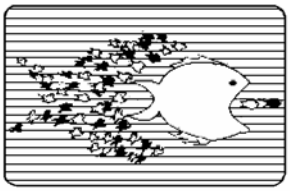
BC Public Interest Advocacy Centre



# Caring for All Canadians

## Brief to the Standing Committee on Finance
## Pre-Budget Consultation

## 2003

Prepared by Jess Hadley on behalf of:

- Active Support Against Poverty (Prince George, BC)
- BC Coalition of People with Disabilities (Vancouver, BC)
- Council of Senior Citizens' Organizations of BC (across BC)
- End Legislated Poverty (Vancouver, BC)
- federated anti-poverty groups of BC (across BC)
- Together Against Poverty Society (Victoria, BC)
- West End Seniors' Network (Vancouver, BC)

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## Who we are

The BC Public Interest Advocacy Centre is a non-profit law office based in Vancouver. Our mandate is to represent those who would not otherwise have the resources to assert their interests effectively.

We have prepared this brief as a joint submission on behalf of the following groups:

- **Active Support Against Poverty**, a Prince George organization that provides advocacy and other assistance to lower-income people dealing with government agencies;
- **BC Coalition of People with Disabilities (Vancouver, BC)**, a province-wide umbrella group that represents and provides advocacy for people with disabilities;
- **Council of Senior Citizens' Organizations of BC (across BC)**, a province-wide umbrella group whose mandate is to advance the welfare of elder citizens in BC;
- **End Legislated Poverty (Vancouver, BC)**, a coalition of BC groups working to reduce and end poverty in BC through public education;
- **federated anti-poverty groups of BC (across BC),** an umbrella organization of over 130 BC groups working to address poverty and social justice issues through education and individual and systemic advocacy;
- **Together Against Poverty Society (Victoria, BC)**, an advocacy organization that assists clients with income assistance, disability benefits, employment insurance, and residential tenancy matters; and
- **West End Seniors' Network (Vancouver, BC),** a volunteer-based community service organization that provides a variety of services for seniors including home support services and peer counselling through the Vancouver Coastal Health Authority.

## Why we're here

According to the Standing Committee's call for submissions, Canada strives to provide its citizens with safe communities and a high quality of life. This is a laudable goal, but it is still a distant one. **Our message to the Standing Committee is that the federal government's current tax and spending priorities are badly neglecting the millions of Canadians who are disadvantaged by poverty.**

Our position is that "caring for Canadians" means ensuring that everyone has access to an adequate income, housing, education, legal representation, and medical treatment. Yet severe cutbacks to social programs across Canada are preventing more and more Canadians from enjoying even a moderate quality of life. Meanwhile, tax measures designed to help those in need are not always effectively structured.

In our view, these problems are especially pressing because among those living in poverty, disproportionate numbers belong to historically disadvantaged or minority groups such as women, people with disabilities, visible minorities, aboriginal people, children, and the elderly.[1] From the perspective of the poor, Canada is moving further and further away from its goal of caring for all citizens. Instead, Canada is neglecting those most in need.

*We recommend three measures that the federal government can take to care for, and invest in, all members of Canadian society.*

## What we're asking the government to do:

1. **Tie transfer payments to the provinces' provision of social services.**

   CHST funding should be conditional on the provinces providing residents with:

   i. an adequate level of income assistance;

   ii. adequate amounts of affordable housing; and

   iii. legal aid for poverty law matters, supplemented by appropriate state-funded advocacy programs provided by non-profit societies.

2. **Create a national Pharmacare program.**

   The range of insured services under the *Canada Health Act* should be broadened to include medically necessary drug therapy outside of hospitals.

3. **Improve the Disability Tax Credit program.**

   The Income Tax Act and the T2201 form should be amended to make the Disability Tax Credit program fairer.

## Tying transfer payments to the provision of social programs

In February 1995 the federal government repealed the Canada Assistance Plan (the "CAP") and introduced the Canada Health and Social Transfer (the "CHST"). Prior to February 1995, the CAP made federal/provincial transfer payments conditional on provinces providing their citizens with certain minimum standards in social programming.

[1] Canadian Centre for Justice Statistics, "Canadians with Low Incomes" (Ottawa: Statistics Canada, 2001).

In contrast, the CHST imposes virtually no conditions on the provinces' receipt of transfer payments.[2] This has resulted in deep cuts to social programs in most parts of the country, and to vast disparities from province to province. The federal government should amend the CHST so that transfer funds are earmarked for important services that are currently being neglected, especially income assistance, affordable housing, and legal aid for poverty law.

