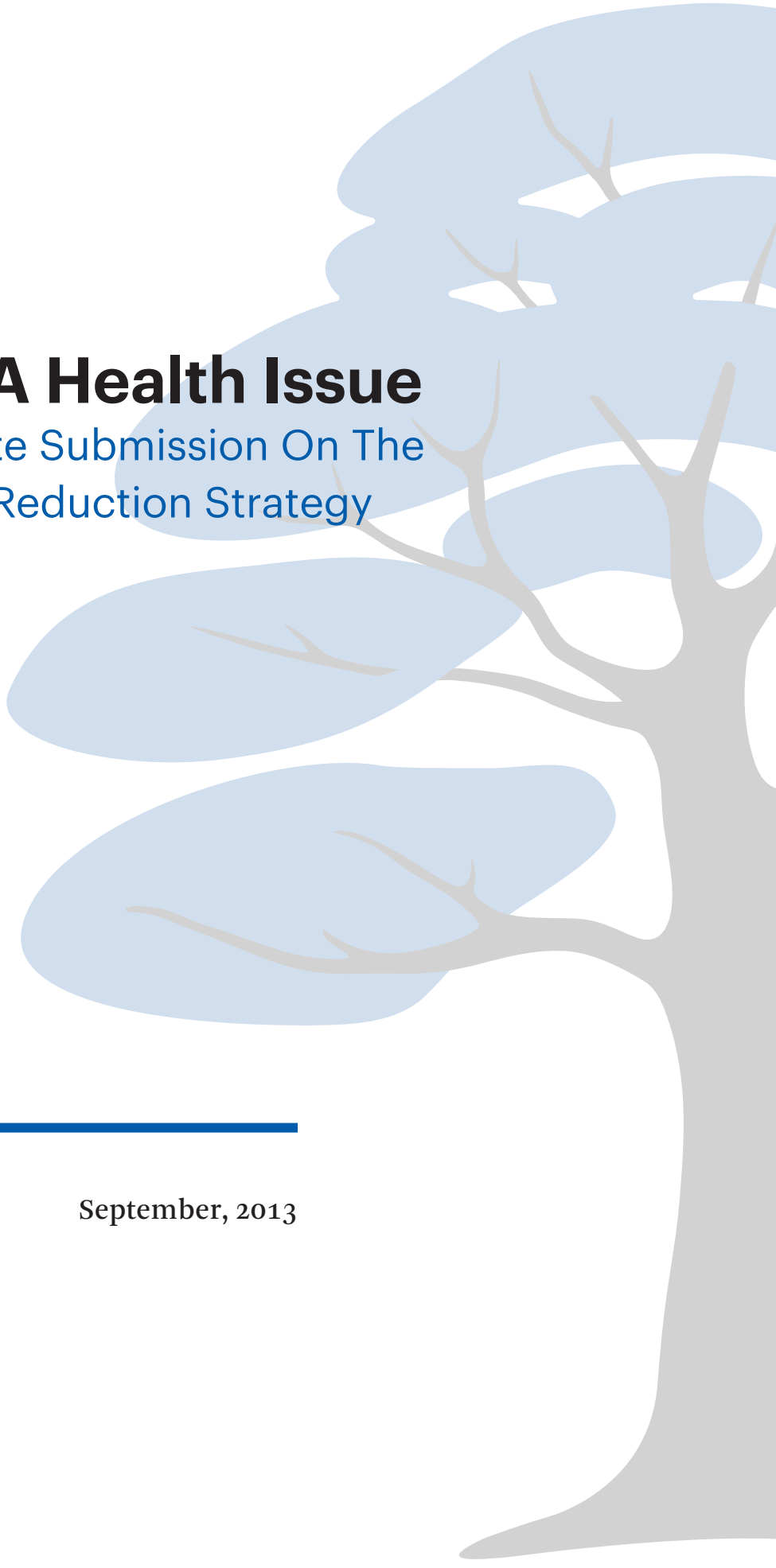
Poverty Is A Health Issue

Wellesley Institute Submission On The Ontario Poverty Reduction Strategy



Wellesley Institute
advancing urban health

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The Wellesley Institute engages in research, policy and community mobilization to advance population health.

