

INTERACTIONS WITH THE SOCIAL ASSISTANCE AND HEALTH CARE SYSTEMS

LEARNING OBJECTIVES

At the conclusion of this chapter, the reader will be able to:

- document the extent of interaction of people living in poverty with the social assistance and health care systems;
- identify the unmet social service and health care needs of people living in poverty;
- describe the perceptions and experiences of people living in poverty with these systems;
- describe the effects of these interactions upon the health and quality of life of people living in poverty;
- outline means of improving the quality of these interactions with the social assistance and health care sectors.

INTRODUCTION

The difficult material and social living conditions experienced by people living in poverty make interactions with a variety of service sectors much more likely. People living in poverty are more likely to access the employment insurance system. And many people living in poverty rely upon the benefits provided by the social assistance system. This is especially the case for people who are unable to participate in the labour force. These groups include people on social assistance, people with disabilities, and people who are unable to find work. These people must—by necessity—interact with social assistance and social service agencies. People living in poverty may also interact more with a range of services that are provided within Canadian communities. These include recreation centres, community health centres, community centres, and other voluntary organizations such as settlement houses, seniors' centres, youth services, and other community-based organizations. Interactions with the education system are also included within these domains.

Similarly, the experience of material and social deprivation makes it more likely that people living in poverty will experience greater incidence of disease and illness. Chapters 8 to 10 document that this is indeed the case: People living in poverty have greater incidences of a wide range of health and health-related problems than those not living in poverty. By virtue of their greater incidence of health-related problems, interactions with the health care system should be more common than those not living in poverty. This chapter considers what is known about the quantity and quality of the interactions with the social service and health care sectors of people living in poverty. Of particular interest are the perceptions people living in poverty have about the quality of these interactions. The extent to which these interactions are shaped by the general Canadian approach to service provision—both social services and health care services—for people living in poverty is examined. The focus here is on income-related benefits and supports. While the purpose of the chapter is not to provide an in-depth presentation of the social services and health care systems, sufficient detail is given to provide a context for understanding how people living in poverty interact with these service systems. Implications of these findings for the health and quality of life of individuals and communities experiencing poverty are examined, and means of improving the quality of these interactions are explored.

INCOME-RELATED BENEFITS IN CANADA

Canada's approach to the provision of income-related social benefits and services is typical of other liberal welfare states such as the USA, UK, and Ireland (Organisation for Economic Co-operation and Development, 2005). In comparison to many European nations, Canada's benefits are less generous and are usually targeted to those in need, as opposed to being available on a universal basis (Esping-Andersen, 1999). Social assistance or welfare is seen as providing benefits of last resort to individuals and families whose resources are inadequate to meet their needs and who have exhausted other avenues of support.

Employment insurance is available to people who are without employment and who meet the eligibility requirements. Recent changes to eligibility, however, have significantly reduced the percentage of Canadians who are eligible for such payments (Tremblay, 2004). Black and Shillington (2005) report that only 40% of Canadians are eligible to receive benefits and this figure drops as low as 30% in urban areas such as Toronto.

Social assistance or welfare is provided to people who have no employment income and very few assets. It is accepted that benefits in Canada provided under social assistance programs do not provide for much more than basic subsistence (Organisation for Economic Co-operation and Development, 1999). This is the case even though many of those who rely on social assistance are children whose health and well-being are especially susceptible to living under conditions of material and social deprivation.

Many provinces have reduced benefits and reduced eligibility for social assistance. (National Council of Welfare, 2005b). Additionally, the imposition of "Workfare" in many provinces has made difficult life situations for many social assistance recipients (National Council of Welfare, 2005a). There is increasing evidence that social assistance and social welfare benefits do little to maintain or improve the health and quality of life of people who must rely on these resources. The National Council of Welfare (2005a) recently stated:

We have carried out extensive research on the welfare system, welfare incomes, and welfare reform. It is our view that welfare policy in Canada has suffered serious neglect and is an utter disaster. Canada's "helping hand" is not working and people who must live on welfare are being left behind. (p. 1)

The Organisation for Economic Co-operation and Development (OECD) carried out a national case study of social assistance in Canada by focussing on approaches in four provinces: Alberta, New Brunswick, Ontario, and Saskatchewan (1999). The OECD pointed out that Canada is among the most affluent nations in the world. The report notes that public spending increased during the 1980's and peaked at 20% of gross domestic product (GDP) in 1993. Public spending has been falling ever since, though more recent data show a slight rise in the last two years. Indeed, during the 1990s, reduction in general government spending in Canada was so substantial that Canada's reductions were the highest among developed nations outside of Greece and Poland. Canada's social assistance programs are seen as barely providing more than subsistence (Organisation for Economic Co-operation and Development, 1999).

THE CANADIAN ASSISTANCE PLAN AND THE CANADIAN HEALTH AND SOCIAL TRANSFER

The federal government is responsible for employment insurance, but social assistance and health are the responsibilities of the provinces. Funding for these provincial responsibilities is provided in part from the federal government through the Canada Health and Social Transfer (CHST). The CHST replaced the Canadian Assistance Plan (CAP) with severe consequences for the provision of social assistance. Day and Brodsky (1998) argue that:

CAP provided that Canadians have a right to social assistance when in need, a right to an amount of social assistance that takes into account basic requirements, and a right to appeal when assistance is denied. Provinces were required to honour these conditions in order to qualify under CAP for 50:50 cost-sharing with the federal government of social assistance and important social services.

In place of CAP, the Budget Implementation Act (BIA) (1995) creates the CHST, a new vehicle for transferring federal funds to the provinces. The BIA eliminates the conditions formerly attached to social assistance spending. It removes the separate designation of funds for social assistance, combines those funds with block funds for health and post-secondary education, and permits the provinces to spend the funds in any way they wish. It continues the general trend of reducing federal contributions to social programs. By doing so, it increases the likelihood that the federal government will not be able to maintain national standards for any of Canada's social programs because of its reduced spending, and because of the demands of the provinces for control over the programs that they are increasingly responsible for funding. (p. 1).

The primary change then, was that the CAP provided separate envelopes for federal support of social welfare, post-secondary education, and health spending, but the CHST lumped all of these envelopes within a single block grant. This has been associated with decreasing spending on social welfare at the expense of health care spending. Very recently, the CHST was again separated into a Canadian Social Transfer and Canadian Health Transfer.

The effects upon social programs such as social assistance of this move are uncertain.

EMPLOYMENT INSURANCE

All employed Canadian workers pay into the Employment Insurance (EI) Program which is operated by the federal government. The rate of weekly benefits is 55% of weekly insurable earnings, which is set at an annual high of \$39,000, or about \$750 a week. This means that benefits can be as high as 55% of \$39,000, or \$21,450 a year (Organisation for Economic Co-operation and Development, 1999). Claimants with children and low family income are eligible for a supplement that increases their benefit to 80% of weekly insurable earnings or up to \$413 dollars a week or \$21,450. Claimants can earn up to 25% of weekly benefits before earnings begin to get deducted from benefits.

Requirements for receiving employment insurance vary from location to location. The benefit is payable for a maximum period of between 42 and 45 weeks after a two-week waiting period. Profound changes have taken place in eligibility for EI, however. EI coverage has fallen across Canada from 80% of workers in 1990 to just over 40% in 2004 (Black and Shillington, 2005). This means that at any given time, less than half of unemployed workers who have paid into the EI program are eligible for benefits if their employment terminates. (See Box 7.1.)

