

**Sick and Tired of Being Sick and Tired:
*Taking Action on Poverty,
Poor Health and
Bad Jobs***

A one-day forum
Monday, February 9, 2009

Forum Proceedings

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Sponsoring Organizations

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



Social Sciences and Humanities
Research Council of Canada



Report Prepared by
Community Social Planning Council of Toronto

March, 2009

Sick and Tired of Being Sick and Tired:
Taking Action on Poverty, Poor Health and Bad Jobs Forum Proceedings

March 2009

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Michael Shapcott
Edna Ucanda
Nancy Vander Plaats
Beth Wilson
Christopher Wulff
Mike Yale

SCHEDULE

Date & Place

Monday, February 9, 9:00AM - 3:30PM
Metro Central YMCA
20 Grosvenor Street, Toronto

Morning Session

Keynote Address

Dr. David McKeown
Medical Officer of Health
City of Toronto

Research Presentations & Discussion

Release of research findings from the new report *"Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario"* and discussion of research findings and policy impacts from the recent release *"Poverty is Making Us Sick: A Comprehensive Survey of Income and Health in Canada"*

Ernie Lightman, Andrew Mitchell, Beth Wilson, Michael Shapcott

Afternoon Session

Action Workshops

Participants had a choice of three afternoon action workshops on poverty reduction campaigns, labour market and income security initiatives, and health equity advocacy:

Poverty Reduction Campaigns

Pat Capponi, 25 in 5 Network for Poverty Reduction
Laurel Rothman, Campaign 2000
Neethan Shan, Colour of Poverty Campaign

Labour Market and Income Security Initiatives

Karen Dick, Workers' Action Centre

Beixi Liu, Workers' Action Centre

Judy Persad, Good Jobs for All Coalition

John Rae, Ontario Coalition for Social Justice

Nancy Vander Plaats, ODSP Action Coalition

Mike Yale, ODSP Action Coalition

Healthy Equity Advocacy

Gary Bloch, Health Providers Against Poverty

Jennifer D'Andrade, Volunteer Health Clinic for the Uninsured and Homeless

Anne Egger, Health Providers Against Poverty

MORNING SESSION

Welcome

Tam Goossen
Chair, CSPC-T Research Advisory Committee

Introduction to Keynote Address

- Being passionate about health is important.
- There has been a tear in the social safety net and we are responsible for putting it together.
- Dr. David McKeown provides public health services to two million people as Medical Officer of Health.
- He has formerly served the regions of East York, and Peel Region in addition to the City of Toronto.

Keynote Address

Dr. David McKeown

Medical Officer of Health, City of Toronto

- Good morning and thank you for the invitation to speak today.
- I would like to congratulate the organizers for hosting this forum and to recognize the important work that has been produced by the agencies and individuals who have collaborated on the research report that is being released today.
- I also want to acknowledge the commitment being demonstrated by everyone who is participating in this event. Your involvement is an example of community capacity building in action.
- In the field of Public Health, we explicitly recognize that successful interventions to address the health needs of the whole population are usually not possible without the sometimes slow and difficult processes of engaging with partners across sectors to find strength in numbers and to build the critical mass necessary to make change happen.
- So, I am pleased to be a part of your process this morning and to note that there are several staff from Toronto Public Health who will be here all day and who will bring back to our organization the benefit of their participation in this forum.

- The research report that is being introduced to you this morning is the latest and an important contribution to an ever-expanding body of evidence confirming and explaining the linkages between income, poverty and health.