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Poverty Reduction Strategy| Submission

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Introduction

Living on a low income affects people's lives in many ways. Living in poverty can mean having fewer opportunities to fully participate in important day-to-day activities like work and education. Further, health and social research also shows that those who live on a low income also experience poorer health than those who are better off.

This submission to the Ministry of Child and Youth Services about the Ontario Poverty Reduction Strategy outlines some of the key areas in which people with low income experience poor health in our province. Our research demonstrates that the health of the poorest Ontarians can be improved by investing in housing and homelessness, income security, and health equity. The new Poverty Reduction Strategy should make good health for all Ontarians a cornerstone.

Poverty Is A Health Issue

Extensive research shows that people with lower income and education, who are unemployed or in precarious or low-paid work have poorer health than those who are better off.[1] Moreover, there is a well-established gradient of health in which people who are in the lowest income group have worse health than people who are even just one step further up the income ladder. This gradient applies whether measured by self-reported overall health, mental health, prevalence of chronic conditions, or many other indicators.[2] In Ontario:

- Over three times as many people in the lowest income quintile report their health to be only poor or fair than in the highest;[3]
- Twice as many men in the lowest income group reported having diabetes as those in the highest income group, while low income women were 2.5 times as likely to have diabetes as high income women;[4]
- Neighbourhoods with the highest level of material deprivation had higher rates of low birth weight babies (60 per 1,000 births) compared to neighbourhoods with the lowest level of material deprivation (43 per 1,000 births);[5]
- People living in the poorest neighbourhoods reported lower positive mental health (66 percent) compared to those living in the best-off neighbourhoods in the (78 percent);[6]
- Only 39.5 percent of people living in households with income of less that $15,000 had dental insurance.[7]

These differences have a significant impact over people's lives. In Toronto, life expectancy was 4.5 years less for men in the lowest income quintile versus the highest and 2.0 years less for women.[8] However, the

1 R. Wilkinson & M. Marmot, *Social Determinants of Health: The Solid Facts,* 2nd edition, World Health Organization, 2003.

2 Commission on Social Determinants of Health*, Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health,* Geneva, World Health Organization, 2008, pp. 31-32.

3 A.S. Bierman, F. Ahmad, J. Angus, R.H. Glazier, M. Vahabi, C. Damba, J. Dusek, S.K. Shiller, Y. Li, S. Ross, G. Shapiro, D. Manuel, 'Burden of Illness', in A.S. Bierman (ed.), *Project for an Ontario Women's Health Evidence-Based Report: Volume 1*: Toronto; 2009. Self-reported health is regarded as a reliable indicator of clinical health status.

4 Bierman et al.

5 2011 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario, *Maintaining the Gains, Moving the Yardstick: Ontario Health Status Report, 2011*, Chief Medical Officer of Health of Ontario, 2011, p. 13.

6 2011 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario, p. 39.

7 L. Sadeghi, H. Mason & C.R. Quiñonez, *Report on Access to Dental Care and Oral Health Inequalities in Ontario*, Public Health Ontario, July 2012, p. 9.

8 Toronto Public Health, *Unequal City: Income and Health Inequalities in Toronto*, Toronto Public Health, 2008.

incremental increases in health status at each step up the income ladder means that raising people in the lowest income group up even one step can have immediate health benefits.[9]

The evidence is clear that people with low income fare poorly in the social determinants of health and, as a result, face a lifetime of poor health. But these negative health outcomes can be mitigated and avoided by investing in poverty reduction.

Income Security

Ensuring that all Ontarians have adequate income is critical to achieving the Poverty Reduction Strategy's goals. We know that many Ontarians are unable to afford basic necessities and that this can have negative health impacts. There are four areas in which policy solutions to improve income security are well-know, actionable and supported by research: increasing the minimum wage, modernizing employment standards, improving labour market regulation, and ensuring the adequacy of social assistance rates.

Minimum Wage

Ensuring adequate income is critical to ensuring that all Ontarians are able to afford basic needs like housing, food, and transportation. Ontario's minimum wage has been frozen at $10.25 per hour since 2010. At the current rate, earning minimum wage means living in or near poverty.