### *Income assistance*

Because the CHST does not require the provinces to provide a particular standard of income assistance programming, the provinces have been able to make drastic cuts to their spending on welfare programs.

One result of these cuts is that many provinces have set shockingly low welfare rates. In 2000, five years after the CHST was implemented, the average welfare income, including all federal and provincial tax credits, ranged from 30.2% of the low-income cut-off (for "single employables"), to 54.3% of the low income cut-off (for families with two parents and two children).[3] Such rates are simply unacceptable in a country as wealthy as Canada. In 2002, the National Council on Welfare called income assistance rates across Canada "abysmally low."[4]

Furthermore, unbridled provincial cuts to income assistance programs have caused many provincial governments to enact extremely harsh income assistance laws. For example, BC's new income assistance laws, which were created to facilitate deep budget cuts in 2001, exclude "employable" persons, even those aged 55-65, from receiving welfare for more than two years out of each five-year period. This will render thousands of British Columbians ineligible for income assistance in April 2004

It is our position that low welfare rates and draconian welfare schemes are simultaneously increasing the numbers of Canadians who live in poverty, and intensifying their level of poverty. We call on the federal government to address this problem by amending the CHST to make funding conditional on the provinces providing an adequate level of income assistance for all Canadians.

### *Affordable housing*

It is essential that all Canadians have access to adequate housing. In our view, housing is the key requirement if those living in poverty are to become stable and progress to a higher standard of living. Adequate housing is also an essential ingredient in Canadians' mental and physical health. The federal government needs to take the lead in developing a sufficient supply of affordable rental housing.

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[2] Brodsky, Gwen and Day, Shelagh, "Women and the Equality Deficit: The Impact of Restructuring Canada's Social Programs" (1998), online: Status of Women Canada <http://www.swc-cfc.gc.ca/pubs/0662267672/199803_0662267672_e.html> (date accessed: August 27, 2003).

[3] *Ibid*.

[4] Canada, National Council on Welfare, "Welfare Incomes 2002," online: <http://www.ncwcnbes.net/htmdocument/reportwelfinc02/Welfare2002.htm#_Toc500047787> (date accessed: August 26, 2003).

Currently, there is a shortage of rental housing across Canada. Vacancies are low in many parts of the country, and rents are increasing while real incomes remain stagnant. Based on the CMHC's statistics, it appears that millions of Canadians lack access to adequate, suitable, or affordable housing, and that millions more are spending half of their income on shelter.[5] High rents are forcing many Canadians, especially seniors, to eat inadequately and go without medically necessary drugs in order to pay their rent. And many more Canadians are homeless.

It is unacceptable that so much of our population is inadequately housed. We call for the federal government to:

- invest $2 billion annually in new spending for affordable housing;[6]
- make this funding conditional on the provinces providing matched funding; and
- earmark separate funding for affordable housing units and for supported/ assisted living units, to prevent provinces from funding one type at the expense of the other.

***Legal aid for poverty law***

Poverty law includes a variety of areas of law important to people with low incomes, such as income assistance, employment insurance, disability benefits, debt, and worker's compensation. Poverty law is closely intertwined with family law, immigration law, and many other areas.

The CHST is intended to provide the provinces with funding for civil legal aid including poverty law, to ensure that poor Canadians can access the justice system.[7] However, there is no *formal* requirement that provinces use the CHST to fund poverty law programs. As a result, the transfer funds that the federal government says are intended to provide Canadians with poverty law legal aid are not being used for this purpose. In British Columbia, for example, the provincial government has all but eliminated poverty law legal aid services.

Universal access to justice is essential if all Canadians are to have a high quality of life. Without proper funding for poverty law legal aid, our justice system is closed to those who cannot afford a lawyer. We call on the federal government to amend the CHST to require that provinces meet a national standard for funding poverty law legal aid.

## Creating a national Pharmacare system

The *Canada Health Act* (the "*CHA*") requires that the provinces provide certain services (medically necessary hospital services, physician services and surgical-dental services) free of charge in order to receive their full federal cash transfer for health care.

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[5] Canada Mortgage and Housing Corporation, "Special Studies on 1996 Census Data: Canadian households in core housing need and spending at least half their income on shelter," (2001), online: <http://www.cmhc-schl.gc.ca/publications/en/rh-pr/socio/socio055-7_e.pdf> (date accessed: September 2, 2003).

[6] We are basing this figure on an amount proposed by the National Housing and Homelessness Network on November 21, 2002.

