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The Health of Canadians on Welfare

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1. Canada's Welfare Recipients

Welfare refers to a collection of long-standing social programs that provide income assistance to individuals whose resources are insufficient to meet their needs and who have exhausted all other avenues of support. In March 2001, according to the National Council of Welfare, an estimated 1,910,900 individuals, or nearly 6.4% of Canada's population, relied on welfare.

Welfare is an indicator of extreme poverty in Canada, as it is generally granted only to households with minimal assets. The National Council of Welfare reports that among households with children whose total household income fell below Statistics Canada's Low-Income Cut-Offs, households with welfare as their primary source of income had total average incomes several thousand dollars lower than households with earnings as their primary source of income.

Welfare recipients may be unemployed because of disability or for some other reason. Those who are unable to work due to disability receive disability benefits; others receive general welfare benefits. Disability benefits are typically several hundred dollars higher per month than general welfare benefits, although levels of welfare assistance differ by province and territory.

Since the early 1990s, federal and provincial funding for welfare programs has decreased substantially and welfare levels have fallen. Also, welfare recipients' access to special, supplementary benefits has been eliminated or severely curtailed.

When welfare benefit levels fall below the cost of basic living needs, recipients' health may be compromised. The association between low income and health has been well documented by researchers and by Statistics Canada. However, in comparison to other low-income groups such as the working poor, welfare recipients may be at greater risk for income-related health inequities.

2. The National Population Health Survey

Research on the health status of welfare recipients in Canada has been limited and most researchers have focused on mental health. Therefore we undertook a study to improve understanding of the health of welfare recipients through a secondary analysis of data from the 1996-97 National Population Health Survey (NPHS). Our objective was to examine the likelihood that adults in households whose main source of income was welfare would report poor general, mental, and social health, and certain chronic conditions.

We used data from the public use microdata health file for the household survey of the Cycle 2 (1996/97) NPHS, but included only respondents who were over 19 years of age (n = 66,435). We chose this cycle of NPHS because the sample size is five times larger than that of Cycle 3 and includes variables of particular interest (e.g. Social Support Index, Health Utility Index Mark 2).

3. Defining the sample

Respondents' main source of household income in the past 12 months was reported as employment, welfare/unemployment insurance/workers' compensation, seniors' benefits, other source, not applicable, or not

stated. Although the main source of income for 76% of those in the welfare/unemployment insurance/workers' compensation category was welfare, the data did not permit us to identify welfare households. Therefore, we made a closer examination of household income levels.

A review of provincial welfare benefit levels in 1997 indicated that welfare incomes typically fell in the lowest or low middle category of income adequacy, as defined by Statistics Canada. For this study, we classified as "on welfare" all households that claimed welfare/unemployment insurance/workers' compensation as the main source of income and reported household incomes in the lowest or low middle category of income adequacy. Those with higher incomes and those for whom employment, seniors' benefits, or "other source" were the main source of household income were classed as "not on welfare."

Because welfare recipients receiving disability benefits have higher benefit levels and would normally be expected to have poorer health than non-disabled welfare recipients, we needed to distinguish between these two groups. The NPHS data did not include a direct measure of disability status, so we used self-reported "restricted activity" to differentiate disabled from non-disabled welfare recipients. (Restricted activity is defined as having any long-term disability or handicap and/or any long-term physical or mental condition or health problem that limits the kind or amount of activity that one can do at home, school, work, or other activities.)

We excluded the 21.8% of adult respondents for whom the main source of income, income adequacy, or activity restriction status was not stated. Our final sample thus consisted of 51,938 respondents.

4. Health variables and statistical methods

Self-reported health was assessed for one randomly selected person in each household using a self-rated health scale, a functional health index, a depression index, a distress index, and a social support index. Four chronic conditions were also considered: heart disease, diabetes, hypertension, and obesity. For each measure, we constructed a dichotomous variable to distinguish individuals whose responses indicated poor health.

We used three logistic regression models to estimate the odds that an individual in a household whose main source of income was welfare would report poor health and selected chronic health conditions. Individuals in households not supported by welfare were used as the reference category for calculations of all odds ratios.