In Ontario, there are a growing number of people who are 'working poor'. In the Toronto Region, this population increased by 42 percent between 2000 and 2005.[10] Working poverty can have serious health impacts: Ontario data show that 66 percent of people who were working and made sufficient incomes reported their health as excellent or very good as compared with 49 percent of those who were working poor.[11] Low-wage jobs are no longer a problem only for young workers: in Ontario between 2004-2012 the share of minimum wage workers aged 35 years and over earning minimum wage increased from 17.3 percent to 27.1 percent.[12]

The government recently established the Minimum Wage Advisory Panel to give advice on the province's minimum wage. While it is encouraging that the province is seeking advice on minimum wage, immediate action is required.

Working in paid employment should be a path out of poverty and an adequate minimum wage is critical. **The new Poverty Reduction Strategy should commit to benchmarking the minimum wage at 10 percent above the Low Income Measure (LIM).** This means that Ontario should set the minimum wage at $14 per

9 S. Block, *Rising Inequality, Declining Health: Health Outcomes of the Working Poor*, Wellesley Institute, 2013, p. 1.

10 J. Stapleton, B. Murphy & Y. Xing, *The "Working Poor" in the Toronto Region: Who they are, where they live, and how trends are changing*, Metcalf Foundation, February 2012, p. 26.

11 Block, pp. 3-4.

12 Armine Yalnizyan, *Boost the Minimum Wage, Boost the Economy*, February 27, 2013. http://www.progressive-economics.ca/2013/02/27/boost-the-minimum-wage-boost-the-economy/.

hour. Additionally, the minimum wage must be indexed to inflation to protect the purchasing power of low wage earners.

Employment Standards

The Ontario Employment Standards Act (ESA) sets out the minimum terms and conditions that all employees can expect with regard to wages and other working conditions. These standards are important to all workers, but they are especially so for marginalized workers who are least able to negotiate fair wages and working conditions for themselves. The 2008 Poverty Reduction Strategy recognized the role of employment standards in protecting workers against poverty by committing $10 million annually to hire new employment standards officers with the goal of improving compliance and reducing the backlog of claims.[13]

Despite this, there are still barriers to workers being guaranteed a safe place to work in which their rights are respected. Barriers include a system of individual complaints-based enforcement, the misclassification of employees by employers, a lack of deterrence for employers who violate the ESA, and gaps in employment standards that leave workers unprotected.[14]

Ensuring that people get paid for the work that they do, and that their pay is in compliance with the law is an effective way to reduce poverty in the province. **The Poverty Reduction Strategy should commit to improving enforcement and modernizing the Employment Standards Act.** This should include identifying strategic enforcement priorities and targeting employers in industries that are know to have high violations and supporting workers to make Employment Standards claims.[15]

Updating The Labour Relations Act[16]

Employment should be a path out of poverty. But increasingly, Ontarians are finding themselves in low-wage work without security or benefits. Research shows that precarious forms of employment are on the rise, that this type of employment has increased by nearly 50 percent in the last 20 years, and that only around half of those working have permanent, full-time positions that provide benefits and job security.[17] Labour market regulation is a powerful tool to reduce employment precarity and poverty and can be done without large costs to government.

Workers in low wage jobs are no longer able to unionize at the same rates as earlier generations, as evidenced by decreasing union density rates in the private sector. The data shows that workers in unionized

13 Government of Ontario, *Breaking the Cycle: Ontario's Poverty Reduction Strategy,* 2008, p. 22. http://www.children.gov.on.ca/htdocs/English/documents/breakingthecycle/Poverty_Report_EN.pdf.

14 For a comprehensive account of the barriers workers face and potential solutions, see Wellesley Institute, *Talking About Jobs*, 2011. http://www.wellesleyinstitute.com/wp-content/uploads/2011/11/6-Good-Ideas-About-Jobs-in-Ontario1.pdf.

15 A complete series of recommendations about enforcing employment standards has been prepared by the Workers' Action Centre. Available at: http://www.workersactioncentre.org/wp-content/uploads/2011/12/pb_wtrecsforchange_eng.pdf.

16 The discussion of labour market regulation and employment standards is adapted from S. Block, *Reducing Labour Market Inequality, Three Steps At A Time*, Wellesley Institute, 2013. http://www.wellesleyinstitute.com/wp-content/uploads/2013/09/Reducing-Labour-Market-Inequality.pdf.

