2023 Poverty and Health Report

To	Chair and Members of the Board of Health
Meeting Date:	September 6, 2023
Report No.	**BH.01.SEP0623.R22** Pages: 14
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Recommendations

It is recommended that the Board of Health:

1. Receive this report for information.

Key Points

- Poverty and poor health outcomes reinforce and perpetuate each other in a cycle that is difficult to break free from.
- Rates of diabetes, arthritis, asthma, anxiety disorders, high blood pressure, obesity, smoking, lack of physical activity, unintentional injury mortality and suicide mortality are higher in groups living in low-income.
- Poverty has detrimental effects on opportunities for education and employment.
- Income inequality has been increasing over the past several decades, while the poorest in society have become less able to exit poverty.
- A long history of stigmatization and systemic discrimination has embedded significant income and health inequalities that can be seen among groups including Indigenous peoples, sexual and racial minorities, and immigrants.

- Pandemic income supplements have distorted low-income statistics, especially in the years 2020-2021.
- Wellington-Dufferin-Guelph (WDG) Public Health uses local poverty data to design more equitable programming.

Discussion

The Impact of Poverty on Health and Well-being

The experience of living in poverty has a far-reaching impact on various aspects of an individual's life trajectory, including education, employment, and health outcomes. Even in affluent countries such as Canada, people who are less well-off have shorter life expectancies, higher rates of illness and face increased levels of stress, social exclusion, unemployment and addiction than those with higher incomes.[1] Poverty and poor health outcomes can reinforce and perpetuate each other in a cycle that is difficult to break. This is sometimes referred to as a "poverty trap," where the socioeconomic disadvantages that poverty brings (e.g., limited access to nutritious food, high stress, inadequate living conditions) lead to poor health outcomes which, in turn, deepen the cycle of poverty by limiting an individual's ability to work, earn a stable income, pursue education and escape the adverse conditions that perpetuate the trap.[1]

It is often tempting to believe that society has been moving steadily toward a more equitable model where more and more people are able to share in the increased wealth and resources that advances in technology and social justice have brought. However, in Canada as well as most other parts of the world, income inequality has steadily increased while the ability of children to achieve higher incomes than their parents has decreased since the 1960s.[2] In Canada, the top 1% of income earners increased their share of the total national income by over 50% between 1980 and 2010. At the same time, the probability that a child from the bottom 20% of the parental income distribution remained in low income increased from 27% to 32%.[2] In effect, those in high income brackets have gained more wealth over time, while the poorest in society have become less able to exit poverty and transition to the middle class.

There is a complex relationship between the socioeconomic factors and systemic barriers that create and reinforce the poverty trap. Being raised in poverty poses significant obstacles to accessing quality education due to health issues, lack of transportation or the need to work to contribute to the family's income. As a consequence, children from impoverished backgrounds may experience lower academic performance, limited cognitive development and diminished prospects for high-paying job opportunities.[1] The absence of professional networks, along with

poor mental health and systemic discrimination exacerbates these challenges to achieving meaningful employment, which can in turn lead to an inability to escape the poor environmental hazards that living in poverty often entails. Higher rates of crime, violence, substance abuse, exposure to pollution and inadequate living conditions are also more common in impoverished neighbourhoods which contributes to further health disparities and restricts the ability to escape the cycle of poverty.[1]

It is not only material contexts (living, working and environmental conditions) that shape the cycle of poverty, but also the harmful sociocultural contexts of power, privilege and exclusion.[3] A long history of stigmatization and systemic discrimination has created significant health inequalities for Indigenous peoples, sexual and racial minorities and immigrants.[3] In Canada, the context surrounding the historic mistreatment of Indigenous peoples and the ongoing marginalization of those groups is of particular note because of its long history and lasting effects. See the “Social determinants of health and health inequalities - Indigenous perspectives” section of the Key Health Inequalities in Canada from the Public Health Agency of Canada for a brief summary of this history.

Health Behaviours and Risk Factors

In Canada, people in the lowest income group were significantly more likely to have high blood pressure, be obese and smoke compared to adults in the highest income group.[4] Income inequalities also affect access to recreational and green spaces, safe built environment and average amount of free time, leading to lower rates of physical activity. Access to healthy foods and the rate of fruit and vegetable consumption decreases as income decreases.[4] Public health designs interventions aimed at impacting health behaviour change in a variety of ways that help to bridge the health equity gap between lower and higher income groups. For example, to increase physical activity within a population public health might run a health promotion campaign aimed at encouraging children to reach a target amount of daily physical activity but they might also work with city planners to advocate communities that encourage residents to use modes of active transportation.