1. Unadjusted odds were obtained from the first model.
2. Age group and sex were included in the second model to control for potentially confounding effects, given the wide spectrum of ages in our sample and the research documenting the age- and sex-related differences in various health measures considered.
3. Significant associations have also been documented among income adequacy, education level, and health. Because education is tightly linked to income, we included this variable in the third regression model to determine if there was an association between welfare and health independent of education level.

Our research goal

We did not hypothesize causal relationships between receipt of welfare and specific health outcomes. Our objective was simply to estimate the odds that someone in a household on welfare would report health problems.

Unlike some other research in this area, we did not hypothesize causal relationships between receipt of welfare and specific health outcomes. Thus we omitted other socio-demographic variables associated with welfare (e.g., single parenthood) and individual-level characteristics that might link to the health measures considered (e.g., smoking status, alcohol or drug use) from our regression models. Our objective was simply to estimate *the odds that someone in a household on welfare would report health problems.*

5. What We Found

Table 1 presents a socio-demographic profile of our sample, stratified by activity restriction and welfare status.

Among those whose activity was not restricted (Table 2), welfare recipients were more likely to report poor/fair health, poor functional health, depression, distress, and poor social support compared to non-welfare recipients. No associations were found between welfare status and heart disease, diabetes, hypertension, or obesity. However, after adjusting for age and sex, welfare recipients were more likely to report heart disease compared to non-welfare recipients. Adjusting for education level did not alter the statistical significance of the observed associations.

Among those with restricted activity (Table 3), welfare recipients were more likely to report poor/fair health, poor functional health, depression, distress, poor social support, and obesity, and less likely to report heart disease, in comparison to non-welfare recipients. No associations were found between welfare status and diabetes or hypertension. However, after adjusting for age and sex, welfare recipients appeared more likely to report diabetes compared to non-welfare recipients. There was no significant relationship between heart disease and welfare status. Adjusting for education level did not alter the statistical significance of any of the observed associations.

6. Welfare and health status

Although other Canadian studies have reported poor mental health among welfare recipients, our findings show that receipt of welfare is also associated with poorer physical health and a lack of social support. Differences in welfare policies and programs limit the comparability of findings across countries, but we note that poorer health has been documented among welfare recipients in other countries. In an analysis of U.K., German, and U.S. data, researchers found that unemployed individuals on welfare-type benefits had higher odds of self-reported poorer health when compared to employed individuals and unemployed individuals supported by insurance-type benefits. Researchers have also documented more chronic conditions, poorer mental health, poorer social support or social integration, and greater odds of hospitalization amongst U.S. welfare recipients.

The finding that welfare recipients are more likely to report heart disease is of particular concern, because this condition can be prevented or managed, at least in part, by lifestyle modifications. Yet many welfare recipients experience financial hardship and are vulnerable to problems of food insecurity and hunger. Income-expense comparisons indicate that, for many recipients, welfare incomes are insufficient to cover the costs of basic needs. Access to healthy foods, exercise opportunities, medications, and medical supplies not covered by government programs may be even more problematic for welfare recipients, because many of these healthy lifestyle choices are associated with increased costs.

A difficult struggle

The financial hardship experienced by households on welfare makes coping with health problems more difficult and may exacerbate existing medical conditions. Welfare programs should protect – not jeopardize – the health of recipients.

The cross-sectional nature of our findings makes it impossible to draw causal inferences about the nature of the relationship between welfare and health. It could be that receipt of welfare predisposes individuals to poor health; the reverse could also be true. Longitudinal data are needed to determine the nature of this relationship. However, we note that welfare was associated with poorer health across a wide spectrum of measures, suggesting that the association between health and welfare is not condition-specific.

Our analyses are further limited by the absence of direct, objective measures of health and welfare status. Although we tried to identify welfare recipients indirectly by considering both source of income and income adequacy, misclassification errors are possible. Further, we did not know the length of time that any particular household had relied on welfare. In addition, the use of self-reported activity restrictions as a means of identifying individuals in households receiving disability benefits would no doubt result in the misclassification of some individuals, because disability status is assessed differently by welfare officials and our measure of activity restrictions was based on one adult in the household – not necessarily the person whose disability status would be the determinant of benefit eligibility in multi-person households. Nevertheless, our findings suggest that adults in households that rely on welfare are more likely to report poor health than others, irrespective of their disability status.

