Canadian Medical Association
Submission on Motion 315
(Income Inequality)

Submitted to the House of Commons Standing Committee on Finance

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

A healthy population and a vibrant medical profession
Une population en santé et une profession médicale dynamique

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 78,000 members and the Canadian public, 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 51 national medical organizations.

ASSOCIATION MÉDICALE CANADIENNE

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Part 1: Introduction

The Canadian Medical Association is pleased to present its views to the House of Commons Standing Committee on Finance regarding income inequality in Canada.

The Canadian Medical Association represents 78,000 physicians in Canada; its mission is to serve and unite the physicians of Canada and to be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

Income inequality is a growing problem in Canada. According to a Conference Board of Canada report, high income Canadians have seen their share of income increase since 1990 while the poorest and even the middle-income groups have lost income share. In 2010 the top quintile of earners accounted for 39.1% of Canadian income while the bottom quintile only accounted for 7.3%. These numbers led to a ranking for Canada of 12 out of 17 among other high income countries in terms of income inequality.[1] Research by the Organization for Economic Co-operation and Development has largely confirmed these results.[2]

Part 2: Why Income Inequality Matters to Canadian Physicians

The issue of income inequality is an important one for Canada's physicians. As physicians, we are not the experts in housing, in early childhood development, income equality and so on. But we are the experts in recognizing the impact of these factors on the health of our patients.

Hundreds of research papers have confirmed that people in the lowest socio-economic groups carry the greatest burden of illness.[3] In 2001, people in the neighbourhoods with the highest 20% income lived about three years longer than those in the poorest 20% neighbourhoods.[4] Mental health is affected as well. Suicide rates in the lowest income neighbourhoods are almost twice as high as in the wealthiest neighbourhoods.[5]

Studies 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.[6]

Finally, the countries reporting the highest population health status are those with the greatest income equality, not the greatest wealth.[7]

These differences in health outcomes have an impact on the health care system. Most major diseases including heart disease and mental illness follow a social gradient with those in lowest socio-economic groups having the greatest burden of illness.[8] Those within the lowest socio-economic status groups are 1.4 times more likely to have a chronic disease, and 1.9 times more likely to be hospitalized for care of that disease.[9]

Income plays a role in access to appropriate health care as well. Individuals living in lower income neighbourhoods, younger adults and men are less likely to have primary care

physicians than their counterparts.[10] Women and men from low-income neighbourhoods are more likely to report difficulties making appointments with their family doctors for urgent non-emergent health problems. They were also more likely to report unmet health care needs.[11] People with lower socio-economic status are more likely to be hospitalized for ambulatory care sensitive conditions and mental health[12], admissions which could potentially be avoided with appropriate primary care.[13]

Those with higher socio-economic status are more likely to have access to and utilize specialist services.[14] Utilization of diagnostic imaging services is greater among those in higher socio-economic groups.[15] Access to preventive and screening programs such as pap smears and mammography are lower among disadvantaged groups.[16]

It is not just access to insured services that is a problem. Researchers have reported that those in the lowest income groups are three times less likely to fill prescriptions, and 60% less able to get needed tests because of cost.[17] Services such as physiotherapy and occupational therapy to name two are often not covered unless they are provided in-hospital or to people on certain disability support programs.[18] Access to psychologists is largely limited to people who can pay for them, through private insurance or out of their own pockets.[19] Similar access challenges exist for long-term care, home care and end-of-life care.

There is a financial cost to this disparity. According to a 2011 report, low-income residents in Saskatoon alone consume an additional $179 million in health care costs than middle income earners.[20] A 2010 study by CIHI found increased costs for avoidable hospitalizations for ambulatory care sensitive conditions were $89 million for males and $71 million for females with an additional $248 million in extra costs related to excess hospitalizations for mental health reasons.[21]

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.[22] According to data in the U.K., those living in the most disadvantaged neighbourhoods experience almost 20 years less disability-free life than those in the highest income neighbourhoods. These individuals will become disabled before they are eligible for old age services, striking two blows to the economy: they will no longer be able to contribute through productive work, and their disability will consume a great deal of health care services.[23]

The reasons for this inequitable access are multifaceted and include patient specific barriers as well as challenges within the health care system itself. CMA recognizes the need for physicians to work to address the system related barriers. However, one of the biggest challenges for patients themselves remains economic. Having a low-income can prevent access through lack of transportation options, an inability to get time off work, and the inability to pay for services that are not covered by government insurance.