Chronic Disease and Mortality

Rates of diabetes, arthritis and asthma were higher in adults with lower income and lower educational attainment. Life expectancy, infant mortality, unintentional injury mortality and suicide mortality were higher in lower income areas and in areas with higher concentrations of First Nations, Inuit and Métis peoples.[3] These high-level indicators speak to the real and observable health inequities seen among historically marginalized groups. Widespread change to improve overall quality of life must come from a cooperative effort between all levels of government, as well as a social change that tackles the problems of discrimination and marginalization.

Mental Health

Self-rated perceptions of mental health decrease as income decreases. People in the lowest income group are less likely to report having their mental health needs fully met or to report being satisfied with life. Increased stress, along with restricted access to both basic needs and mental health care, contributes to both poorer mental health and increased rates of mental illness in people living with poverty.[5]

Adults living in the lowest income group report having an anxiety disorder at a rate 2.4 times higher than adults in the highest income group. Women experience nearly double the rate of anxiety disorders compared to men in all income quintiles. Women in low income households experience the highest rates of life stress overall.[5]

Food Insecurity

Individuals and families with low-income struggle to meet their basic needs, such as adequate housing and nutritious food.[6] The risk of food insecurity extends beyond low-income households, encompassing those with limited assets, Indigenous households, various racial/cultural groups, lone-parent households led by females and households dependent on income supports. The prevalence of food insecurity is significantly higher among individuals with lower levels of education compared to those in households with a university education. Specifically, youth are 5.0 times more likely to experience food insecurity, adults are 6.8 times more likely and older adults are 3.2 times more likely in households with less than a high school education compared to those in households with university-level education.[7] The unequal access to food among these groups speaks to the need for public health to continue to advocate for policies addressing not only income supplements, but also long-term investment in community development including access to quality education and job training.

How do we Measure Poverty?

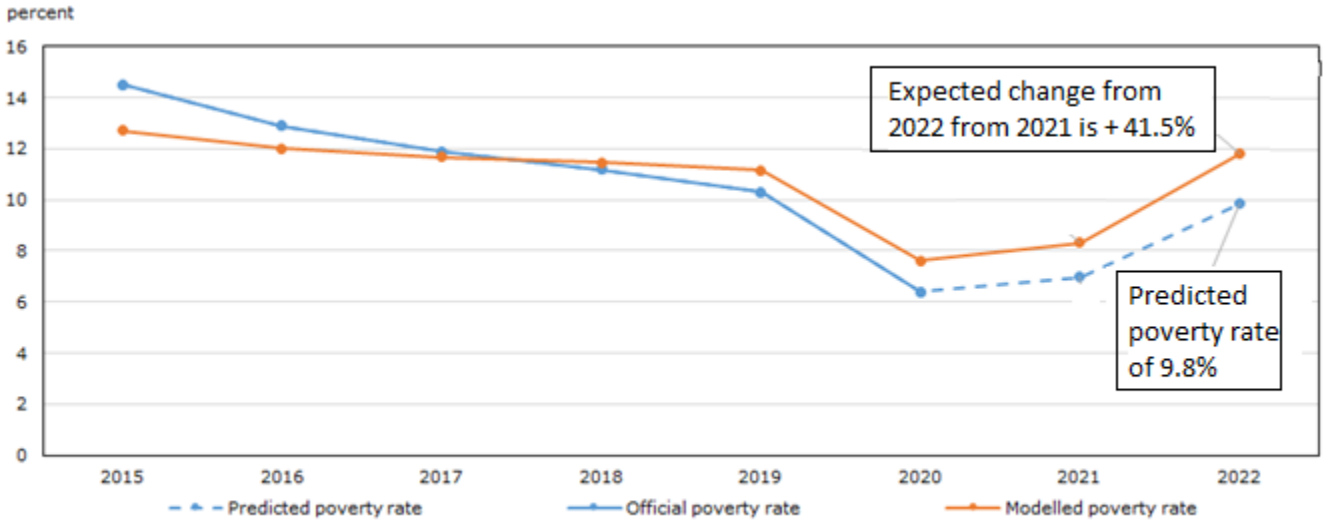
In Canada, some of the most common indicators used to measure poverty include the Market Basket Measure (MBM), Low-Income Measure, after tax (LIM-AT), Low-income Cut-Offs (LICOs) and the Ontario Marginalization Index (ON-MARG) of material deprivation. Additionally, there are tools such as the Nutritious Food Basket which estimate the basic cost for an individual or household to eat healthy.