17 W. Lewchik, M. Lafleche, D. Dyson, L. Goldring, A. Meisner, S. Procyk, D. Rosen, J. Shields, P. Viducis & S. Vrankulj, *It's More than Poverty: Employment Precarity and Household Well-being*, Poverty and Employment Precarity in Southern Ontario, McMaster University & United Way Toronto, February 2013. http://pepsouwt.files.wordpress.com/2013/02/its-more-than-poverty-feb-2013.pdf.

workplaces are able to negotiate higher wages than non-unionized workers. Further, the gap between lower paid employees and higher paid employees is smaller for unionized workers.[18] Higher levels of unionization also have an important spill over effect; increasing wages in non-union workplaces. Increased inequality and decreased levels of unionization are strongly correlated in many countries – including Canada.[19]

One modest change to the Labour Relations Act would be to protect workers' collective bargaining rights for contracted services like security guards or food services providers. Currently, if a manufacturing business is sold, employees are able to keep their union and their contract. If the company uses contract cleaners, on the other hand, these workers cannot keep their union or contract despite continuing to work the same job in the same location. Saskatchewan has corrected this gap for workers whose employers have contracts with the public sector – Ontario should adopt and expand this model. **The Poverty Reduction Strategy should update the Labour Relations Act to protect workers' collective bargaining rights**.

Social Assistance Adequacy

Social assistance rates are currently set at levels that are too low for recipients to maintain good health. Research on the health of people receiving social assistance showed that they are five times more likely than the non-poor to report their health as poor or fair; have 2.4 to 4.6 times the rates of diabetes, heart disease, mood and anxiety disorders and other chronic conditions than the non-poor; and are over four times more likely to consider suicide sometime in their lives than non-poor, and almost twenty times more likely to attempt suicide.[20]

The 2013 Ontario Budget made progress toward adequacy of social assistance by raising the rates by one percent, allowing people receiving social assistance to keep more of their earned income, providing a $14 per month additional top-up for single people on Ontario Works, and increasing asset limits for all Ontario Works recipients. These moves were broadly welcomed by stakeholders.

The new Poverty Reduction Strategy offers an opportunity for the government to take the next step in ensuring the adequacy of social assistance rates. The Wellesley Institute was part of a broad partnership of health sector leaders that provided advice to the Commission for the Review of Social Assistance in Ontario on how to build health into social assistance.[21] The report by Commissioners Lankin and Sheikh made the case for setting a rational rate methodology to ensure that rates are set at a level that reflect the actual costs of living across Ontario. The Commission recommended the creation of a Basic Measure of Adequacy (BMA). The proposed BMA included the cost of food, clothing and footwear, basic personal and

18 A. Jackson, *Work and Labour in Canada Critical Issues: 2nd Edition*, Canadian Scholar's Press, Toronto, 2009, p. 209.

19 N. M. Fortin, D.A. Green, T. Lemieux, K. Milligan & W.C. Riddell, 'Canadian Inequality: Recent Development and Policy Options', *Canadian Public Policy* , Vol. 38, No. 2, June 2012, p. 15

20 B. Wilson, E. Lightman & A. Mitchell, *Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario*, Community Social Planning Council of Toronto, University of Toronto's Social Assistance in the New Economy Project & Wellesley Institute, Toronto, 2009.

21 The partnership published two reports on social assistance reform: B. Gardner, S. Barnes and the Social Assistance Review Health Working Group, *Towards a Social Assistance System that Enables Health and Health Equity: Submission to the Commission for the Review of Social Assistance in Ontario*, October 2011, http://www.wellesleyinstitute.com/wp-content/uploads/2011/11/Towards-a-Social-Assistance-System-that-Enables-Health-and-Health-Equity-Brief-to-the-Commission-for-the-Review-of-Social-Assistance-in-Ontario2.pdf; and S. Barnes, B. Gardner and the Social Assistance Review Health Working Group, *Response to the Social Assistance Review Discussion Paper*, March 2012, http://www.wellesleyinstitute.com/wp-content/uploads/2012/03/Response-to-the-Social-Assistance-Review-Discussion-Paper-FINAL1.pdf.

household needs, transportation, and shelter.[22] **The Poverty Reduction Strategy should commit to ensuring that social assistance rates are set at a level that allows recipients to afford these basic necessities of life.**

Housing And Homelessness

Housing insecurity and homelessness have significant health impacts. The poorest neighbourhoods have the poorest quality housing and the poorest health profiles.[23] Critically, the death rate for homeless people is eight to ten times higher than for housed people of the same age.[24] Having a safe and affordable home is an important foundation for good health.

