CMA Submission:

CMA's Recommendations for Effective Poverty Reduction Strategies

Submission to the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is helping physicians care for patients.

On behalf of its more than 83,000 members and the Canadian public, the CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and over 60 national medical organizations.

Introduction

The Canadian Medical Association is pleased to present its views to the study on poverty reduction strategies by the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities.

The focus of the Committee's study on improving the delivery of federal resources and services for the Canadian Poverty Reduction Strategy is of profound interest to the CMA, given our concerns about the need to address the social determinants of health. It is that perspective from which this paper will approach the Committee's areas of interest.

Social Determinants of Health

The consequences of poverty on health are well established and include lower life expectancy, higher disease burden, and poorer overall health. Research suggests that 15% of population health is determined by biology and genetics, 10% by physical environments, 25% by the actions of the health care system, with 50% being determined by our social and economic environment.[1] Many studies show that people low on the socioeconomic scale are likely to carry a higher burden of just about any disease.[2]

Reducing inequities and thereby improving population health should be an overall objective for all governments in Canada.

The societal cost of poor health extends beyond the cost to the health care system: healthier people lose fewer days of work and contribute to overall economic productivity.[3] Those living in the most disadvantaged neighbourhoods experience almost 20 years less disability-free life.

It is fundamental that the health impact of social and economic decisions be part of the policy development and decision-making process.

Recommendation

1. The CMA recommends that health impact assessments be included as part of the policy development and decision-making process in poverty reduction strategies, including in the development of legislation and regulations.

[1] Keon, WJ, Pépin L. (2008) Population Health Policy: Issues and Options. Ottawa: The Senate of Canada; 2008. Available at: https://sencanada.ca/content/sen/Committee/392/soci/rep/rep10apr08-e.pdf
[2] *Op cit.* Dunn JR. The Health Determinants Partnership Making Connections Project
[3] Munro D. Healthy People, Healthy Performance, Healthy Profits: The Case for Business Action on the SocioEconomic Determinants of Health. The Conference Board of Canada, Ottawa (ON); 2008.

Neighbourhoods and Housing

Mounting evidence suggests that the built environment can play a significant role in our state of health. The literature indicates that the following connections between the built environment and public health are possible:

- o Decreased physical activity;
- o Increased prevalence of obesity;
- o Increased prevalence of asthma and other respiratory diseases;
- o Injuries and unintended fatalities;
- o Heat exposure.[4]

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Canada's physical activity guidelines recommend that children ages 5 to 11 should be active for at least 60 minutes a day; those 18 and over should be active for at least 150 minutes per week.[5] However, physical activity includes more than exercise and leisure time activity, it also includes active transportation such as walking to school, work or errands as part of daily living. CMA's policy on Active Transportation recommends that all sectors (physicians and other health professionals, government, business and the public) work together, as a matter of priority, to support and encourage active transportation and physical activity.[6] Urban planners must work together with health professionals to understand the impact on health.

Research shows that specific populations, such as children, the elderly, and low-income populations, are more affected.

Children: Obesity is an issue for Canadians nationwide, but particularly so for children. Between 1978 and 2004 there was a 70% increase in overweight and obese children aged 12-17.[7] Obesity in children can lead to health issues such as hypertension, glucose intolerance, and orthopaedic complications.[8] Furthermore it has a high likelihood of carrying over into adulthood and may result in further health problems such as diabetes and heart disease.[9] Environments that promote physical activity are

[4] Frank , L., Kavage S, & Devlin A. (2012). Health and the Built Environment: A Review. World Medical Association
[5] Canadian Society of Exercise Physiology. (2011). Canadian Physical Activity Guidelines. Canadian Society of Exercise Physiology
[6] CMA. Active Transportation http://policybase.cma.ca/dbtw-wpd/Policypdf/PD09-04.pdf 2009
[7] Statistics Canada. (2006, June 28). Childhood Obesity: A Troubling Situation. Retrieved July 15, 2012, from StatsCan: http://www41.statcan.ca/2006/2966/ceb2966_004-eng.htm
[8] *Ibid*
[9] *Ibid*

especially important, including mixed use communities with walkable destinations, parks and recreational facilities.[10]

Elderly: The elderly population is generally less physically robust and more prone to chronic illnesses, which make them especially vulnerable to air pollution and heat exposure. Physical activity is an important aspect of daily life for this age group as it has been shown to reduce the negative health impacts of aging.[11] Being physically active, however, requires accessible and safe streets, and transportation systems that cater to the needs of individuals with mobility issues. Special consideration is required when constructing the built environment to ensure the needs of this growing population.