WDG Public Health, like many public health units across the country, largely uses the LIM-AT to measure poverty in WDG. The LIM-AT is calculated as 50% of the median after-tax income of households, adjusted to scale with the number of people in a household.[8] In 2021, the LIM-

AT thresholds in Canada for a household of one person was $27,352 after-tax while it was $54,704 for a household of four people.[9] The poverty statistics in this report are all based on the LIM-AT.

One of the largest and most important sources of information on local poverty conditions is the Statistics Canada Census of Population. The most recent Census data cycle was conducted in 2021, and the questions related to income were based on the year 2020. As a result, the income data for this cycle includes the contributions of various COVID-19 related emergency benefits and top-ups to existing programs (e.g., Canada Emergency Response Benefit, Canada Emergency Student Benefit, Canada Child Benefit top-up). This has had the effect of reducing the rate of all low-income measures in the Census across almost all population groups and levels of geography.[10]

Preliminary data from 2021 and 2022 show a significant increase in national poverty rates since the rollback of these benefits.[11] As the chart below describes, official and modeled poverty rates for Canada are predicted to rise over 50% from 2020 to 2022.



Source: Statistics Canada. Table 18-10-0005-01 Consumer Price Index, annual average, not seasonally adjusted Statistics Canada. Table 18-10-0004-01 Consumer Price Index, monthly, not seasonally adjusted.

Figure 1: Percentage of people living in poverty in Canada, 2015-2022

Because of the unique financial circumstances in Canada during the pandemic, low-income rates from the 2021 Census are not directly comparable to previous cycles. Despite this lack of comparability, the low-income rates in the 2021 Census continue to provide a useful snapshot of poverty in the WDG region, and its unequal distribution in the population. Older adults, the Indigenous population, immigrants, and racialized groups continue to face disproportionate rates of living in poverty compared to the total population.

Local Picture

Low Income

In WDG there were 22,510 people living in low income according to the 2021 Census of Population. This is 7.4% of the WDG population. While this is a significant reduction in the overall poverty rate compared to 2016, as previously mentioned in this report, COVID income supplements had a strong downward impact on poverty rates during the data collection period. Despite this effect, many groups faced higher than average rates of poverty. By age group, youth (aged 0 – 17 years) and older adults (aged 65 years and over) faced higher rates of poverty. Overall, there were more women than men living in low-income, especially in older age groups. Poverty rates differed by geography with municipalities such as Wellington North, Minto, and Mapleton having the highest rates in the WDG region. Within Guelph, some neighbourhoods had higher rates of poverty including Onward Willow and Exhibition Park.

People who live in poverty in WDG are more likely to:

- not have a high school diploma or equivalency (24%) as compared to the total population (11%).
- be unemployed (18%) as compared to the total population (9%).
- have moved in the past year (15%) as compared to the total population (12%).
- take a bus or walk to work (15%) as compared to the total population (7%).

One promising intervention in helping to break the cycle of poverty is the Pathways to Education program. This model provides comprehensive after-school programming to disadvantaged youth in order to help them complete their education and transition to additional training and increased earning potential in the longer term.[12] Evaluations of Canadian pilots showed that Pathways increased high school graduation rates, enrollment to post-secondary education and improved labour market outcomes.[12] A model based on the successes of this program would be worthwhile to explore for the communities in our region most affected by poverty.

Population Groups

Older Adults

In WDG, older adults (those aged 65 years and over) were more likely to live in poverty than youth aged 0 to 17 years or adults aged 18 to 64. Older women were more likely than older men to live in poverty (11.1% vs. 7.4%), and this trend increases with age.