The results of this study indicate that adults supported by welfare struggle with a broad spectrum of health problems. The financial hardship experienced by households on welfare makes coping with health problems more difficult and may exacerbate existing medical conditions. Although welfare programs in Canada have never provided generous levels of income support, welfare incomes have declined over the past decade in most provinces and territories, with little apparent attention paid to the health consequences of these changes. Further cuts to welfare benefit levels may put recipients at even greater health risk. As welfare programs continue to be reformed, the impact of program changes on recipients' health and well-being needs to be assessed and monitored. By design, welfare programs should protect – not jeopardize – the health of recipients.

Table 1 – Socio-demographic profile of analytic sample by activity restriction status and welfare status

	Unrestricted activity			Restricted activity		
	Number	% Welfare (n = 1,289)	% Non-welfare (n = 41,334)	Number	% Welfare (n = 675)	% Non-welfare (n = 8,639)
Sex						
Male	21,221	1.8	98.2	4,382	7.1	92.9
Female	21,402	4.2	95.8	4,932	7.4	92.6
Age group						
20-39 years	20,125	4.2	95.8	2,456	11.1	88.9
40-59 years	15,422	2.5	97.5	3,359	10.1	89.9
60+ years	7,076	0.9	99.1	3,499	1.8	98.2
Education level						
No schooling/elementary/ some secondary	8,706	6.8	93.2	3,174	9.4	90.6
Secondary school graduation	7,419	2.8	97.2	1,234	7.6	92.4
Some trade or college/ other postsecondary	7,555	3.2	96.8	1,663	6.8	93.2
Diploma/certificate–college, trade, CEGEP	8,526	1.8	98.2	1,675	7.3	92.7
Some university	2,770	1.6	98.4	527	3.6	96.4
Bachelor degree	5,852	0.7	99.3	787	2.9	97.1
Master, PhD, medicine degree	1,673	0.4	99.6	219	3.0	97.0
Not applicable/not stated	121	1.4	98.6	36	4.0	96.0
Area of residence						
Atlantic Canada	3,685	5.0	95.0	1,061	8.8	91.2
Central Canada	26,682	3.5	96.5	4,948	7.7	92.3
Western Canada	12,257	1.5	98.5	3,305	6.1	93.9
Household type						
Single	5,996	5.6	94.4	1,945	12.9	87.1
Single parent, children <age25	2,148	21.2	78.8	449	24.3	75.7
Couple alone	10,094	0.8	99.2	3,035	1.8	98.2
Couple with children <age25, with or without others	19,365	1.6	98.4	2,582	6.4	93.6
Other household types	5,017	2.0	98.0	1,303	7.2	92.8
Not stated	3	18.0	82.0	0	-	
Own dwelling						
Yes	30,646	0.5	99.5	6,288	2.8	97.2
No	11,878	9.5	90.5	2,993	16.7	83.3
Don't know/refused/not stated	99	0.3	99.7	33	4.0	96.0

Table 2 – Odds of adult respondents with unrestricted activity supported by welfare reporting poor general, mental, and social health, and selected chronic conditions