- Over the last several years there have been a number of important projects with a specific Toronto focus, reflecting a very rich range of expertise and points of view.
- The United Way, the Centre for Research on Inner City Health, Access Alliance, the Centre for Urban and Community Studies – all have added tremendous depth and substance to our shared understanding of the intersections between the determinants of health - housing, education, income, racialization, settlement status - as they relate to the residents of our own, local neighbourhoods and communities.
- Similar work is increasingly being undertaken by academics, health advocates and government agencies at the national level. I have been working for several years on a project with Medical Officers of Health from other big cities across Canada and this past November we released a report supported by the Canadian Institute for Health Information called “Reducing Gaps in Health: a Focus on Socio-Economic Status in Urban Canada” .
- Canada’s Chief Medical Health Officer, David Butler-Jones, also released an important report last year calling for a concerted action agenda to address health inequalities.
- And much of the work in these projects has made reference to and benefited from the significant international leadership performed by the special commission of the World Health Organization on Social Determinants of Health.
- The final report of the Commission “Closing the Gap in a Generation” was released last year and provides a vital foundation for these activities around the world.
- So, our coming together here today is part of a global movement to seek social justice through increased equity in health.
- Before I refer to the work we are doing in this area at Toronto Public Health, I would like to briefly refer to the provincial context.
- It is especially important that the subject of today’s research presentation has an Ontario-wide focus. Just last week I was meeting with Medical Officers of Health and members of Boards of Health from across the province.
- For those of us working in local public health agencies, what happens at the provincial level is critically important because we receive most of our funding and our program directions from provincial Ministries.
- We are also keenly aware of the overriding public policy context for the work we do. I would say that the community of local public health leaders has been cautiously pleased with the initial undertakings made by the provincial government through its Poverty Reduction Strategy.
- We have seen immediate enhancements to key programs we deliver such as the Student Nutrition Program and the dental program for Children in Need of Treatment.
- These expenditures are concrete steps that will enable us to address unmet health needs and to bridge health gaps by reaching significantly more vulnerable people with health services that we know are badly needed.

- Needless to say, there is much more to do to put in place policies and programs which are comprehensive, integrated, and sustainable over the long term.
- That is why we are active participants in the 25-in-5 Network for Poverty Reduction and why we are also working with our colleagues across Ontario through the Association of Local Public Health Agencies and the Ontario Public Health Association.
- We want to make sure that as community voices are heard in the consultations around the government's poverty reduction agenda, that the public health point of view is solidly embedded within this advocacy work.
- Many of the themes that emerge from the provincial data in today's new report reinforce the findings of a research report I presented to the Board of Health in October last year, which we called "The Unequal City: Income and Health Inequalities in Toronto".
- Among other things, this report adds to the growing awareness of the particular challenges we are experiencing in Toronto compared to other jurisdictions.
- Toronto has by far the greatest proportion of people living with low income among health units in Ontario. In 2005, one quarter of the population lived below the low-income cutoff, a measure of poverty as defined by Statistics Canada. This rate was twice as high as the average for the rest of Ontario and far higher than the 15% for Canada as a whole.
- Approximately one third of children in Toronto under age six live below the low-income cutoff - again, more than double the rate for the rest of the province, and compared to 19% nationally.
- Recent income trends show these disadvantages affecting Toronto are worsening and the distribution gaps within the city are widening, most recently seen this past weekend in media coverage of David Hulchanski's updated report on the "Three Cities" within Toronto.
- At this time of deepening economic crisis, we can only speculate on the specific impacts that will occur in our city, but we know for certain that we are in for very rough times and things are going to get worse before they better.
- The findings in The Unequal City report show that those areas of Toronto that have a greater proportion of people living with low income experience greater risk factors for illness, higher rates of disease, and death at an earlier age.
- For example, residents of low income areas experience:
 - Lung cancer rates are 1.5 time higher than for high income areas
 - Rates of gonorrhoea among female youth are 3.5 times higher than in high income areas
 - And males in low income areas die on average 4.5 years younger than those in high income areas
- While the focus in our report is on the relationship between income and health, we know that health inequalities are also associated with other social determinants such as racialization and education. These other determinants are linked to and interact with income to influence health status.

- For example, the lowest-income group in our study includes the largest proportion of recent immigrants compared to other income groups, and a significantly higher proportion of the population classified by Statistics Canada as visible minorities.
- As has been demonstrated in other similar studies, and as our report shows, the relationship between income and health is not just about the extremes of wealth and poverty.
- For most of the indicators we measured, there is a continuous gradient in the data such that health status improves with each increase in income.
- This means that Toronto residents who live in high income areas are generally healthier than those living in middle income areas, and those who live in middle income areas are healthier than those living in low income areas.
- The implication of this is that health inequalities affect us all. We are all included somewhere on this gradient and we all have a stake in reducing the health gaps between us.
- While health inequality refers to the differences in health status that are linked to social determinants, health *inequity* is a concept increasingly used to refer to the differences that result from preventable causes – systemic barriers and forms of social exclusion.
- Or, to quote the WHO Commission:
 - “The unequal distribution of health-damaging experiences is not in any sense a natural phenomenon, but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.”
- At Toronto Public Health we have made a number of commitments to act on the findings in our own report in a way that represents our effort to respond to the call to action by the WHO Commission.
- We are working with our Board of Health to develop initiatives that will help deepen our understanding of the causes and effects of the social determinants of health in the Toronto setting.
- We will be working with partners in the community, with many of you, and with researchers and academics to strengthen our collective ability to measure and understand health inequalities in our communities.
- Last year we celebrated the 125th Anniversary of public health in Toronto. This occasion prompted us to reflect on the long tradition of community engagement and the continuous efforts of successive generations to promote social justice as a key health intervention.
- In the current period of economic distress and widening disparity, we take our cue from our predecessors and re-dedicate ourselves to working with others to build movements for positive social change.
- We will continue our efforts to be an active voice in calling for health equity, in providing services which respond to the health needs of marginalized populations, in urging governments to adopt progressive public policies, and in supporting the activities of agencies like the Social Planning Council and others who are contributing to the successful hosting of this event today.

