From Surviving to Thriving

Understanding the needs of a healthy life

Nishi Kumar

Wellesley Institute
advancing urban health

April 2017

Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health.

From Surviving to Thriving | Think Piece

Copies of this report can be downloaded from www.wellesleyinstitute.com.

10 Alcorn Ave, Suite 300
Toronto, ON, Canada M4V 3B2
416.972.1010
contact@wellesleyinstitute.com

Wellesley Institute
advancing urban health

Poverty is now a major consideration of the municipal and provincial policy agendas. Toronto is not doing well. It has earned the title of "Canada's child poverty capital" (Polyani et al., 2016), prompting widespread public concern. To address this, the City of Toronto and the Province of Ontario have developed Poverty Reduction Strategies aimed at raising incomes, lowering the cost of living, and improving the quality of life (City of Toronto 2015; Government of Ontario 2014).

There is broad agreement that action on poverty is needed, but less agreement on what the targets of such policies should be. Poverty reduction strategies are designed to improve peoples' standard of living measured through a series of benchmarks and targets. However, the appropriate standard of living is not clear-cut. It is grounded in societal values, governmental priorities, and community norms. The right level of support is very much up for debate.

Wellesley Institute argues that health is a priority and that decreasing health disparities should focus on poverty reduction. Instead of focusing on subsistence or comparative levels of income, policies and programs could aim to give people access to a standard of living that offers the opportunity to achieve good health, which includes social, physical and psychological well-being and resilience.

In this paper, I argue that we need to reconsider our targets for poverty reduction if we are to reap benefits for health and health equity. I investigate the evidence on income-related health disparities and their social and economic implications. I describe common ways of defining poverty in Canada, consider how they align with indicators of health equity, and suggest an alternative standard that takes into account the evidence on health and well-being.

The need for action on income-related health disparities

Addressing poverty is an investment in the health and well-being of our population. There are a number of intersecting pathways that link income and poverty to health outcomes. Income allows people to buy the goods and services they need to live a healthy life, such as nutritious food (Power 2005; Mark et al. 2012), safer housing (Hwang et al. 1999; Bryant 2015), and medication (Barnes 2015). But good income also gives people access to opportunities like training for a better paying job that can help them build wealth. This financial security offers some protection from the stress and anxiety that accompanies life events like job loss (Corna 2012; Bravemen et al. 2011). Income allows people to invest time and resources into activities that they enjoy such as taking a holiday with family or friends, which can improve emotional well-being and mental health (CIHI 2016; Solar & Irwin 2010). Arguably most important is the fact that a good income allows people to participate more in social and civic life. Those with better incomes have a greater degree of influence on the community around them and a stronger sense of belonging among their peers (Macinko et al. 2003; Bravemen et al. 2011).

The impact of these factors is both material and psychological; they lead to real and persistent health inequities.

The relationship between poverty and health is evident throughout Canada. There is clear and strong evidence that those with lower incomes have worse health outcomes, as measured by a range of indicators, than those with higher incomes. Throughout Ontario, people with lower incomes face higher rates of chronic diseases like diabetes, more hospitalizations, and poorer mental health compared to those with higher incomes (CIHI 2016). Evidence from Toronto indicates that people with lower incomes have shorter life expectancies and poorer self-rated health (Toronto Public Health 2015; Stratton & Mowat 2012). Income-related health disparities are an ongoing challenge in Canada – one that a thoughtful poverty reduction approach can help to tackle. But poverty reduction strategies will need to be able to address the fact that these differences in health and life expectancy are a continuum. Those in poverty do not live as long as the rich, but those who are just above the poverty line also have shorter life expectancies.

The pervasive and persistent health disadvantages faced by those in poverty run contrary to Canada's stated commitment to the Right to Health (Abban 2015). As a signatory to the International Covenant on Economic, Social & Cultural Rights (ICESCR), among other agreements, Canada's governments have a responsibility to strive towards "the right of everyone to the highest attainable standard of physical and mental health." This right refers not only to the provision of health care but also to the underlying drivers of health, including income. Arguably, the Right to Health grants everyone the highest attainable standard of health and goes futher than only applying to those living in poverty.

Canada has come under fire internationally for failing to honour its commitments. In 2012, a United Nations report declared that minimum wage and social assistance levels "are insufficient to access the basic goods and services required for an adequate standard of living" (DeSchutter 2012). As a wealthy and well-developed nation, Canada has an obligation to allocate more resources towards making the Right to Health a reality for all Canadians. This means investing in the social determinants of health – including adequate income for all.

