

# HOW (UN)HEALTHY ARE POOR WORKING-AGE CANADIANS?

Myriam Fortin

Is there a quantifiable difference between the health of the working poor and that of more affluent Canadians? Myriam Fortin, senior researcher with Human Resources and Social Development Canada, examines data and, as she writes, “compares major health outcomes and behaviours for working-poor and welfare-poor Canadians.” Not surprisingly, the prevalence of illness is higher among poor than it is among nonpoor Canadians.

Y a-t-il un écart quantifiable entre la santé des travailleurs pauvres et celle des Canadiens mieux nantis ? Chercheuse principale à Ressources humaines et Développement social Canada, Myriam Fortin a examiné les données disponibles et « comparé les principaux résultats et comportements en matière de santé chez les travailleurs à faible salaire et les bénéficiaires de l'aide sociale ». Comme il fallait s'y attendre, on observe dans ce groupe une plus grande incidence des maladies que chez les Canadiens plus fortunés.



Surveys consistently show that health is a top priority for the majority of Canadians (for instance, health care services and the health care system were found to be Canada's most important challenges in an Environics survey conducted among Canadian adults in the fall of 2007). This interest in health is not surprising considering that being ill can have serious financial consequences. However, the reverse is also true; those who have limited financial means (the poor) are more likely than others to be ill, to have shorter life expectancy, to go hungry and to live in a neighbourhood where the crime rate is high or in unhealthy or noisy housing. Nevertheless, we know that not all poor persons are “equal.” For instance, while those who work many hours per year, the so-called “working poor,” have a better chance of escaping poverty than other poor Canadians who do not work as much or do not work at all, often the so-called “welfare poor,” they do not enjoy the same health benefits, even though they are as poor as the welfare poor and face more binding time constraints. Indeed, while many of the welfare poor have at least minimal coverage for dental, optometric and chiropractic services, prescription drugs, ambulance transportation and medical supplies through provincial income assistance, this coverage is the exception for the working poor.

This article summarizes findings from a lengthier study. Using 2005 data, it compares major health outcomes and behaviours for working-poor and welfare-poor Canadians. Using 1994 to 2004 data, it also examines insurance coverage among these groups as well as the causal connection between low income and poor health (in other words, is low income generally a precursor to poor health or is the reverse truer?).

Part of our health is explained by age and genetics but part of it is attributable to other factors, the most important being the so-called “social determinants of health” (income and social status, employment status, education level, social networks, etc.). In many of these, there were important differences between the working poor and the welfare poor. The former were more likely than the latter to be male, to be young, to live in central or western Canada, to be part of a couple with children and to have a higher education. By definition, the working poor also had a much stronger attachment to the labour market than the welfare poor (although, contrary to what one might have expected, over 40 percent of the welfare poor had wages, salaries or self-employment as their main source of income, while for less than a quarter of them social assistance was the main source of income). As we will see, being unemployed, even more than being poor, seems to increase the chances of becoming ill.

Many aspects of the health of working-age Canadians are of interest. This article focuses on four of them: the incidence of illnesses and perceived health, risk behaviours, disabilities and discrimination, and food insecurity.

The most common causes of death in industrialized countries are cardiovascular disease (mainly heart attacks), cancer, Alzheimer's disease and accidents, in that order. How do poor working-age Canadians fare in this respect? The research shows that the prevalence of heart disease, cancer and stroke, as well as of individuals reporting fair or poor health, was two to five times higher among the welfare poor than among the non-poor. The incidence of chronic physical and mental illness was

also significantly higher for the welfare poor, while the incidence of individuals reporting a decline in health over 1994-95 was two times higher among this group (table 1). On all of these indices, the working poor were generally as healthy as the nonpoor. In other words,

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poor working-age Canadians with a limited attachment to the labour market were much more likely than any other Canadian adults to be afflicted with an illness that could eventually kill them.