SOCIAL ASSISTANCE OR WELFARE

Social assistance or welfare programs are the responsibility of provinces and territories in Canada. Social assistance programs across Canada distinguish among recipients along a number of dimensions. There are benefits for those who are deemed to be unable to participate in paid work and benefits for those deemed able to participate in paid work (National Council of Welfare, 2005b). These benefits are very low. The Organisation for Economic Co-operation and Development (OECD) (1999) notes, "Everywhere the basic social assistant payment is not intended to cover much more than immediate basic needs for housing, clothing, food, and recurring household expenses" (p. 42). This analysis merely states the obvious. The National Council of Welfare has long argued that social assistance benefits fall far short of providing recipients with resources to assure the necessities of life (National Council of Welfare, 2004).

In Canada, the OECD notes, the basic principle is that social assistance should not exceed the income of employed low-income workers. It is intended "*not* to give a reasonable standard of living" (Organisation for Economic Co-operation and Development, 1999, p.43). In Switzerland, as an alternative example, "[t]he CSIAS guidelines ... define a basic payment rate sufficient to 'guarantee the beneficiary an existence which respects human dignity' and to 'give (beneficiaries) the possibility of actively participating in social life'" (p. 43).

There are assets tests in Canada that are strict in comparison with other OECD nations. Possession of liquid financial assets such as savings and private pension plans preclude receipt of social assistance. These assets must be spent prior to benefits being received. In essence, one must almost be destitute before assistance can be provided (National Council of Welfare, 2005b).

The OECD points out that the 1990s saw reductions in benefits and/or restriction of eligibility for benefits across Canada. In 1992, Saskatchewan sharply reduced benefits to those deemed to be "fully employable." In 1993, Alberta cut benefit rates and New Brunswick

Box 7.1: Ontarians Can No Longer Count on Employment Insurance to Provide Temporary Income between Jobs: Toronto and Ottawa Have Lowest Coverage in Canada**Toronto, October 6, 2005**

The Task Force for Modernizing Income Security for Working Age Adults released its review of Employment Insurance (EI) today, revealing that EI no longer fulfils its role of providing temporary income to most unemployed Canadians who are between jobs.

The inadequacy of EI is most pronounced in Ontario's large cities. The report discloses that Ottawa and Toronto have the lowest levels of coverage in the country with only one in five unemployed workers in those cities receiving any EI benefits.

"EI is irrelevant for the majority of unemployed in Ontario's cities, including Toronto," says Susan Pigott, CEO of St Christopher House and Co-Chair of the Task Force. "The result is that those folks fall straight through what should be the first layer of our social safety net, and many do not stop falling until they land on social assistance. There needs to be a new approach."

Highlights of the MISSWA report include:

- EI coverage has fallen across Canada to just over 40% of the unemployed in 2004, from 80% in 1990.
- The precipitous decline in EI coverage was the result of changes in EI combined with changes in the labour market. More self-employed and more people in 'non-standard' jobs such as temporary and contract work can't get EI.
- Cities like Toronto with high immigration levels and high rates of temporary and contract employment have fared the worst in coverage.
- The unemployed across Ontario have always had lower coverage than the rest of Canada and the gap has grown over the past twelve years.
- While Toronto would be expected to be a net contributor to EI given its lower unemployment rate, the gap in coverage has seen a huge gap in contributions versus benefits—Toronto now contributes 19% of EI funds and receives only 10% of EI benefits.

"Toronto's very low EI coverage relative to other regions with similar unemployment rates is primarily the result of high immigration levels," say study authors Jill Black and Richard Shillington. "Many unemployed immigrants face much tougher rules to qualify for EI creating a penalty for those cities like Toronto where immigration has been so important to labour force growth."

David Pecaut, Chair of the Toronto City Summit Alliance and Co-Chair of the Task Force, says, "Poor EI coverage in our large cities like Toronto shows that the Canadian social safety net needs fundamental reform. This is both a social and an economic imperative as cities like Toronto could face fiscal disaster in the next recession as the unemployed fall through the safety net and land on provincially and municipally funded social assistance."

Source: From Toronto Summit Press Release, October 6, 2005. The review is available at www.torontocitysummit.ca and www.stchrishouse.org.

restricted access to benefits. In 1995, Ontario cut benefits by 21.6%. The introduction of mandatory “workfare” requirements in many localities made receipt of benefits dependent upon looking for and/or finding paid employment or gaining participation as unpaid volunteers in various settings.

The National Council of Welfare summarizes how eligibility for social assistance benefits is assessed (2005b). The person must be between 18 and 65. Students can qualify in some provinces/territories if they meet certain stringent requirements. Parents must try and secure any court-ordered support. Strikers are usually not eligible. Immigrants must go to their sponsors for support. Applicants must meet a means test. The assets of the applicant and of his or her household are compared to budgetary levels set by the government. The NCW argues that these requirements are usually set much too low.

Applicants’ liquid and fixed assets are examined by the welfare system. In most provinces, a principal residence and furniture are excluded, as is the value of a car. If applicants’ assets are above these levels, the person is not eligible for assistance. Income from sources such as employment, pensions, and EI will exclude receipt of benefits. The Child Tax Benefit, but not the supplement, is considered exempt. All non-exempt income is subtracted from the total needs of the household’s resources. Table 7.1 summarizes levels of liquid assets that can be retained in Canada.

These are very strict criteria for support by international standards. A 2004 report prepared for the Ontario Minister of Community and Social services pointed out that there are 800 rules and regulations that need to be applied to calculate if Ontarians are eligible for social assistance and how much they are entitled to each month (Matthews, 2004). According to the report,

Many of those rules are punitive and designed not to support people, but rather to keep them out of the system. Because there are so many rules, they are expensive to administer and often applied inconsistently from one caseworker to another, even within the same office. Further, the rules are so complicated that they are virtually impossible to communicate to clients, and it takes years to train a caseworker. (p. 25)

In its analysis of Canada’s social assistance system, the OECD (1999) outlines two opposite poles of benefit administration that result from elected officials exercising their power to determine the procedures that professional staff should follow. These are described as follows:

- One view is that benefits are a right; that potential claimants should be informed of their rights and encouraged to apply; that claimants should be treated as customers of a service; and that the role of the administration should be to process claims as quickly and accurately as possible.
- The other approach is that social assistance is not unrequited (the claimant has to do something in return for benefit receipt). Benefit availability is contingent on tight eligibility criteria and can be accessed only when all other sources have been exploited. Clients need not be informed of any “right”—if they really need help they will apply. Claimants should be discouraged to the greatest extent possible, as the benefit is still fulfilling its role as a safety net even if potential claimants chose to avoid the

Table 7.1: Liquid Assets Allowable for Receipt of Social Assistance or Welfare

	Unemployable			Employable	
	Single Person	Single Parent, One Child	Single Person with Disability	Single Person	Family
Newfoundland	\$500	\$1,500	\$3,000	\$500	\$1,500
Prince Edward Island	N/A	\$1,200	\$900	\$50 to \$200	\$50 to \$2,400
Nova Scotia	\$500	\$1,000	\$500	Province generally requires applicants to exhaust liquid assets to meet basic needs	
New Brunswick	\$1,000	\$2,000	\$3,000	\$1,000	\$2,000
Quebec	\$2,500	\$2,845	\$2,500	\$1,500	\$2,943
Ontario	N/A	\$5,500	\$5,000	\$520	Adult, one child: \$1,457 Couple: \$901 Each additional child: \$500
Manitoba	N/A	\$2,000	\$2,000	\$0 at enrolment \$400 after enrolment	\$0 at enrolment Couple, two children: \$1,600 after enrolment
Saskatchewan	\$1,500	\$3,000	\$1,500	\$1,500	Adult, one child: \$3,000 Couple, two children: \$4,000 Each additional child: \$500
Alberta	\$1,500	\$2,500	\$1,500	\$50 in cash plus the equivalent of \$1,450 in cash assets	\$250 cash plus the equivalent of \$2,250 in cash assets
British Columbia	\$1,500	\$2,500	\$3,000	\$1,500	\$2,500
Yukon	\$1,500	\$2,500	\$1,500	\$500	Couple, two children: \$1,600
Northwest Territories	The director may determine that some assets should not be converted into cash for social or economic reasons and that they therefore are not considered as a personal resource				
Nunavut	The director may determine that some assets—such as those used in traditional activities—should not be converted into cash for social or economic reasons and that they are therefore not considered as a personal resource.				

