The financial crisis and health equity in ontario: key pathways and policy challe...

Economics, Tax

The Financial Crisis and Health Equity in Ontario: Key Pathways and Policy Challenges Arne Ruckert Abstract This working paper explores the impacts of the financial crisis on health equity in Ontario. It proposes a research framework and identifies key pathways by which the financial crisis has begun to impact the social determinants of health. In doing so, it attempts to contribute to a better understanding of the various ways in which global forces are shaping SDH in Ontario in the aftermath of the financial crisis. The paper first reviews the existing literature on globalization and SDH. It then discusses the impact of the financial crisis on SDH in Ontario and identifies causal pathways that link the financial crisis to SDH, especially changes in employment conditions and budgetary challenges in the realm of fiscal policy. It next assesses empirically the development of the most equity-relevant SDH since the beginning of the financial crisis in Ontario, demonstrating that a number of new health equity challenges are currently emerging as the social fabric of Ontario is being strongly undermined. It next reviews the on-going policy response of the Ontario government to the financial crisis, discussing its possible health-equity implications. It concludes by suggesting that the financial crisis and the policy response to it will largely determine the extent to which SDH will either improve or deteriorate in Ontario in the near future, with important implications for health equity. It finally raises a range of issues and questions that require further research and conceptual clarification. Acknowledgements: This research was made possible through the Emerging Researcher Award provided by the Population Health Improvement Research Network (PHIRN), with funding from the Ontario Ministry of Health and Long-term Care. Introduction Health equity

has recently become a central concern in health research, as the tenacity of health disparities in countries around the world has been identified as one of the most serious public health threats of the 21st century (Edwards & Di Ruggiero, 2011). Health inequities prevent people from achieving their full potential and living healthy and productive lives. As the WHO Commission on Social Determinants of Health (CSDH) recently put it: “ Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death" (CSDH, 2008, p. iii). In Canada, health equity concerns have started to receive attention from policy-makers at both the federal and provincial level, and a wide-ranging interdisciplinary field of health equity research has been established (for a scoping review of population health research in Ontario, see PHIRN, 2011). Health equity was initially introduced at the federal level of politics in Canada, for example, in the first annual report of Canada’s Chief Public Health Officer (Government of Canada, 2008), which targeted health inequities and noted the importance of policy intervention in improving health outcomes. However, health equity concerns have recently found entry into provincial health discussions, with the Government of Ontario recognizing in its Poverty Reduction Strategy social inequalities as important to health outcomes (Government of Ontario, 2008). Health equity is defined by the WHO as the absence of systematic differences in health, between and within countries that are avoidable by reasonable action (CSDH, 2008, p. 1). Similarly, in a widely cited paper on The Concepts and Principles of Equity, Whitehead defines health inequities as differences in health that are unnecessary, avoidable, unfair and unjust (1992). A more operational

definition of health equity was provided in 2003 by Braveman and Gruskin, which suggest that for the purpose of measurement, “ health equity can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups which have different levels of underlying social advantage/disadvantage - that is different positions in the social hierarchy (Braveman and Gruskin, 2003, p. 254). An important element of Braveman and Gruskis discussion concerns the way in which social determinants are connected to health inequities, by noting that the causes of health inequity can be multifaceted and complex, rather than proximate and immediate (2003, p. 256). This is particularly pertinent for an understanding of how global forces, such as the global financial crisis, are affecting health equity domestically. In fact, the field of health equity starts from the assumption that many of the differences in health outcomes between different segments of the population are directly traceable to inequalities in the underlying social and economic conditions that are essential for health. The Social Determinants of Health (SDH) refer to these underlying social factors. Health equity research is concerned with the unequal distribution of SDH, and aims to identify policy interventions to mitigate such inequalities (Raphael, 2006). Thus, while health equity is ultimately a normative concept based on a subjective assessment of how much disparity in health is desirable, growing social inequality directly undermines health equity through a deterioration of SDH. There is a rapidly growing body of literature on the SDH that surfaced in the 1990s and has recently gained momentum with the establishment of the CSDH (for a good overview, see Raphael, 2011; and Navarro, 2009). As part of this literature, a

small branch is focusing on the global factors and forces that are shaping SDH domestically and locally (e. g. Labonté & Schrecker, 2007a, 2007b, and 2007c; Labonté & Torgerson, 2005; Edwards & Di Ruggiero, 2011). However, this literature has remained relatively generalized and abstract, and little attention has been paid to the impacts of global factors on SDH in the Canadian context, in general, or in Ontario, in particular. The various ways in which globalization processes directly and indirectly impact health equity outcomes in Ontario, and the appropriate policy responses to globalization's impact on health outcomes have thus remained understudied. This is surprising given the leadership role of Canadian institutions and researchers in contributing to the knowledge base surrounding questions of globalization and health equity. What is more, recent global developments, in particular the on-going global financial crisis and the concomitant austerity drive that it unleashed, present a whole new set of challenges for understanding the multiple links between globalization and health equity that remain unaddressed in the academic literature. This discussion paper attempts to contribute to a better understanding of the various ways in which global forces are shaping SDH in Ontario, with a special reference to the on-going global financial crisis. It starts from the assumption that globalization processes have wide-ranging impacts on health outcomes through a number of key pathways, and draws extensively on conceptual precepts developed by Labonté and Schrecker (2007a; 2007b; and 2007c). The paper unravels as follows: it first interrogates the relationship between globalization and SDH, and reviews the existing literature on globalization and SDH. It then discusses the impact of the financial crisis on SDH in Ontario and identifies

causal pathways that link the financial crisis to SDH, especially changes in employment conditions and fiscal policy. It next assesses empirically what has happened to some of the most equity-relevant SDH since the beginning of the financial crisis in Ontario, demonstrating that a number of new challenges are emerging as the social fabric of Ontario is being strongly undermined. It concludes by suggesting that the financial crisis and the policy response to it will largely determine the extent to which SDH will either improve or deteriorate in Ontario in the near future, with important implications for health equity. Finally, the paper raises a range of issues and questions that require further research and conceptual clarification. Globalization, Global Factors and SDH in Ontario Although globalization is not a new phenomenon, interest in its potential health impacts is relatively recent (Labonté & Torgerson, 2005). This is arguably linked to the difficulty of directly relating global developments to local health outcomes, on the one hand, and the methodological predispositions of health researchers, on the other. However, a number of recent academic contributions have attempted to provide a conceptual frame for understanding the multiple links between globalization, health equity, and health outcomes. The most comprehensive attempt is provided by Labonté and Schrecker (2007a; 2007b; and 2007c) who propose seven clusters of pathways that link various aspects of globalization with SDH and health equity: trade liberalization, reorganization of labour markets, debt crises, financial liberalization, restructuring of cities, environmental impacts of globalization, and marketization of health systems (Labonté & Schrecker, 2007b). However, not all of the clusters indentified by Labonté and Schrecker are necessarily relevant for understanding the