Health equity is increasingly recognized as a necessary means by which we will make gains in the health status of all Canadians and retain a sustainable publicly funded health care

system. Addressing inequalities in health is a pillar of CMA's Health Care Transformation initiative.

Part 3: Ensuring adequate income for all Canadians

> *"The rates of family and child poverty are unacceptably high taking into account Canada's high quality of living standard."*
> 2010 Report of the Committee on Human Resources, Skills and Social Development and the Status of Persons with Disability

One reason income is so critical to individual health is that it is so closely linked to many of the other social determinants of health. These include but are not limited to: education, employment, early childhood development, housing, social exclusion, and physical environment.

The CMA and its members are concerned that adequate consideration during the decision-making process is not being given to the social and economic determinants of health, factors such as income and housing that have a major impact on health outcomes.

Recent decisions such as changes to the qualifying age for Old Age Security, and new rules for Employment Insurance, among others, will have far reaching consequences on the income of individuals, especially those in vulnerable populations. We remind the government that every action that has a negative effect on health will lead to more costs to society down the road.

One method to ensure that these unintentional consequences do not occur is to consider the health impact of decisions as part of the policy development and decision-making process.

A Health Impact Assessment (HIA) is a systematic process for making evidence-based judgments on the health impacts of any given policy and to identify and recommend strategies to protect and promote health. The HIA is used in several countries, including Australia, New Zealand, the United Kingdom, and increasingly the United States.
The HIA can ensure that government departments consider the health impacts of their policies and programs by anticipating possible unintended consequences and taking appropriate corrective action. The use of HIA will allow the federal government to demonstrate leadership in health care in Canada and provide greater accountability to all Canadians.

The CMA recommends that:

1. The federal government recognize the importance of the social and economic determinants of health to the health of Canadians and the demands on the health care system; and

2. The federal government requires a health impact assessment as part of Cabinet decision-making.

We are hearing about the need to address the poverty and income security of Canadians from stakeholders across the country. We have conducted a series of town halls with Canadians asking them questions about how the social and economic conditions of their communities affect their health. From Winnipeg, to Hamilton to Charlottetown we have heard how poverty and a lack of income is undermining Canadians' health.

This public response is not surprising. According to the Conference Board of Canada, more than one in seven children in Canada live in poverty.[24] This poverty will severely limit the ability of these children to achieve good health in the future.

There are systemic barriers that contribute to this poverty. The *annual* welfare income in Canada varies between $3,247 for a single person to $21,213 for a couple with two children. The 'best' of Canadian programs provides an income within only 80% of the poverty line. The lowest income is barely 30% of that needed to 'achieve' poverty.[25]

It is not just people on social assistance, however, that are facing poverty. Data from 2008 indicates that one in three (33%) of children living in poverty had a parent that was employed. Based a review conducted in 2010, one in 10 workers still earned less than $10 an hour in 2009, with 19% paid less than $12. The same study found that roughly 400,000 full-time adult workers, aged 25+, were making less than $10/hr. and therefore paid less than poverty line wages.[26]

Some physicians are working directly with patients to try and address the income inadequacy which is undermining their health. Physicians from Health Providers Against Poverty in Ontario have developed a tool for physicians to use in screening their patients for poverty and linking them with provincial/territorial and/or federal programs that might help mitigate the health effects of their poverty. This group is also involved in training health care providers to support this work. While this program and others like it are serving as a 'band aid' solution for some living in poverty, the CMA feels that physicians and their patients should not be placed in this position.

As part of its study on income inequality, the CMA encourages the Finance Committee to review two recent reports from Parliamentary committees on the same topic. The first and most recent is the report of the House of Commons Committee on Human Resources, Skills and Social Development and the Status of Persons with Disability, *Federal Poverty Reduction Plan: Working in Partnership Towards Reducing Poverty in Canada*.[27] The second is the report of the Senate Committee on Social Affairs, Science and Technology *In From the Margins: A Call to Action on Poverty, Housing and Homelessness.*[28]

The Committee on Human Resources, Skills and Social Development and the Status of Persons with Disability, noted that the federal government's efforts to address poverty among Canadian seniors "is generally recognized as one of Canada's most notable achievements of the past 30 years."