Source: From *Welfare Incomes: 2004* (pp. 5–6), by the National Council of Welfare, 2005b. Ottawa: National Council of Welfare.

administrative hassle by seeking other means of support. Claimants are not customers; they are people who have thrown themselves at the mercy of the taxpayer, and the taxpayer has every right to expect that every possible check for eligibility is undertaken, however long that may take. (p. 72)

The first scenario is that benefit claimants' requests are considered legitimate and expedited. The second scenario is the opposite. Alberta is seen as an exemplar of the second scenario. And Ontario is seen as not being far behind: *An extended amount of time is spent on intake, challenging and checking every detail of a claim in detail so that no-one receives a cent more that she is entitled to* (Organisation for Economic Co-operation and Development, 1999, p. 74).

In Ontario, a variety of restrictive regulations were initiated as part of the "Common Sense Revolution" of the Mike Harris Conservative government. Included among these were various rules that assumed that any male and female sharing a dwelling were in a common-law relationship and subject to having benefits rescinded. This "spouse in the house rule" was recently deemed to be unconstitutional. Another change was that people attending post-secondary educational institutions were no longer eligible to receive social assistance benefits. Ontario also instituted a lifetime ban on receiving benefits if convicted of "welfare fraud." These two regulations came together to produce at least one well-known tragic outcome (see Box 7.2).

The restrictive approach to social assistance is less intense in New Brunswick and Saskatchewan where much processing of claims takes place over the telephone and where cross-referencing of records is done to expedite claim processing (Organisation for Economic Co-operation and Development, 1999). In every province, however, there has been intense emphasis on fraud control. Welfare fraud hotlines take anonymous calls, and while provinces report these procedures have proved worthwhile, other argue that the actual amount of welfare fraud is minimal. Any fraud that does occur results from the desperation experienced by people unable to live on the benefits provided (Chunn and Gavigan, 2004; Mosher, Evans, Morrow, Boulding, and VanderPlaats, 2004). The politics driving this emphasis on curbing welfare fraud are considered in Chapter 11.

INTERACTIONS WITH THE SOCIAL ASSISTANCE SECTOR

There are a few studies that focus on the experiences of people who interact with the social assistance sector. The findings of these studies are consistent with a wealth of anecdotal information that has accumulated: People who receive social assistance are likely to feel hassled, degraded, and stigmatized by the social assistance system. There is a great gap between what authorities state these programs are designed to accomplish, and their actual effects upon those who participate in these programs.

CANADA WEST FOUNDATION (CWF) STUDY OF ALBERTANS RECEIVING SOCIAL ASSISTANCE

A CWF study examined the experiences of Albertans who had been on social assistance during the 1960's (Elton, Sieppert, Azmier, and Roach, 1997). Alberta's system was significantly reorganized, with the primary result being the reduction of the number of people receiving social assistance by close to 80%. CWF was able to contact 769 people who had left the system. While some of the comments are positive, many are extremely negative.

Box 7.2: The Case of Kimberly Rogers**Let's keep fighting system for Kim Rogers' sake****Michele Landsberg***Toronto Star*

We thought we knew her.

All of us had labels summing up Kimberly Rogers' life: welfare cheat, loser, unwed mother-to-be. Suicide. We never heard her own voice or saw her eyes. We all—even the compassionate—had unspoken subtitles to the silent movie of her life, projected fuzzily to us in news stories: Guilty of welfare fraud. Sentenced to six months' house arrest in a tiny Sudbury apartment. Then, on Aug. 9, 2001, found dead after a sizzling heat wave sent temperatures in her prison soaring to more than 40C.

But a more touchingly rounded picture of Kim Rogers began to emerge for those who actually attended the inquest into her death.

"Amazingly, you could see attitudes shifting," recalled Jacquie Chic, a lawyer for the Income Security Advocacy Centre in Toronto, who was there. "The jury and even her estranged family weren't sympathetic at first. They seemed to believe the government was right to force welfare rates so low. But as they heard the evidence of how cruel the system is, you could see the shock on their faces."

A working-class woman who struggled all her life against poverty, Kim fled an abusive relationship in Toronto to move home to Sudbury and start fresh.

"To me, she was a hero," Chic said. "She graduated from social services at Cambrian College with high praise for her work with handicapped children."

But how dumb a policy is this: You can't live on Ontario student loans, and yet you're a criminal if you get welfare at the same time. Kim was pregnant—and she needed welfare because, battling ill health, she couldn't work. In Ontario, while inflation leaped 15 percent and rents by 26 percent, welfare rates remained frozen for seven years at \$520 a month for a single person.

When Kim pleaded guilty to having received \$13,000 of welfare over three years, Judge Greg Rodgers ordered her into house arrest, with three hours a week to go out to shop. Shop? She had no income. Her welfare was automatically cut off. The judge was very righteous in denouncing her. "Welfare is there for people who need it," he said, "not for people who ... want things and who want money."

Right. Kim wanted "things" like food to eat while she prepared to give birth to a much-wanted child.

Bravely, although she dreaded the humiliation of public scrutiny and contempt, Kim launched a court Charter challenge of her six-month welfare ban. She told the court about running out of food, with no local agencies able to provide more. She was depressed, sleepless, frightened about her baby's future. I was heartstruck by a handwritten list of desired foods—yogurt, crackers, fresh veggies—that Kim Rogers gave her welfare worker. She titled it "foods I like." And she was so diffident, so self-denigrating, that she put the "I" in quotation marks, as though she had no right to use the first person pronoun.

Judge Gloria Epstein of the Superior Court heard her and denounced the welfare ban as “adversely affecting not only the mother and child, but also the public—its dignity, its human rights commitments and its health care resources.”

But even after her welfare was ordered restored, Kim had only \$18 left a month after rent and the student loan claw-back. Penned up in her stifling apartment, she was terrified to go outside, even into the backyard, lest authorities punish her by seizing her infant once it was born. (The eight-month fetus, a girl, died with Kim.)

What kind of people harden their hearts so brutally that it seems a splendid idea to let people starve and despair in the midst of plenty?

The Ontario Tories don’t stint themselves. And they don’t exercise “zero tolerance” for their own self-indulgent spending. In their first six years in pig heaven, Tory MPPs charged the public purse for lavish steak dinners, fancy hotels, movies, trips to Las Vegas—\$2 million total in expenses. One minister was sent to the back benches. Not exactly starvation and death.

Most Ontarians aren’t as withered of conscience as their elected members. The Kim Rogers jury, sobered and saddened by the evidence, asked Ontario to raise welfare rates and end the cruelty of “zero tolerance.” So far, 15 cities have echoed the demand.

Social Services Minister Brenda Elliott, a former teacher and entrepreneur, was unmoved. She instantly retorted that “zero tolerance” and the lifetime welfare ban “work” and will not be changed.

Ms. Elliott has a strange cabinet record. As environment minister, she boasted of taking chauffeured limos instead of the bus for brief trips to the Legislature. She went to the Walkerton inquiry and refused to take responsibility for those deadly decisions in her ministry. (“We’re a team.”) She hangs tough on refusing treatment for autistic children over the age of 6.

