age-Adjusted Rates per Thousand Population

Ontario, Population 18-64 Years, 2005

	Non-Poor	Working Poor	Social Assistance
Chronic conditions			
Has a chronic condition	689****	626****	847****
Has more than 2 chronic conditions	215**	239****	540****
Total number of chronic conditions	1,549	1,529****	3,460****
Endocrine or metabolic condition	387****	363****	482****
Thyroid condition	48	50**	72**
Diabetes	31***	52****	113****
Food allergies	75	81	104*
Multiple chemical sensitivities	19***	30**	54****
Other allergies	303****	252****	350****
Circulatory system condition	131****	102****	249****
Effects of a stroke	n/a	n/a	n/a
Heart disease	25**	34****	75****
High blood pressure	114****	83****	200****
Eye disease	20	17*	31*
Cataracts	n/a	n/a	n/a
Glaucoma	n/a	n/a	n/a
Disease of the nervous system or developmental disorder	142****	175****	371****
Learning disability	23***	34****	123****
Epilepsy	4	7****	29****
Migraines	120****	145****	287****
Disease of the respiratory tract	91	91****	203****
Chronic bronchitis	20****	33****	92****
Asthma	78	68****	159****
Musculoskeletal disease	278*	260****	501****
Back problems (excluding arthritis and fibromyalgia)	195	193****	396****
Arthritis or rheumatism	127	130****	299****
Fibromyalgia	13	13****	60****
Chronic fatigue syndrome	11	7****	64****
Mental and behavioural disorder	87	90****	327****
Anxiety disorder	43	46****	181****
Mood disorder	61	62****	253****
Alzheimer's disease or dementia	n/a	n/a	n/a
Schizophrenia	n/a	n/a	n/a
Miscellaneous condition	87*	70****	202****
Cancer	9	11	15
Stomach or intestinal ulcer	30	26****	99****
Urinary incontinence	17**	9****	63****
Bowel disorder	42**	27****	65**
Other chronic condition	125*	111****	216****

Statistical significance levels: * p<.05** p<.01*** p<.001**** p<.0001; significance levels in the non-poor and working poor columns refer to comparisons with the group in the column to the right; significance levels in the social assistance column refer to comparisons with the non-poor group.

Table C

Access to, and Utilization of Health Care Services: Age-Adjusted Rates per Thousand Population

Ontario, Population 18-64 Years, 2005

	Non-Poor	Working Poor	Social Assistance
Consultations with medical professionals			
Has no regular medical doctor	95****	127	148****
Total number of consultations with all medical practitioners	9,988***	8,798****	19,360****
Total number of consultations with general practitioners	2,960**	3,344****	7,374****
Total number of consultations with specialists	1,489*	1,236****	2,525****
Total number of consultations with medical practitioners other than general practitioners and specialists	5,549****	4,218****	9,935****
Number of nights in a hospital, nursing home or convalescent home	381	374****	1,433****
Has self-perceived unmet health care needs	125***	150****	263****

Statistical significance levels: * p<.05 ** p<.01 *** p<.001 **** p<.0001; significance levels in the non-poor and working poor columns refer to comparisons with the group in the column to the right; significance levels in the social assistance column refer to comparisons with the non-poor group.

Table D

Health-Related Measures: Percentages (not adjusted for age)

Ontario, Population 18-64 Years, 2005

	Non-Poor	Working Poor	Social Assistance
Reasons care was not received			
Care not available at time required	14.1	11.8	9.8
Felt care would be inadequate	3.3	3.5	6.1
Cost	8.8****	20.3	21.6****
Didn't get around to it	7.6*	4.6	5.3
Personal or family responsibilities	1.1	1.9	1.7
Transportation problems	1.1****	4.0	6.6****
Access to health insurance			
Prescription medications	80.6****	43.2****	82.7
Dental care	78.1****	38.7****	65.8****
Eyeglasses or contact lenses	71.1****	28.9****	70.3
Hospital charges	72.6****	27.5	24.3****
Household food insecurity	3.2****	16.5****	49.3****

Statistical significance levels: * p<.05 ** p<.01 *** p<.001 **** p<.0001; significance levels in the non-poor and working poor columns refer to comparisons with the group in the column to the right; significance levels in the social assistance column refer to comparisons with the non-poor group.