In addition to considering the impacts of income on individuals, income-related health disparities cost all levels of government. The case for a Basic Income pilot in Ontario asserts: "in short, poverty hurts all of us, and poverty costs all of society vast amounts of money" (Segal 2016). There are a number of statistics that support this. The lowest-income Canadians are consistently the highest health care users (Briggs et al. 2016). In Ontario, those with the lowest incomes spent nearly 80 percent more days in the hospital than those with the highest incomes. Reducing poverty could lead to a significant reduction in hospitalizations and health service use. In the MINCOME project, funded by the federal government in the 1970s, residents in a small community and an urban centre in Manitoba received a

guaranteed income for four years. The result was an 8.5 percent reduction in hospital visits, with significant reductions for visits related to mental health and accidents or injuries (Forget 2011). By one estimate, Ontario would save nearly $3 billion per year in health costs if every person in the lowest income quintile had the same health as those in the second-lowest quintile (Laurie 2008). In Toronto, these savings could be upwards of 700 million per year (Briggs et. al. 2016); at the federal level it could amount to $7 billion (Laurie 2008). These figures do not even account for the broader economic benefits of a healthier population, like greater workforce productivity and fewer encounters with the criminal justice system. Although it requires investment, addressing income-related health disparities by reducing poverty would pay off in the long run.

Defining poverty

The municipal and provincial Poverty Reduction Strategies set broad, bold goals for addressing poverty. For example, the guiding goal of the Ontario Poverty Reduction Strategy is to reduce child poverty by 25 percent.

As a concept, poverty is open to interpretation, so much so that the federal government of Canada has resisted providing a clear explanation of what poverty is and how it should be measured (Collin et al. 2008; Statistics Canada 2015).

Canada does not have an official "poverty line" but most policy-makers use one of three low-income metrics to guide their action and to measure their impact; these are the Low Income Measure (LIM), the Low Income Cut Off (LICO), and the Market Basket Measure (MBM).

The LIM and the LICO are both relative measures. The LIM is straightforward: the line is set to half of the median income of the national population, or $21,201 for a single person before taxes and transfers as of 2013 (Statistics Canada 2015). The LICO is more complex: it is set at the income level below what a family would need to allocate a higher-than-average proportion of their income towards food, clothing, and shelter. The corresponding income value varies from region to region; Toronto's is $24,328 before tax as of 2014.

The MBM was introduced in 2000. It is the amount of income a family would need to buy a list of generic goods and services, like groceries, household items, shelter, and transportation. In Toronto, that amount is $19,891 for a single person as of 2014.

Statistics Canada monitors and updates each of these measures, making them an easy benchmark for policy-makers to use when setting poverty reduction goals. They allow a straightforward comparable narrative about poverty and how to tackle it. However, it is not clear that these measures are not grounded in peoples' real-life experiences. There is little consideration of health. There is a mismatch between who is considered low income based on these technical metrics and who is able to live a healthy life in reality.

Let's consider how these definitions align with other health indicators. Take food insecurity as an example: a household is considered food insecure if access to sufficient, healthy food is limited because of their financial situation (Tarasuk et al. 2016). As would be expected, national monitoring consistently shows that those with lower incomes face greater food insecurity. But 12.7 percent of households *above* the LIM – that is, households that are not technically low income – are still food insecure. Up to 7.6 percent of households above the LIM are moderately or severely insecure, meaning that they skip meals or have to buy unhealthy, cheap options to stretch their budget.

There are similar gaps when it comes to housing, according to a recent survey to measure risk of homelessness among families in Toronto's rental towers. A household is considered in core housing need and at risk of homelessness if the rent is unaffordable or if the apartment is overcrowded, unsafe, or in need of major repairs. Of the families who are at risk of homelessness in Toronto's rental towers, over 23 percent of them are *above* the LICO (Paradis et. al. 2014).

These discrepancies illustrate the shortcomings of the LICO and the LIM as low-income metrics. They evaluate only one side of the poverty equation – how much money a household or individual makes – without accounting for what material goods that money can buy in real terms. They do not measure what that money means for social inclusion and participation which are vital factors in psychological well-being. In addition, because they are relative measures, they are only responsive to changes in the distribution of income: if everyone's income declines or rises at the same rate, the LICO and the LIM will remain unchanged.

The MBM is more sensitive to changes in the cost of living. It captures variation across provinces and regions, and it's much easier to interpret, but it has not been used by policy-makers nearly as often as the LICO and the LIM. One criticism of the MBM is that it is designed to meet a very basic standard of living, one that is above subsistence but falls well below the norm for a Canadian family (Fisher 2007). To put it in perspective, the average income of a single person in core housing need in Toronto in 2011 was over $1,500 more than the MBM (CMHC 2016).

