

SPECIAL DIET ALLOWANCE ACTION KIT

Fighting Poverty to Improve Health

Dear Health Providers and Health Organizations:

Recent cuts to the Special Diet Allowance are resulting in a cut to the welfare cheques of thousands of social assistance recipients in Ontario. New regulations, implemented in November 2005, make this allowance almost unattainable, by severely restricting the number of health conditions that qualify, and by cutting the amount of money available for these conditions to insignificant amounts.

This is a health issue! This supplement was intended for health providers to prescribe an income supplement for nutrition to those who, in our professional opinions, require it. The new regulations not only have a negative impact on the health of our clients but impact on our ability to provide the best possible care.

Health Providers Against Poverty, along with other groups, is working to reinstate this benefit and to have social assistance rates increased by 40%. We believe poverty needs to be at the forefront of the health agenda in Ontario, **and we feel we have a duty to speak out.**

This action package provides you and your clients with **information** to educate yourselves about poverty and health, and the new changes to the special diet allowance; and **tools** to let the government know that this situation is unacceptable, and is a threat to the health of the hundreds of thousands of Ontarians living on social assistance.

This package contains:

1. **Telephone Scripts: one for clients and one for you to use to call MPPs. *If every health provider and client calls regarding every supplement that is cut that will create a very strong impression with the government.***
2. **Form Letters to MPPs: to be filled out by clients. These can be mailed by clients or collected and mailed en masse by yourself. (These may require some help from you to fill out.)**
3. **GTA and surroundings MPP contact information.**
4. **An evidence-based backgrounder on health, poverty, and nutrition.**
5. **The list of money allotted for each of the conditions listed on the new Special Diet Application forms, to help you and your clients assess the impact of these cuts.**

Please use those elements you feel are appropriate, and offer your clients the same. Feel free to photocopy and disseminate these materials as you see fit.

Please do not hesitate to contact *Health Providers Against Poverty* for more information at hpagainstpoverty@gmail.com.

SD Action Kit GTA area MPP contacts

Find your riding below and the Minister's name.

Then look below this list for the email, address, and phone number of your MPP.

Ancaster--Dundas--Flamborough--Aldershot — **Ted McMeekin**

Barrie--Simcoe--Bradford — **Joseph N. Tascona**

Beaches--East York — **Michael Prue**

Bramalea--Gore--Malton--Springdale — **Kuldip Kular**

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<p>Jim Wilson Simcoe-Grey, Progressive Conservative Rm 203, North Wing, Legislative Building Toronto ON M7A 1A8 Tel : 416-325-2069 Fax : 416-325-2079 jim_wilson@ontla.ola.org 50 Hume St Collingwood ON L9Y 1V2 Tel : 705-446-1090 Fax : 705-446-3397 Toll Free : 1-800-268-7542</p>	<p>General Willowdale, Liberal Ministry of the Attorney General 720 Bay St, 11th Flr Toronto ON M5G 2K1 Tel : 416-327-4464 Fax : 416-325-4175 dzimmer.mpp@liberal.ola.org Newtonbrook Plaza 3 - 5801 Yonge St North York ON M2M 3T9 Tel : 416-733-7878 Fax : 416-733-7709 dzimmer.mpp.co@liberal.ola.org</p>
<p>Elizabeth Witmer Kitchener-Waterloo, Progressive Conservative Rm 422, Main Legislative Building</p>	<p>Tony C. Wong, Parliamentary Assistant to the Minister of Economic Development and Trade</p>

<p>Toronto ON M7A 1A8 Tel : 416-325-1306 Fax : 416-325-1329 elizabeth_witmer@ontla.ola.org 375 University Ave E Waterloo ON N2K 3M7 Tel : 519-725-3477 Fax : 519-725-3667</p>	<p>Markham, Liberal Ministry of Economic Development and Trade Hearst Block, 8th Flr, 900 Bay St Toronto ON M7A 2E1 Tel : 416-325-6910 tcwong.mpp@liberal.ola.org 208 - 500 Alden Rd Markham ON L3R 5H5 Tel : 905-305-1935 Fax : 905-305-1938 tcwong.mpp.co@liberal.ola.org</p>
<p>Kathleen O. Wynne, Parliamentary Assistant to the Minister of Education Don Valley West, Liberal Ministry of Education 900 Bay St, 22nd Floor, Mowat Block Toronto ON M7A 1L2 Tel : 416-325-7204 Fax : 416-325-7249 kwynne.mpp@liberal.ola.org 146 Laird Dr, Suite 101 Toronto ON M4G 3V7 Tel : 416-425-6777 Fax : 416-425-0350 kwynne.mpp.co@liberal.ola.org</p>	

SD Action Kit MPP letter

Date: _____

MPP's name: _____

MPP's Address: _____

Dear _____

I am one of your constituents. I receive social assistance, and I am writing to inform you that my *Special Diet Supplement* has been cut and to tell you what kind of an impact this will have on my health and my life.

