Poverty: An Influential Social Determinant of Health

To:	Chair and Members of the Board of Health	
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Recommendations

It is recommended that the Board of Health:

1. Receive this report for information.

Key Points

- There is a clear and robust relationship between income and health. Poverty leads to lower health status.
- People living in poverty are more likely to have poor outcomes including: higher rates of chronic disease, mental health challenges, housing instability, food insecurity and social exclusion.
- Some population groups are disproportionately impacted by poverty. These groups include: children, older adults, immigrants and indigenous populations.
- The Wellington-Dufferin-Guelph Public Health (WDGPH) Health Analytics Team has developed online interactive reports to visualize local data. These reports can be accessed at wdgpublichealth.ca/data and can be used to explore poverty and other social determinants of health in our communities.

Discussion

The impact of poverty on health and well-being

There is a clear and robust relationship between income and health. Poverty leads to lower health status.[1] Extensive and robust research has demonstrated a direct link between socioeconomic status and health. People living in poverty have the greatest burden of illness.[2]

Evidence has shown a health gradient that runs from top to bottom of the socioeconomic spectrum. What this means is that illness, and mortality due to illness, is highest among those in the poorest income group and, as income increases, rates of illness decrease. This is the case for conditions such as cardiovascular disease, cancer, diabetes and mental illness.[2]

> *"It is said that there is a profound two-way relationship between poverty and health. What this means is people with limited access to income are often more socially isolated, experience more stress, have poorer mental and physical health and fewer opportunities for early childhood development and post-secondary education. They also often have inadequate housing, more exposure to environmental pollution and are unable to access healthy foods. In the reverse, it has been found that chronic conditions, especially those that limit a person's ability to maintain viable stable employment, can contribute to a downward spiral into poverty. This is especially true for Canadians living with severe mental health or addictions issues — but also individuals who are living with physically debilitating conditions — who often find that the Canadian patchwork quilt of social benefits, including various sorts of disability insurance, public-sector payments for people living with a disability and related pension payments do not, even in combination, provide an adequate living wage. Studies do show the predominant causal relationship is more frequently from poverty to poorer health*."[3]

Chronic disease

Canadians living in low-income have higher incidence and mortality rates for several types of cancer than those with higher incomes. Low-income Canadians also have higher rates of cardiovascular disease and type 2 diabetes.[3] Children who live in poverty are more likely than other children to have higher rates of death due to

unintentional injuries and to have low birth weights, asthma, type 2 diabetes, poorer oral health and suffer from malnutrition.[3]

People living in poverty face more barriers to access and care. Canadians living in poverty are more likely to visit the emergency department for treatment but less likely to see a specialist or get care in the evenings or on the weekends. Canadians in the lowest income groups are less likely to fill prescriptions and less able to get needed tests because of cost.[3]

Mental health

People with mental illness face many barriers which may prevent them from succeeding in educational programs and securing employment. This can lead to poverty. People with mental health challenges who are living in poverty are often socially isolated which increases their risk of chronic poverty. Conversely, poverty and the challenges associated with it, has a negative impact on mental health and can lead to depression and anxiety.[4]

Housing

Housing is considered to be affordable when a household spends less than 30% of its pre-tax income on adequate shelter. Households that spend more than 30% of their income on shelter are deemed to be in *core housing need*.[5] Families that spend a greater proportion of their income on shelter costs have less money left for purchases such as food, clothing and school expenses.

Food insecurity

According to the Nutritious Food Basket report, individuals and families with low incomes do not have enough money to pay for their basic needs, including shelter and healthy food. When a large portion of income must be spent on rent, there is very little money left over to purchase food and cover other basic expenses.[7]

Food insecurity is strongly related to poor nutrition and poor physical and mental health in adults and children. In order to have a healthy diet, people need economic access to nutritious food. The most effective response to food insecurity is improving incomes.[7]

Social exclusion

People who are socially excluded experience a lack of belonging, acceptance and recognition. They tend to have diminished life experiences because they are more economically and socially vulnerable.[2]

Children living in poor families are less likely to have positive experiences at school and they are less likely to participate in recreation.[8] They are also more likely to report being bullied at school than children in higher-income families.[9]

How do we measure poverty?