In short, the way that we conceptualize and measure poverty is not grounded in realistic expectations of what people need. Individuals and families who are not considered to be in poverty are still struggling to live healthy lives. They are not able to attain the maximum possible level of health; their social, psychological and physical health needs are not met. By these definitions, we can eliminate poverty and still have serious health disparities between Canadians based on income. A better approach to setting goals for poverty reduction would be to consider the income level needed based for good health.

Making health a priority

If we are serious about addressing health disparities we need to set the bar higher. Reducing poverty should not just be about getting everyone to a level where they can just scrape by, or simply a higher level than they are now. It's about creating an environment in which people can truly thrive and where they have the resources and opportunities for good health. Our baseline should be a healthy standard of living for all.

We can start by rethinking how we measure peoples' needs for living. Rather than asking "What does a person need to survive?" or "What should a person get compared to everyone else?" The central question should be "What does a person need *to live a healthy life*?" We have plenty of rigorous scientific evidence available to answer this question. Some of the factors are already part of our approach to poverty and poverty reduction: nutritious food, a safe place to live, and access to health care. But beyond these straightforward requirements for physical health, there are a whole host of other factors that influence peoples' ability to thrive: social and leisure activities, financial security, and being an active member of a community. These factors can be tougher to measure, but evidence shows that they are just as important for health and well-being.

My goal is to answer this question. The Thriving Income Project at Wellesley Institute will start by compiling a list of the goods, services, and resources that a person needs to achieve good health based on the best available evidence. We hope that this evidence-informed, health-centred benchmark will be used to guide policies related to poverty reduction and income security. It could help bring health to the forefront of discussion on poverty, tackle income-related health disparities and create a healthier and more equitable GTA.

References

1. Polyani, M., Mustachi, J., Kerr, M. & Meager, S (2016). *The Divided City: Life in Canada's Child Poverty Capital.* Children's Aid Society of Toronto, Family Service Toronto, Colour of Poverty – Colour of Change & Social Planning Toronto: Toronto. Retrieved from: http://www.citynews.ca/wp-content/blogs.dir/sites/10/2016/11/14/CAST-2016-report-v8-web.pdf.

2. City of Toronto (2015). *TO Prosperity: Toronto Poverty Reduction Strategy*. Toronto: City of Toronto. Retrieved from: http://www.toronto.ca/legdocs/mmis/2015/ex/bgrd/backgroundfile-84626.pdf

3. Government of Ontario (2014). *Realizing Our Potential: Ontario's Poverty Reduction Strategy.* Toronto: Government of Ontario. Retrieved from: https://www.ontario.ca/page/realizing-our-potential-ontarios-poverty-reduction-strategy-2014-2019-all

4. Ministry of Labour (2016). "Ontario increasing minimum wage on October 1st".

Toronto: Government of Ontario. Retrieved from: https://news.ontario.ca/mol/en/2016/09/ontario-increasing-minimum-wage-on-october-1.html

5. Segal, H. (2016). *Finding a Better Way: A Basic Income Pilot Project for Ontario.* Toronto: Government of Ontario. Retrieved from: https://www.ontario.ca/page/finding-better-way-basic-income-pilot-project-ontario

6. Ministry of Community & Social Services (2016). "Ontario establishing an Income Security Reform Working Group". Toronto: Government of Ontario. Retrieved from: https://news.ontario.ca/mcss/en/2016/06/ontario-establishing-income-security-reform-working-group.html

7. Mark, S., Lambert, M., O'Loughlin, J., & Gray-Donald, K. (2012). Household income, food insecurity and nutrition in Canadian youth. *Canadian Journal of Public Health,* 103(2), 94-99.

8. Power, E. M. (2005). Determinants of healthy eating among low-income Canadians. *Canadian Journal of Public Health*, 93(S6), S37-S42.

9. Hwang, S., Fuller-Thomson, E., Hulchanski, D. J., Bryant, T., Habib, Y., & Regoeczi, W. (1999). *Housing and population health: a review of the literature*. Toronto: Centre for Applied Social Research.

10. Bryant, T. (2016). Housing and Health. In Raphael, D. (ed.) *Social Determinants of Health: Canadian Perspectives,* 360-374. Toronto: Canadian Scholar Press.

11. Barnes, S., Abban, V. & Weiss, A. (2015). *Low Wages, No Benefits.* Toronto: Wellesley Institute. Retrieved from: http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Low-Wages-No-Benefits-Wellesley-Institute-Feb-2015.pdf

12. Corna, L. (2013). A life course perspective on socioeconomic inequalities in health: a critical review of conceptual frameworks. *Advances in Life Course Research* 18, 150-159.