She is especially contemptuous on the subject of Kim Rogers’ lonely, anguished death. The minister says she is very satisfied that the “numbers on welfare continue to drop.”

Let’s put the screws to these callous MPPs even before the coming election. Join the campaign to phone the compassion-challenged minister at 416-325-5225 and insist that she raise the welfare rates to a living level.

This activism will be the only decent farewell we can offer to Kim Rogers.

Source: From the *Toronto Star*, K01, Saturday, January 25, 2003.

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- “Welfare really made a big difference. To get that when I did, as I was out of options, and it gave me time to get my life together. I had to get the pieces together and get on. Being on social services gave me a chance to do that.”
 - “This has not been easy going on welfare, but the character and the goodness of the people—I think they care. Personally I think they are really neat people. Paperwork is the big staler.”
 - “I was often treated as a statistic, number or nobody. I found I had to make an effort to make these people see me as a person of quality and worth.”

- “It’s very frustrating for single moms trying to juggle the kids and the job. How can you get ahead when social services takes everything extra that you get? They even take away child support payments. You need things for your child, and they take away the money.”
- “I was never happy when I was on welfare. I went through hell. I was treated like hell. Honest people get treated like garbage and the people that rip them off are never checked up on.”
- “Nobody wants to go on welfare. It’s a humiliating process no matter how much social welfare wants to help.” (p. 7)

Overall, the study found that over 60% of study participants rated their interactions with Alberta authorities negatively. Indeed, there have been so many concerns about the treatment of social assistance claimants in Alberta that a lawsuit against the government was instituted. It claimed damages against the government for its shoddy treatment of people. A court ruled in favour of the complainants, and the Alberta government was required to pay out over \$100 million (see Box 7.3).

Only about half (53.3%) of study participants left social assistance as a result of finding employment. And about 16% were transferred to other benefit programs. An important finding concerns the situation of those who have left social assistance. The Canada West Foundation study found that many of these former social-assistance clients remain in extremely precarious living situations. Over two thirds (68.2%) reported not having enough money to meet their food and shelter requirements at least once since leaving the program. And more than 4 in 5 who returned to the program (83.9%) reported not having these basic resources. The study concluded as follows:

- Those who have left welfare are, as a group, better off financially and psychologically than those that are back on welfare.
- The findings show that many former welfare recipients are engaged in a daily struggle to achieve self-sufficiency.
- The multiple and complex nature of the personal problems and circumstances that lead people to seek welfare reinforces the need for continual improvements and adaptations in the delivery of social assistance. (p. 8)

THE WOUNDS OF EXCLUSION: INTERACTIONS WITH SOCIAL ASSISTANCE

Reid (2004) studied the interactions of women with the social assistance system in British Columbia as part of a major study of women’s lived experience of poverty. Reid interviewed 20 women, 12 of whom provided a second interview. Reid summarized her findings as follows:

In the interviews and research team meetings, the women spoke at length about their encounters with the welfare office, social workers, and financial aid workers. The women said they were belittled, abused and treated as files, numbers, and “non-persons.” The women described their workers as snarky, ride, high and mighty, snooty, discriminating, and low-level threatening. (p. 135)

Box 7.3: Alberta Provincial Lawsuit Settled

EDMONTON (CP)—The Klein government has quietly agreed to spend more than \$100 million to settle a class-action lawsuit over its treatment of severely handicapped, widowed, and poor Albertans.

The settlement, believed to be the first in Alberta's history, was approved by the Alberta Court of Queen's Bench last month.

The settlement, which could affect as many as 30,000 Albertans, stems from decades of what the lawsuit claimed was the illegal and abusive bureaucratic treatment of people using social programs.

Donald Fifield, a truck driver who has been on the provincial Assured Income for the Severely Handicapped program, or AISH, since suffering a devastating leg injury in 1983, said his family was forced to eat porcupine to survive after the province mistakenly docked his allowance.

"We ate porcupine meat and did all kinds of stuff trying to keep alive because we couldn't afford nothing else," he said. "This goes back a long ways and there's been a lot of hurt." Fifield, now 64, and another man filed the suit in September 2004, just before the last provincial election.

They challenged policies that arbitrarily docked them for overpayments caused by administrative errors and denied them full compensation when they were underpaid.

The Fifields were docked allowance for failing to report Donald's wife, Carol, had found a temporary minimum-wage job.

Officials later discovered when they reviewed the file they had been notified. They also cut the family off assistance and made the Fifields send back their entire December cheque one year because they earned \$58 too much to qualify.

Their lawyer, Phillip Tinkler, said it was ironic that after passing the Class Proceedings Act, the provincial government was its first target.

Gwen Vanderdeen-Paschke of Alberta Human Resources says the province disputes the allegations, but decided it was in the best interests of Albertans to settle.

"We decided it was better to enter into a settlement that does provide some fair and reasonable terms for people who come forward than expending all those resources on defending our position," she said.

Fifield, in a wheelchair since his leg was amputated nine years ago, is thrilled the case is settled. "We're helping a lot of people. That's what makes us feel the best," he said. "We were worried that if we lost the case we might lose our house."

Liberal Leader Kevin Taft called the government treatment of settlement plaintiffs "a profound and enduring betrayal of widows, of the severely handicapped, of the most vulnerable members of society."

Taft called on Premier Ralph Klein to apologize and said the government should investigate how the problems continued undetected for so long.

Since some of the funds paid to benefit recipients were federal monies transferred to the province for income support programs, Taft also suggested more accountability for transfer payments may be in order.

Source: From the *Edmonton Sun*, p. 3, January 15, 2006.

Social workers were seen as young and inexperienced with no appreciation of the life situations of their clients. One client stated: "These welfare workers, they're just these younger pups right out of school, and you can tell they're reading right out of their text book, they don't know a thing about real life" (p. 136). The workers that were seen as sensitive and caring were seen as likely to burn out and leave.

Women reported that the attitudes of workers were judgmental and threatening and acted as if they assumed that clients were not capable of taking care of themselves. This general distrust led to careful surveillance of client's activities and constant questioning of their claims and situation. Some specific comments from women were:

- "It's low-level threatening is what it is. And if you go into any of the offices it tells you how you are supposed to be treated and how you're supposed to treat the person... lack of integrity comes into it for a lot of these workers." (pp. 136–137)
- "I hate having them [welfare workers] go up my ass with a microscope. That's kind of a rude way to put it, but that's how I feel. I feel like I'm under a microscope all the time." (p. 137)
- "They [the social workers] never say 'how would it be to be in their shoes, how would it be to be in her pain, in her depression?' They never do that. They never return phone calls, it's not possible to make appointments." (p. 137)
- "If you go in and ask if you can get a food voucher, 'well, why didn't you judge your money better?' And they give you such an attitude. And it's just so hard. And there's no privacy in that place at all. You and everyone in the world can hear you. But you know all that plays on you. I get this big knot in my stomach." (p. 138)
- "The one thing I think that's missing there under 'experiences of welfare' is the fact that you're treated as a liar when you walk through the door." (p. 139)

An important issue—related to the inability to make appointments—was that clients would have to line up outside the office in order to see their workers. Women commented:

- "You have to stand out there and line up, there's no such thing as an appointment, so it doesn't matter what the weather is, what your health is, you stand in that line and they only take the first so many and the rest come back tomorrow.
- "They start lining up about 6:30 in the morning on welfare day and the people walking by you—you can just see their faces. They're like 'look at all those bums.'" (p. 137)

Finally, there is the issue of information. Women consistently reported being unable to find out what benefits, training, and other opportunities were available to them. Some comments:

- "They don't tell you benefits, they don't tell you how it works, they don't tell you about your healthcare... they don't offer information, you have to extract it from them like,

it's like doing a root canal or something. They don't explain all of it, they don't tell you your rights."