[7] See the federal Department of Justice website at <http://canada.justice.gc.ca/en/ps/pb/legal_aid.html> (date accessed: August 29, 2003).

However, the *CHA* does not require provinces to provide prescription drugs free of charge, *except* where the drugs are provided to a patient during a stay in hospital. This policy is in stark contrast to the policies of most other OECD countries, which provide publicly funded coverage for prescription drugs as well as hospital and doctor services.[8]

Without a national standard to guide the provinces' funding of drug therapy outside hospitals, drug policies and drug financing has been inconsistent across Canada and over the years. According to Roy Romanow's recent Commission on the Future of Health Care in Canada, our system of drug coverage is so fragmented that "to a very large extent, people's income, the kind of job they have, and where they live determine what type of access they have to prescription drugs."[9] This problem is aggravated by provincial governments' attempts to cut costs by raising deductibles, replacing universal coverage with selective coverage, and limiting the drugs that can be covered.

Any gap in provincial coverage for prescription drugs is problematic. This is because while most Canadians have some form of drug insurance, their coverage is usually subject to caps, co-payments or restrictions. Even worse, many lower-income Canadians are unable to afford any drug coverage at all. The Canadian Health Coalition estimates that approximately 6 million Canadians lack adequate drug insurance.[10]

The Standing Senate Committee on Social Affairs, Science and Technology recognized in 2002 that "[f]inancial hardship due to high prescription drug expenses is increasingly a real risk – indeed, it is a reality – for many individual and families in Canada."[11] We agree. Indeed, our clients have reported that many British Columbians, especially seniors, are being forced to choose between purchasing life-maintaining medication, and purchasing food.

These problems call for a national Pharmacare system setting a consistent standard for the provision of medically necessary drugs. There are four key reasons why we need Pharmacare:

1. **Drugs are medically necessary.** This is true even where drugs are provided outside of a hospital.

2. ***All* Canadians need access to drug therapy.** Everyone should be able to obtain medically necessary drugs, regardless of where they live and whether their drugs are delivered in a hospital or in the community.

3. **Canadians should not have to choose between groceries and medication.** As the Standing Senate Committee on Social Affairs, Science and Technology stated in 2002, no

[8] Canada, Standing Senate Committee on Social Affairs, Science and Technology, "The Health of Canadians – the Federal Role" (2002) at chapter 7.
[9] Canada, *Building on Values: The Future of Health Care in Canada* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) (Commissioner: Roy Romanow) at 194.
[10] Canadian Health Coalition, "Index on Medicare," online: <http://www.healthcoalition.ca/RC-index.pdf> (date accessed: August 27, 2003).
[11] *Supra* note 8.

Canadian should suffer undue financial hardship as a result of having to pay health care bills including prescription drug expenses.[12]

4. **National Pharmacare *is* financially viable.** The Canadian Centre for Policy Alternatives has stated "there is compelling evidence that a national drug plan would actually reduce overall costs, not increase them," because drug prices and administrative costs would both drop under a public plan.[13]

Accordingly, we call on the federal government to amend the Canada Health Act so that medically necessary drug therapy outside of hospitals is included as an insured service.

## Improving the Disability Tax Credit program

Taxation is one of the federal government's most important tools in combating poverty and ensuring that all Canadians are cared for. In this brief we focus on a relatively narrow tax issue that is of particular concern to our clients: the Disability Tax Credit (the ("DTC")). In particular, we are concerned that the *Income Tax Act*[14] and the T2201 form define disability too restrictively for the purpose of the DTC. This makes it very difficult for many people with disabilities to qualify for the DTC, and increases the number of people with disabilities living in poverty.

Our concern about the criteria for DTC breaks down into the following two issues:

1. The T2201 form is inconsistent with the purpose and provisions of the *Income Tax Act*.

2. The *Income Tax Act* itself is in conflict with the *Canadian Charter of Rights and Freedoms* (the "*Charter*")[15]

### *The T2201 Form is inconsistent with the Income Tax Act*

The T2201 form is configured so that an applicant cannot qualify as having a markedly restricted ability to walk unless a doctor certifies that he or she "cannot walk 50 meters on level ground or he or she takes an inordinate amount of time to do so." The language of the *Income Tax Act* does not support this extremely narrow interpretation of what it means to be unable to walk. It is arbitrary and inappropriate for the T2201 form to require that an applicant must be unable to walk "50 meters on level ground" to qualify for the DTC.