Table E

Preventative Health Care Service Use: Age-Adjusted Rates per Thousand Population

Ontario, Population 18-64 Years, 2005

	Non-Poor	Working Poor	Social Assistance
Eye Care			
Never had eye exam before	36****	74	54*
Had eye exam less than 2 years ago	648****	574	599*
Dental Care			
Never visited dentist before	7****	51****	10
Visited dentist in past 12 months	750****	495	474****
Women's Health			
Never had breast exam	209****	351	399****
Had breast exam less than 2 years ago	872	856	828
Never had mammogram (40-64 years)	281****	370	415****
Had mammogram less than 2 years ago (40-64 years)	765	710	686
Never had pap smear test before	96****	223*	163****
Had pap smear test less than 1 year ago	553****	461	462***
Colon Care (40-64 years only)			
Never had colorectal cancer screening	747****	814**	731
Had colorectal cancer screening less than 3 years ago	585	531	582

Statistical significance levels: * p<.05 ** p<.01 *** p<.001 **** p<.0001; significance levels in the non-poor and working poor columns refer to comparisons with the group in the column to the right; significance levels in the social assistance column refer to comparisons with the non-poor group.

Table F

Results of Multivariate Analyses Predicting Chronic Conditions

Ontario, Population 18-64 Years, 2005

Chronic condition	Income	Age	Sex (female)	Racialized group (yes)	Aboriginal status (yes)	Less than secondary school (yes)	Some post-secondary (yes)	Post-secondary graduate (yes)	Physically active (yes)	Daily smoker (yes)	Social assistance receipt (yes)	Currently employed (no)	Often has activity limitations	Sometimes has activity limitations
Endocrine or metabolic condition	-.0003	.0823****	.4357****	-.2898****	.1806	.0692	.3706****	.1875**	.0492	-.1334*	.2781*	.0930	.6566****	.5009****
Thyroid condition	-.0004	.4375****	1.7171****	-.1924	.1639	.0189	-.1722	.0562	-.1035	-.3301*	.1336	.2542*	.4439***	.1611
Diabetes	-.0078****	.8111****	-.6217****	.0916	.2952	-.1252	-.3213	-.2574	-.1856	.1084	.7940****	.2361*	.7288****	.1612
Food allergies	.0014	-.0330	.4848****	-.0613	.4588*	.0029	.4414**	.3492***	.0313	-.0845	.3030	-.0052	.6319****	.5891****
Multiple chemical sensitivities	-.0079***	.2592****	1.0272****	-.0055	-.0004	-.1967	.0050	.2891	.0677	.0551	.1787	.1554	1.7265****	1.0464****
Other allergies	.0001	-.0343	.3835****	-.3854****	.1778	.0377	.4308****	.2457****	.0682	-.1152*	.2186	-.0135	.5538****	.4914****
Circulatory system condition	-.0014	.8777****	-.3810****	.0351	.3578	.1023	-.0271	-.1406	-.2961****	-.1064	.5806**	.1054	.6216****	.4416****
Effects of a stroke	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Heart disease	-.0015	.9108****	-.6468****	.1233	-.1186	.2599	-.0691	-.0893	-.1442	-.0597	.6895**	.1447	1.1236****	.8986****
High blood pressure	-.0012	.8514****	-.3147****	-.0184	.3165	.0722	.0309	-.1479	-.3392****	-.0909	.4562*	.0894	.5121****	.3665****
Eye disease	-.0039	1.0256****	-.2288	-.4387	.7999	-.0724	.2056	.1053	.2201	.2314	-.1189	.3428*	.8773****	.7165****
Cataracts	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Glaucoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Disease of the nervous system or developmental disorder	-.0025*	-.2069****	.8892****	-.4358****	.0301	.1096	.1141	-.0080	-.0763	.2063**	.7254****	.0064	.9760****	.7718****
Learning disability	-.0029	-.5206****	-.6022****	-1.2833****	.5589*	.5293**	.0875	.0455	.1732	.3573*	.6926**	.4496**	1.6435****	1.2607****
Epilepsy	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Migraines	-.0026*	-.1521****	1.1165****	-.2956**	-.1471	-.0008	.1515	.0087	-.1175	.2118**	.5976***	-.0411	.8657****	.6881****
Disease of the respiratory tract	-.0009	-.1437****	.4641****	-.5922****	.4444**	.2242	.3243*	.0401	.0425	.1128	.4392**	.0700	.9656****	.7134****
Chronic bronchitis	-.0068*	.0678	.6055****	-.4713*	.5119	.3274	.4519	-.2976	.0058	.7879****	.3055	.0193	1.4602****	.9704****