	Number (%) [a]	Crude OR (95% CI)	Adjusted OR (95% CI) Model 1 [b]	Adjusted OR (95% CI) Model 2 [c]
General health				
Poor/fair self-rated health	1,900			
Non-welfare	(4.2%)	1.0	1.0	1.0
Welfare	(12.0%)	3.1 (2.1-4.4)	4.0 (2.8-5.7)	3.1 (2.1-4.5)
Poor functional health	2,432			
Non-welfare	(5.5%)	1.0	1.0	1.0
Welfare	(14.4%)	2.9 (2.1-4.0)	3.7 (2.7-5.1)	3.3 (2.4-4.6)
Mental and social health				
Major depression	1,348			
Non-welfare	(3.1%)	1.0	1.0	1.0
Welfare	(7.8%)	2.7 (1.7-4.1)	2.0 (1.3-3.2)	2.0 (1.2-3.2)
Distress	3,325			
Non-welfare	(7.5%)	1.0	1.0	1.0
Welfare	(26.4%)	4.4 (3.4-5.9)	3.7 (2.8-5.0)	3.3 (2.5-4.5)
Poor social support	5,495			
Non-welfare	(12.9%)	1.0	1.0	1.0
Welfare	(23.9%)	2.1 (1.6-2.8)	2.9 (2.1-3.9)	2.6 (1.9-3.5)
Selected chronic conditions				
Heart disease	891			
Non-welfare	(2.1%)	1.0	1.0	1.0
Welfare	(3.3%)	1.6 (0.6-4.5)	3.7 (1.3-10.6)	3.7 (1.3-10.6)
Diabetes	980			
Non-welfare	(2.3%)	1.0	1.0	1.0
Welfare	(2.7%)	1.2 (0.5-2.8)	2.5 (1.0-5.9)	2.3 (1.0-5.5)
Hypertension	3,835			
Non-welfare	(9.1%)	1.0	1.0	1.0
Welfare	(7.4%)	0.8 (0.5-1.2)	1.6 (1.0-2.4)	1.5 (1.0-2.3)
Obesity	4,114			
Non-welfare	(12.0%)	1.0	1.0	1.0
Welfare	(11.8%)	1.2 (0.7-1.4)	1.1 (0.8-1.6)	1.0 (0.7-1.4)

OR = odds ratio; CI = confidence interval.

[a] Number represents the total number of respondents who reported the condition. Calculations include those respondents who answered affirmatively or negatively to the item, but omitting non-respondents and those for whom the item was not applicable.

[b] Adjusted for age group and sex.

[c] Adjusted for age group, sex, and education level.

Table 3 – Odds of adult respondents with restricted activity supported by welfare reporting poor general, mental, and social health, and selected chronic conditions

	Number (%)[a]	Crude OR (95% CI)	Adjusted OR (95% CI) Model 1[b]	Adjusted OR (95% CI) Model 2[c]
General health				
Poor/fair self-rated health	3,359			
Non-welfare	(34.1%)	1.0	1.0	1.0
Welfare	(61.3%)	3.1 (2.2-4.2)	4.4 (3.2-6.0)	3.9 (2.8-5.3)
Poor functional health	4,450			
Non-welfare	(47.4%)	1.0	1.0	1.0
Welfare	(57.7%)	1.5 (1.1-2.1)	2.1 (1.5-3.0)	2.0 (1.4-2.8)
Mental and social health				
Major depression	860			
Non-welfare	(8.8%)	1.0	1.0	1.0
Welfare	(24.9%)	3.5 (2.4-5.0)	2.7 (1.9-3.9)	2.7 (1.9-4.0)
Distress	1,869			
Non-welfare	(19.7%)	1.0	1.0	1.0
Welfare	(44.4%)	3.3 (2.4-5.4)	3.1 (2.2-4.3)	2.7 (2.0-3.8)
Poor social support	1,679			
Non-welfare	(18.0%)	1.0	1.0	1.0
Welfare	(35.4%)	2.5 (1.8-3.4)	2.8 (2.0-3.9)	2.6 (1.9-3.7)
Selected chronic conditions				
Heart disease	1,346			
Non-welfare	(14.9%)	1.0	1.0	1.0
Welfare	(9.0%)	0.6 (0.4-0.9)	1.2 (0.7-1.9)	1.1 (0.7-1.8)
Diabetes	896			
Non-welfare	(9.4%)	1.0	1.0	1.0
Welfare	(12.9%)	1.4 (0.8-2.5)	2.4 (1.3-4.4)	2.4 (1.3-4.4)
Hypertension	2,128			
Non-welfare	(23.4%)	1.0	1.0	1.0
Welfare	(16.2%)	0.6 (0.4-0.9)	1.1 (0.7-1.7)	1.1 (0.7-1.6)
Obesity	1,130			
Non-welfare	(17.8%)	1.0	1.0	1.0
Welfare	(25.7%)	1.6 (1.1-2.4)	1.7 (1.1-2.5)	1.6 (1.1-2.3)

OR = odds ratio; CI = confidence interval.

[a] Number represents total number of respondents who reported the condition. Calculations include those who answered affirmatively or negatively to the item, but omit non-respondents and those for whom the item was not applicable.

[b] Adjusted for age group and sex.

[c] Adjusted for age group, sex, and education level.

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