With the money from the *Special Diet Supplement*, I was able to buy healthy food and eat properly. Without the special diet allowance, I have _____ dollars per month left to spend on food after paying my rent and other bills. I will no longer be able to afford a healthy diet. I will need to use food banks, go without fresh fruit and vegetables and be without food at some point during every month. I know, and my health provider confirms, this will put my health at risk.

The Liberal party promised to increase social assistance rates to alleviate suffering and ill health faced by people depending on government assistance. Since the government cuts in 1995, you have raised the rates only 3%. The *Special Diet Supplement* provided an essential lifeline for me. The changes your government made in the regulations have simply resulted in another cut to welfare.

I urge you to work to raise welfare rates by at least the 40% they have dropped, or release the full \$250 per month special diet supplement immediately. This will result in improved health for me, and for every other person who depends on social assistance to survive.

Sincerely,

Your name and signature

(Optional) Your address and phone number: _____

Telephone Call Script for Social Assistance Recipients:

(This script is just a rough guide, and you must please feel free to use all or none of it and add whatever you think is appropriate to tell your story)

Please ask your health care provider to give you your MPP's name and number from the list in their package.

Hello (*your MPP's name*):

I am one of your constituents. My name is _____ and I am calling to let you know that my social assistance cheque has been cut. Thanks to the special diet supplement, I used to receive \$250 per month to buy nutritious food and protect my health. Now, I receive only \$_____ per month from the special diet supplement. After I pay my rent and my bills I now have only \$_____ per month left to buy food. This is not enough to live off of and I am forced to go to food banks and rely on charity to survive. This is incredibly stressful, it is hard on my physical and mental health. This is a tragedy in a province as proud of its social programs as Ontario. Please do your best to help fix this situation, by working to raise welfare rates by at least 40%, and by removing the new restrictions on the special diet supplement.

Thank you very much,

(Optional: If you want to discuss this with me further, you can feel free to contact me at _____ [your phone number or address])

Telephone Call Script for Health Care Providers:

(This script is just a rough guide, and you must please feel free to use all or none of it and add whatever you think is appropriate)

You can find your MPP's name and phone number on the list of contacts included with your package.

Hello *(your MPP's name)*:

My name is _____ and I am a _____ *(your job title)* with _____ *(your organization if appropriate)*. I have just seen a patient who lives on social assistance, who asked me to fill out the new form for the special diet supplement. This patient previously received \$250 *(or other amount)* per month through this program, which allowed her to buy nutritious food and maintain her/his health. Under the new regulations, she will only receive \$_____. This will leave her/him only \$_____ per day to buy food. In my opinion, this reduction in her income puts her at very high risk for serious health problems. I feel sad and frustrated that I am no longer able to prescribe the supplement I think is appropriate to protect my patients' health. I urge you to work towards improving my patients' health by increasing welfare rates by at least the 40% they have dropped in the past decade, and by reversing these oppressive regulatory changes to the special diet supplement program. This is essential to head off the health crisis this cut to social assistance is causing.

Thank you very much.

(Optional: If you want to discuss this with me further, you can feel free to contact me at _____ [your phone number or address])

Poverty and Health Backgrounder

Poverty Leads to a General Increased Risk of Developing Health Problems:

It has been well documented that one of the strongest determinants of health is poverty.¹ Literature scans consistently demonstrate the robust relationship between low income and poor health, leaving little doubt that poverty leads to ill health.² Furthermore, Phipps notes that the literature supports the notion that the causal effect is one of poverty leading to poor health, and not the reverse.