There are several ways to measure poverty:

i) Recently, the government of Canada chose the Market Basket Measure (MBM) as the tool to measure Canada's official poverty line. It plans to use the MBM to measure its progress on meeting its poverty reduction goals. Individuals and families are considered to be living in poverty when they can't afford the cost of a pre-calculated "basket" of goods and services that are required to meet basic needs.[10]

ii) Many Public Health Units use the Low-Income Measure, after tax (LIM-AT). This measure is a fixed percentage (50%) of median adjusted household income, where "adjusted" indicates that household needs are taken into account. Adjustment for household sizes reflects the fact that a household's needs increase as the number of members increases.[11] The poverty statistics in this report are all based on the LIM-AT.

iii) The Low Income Cut-Offs (LICOs) are income thresholds. It is a measure that represents income levels at which people are spending 20% more than average of their after-tax income on the necessities of food, shelter and clothing.[12]

iv) Another commonly used measure is the Ontario Marginalization Index (ON-Marg). There are four dimensions in the ON-Marg that contribute to the process of marginalization: residential instability, material deprivation, dependency and ethnic concentration.[13]

v) The Nutritious Food Basket (NFB) is a tool that estimates the basic cost for an individual or household to eat healthy. Data from NFB costing is used by WDGPH for program planning and to promote access to healthy, nutritious food.[7]

Local picture

Low income

In Wellington, Dufferin, Guelph (WDG) there are 27,720 low income households. This is 10% of the WDG population. Most (62%) of those living in poverty are adults (15-64 years of age), almost a quarter (23%) are children and some (15%) are older adults. There are more females (just over 15,000) than males (less than 13,000) living in poverty in WDG. The WDG municipalities with the highest rate of impoverished households are Melancthon (15%) and Wellington North (15%). Although the rate of people living in poverty in Guelph is 11%, some neighbourhoods such as Onward Willow (22%), Two Rivers (19%) and Downtown/Sunny Acres (17%) have higher rates of low-income households.[6]

In WDG, 46% of tenant households and 17% of owner households spent 30% or more of their income on shelter.[6]

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

- not have a secondary school diploma (29%) as compared to the total population (18%).
- be unemployed (13%) as compared to the total population (5%).
- have moved within the past year (20%) as compared to the total population (13%).
- take a bus or walk to work (24%) as compared to the total population (9%).

Population groups

Some population groups are disproportionately impacted by poverty.

Working poor

The concept of working poor is generally well understood as individuals who are employed, but still cannot lift themselves and their families out of poverty. Research has demonstrated that challenges and issues associated with low-income are intensified by precarious employment. Employment precarity has significant impacts on household well-being, individual health, the well-being of children and community connections. Research also demonstrates that working poverty disproportionally impacts women, youth, racialized and recent immigrant workers. In Guelph-Wellington 5% of working age individuals (18-64 years of age) met the definition of working poor.[14]

In 2017, the Guelph & Wellington Task Force for Poverty Elimination surveyed residents of the City of Guelph and the County of Wellington to gain an in-depth understanding of the experiences of the working poor.

For the purposes of this project, working poor were defined as those who:

- have an after-tax income BELOW the Low-Income Measure (LIM),
- have earnings of at least $3,000 a year,
- are between the ages of 18 and 64,
- are not a student, and
- live independently.[14]

Survey results showed that:

- 52% of the working poor, compared to 10% of the working non-poor, reported that they do not have enough income to meet basic needs.
- Among the working poor, 66% indicated that they do not have enough money to support their family, compared to 13% of the working non-poor.
- 71% of working poor respondents reported that they have trouble accessing food, compared to 23% of the working non-poor.
- Of the working-poor respondents, 18% reported working multiple part-time jobs, 5% reported working multiple full-time jobs, and 5% reported working a combination of full-time and part-time jobs.
- 73% of working poor respondents indicated they have no health benefits and 77% reporting no dental benefits.
- More than three-quarters (80%) of the working non-poor rated their mental health as good to excellent, while only 38% of the working poor reported the same.
- A higher percentage of the working poor (57%) ranked their physical health as poor or fair, compared to the working non-poor (17%).[14]

Older adults

In WDG, female older adults are more likely to earn an after-tax income below $40,000 per year (78% vs 54%) and to live in poverty (10% vs 6%) than male older adults. In WDG, a lower percentage of older adults (8%) live in low-income compared to the rest of Ontario (10%).

Children

Poverty has a profound impact on the physical and mental health of children as well as their cognitive and social development. Poor families struggle to meet basic needs and often can’t afford nutritious food and safe places to live. The stress of coping with

chronic poverty limits the capacity of poor parents to provide a stimulating and nurturing environment for their children. In fact, the experience of poverty more than doubles many indicators of child ill health including: the accidental death rate, low birth weight, infant mortality rate, poor school performance and psychiatric disorders.[15]

In WDG, 14% of children live in low-income households. The highest rates are in Melancthon (26%), Mapleton (23%) and Wellington North (22%). Although the rate of children living in low-income in the City of Guelph is 14%, some neighbourhoods have much higher rates. In the Onward Willow neighbourhood, 35% of children 0-5 years of age are living in poverty.