The report of the Senate Committee made a number of significant observations, two bear repeating:

- "[W]hen all the programs are working, when the individual gets all possible income and social supports, the resulting income too often still maintains people in poverty, rather than lifting them into a life of full participation in the economic and social life of their communities."

- "[A]t their worst, the existing policies and programs entrap people in poverty, creating unintended perverse effects which make it virtually impossible for too many people to escape reliance on income security programs and even homeless shelters."

The public policy debate on addressing income inequality in Canada is not new. For instance, the 1971 report of the Special Senate Committee on Poverty recommended that a guaranteed annual income financed and administered by the federal government be established. In consideration of this concept, from 1974 to 1979, the Governments of Canada and Manitoba funded the Manitoba Basic Guarantee Annual Income Experiment (referred to as "Mincome"). While this was initially designed to be a labour market study, the results were also relevant from a health perspective. A recent study of this data concluded that hospitalizations declined by 8.5 per cent for the Mincome subjects.[29]

The CMA recommends that:

3. The federal government gives top priority to the development of strategies to minimize poverty in Canada.

Part 4: Addressing access barriers in the health sector

Access to services not covered by provincial health plans remain a large barrier for Canadians. Those with low incomes are less likely to be able to access needed pharmaceuticals and services due to this barrier. One in 10 Canadians can not afford the medications that they are prescribed.[30] This further exacerbates the income inequality that exists. While we urge the federal government to take action on reducing poverty among Canadians, at the minimum action needs to be taken to ensure universal access to needed medical care.

The CMA recommends that:

4. Governments, in consultation with the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies;

5. Governments examine methods to ensure that low-income Canadians have greater access to needed medical interventions such as rehabilitation services, mental health, home care, and end-of-life care; and

6. Governments explore options to provide funding for long-term care services for all Canadians. This could include public insurance schemes or registered savings plans allowing Canadians to save for their future long-term care needs.

Finally, there is a need to recognize the effect on income related to providing care to family members who are ill. Many Canadians take time off work to care for their children or parents. Without adequate long-term care resources and supports for home care, Canadians may be forced to take a leave from the workforce to provide this unpaid care. Research suggests that more than one third of parents (38.4%) who care for children with a disability are required to work fewer hours to care for their children.[31] While the 2011 federal budget provided some relief in the form of a Family Caregiver Tax Credit of up to $300, it is not enough. A 2004 Canadian study placed the value of a caregiver's time at market rates from $5,221 to $13,374 depending on the community of residence.[32] This is a significant amount of unpaid work and may further add to income inequalities. Expanding the tax credit available to these individuals would help but there is a need to provide further supports to family caregivers.

The CMA recommends that:

7. The federal government expands the relief programs for informal caregivers to provide guaranteed access to respite services for people dealing with emergency situations, as well as increase the Family Caregiver Tax Credit to better reflect the annual cost of family caregivers' time at market rates.

Part 5: Conclusion

Once again, we commend the Standing Committee on Finance for agreeing to study this important issue. Canada's physicians see the examples of income inequality in their practices on a daily basis. Tackling this important social issue will contribute to not only reducing the burden of disease in Canada but to providing Canadians with the necessary financial resources to achieve good health.

Summary of Recommendations

Recommendation 1

The federal government recognizes the importance of the social and economic determinants of health to the health of Canadians and the demands on the health care system.

Recommendation 2

The federal government requires a health impact assessment as part of Cabinet decision-making.

Recommendation 3

The federal government gives top priority to the development of strategies to minimize poverty in Canada.

Recommendation 4

Governments, in consultation with the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies.

Recommendation 5

Governments examine methods to ensure that low-income Canadians have greater access to needed medical interventions such as rehabilitation services, mental health, home care, and end-of-life care.

Recommendation 6

Governments explore options to provide funding for long-term care services for all Canadians. This could include public insurance schemes or registered savings plans allowing Canadians to save for their future long-term care needs.

Recommendation 7

The federal government expand the relief programs for informal caregivers to provide guaranteed access to respite services for people dealing with emergency situations, as well as increase the Family Caregiver Tax Credit to better reflect the annual cost of family caregivers' time at market rates.