Researchers from the University of Toronto have demonstrated convincingly that current welfare rates in Ontario are inadequate to meet the nutritional needs of recipients, for single person, single parent, and two parent family households.³ A survey of food bank users in Toronto demonstrated that 94% experienced some level of food insecurity over the previous year.⁴ Nutritional scientists have argued that social assistance recipients may be at greater risk for income related health inequalities than other low income individuals because generally social assistance is granted only to those with very minimal liquid assets.⁵

Low income results in huge disparities in key health indicators, including life expectancy, infant mortality, disability and long-term illness.⁶ On an individual level, Canadians living in poverty are at higher risk of dying from cancer, heart disease, diabetes, and respiratory diseases.⁷ According to census tract data, Canadians living within the poorest 20 percent of urban neighbourhoods have much higher mortality rates for cardiovascular disease, cancer, diabetes and respiratory diseases than other income groups.^{8,9} Twenty three percent of all premature years of life lost to Canadians are attributable to income differences.¹⁰ Analysis of the 1996-1997 National Population Health Survey (NPHS) indicates that food insufficient households had significantly higher risks of having poor functional health, of suffering from multiple chronic health problems, of having major depression and psychological distress as well as being significantly more likely to report having heart disease, diabetes, high blood pressure and food allergies.¹¹ Analysis of the NPHS for the 1998/99 data show that approximately one in five people living in food insecure households reported having at least three chronic conditions.¹²

These effects accumulate across the lifespan. Children's immediate and future health is especially susceptible to such exposures to material deprivation.¹³ Canadian children living in poverty are more likely to develop a variety of illnesses and injuries, and are more likely to experience hospitalization, mental health problems, lower school achievement, and early school leaving.¹⁴

Poverty Leads to Increased Risks of Developing Specific Health Conditions:

- 1) **Cardiovascular disease (CVD):** Cardiovascular disease remains the leading cause of death in Canada, resulting in approximately 40% of all deaths.¹⁵ Raphael states that the factor having the greatest influence on the development of CVD is low income.¹⁶ He argues that the diseases most directly related to income differences are heart disease and stroke.¹⁷ Low income has been shown to be an important predictor of mortality

following acute myocardial infarction (heart attack).¹⁸ In addition, others have noted that having low income during childhood and adulthood contributes independently to the risk of developing CVD.¹⁹ Low income children carry a high risk of CVD into adulthood regardless of adult income status.²⁰

- 2) Diabetes mellitus (type 2): Type 2 diabetes mellitus is more prevalent among low income individuals.^{21 22} In Ontario, the risk of developing diabetes is four times greater among low income women as compared to high income women, and forty percent greater among low income men.²³ Looking across Canada, the prevalence of diabetes among Canadians aged 45-64 years with household incomes of \$10,000-\$29,000 is twice that of those living in households with incomes of \$60,000 or more.²⁴ Startling research has shown that rates of death from diabetes in urban Canada declined during the 1970s and 1980s and then began to increase during the mid 1980s, most notably in the poorest socioeconomic quintiles.²⁵ The Institute for Clinical and Evaluative Sciences characterizes low income as a strong modifiable risk factor for Type 2 diabetes.²⁶
- 3) Nutritional deficiencies: A prospective study of low income lone mothers demonstrated that these women compromised their nutritional intake to provide their children with adequate nutrition.²⁷ Specifically, the women failed to meet their requirements for total caloric intake and a number of essential nutrients including folate, vitamin C, vitamin A, vitamin B6, vitamin B12, iron, zinc and calcium. Another Toronto based study showed that low income women's dietary intakes of energy decreased systematically as household food insecurity worsened, and that estimated prevalences of inadequacy in excess of 15% were noted for vitamin A, folate, iron and magnesium.²⁸ Similarly, dietary assessments of food bank users and breastfeeding low income women indicated inadequate nutrient intakes in these groups.^{29 30 31} Che and Chen note that deficiencies in nutrients such as zinc and vitamins A, C, and D can compromise the immune system and increase susceptibility to infections.³²
 - a. Iron: American research has shown a significantly increased risk of iron deficiency in low income children, a condition which can lead to iron deficiency anemia.³³
 - b. Folate: Besides the well known link to neural tube defects in babies born to pregnant women with folate deficiencies, research has now shown that folate deficiency contributes to cell damage which can lead to heart disease, cancer and neurodegenerative damage.³⁴
 - c. Calcium: Low dietary calcium increases the risk of low bone mass. Vitamin D deficiency increases the risk of osteomalacia, which causes poor bone quality. Both deficiencies increase the risk of osteoporosis. In 1988 in Canada, 15,000 hip fractures were recorded in both women and men. Seventy percent of these were considered attributable to osteoporosis. It is estimated that by 2021 the annual incidence of hip fractures will be 28,000.³⁵ A Toronto based study showed that all of the low income women surveyed had very low intakes of milk products compared to the general population.³⁶