13. Canadian Institute for Health Information (2015). *Inequalities in Canada: Summary Report.* Ottawa: Canadian Institute for Health Information. Retrieved from: https://www.cihi.ca/en/summary_report_inequalities_2015_en.pdf

14. Solar, O. & Irwin, A. (2010). *A Conceptual Framework for Action on the Social Determinants of Health.* Discussion Paper #2, Policy and Practice. Geneva, Switzerland: World Health Organization. Retrieved from: http://apps.who.int/iris/bitstream/10665/44489/1/9789241500852_eng.pdf

15. Braveman, P., Egerter, S., & Barclay, C. (2011). *How Social Factors Shape Health: Income, Wealth and Health*. Princeton: Robert Johnson Wood Foundation.

16. Macinko, J. A., Shi, L., Starfield, B., & Wulu, J. T. (2003). Income inequality and health: a critical review of the literature. *Medical Care Research and Review,* 60(4), 407-452.

17. Toronto Public Health (2015). *The Unequal City 2015: Income and Health Inequities in Toronto*. Toronto: City of Toronto. Accessed by: http://www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-79096.pdf

18. Stratton, J., Mowat, D. L., Wilkins, R., & Tjepkema, M. (2012). Income disparities in life expectancy in the City of Toronto and Region of Peel, Ontario. *Chronic Diseases and Injuries in Canada,* 32(4), 208-215.

19. Abban, V. (2015). "Does upholding the right to health decrease health inequities?" Toronto: Wellesley Institute. Accessed by: http://www.wellesleyinstitute.com/healthy-communities/do-canadians-have-a-right-to-health

20. DeSchutter, O. (2013). *Report of the Special Rapporteur on the Right to Food: Mission to Canada.* Geneva: United Nations Human Rights Council. Accessed by: http://www.srfood.org/images/stories/pdf/officialreports/20121224_canadafinal_en.pdf

21. Briggs, A., Lee, C., & Stapleton, J. (2016). *The Costs of Poverty in Toronto.* Toronto: United Way of Toronto & Open Policy Ontario. Accessed by: http://openpolicyontario.com/wp/wp-content/uploads/2016/11/Cost-of-Poverty-R10-Final

22. Forget, E. L. (2011). The town with no poverty: the health effects of a Canadian Guaranteed Annual Income Field Experiment. *Canadian Public Policy*, 37(3), 283-305.

23. Laurie, N. (2008). *The Cost of Poverty: An Analysis of the Economic Cost of Poverty in Ontario.* Toronto: Association of Ontario Food Banks. Accessed by: https://www.oafb.ca/assets/pdfs/CostofPoverty.pdf

24. Collin, C. (2008). *Measuring Poverty: A Challenge for Canada.* Ottawa: Library of Parliament. Accessed by: http://www.lop.parl.gc.ca/content/lop/researchpublications/prb0865-e.pdf

25. Statistics Canada Income Statistics Division (2015). *Low Income Lines 2013-2014.* Ottawa: Statistics Canada. Accessed by: www.statcan.gc.ca/pub/75f0002m/75f0002m2015001-eng.pdf

26. Tarasuk, V., Mitchell, A., & Dachner, N. *Household Food Security in Canada, 2014.* Toronto: PROOF Food Insecurity Policy Research. Accessed by: http://proof.utoronto.ca/wp-content/uploads/2016/04/Household-Food-Insecurity-in-Canada-2014.pdf

27. Paradis, E., Wilson, R., & Logan, J. *Nowhere Else to Go: Inadequate Housing & Risk of Homelessness Among Families in Toronto's Aging Rental Buildings.* Toronto: University of Toronto Cities Centre. Accessed by: http://neighbourhoodchange.ca/docu-

ments/2014/04/paradis-et-al-2014-nowhere-else-to-go-inadequate-housing-risk-of-homelessness-among-families-in-torontos-aging-rental-buildings-rp231.pdf

28. Fisher, G. (2007). *An Overview of Recent Work on Standard Budgets in the United States and Other Anglophone Countries.* Washington: U.S. Department of Health and Human Services, Office for Planning and Evaluation. Accessed by: https://aspe.hhs.gov/basic-report/overview-recent-work-standard-budgets-united-states-and-other-anglophone-countries

29. Canada Mortgage & Housing Corporation (2016). *Housing in Canada Online* [database – non-family households in Toronto in core housing need]. Accessed by: http://cmhc.beyond2020.com/TableViewer/tableView.aspx

30. Morris, J. N., Wilkinson, P., Dangour, A. D., Deeming, C., & Fletcher, A. (2007). Defining a minimum income for healthy living (MIHL): older age, England. *International Journal of Epidemiology*, 36(6), 1300-1307.