impacts of the financial crisis on SDH in Ontario. In fact, the following discussion will focus on what have become the two the most relevant pathways: labour market restructuring and financial liberalization, as these are considered to be the most impactful in the aftermath of the global financial crisis. Globalization of Labour Markets: The Financial Crisis and Precarious Employment The globalization of labor markets has led to a restructuring of the composition of the work force and noticeably transformed working conditions, with deep implications for SDH. Neoliberalism can be defined as a political project that proposes that human well-being can best be achieved by liberating entrepreneurial freedoms and skills within an institutional framework of strong property rights, free markets, and free trade (Harvey, 2005, p. 2). Consequences of three decades of neoliberal policy include the widening of social disparities, the concentration of income and wealth among a few at the top of the social hierarchy, and state retrenchment in the provision of social services, including quality health care. The reorganization of global production, and with it the emergence of various forms of precarious employment, have been singled out as a key global force shaping the SDH in jurisdictions all around the globe (Labonté & Schrecker, 2007b). This development is facilitated by trade liberalization and the associated transnationalization of the production process, with global value chains emerging that reorganize and fragment global production across multiple national borders (Dicken, 2003). In Canada, increased ‘ flexibility’ in the labour market has been a corner stone of this process, which has lastingly transformed the landscape for workers across Canada (Vosko, 2006). In this context, flexibility can best be defined as “

reducing the constraints on the movement of workers into and out of jobs previously constrained by labour laws, union agreements, training systems, or labour markets that protect workers income and job security" (Hadden, Muntaner, Benach, Gimeno & Benavides, 2007, p. 6). This flexibilization resulted in an increase in diverse contractual forms such as temporary, part-time, and self-employed workers. Flexibility in the labour force has also been reflected in varying schedules, multiple job holdings, and wage depreciation. Previously, standard arrangements generally provided social benefits, security, modest income, and various other entitlements. However, the standard employment relationship is shifting, so that employers are reducing their ‘ commitments’ and entitlements offered to their workers. The responsibility and costs for benefits such as training, extended health care, and pensions are being shifted away from employers to workers, creating new burdens for them and their families, and undermining SDH in the process. What is more, economic recessions tend to exacerbate the deviation from the standard employment relationship (Vosko, 2006), as will be discussed in more detail for the case of Ontario below. Therefore, the financial crisis has the potential to further undermine the working conditions of Canadians, and in doing so, will negatively impact the basis upon which good health for many Canadians is based: a secure job that offers adequate pay, and health and pension benefits. While the literature on the relationship between employment, SDH, and health outcomes is still in its infancy, there are some important findings that have recently emerged. The WHO’s CSDH suggests that employment and working conditions are the origin of many social determinants of health, as work in its optimal form can provide

financial security, social status, self esteem, personal development, and many other health promoting attributes (CSDH, 2008, p. 72). Being unemployed is directly associated with various adverse health outcomes, and the link between unemployment, psycho-social stress and poor health is quite straight-forward. In the published literature, unemployment has been associated with increased self harm and suicide and decreased mental health status (Moser, Fox, and Jones, 1986; Blakely, Collings, and Atkinson, 2003). It is important to note that these findings have been contested in the business cycle and health literature in the field of health economics, with Ruhm (2005) suggesting that mortality decreases when the economy temporarily deteriorates. However, in this literature psychological and long-term effects of unemployment remain unaccounted for, which arguably distorts the findings, as Ruhm acknowledges himself (2005, p. 343). Workers in precarious arrangements often share similar characteristics with the unemployed, with some evidence suggesting that chronic job insecurity may be more damaging than actual job loss. In fact, dimensions which are typically, but not exclusively, related to precarious work arrangements, such as job insecurity, have long been linked to adverse health outcomes such as psychosocial morbidity (Virtanen, Kivimaki, Joensuu et al., 2005; Ferrie, Shipley, Stansfeld, and Marmot, 2002). Studies suggest that workers that are involuntarily involved in temporary work contracts are at an increased risk for mortality (Natti, Kinnunen, Makikangas, and Mauno, 2009). Using cross-sectional data from a Canadian based questionnaire, Lewchuck, Clark, and De Wolff point out that insecure employment relationships (where future employment is unknown) are associated with poorer health indicators

(2008). More importantly, Lewchuck, Clark, and De Wolff’s findings point to a “ complex association between less permanent employment and health, where it is the characteristics of the employment relationship as much as having or not having permanent employment that are associated with different health outcomes" (2008, p. 388). This implies that changes in the employment form might be as important as changes to levels of unemployment in understanding challenges to health equity. Canada has done comparatively well at cushioning the unemployment rate during the most recent economic recession, through its Economic Action Plan. However, simply maintaining a relatively low unemployment rate during a recession can be misleading when accounting for the impact of the financial crisis on health. A deeper examination of the rise of precariousness in the labour force can offer a rather different picture, due to the negative effects of the further flexibilization of the labour marked associated with the financial crisis, as discussed in more detail below. Before turning to the impact of the financial crisis on Ontario’s labor market, the paper next discusses how financial liberalization has reduced policy space in Ontario, with strong implications for health equity. Globalization of Finance: The Financial Crisis and Fiscal Austerity The globalization of finance has been widely identified as one of the key pillars of neoliberal globalization, with strong implications for health equity and SDH (Labonté and Schrecker, 2007b, p. 7). Financial liberalization refers to the global integration of financial markets and predominantly consists of the deregulation of the foreign sector capital account, the domestic financial sector, and the stock market. A fully liberalized domestic financial system is characterized by lack of controls on

