CANADIAN NURSES ASSOCIATION

ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

Federal Contribution to Reducing Poverty in Canada

Brief to the House of Commons
Standing Committee on Human Resources,
Skills and Social Development and the
Status of Persons with Disabilities (HUMA)

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Introduction

The Canadian Nurses Association (CNA) is a federation of 11 provincial and territorial registered nurses (RN) colleges and associations representing more than 136,200 Canadian RNs and nurse practitioners. CNA is the national professional voice of RNs, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system.

Nurses work with individuals and families – including those living in poverty – in many settings and in all communities across the country. They work in primary care in community health centres and family health centres, in home care (visiting individuals and families in their homes), in schools, in community-based programs, in hospitals and long-term care facilities, in public health, in universities conducting research on effective ways to provide care for individuals and families, and in community-based and institutional mental health programs. RNs work in inner cities and in street health programs, and in those communities they most often work with the poorest of individuals and families.

As such, RNs witness the impact that poverty has on the health of Canadians every day, and they work diligently to mitigate these effects and to advocate for public policy that will change the fate of these Canadians.

Poverty and health

RNs are concerned about the impact of poverty on health. There is a significant amount of indisputable evidence that those who live in poverty are in poorer health and die earlier than those who have better access to resources. People living in poverty in Canada are often socially excluded and lack access to economic, social and political resources.

There are many examples of this.

In urban Canada, Canadians living in lower income neighbourhoods have a lower life expectancy. In 1996, men living in the poorest neighbourhoods in urban Canada had a life expectancy at birth of 73 years whereas those in the richest neighbourhoods had a life expectancy of 76 years. Poor people are more likely to die than are rich people. In 1996, men aged 35 to 44 years living in the poorest neighbourhoods in urban Canada were more than three times more likely to die than those living in the richest neighbourhoods. Women in the same age group were twice as likely to die (Wilkins, 2007; Wilkins, Berthelot & Ng, 2002).

Poverty is particularly influential on young children. A child's future health is greatly influenced by their family's financial status in their early years. Healthy child development depends upon health conditions in pregnancy, at the time of birth and in the first year of life. The risks of problem pregnancies and poor birth outcomes increase with socio-economic disadvantage. Being born early (preterm birth, or birth before 37 weeks of pregnancy) is considered the single most important cause of death, illness and disability early in life. The Public Health Agency of Canada says that Canadian women who are poor are more likely to experience preterm births and intrauterine growth restriction than are women with higher incomes (Public Health Agency of Canada, 2005). Infants in Canada's richest urban neighbourhoods were 1.6 times more likely to die than were those in Canada's poorest neighbourhoods (Wilkins, Berthelot & Ng, 2002).

At 13.6 per cent, Canada's child poverty rate is higher than the Organisation for Economic Development and Co-operation's average. Canada ranked 12th out of 17 measured countries. In 1989, the Canadian government unanimously resolved to eliminate child poverty by the year 2000. Between 1971 and 2000, Canada's child poverty rate was reduced by just one per cent (Luxembourg Income Study, 2008).

Obesity has become a serious public health problem in Canada. There is accumulating evidence that poor children are more likely to be obese than are non-poor children. For example, a recent study of children aged 5 to 17 years in Canadian cities found that children who live in neighbourhoods with higher unemployment rates, lower average family incomes or fewer neighbours with post-secondary education were at greater risk of being overweight or obese. The percentage of overweight children varied from 24 per cent in areas with high socio-economic status to 35 per cent in neighbourhoods with low socio-economic status (Oliver & Hayes, 2005).

Mental health problems have been described as the "new morbidity" for Canadian children and youth. Renowned child psychiatrist and advocate Dan Offord stated that "it should be kept in mind that the leading group of conditions that lower life quality and reduce the life chances of Canadian children and youth are emotional and behavioural problems and learning difficulties" (Canadian Institute of Child Health, 2000). Offord's sentinel *Ontario Child Health Study* found that the prevalence of psychiatric disorders among poor children and youth was 35 per cent compared with 16 per cent for their counterparts who were not poor (Offord, Boyle & Jones, 1987). In later work he found that 39 per cent of Canadian children who were very poor had one or more emotional and behavioural problems compared with 23 per cent of children who were well off (Offord & Lipman, 1996).

As Canada's chief public health officer noted, "if all neighbourhoods had the age- and sex-specific mortality rates of the highest-income quintile neighbourhoods, then the total potential years of life lost for all urban neighbourhoods would have been reduced by approximately 20 per cent" (Butler-Jones, 2008).

Many researchers over the years have shown that living in poverty early in life affects long-term morbidity (frequency of illnesses and diseases) and mortality, yet it was not understood why this was the case. A study from Cornell University described how low socio-economic status takes its toll on health. In the first longitudinal study on the physiological effects of poverty in young children, researchers reported that the longer 13-year-olds had spent living in poverty, the less efficient their bodies were in handling environmental demands. The researchers suggested that the mechanisms underlying these findings may be related to the fact that children who grow up in poverty have a steeper life trajectory of premature health problems than other children, regardless of their socio-economic status in adulthood. They demonstrated that poor children had muted responses of their stress regulatory mechanisms. This, in turn, compromised the children's ability to respond to stressors and indicated that they were suffering from more stress-induced physiological strain on their organs and tissues than other young people (Evans & Kim, 2007).