For most, having a job, preferably one with good working conditions, is not only essential to avoid poverty and to be accepted socially, but is also important for physical and mental health. The research suggests that the poor who were employed were less satisfied with their jobs than their nonpoor counterparts (over 18 percent of the welfare poor and 14 percent of the working poor were dissatisfied versus 8 percent of the nonpoor). Also, while there were no significant differences between the groups with regard to injuries serious enough to limit normal activities, the incidence of repetitive physical strains was highest among the working poor (70 percent of the working poor had recurring strains versus less than 40 percent of the welfare poor and 57 percent of the nonpoor).

Apart from illnesses, a number of behaviours can also be detrimental to health (for example, smoking or drinking too heavily, being inactive and eating too much). The good news is that with the proper financial and educational support these behaviours can be modified relatively quickly. The bad news is that the poor are a lot less likely than other Canadians to have either.

**A**ccording to this study, over 50 percent of all working-age Canadians

(whether poor or not) did not have a "normal" weight. However, the welfare poor were the most likely to be obese (over a quarter of them versus 17.3 percent of the working poor and 16.4 percent of the nonpoor). The proportion of inactive individuals was also higher

among the poor than the nonpoor (around 58 percent of working- and welfare-poor Canadians were inactive compared with 47 percent of the nonpoor), and a much higher proportion of the poor smoked cigarettes daily (about 30 percent of the working poor and the welfare poor were regular smokers compared with 19 percent of the nonpoor). Furthermore, the welfare poor had the lowest frequency of daily fruit and vegetable consumption of all working-age Canadians. However, contrary to popular belief, the incidence of regular drinkers

was lower among the poor than among the nonpoor (close to 90 percent of nonpoor working-age Canadians drank regularly compared with 78 percent of the working poor and 67 percent of the welfare poor), and the poor were not more likely than the nonpoor to drink heavily.

Having a disability makes it harder to find (or to keep) a job, but it also increases the chances of being excluded from the mainstream. For example, as noted in *A Report on Mental Illness in Canada*, discrimination against the mentally ill can have serious consequences. "Stigma and discrimination result in stereotyping, fear, embarrassment, anger and avoidance behaviours. They force people to remain quiet about their mental illnesses, often causing them to delay seeking health care, to avoid following through with recommended treatment and sharing concerns with family, friends, co-workers, employers, health service providers and others in the community." This research suggests that the welfare poor were much more likely than other poor and nonpoor working-age Canadians to report having

TABLE 1. PREVALENCE OF ILLNESSES AND PERCEIVED HEALTH, WORKING-AGE CANADIANS, 2005 (PERCENT)

	Working poor	Welfare poor	All poor	Nonpoor
Has a heart disease	—	6.4	4.3	2.5
Has cancer or has ever been diagnosed with cancer	—	2.7	1.1	0.9
Suffers from the effects of a stroke	—	2.1	1.6	0.4
Has at least one chronic health condition	65.2	76.1	71.0	68.1
Has other chronic condition	11.0	19.7	15.4	12.9
Self-rated health is fair or poor	9.7	27.6	19.7	7.3
Feels health has deteriorated over the past year	9.0	16.5	14.3	8.7

Source: Statistics Canada, Canadian Community Health Survey, cycle 3.1.

a physical or mental condition or a health problem that reduced the amount or kind of activity that they could do at home (12.1 percent did report it compared with 3.9 percent of the working poor and 4.9 percent of the nonpoor). They were also much more likely to say that they experienced discrimination or unfair treatment because of their health condition (27 percent did say it com-

pared with 16 percent of the working poor and less than 12 percent of the nonpoor), as well as to avoid conversation or contact with others or laughing or smiling because of a poor oral health condition (over 13 percent did versus less than 3 percent of the nonpoor).