Low Income Populations: Low income populations are at higher risk for chronic illnesses such as high blood pressure and diabetes, and have a lower overall survivability for major heart attacks.[12,13] They are also more likely to smoke, be overweight or obese, and are less likely to be physically active.[14] Many of these factors can be linked to limited access to stable housing, housing location (normally close to highways or industrial zones with high pollution exposure), neighbourhood safety, and lack of access to or affordability of healthy food options.

Recommendation

2. The CMA recommends that the federal government work with all sectors to create a culture within communities that supports and encourages active transportation and physical activity.

Income

Hundreds of research papers have confirmed that people in the lowest socio-economic groups carry the greatest burden of illness.[15] Studies also suggest that adverse socio-economic conditions in childhood can be a greater predictor of cardiovascular disease and diabetes in adults than later life circumstances and behavioural choices.[16] Finally,

[10] Dannenberg, A., Frumkin, H., & Jackson, R. J. (2011). Making Healthy Places Designing and Building for Health, Well-Being and Sustainability. Island Press.
[11] Vogel, T., Brechat, P., Lepetre, P., Kaltenbach, G., Berthel, M., & Lonsdorfer, J. (2009). Health Benefits of Physical Activity in Older Patients: A Review. The International Journal of Clinical Practice, 63(2), 303-320.
[12] Centre for Chronic Disease Prevention and Control. . (2002). Diabetes in Canada, 2nd Edition. Ottawa: Health Canada
[13] Statistics Canada. (1996-97, May 29). National Population Health Survey, Cycle 2. Canada: The Daily.
[14] Creatore, M., Gozdyra, P., Booth, G., & Glazier, R. (2007). Chapter 1: Setting the Context. In M. Creatore, P. Gozdyra, G. Booth, R. Glazier, & M. Tynan, Neighbourhood Environments and Resources for Healthy Living - A Focus on Diabetes in Toronto: ICES Atlas. Toronto: Institute for Clinical Evaluative Sciences.
[15] *Op cit* Dunn JR. The Health Determinants Partnership Making Connections Project
[16] Raphael D. Addressing The Social Determinants of Health In Canada: Bridging The Gap Between Research Findings and Public Policy. Policy Options. March 2003 pp.35-40.

the countries reporting the highest population health status are those with the greatest income equality, not the greatest wealth.[17]

Income plays a role in access to appropriate health care as well. Individuals living in lower income neighbourhoods, are less likely to have primary care physicians[18], and are more likely to report unmet health care needs.[19] They are more likely to be hospitalized for conditions which could potentially be avoided with appropriate primary care.[20,21]

In 2015, the CMA passed a resolution endorsing the concept of a basic income guarantee"[22], which is a cash transfer from government to citizens not tied to labour market participation. It ensures sufficient income to meet basic needs and live with dignity, regardless of employment status. A basic income guarantee has the potential to alleviate or even eliminate poverty. It has the potential to reduce the substantial, long-term social consequences of poverty, including higher crime rates and fewer students achieving success in the educational system.

In addition, resources and supports are needed to assist low-income Canadians regarding diet, shelter, skills development and other needs..

Recommendation

3. The CMA urges the Government of Canada to prioritize consideration of a basic income guarantee as a policy option for reducing poverty.