lending and borrowing interest rates, a lack of credit controls, i. e. no subsidies to certain sectors or certain credit allocations, and the free flows of financial resources across national borders (Arestis, 2004). A central element of the liberalization of the financial system since the early 2000s has been the self-regulation of banking entities, with risk assessments performed internally through models developed and controlled by banks themselves. The liberation of financial capital from the regulatory constraints of the nation state have ushered in a new era of market discipline, the main reason for why Stephen Gill has called this era one of disciplinary neoliberalism (Gill, 1995). Disciplinary neoliberalism refers to the heightened power of capital to discipline both the state and labour in liberalized and market-oriented economies. This is linked to the increasingly free flow of capital and the power associated with the “ exit option" for capital (Bakker & Gill, 2006, p. 43), on the one hand, and the ability of transnational institutions and agreements to discipline political actors, by removing decisions from the purview of domestic deliberative processes and enshrining the rights of capital through ‘ neoliberal constitutions’, on the other hand (Gill, 1995). The notion of disciplinary neoliberalism is useful for conveying the disciplinary power of capital and the associated loss of policy space, with policy space being defined as the freedom, scope, and mechanisms that governments have to choose, design, and implement public policies to fulfill their aims (Koivusalo, Schrecker and Labonté, 2009). Loss of policy space is related to the ways in which investor decisions can influence the policy making process, given that under globally integrated financial markets, governments require the confidence of large international institutional investors to fund

their operations through sovereign debt markets. In the realm of health this implies that even governments committed to improving access to better and more equitable health care are reluctant to risk the effects of displeasing financial markets. Governments may also be reluctant to implement policies that might be viewed negatively by sources of foreign direct investment (Labonté, Schrecker, Packer and Runnels, 2009, p. 118). The extent to which financial markets can influence decision-making is, however, not universal and depends on the economic position of a country in the global marketplace. Notwithstanding, even powerful developed economies, such as Canada, are in their decision-making process subject to financial market forces that through their investment allocation decisions directly impact fiscal policy. In fact, the loss of policy space is arguably increasing in the aftermath of the financial crisis, as political actors seem to be responding directly to the dictates of financial markets, irrespective of their position in the international system. For example, rising bond rates in Europe are currently demonstrating the unwillingness of financial market actors to accept higher budget deficits and to address the slow-down in the global economy through further stimulus measures. This demonstrates that even powerful and developed economies are subject to financial market pressure. At the same time, financial markets, in concert with powerful international organizations, such as the International Monetary Fund, are driving political actors to reduce welfare spending, with direct negative consequences for health equity, given the importance of social expenditure for health equity (Stuckler, Basu, and McKee, 2011). The deep impacts of the global financial crisis on health equity are already present in some European countries, and

a range of studies have started to report the health implications of the financial crisis as they percolate down to the level of health policy making through a number of avenues. First, studies confirm that financial crises produce far more significant declines in overall economic activity than ‘ normal’ recessions (Reinhart & Rogoff, 2009), and thus constrain the government’s ability to maintain social, and in particular, health care spending. In fact, the IMF recently estimated that after a financially induced recession, output is about 10 per cent below its previous trend in the medium term, which it defines as 7 years (Gill & Bakker, 2011). Second, the general decline in economic activity linked to the financial crisis leads to cut-backs in government spending, as the crisis response thus far has focused on spending cuts and tax increases, mostly by way of socially regressive taxes (such as the VAT), both of which have the potential to further undermine SDH. What is more, lack of economic dynamism translates into job losses and heightened levels of unemployment. The International Labour Organization (ILO) has recently noted in its Global Employment Trends report that unemployment has reached unprecedented proportions, with more than 200 million workers globally entering the reserve army of unemployed workers, putting global unemployment on the highest level on record (ILO, 2011). In addition, previous experiences with economic recessions suggest that the negative distribution of health impacts is likely to be concentrated amongst those who are already socioeconomically deprived, and in ethnic minority groups (Blakely & McLeod, 2009). The financial crisis is arguably the most potent pathway by which globalization is currently impacting health equity outcomes, and it is imperative to study in more detail the articulation

of the financial crisis with health outcomes in local and regional contexts. The next section will assess in more detail how globalization processes, especially through the on-going financial crisis, have recently impacted SDH in Ontario. The Financial Crisis, Fiscal Austerity and SDH in Ontario It is commonly accepted that Canada has not been affected by the financial crisis to the same extent as other developed economies, especially the United States. The official story of Canada's recovery suggests that Canada has largely avoided the negative social consequences of the global market collapse, with the federal government noting that levels of employment have almost reached the level that existed before the financial crisis. The Canadian fiscal house is also in better shape than that of most other OECD countries, with deficits running at a lower percentage of GDP than in most other OECD countries. At the same time, there is universal acceptance that in light of the fiscal pressures related to the financial crisis, especially at the provincial level, deep austerity measures will be necessary to return to balanced budgets in the near future. To this end, Ontario is currently engaged in a major review of its Social Assistance programs, which will make recommendations by early 2012 (Commission for the Review of Social Assistance in Ontario, 2011). In Canada, the Harper administration has already hinted at the need to adjust health transfer payments to the provinces downwards when they are up for renegotiation in 2012-2013, and the growth rate in health transfers is likely to be reduced from the current 7 per cent to 3 per cent. Healthcare spending in Ontario has long been growing faster than the rate of economic growth. In the decade leading up to the financial crisis, health care spending has been increasing by more than 7 per

cent annually, and now makes up almost 50 per cent of government program spending in Ontario (Drummond, 2011). This implies that in order to return to a balanced budget, Ontario will likely have to find savings in the health care system. Drummond predicts that given the reluctance to rely on tax increases and the 40 to 50 per cent weight of health care in total program spending, Canadian provinces will not likely hit their deficit targets if health spending increases by more than 3 to 4 percent per annum over the next several years (Drummond 2011, p. 10). This resonates with a recent high level WHO consultation paper on the financial crisis which has noted that the financial crisis will likely exert a downward pressure on total health spending worldwide (WHO, 2009). In this context, it is important to highlight that research suggests that adverse health impacts related to government cutbacks will most directly affect vulnerable population groups, such as immigrants, the elderly and aboriginal people (Banoob, 2009; Phua, 2011), and others relying extensively on government services, and thus undermine efforts to improve equitable access to health care. However, cutbacks in health care spending are only one pathway by which the financial crisis will impact health outcomes. As the Senate Subcommittee on Population Health has recently pointed out, the healthcare system accounts for only about 25 percent of population health outcomes (Keon, 2009). Risks of chronic diseases are highly associated with life stage and exposure to health risks, while half of the variation in risks can be explained by socioeconomic factors such as education and income (Drummond, 2011). This is why it is imperative to assess the impact of the financial crisis on the wider social and economic environment which indirectly determines the health of population