- I wish you well in your deliberations today, and on behalf of all my colleagues at Toronto Public Health, I look forward to strengthening our networks and collaborating with you in the future.

Presentation of Research Results

Introduction

Ernie Lightman

Ernie Lightman has taught at the London School of Economics and the University of Toronto. He is the Principal Investigator of the current study and the Social Assistance in the New Economy (SANE) project.

- The current study developed out of the SANE project. SANE received four major grants from the Social Sciences and Humanities Research Council of Canada to explore the impacts of welfare reform and precarious employment in the context of an increasingly globalized economy. One of its key projects involved a longitudinal panel of social assistance recipients. One of the few, or perhaps only, investigations of its kind. This project followed social assistance recipients over time and involved in-depth interviewing.
- The SANE panel study demonstrated clearly the impacts of poverty and low income on health.
- The current work resulted in two studies, with consistent and complimentary conclusions. Andy Mitchell will present results from first study, Beth Wilson will present results from the second.

Study #1

Andrew Mitchell – Results from Poverty is Making Us Sick

- Study views health from a social determinants' viewpoint
- Graph #1 Musculoskeletal conditions: Arthritis or Rheumatism
 - Reveals health gradient; rates decrease as income increases; shows that difference in health is not just reducible to poverty.
 - Diabetes, heart disease, mood disorders, depression etc also show similar results, as well as many other conditions
- Why do we do this research?
 - Data from the Canadian Community Health Survey, 2005,
 - Close to the peak of the global economy (2005),
 - Current and comprehensive,
 - Worth looking at,
 - Reinforcement of message.
- Graph # 2 Access and Utilization: Visits to Medical Professionals
 - Declines with income,
 - Consultation with specialists rises a little in the higher income quintiles,
 - People with higher incomes know how to navigate the system.
- Multivariate results for chronic conditions:
 - What happens at smaller gradients of income?
 - Do we see improved health effects when we increase income?
 - Bottom line: When age, gender, race, education etc. are controlled for, there is still a correlation between income and health.
- Increasing incomes:
 - Small increases in income (\$1,000) among the lowest income Canadians is associated with fewer cases of various chronic conditions and poor health outcomes
 - Clear implications for individual health and cost-savings for the health care system

Study #2

Beth Wilson – Results and Recommendations from Sick and Tired

- Sick and Tired study focuses on social assistance recipients (SA), working poor (WP), non-poor (NP) in Ontario
 - SA and WP are disproportionately represented by women, Aboriginals, racialized groups and immigrants.
 - SA recipients have the least amount of household income and have the poorest health.
 - WP have worse health than NP.
 - However, NP sometimes have worse health than WP, i.e. due to healthy immigrant effect: newcomers have better health at first; the longer immigrants stay in Canada, the more their health resembles Canadian-born population (working conditions make a difference too). Because WP included large proportion of immigrants compared to NP, saw some unexpected findings where WP had better health than NP
- Graph #1 Poor or Fair Self-Reported Health
 - SA had higher rates of poor health, WP more than NP.
 - E.g. Diabetes, arthritis, Similar patterns.
 - Multivariate models control for all factors, but income and SA are still powerful predictors of ill health.
- Health-related measures
 - SA → 49.3% live in food insecure households,
 - WP → 16.5%,
 - NP → 3.2%.
- Graph #2 Suicide Thoughts and Attempts
 - SA have highest rates: one out of every ten SA recipients considered suicide in year leading up to study; suicide attempts were 10 times higher for the SA compared to NP.
 - WP rates are double that of NP.
- Major Results
 - Health care use: SA and WP less likely to have a regular doctor; SA have more consultations with medical professionals of all kinds; WP have more consultations with GP but less with specialists compared to NP.
 - Preventative Care: WP less likely to get it.
 - Health Insurance: majority of WP do not have coverage for meds, vision, dental
 - Unmet Health Care Needs: SA → 26.3% ; WP→ 15% ; 12.5 → NP.
 - Cost is a factor for 1 in 5 poor with unmet health care needs.

