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Special Diet Expert Review Committee  
c/o Director, Ontario Disability Support Program  
80 Grosvenor St., 3<sup>rd</sup> floor  
Toronto, Ontario, M7A 1E9

June 5, 2006

To Whom It May Concern,

Re: Evidence-based submissions for consideration by the expert committee

I am writing on behalf of Health Providers Against Poverty to ask that “Poverty” be included as a medical condition in the Special Diets Schedule.

There is clear evidence in the medical literature linking poverty to morbidity and mortality. Attached, please find a referenced summary that details this relationship between poverty and health. In addition, please find a document prepared by Toronto Public Health entitled “The Cost of a Nutritious Food Basket in Toronto – 2004”.

It is our opinion that the diagnosis of Poverty should be added to the Schedule; this diagnosis should mandate a special diet consisting of the Nutritious Food Basket as described by Toronto Public Health. The analysis by Toronto Public Health states that a single person on Ontario Works needs \$285.43 more money per month to afford to purchase the Nutritious Food Basket while living in market rent accommodation. As per their analysis, we are asking that the committee grant every person on social assistance who is diagnosed with Poverty \$285.43 per month so that they can afford to purchase a Nutritious Food Basket.

We realize that a better solution to the poverty of people on social assistance is to raise social assistance rates themselves by the needed 40% and we hope that you will join us in lobbying the provincial government to that effect. But, until social assistance rates are raised, including Poverty as a medical diagnosis in the Schedule will allow health providers to directly improve the morbidity and mortality of impoverished social assistance recipients by prescribing them money for a healthy diet.

We thank you for considering our submission. If you have any questions, please do not hesitate to contact me at [tara.kiran@utoronto.ca](mailto:tara.kiran@utoronto.ca) or at 416-203-4507.

Sincerely,

Tara Kiran, MD, CCFP  
Steering Committee Member  
Health Providers Against Poverty

## Summary:

# 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.<sup>i</sup> Literature scans consistently demonstrate the robust relationship between low income and poor health, leaving little doubt that poverty leads to ill health.<sup>ii</sup> 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.<sup>iii</sup> A survey of food bank users in Toronto demonstrated that 94% experienced some level of food insecurity over the previous year.<sup>iv</sup> 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.<sup>v</sup>

Low income results in huge disparities in key health indicators, including life expectancy, infant mortality, disability and long-term illness.<sup>vi</sup> On an individual level, Canadians living in poverty are at higher risk of dying from cancer, heart disease, diabetes, and respiratory diseases.<sup>vii</sup> 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.<sup>viii ix</sup> Twenty three percent of all premature years of life lost to Canadians are attributable to income differences.<sup>x</sup> 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.<sup>xi</sup> 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.<sup>xii</sup>

These effects accumulate across the lifespan. Children's immediate and future health is especially susceptible to such exposures to material deprivation.<sup>xiii</sup> 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.<sup>xiv</sup>

## 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.<sup>xv</sup> Raphael states that the factor having the greatest influence on the development of CVD is low

income.<sup>xvi</sup> He argues that the diseases most directly related to income differences are heart disease and stroke.<sup>xvii</sup> Low income has been shown to be an important predictor of mortality following acute myocardial infarction (heart attack).<sup>xviii</sup> In addition, others have noted that having low income during childhood and adulthood contributes independently to the risk of developing CVD.<sup>xix</sup> Low income children carry a high risk of CVD into adulthood regardless of adult income status.<sup>xx</sup>

- 2) Diabetes mellitus (type 2): Type 2 diabetes mellitus is more prevalent among low income individuals.<sup>xxi xxii</sup> 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.<sup>xxiii</sup> 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.<sup>xxiv</sup> 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.<sup>xxv</sup> The Institute for Clinical and Evaluative Sciences characterizes low income as a strong modifiable risk factor for Type 2 diabetes.<sup>xxvi</sup>
  
- 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.<sup>xxvii</sup> 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.<sup>xxviii</sup> Similarly, dietary assessments of food bank users and breastfeeding low income women indicated inadequate nutrient intakes in these groups.<sup>xxix xxx xxxi</sup> 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.<sup>xxxii</sup>
  - 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.<sup>xxxiii</sup>
  
  - 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.<sup>xxxiv</sup>
  
  - 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.<sup>xxxv</sup> 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.<sup>xxxvi</sup>

- 4) Mental Health Issues: Food insufficiency is significantly associated with major depression, psychological distress and poor social support.<sup>xxxvii</sup> These findings are consistent with research in other jurisdictions.<sup>xxxviii xxxix</sup> 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.<sup>xl</sup> A Quebec study noted that parental stress identified in food insecure households included the fear of losing custody of children.<sup>xli</sup> 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.<sup>xlii</sup> Food insufficiency has also been shown to be associated with negative psychosocial outcomes in American children.<sup>xliii xliv</sup>
  
- 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.<sup>xlv</sup> These researchers characterize the association with low income as being "strong and consistent."<sup>xlvi</sup> 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.<sup>xlvii</sup>

### 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).<sup>xlviii</sup>

Research on low income families and food insecurity has concluded that household food insecurity appears inextricably linked to financial insecurity.<sup>xlix</sup> People living on social assistance have been shown to be at much greater risk of food insecurity than those with other income sources.<sup>1</sup> 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.<sup>li</sup> 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.<sup>lii</sup> 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.<sup>liii</sup>

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](http://ocap.ca/taxonomy/term/44).

*This paper was assembled by Regent Park Community Health Centre Nurse Practitioner Kathy Hardill in January, 2006.*

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