groups. Since employment is widely assumed to be one of the most important of the social determinants of health, the discussion will now turn to the impact of the financial crisis on the labour market. Labour Market Transformation in the Aftermath of the Financial Crisis It is widely acknowledged that the financial crisis that first unravelled in the United States in 2008 and rapidly spread all over the world led to a steep economic recession in Canada, which in turn created a strong shock to the labour market, leading to a rise in the level of unemployment (CLC, 2010). In Canada, the Ontario labour market was hit particularly hard due to the export dependence of its manufacturing sector. However, as noted previously, the official story about the impact of the financial crisis on the labour market has focused on the success of the federal government's Economic Action Plan to quickly bring unemployment levels in Canada back down to almost pre-recession levels. When the Canadian economy plunged into a deep recession in October 2008, the national unemployment rate hovered around 6. 2 per cent. The recession bottomed out in the summer months of 2009 when the national unemployment rate peaked at 8. 7 per cent (Statistics Canada, 2011). In the beginning of 2011 the federal government proudly announced that the total absolute number of employed Canadians had returned to the pre-recession level. Yet, the employment rate in February 2011 – the proportion of the working-age population with some kind of job – was 61. 8%, down from 63. 5% two years earlier (CLC, 2011). This implies that some people have stopped looking for work altogether and consequently dropped out of the unemployment statistic entirely. As of October 2011, the national unemployment rate had fallen back to 7. 3 per

cent. In Ontario, the unemployment rate is amongst the highest in Canada, currently hovering at around 8 per cent, representing a significant increase from the beginning of the recession in 2008 when unemployment was around 6. 7 per cent. However, a significant rise in unemployment is by no means the only way in which the financial crisis has undermined SDH in Ontario. The arguably more important transformation of the labour market from secure and well-paid towards flexible and poorly paid jobs has been accelerating since the onset of the financial crisis and was further intensified by the subsequent Great Recession. Yet, this transformation is rarely discussed in terms of the health consequences that it implies. In a recent report on the impacts of the financial crisis on labour markets, the Canadian Labour Congress notes that " while the total number of employed Canadians has returned to pre-recession levels, the jobs that have been created in the recovery have tended to be more insecure than the jobs which were lost in the recession" (CLC, 2011, p. 4). In particular, more workers are employed part-time, and more workers are self-employed than before the recession hit. Temporary work has increased from 10. 8 per cent in February 2008 to 12. 2 per cent by February 2011. While part-time and temporary jobs might work well in certain individual circumstances, it is clear from Statistics Canada`s Labour Force Survey that a large share of part-time workers are working part-time involuntarily as they cannot find full employment (CLC, 2011). This is particularly concerning from a health perspective, as studies show that workers under conditions of unemployment uncertainty, such as temporary work or involuntary part-time work, tend to struggle with a range of health issues (Lewchuck, Clarke, and De Wolff, 2011). As Figure 1 below indicates,

the trend towards part-time employment is not entirely new but rather has been intensifying since the beginning of the neoliberal era in the late 1970s. However, during each of the three recessions that Canada experienced since the 1970s, the percentage of workers in Canada having to resort to part-time employment increased, and then stayed at an elevated level, not dropping back to pre-recession levels. Figure 1. Part-Time Employment and Unemployment Rate in Canada Source: Statistics Canada, No date. Table 282-0008. Labour Force Survey Estimates (LFS), Annually (table). CANSIM (database). Using E-Stat (distributor). Last updated June 8th, 2011. http://estat. statcan. ca/cgi-win/cnsmcgi. pgm? regtkt=&C2Sub=&ARRAYID= 2820008&C2DB= EST&VEC=&LANG= E&SrchVer= 2&ChunkSize= 50&SDDSLOC=&ROOTDIR= ESTAT/&RESULTTEMPLATE= ESTAT/CII_PICK&ARRAY_PICK= 1&SDDSID=&SDDSDESC= Another health concern related to the transformation of the job market in the aftermath of the financial crisis is that well-paying manufacturing jobs are increasingly replaced with poorly paid service sector jobs. This development has been particularly pronounced in Ontario, as the manufacturing sector was hit by the rise in the value of the Canadian dollar. Statistics Canada reported in 2010 that employment levels in Ontario had fallen by 232, 000 since October 2008, and that over half of these job losses were in the manufacturing sector. This trend towards replacing well-paying with low-paying jobs is a Canada-wide phenomenon as recently noted by Benjamin Tal, chief economist for CIBC World Markets: “ The composition of the labour market is changing in a way that doesn’t support wages. We see more people working in lower paying jobs and less people in high paying jobs" (The Globe and

Mail, 01. 12. 2012, “ More Canadians in low-paying jobs"). This trend has also been confirmed by a study conducted by the Resolution Foundation, which shows that Canada had the weakest median wage growth of all OECD countries since the beginning of the Great Recession in 2008 (Resolution Foundation, 2011). What is more, these pressures on wages are likely to continue given the structural changes of the labour market away from manufacturing and towards service sector jobs. At the same time, service sector, part-time, and temporary jobs often do not provide the same health benefits that are attached to manufacturing jobs, especially drug insurance, and thus further undermine health equity goals. The Financial Crisis and the Changing Ontario SDH Scene The next section will focus on some of the key SDH-related developments, especially income inequality, the incidence of poverty, food security, and housing affordability to provide a preliminary assessment of how the financial crisis has already impacted the SDH scene in Ontario. It is important to note that many of the data on socio-economic and SDH trends are not yet fully available, hence the picture that will be emerging is somewhat tentative, and will be improved as new data (especially for 2010) becomes available . The paper will then discuss the various ways in which the Ontario government has responded to these challenges. This will, again, represent a preliminary discussion as a major review of social assistance programs in Ontario is currently under way and key recommendations will not be available until mid 2012. However, some recent changes to social assistance programs will nevertheless be discussed, such as the scrapping of the Ontario Diet Allowance which has been strongly deplored by poverty and health activists. Adequate income is a central

