Submission to the House of Commons Standing Committee on the Status of Women

May 16, 2017

Submission of the Canadian Women's Health Network (CWHN)

Income Security of Women in Canada

What is the Canadian Women's Health Network?

For over 25 years the CWHN has been a leading independent national voice for women's health in Canada. We believe that health is a human right often denied to women, because of poverty and geography, ethnicity, language or cultural barriers, age, government policies that restrict services and the increasing privatization of services that put them out of reach for many women. We believe that the effects of poverty on women can be most clearly discerned by looking at the outcomes on health.

Women lag behind men on most indicators of social and economic status. They constitute a larger proportion of the poor in all societies. While poverty affects the health of both men and women, the impacts on women are broad in scope and particularly influenced by sex and gender.

Among women as a whole there are specific groups that have higher rates of poverty and are therefore more susceptible to impacts on their health. These groups include First Nations women living off reserve, visible minority women, disabled and older women and women who are single parents. 22% of food bank users in Canada are single heads of families and most of these are women. Where women are impoverished so are their children.

CWHN supports any policy, program or funding approach that improves the income security of impoverished women and their children. However, in order to address women's poverty effectively, we want to stress the importance of taking a comprehensive policy and program approach to reducing women's poverty which takes into account all social determinants and the consequences of poverty on health.

I am addressing three questions today.

1. What is the impact of poverty on women's health?
2. Can poverty be addressed primarily through economic or income support measures?
3. What is necessary to address the poverty of Canadian women?

What is the impact of poverty on women's health?

Poverty affects women's health in three main ways:

1. It creates conditions that have direct health consequences for women
2. It restricts access and opportunities to women that can protect health or lead to health improvements
3. It leads to social disengagement and disempowerment which can expose women to harm, including addictions, abuse and violence.

Poverty creates conditions that have direct health consequences for women.

a. Women who are poor are more susceptible to chronic diseases and infections, including TB
b. Poverty frequently results in homelessness or women living in substandard or precarious housing. This exposes them to a lack of clean water and sanitation, exposure to lead, mold and vermin, poor heating in winter, lack of ventilation and overcrowding.
c. Poverty is associated with shortened life expectancy.
d. Poverty is associated with higher rates of HIV/AIDs in women.
e. Poverty exacerbates food insecurity. Food insecurity can expose women and their children to malnutrition and is associated with cardiac risk factors. The growing problem of food insecurity as reflected in the use of foodbanks is associated with maternal anxiety and depression.
f. Obesity caused by poverty and dietary limitations exposes women to a higher risk of diabetes and arthritis, both chronic conditions that have cumulative effects on women's lives.
g. Low income women are much more at risk of developing chronic and multiple chronic conditions.
h. Poverty is also associated with a higher rate of heart disease among women. This is related to other risk factors such as poor diet and smoking.
i. Relative and absolute poverty are associated with depression among women. Among poor women aged 45-64 in the lowest income category only 55% described their mental health as good or excellent; this contrasts with 81% of women who described their health as positive in the high income category. Women comprise 2/3 with diagnosed mood disorders and are prescribed 2/3 of psychiatric drugs, many of which have debilitating adverse effects.

One of the features of the impact of poverty on women's health is the cumulative or "cascading" nature of effects and the importance of looking at this issue from a multi-sectorial point of view.

A women who is impoverished and has children will likely live in substandard housing and have an inadequate budget or access to food. Poverty will affect her autonomy and access to resources. Stress may contribute to smoking which increases the risks of heart disease and cancer. Poor diet may contribute to obesity. These factors may lead to chronic diseases such as diabetes and arthritis. The development of multiple chronic conditions leads to increased depression and lower income and autonomy.

Poverty restricts access and opportunities to women that could protect or maximize health or lead to health improvements and contributes to social disengagement and lack of autonomy.

a. Poverty results in an inability of women to select and exercise the range of resources necessary to support health for themselves and their children. Poor women may not be able to move to a safer environment or find more stable employment.
b. Poor women may not have access to services in their community that support health and well-being. This includes access to therapy or physiotherapy
c. Poor women are less likely to access preventative care even if it falls within paid health care services. This includes prenatal care or routine cervical screening.
d. Poverty leads to social isolation and disempowerment which can expose women to harm such as addictions and violence.

2. **Can women's poverty be addressed primarily by economic measures?**

The health impacts of poverty cannot be addressed by income measures alone. A major contributor to the growing feminization of poverty has been due to government policies related to austerity, destructuralization and privatization. To address poverty we need to take into account the contribution of social determinants on poverty and the outcomes of poverty on health.

For example, the impact of the downsizing of government programs and services and the growing casualization of the workforce has led to the loss of fulltime work and its replacement with contract or shift work with no income security or benefits. The downsizing of services in the public sector have had a disproportionate effect on women who comprise most of the workers in the health and education sectors. These issues must be addressed by employment and labor as well as income policies.

Gaps in government policies and programs has meant that more and more of the care of the sick has fallen onto women. Women have become unpaid unscripted health care workers and are meant to absorb the personal, financial, emotional and other costs of caregiving. There is evidence that women who are heavily involved in caregiving suffer detrimental health effects that accumulate as they age. To address the care gap requires improved policies related to homecare and respite access and as well as income replacement support for caregivers.

3. Recommendations

We applaud of the work of this committee in bringing forward discussion on the economic security of women in Canada. As this work continues, we hope the following will be kept in mind.

a. The effects of poverty on health are myriad, interconnected, and cumulative and restrict women's options and autonomy.
b. Poverty affects groups of women differently. Any analysis should include an understanding of the unique aspects of poverty on the groups described above.
c. To address poverty effectively requires government will, policies, funding and programs that take into account and address the key social determinants of poverty among women such as access to safe and affordable housing and the right to food security and women's role in caregiving.
d. The medical model to treat depression needs to be reconsidered and replaced with a greater understanding of how poverty and powerlessness affect the mental health of women.
e. In 2013, CWHN, along with all the other regionally located Centres of Excellence on Women's Health, lost their core funding which had been provided by Health Canada for 20 years. Health Canada has confirmed that the Ministry has no intention of reconstituting a women's health division nor will it re-establish its community grants program which enabled community-based women's groups such as ours to represent and address the needs of women.

Health Canada must be engaged in addressing the social determinants of poverty that impact on women's health. We strongly urge parliamentarians who are concerned about income security for Canadian women to encourage Health Canada to rethink these decisions so that it can be an active partner in addressing the health impacts of poverty on Canadian women.

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