- "Like it seems like when you do start asking all they do is get snotty with you and you get the run around and all you're trying to do is better yourself. You want to go back to school or you want to find out what's available to you to better yourself. And it's just crazy."
- "They want you to get off welfare, but once you do get ahead, they penalize you." (p. 138)

Box 7.4: Restructuring of BC's Social Assistance System

- British Columbia's welfare application system is not working—it discourages, delays and denies people who need help. The process of seeking income assistance has become so restrictive, and so complicated to navigate, that it is systematically excluding from assistance many of the very people most in need of help.
- The government's narrative about more people leaving welfare for work is not supported by the evidence. Data shows that the recent drop in the caseload is not the result of more people leaving welfare. Rather, fewer people are entering the system and accessing assistance. Simply put, the caseload reduction is mainly a front-door story.
- In the first year after the new welfare legislation was introduced in April 2002, the number of applicants who began to receive welfare benefits dropped by 40%, from an average of 8,234 entries (or "starts") per month to just 4,914 starts per month. The number of welfare "exits" also fell, but only slightly, from 8,388 to 7,631 per month.
- The acceptance rate for those who apply for welfare has dropped dramatically. In June 2001, 90% of people who began an application for welfare were successful in gaining income assistance. By September 2004, only 51% of those who sought welfare were granted assistance.
- The application system is now so complicated that many people need help from an advocate to successfully navigate the process.
- Many people are being "diverted" to homelessness, charities and increased hardship. The Ministry claims that people are being "diverted to employment"; however, the evidence shows that many are not.
- In some cases, denying people assistance reduces their ability to be self-sufficient. Lack of assistance forces some people to focus their time and resources on meeting basic shelter and food needs rather than looking for work. Without a permanent residence, a phone line, access to transportation or appropriate clothing, searching for work is difficult if not impossible.

Source: From *Denied Assistance: Closing the Front Door on Welfare In BC* (pp. 5–7) by B. Wallace, S. Klein, and M. Reitsma-Street, 2006. Vancouver: Canadian Centre for Policy Alternatives. Online at www.tinyurl.com/h8jzm.

OTHER STUDIES OF SOCIAL ASSISTANCE

An extensive study analyzed the structure of the social assistance system in British Columbia and the experiences of people within the system (Wallace, Klein, and Reitsma-Street, 2006). It concluded that unreasonable barriers are preventing people in real need from assessing benefits of last resort. (See Box 7.4.)

In Ontario, Neysmith and colleagues examined the effects of recent policy changes—including welfare policy—on the lives of 50 families (Neysmith, Bezanson, and O’Connell, 2005). With specific regard to families receiving social assistance, the study identified how bureaucratic control made the receipt of social assistance very difficult. Much of this is related to the general attitude towards welfare common to administrative systems in Canada. The following comments were representative:

- “[My welfare worker] wanted a letter of explanation from my son’s doctor. She wanted medical records proving that my son was sick. I drew the line, and I almost went back with my ex. I was this close [holding her thumb and index finger close together] because I thought, with his income and me working part-time, I could tell [my worker] to go to hell. But I’m trapped. That’s not an option either. It’s either deal with this abusive woman or deal with a previous partner and I’m stuck in the middle. And I just find she’s been very militant since this whole concept of Ontario Works came in play—very, very militant.” (p. 79)
- “I had a nice relationship with my worker where I lived before. I moved here and I don’t know what happened. They want a doctor’s letter; I take the doctor’s letter to show them I need treatment. I need to see the doctor often. Welfare said they want another letter, my doctor sent them [another one]. Now my doctor is tired of them and doesn’t send nothing. [Welfare also] wanted a school letter, every day I have to go to school. They wanted an income tax return letter or they would kick my baby out of day care. I went to school to register, they said they need last year’s attendance. Where am I going to get last year’s attendance? They ask for so much. They need an excuse to kick you off. No, they’re not supporting me. They do not listen to me.” (p. 87)
- “Somebody reported to the Mother’s Allowance hotline that my husband was living here. I flipped. I was in the hospital! I have four children that I could not take care of! Yes, he was here, but normally he isn’t here at all. He was staying here to care for his children for the three days that I was sick in the hospital! He doesn’t even pay support. It took me two years to get away from him. Did they think I’m just going to let him move back in here?” (p. 90)

And similar findings are seen in the examination of British Columbia’s social assistance program (Wallace et al., 2006). The report provides many instances of people being treated in a degrading and humiliating manner:

- “I’m not saying they should be coddling people, but I mean, people need to be civil, you know what I mean? ... People think they’re worthless because they’re treated that way. They won’t think that trying for anything else is even worth their time, because you know, who’s gonna give them a chance? You know, half of this attitude really is the

government. If they could treat people like they're human beings maybe people could start acting like that, you know."

- "Before it was not as dehumanizing as it is now. Now you just know you have no rights. Actually, I did notice something on TV the other day about the relief camps they had during the Depression and apparently once someone was there they didn't even have a vote. You just became a non-person. And I almost feel they would be quite happy if they could do that." (p. 43)

PROPOSALS TO IMPROVE THE WELFARE SYSTEM

The National Council of Welfare (2003) prepared a brief based on a Welfare-to-Work Roundtable held in 2002 in Ottawa. (National Council of Welfare, 2003) The NCW urged the system to be made simpler to understand and easier for people to use to get the right benefits and services in order to get on with improving their lives. The NCW specifically recommended:

- Ending the clawback of federal child benefits,
- Providing basic maternity support for all mothers and newborns,
- Building a national child care program for all families,
- Developing training and bridging programs for new and re-entrants into the labour market,
- Allowing welfare recipients to maintain and develop assets,
- Enabling lone parents with student loans to continue to receive welfare, at least until the amount of child benefits reaches the actual cost of raising a child, and
- Providing supplements to low-income lone parents who can't fully benefit from tax credits available to higher earning lone parents. (p. 18)

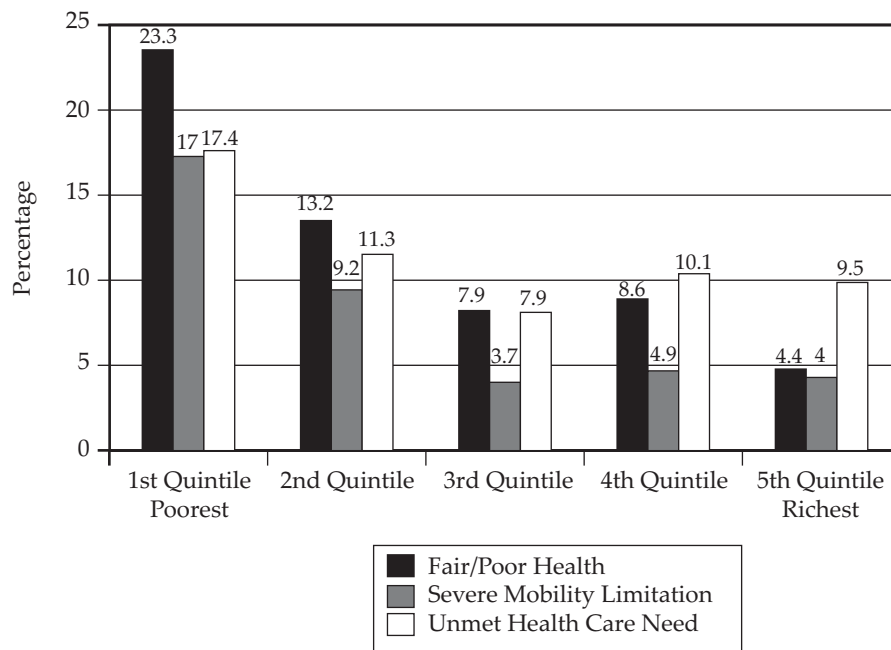
HEALTH CARE IN CANADA

Canada's health care system entitles all Canadians, regardless of income, status, or any other grouping to health care services. While close to 30% of all health care expenditures in Canada come from private sources, Canadians rightly view their nation as providing health care to people based on the basis of need, not wealth (Organisation for Economic Co-operation and Development, 2005). The key question to be asked is whether people living in poverty are having their health care needs met. Numerous studies have addressed this issue and some have particularly focused on the role that income plays in access to health care services. Also of importance is the nature of the interactions of people living in poverty with the health care sectors and the identification of means by which these interactions could be improved. Another important question is whether the quality of these interactions appears to be as negative as the ones with the social assistance sector that were reported by people living in poverty.