Chronic condition	Income	Age	Sex (female)	Racialized group (yes)	Aboriginal status (yes)	Less than secondary school (yes)	Some post-secondary (yes)	Post-secondary graduate (yes)	Physically active (yes)	Daily smoker (yes)	Social assistance receipt (yes)	Currently employed (no)	Often has activity limitations	Sometimes has activity limitations
Asthma	-.0003	-.1735****	.4566****	-.6125****	.3787*	.2661	.2696	.1307	.0569	-.1022	.4208*	.1020	.8843****	.6899****
Musculoskeletal disease	-.0025***	.4209****	.1682***	-.3121****	.2700*	.1897*	-.0566	-.1138	-.0619	.2403****	.2377	.1296	1.7727****	1.5255****
Back problems (excluding arthritis and fibromyalgia)	-.0020*	.1653****	-.0378	-.2302**	.1393	.2106*	-.1203	-.0406	-.0522	.2116***	.3387*	.0450	1.5449****	1.3664****
Arthritis or rheumatism	-.0041***	.8009****	.5067****	-.3931***	.2256	.1929	-.0703	-.1356	.0079	.2310**	.3229	.1978*	1.6895****	1.2473****
Fibromyalgia	-.0069**	.3676****	1.4979****	.2374	.0478	.1576	-.1114	.2757	-.2501	.3512	.1384	.5582***	2.3027****	1.5741****
Chronic fatigue syndrome	-.0066	.1223	.6665***	-.2506	.1920	.0972	.4090	.2017	-.2025	.1728	.3645	.7052****	2.3647****	1.2473****
Mental or behavioural disorder	-.0037**	-.0583*	.5894****	-.8362****	-.0962	.1057	.2136	.1051	-.1097	.6305****	.5917****	.5451****	1.4756****	1.0129****
Anxiety disorder	-.0026	-.1264****	.4150****	-.9333****	-.0685	.1580	.2382	.0318	-.0518	.7148****	.4418*	.6464****	1.2897****	.9979****
Mood disorder	-.0038*	-.0562	.6792****	-.6241****	-.1851	.0455	.1150	.1161	-.1922*	.5376****	.5400**	.6082****	1.6771****	1.1376****
Alzheimer's disease or dementia	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Schizophrenia	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Miscellaneous condition	-.0015	.2094****	.5798****	-.5398****	.4540*	-.0699	-.0566	.0653	-.0810	.1701*	.2966	.2009*	1.2765****	.8454****
Cancer	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Stomach or intestinal ulcer	-.0045*	.0778	-.0427	-.1279	.5172	.5912***	.1571	.3671**	-.0017	.4551****	.3202	.2532	1.1212****	.5907****
Urinary incontinence	-.0010	.6273****	1.1906****	-.2548	.2293	-.1769	.0891	.0832	-.0393	.1988	.5777*	.0049	1.4326****	.8066****
Bowel disorder	.0007	.0802*	.8513****	-1.0037****	.1386	-.4383*	-.0544	-.0370	-.2086*	-.0346	.0877	.1850	1.2633****	.9551****
Other chronic condition	.0009	.2039****	.0366	-.4266****	.0231	-.0727	.2215	.2793**	.0072	-.0395	.1878	.2654***	1.5472****	1.0214****

Statistical significance levels: * p<.05 ** p<.01 *** p<.001 **** p<.0001