aspect of a healthy society and has been identified by various sources as a key determinant of health (Bryant, Raphael, Schrecker, and LabontÃ¨, 2011; CSDH, 2008; Marmot, 2002). The relationship between socioeconomic status, income, and health outcomes is one of the most persistent themes in the social epidemiological literature. The strong and growing evidence that higher social and economic status, and small gaps in income equality are associated with better health has led most researchers to conclude that these factors are fundamental determinants of health (Scott, 2002). For example, Marmot finds two causal pathways through which income is related to health: through a direct effect on the material conditions necessary for biological survival, and through an effect on social participation and opportunity to control life circumstances. Marmot also notes that the fewer goods and services are provided publicly by the community, the more important individual income becomes for health (Marmort, 2002). What is more, adequate income is directly linked to the fair distribution of income in society, and growing income inequality tends to undermine SDH. As is well documented, in Canada income inequality has been increasing since the emergence of the neoliberal paradigm in the late 1970s, but has been gaining significant speed since the late 1990s. In the past 20 years, according to the Conference Board of Canada, income inequality in Canada has increased steeply. During that period, only the top 20 per cent of income earners increased their share of national income, with the “ super rich, " or the top 1 per cent, doing best of all. The Conference Board`s data on income show that earnings increased by 16. 4 per cent for those in the top income group, earnings stagnated for those in the middle income group, and

earnings fell by 20. 6 per cent for those in the bottom group (Conference Board of Canada, 2011). Similarly, the recent OECD report Divided We Stand: Why Inequality Keeps Rising finds that income inequality in Canada has been rising rapidly since the mid 1990s, at the fastest pace in the whole OECD world, driven largely by a widening disparity in labour earnings between high- and low-paid workers and by a declining level of wealth redistribution. Taxes and benefits now reduce inequality in Canada less than in most other OECD countries, with the exception of the US and Mexico (OECD, 2011). The Canadian tax-benefit system has been severely undermined since the mid-1990s, when the tax-benefit system was offsetting roughly 70 per cent of the rise in market income inequality; this has been reduced to a worrying 40 per cent by the late 2000s, with wealthy Canadians paying less tax than they did in the past. For example, during the post-war economic boom years in the 1940s, the top marginal tax rate was 80 per cent on incomes over $250, 000, or $2. 37 million in today’s dollars. The top rate in 2009, averaged across Canada to account for different provincial rates of taxation, was 42. 9 per cent for incomes above $126, 264. The last time wealthy Canadians faced a tax burden this light was in the roaring 1920s. The income tax system has also become less progressive over time. Today the top federal income tax bracket of 29 per cent kicks in at $128, 800. There are no further brackets for higher earners and only four tax brackets overall. According to the OECD, the move towards lower paid ‘ self-employment’ in Canada explains 25 per cent of the increase in income inequality. The OECD`s finding that increased earnings inequality was driven by a rise in self-employment is particularly concerning, as a large share of employment

growth in Ontario in the aftermath of the financial crisis has been self-employment, suggesting that income inequality is likely to increase even further. This has led the OECD to call for better redistributive policies and higher taxes on the rich in its recent Divided We Stand report, a complete reversal from its previous political position (OECD, 2011). This trend towards more income inequality has not been reversed since the onset of the financial crisis. In fact, the first snapshot of how the financial crisis has been impacting working Canadians by Statistics Canada is rather worrying. In June 2011, Statistic Canada released the 2009 Income of Canadians report, which paints a devastating picture surrounding the impact of the recession upon working families, and underlines the importance of income support programs like Employment Insurance (Statistics Canada, 2011). In 2009, average earnings fell from $39, 100 to $38, 500 due to the steep rise of unemployment and an increase in short-term jobs (median earnings fell from $29, 600 to $ 28, 700, or by 3%.). This fall in average earnings happened even though the earnings of those who were steadily employed actually rose over the year. This attests to the aforementioned dangers of temporary and part-time work to undermine what is arguably the most important element of a healthy society, a fair and living wage. As discussed above, the number of Canadians working full-time year round decreased rapidly since the onset of the financial crisis. In 2009, 8, 916, 000 Canadians were working full-time year round, compared to 9, 593, 000 in 2008, a decrease of 677, 000 full-time, full-year jobs over a year. Mainly because of reduced earnings for those hit by the downturn, the average market income of families fell from $63, 500 to $61, 900 (Statistics Canada, 2011). However, this was offset by an

increase in government transfers, from an average of $3, 900 to an average of $5, 100. Since taxes also fell slightly, the average after tax income of families remained roughly the same at $59, 700. Statistics Canada reports that half of the increase in transfers came from Employment Insurance, as the number of families receiving benefits rose by 20% (Statistics Canada, 2011). The rise in EI take-up partly reflected the fact that eligibility for benefits gradually increases as unemployment rises, but also relates to the fact that the government was pushed into a temporary five week increase in benefits for those who managed to qualify (Jackson, 2011). The data underline the importance of Canada’s EI program in a time of recession, even though one half of all unemployed workers fell through the cracks and did not collect benefits, while many others ran out of benefits before finding a new job (CLC, 2011). The wage depression of 2009 does not seem to be an isolated incident but rather a trend. While wages started to grow briefly in 2010, by mid 2011 wage deflation had again taken hold of the Canadian economy, as wage growth has fallen behind the rate of inflation. As Jim Stanford points out, average hourly wages started to decline again in 2011, and wages have been falling at an annualized rate of almost 2 per cent since June. What is particularly problematic is that already the decline in nominal employment incomes (especially measured by weekly earnings) is worse than that which occurred during even the worst months of the 2008-09 recession (Stanford, 2011). While incomes for the average Canadian have been declining since the onset of the financial crisis, a recent report by the Canadian Centre for Policy Alternatives found that salaries of business executives have been largely recession-proof (McKinsey, 2011). The study