References

[1] Conference Board of Canada. How Canada Performs: Income Inequality. Ottawa (ON); 2013. Available: http://www.conferenceboard.ca/hcp/details/society/income-inequality.aspx (accessed 2013 Apr 11).
[2] Organisation for Economic Co-operation and Development. Divided We Stand: Why Inequality Keeps Rising: An Overview of Growing Income Inequalities in OECD Countries: Main Findings. Paris (FR); 2011. Available: http://www.oecd.org/els/soc/49499779.pdf (accessed 2013 Apr 11).
[3] Dunn JR. The Health Determinants Partnership Making Connections Project: Are Widening Income Inequalities Making Canada Less Healthy? Toronto (ON); 2002. Available: http://www.opha.on.ca/our_voice/collaborations/makeconnxn/HDP-proj-full.pdf (accessed 2011 March 15)
[4] Wilkins R, Berthelot JM and Ng E. Trends in Mortality by Neighbourhood Income in Urban Canada from 1971 to 1996. Statistics Canada, Ottawa (ON); 2002. Health Reports 13 [Supplement]: pp. 45–71
[5] Marmot, M. Fair Society Healthy Lives: The Marmot Review: Executive Summary. *London (UK): 2010.* Available: http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLivesExecSummary.pdf (accessed 2011 Jan 25); Mikkonen J, Raphael D. Social Determinants of Health: The Canadian Facts. Toronto (ON); 2010. Available: http://www.thecanadianfacts.org/The_Canadian_Facts.pdf (accessed 2011 Jan 14)
[6] 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.
[7] 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. Available: http://www.acphd.org/axbycz/admin/datareports/ood_naccho_handbook.pdf accessed (2012 Mar 16).
[8] Dunn, James R. (2002) *The Health Determinants Partnership…*
[9] Canadian Population Health Initiative. Disparities in Primary Health Care Experiences Among Canadians with Ambulatory Care Sensitive Conditions. Canadian Institute for Health Information, Ottawa (ON); 2012. Available: http://secure.cihi.ca/cihiweb/products/PHC_Experiences_AiB2012_E.pdf(accessed 2012 Jan 25).
[10] 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. Available: http://powerstudy.ca/wp-content/uploads/downloads/2012/10/Chapter7-AccesstoHealthCareServices.pdf (accessed 2012 Dec 10).
[11] 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 Evidence-Based Report; 2010. Available: http://powerstudy.ca/wp-content/uploads/downloads/2012/10/Chapter12-SDOHandPopsatRisk.pdf (accessed 2012 Dec 10...; 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.
[12] 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 2013 Feb 6)
[13] 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.
[14] Allin S. Does Equity in Healthcare Use Vary across Canadian Provinces? Healthc Policy 2008; 3(4): 83-99.;Frolich N, Fransoo R, Roos N. Health Service Use in the Winnipeg Regional Health Authority: Variations Across Areas in Relation to Health and Socioeconomic status. Winnipeg (MB) Manitoba Centre for Health Policy. Available: http://mchp-appserv.cpe.umanitoba.ca/teaching/pdfs/hcm_forum_nf.pdf (accessed 2013 Feb 6); McGrail K. Income-related inequities: Cross-sectional analyses of the use of medicare services in British Columbia in 1992 and 2002. Open Medicine 2008; 2(4): E3-10; Van Doorslaer E, Masseria C. Income-Related Inequality in the Use of Medical Care in 21 OECD Countries. Paris(FR) OECD; 2004. Available: http://www.oecd.org/els/health-systems/31743034.pdf (accessed 2013 Feb 6).;Veugelers PJ, Yip AM.

Socioeconomic disparities in health care use: Does universal coverage reduce inequalities in health? J Epidemiol Community Health 2003; 57:424-428.

[15] Bierman AS, Angus J, Ahmad F, et al. Ontario Women's Health Equity Report : Access to Health Care Services…Demeter S, Reed M, Lix L, et al. Socioeconomic status and the utilization of diagnostic imaging in an urban setting. CMAJ 2005; 173(10): 1173-1177.