Children

Among those aged 0 to 5 years in WDG, 9.2% (1,870 individuals) lived in poverty according to the 2021 Census. Mapleton (18.2%) and Wellington North (16.9%) were the WDG municipalities with the highest rates of children living in low income. Although the rate of children living in low income in the City of Guelph was 8.2%, some neighbourhoods had much higher rates. In the Onward Willow neighbourhood, 19.2% of children were living in low-income. Children living in a one-parent family were nearly four times as likely to live in low-income compared to children in a two-parent family (16.3% compared to 4.3%). Children's development in their early years is a particularly sensitive time in terms of future health outcomes.[3] Public health interventions supporting pregnant women and parents with young children such as the Healthy Babies Healthy Children (HBHC) program are important initiatives that promote healthy development.

Immigrants

Recent immigrants in WDG (those who immigrated to Canada from 2016 – 2021) face significantly higher rates of low income compared to non-immigrants. Children (aged 0 to 5 years) who recently immigrated were over 2.5 times more likely to live in low-income compared to non-immigrant children while adults (aged 18 to 64 years) were 1.6 times more likely to live in low-income. While the number of permanent residents in WDG in the 2021 Census was too low to analyze rates of low income, this group has historically fared much worse than the recent immigrant population in terms of living in poverty. Immigrant support services such as Settlement Services (funded by Immigration, Refugees and Citizenship Canada) and Immigrant Services Guelph-Wellington contribute to the long-term wellbeing of newcomers to our region by helping individuals integrate and adapt to their new communities. Building public health ties with these kinds of organizations could help extend our important programming to this marginalized group.

Indigenous populations

In WDG, 1.7% of the population identify as having an Indigenous identity. Among the WDG Indigenous population, there were higher rates of living in low income across all age groups compared to the non-Indigenous population.

	Indigenous identity	Non-Indigenous identity	Rate Ratio
In low-income based on the Low-income measure, after tax (LIM-AT)	9.5%	7.4%	1.29
0 to 17 years	9.7%	8.3%	1.16
0 to 5 years	11.1%	9.1%	1.22
18 to 64 years	9.1%	6.5%	1.39
65 years and over	13.0%	9.4%	1.39

Table 1 *Poverty Rates by Indigenous Identity Status and Age in WDG, 2021* (Census 2021)[13]

As the above table shows, Indigenous adults (aged 18 to 64 years) and older adults (aged 65 years and over) saw the most inequality in rates of living in low income compared to their non-Indigenous counterparts in 2021.

In addition, people in WDG who identity as Indigenous were more likely than their non-Indigenous counterparts to not have a high school diploma (22.6% compared to 17.6%) or be unemployed (13.5% compared to 9.4%).

Racialized Groups

Overall, racialized groups in WDG faced higher rates of living in poverty (8.8%) than their non-racialized peers (7.1%). Those who identified as Arab (17.9%), Korean (15.6%) and Black (12.2%) faced much higher rates of low-income than the total population.

Transgender and Non-Binary

The 2021 Census included changes to questions relating to gender, making Canada the first country to provide census data of transgender and non-binary people.[14] Although local data on low income rates in these populations are not currently available, on a national level,

transgender men (12.9%) and women (12.0%) were more likely to experience poverty than their cisgender counterparts (8.2% and 7.9%, respectively). Additionally, more than one-in-five (20.6%) of non-binary people lived in poverty which is more than twice the rate of the total population.[14]

Homelessness

Both the County of Dufferin and the County of Wellington conduct Point-in-Time (PiT) counts to understand the scope and extent of homelessness on a local level. PiT counts provide an estimate of the number of individuals experiencing homelessness on a single night as well as certain demographic characteristics and information about the needs of people experiencing homelessness. For both jurisdictions, the most recent PiT count was conducted in 2021.

Having taken place during the COVID-19 pandemic, the methodologies of the two 2021 PiT counts were quite different to previous years and, as a result, direct comparisons to previous years cannot be made. The results of the 2021 PiT counts should be considered as the minimum number of people experiencing homelessness.

In Guelph and Wellington County:

- A total of 270 individuals were identified as experiencing homelessness on October 20, 2021. These include 161 who completed the “Everyone Counts” survey, 24 dependent children identified in the survey and 85 individuals known to be experiencing homelessness who did not complete the survey.
- Of those who completed the survey, 23% identified as Indigenous. In the 2021 Census, only 1.7% of the population of Wellington County (including the City of Guelph) identified as Indigenous. A much higher proportion of Indigenous respondents (69%) experienced foster care or lived in a youth group home compared to all survey respondents (29%).
- Most (65%) were male, while 33% identified as female and 2% identified as non-CIS gender.
- Half (50%) of respondents were aged 40 to 64 years while 34% were aged 25 to 39.
- Almost half (42%) reported first experiencing homelessness under 18 years old.
- Approximately three-quarters of respondents reported experiencing mental health issues (72%) and/or substance use issues (75%).[15]