points out that the total average compensation for Canada’s best paid 100 CEOs was $6, 643, 895 in 2009 – a stark contrast from the total average Canadian income of $42, 988 and the total average minimum wage worker’s income of $19, 877. Even in the worst of recession, Canada’s best paid 100 CEOs earned, on average, 155 times more than Canadians earning an average income (McKinsey, 2011, p. 3). What is more, despite the increase in EI and other income transfers in the aftermath of the financial crisis, it is evident that poverty has been creeping up in Canada, with the poverty rate for all persons in Canada rising modestly from 9. 4% to 9. 6% in 2009 compared to 2008, and the child poverty rate increasing from 9. 1% to 9. 5%, based on Statistics Canada`s Low Income Cut-off Measure (LICO), its principal poverty measure. The LICO is an income threshold below which a family will likely devote a larger share of its income to the necessities of food, shelter and clothing than an average family would. According to the most recent base for LICOs, the 1992 Family Expenditures Survey, the average family spent 43% of its after-tax income on food, shelter and clothing. For 2008, the 1992 based after-tax LICO for a family of four living in an urban community with a population between 30, 000 and 99, 999 is $29, 013, expressed in current dollars. This increase in poverty is disturbing since the 2009 reading really takes us only to the mid-point of the recession, which continued into 2010. The Ontario government has already acknowledged that the economic crisis could disrupt the Ontario Poverty Reduction Strategy, established in 2008 with the aim to reduce child poverty by 25 per cent over the next five years. Ontario Premier Dalton McGuinty has signaled a retreat on the timing for that goal, citing a slowing economy, insufficient

provincial revenues and lack of federal support (The Star, Economic Crisis no Excuse to abandon anti-poverty fight, October 21, 2008). This is not surprising given the explosive growth of poverty in Ontario since the beginning of the financial crisis. Using the official poverty indicator adopted by Ontario as part of its poverty reduction strategy in 2008 (the Low Income Measure After Tax — LIM-AT), Ontario's poverty rate increased from 11. 3 to 13. 1 per cent in 2009, a staggering growth rate of 17% since the beginning of the financial crisis (see Figure 2 below). The Low Income Measure after tax (LIM — AT) is a purer measure of relative income than the LICO. It is defined as 50 per cent of median income, adjusted for family size. In effect, the LIM-AT indicates the percentage or number of people in the bottom income quartile. Poverty Free Ontario notes that the proportion of working age adults (18 to 64 years old) living in poverty increased from 11. 2% to 13. 4%, a growth rate of 19. 6%. Ontarians 65 years and older also show an extremely high poverty growth rate of 41. 9% since 2007, although the overall proportion of seniors in poverty still remains below 9% (Poverty Free Ontario, 2011). What is more, Ontario is the province in which poverty has been growing the fastest in Canada since the financial crisis hit. Figure 2: Poverty Levels in Canada and Rates of Growth/Decrease Source: Poverty Free Ontario, 2011. " 2009 Figures Show Growth Rate of Poverty the Highest of all Regions in Canada since 2007 Election". Retrieved from: http://www. povertyfreeontario. ca/wp-content/uploads/2011/06/poverty-2009. png Another area where the financial crisis has clearly undermined SDH in Ontario is the realm of food security. The Hunger Count 2011 survey found that far too many people are being left behind on Canada's road to economic

recovery. HungerCount 2011 results indicate a staggering 25. 7% increase in food bank use in Ontario between 2008 and 2011, with a 37. 5 per cent increase for those under the age of 18 (Canada Food Banks, 2011). The report highlights that in a typical month, food banks across the country provide food to more than three quarters of a million separate individuals — 851, 000 people — and more than 322, 000 (38%) of those helped are children. The level of food bank use over the past three years has grown at an alarming rate and now represents the highest level of food bank use on record (Food Banks Canada 2011, p. 5). At the same time, 1 in 5 users of food banks are employed full-time but fail to earn a living that would allow them to cover the most basic needs, such as housing, food and transportation. It also found that 11 per cent of those receiving food each month — 94, 000 people — are accessing a food bank for the first time, 20 per cent of households helped are living on an old age or disability pension, and half of households receiving food are families with children. This suggests that those particularly vulnerable are not properly protected by the social welfare system in Ontario. Housing is another area of concern to SDH as the links between housing and health have been recognized by the Ottawa Charter for Health Promotion (WHO, 1986), and more recently, by the Public Health Agency of Canada (Public Health Agency of Canada, 2002). Recent research from the Conference Board of Canada makes a convincing case that improved affordability of housing leads to increased individual health and productivity, and to decreased costs related to health care and social programs (Conference Board of Canada, 2010; Suttor, 2007). Hadi and Labonté (2011) note that spending on housing programs for marginalized

communities can also generate desired social returns in the long run. The Canada Mortgage and Housing Corporation (CMHC) uses the term 'core need' to track the number of households unable to access adequate accommodation in their community. The term measures affordability, suitability, adequacy of accommodation. Increasing evidence shows that households with core housing needs face one or more of the following issues: affordability, defined as spending less than 30 per cent of their gross income on housing; suitability, defined as not living in overcrowded conditions, i. e., household size and composition exceeds their actual home space requirements; and adequacy, meaning homes do not lack full bathroom facilities, or require significant repairs (Layton, 2000). Housing affordability has been worsening in Canada for a number of years, especially since 2001 when the housing market started going though an unprecedented boom with annual double digit price increases. A recent Conference Board of Canada report notes that, in total, over 3 million Canadian households faced challenges with affordability in 2010 (Conference Board of Canada, 2010, p. 21), as one quarter of Canadians spent more than 30 per cent of their income on housing. Since housing affordability is largely dependent on housing prices, many economists predicted that the financial crisis would contribute to restoring affordability as housing prices were expected to decline. However, the policy response to the financial crisis, especially low levels of interest rates and government purchase incentives, have contributed to a rapid rebound of prices in 2010, after prices started dropping steeply in 2009. In Canada, the global financial crisis proved to be only a brief setback, with the growth of house prices resuming at an