- Transportation is one of the barriers to health care access for poor.
- Recommendations
 - Improving Poverty Reduction Strategy
 - Should be expanded to reduce poverty reduction to 25% for *all* Ontarians.
 - Live up to UN commitment for access to food.
 - Review ODSP barriers in SA review.
 - Have better employment standards.
 - Higher minimum wage.
 - Federal Level
 - Have a national poverty reduction strategy with concrete targets and timelines.
 - Universal employment insurance for workers.
 - Improve access to health care e.g. Ontario Trillium Drug Plan, increased funding for CHCs etc.

Public Policy Implications

Michael Shapcott

Director of Community Engagement
The Wellesley Institute

- Today's Sick and Tired release is only the latest in a string of compelling research.
- Links between research and good policy.
- Observations:
 - Cost of doing nothing is staggering.
 - Toronto Emergency Medical Services says it costs \$785 to take someone to hospital, \$200 for room, \$605 for bed, acute patient would cost \$1,048.
 - We are all paying for poverty even if not personal health.
- OECD says we were doing well for the 1970s-90s, but since then we have the 2nd worst poverty rates in the world out of developed, western countries.
- Why is poverty so high in Canada?
 - We do not put money into income transfer programs.
 - Every \$1,000 income benefit translates to better health.
 - Must ensure that people are paid adequately.
 - As of 2007, average income levels have gone down across the country compared to 1998 levels.
 - Income assistance rates have to be raised as a result.

- Former Premier David Peterson wanted to bring these rates up 20 years ago, but it was not implemented.
 - Poverty Reduction Strategy is an affordable way to reduce/end poverty in ON.
 - Geneva Convention found it surprising that the national government has yet to come up with an adequate program to end poverty.
- Why are researchers asking for more research?
 - Canada is not doing well in terms of tracking poverty.

Ernie Lightman

- Important to look at social problems from an economics perspective.
 - We talk about a commitment to food security, but we do not act on it.
 - Importance of human capital.
- If we put more money into poor people's hands then we save money on the whole because we have more productive workers.
- Ontario poverty reduction strategy *must* be open to everyone not just kids.
- Poor people live closer to factories; they breathe bad air - no environmental safety.
 - They refuse to do something until they get more data, but everyone will be dead by then.
- Bottom line: Poverty is not acceptable, not moral, not ethical, nor economical.

Summary of Discussion from Action Workshops

Poverty Reduction Campaigns

Moderator: Yasmin Khan, Community Social Planning Council of Toronto

Recorder: Vanessa Ibe

Speakers: Pat Capponi, 25 in 5 Network
Laurel Rothman, Campaign 2000
Neethan Shan, Colour of Poverty Campaign

Presentations

Pat Capponi 25 in 5 Network

- Chronic disease and poverty go hand in hand and in order to fight chronic disease, you also have to fight poverty.
- In the case of Parkdale, the money appears to be misused or not used effectively. Agencies in Parkdale are growing and thriving but the residents in need of assistance (who the presenter described as psychiatric survivors, simply poor and new immigrants) are still facing difficulties - financially and health-wise. Fighting poverty is not solely in the government's hands. Individuals need to help as well and in this area, individuals are failing remarkably.
- People with direct experience in poverty (like Pat) cannot leave to others the role of advocating for them and others in poverty.
- The 25 in 5 Coalition is a network of organizations and individuals working towards the goal of reducing poverty by 25% in 5 years and 50% in 10 years. In the last year, 25 in 5 has engaged the government in a pro-active way in trying to help them understand what poverty is and how to help find "pathways out of poverty."
- There is an ongoing need to monitor the progress including: the reduction of child and family poverty, pending legislation, poverty reduction targets, observe barriers to find pathways to opportunity, temporary work legislation and poverty reduction strategies. The coalition also requires ongoing consultation by government in respect of its poverty reduction strategy and also annual reporting back to the coalition by the government.
- While the government has made progress, what is still missing is the provision of nutritious food to ensure good health. Both of these will be major focuses of the coalition in the coming year as well as the issue of livable incomes and a review of social assistance.