The T2201 form also purports to illustrate the meaning of "markedly restricted ability to perceive, think and remember" using the example of an applicant who "cannot manage or initiate personal care without constant supervision." By using this example, the form sets a very high

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[12] *Supra* note 8.
[13] Lexchin, Joel, "A National Pharmacare Plan: Combining Efficiency and Equity" (2001), online: Canadian Centre for Policy Alternatives <www.policyalternatives.ca/publications/pharmacare.pdf> (date accessed: August 29. 2003).
[14] *Income Tax Act*, R.S.C. 1985, c. 1 (5th Supp) at ss. 118.3 and 118.4.
[15] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

threshold for what it means to be unable to perceive, think and remember. Physicians we have consulted about the T2201 form say they treat the examples as a *baseline* for their decisions on how to complete the T2201. Given the current wording on the form, most physicians will only certify that a patient is unable to perceive, think, and remember if their patient is *at least* disabled enough to require constant supervision to manage or initiate personal care. The T2201 form's use of an example to guide the interpretation of what it means to be unable to "perceive, think and remember" is arbitrary and inappropriate.

As far as we know, there is no regulation under the *Income Tax Act* that prescribes *any* version of the T2201 form, and the CCRA's only authority to create the T2201 derives from the authority to administer ss. 118.3 and 118.4 of the *Income Tax Act*. As a result, the form must immediately be amended to reflect the legislation.

***The Income Tax Act infringes s. 15 of the Charter of Rights and Freedoms***

In addition to the discrepancy between the provisions of the T2201 form and the wording of the *Income Tax Act*, we believe that the eligibility criteria in the *Income Tax Act* itself are too restrictive. They make it extremely difficult for those with mental health disabilities to qualify for the DTC. Indeed, we believe the criteria are restrictive in a discriminatory manner that infringes s. 15 of the *Charter*. S. 15 provides:

> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Many people with disabilities have a combination of conditions that work in concert to cause a *cumulative* marked restriction in their ability to perform basic activities. Yet such individuals can only qualify for the DTC if there is at least one statutory "basic activity" which they are always or substantially always unable to do. This fails to reflect the reality that a person's ability to perform basic activities is often markedly restricted by a *combination* of conditions none of which is, in isolation, sufficient to cause a marked restriction. For example, if a person suffers from severe osteoarthritis and chronic severe depression, her conditions will seldom prevent her altogether from doing any one of the daily activities. However, the combined effect of her disabilities may well markedly restrict her ability to perform the class of statutory "basic activities" as a whole, by limiting (but not removing) her ability to walk, feed herself, dress herself, perceive, think, and remember. The current wording of the *Income Tax Act* discriminates against those who have a combination of disabling conditions that act together to create a marked restriction when viewed holistically. We call for a revision of the *Income Tax Act* to recognize that multiple impairments can combine to create a marked impairment.

Another problem is that the *Income Tax Act*'s approach to mental impairments is much narrower than its approach to physical impairments. In order to qualify for the DTC as a person with mental impairment, an applicant must be unable to perceive, think, and remember. Yet most people with mental impairments retain at least some capacity to "think, perceive, and remember"

even while these functions may be severely impaired. The *Income Tax Act* sets an extremely high threshold, one that discriminates against people with impairments such as psychiatric illnesses, brain injuries, and learning disabilities by systemically excluding them from the DTC program.

Accordingly, we call for a rewording of the *Income Tax Act* to provide a broader test that allows people with serious mental impairments to qualify for the DTC even where they retain some ability to think, perceive, and remember.

## Recommendations

***Tied transfer payments:***

- Make CHST payments to provinces conditional on the provinces providing residents with:
  i. an adequate level of income assistance;
  ii. adequate amounts of affordable housing; and
  iii. legal aid for poverty law matters, supplemented by appropriate state-funded advocacy programs provided by non-profit societies.

***National Pharmacare:***

- Amend the *Canada Health Act* so that medically necessary drug therapy outside of hospitals is included as an insured service.

***Disability Tax Credit:***

- Amend the T2201 form to reflect the language of ss. 118.4 of the *Income Tax Act*; and
- Amend s. 118.4 of the *Income Tax Act* to conform to the *Charter*.

## Conclusion

This brief addresses some of the issues that we believe most affect the millions of Canadians who live in poverty. These issues should be among the first that the federal government considers in its quest to provide Canadians with safe communities and a high quality of life.

**It is our position that if Canada is to invest in, and care for, all members of our society, then our government *must* focus especially upon helping those who are most in need.** Accordingly, we urge the Standing Committee to support our recommendations.

We applaud the Standing Committee for inviting our input on these issues.