exhilarating pace. Nationally, house prices have risen 31 per cent from their trough in early 2009, to stand 13 per cent above their pre-crisis peak. In Toronto, the rebound has been even stronger, with prices having increased by almost 40 per cent (Bank of Canada, 2011). This has translated into levels of affordability declining further. The Social Policy Response by the Ontario Government As noted above, it is difficult to assess the impacts of the financial crisis on social policy as the Ontario government is currently engaged in a major review of social assistance at the provincial level. This review unfolded in the context of the development of the 2008 Poverty Reduction Strategy but is also related to the strong financial pressures on provincial budgets in the aftermath of the financial crisis. The review has as its main goal to put welfare programs in Ontario on a sustainable financial path, while improving the lives of Ontarians dependent on welfare payments (Commission for the Review of Social Assistance, 2011). Interestingly, the Commission notes that its recommendations will enable the Ontario government to " place reasonable expectations on, and provide supports for, people who rely on social assistance with respect to active engagement in the labour market and participation in treatment and rehabilitation" (p. 7). In the 2008 Poverty Reduction Strategy, the Ontario government committed to reviewing social assistance –especially Ontario Works and the Ontario Disability Support Program (ODSP) – with a focus on removing barriers and increasing opportunities for people to work. In this context, it is important to note that a string of previous welfare reforms, especially the 21. 6 per cent reduction of social assistance payments in 1995, have undermined SDH in Ontario. Despite a series of social assistance rate increases totalling 13 per

cent over 8 years to both Ontario Works and ODSP starting in 2004; however, this 13 per cent increase over 8 years amounts to a decline of payments in real terms, with inflation running at around 2 per cent annually over this period. In 2010, payments to recipients were still far below 1995 levels in real terms. Maximum social assistance payments to a couple with two children in the early 1990s would add up to a total of almost $30, 000, but have dropped by 2007 to just above $20, 000 (in constant 2007 dollars), representing almost a 30 per cent drop, while the size of the economy has almost doubled during the same time frame. Before discussing changes to social assistance programs in the aftermath of the financial crisis, the paper will briefly review the most important aspects of Ontario's welfare benefits regime. The two main programs of social assistance in Ontario currently in place are Ontario Works and the Ontario Disability Support Program (ODSP). Ontario Works' main task is to provide financial and employment assistance to help people in temporary financial need find sustainable employment and achieve self"reliance. ODSP is intended to help people with disabilities live as independently as possible and to reduce or eliminate disability"related barriers to employment. Together, Ontario Works and ODSP serve approximately 857, 000 Ontarians each month. In 2009—10, total provincial expenditures on social assistance were about $6. 6 billion, or about 6 per cent of the provincial budget. There are a number of eligibility criteria to qualify for Ontario Works and ODSP. Financial eligibility for both Ontario Works and ODSP is based on family size, income, assets and housing costs. To be eligible for ODSP, an applicant must also meet the financial eligibility criteria and Ontario's legislative definition of a person with a disability: a

person who has a substantial physical or mental impairment that is expected to last for at least one year and a substantial restriction in an activity of daily living. As social assistance is intended by the government as a last resort, there are various limits on the assets that people can have in order to qualify. For Ontario Works, it is roughly equal to one month's assistance (e. g. $599 for a single person). For ODSP, liquid asset limits are somewhat higher: $5, 000 for a single individual and $7, 500 for a couple with no dependents. Some assets are exempt under both Ontario Works and ODSP, including a principal residence, cars (up to a maximum value of $10, 000 for Ontario Works), Registered Education Savings Plans and Registered Disability Savings Plans. As noted above, social assistance rates have been raised moderately by the Liberal government since 2004. As of December 2011, Ontario Works consists of a Basic Needs Allowance, a Shelter Allowance, and the Ontario Child Benefit, with total maximum benefits of $1, 174 for a couple with one child. Since the beginning of the financial crisis, Ontario Works has been undergoing some transformation; these changes are not directly related to the financial crisis, but rather represent an attempt to streamline some of the benefits provided through Ontario Works in the context of the development of Ontario`s poverty reduction strategy in 2008. As part of this transformation of Ontario Works, the Ontario Child Benefit (OCB) was introduced in 2008, replacing the Basic Needs Allowance for Children and the Back to School Allowance and Winter Clothing Allowance previously administered through Ontario Works. In July 2009, the OCB was increased from a maximum of $600 to $1, 100 annually per child, two full years ahead of schedule, despite the fiscal challenges faced by the Ontario

government (Government of Ontario, 2011). The OCB currently provides up to $1, 100 annually per child and benefits over one million children in about 530, 000 families. The OCB is a non-taxable, income-tested monthly benefit paid to low- to moderate-income families with children under age 18. It has transformed the children’s benefit system by providing support to all low- to moderate-income families with children, regardless of the source of their income. This implies that recipients who move from receiving social assistance to being integrated into the labour market do not lose the allowance, as would have been the case under the previous regime. The OCB treats all children in these families equally and makes it easier for parents to transition from social assistance to employment. Another part of the transformation of Ontario Works initiated in 2008 was the provincial commitment to upload social assistance payments from the municipal to the provincial level, given that municipalities currently pay 20 per cent of Ontario Works benefits. This uploading of social assistance is based on the understanding that broad-based social assistance benefit programs should not be funded from property taxes. The province of Ontario will phase in an upload of Ontario Works benefits costs between 2010 and 2018. However, the cost of administration of Ontario Works will continue to be cost-shared on a 50: 50 provincial/municipal basis. Some changes have also been proposed to the ODSP through Bill 23 which was introduced to the Ontario legislature by Toby Barrett, and is currently being debated by the Standing Committee on Finance and Economic Affairs. The bill provides incentives for those on ODSP to earn and keep more of their own money. A percentage of people qualifying for ODSP work at least part-time in an effort to enhance their

quality of life based on the challenge of running a household on that level of funding. Current regulations claw back 50% of wages earned by ODSP recipients, significantly reducing the incentive to work. The bill proposes to allow ODSP recipients to retain the first $700 of additional monthly income, $1, 000 if they live with a spouse. It would also raise asset limits from the current $5, 000 to $12, 000 for individuals, or $20, 000 if there is a spouse also on disability, and allow recipients to retain child support income through the OCB, which is currently clawed back at a 100% rate. It would moreover feature tax incentives, for up to five individuals to encourage employers to take on more people with disabilities. While the proposed changes would lead to higher overall incomes for those that receive ODSP and participate in the labour market, the level of ODSP support remains far below what is required to guarantee a decent standard of living (with the maximum ODSP amount for a single person currently standing at $1, 064, and at $1, 618 for a couple with disabilities with no dependents). This places recipients of OSDP far below the poverty line in Ontario. A positive policy development for Ontario’s SDH scene has been the string of recent increases to the minimum wage; as noted above, employment conditions have a direct impact on health outcomes. The Ontario government has raised the minimum wage by 50 per cent since 2003, outpacing inflation and reversing a nine-year freeze in Ontario’s minimum wage from 1995 through 2003. However, the Ontario minimum wage will remain at $10. 25 per hour in 2011, after following seven consecutive annual increases. In constant (2011) dollars, the minimum wage has finally reached its previous peak from 1976 after having fluctuated up- and downwards for three decades (Caledon Institute for Social Policy, 2011).