There were a number of housing-related commitments made in the 2008 Poverty Reduction Strategy. The government committed to stabilize funding for the Provincial Rent Bank, establish a long-term affordable housing strategy, and encourage all three levels of government to take action on housing issues. The province also introduced a housing-related poverty indicator to measure need and assess progress.

Despite these commitments, a lack of safe and affordable housing continues to be a major barrier to good health for many Ontarians. In Toronto, as of August 2013, there were 165,723 people on the affordable housing waitlist. This was an increase from 165,215 in July 2013, which was an increase from 163,858 in June 2013.[25]

In Ontario, limited safe and affordable private rental housing is a major barrier to good health. Within private units, there are four major challenges: 1) a lack of supply, as evidenced by low vacancy rates; 2) a lack of affordability, as shown by the large proportion of households that pay more than 30 percent of their income on housing; 3) the poor condition of the housing stock; and 4) a lack of adequate social and health supports for people who may require special help to access and maintain their housing. These issues should be addressed in Ontario's Poverty Reduction Strategy.

Addressing the lack of supply can be achieved by incorporating inclusionary housing into the Planning Act. Currently, there are few incentives for developers to include affordable housing in their projects. While Section 37 of the Planning Act allows for developers and municipalities to strike individual deals on particular projects, this process has not led to consistent results. Hundreds of US municipalities use various forms of mandatory inclusionary housing to achieve more certain results. Empowering municipalities to use concessions available through regulatory and approval processes can help to provide incentives for developers to provide affordable housing on a permanent basis. Potential concessions could include increased height and density allowances.[26] **The Poverty Reduction Strategy should commit to incorporating inclusionary housing into the Planning Act.** This reform would require only a minor amendment to the Act and represents an important partnership between municipal governments and the private sector to address the shortage of affordable housing in Ontario.

22 F. Lankin & M. Sheikh, *Brighter Prospects: Transforming Social Assistance in Ontario*, 2012, p. 67.

23 See, for instance, www.torontohealthprofiles.ca.

24 A.M. Cheung & S.W. Hwang, 'Risk of Death among Homeless Women: A Cohort Study and Review of the Literature', *Canadian Medical Association Journal*, Vol. 170, No. 8, 2004, pp. 1243-1247.

25 Housing Connections, *Housing Connections Statistical Reports*, http://www.housingconnections.ca/information/reports.asp.

26 See Richard Drdla Associates, *A Guide to Developing an Inclusionary Housing Program*, September 2010 (http://www.wellesleyinstitute.com/wp-content/uploads/2010/06/Inclusionaryhousing_Drdla.pdf) for more information about inclusionary housing. The Wellesley Institute has a range of resources that address inclusionary housing, available at http://www.wellesleyinstitute.com/our-work/housing/inclusionary-housing/.

Recently, Ontario has shown leadership on the need for a national housing strategy. At the 2013 Council of the Federation meeting, Canada's premiers "called on the federal government to work with ministers of housing on a long-term federal funding commitment for housing, which would outline a comprehensive and sustainable strategy to effectively meet the country's diverse housing needs for both today and future generations".[27] A national housing strategy that includes consistent federal funding is critical to addressing Canada's affordable housing crisis. **The Ontario Poverty Reduction Strategy should underscore this point and commit to continue to advocate for the federal government to develop a national housing strategy in conjunction with the provinces and territories.**

Addressing the poor condition of housing stock in Ontario requires capital investments. In 2008, the Ontario government announced a $500 million affordable housing loan fund as part of Infrastructure Ontario.[28] The loan fund is available for both new construction of affordable housing and for upgrades to existing stock.