Prenatal and Early Childhood

[17] Hofrichter R ed. Tackling Health Inequities Through Public Health Practice: A Handbook for Action. The National Association of County and City Health Officials & The Ingham County Health Department. Lansing (USA); 2006.
[18] Bierman AS, Angus J, Ahmad F, et al. Ontario Women's Health Equity Report : Access to Health Care Services : Chapter 7. Toronto (ON) Project for and Ontario Women's Health Evidence-Based Report; 2010.
[19] Bierman AS, Johns A, Hyndman B, et al. Ontario Women's Health Equity Report: Social Determinants of Health & Populations at Risk: Chapter 12. Toronto (ON) Project for and Ontario Women's Health EvidenceBased Report; 2010.; Williamson DL, Stewart MJ, Hayward K. Low-income Canadians' experiences with health-related services: Implications for health care reform. Health Policy 2006; 76:106-121.
[20] Canadian Institute for Health Information. Hospitalization Disparities by Socio-Economic Status for Males and Females. Ottawa(ON); 2010. Available: https://secure.cihi.ca/free_products/disparities_in_hospitalization_by_sex2010_e.pdf (accessed 2017 Jan 5)
[21] Canadian Institute for Health Information. Hospitalization Disparities by Socio-Economic Status…;Roos LL, Walld R, Uhanova J, et al. Physician Visits, Hospitalizations, and Socioeconomic Status: Ambulatory Care Sensitive Conditions in a Canadian Setting. HSR 2005; 40(4): 1167-1185.
[22] Canadian Medical Association. Policy resolution GC15-70 - Basic income guarantee. Approved August 26, 2015

Research suggests that 90% of a child's brain capacity is developed by age five.[23] High quality early childhood programs including programs to nurture and stimulate children and educate parents are highly correlated with the amelioration of the effects of disadvantage on cognitive, emotional and physical development among children.[24,25]

In 2007, the Canadian Medical Association, the Canadian Paediatric Society and the College of Family Physicians of Canada released *Canada's Child and Youth Health Charter*.[26] To reach their potential, children and youth need to grow up in a place where they can thrive — spiritually, emotionally, mentally, physically and intellectually — and get high-quality health care when they need it. That place must have three fundamental elements: a safe and secure environment; good health and development; and a full range of health resources available to all. Children and youth of distinct populations in Canada, including First Nations, Inuit and Métis, must be offered equal opportunities as other Canadian children and youth through culturally appropriate resources.

Our children and youth must have a safe and secure environment where they can access clean water, air and soil; be protected from injury, exploitation and discrimination; and live in healthy family, homes and communities. Further, to ensure good health and development there must be access to prenatal and maternal care for the best possible health at birth and access to quality nutrition for proper growth, development and long-term health.

As well, early learning opportunities and high-quality care, at home and in the community must be accessible. Opportunities and encouragement for physical activity are crucial as well as access to high-quality primary and secondary education. Finally, affordable and available post-secondary education and a commitment to social well-being and mental health are paramount.

Recommendation

4. The CMA recommends that the federal government and the provinces and territories work to ensure that poverty does not continue to be a barrier to the healthy development of Canadian children, particularly in their first five years.

[23] Arkin E, Braveman P, Egerter S & Williams D. Time to Act: Investing in the Health of Our Children and Communities: Recommendations From the Robert Wood Johnson Foundation Commission to Build a Healthier America. Robert Wood Johnson Foundation. Princeton (NJ); 2014.
[24] Braveman P, Egerter D & Williams DR. The Social Determinants of Health: Coming of Age. Annu Rev Publ Health. 32:3.1-3.18. 2011.
[25] European Union. Commission Recommendation of 20.2.2013: Investing in children: breaking the cycle of disadvantage. Brussels (Belgium); 2013.
[26] Canadian Medical Association, Canadian Paediatric Society, College of Family Physicians of Canada. Child and Youth Health: Our Challenge: Canada's Child and Youth Health Charter. Ottawa October 9, 2007.

Conclusion

Socio-economic factors play a larger role in creating (or damaging) health than either biological factors or the health care system. Health equity is increasingly recognized as a necessary means by which we will make gains in the health status of all Canadians. Despite a commitment to equal access to health care for all Canadians there are differences in access and quality of care for many groups. For those that are most vulnerable, this lack of access can serve to further exacerbate their already increased burden of illness and disease. Action is still required by the federal government to tackle the underlying social and economic factors which lead to the disparities in the health of Canadians.