The state of poverty in Canada

RNs are concerned about the state of poverty in our country. Poverty is a constant and long-term problem in Canada (Hay, 2009). More than 3.5 million Canadians live in poverty (Canada

Without Poverty, 2009). The Canadian Council on Social Development reports that poverty rates based on the before-tax low-income cut-offs have fluctuated between approximately 15 per cent and 20 per cent over the past 30 years. In addition, over the last 25 years, the rates based on the after-tax low-income cut-offs have also fluctuated within a five-per-cent range (i.e., between 10 per cent and 15 per cent). Fluctuations in the rates are primarily due to fluctuations in the business cycle (i.e., employment levels), but they also reflect changes in tax levels and income transfer programs (benefits, pensions, etc.). Although the evidence suggests that there has been a downward trend in poverty rates, the Canadian Council on Social Development cautions that it depends on the time frame examined. For example, if one looks at low-income cut-offs after taxes and transfers, the poverty rate dropped by only one per cent between 1990 and 2005 (from 11.8 per cent to 10.8 per cent), but it dropped nearly five per cent between 1996 and 2005 (from 15.7 per cent to 10.8 per cent). If one uses the measure of the total number of people in poverty in Canada the poverty levels were essentially unchanged, although they were slightly higher in 2005 than in 1990 (3,191,000 in 1990 versus 3,409,000 in 2005) (Hay, 2009).

Some groups in Canada are more vulnerable to poverty than others. These include single parents, most of whom are women; recent immigrants; persons with disabilities; aboriginal Canadians; people who do not complete high school; women; and visible minority groups.

Although having a job is still the best way to avoid poverty, it is not a guarantee. People earning low wages – around $11 per hour or less – can work full time for a full year and still live below the poverty line. A single earner supporting a family of two or more people needs much more than $11 per hour to keep themselves and their dependents out of poverty. Furthermore, a number of Canadians are unable to work, either temporarily or permanently (Hay, 2009).

A comprehensive poverty reduction strategy in Canada

CNA believes that Canada needs a comprehensive, national poverty reduction strategy. We urge the federal government to take a leadership role in this critical public policy initiative.

A federal strategy would have to include a mix of policies and programs to alleviate poverty and contribute to income security for Canadians. The groups that have studied the policy mix necessary to address poverty agree that the mix must include child and family benefits, employment benefits, benefits for seniors and other benefits (such as tax credits, housing allowances and supports, food allowances and supports), including benefits for specific population sub-groups such as people with disabilities, Aboriginal Peoples, recent immigrants, farmers and rural residents. They also promote an “active social policy” orientation that promotes education, training and labour market attachment as the main route to achieving an adequate income (Hay, 2009). The comprehensive, integrated federal plan for poverty reduction must be linked to and supportive of provincial and territorial poverty action plans. The plan must include: a meaningful, inclusive consultation process with a wide range of stakeholders, especially those with direct experience of living in poverty; targets for poverty reduction within a specific time; and accountability measures to track progress.

The federal poverty reduction strategy could include the following actions:

- Implement strategies to generate good jobs that pay a living wage (Benach, Muntaner, & Santana, 2007).

- Reform Canada's employment insurance system by expanding eligibility and improving benefit levels (Yalnizyan, 2009).
- Invest in a national, affordable housing plan. Increase access to affordable housing by making major investments in the construction and maintenance of affordable housing units and invest in supportive housing for those with physical, cognitive and/or mental health challenges.
- Ensure income support so that all may live in health and dignity – that is, ensure that social assistance rates provide recipients with benefits that match the cost of living (Campaign 2000 & Income Security Advocacy Centre, 2008; National Council of Welfare, 2006).
- Increase the national child benefit to a maximum of $5,200 (in 2009 dollars).
- Invest in universal, regulated, affordable, not-for-profit, public systems of early learning and child care.
- Expand medicare to include a publicly funded and publicly controlled national pharmacare program.

Federal public policies aimed at providing income security and reducing poverty ***do work.*** There are two important Canadian examples. The Canadian Population Health Initiative has reported that if there were no income benefits for seniors, their poverty rates would be nearly 10 times what they are today (Canadian Population Health Initiative, 2004). If there were no federal child benefits, the poverty rate for families with children would be 15 per cent compared with just over nine per cent under the current benefits system (Battle, 2008).

There are also international examples. In 2000, the European Union developed the Social Inclusion Process aimed at making an impact on eradicating poverty by 2010. Since then, the European Union has provided a framework for national strategy development as well as for policy coordination between the member states on issues relating to poverty and social exclusion. Participation by actors such as non-governmental organizations, social partners and local and regional authorities has become an important part of this process (European Commission DG Employment, Social Affairs and Equal Opportunities, 2009). In 1999, the British government announced its aim to eradicate child poverty by 2020. That government now plans to enshrine this pledge in legislation. Since the commitment to eradicate child poverty was announced, good progress has been made. In 1998-99, 3.4 million children (26 per cent) were living in poverty. By 2006-07 (the latest figures available) this number had fallen to 2.9 million children (Department for Work and Pensions, 2008) The British strategy is multi-pronged and engages action locally and nationally to tackle the causes and consequences of child poverty.

Furthermore, the UN Human Rights Council's Universal Periodic Review of Canada for 2009 recommends the development of a national strategy to eliminate poverty.

It is time to take action now

The Canadian Nurses Association urges the federal government to take a leadership position on this critical issue, which is influencing the health and well-being of millions of Canadians now. CNA would be a strong partner and advocate working with the government to achieve the goal of reducing poverty in Canada.

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