There is no information publicly available on how much, if any, of the original $500 million that was allocated to the housing loan fund is available. However, based on earlier reports, and a list of recent projects that have been financed through the fund, it appears that additional capitalization is required to ensure that financing remains available for vital affordable housing initiatives. **The Ontario Poverty Reduction Strategy should commit to ensuring that the Infrastructure Ontario affordable housing loan fund remains capitalized at $500 million to enable the continuing construction and upgrade of affordable housing across the province.**

As part of its Long-term Affordable Housing Strategy, the Ontario government's Housing Policy Statement (HPS) requires municipalities to create 10-year housing and homelessness plans that provide a comprehensive and long-term response to local needs. However, the province has not given municipalities any additional legislation, programs, or funding to help them meet the requirements of the Housing Policy Statement. In addition, the HPS 10-year plans are not coordinated with the Poverty Reduction Strategy – and a valuable opportunity to make connections across governmental departments risks being lost. **The Poverty Reduction Strategy should commit to coordinating with Ontario's Housing Policy Statement and providing appropriate legislation, programs, and funding to enable municipalities to meet its requirements.**

Housing Supports For People Receiving Social Assistance

The Ministry of Community and Social Services eliminated the Community Start-Up and Maintenance Benefit (CSUMB) in January 2013. The CSUMB helped people receiving social assistance to pay for large or unexpected housing-related costs, supporting them to become and remain housed. When the CSUMB ended only 50 percent of its funding was passed to municipalities as part of a consolidation of housing programs, although additional transitional funding was provided for 2013.

The Wellesley Institute, in partnership with the Income Security Advocacy Centre, has been collecting information on the elimination of the CSUMB since January 2013. We asked municipal, community, and

27 The Council of the Federation, *Canada's Premiers are committed to a fair and inclusive society*, July 26, 2013. http://www.councilofthefederation.ca/phocadownload/newsroom-2013/fair_and_inclusive_july26-final.pdf.

28 Details about Infrastructure Ontario's affordable housing loan fund are available at http://www.infrastructureontario.ca/What-We-Do/Loans/Housing-Providers/.

other staff working with clients who would have been eligible for the CSUMB to submit their stories via a simple survey tool.[29] These examples illustrate the impact of eliminating the CSUMB on the housing and health of Ontarians.

As of September 2013, 119 submissions had been received. Many of these submissions confirm that the elimination of the CSUMB has contributed to negative housing and health outcomes. The most common situations people are facing are being unable to pay rent (26 percent of cases), trying to purchase new or replacement furniture (for example, replacing bed bug infested furniture) (25 percent), trying to leave unsafe housing (21 percent), and trying to leave a homeless shelter (18 percent). There are also cases reported of families being unable to pay their utility bills and women trying to leave domestic violence. Approximately a quarter of the cases concern households with dependent family members.

These results demonstrate that safe and affordable housing is still not achievable for many people living on a low income. Social assistance rates are not adequate to ensure that recipients can withstand even minor financial 'shocks'. Municipalities are currently submitting their long-term housing and homelessness plans to the province; it is essential that strong provincial standards are implemented to ensure that, in the absence of CSUMB, people receiving social assistance and who are living on a low income have a range of supports that are consistent across the province. **The Poverty Reduction Strategy should ensure that all low income Ontarians have access to appropriate housing supports and should ensure that services are consistent across the province.**

Setting Targets To Improve Health

Health inequities – differences in health outcomes that are avoidable, unfair, and systematically related to social inequality and disadvantage – are rooted in structural features of our society and are beyond individuals' control. These inequities are not because of lifestyle, genetics or bad luck, but are rooted in structural features of our society.[30]

Given that health inequities are avoidable and strongly connected to income, the new Poverty Reduction Strategy must include specific health equity related targets. The province has already flagged diabetes and childhood obesity as key priorities for reducing demands on the health care sector. These conditions are both sensitive to social context and poverty and are good examples of how the Poverty Reduction Strategy can incorporate health equity targets.

Diabetes Prevention And Management

Healthy eating and exercise are important to preventing and managing chronic diseases like diabetes. However, not everybody has the ability to manage these kinds of lifestyle factors. People with low income are more likely to live in neighbourhoods that may lack basic infrastructure like sidewalks and parks that

29 The survey tool is available in English and French at http://www.wellesleyinstitute.com/news/tracking-the-impact-of-cuts-to-housing-and-homelessness-supports/.