Laurel Rothman Campaign 2000

- Campaign 2000 is a non-partisan national coalition of more than 120 organizations and is committed to securing the implementation of the 1989 all-party resolution to eliminate child poverty by the year 2000. The year 2000 has passed and there has not been a significant and sustained reduction in child and family poverty achieved.
- Campaign 2000 started with a report card in the early 1990s charting about 5-8 indicators. As the years went by, 7 provinces became partners and also do report cards. The report cards is one way to raise awareness, build support and create pressure on public decision-makers to do what needs to be done. Although the year 2000 has passed, the Founding Charter of Campaign 2000 saw the 1989 resolution as a very important first step towards the eventual eradication of poverty.
- Children are the “canary in the coal mine”. They do not live in poverty on their own; they live in poverty in their families. Almost 1 in every 9 children lives in poverty in Canada.
- To fight poverty, it is important to have a specific target, timetable and know how to measure progress.
- Currently, the average low-income family in Ontario lives about \$7,100 below the poverty line (not hovering on the poverty line). 45% of low-income children have at least one parent working full time (or equivalent) throughout the year. Poverty rates for children in Aboriginal families (First Nations and off-reserve), racialized families and immigrant families have at least double the poverty rate as the 1 in 9 children rate.
- Campaign 2000 has always seen itself as addressing the issue from the public issue perspective but needs to determine how to get people interested in their cause. Currently, they build on Canadians’ expressed commitment to fairness and value system to promote their cause. Also, there is increasing evidence that poverty affects everyone. For example, in a recent poll taken in September 2008, 81% of Ontarians believe that it is more important than ever in a recession time to make it a priority to help low-income citizens. A vast majority of Ontarians also support increasing the minimum wage as a key strategy to improve life chances, livelihood and the decency of living for low income families.
- In order to continue to make progress in the fight against poverty, mobilization and support are needed.

Neethan Shan

Colour of Poverty Campaign

- The Colour of Poverty Campaign initiated as a result of many activists noticing that the anti-poverty movement was predominantly white and did not have representation from racialized groups.
- The main objective is to address the racialization of poverty and get it on the agenda.
- Poverty affects everybody but there also exist systemic barriers that can affect the racialized and already-marginalized more so. Different populations are affected by poverty in different ways and even though this is being noticed, more work needs to be done because programs are not recognizing these inequalities.
- The Colour of Poverty Campaign wants to make sure that poverty is being brought forward to talk about racialization. The lack of adequate income in racialized communities can lead to other things including an overrepresentation of racialized communities in the criminal justice system, community housing and being pushed out of schools.
- The Campaign wants to conduct further research but cannot find willing parties to do it. Without research, the Campaign cannot push for policy change. So the Campaign is trying to influence policy through research.
- The Children's Aid Society of Toronto released a report that showed the increased rate of poverty among children for members of racialized communities. They found that among children with African background, 1 in 2 live in poverty, compared to 1 in 10 children with European background who live in poverty.
- The Colour of Poverty Campaign did a symposium and formulated a shared action framework. They have also released a report card evaluating where Canada is in terms of social justice and inequality. The focus this year is to try to get the provincial government's poverty reduction strategy to start incorporating some targeted strategy for racialized communities.

Discussion Points

- More research needs to be done on the relationship between injured workers (those who get injured at work) and poverty. Existing research shows that 50% to 80% of injured workers become unemployed and in poverty. A survey of injured workers showed that 42% of people surveyed were on welfare or ODSP. Also, 57% of homeless people interviewed had been hurt at work. Although their work injuries were not the sole root cause of their homelessness, it is one of many causes that led to an overall downward spiral.
- Transparency appears to be lacking in the social service sector; the sector is constantly failing communities because of their use of the charitable model. These agencies are not becoming places of change. The way in which services are

- offered has to change and also has to be evaluated in terms of how much of the community is actually being served.
- There are systemic barriers in agencies that disable people as opposed to enabling them. There is a problem with the “professionalization and over-credentialed” nature of these agencies. Too much emphasis is placed on staff that prevents the clients from feeling empowered. The clients of these agencies want to be architects of their own future and want people to recognize their abilities. These agencies need to become real places that facilitate pathways out of poverty.
 - People in poverty not only experience income poverty but relationship poverty (isolation) as well. One cause may be that social relationships are hurt when too much time and effort is focused on surviving. Training in this respect is also important because most people are ashamed of their situation. Through training, these individuals who are isolated out of shame can be reoriented so that they have a sense of value.
 - For many poor people who are depressed, only work and money can cure that depression.
 - Empowerment is an important part of fighting poverty. People need to feel as though they can take control of their situation and use that to affect change.
 - Mobilization is important but within limits. Organizations trying to affect change should engage with people, build relationships, trust and get access to institutions to keep pushing the cause forward. If there is a stall in progress, then the action can take on a heavier tone. Sometimes a movement needs to include more aggressive groups; their work can create interest in an issue and lead the policymakers to connect with more moderate groups within the movement. Rallies will not change policy but they are effective tools for getting support and raising awareness.
 - The relationship between seniors and poverty must also be remembered. Starting in the 1970s Canada became one of the leaders internationally in reducing poverty among seniors. There are legislative mechanisms in place that set a decent floor. However, certain groups representing seniors (such as Canadian Pensioners Concerned) continue to raise awareness about the poverty of seniors. The overall rate of poverty among seniors is better than that of other groups. However there are a large number of seniors who do live in poverty, particularly among women, people with disabilities, immigrants and racialized groups.