The recent increases to the minimum wage arguably fall short as a full-time worker, earning $10. 25 per hour (or $18, 633 annually), actually remains below the poverty line in Ontario (which in 2011 was fixed through the low-income cut off at $19, 719 for a single adult). Many poverty advocates, including various unions, argue that a real living wage would require a minimum wage of at least $15. The City of Ottawa has pegged a living wage at $13. 25 in Ottawa's Poverty Reduction Strategy (NUPGE, 2010). A report by the Canadian Centre for Policy Alternatives suggests that a wage of $16. 15 per hour is required to allow a family with two children to meaningfully participate in social life and escape poverty (CCPA, 2008). Despite improvements, what is clear is that the current minimum wage rate is inadequate and does not guarantee that people on welfare can afford a standard of living that will allow them to maintain good health (Social Assistance Review Health Working Group, 2011). Given the pressures of the financial crisis on the bottom line of businesses in Ontario, it is unlikely that significant rate increases will materialize in the near future. Another area in which the Ontario government has committed to making improvement through better investments in the aftermath of the financial crisis is affordable housing. Safe and affordable housing is an important component of Ontario's Poverty Reduction Strategy, and as discussed above is a key element in improving health equity in Ontario. In November 2010, the Province released its Long-Term Affordable Housing Strategy (Government of Ontario, 2010). In that strategy, the Ontario government notes that building on investments in the housing sector, implementing the strategy will make the existing housing system more accountable, transparent and accessible,

and will improve the lives of people who need housing. The 2011 Ontario budget further outlines that the Province is working with the federal government on a new affordable housing initiative that would extend federal and provincial funding. And indeed, as part of stimulus investments in 2009—10 and 2010—11, the Province and the federal government invested $704 million for social housing rehabilitation and energy retrofits of more than 185, 000 social housing units in Ontario. However, critics have pointed out that these investments do not nearly go far enough to address the problem of housing affordability, and that much larger investments would be needed to properly address the housing crisis afflicting low-income Canadians (Conference Board, 2010; Hadi and Labonté, 2011). At the same time, policy decisions taken at the federal level have arguably re-inflated housing prices and further undermined affordability in the aftermath of the financial crisis. The rapid bounce-back in housing cannot be understood without reference to federal government policy initiatives, notably the Insured Mortgage Purchase Plan and the Home Renovation Tax Credit (Bank of Canada, 2011). With this renewed vigour building on the decade-long boom that preceded the crisis, the average level of house prices nationally stands currently at nearly four-and-a-half time average household disposable income. This contrasts with an average ratio of three-and-a-half over the past quarter-century. Financial vulnerabilities for Canadian households have increased as a result. The Bank of Canada notes that “ the proportion of Canadian households that would be highly vulnerable to an adverse economic shock has risen to its highest level in nine years, despite improving economic conditions and the ongoing low level of interest rates" (Bank of Canada 2011, p. 4). This partly reflects the

fact that the increase in aggregate household debt over the past decade has been driven by households with the highest debt levels. As discussed above, food security in Ontario has been undermined by the financial crisis. Unfortunately, the policy response of the Ontario government has actually contributed to this rise in food insecurity. The Special Diet Allowance (SDA) introduced in 2003, with a total maximum benefit of up to $250 monthly, played an important role in supplementing social assistance as it helped one in five people on social assistance in Ontario to pay for additional food costs related to chronic health conditions, such as diabetes and high blood pressure. The special diet allowance program was increasingly used by welfare recipients, especially in the aftermath of the financial crisis, as various campaigns by poverty activists in Toronto heavily promoted the use of the SPA. More than 160, 000 people on welfare or disability support payments also qualified for the special allowance, as applications had been supported and signed by a doctor, nurse, dietician or midwife. This led Premier Dalton McGuinty to suggest that people might be abusing the SDA and that the cost of the special diet program for people on social assistance, which jumped from $6 million in 2003 to $250 million in 2008, was unsustainable and must be reined in given the budgetary constrains (The Star, March 25 2010, " Poverty advocates decry loss of diet allowance"). Hence, the SDA was scrapped by the Ontario government, only to be reintroduced in a scaled-down version, after an outcry by poverty activists. The new SDA introduces a number of new restrictions though, with the explicit goal of limiting access to the SDA by social assistance recipients. Conclusion This paper provided a broad outline of how globalization through

multiple pathways influences SDH and health equity in Ontario in the aftermath of the financial crisis. It identified two key pathways which seem to be instrumental for understanding the impacts of the financial crisis on SDH and health equity in Ontario: the transformation of the labour market from secure and well-paid to flexible and part-time positions, and the budgetary and fiscal pressures related to the economic decline and concomitant increases in transfer payments. It next painted a preliminary picture of the SDH scene in Ontario, showing that most of the main equity-relevant SDH have been undermined and social inequality seems to be deepening with a disconcerting speed, with poverty growing at an eye-popping rate in Ontario and wages currently declining faster than during their height of the financial crisis. The paper finally traced the policy response by the Ontario government which is still in its infancy stage, as major spending cutbacks have not yet materialized and a major social assistance review is still on-going. While the Ontario government has thus far largely stayed the course in its delivery of social assistance programs, some minor modifications have been made with negative implications for health equity, notably the cancellation of the Special Diet Allowance. However, the key future challenge will be whether (or not) the social assistance review of Ontario will produce recommendations and policy changes that will further undermine SDH, deepen inequitable access to health and other social services, and lead to more social inequality. In this context, it is important to highlight that a range of international institutions, such as the International Monetary Fund (IMF) and the OECD, have recently warned against the dangers of growing inequality as it undermines the social fabric of society

and challenges social cohesion. In fact, the OECD has recently singled out Canada as the country in the OECD world where income inequality has been growing the fastest since the 1990s (OECD, 2011). This suggests that from a health equity perspective it is imperative that Ontario in its austerity drive focuses on policies that avoid any