Immigrants

In WDG, 14% of children and 9% of adults are living in low-income households. In comparison 52% of children who immigrated to Canada recently (2011-2016) and 18% of adults live in low-income households. The picture is even worse for immigrants who are non-permanent residents where 61% of children and 38% of adults are living in low-income households. Both of these groups are more likely to have a high school diploma than the general population. As immigrants are in Canada longer, many are able to move out of poverty and are no longer living in low income. For WDG residents who immigrated before 2011 the rate of adults living in low-income is 9%.

Some groups who identify as visible minorities are also more likely to live in poverty, in particular those who identify as Arab (36%) and Korean (32%). This trend is especially pronounced among children under the age of 6 years whose parents identify as visible minorities. A high proportion of Arab (70%) and Latin American (47%) children under the age of 6 years live in poverty in WDG. The differences in poverty rates among visible minorities and age groups demonstrates the complex and intersectional nature of poverty within WDG.

Indigenous populations

The health issues of First Nations, Inuit and Métis in Canada are considerable and complex. This is due to historical and contemporary forces which influence the health, health status and health outcomes of indigenous people. This includes the social determinants of health but also includes legislation, health policies and programs, colonization, intergenerational trauma, racism and urbanization.[16]

In WDG, 1.5% of the population (4,290 residents) identify as First Nations, Métis or Inuk (Inuit). Among the WDG indigenous population there are higher rates of adults living in low-income (13% compared to 9%) and much higher rates of children living in low-

income (31% compared to 14%). In addition, people who identify as indigenous are more likely to be unemployed (7% compared to 5%) and more likely not to have a high school diploma (28% compared to 18%).

Homelessness

Point-in-time counts were conducted in the City of Guelph and Wellington County (April 2018) and in Dufferin County (May 2018) to provide a snapshot of the population experiencing homelessness on one day of the year. The count is intended to capture an estimate of the number of people experiencing homelessness, as well as basic demographics, reasons for homelessness, and service use of people experiencing homelessness at a single point in time.

During the point-in-time counts, 263 people in Guelph, 62 people in Wellington County and 44 people in Dufferin County were identified as experiencing homelessness.[17+18]

In Guelph and Wellington County:

- A count of 41 (13%) self-reported that they were First Nations, Inuit, Metis or had Indigenous ancestry.[19] This is a high number given that only 1.5% of the WDG population identifies as indigenous.
- Most (61%) were male; 31% were female; 1% were transgender and <1% were two-spirit.
- 32% of those who were homeless were youth between 16-24 years of age.
- Nearly half (49%) of those who were homeless reported that they had first experienced homelessness as a child under the age of 18.
- A high number of those who were homeless reported they have addictions (61%) and mental health issues (64%). Nearly half of those who were homeless (45%) reported having both addiction and mental health issues.[17]

In Dufferin County:

- Eighteen percent (18%) self-reported that they were First Nations, Inuit, Metis or had Indigenous ancestry. This is a high number given that only 1.5% of the WDG population identifies as indigenous.
- Half (50%) were male; 45% were female and 5% identified as being gender non-conforming.
- 48% of those who were homeless were youth between 16-24 years of age.
- Many of those who were homeless (64%) reported that they had first experienced homelessness as a child under the age of 18.

- A high number of those who were homeless reported they have addictions (55%) and mental health issues (70%). Nearly one third of those who were homeless (32%) reported having a physical disability.[18]

Conclusion

There is a clear and robust relationship between income and health. Poverty leads to lower health status. People living in poverty are more likely to have poor outcomes including: higher rates of chronic disease, mental health challenges, housing instability, food insecurity and social exclusion.

The WDGPH Health Analytics team has developed online interactive reports to visualize local data. The interactive reports are dynamic and include data visualizations (maps, graphs, tables) to better illustrate the issues that impact the health of local residents. These reports can be accessed at wdgpublichealth.ca/data and can be used to explore poverty and other social determinants of health in our communities.

Ontario Public Health Standard

The monitoring and assessment of poverty is relevant to the and the Population Health Assessment and Health Equity sections of the Foundational Standard.

Population Health Assessment

"Population health assessment includes the **measurement, monitoring, analysis, and interpretation of population health data** and knowledge and intelligence about the health status of populations and subpopulations, including social determinants of health and health inequities. Population health assessment **provides the information necessary to understand the health of populations** through the collaborative development and **ongoing maintenance of population health profiles, identification of challenges and opportunities**, and monitoring of the health impacts of public health practice.[20]

Health Equity Standard

"Public health practice results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances."[20]

WDGPH Strategic Direction(s)

☒ **Health Equity**: We will provide programs and services that integrate health equity principles to reduce or eliminate health differences between population groups.

☐ **Organizational Capacity**: We will improve our capacity to effectively deliver public health programs and services.

☐ **Service Centred Approach**: We are committed to providing excellent service to anyone interacting with WDG Public Health.

☒ **Building Healthy Communities**: We will work with communities to support the health and well-being of everyone.

Health Equity

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

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Appendices

None.