In Dufferin County:

- A total of 23 individuals met the definition of homelessness and completed the survey in April 2021.
- Just over half of respondents were aged 25 to 49 years (52%) while 17% were aged 16 – 24.
- Almost two-thirds of respondents (64%) reported first experiencing homelessness as a child under the age of 18.
- No respondents in 2021 reporting identifying as Indigenous or having Indigenous ancestry.
- Over one third of respondents (35%) reported that they were staying in a transitional shelter while 22% of respondents reported being completely unsheltered, meaning they were staying in parks, on the streets, in vehicles or other public spaces.[16]

Data into Action

WDG Public Health can use poverty data to gain insights into the specific needs and vulnerabilities of populations living in poverty. These data can inform the development of targeted interventions that aim to address the social determinants of health and reduce health inequities. For example, as described in an April 2023 Board of Health Report, the Healthy Smiles Ontario program helps to eliminate barriers to accessing oral health care for vulnerable groups such as low-income families.[17]

It is also important for Public Health to share local data with community partners. The WDGPH Health Analytics team has developed online interactive reports to visualize local data related to both social determinants of health as well as key health trends in the community. These reports can be accessed at www.wdgpublichealth.ca/data and can be used to explore poverty and other social determinants of health in our communities. An updated version of this data portal will be available in the early fall of 2023 as the Health Analytics team plans to release new data products with the most recently available data on these topics.

WDG Public Health's 2022 Nutritious Food Basket Report describes the role income-based policy solutions can play in tackling poverty and improving health equity. Public health must continue to work with community partners to advocate for effective policies that ensure families and individuals are not financially constrained and can access basic needs for health and safety.

Conclusion

Poverty and poor health outcomes create a self-perpetuating cycle that is incredibly challenging to escape. Various health issues such as diabetes, arthritis, asthma, anxiety disorders, high blood pressure, obesity, smoking, lack of physical activity, unintentional injury mortality and suicide mortality are more prevalent among low-income groups. Poverty also hampers opportunities for education and employment, leading to limited upward mobility. Furthermore, significant income and health disparities persist among marginalized groups due to a long history of stigmatization and systemic discrimination. This inequality can be observed among Indigenous peoples, sexual and racial minorities and immigrants. It's worth noting that the COVID-19 pandemic has further complicated the assessment of low-income statistics, as pandemic income supplements have distorted the data, particularly in the years 2020-2021.

While the linkages between poverty, health and the other social determinants of health are complex, what is clear is that the work of WDG Public Health is tied to addressing these systems that create health inequalities as well as their effects. Public Health programs, interventions and partnerships are designed specifically to keep health equity at the forefront. From an upstream perspective, Public Health educates the population on issues of health equity, provides data on distribution of poverty and other sociodemographic data, and advocates for broader policy changes to guide national, provincial, and municipal policies toward the goal of greater equality. Further downstream, Public Health provides programs such as Healthy Smiles Ontario and Healthy Babies Healthy Children helps to increase access at an individual level to much needed health services in vulnerable populations.

Ontario Public Health Standard

Foundational Standards

☒ Population Health Assessment

☒ Health Equity

☐ Effective Public Health Practice

☐ Emergency Management

Program Standards

☐ Chronic Disease Prevention and Well-Being

☐ Food Safety

☐ Healthy Environments

☐ Healthy Growth and Development

☐ Immunization
☐ Infectious and Communicable Diseases Prevention and Control
☐ Safe Water
☐ School Health
☐ Substance Use and Injury Prevention

WDGPH Strategic Direction(s)

☒ **People & Culture:** We will maximize relationships through meaningful in-person interaction. Further integrate equity, diversity, and Inclusion objectives throughout the organization and equip ourselves for change.

☐ **Partner Relations:** We will strategically collaborate with partners to address priority health issues in the community, re-engage with community partners and work with a range of partners to achieve positive health outcomes.

☒ **Health System Change:** We will ensure we are positioned to be an agent of change within the broader health sector, advance the work of Ontario Health Teams and lead change in public health.

Health Equity

Some population groups are disproportionately impacted by poverty. These groups include children, older adults, immigrants, and Indigenous populations.

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