- 4) Mental Health Issues: Food insufficiency is significantly associated with major depression, psychological distress and poor social support.³⁷ These findings are consistent with research in other jurisdictions.^{38 39} Analysis of Statistics Canada's National Population Health Survey (1998/99 data) showed that the odds of food insecure individuals experiencing distress or a major depressive episode were at least three times greater than those who are not food insecure.⁴⁰ A Quebec study noted that parental stress identified in food insecure households included the fear of losing custody of children.⁴¹ The majority of women in a Toronto survey of low income women (sixty four percent) reported feeling isolated and alone some or most of the time.⁴² Food insufficiency has also been shown to be associated with negative psychosocial outcomes in American children.^{43 44}

- 5) Developmental problems in children: Canadian research which reviewed longitudinal data from a population-based survey (the National Longitudinal Survey of Children and Youth, 1994-1997) determined that maternal depression and living in a household with low income were among factors which increased the risk of poor developmental attainment in children aged one to five years.⁴⁵ These researchers characterize the association with low income as being "strong and consistent."⁴⁶ Analyses from the 1998/99 cycle of Statistics Canada's National Population Health Survey caution that food insecure children are at risk for nutrition related problems including growth retardation, impaired psychomotor development, decreased ability to concentrate and poor school performance.⁴⁷

Why the Raise the Rates Campaign?

Welfare rates in Ontario were cut by 21.6% in 1995, and have decreased, in real terms, steadily with inflation in the ten years since, leaving recipients with 21-37% less spending power than they were entitled to in 1994. Welfare incomes in 2003 in Ontario provided 35-59% of the income needed to reach the poverty line (depending on the size of the family receiving assistance).⁴⁸

Research on low income families and food insecurity has concluded that household food insecurity appears inextricably linked to financial insecurity.⁴⁹ People living on social assistance have been shown to be at much greater risk of food insecurity than those with other income sources.⁵⁰ Food shortages may be caused by circumstances such as having to pay bills for essential services (such as rent, electricity or telephone) or by unusual expenditures such as changing place of residence, purchasing a child's birthday gift or needing to buy a school uniform.⁵¹ However, it is common among low income families that they simply do not have enough money to be able to purchase food to last the entire month. This then precipitates the use of strategies to augment resources such as borrowing money, utilizing foodbanks, reducing portion sizes and "stretching" meals with low cost ingredients. In addition, people use other strategies such as failing to make full rental payments, sending children to a friend or relative's home for a meal, delaying payment of bills, giving up services such as telephones and selling or pawning possessions.⁵² In the context of poverty, feeding a family is a constant struggle, placing anxiety about food and the lack of it to the forefront of daily living.⁵³

The campaign to approve the Special Diet Supplement for all social assistance recipients in Ontario rests on the belief that, given the inadequacy of current welfare rates to cover basic needs for shelter, clothing, and food, living on currently available levels of social assistance places one at high risk for nutritional deficiency and other health conditions strongly associated with poverty. The Special Diet Supplement helps to mediate these risks. With the decline in welfare rates, the exceptional need for a “special diet” has become a general need to prevent nutritional deficiency.

Ultimately, this campaign’s goal is to advocate for an overall 40% increase in welfare rates for all recipients of social assistance, to fundamentally address a strong, reversible risk factor for poor health for hundreds of thousands of Ontarians. For further information about the campaign to Raise the Rates, please see ocap.ca/taxonomy/term/44 .

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⁴ V. Tarasuk & G. Beaton, “Household Food Insecurity and Hunger Among Families Using Food Banks,” *Canadian Journal of Public Health*, Mar/Apr 1999, 90(2): p. 109-113.

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¹⁹ G. Davey-Smith & D. Gordon, “Poverty across the life course and health,” in Pantazis, C. and Gordon, D. (Eds), *Tackling Inequalities: Where Are We Now and What Can Be Done?*, 2000, Bristol, U.K., Policy Press.