HEALTH STATUS AND USE OF THE HEALTH CARE SYSTEM

It would be expected that people of lower income—especially those living in poverty—would make greater use of the health care system. Living in poverty is associated with generally poorer health. And findings indicate that this is indeed the case. The Canada/United States

Figure 7.1: Percentage of Canadians Indicating Various Health Care Problems by Household Income Quintile, 2002/2003



Source: Adapted from *Joint Canada/United States Survey of Health, 2002–03* (pp. 26, 27, 32), by C. Sanmartin, E. Y. Ng, D. Blackwell, J. Gentlemen, M. Martinez, and C. Simile, 2004. Ottawa: Statistics Canada.

Survey of Health surveyed a representative sample of Canadians and provides insights into these health and health care issues (Sanmartin and Ng, 2004).

The 3,505 Canadians sampled in this study were divided, upon the basis of household income, into five quintiles. The participants were then asked to rate their health as either excellent, very good, good, fair, or poor. The participants also reported the presence of a severe mobility problem and any unmet health care needs. Figure 7.1 shows the percentage of respondents, by income quintile, providing a fair or poor response, a mobility restriction, and unmet health care needs. Findings are consistent with numerous other studies that show that income level is a strong predictor of reported health status. Canadians within the lowest income quintile reported the greatest likelihood of fair or poor health, of having a severe motor mobility, and of having an unmet health care need. This survey did not assess frequency and type of health services used, but other Canadian studies have addressed this issue.

Glazier and colleagues carried out an analysis of hospital use from 1990 to 1992 in Southeast Toronto and examined whether such use was related to income (Glazier, Badley, Gilbert, and Rothman, 2000). The researchers classified the 28 census tracts in this area into one of five

quintiles based on the median household income of the area. They then examined a number of indicators of hospital use. The percentage of households identified, by using Statistics Canada's Low Income cut-offs, as being of low income was 12% in the richest quintile, 19% in the second quintile, 23% in the middle quintile, 30% in the second-lowest quintile, and 50% in the lowest income quintile. Table 7.2 provides findings concerning differential hospital use and cost for those found in the five different income quintiles. Number of individuals admitted to hospital, actual number of total admissions, and health care costs were highest among those living in the lowest income quintile. These findings are consistent with a large number of findings from Canadian studies.

Roos and Mustard (1997) carried out a very extensive study of health care utilization among 600,000 residents of Winnipeg that assessed whether primary care and specialist services were equally likely to be accessed by Canadians of different incomes. Enumeration areas of approximately 700 people were classified, based on median income, into one of five income quintiles. Table 7.3 shows that income quintile was also related to a number of other indicators such as female-led households, unemployment rate, and educational level.

Table 7.3 also shows how a wide range of health indicators are related to income quintile. These indicators include age-standardized death rates, life expectancy, and death rates from specific diseases. For virtually every indicator, health is worse among the lowest-quintile population. Not surprisingly, the study also found that hospital use indicators (numbers of people hospitalized, number of discharges, and hospital days) was strongly related to income quintile with the rates highest for the lowest income areas. On average, the number of people hospitalized per 1000 residents was 102 in the poorest quintile, compared to 65 in the richest quintile. Similarly, the average number of days spent in hospital for the poorest quintile per 1000 residents was 937 days for the poorest quintile and 500 for the richest. But an important question is whether this clearly higher health need among lower-income

Table 7.2: Population-Based Age-Sex Adjusted Rates of Hospital Admissions, Bed Days, and Costs and Distribution by Income Quintile, Southeast Toronto, 1990–1992

Per 1,000 population	Overall Rates	Neighbourhoods as a Function of Households in Poverty				
		Q1: Richest	Q2	Q3	Q4	Q5: Poorest
Individuals Admitted	73.2	60.9	65.0	67.0	75.5	87.5
Admissions	111.6	88.1	96.1	100.9	118.4	136.6
Bed days	1023.3	814.4	817.3	918.0	1104.0	1293.0
Cost in \$	\$557	\$456	\$458	\$503	\$597	\$684

Source: From "The nature of increased hospital use in poor neighbourhoods: Findings from a Canadian inner city," by R. H. Glazier, E. Badley, J. E. Gilbert, and L. Rothman, 2000, *Canadian Journal of Public Health*, 91(4), pp. 268–273.

Table 7.3: Characteristics of Residents, Health Indicators, and Physician Contact Rates by Relative Affluence of Neighbourhood, Winnipeg, 1992

Measure	Q1 Poorest	Q2	Q3	Q4	Q5 ^d Richest	Ratio ^e
Resident Characteristics						
Mean household income (\$)	18,607	25,719	31,050	37,942	53,777	2.9
Female-headed household (%)	31	16	13	6	4	7.8
HS graduates aged 25–34 (%)	63	65	71	75	82	1.3
Unemployed aged 45–54 (%)	10	7	5	4	3	3.3
Treaty status Aboriginals (%)	7	2	1	0	0	3.3
Age-Standardized Death Rates						
Males	13.7	10.2	8.7	7.8	6.2*	2.2
Females	9.4	8.0	7.3	6.7	6.6*	1.4
Ages 0–74	6.7	4.5	3.9	3.1	2.7*	3.4
Life Expectancy^a						
Males	65.3	70.5	72.8	74.3	76.6	1.2
Females	74.4	77.8	79.5	80.0	82.1	1.1
Deaths by Type of Disease						
Chronic diseases ^b	4.0	3.1	2.9	2.5	2.3*	1.7
All cancers	2.9	2.3	2.2	1.9	1.8*	1.6
All injuries ^c	0.8	0.5	0.4	0.3	0.2*	4.0
Mean Visits per Resident to:						
All physicians	5.8	5.2	5.0	4.8	4.7*	1.2
General practitioner	4.2	3.6	3.4	3.3	3.0*	1.4
Specialist						
Referred	0.2	0.2	0.2	0.2	0.2	1.0
Unreferred	1.4	1.4	1.4	1.3	1.5	0.9
Percent with one or more annual contact with:						
Any physician	84.0	85.0	85.2	84.6	85.0	1.0
General practitioner	76.2	65.6	75.6	75.0	73.1	1.0
Specialist						
Referred	18.0	17.9	18.0	18.0	18.0	1.0
Unreferred	36.5	37.9	37.7	37.4	40.3	0.9

a Life Expectancy is based on five years of mortality data from 1989–1993.

b Chronic diseases: deaths from ischemic heart disease, diabetes, asthma, hypertension, vascular complications, and emphysema.

c All injuries: deaths from motor vehicles, falls, vehicular nontraffic, drowning, poisonings, fire and flames, and suicide.

d From chi square test of linear trends in rates across income groups, * p<.001.

e Ratio= Q1/Q5: Q1=Poorest; Q5=wealthiest

Source: Adapted from "Variation in Health Care Use by Socioeconomic Status in Winnipeg, Canada: Does the System Work Well? Yes and No," by N. P. Roos, and C. A. Mustard, 1997, *Milbank Quarterly*, 75(1), pp. 94, 95, 100.

people is translated into greater use of primary care and specialist services. If health care is provided on the basis of need, it would be expected that greater contact would be seen for lower-income people. As shown in Table 7.3, lower-income residents were more likely to see physicians, including general practitioners. But they were not more likely to see or be referred to specialists than those living in the wealthiest quintile of neighbourhoods.