Labour Market and Income Security Initiatives

Facilitator: Lesley Johnston, CSPC-T

Recorder: Esther Guttman, CSPC-T

Speakers: Karen Dick, Workers' Action Centre
Beixi Liu, Workers' Action Centre
Judy Persaud, Good Jobs for All Coalition
John Rae, Ontario Coalition for Social Justice
Nancy Vander Plaats, ODSP Action Coalition
Mike Yale, ODSP Action Coalition

Presentations

Karen Dick & Beixi Liu
Workers' Action Centre

- 40% of people are outside of the 'normal' workforce. Temp agencies pop up at an alarming rate wherever manufacturing plants are shut down. There are 700,000 temp workers in Canada, and the number is rising.
- Temp workers usually get no benefits, and make only close to minimum wage. The fact that they did not get access to public holiday pay is not right. Only a threat to file a complaint convinces temp agencies to allow workers their rights.
- The Workers' Action Centre is working on a campaign called Ontario Workers Need a Fair Deal, focusing on the following:
 - o Enforcement: \$100 Million of unpaid wages have been recovered in the past four years. Employers have less than a 1% chance of being inspected.
 - o Low Wages: Some workers work up to three minimum wage jobs in order to make ends meet.
 - o Precarious Work: Bad Boss Bus Tours enlighten workers about bad employers. New legislation in January makes public holiday pay a legal right to all temp workers. Bill 139 has passed first reading, and if implemented, will make it illegal for temp agencies to charge fees to workers in order to get a job, and to charge client companies a penalty when trying to hire a temp worker full time.
- \$100 million was promised for hiring new inspectors, but it may not be included in the budget.
- Temp workers are twice as likely as others to work in pain or have mental health issues. This has been attributed to the lack of job and income security.

Judy Persaud
Good Jobs for All Coalition

- The Good Jobs for All Coalition was formed in June 2008 to talk about the state of jobs in the GTA. There are currently 36 member organizations. A summit was held with 1000 people on November 22. Pre-summit dialogues involved over 3000 people in discussions about the definition of and barriers to good jobs. A declaration was made based on this feedback.
- Companies send jobs overseas and bring in temporary foreign workers in order to exploit them.
- The coalition focuses on good paying jobs, healthy communities, a strong social services sector, and equity. A good job has been defined as one that has decent wages, access to training, and an opportunity to unionize. Everyone deserves a good standard of living; there is no reason for anyone to work a full time job and still be living in poverty.
- Four priority areas have been identified for campaigns: Employment Insurance, empowering workers, investing in social infrastructure and a green economy, and a living wage.

Nancy Vander Plaats & Mike Yale
ODSP Action Coalition

- ODSP was founded on the idea that the disabled should not be on welfare and should have specific disability supports. The ODSP Action Coalition was started in late 2001 through feedback from 16 community forums that discussed the overwhelming number of denied applications, the difficulty of the application process, the fact that many people are unaware of all the benefits they are entitled to, and the rate freeze that occurred between 1993 and 2005.
- Victories for the coalition have included medical transportation to mental health appointments (originally it was only for ‘doctors’) improved training for ODSP workers to better understand disabilities, and some raises in rates.
- The coalition is currently fighting for a raise in rates that will cover the actual cost of living, an independent body outside of the government to decide those rates, and an improvement on the rules of earning wages while on ODSP.
- Applicants are more likely to get benefits if they fight for them. There is a high success rate at appeals tribunals.
- Improvements to disability supports have focused on physical accessibility. Information sharing is still lacking. Many people on ODSP do not know about all of the options for supports available to them. Toronto’s caseload is overwhelming, but that should not prevent the creation of pamphlets and information sheets for applicants to read before speaking to a caseworker.