[16] Bierman AS, Johns A, Hyndman B, et al. Ontario Women's Health Equity Report: Social Determinants of Health & Populations at Risk: Chapter 12...); Frolich N, Fransoo R, Roos N. Health Service Use in the Winnipeg… Wang L, Nie JX, Ross EG. Determining use of preventive health care in Ontario. Can Fam Physician 2009; 55: 178-179.e1-5; Williamson DL, Stewart MJ, Hayward K. Low-income Canadians' experiences with health-related services…

[17] Mikkonen J, Raphael D. Social Determinants of Health: The Canadian Facts….

[18] Barnes S, Dolan LA, Gardner B, et al. Equitable Access to Rehabilitation : Realizing Potential, Promising Practices, and Policy Directions. Toronto (ON) Wellesley Institute; 2012. Available : http://www.wellesleyinstitute.com/wp-content/uploads/2012/06/Equitable-Access-to-Rehabilitation-Discussion-Paper1.pdf (accessed 2013 Feb 6).

[19] Kirby M, Goldbloom D, Bradley L. Changing Directions, Changing Lives: The Mental Health Strategy for Canada.Ottawa (ON): Mental Health Commission of Canada; 2012. Available: http://strategy.mentalhealthcommission.ca/pdf/strategy-text-en.pdf (accessed 2013 Mar 12).

[20] Saskatoon Poverty Reduction Partnership. From poverty to possibility…and prosperity: A Preview to the Saskatoon Community Action Plan to Reduce Poverty. Saskatoon (SK): Saskatoon Poverty Reduction Partnership; 2011.Available: http://www.saskatoonpoverty2possibility.ca/pdf/SPRP%20Possibilities%20Doc_Nov%202011.pdf (accessed 2012 Mar 13)

[21] Canadian Institute for Health Information. Hospitalization Disparities by Socio-economic status…

[22] Munro D. Healthy People, Healthy Performance, Healthy Profits: The Case for Business Action on the Socio-Economic Determinants of Health. The Conference Board of Canada, Ottawa (ON); 2008. Available: http://www.conferenceboard.ca/Libraries/NETWORK_PUBLIC/dec2008_report_healthypeople.sflb (accessed 2012 Mar 26).

[23] Marmot Sir M. Achieving Improvements in Health in a Changing Environment. Presentation to the World Medical Association, Vancouver (BC); 2010.

[24] Conference Board of Canada. How Canada Performs: Child Poverty. Ottawa (ON); 2013. Available: http://www.conferenceboard.ca/hcp/details/society/child-poverty.aspx (accessed 2013 Apr 11).

[25] National Council of Welfare. Poverty Trends in Canada: Solving Poverty Information Kit. Her Majesty the Queen in the Right of Canada. Ottawa (ON); 2007. Available: http://www.ncw.gc.ca/l.3bd.2t.1ils@-eng.jsp?lid=140 (accessed 2012 Jan 25).

[26] Campaign 2000. 2010 Report Card on Child and Family Poverty in Canada: 1989 – 2010. Toronto (ON); 2010. Available: http://www.campaign2000.ca/reportCards/national/2010EnglishC2000NationalReportCard.pdf (accessed 2013 Apr 11).

[27] Hoeppner C, Chair. Federal Poverty Reduction Plan: Working in Partnership Towards Reducing Poverty in Canada. House of Commons Canada. Ottawa (ON); 2010. Available: http://www.parl.gc.ca/content/hoc/Committee/403/HUMA/Reports/RP4770921/humarp07/humarp07-e.pdf (accessed 2013 Apr 17).

[28] Eggleton A, Segal H. In From the Margins: A Call TO Action On Poverty, Housing and Homelessness. The Standing Senate Committee on Social Affairs, Science and Technology. Ottawa(ON);2009. Available: http://www.parl.gc.ca/Content/SEN/Committee/402/citi/rep/rep02dec09-e.pdf (accessed 2013 Apr 17).

[29] Forget, Evelyn L. *The town with no poverty: the health effects of a Canadian Guaranteed Annual Income Field Experiment*. University of Toronto Press. Canadian Public Policy 37(3), 283-305.

[30] Law MR, Cheng L, Dhala IA et al. The effect of cost adherence to prescription medications in Canada. CMAJ February 21, 2012 vol. 184 no.3.

[31] Campaign 2000. 2010 Report Card on Child and Family Poverty…
[32] Chappell NL, Dlitt BH, Hollander JA et al. Comparative Costs of Home Care and Residential Care. The Gerontologist 44(3): 389-400.