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Special Diet Supplement Amounts

MEDICAL CONDITION that requires a Special Diet	Monthly Amount for Special Diet Unless Otherwise Specified
Amyotrophic Lateral Sclerosis	\$10
Cardiovascular Disease	\$10
Celiac Disease	
less than 2 years of age	\$58
2-10 years of age	\$115
11-18 years of age	\$147
19 years of age or older	\$131
Chronic Constipation	\$10
Chronic wounds requiring protein	\$10
Congenital Abnormalities of the Metabolic Type — Adults	\$10
Congenital Abnormalities of the Metabolic Type — Infants & Children	\$10
Congestive Heart Failure	\$44
Crohn's Disease/Ulcerative Colitis	
2% of weight loss \leq usual body weight	\$75
weight loss > 5% 2% and \leq of usual body weight	\$150
weight loss > 10% 5% and \leq of usual body weight	\$180
weight loss > 10% of usual body weight	\$240
Cystic Fibrosis	
2% of weight loss \leq usual body weight	\$75
weight loss > 2% of usual body weight	\$150
Diabetes	\$42
Diverticulum/Diverticulitis	\$10
Dysphagia/Swallowing or Mastication Difficulties	\$25 AND \$75 one-time amount for the cost of a blender, if funding for a blender has not been previously provided
Extreme Obesity: Class III BMI > 40	\$20
Food Allergy — Eggs	\$10
Food Allergy — Milk/Dairy or Lactose Intolerance	
less than 2 years of age	\$95
2-10 years of age	\$97
11-18 years of age	\$55
19 years of age or older	\$35
Food Allergy — Soya	\$83
Food Allergy — Wheat	
less than 2 years of age	\$38
2-10 years of age	\$77
11-18 years of age	\$98
19 years of age or older	\$57
Gestational Diabetes	\$44
<i>[Diet is available during pregnancy and for 3 months post partum]</i>	

Gout	\$32
Hepatic Disorders	\$10
HIV/AIDS	
2% of weight loss \leq usual body weight	\$75
weight loss > 2% and \leq 5% of usual body weight	\$150
weight loss > 10% 5% and \leq of usual body weight	\$180
weight loss > 10% of usual body weight	\$240
Hyperlipidemia	\$10
Hypertension	\$10
Hypertension and Congestive Heart Failure and Grade 1 to 2 left ventricular function	\$44
Hypercholesterolemia	\$22
Inadequate lactation to sustain breast-feeding or breast-feeding is contraindicated during the first 12 months of infant's life	
lactose tolerant	\$75
lactose intolerant	\$83
<i>A Special Diet Allowance will be paid during the first 12 months of an infant's life, if formula is necessary due to inadequate quantity of breast milk or if breastfeeding is contraindicated [e.g. infant is unable to tolerate breast milk; mother's milk is contaminated due to other conditions or medical treatments such as HIV/AIDS, chemotherapy; infant has galactosemia].</i>	
Liver Failure	\$10
Macrocytic Anaemia	\$10
Malabsorption	\$20
Malignancy	
2% of weight loss \leq usual body weight	\$75
weight loss > 5% 2% and \leq of usual body weight	\$150
weight loss > 10% 5% and \leq of usual body weight	\$180
weight loss > 10% of usual body weight	\$240
Marasmus or Kwashiorkor or Anorexia	
2% of weight loss \leq usual body weight	\$75
weight loss > 2% of usual body weight	\$150
Microcytic Anaemia	\$30
Osteoporosis/Osteomalacia/Osteopenia	\$10
Ostomies [e.g., jejunostomy, ileostomy]	
2% of weight loss \leq usual body weight	\$75
weight loss > 5% 2% and \leq of usual body weight	\$150
weight loss > 10% 5% and \leq of usual body weight	\$180
weight loss > 10% of usual body weight	\$240
Pancreatic Insufficiency	
2% of weight loss \leq usual body weight	\$75
weight loss > 5% 2% and \leq of usual body weight	\$150
weight loss > 10% 5% and \leq of usual body weight	\$180
weight loss > 10% of usual body weight	\$240
Post-gastric surgery	\$10
Prediabetes: Impaired Glucose Tolerance (IGT) or Impaired Fasting Glucose (IFG)	\$42
Renal Failure — Dialysis	\$44

Renal Failure — Pre-Dialysis	\$44
Short Bowel Syndrome	
2% of weight loss \leq usual body weight	\$75
weight loss > 5% 2% and \leq of usual body weight	\$150
weight loss > 10% 5% and \leq of usual body weight	\$180
weight loss > 10% of usual body weight	\$240