These findings concerning seeing specialists have been replicated by others. Dunlop and colleagues looked at national data from the National Population Health survey (Dunlop, Coyte, and McIsaac, 2000). They found that need of health care—itsself related to income—was related to greater use of physician services. These services included both primary care and specialist care. However, when analyses looked specifically at income, it was found that while those in the lowest income quintile were more likely to access general practitioners, they were less likely than wealthier Canadians to have visited a specialist. These and other findings point to clear problems with universal access to specialist care among lower-income Canadians. The reasons for these findings have not been identified.

Finally, an extensive international study examined a very wide range of general and cost-related access and medical bill problems among Canadians classified as below-average, average, and above-average in income (Schoen and Doty, 2004). The findings were that 20% of Canadians with below-average income found it difficult to see a specialist as needed, while only 14% of Canadians with above-average income had this problem. Canadians with below-average income were also more likely to have to wait more than five days or more to see a doctor (27% of these Canadians) than above-average income Canadians (20% of these Canadians). There was a variety of other physician-related issues identified by the study. Especially important were differences for cost-related access problems between above-average and below-average income Canadians.

In analyses that controlled for a wide range of factors such as age, education, minority status and residential location, below-average-income Canadians were—as compared to above-average-income Canadians—50% less likely to see a specialist when needed, 50% more likely to find it difficult to get care on weekends or evenings, and 40% more likely to wait five days or more for an appointment with a physician. There were no reliable differences between average-income Canadians and above-average income Canadians on these measures.

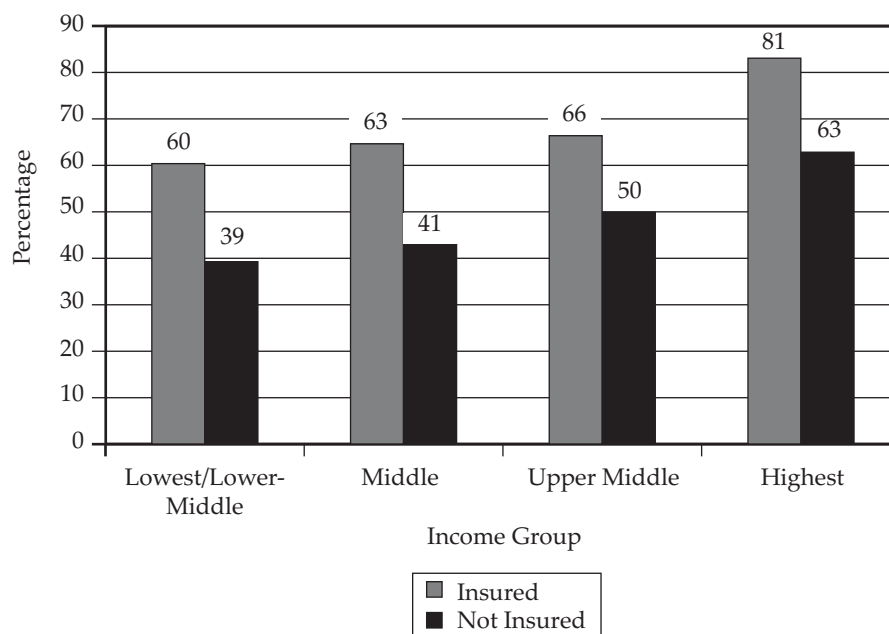
However, differences were seen for average-income Canadians as well as below-average Canadians for cost-related measures. Compared to above-average income Canadians, lower average-income Canadians were three times more likely to not fill a prescription due to cost, three times more likely to have a medical problem but not be able to see a doctor due to cost, and 60% more likely to not get a needed test or treatment. Even average-income Canadians were almost twice as likely to not get a prescription filled, and 60% more likely to not see a dentist when needed due to cost, compared to above-average-income Canadians. Average-income Canadians were also twice as likely to have problems paying medical bills than above-average income Canadians.

Additionally, below-average-income Canadians were four times more likely to report a dental problem but not see a dentist due to cost, and over four times more likely to have problems paying medical bills than above-average Canadians. On more specific measures of patient-doctor interaction, such as being treated with respect and dignity, having health

concerns taken seriously, having enough time with the physician, and receiving good information, there were no differences among Canadians with higher-than-average income, average income, and below-average income.

Studies that have looked at dental care find a strong relationship between income and use of dental services. Income is related to seeing a dentist. The lower one's income, the less likely they will have seen a dentist (Millar and Locker, 1999). This relationship holds for both those insured and not insured (see Figure 7.2), though Millar and Locker found that just about all low-income Canadians were not insured. They also found that the lowest-income quartile group of Canadians was more likely to have fillings and extractions than wealthier groups, but were less likely to come in for cleaning and insured check-ups.

Figure 7.2: Percentage of Canadian Population Aged 15 or Older Who Visited a Dentist, by Dental Insurance Status and Household Income, 1996/97



Source: From "Dental Insurance and Use of Dental Services," by W. Millar and D. Locker, 1999, *Health Reports (Stats Can)*, 11(1), p. 59.

Little detail is known about the actual lived experiences of people living in poverty with the health care system. As part of a larger ethnographic study of women living in poverty, Reid (2004) found about half of women reported interactions to be generally negative. Reid identified two key issues. The first was that these women did not have resources to access the "extras" that keep one well. Two such examples are:

- “I don’t have the income so I can’t take part in physiotherapy and do the exercises. Because I don’t have the money I can’t do all the things I would need to get myself in that healthy state of mind and every thing ... I feel I’m limited to the resources I can get to because of money.” (p. 139)
- “This month I had to go off my supplements because I had to pay for other things. So I’m feeling it ... the supplements are very expensive. They’re good quality and they’re what I need. But it was a choice this month to not feel very good.” (p. 140)

The other issue was that about half the women felt they were not being treated fairly by the health care system. As the following quotations highlight, they felt they were not treated as well as those with more financial resources.

- “Because we have no money, they don’t keep us long. They are like, ‘next’. But if you’re rich you have a private room then you can stay longer, the nurses treat you better, everybody treats you better.”
- “I went to Pearl Vision, and I said that I was on low-income disability, and what was the price range for my glasses, and he just pointed his finger over, and said ‘the welfare glasses are over there.’” (p. 141)

However, the primary concern of the women was not being able to afford aspects of health care that were not covered by the system. The reports of unsatisfactory interaction with health care providers are not consistent with the international study reported earlier (Schoen and Doty, 2004), but it should be noted that the Commonwealth study did not specifically identify the responses of people living in poverty.

CONCLUSIONS

Many people living in poverty are forced to interact with the social assistance system. The benefits they receive from this system are not at a level that allows for experiences consistent with what is expected to keep them living well and healthy within a developed nation like Canada. In addition, the social assistance system is frequently organized in such a way as to make receipt of assistance at best difficult, and at worse, degrading and humiliating. Additionally, governments have put forward the idea that people receiving social assistance are somehow undeserving of these benefits and of respect from others.