- The proposed \$100 food benefit will help bring ODSF recipients up to the poverty line. A poverty reduction strategy must be comprehensive, with the goal of complete eradication of poverty for all age groups to be effective.

John Rae
Ontario Coalition for Social Justice

- It comes as a surprise to anyone that poverty is a determinant of health. The historical notion was that the benefits of Canada’s prosperity would trickle down to everyone, but it appears to have missed the disabled community in particular, amongst others.
- The problem with governments is that they work in silos. Child poverty cannot be solved if their families are ignored. The government’s strategy of throwing us ‘bread crumbs’ makes us fight amongst ourselves; we need to be given something substantial.
- Research has its place; it aids activists in their work. The benefit of this research is that it has automatic credibility and reminds the government of what must be done. Researchers, however, are often not members of the communities they study. Where are the disabled researchers? Why does research money keep going to ‘outsiders’? This is just one example of the myriad of ways discriminatory practices continue.
- While the government wants to cut inspectors, many more are needed. Regulation is always slow; there needs to be a better way of getting access to rights than the worker threatening the employer with reports and lawsuits.
- It is assumed in current times that everyone will switch jobs and possibly careers at least once in their lifetime. It takes disabled people longer to find a single job, often because employers are unwilling to accommodate their needs. Disabled people face even further barriers now that they must spend more time searching for more jobs.

Discussion Points

- Many European countries attempted to ban temp agencies. They were not successful, but our demands are based on the rights that those workers have subsequently received.
- An upfront, guaranteed/citizen’s income would bring people out of poverty. Employers should be chasing employees and not the other way around.
- If social assistance gave rates that were equal to the cost of living, recipients may not want to work; however, temp agencies would then struggle to find workers. Many people would still choose to work in order to pass the time and find meaning in their lives.

- A good quality of life means having choices. Without money, there are no good choices. When a wealthy person leaves their job, it is said that the job wasn't for them, but when a poor person leaves a job, they are considered to have failed.
- It is a positive change that people with disabilities are no longer labeled as 'handicapped.' The only two real handicaps are public attitudes and poverty.
- Subsidies that encourage employers to hire certain people end up giving employers cheap labour. A system is needed where the worker is offered a full time job or linked to one at another company once a subsidy runs out. If a subsidy is offered for training, the employer should be required to provide a training plan.
- The government does not spend money effectively. For example, the government will pay for retraining programs for workers, but will often pay for the most expensive program. The same or a similar program is often available at another institution for much lower price.
- Too much emphasis is often put on credentials. Self-taught skills are often not recognized.

Health Equity Advocacy

Facilitator: Israt Ahmed, CSPC-T

Recorder: Raluca Fletcher, CSPC-T

Speakers: Gary Bloch, Health Providers Against Poverty
 Jennifer D'Andrade, Volunteer Health Clinic for the Uninsured and Homelessness
 Anne Egger, Health Providers Against Poverty

Introduction

Israt Ahmed introduced the speakers and stated that this is a great opportunity to learn from each other.

Presentations

Gary Bloch

Special Diet Campaign and HPAP (Health Providers Against Poverty)

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- Participated with OCAP (Ontario Coalition Against Poverty) in organizing mass assessment clinics across Toronto. Approximately 6000 people have been seen. Gary mentioned the Queen's Park Hunger Clinic that diagnosed a cure for people in poverty- the \$250 (for the people who registered as patients).
 - The Special Diet Campaign evolved into lobbying policy makers, raising awareness around the relationship between health and poverty (through radio,

- Toronto Star, etc), mobilizing health organizations and into starting alliances with several anti-poverty groups.
- Lessons learned from the Special Diet Campaign: engage in action with real impact on people living in poverty; involve people living in poverty; think long-term, beyond the idea of this campaign to 5-10 year plans; this matured into the “Health Providers Against Poverty”.
 - HPAP is involved in providing education and translating poverty into the language of providers: “evidence, evidence, evidence”. This will result in a change for individuals living in poverty plus there is a need for new members and a collective voice to be heard.
 - HPAP is involved in advocacy with the government to provide public policy approaches that could address poverty as a health issue in Ontario. It also has a strong focus on coalitions (“25 in 5”, “OCAP”). The rationale behind the advocacy is that HPAP is a professional organization and its members have health expertise.
 - In order to assist with the advocacy efforts, HPAP developed a strong interest in research for collecting evidence about the correlation between poverty and health. There have been systemic reviews of literature on the relationship between changes in welfare and health outcomes and on the primary care interventions.
 - Through the Special Diet Campaign and multi-disciplinary anti-poverty clinics, HPAP believes that it can make a real change for people living in poverty.
 - Opportunities for HPAP: articles on poverty and health were published in the Ontario Medical Review and OMA (Ontario Medical Association) passed a resolution calling on a public policy that will address poverty.
 - Challenges: need of long-term prospects and commitments; need to increase capacity; public opinion that “this is not a medical issue”.