30 Commission on Social Determinants of Health, p. 1.

allow them to be physically active.[31] Lower income communities may also lack access to grocery stores that sell healthy food and do not always have transit connections to travel to the nearest healthy food source.[32] Fundamentally, however, people on low income may not be able to afford healthy food regardless of whether it is available in their neighbourhood. Compounding these disadvantages, poorer people may have worse access to primary health care, which contributes to poor health and more difficulty managing chronic conditions like diabetes. **The Ontario Poverty Reduction Strategy should set specific targets related to income and diabetes prevention and management.**

In 2012, the Ontario government released its provincial diabetes strategy that incorporated a series of specific targets, including ensuring that all people with diabetes have access to a primary health care provider and ensuring that 80 percent of adult Ontarians with diabetes have all three key diabetes tests within the recommended guideline period for optimal diabetes management.[33] Given that diabetes is already a priority for the province and that lower income communities are disproportionately affected by this condition, the Ontario Poverty Reduction Strategy should include specific targets for reducing the prevalence of diabetes in low income communities.

One potential metric could be to reduce the prevalence of diabetes in low income neighbourhoods by 20 percent in five years. Local Health Integration Networks (LHINs) are already collecting data about diabetes rates – this data could easily be combined with neighbourhood-level census data to identify low income neighbourhoods with high diabetes rates. Raising incomes through policy changes such as increases to social assistance rates and minimum wage is the most important lever for addressing the connection between low income and diabetes, but tracking neighbourhood-level data allows local interventions that could have broader population health impacts, for example, transit expansion, provision of recreation services, and construction of sidewalks and parks, as well as better targeting of health promotion initiatives.[34] Another critical metric that aligns with the Ministry of Health and Long-Term Care's existing targets is to reduce inequities in the completion of all three key diabetes tests between high and low income neighbourhoods.

Childhood Obesity

Growing up in poverty can lead to a lifetime of poor health. Not all families in Ontario are able to afford both rent and healthy food. Moreover, living in poverty can reduce families' ability to access child care, recreational activities, and early childhood education – all of which are important to ensuring positive

31 A.S. Bierman, A. Johns, B. Hyndman, C. Mitchell, N. Degani, A.R. Shack, M.I. Creatore, A.K. Lofters, M.L. Urquia, F. Ahmad, N. Khanlou & V. Parlette, 'Social Determinants of Health and Populations at Risk', in A.S. Bierman (editor), *Project for an Ontario Women's Health Evidence-Based Report: Volume 2*: Toronto, 2012, p. 29.

32 S. Kumanyika & S. Grier, 'Targeting Interventions for Ethnic Minorities and Low-Income Populations', *The Future of Children*, Vol. 16, No. 1, Spring 2006.

33 Ontario Ministry of Health and Long-Term Care, Ontario Diabetes Strategy, http://www.health.gov.on.ca/en/public/programs/diabetes/intro/strategy.aspx.

34 For a review of diabetes prevention and management in Ontario and potential policies that extend beyond lifestyle interventions, see K. Kongats, *Diabetes Prevention and Management Through a Health Equity Lens*, Wellesley Institute, August 2013. http://www.wellesleyinstitute.com/wp-content/uploads/2013/08/Diabetes-Prevention-and-Management.pdf.

child health.[35] In Canada, 24 percent of children growing up in the best-off neighbourhoods are obese, compared with 35 percent of children in the poorest neighbourhoods.[36]

Reducing rates of childhood obesity is already a provincial priority. The Healthy Kids Panel, established by the Ministry of Health and Long-Term Care, reported back to the province in Fall 2012 about how to reduce childhood obesity by 20 percent in five years.[37] The Panel made recommendations that focused on prenatal health for women, using well-baby visits to promote healthy weights, changing the food environment and creating healthy communities. Critically, the Panel also recommend that the province speed up its implementation of the Poverty Reduction Strategy.

In our advice to the Healthy Kids Panel the Wellesley Institute recommended that the province should build on its poverty reduction commitments by ensuring that children growing up in families on social assistance have adequate income and other essential supports, such as allowances for healthy food, transportation, and child care, that enable good health. We also recommended raising the minimum wage and employment standards to levels that support good health for families and children and exploring options for expanding health benefits to all low income Ontarians.[38]

These recommendations reinforce the importance of improving income security for low income families. **The Poverty Reduction Strategy should also create specific targets for reducing childhood obesity that are growing up in low income families.** One option could be to commit to reducing rates of childhood obesity in the lowest income neighbourhoods over and above the provincial target of 20 percent in five years.