In contrast, interactions with the health care system seem to be relatively free of such problems. People living in poverty make greater use of the hospital system and are as likely to have access to primary care—with some exceptions—as people who are not living in poverty. They are, however, less likely to be referred to specialist care. The reasons for this have not been sufficiently investigated. In general, findings presented in this chapter indicated that social assistance is a process characterized by stigma, personal humiliation, and attitudes unworthy of a modern developed nation. In contrast, the organization and provision of services in the health care system are generally free of these issues. There are serious concerns, however, related to the ability of people living in poverty to access medicines, and additional required services. These problems appear to be especially relevant to issues of dental care.

CRITICAL THINKING QUESTIONS

1. What do you think are some of the effects of having so many working Canadians ineligible to receive employment insurance? Are you willing to support and pay into a system that will not be available for you if you need it?
2. Why do you think the benefits provided by the social assistance system are so meagre? Do you think that providing people with so little to live on motivates them to achieve employment, or makes their lives so difficult as to make gaining employment even more difficult?
3. Why do you think that people living in poverty are less likely to be seen by health care specialists? What could be done to improve this situation?
4. Why do you think that people on social assistance are looked down upon, while users of the health care system are not?
5. How does having fewer people eligible for employment insurance and receiving extremely low benefits affect the operation of the job market and the quality of jobs? What are the effects on job quality of having large numbers of people desperate to gain any source of income, however meagre?

RECOMMENDED READINGS

Matthews, D. (2004). *Review of employment assistance programs in Ontario Works and Ontario Disability Support Program*. Toronto: Ministry of Community and Social Services. Online at www.tinyurl.com/65y8q.

This report was prepared for Ontario's Minister of Community and Social Services upon election of the Liberal government. It presents a series of recommendations based on extensive consultations with service providers and users of social assistance across the province. It outlines a picture of an unresponsive system whose primary purpose is one of preventing people from receiving social assistance rather than supporting them in their period of difficulties.

Mosher, S. (2005). *Walking on eggshells: The experience of abused women with social assistance in Ontario*. Online at <http://tinyurl.com/2xhjb>.

This report was prepared for the Law Commission of Ontario and provides a very disturbing picture of the difficulties women who have been abused experience with the social assistance system in Ontario. In the words of women themselves, backed up by extensive legal and critical analyses, a picture emerges of women who, already having been abused once, are submitted to another round of institutional abuse as they attempt to receive social assistance.

Organisation for Economic Co-operation and Development (OECD). (1999). *The battle against exclusion: Social assistance in Canada and Switzerland*. Paris: OECD.

This is one of a series of extensive analyses of social assistance practices in developed nations. In this volume, Canada and Switzerland are the focus. Canada's approach

is seen as one of begrudging the provision of supports to people in need of social assistance. Benefits are very low, and numerous roadblocks to receiving benefits exist.

Schoen, C., Blendon, R., DesRoches, C. M., and Osborn, R. (2002). *Comparison of health care system views and experiences in five nations: Findings from the Commonwealth Fund 2001 International Health Policy Survey*. New York: Commonwealth Fund.

This report provides extensive analyses of citizens' views about their access to and satisfaction with their health care systems. It details how low-income people in Canada are unable to access health care services that entail any degree of costs. The findings are consistent with Canadian studies concerning the impact of poverty on the ability to access health care services.

Swanson, J. (2001). *Poor-bashing: The politics of exclusion*. Toronto: Between the Lines Press.

Jean Swanson has been a service provider and volunteer for decades with anti-poverty organizations in British Columbia and elsewhere. She wrote this book to document how Canadians living in poverty—and especially those receiving social assistance—are subjected to exclusion and vilification by elected officials of all political stripes, by the media, and, increasingly, by the public. Her analysis looks at which sectors of society benefit from bashing people living in poverty and outlines various means by which poor-bashing can be countered.

Wallace, B., Klein, S., and Reitsma-Street, M. (2006). *Denied assistance: Closing the door on welfare in BC*. Vancouver: Canadian Centre for Policy Alternatives. Online at <http://tinyurl.com/h8jzm>.

This report documents how the Campbell government in British Columbia has made the receipt of social assistance more and more difficult for people already living in very difficult situations. The barriers include unreasonable criteria for receipt of benefits, and lengthy waiting periods during which people have no means of support. The result has been a dramatic reduction of the number of people receiving benefits. This has occurred in tandem with increasing economic and social inequalities that are making the lives of people living in poverty even more precarious.

RELEVANT WEBSITES

Canadian Institute for Health Information (CIHI)—www.cihi.ca

The Canadian Institute for Health Information provides information about health status and the health care system in Canada. CIHI attempts to support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health

Canadian Social Research: Welfare Links—www.canadiansocialresearch.net/welfare.htm

This website has links to just about every aspect of social policy and welfare in Canada. Gilles Séguin established “Canadian Social Research Links, on my own time and on my own dime, so that I could share my collection of web links with colleagues in the

social research community, whether in government, the non-governmental sector or academia.”

Disabled Women’s Network Ontario (DAWN)—www.dawn.thot.net

DAWN Ontario is a feminist, cross-disability organization working towards access, equity, and full participation of Women with Disabilities. It is a very up-to-date website that has lots of information concerning poverty and activism.

National Council on Welfare (NCW) —www.ncwcnbes.net

The NCW website contains reports, fact sheets, and press releases that describe social assistance programs across the provinces and the gap between expectations and realities in the system. Over the years these reports have become increasingly critical of governmental approaches to social assistance. At the site you can sign up to receive printed copies of their reports as soon as they are released.

POVNET—<http://www.povnet.org>

PovNet is an internet site for advocates, people on welfare, and community groups and individuals involved in anti-poverty work. It provides up-to-date information about welfare and housing laws and resources in British Columbia and Canada. PovNet links to current anti-poverty issues and also provides links to other anti-poverty organizations and resources in Canada and internationally.

Statistics Canada Health Reports—www.statcan.ca/english/ads/82-003-XPE/

Health Reports is a peer-reviewed quarterly journal of accurate health data and superior analyses in one convenient source. Available in both print and PDF formats, each issue contains at least three articles detailing vital, current topics in health and healthcare. You may need to access this site through your university’s library.

GLOSSARY OF TERMS

Poor-bashing is a process by which people living in poverty are not only blamed for their own problems but are assumed to have any number of negative characteristics of sloth, dishonesty, and immorality. Poor-bashing is manifested in very low social assistance rates, severe restrictions and surveillance, and negative government and media coverage. Poor-bashing seems to increase as objective living conditions of the most vulnerable decline.

Social assistance or *welfare* is a program that provides benefits of last resort in Canada. To qualify for social assistance one must be almost destitute. Applications for social assistance are onerous and difficult, and treatment of people on social assistance tends to be harsh and punitive.

Specialist health care refers to health care provided by physicians not considered to be general practitioners. In most provinces access to specialist care occurs through the recommendation of the general practitioner or primary care physician. Specialists include dermatologists, cardiologists, neurologists, etc.

Surveillance is a term used to refer to institutions exerting undue control over receivers of assistance or benefits. In the case of recipients of social assistance, it can involve intrusive questioning, unannounced inspections of premises, and general intrusion into personal affairs.

Unmet health care needs are needs that are not met by the health care system. These can occur through lack of access to care covered under Canada's health care system because of doctor shortages, scheduling issues, or other barriers. It can also result when services are not covered under the system, which may include rehabilitation, medicines, or other de-listed services.

Welfare fraud occurs when receivers of social assistance are not entitled to benefits and are aware of this. In recent years welfare fraud has been blown up into an issue out of proportion to its actual incidence. In addition, many argue that to survive on the benefits that are provided, accepting benefits that one may not be entitled to is not fraud, but actually a survival technique.

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