Anne Egger

A Proposal for an interdisciplinary clinic, which will address the social determinants of health for people on social assistance

- Target the people on social assistance and draw the attention on the social determinants of health.
- This will develop from a community-based model as it evolves from the Special Diet clinic experience.
- Focus would not be on the physical health status but on the social determinants of health and on how to help individuals to access benefits (as there are people who do not access the available benefits).
- Would also help candidates move from OW to ODSP and address food security and housing issues.

- The clinic would be open every 2-4 weeks for one year minimum and it would involve a coordinator, one or more medical doctors, a social worker, community organizer, psychiatrist and volunteers.
- How it would work: pre-screening of individuals, detailed intake, medical interview, internal and external referral, setting up of a medical record system.
- It would also provide information on accessing the GST credit, income tax, child tax credit, legal advice, and senior benefits.
- Further, it should not be Toronto-centred and we should replicate the model in other areas across Ontario and link the clinic with other community organizations.
- Anne stated that this is only a proposal at the moment and there is a need for stable funding. She also requested feedback.

Jennifer D'Andrade

The Volunteer Health Clinic for the Uninsured and Homelessness

- The clinic's objective is to provide health care for Scarborough residents who don't have coverage as there are a number of people in shelters or on the street who don't have a health card and, as a result, they could be refused care. Residents also deal with legal, non-status, and housing issues.
- The clinic started in 2000, has a donated space, a local lab and it can serve up to 24 people in one night. There are approximately 25 family physicians who volunteer.
- Operating principles: confidentiality, quality care, combined services, diagnosis, secondary care capabilities, and convenient and accessible community location.
- Services provided: primary medical care, assessment, treatment, diagnostic, referral to specialists, link to community resources (volunteer lawyers, volunteer dental clinic for low income adults and youth not in school, small food bank and baby clothing).

Statistics from June 2000 - December 2007

- Total number of patients: 10,000
- Number of new patients: 5,000 (50%)
- OHIP status: 35% eligible and 63% not eligible
- Nature of visit: pregnancy 18%, medical 66%, mental health 3%, immunization 8% and infectious diseases 3%
- Gender and age: females 70%, males 30%. Also 61% are between 20-65 years old

Clinic Highlights

- Started with donations
- Have annual funding through the Ministry
- Reduced hospital rates
- Option of payment plans so there are no collections agencies after clients
- Increased awareness of staff towards this population
- Access to the early years challenge fund for new immigrant families
- Participation in coalitions and networks like the “Right to health care coalition” that advocates for health coverage for Canadian-born babies of non-status parents plus for the elimination of the 3 month waiting period for OHIP coverage. Other community groups that the Clinic is networking with are “Women’s College Task Force” and “Scarborough Women’s Action Group”.
- Challenges: hospital deficits; limited access for uninsured people; working poor individuals are unable to pay for medications/medical equipment; CHCs have limited funding and space; volunteer burnout.
- Opportunities: joint community hospital collaboration; greater awareness for new landed immigrants.

Discussion Points

- The health care coverage for landed immigrants is a federal-provincial issue: in some provinces the coverage is in place right from the landing time. It will be good to have the same national standard but the federal government considers this a provincial issue because the health care is provincially administrated.
- Some participants expressed concerns about the ways of collecting data and evidence that could be useful in grants applications. Israt recommended the City of Toronto’s research division for providing information. Others mentioned previous workshops organized by CSPC-T and suggested that parties interested will make a request to the CSPC-T for re-launching these workshops. Gary mentioned that having evidence is a strategic decision as it would serve as a solid argument for the people who are not convinced that making these changes is the right thing to do.
- Other participants disagreed with the proposal for the interdisciplinary clinic as it may add to the stigma already associated with poor people; this will be disempowering for them as it is the same as saying that people on OW should only live in public housing.
- It was also mentioned that there is a lack of knowledge about other sectors. The “Every Child Matters” program from the UK was given as a positive example as it is a national strategy that provides an electronic template of children’s records that various sectors and people can access.
- Next strategic move: to gather a meeting of potential partners.