Health Equity Targets

The ultimate goal of the Poverty Reduction Strategy is to reduce levels of poverty and increase the well-being of the poorest among us. Because poverty has such a damaging effect on health, one very effective way to measure the overall success of the strategy is to measure changes in health. One key goal of the Poverty Reduction Strategy should be to reduce health inequities between low income people and the general population – to "level up" so that the differences in health outcomes between the worst and better off are steadily reduced. We have illustrated this through two high priority areas for the province and have set out recommendations for how the Poverty Reduction Strategy can include targets for reducing overall health inequities.

Disaggregating data based on income, education, immigration status, race, and other factors is critical to identifying meaningful health equity targets and appropriate interventions. Enough data already exists to make a start, but **the Poverty Reduction Strategy should commit to the Ministry of Health and Long-Term Care collecting and publishing a greater range of disaggregated data about health inequities.** There should also be a commitment to analyze these data with a health equity lens using tools such as the

35 K.D. Raine, *Overweight and Obese in Canada: A Population Health Perspectiv*e, Canadian Institute for Health Information, 2004.

36 L.N. Oliver & M.V. Hayes, 'Neighbourhood socio-economic status and the prevalence of overweight Canadian children and youth', *Canadian Journal of Public Health,* Vol. 96, No. 6, pp. 415-420.

37 Healthy Kids Panel, *No Time to Wait: The Healthy Kids Strategy*, 2012. http://www.health.gov.on.ca/en/common/ministry/publications/reports/healthy_kids/healthy_kids.pdf.

38 S. Barnes, *Reducing Childhood Obesity in Ontario through a Health Equity Lens*, Wellesley Institute, October 2012. http://www.wellesleyinstitute.com/wp-content/uploads/2012/10/Reducing-Childhood-Obesity-in-Ontario.pdf.

Ministry's own Health Equity Impact Assessment.[39] The Poverty Reduction Strategy should continue to draw upon these data and analyses. A commitment should be made to work with Health Quality Ontario, Public Health Ontario and other experts to identify other health equity indicators, such as infant mortality rates and testing for chronic and other preventable conditions.

Next Steps In Poverty Reduction

Ontario has an important opportunity to make strides in reducing poverty across our province. The new Poverty Reduction Strategy can build on the successes of the last five years, but sustained commitments and investments are required.

Poverty is not caused by a single factor, but rather through the interaction of various social and economic factors such as job insecurity, poor education, and poor access to housing and health care options. The Poverty Reduction Strategy needs to take a social determinants of health approach that addresses these complex and overlapping factors. By making sustained commitments to improve income security and housing, and by building in health and health equity, the new Poverty Reduction Strategy can make steps toward better health for the most vulnerable Ontarians.

39 The Ministry of Health and Long-Term Care's Health Equity Impact Assessment tool is available at http://www.health.gov.on.ca/en/pro/programs/heia/.

Summary Of Recommendations

Income Security

1. Benchmark the minimum wage at 10 percent above the Low Income Measure (LIM).
2. Update the Labour Relations Act to protect workers' collective bargaining rights.
3. Improve enforcement and modernize the *Employment Standards Act.*
4. Ensure that social assistance rates are set at a level that allows recipients to afford the basic necessities of life.

Housing And Homelessness

5. Incorporate inclusionary housing into the Planning Act.
6. Advocate for the federal government to develop a national housing strategy in conjunction with the provinces and territories.
7. Ensure that the Infrastructure Ontario affordable housing loan fund remains capitalized at $500 million to enable the continuing construction and upgrade of affordable housing across the province.
8. Coordinate with Ontario's Housing Policy Statement and provide appropriate legislation, programs, and funding to enable municipalities to meet its requirements.
9. Ensure that all low income Ontarians have access to appropriate housing supports and that services are consistent across the province.

Setting Targets To Improve Health

10. Set specific targets related to income and diabetes prevention and management and childhood obesity.
11. Commit the Ministry of Health and Long-Term Care to collect and publish a greater range of disaggregated data about health inequities.