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Working or going to school on an empty stomach is far from ideal, and relying on food banks to feed one’s family not only is stigmatizing but also takes time, which the poor who work have very little of. This research indicates that the poor were much more likely than the nonpoor to be food insecure (to compromise in the quality and/or quan-

tity of food that they ate) or severely food insecure (to have reduced food intake and disrupted eating patterns). Close to 30 percent of the welfare poor and over 20 percent of the working poor were food insecure compared with less than 4 percent of the nonpoor, and 13.5 percent of the welfare poor experienced severe food insecurity compared with 6 percent of the working poor and only

0.8 percent of the nonpoor. Hence, although generally as healthy as nonpoor working-age Canadians, the working poor were a lot more likely to be food insecure. This is one of the few instances where the working poor were more like other poor persons than the nonpoor.

**T**he results presented in this article show that whatever the health indicator chosen, the poor who have a weak attachment to the labour market, the welfare poor, are in much worse health than other poor and nonpoor working-age Canadians. But is their health poor as a result of living in poverty or is it the rea-

son why they became poor in the first place? This question has to be addressed before considering policy implications.

From 1994 to 2004, more than one-third of Canadians reported experiencing poverty, while less than one-fifth reported being in fair or poor health. This indicates that Canadians are generally quite healthy and that low income is much more common than poor health in Canada. With respect to private health insurance coverage, table 2 shows that in 1996 and in 2002, the poor were much less likely than the nonpoor to have any type of insurance. Although coverage increased for both groups in that period, the only type of insurance for which the

gap between them closed significantly was coverage for prescription medications, and this was mainly due to a significant improvement in conditions for the welfare poor. In fact, except for coverage for dental expenses, the welfare poor were the group that experienced the most important gains in coverage between 1996 and 2002. Interestingly, in both 1996 and 2002 the working poor were the most likely to lack coverage for prescription medication.

**I**nvestigating the connection between low income and poor health, this research found that for those of working

TABLE 2. INSURANCE COVERAGE AMONG CANADIAN POPULATION, 1996 AND 2002 (PERCENT)<sup>1</sup>

	Working poor in 1996	Welfare poor in 1996	Poor (all) in 1996	Not poor in 1996	Working poor in 2002	Welfare poor in 2002	Poor (all) in 2002	Not poor in 2002
Has any type of medical insurance	47.4	47.8	48.2	79.5	65.4	79.0	71.9	86.2
Has insurance that covers all or part of the cost of prescription medications	36.1	43.0	40.0	69.8	63.0	77.3	69.5	83.8
Has insurance that covers dental expenses	32.0	23.6	26.3	62.3	45.2	33.8	40.2	69.2
Has insurance that covers eyeglasses or contact lenses	25.5	22.8	22.8	52.9	37.1	36.2	36.2	61.2
Has insurance that covers hospital charges	30.7	16.6	24.3	60.8	36.7	31.6	35.4	69.9

Source: Statistics Canada, National Population Health Survey, cycles 1-6.

<sup>1</sup> The reference year was 1994.

TABLE 3. LOW INCOME LEADING TO POOR HEALTH: ALL CANADIANS<sup>1</sup> IN GOOD HEALTH AND NOT POOR IN 1994 (PERCENT)

Economic status in 1996	Self-rated health was good, very good or excellent in 1996 but fair or poor in any cycle between 1998 and 2004	Economic status in 1996	Self-rated health was good, very good or excellent in 1996 but fair or poor in any cycle between 1998 and 2004
Poor	23.4	Working poor	18.9
Not poor	14.0	Unemployed poor	32.2
Unemployed	26.0	Working, not poor	11.7
Working	12.2	Unemployed, not poor	24.9

Source: Statistics Canada, National Population Health Survey, cycles 1-6.  
<sup>1</sup> Population limited to persons aged 15 years and over whose employment status is known.

TABLE 4. POOR HEALTH LEADING TO LOW INCOME: ALL CANADIANS<sup>1</sup> IN GOOD HEALTH AND NOT POOR IN 1994 (PERCENT)

Health status in 1996	Not poor in 1996 but became poor in any cycle between 1998 and 2004	Health status in 1996	Not poor in 1996 but became poor in any cycle between 1998 and 2004
Healthy	18.3	Healthy, insured	15.5
In poor health	27.2	Healthy, not insured	34.6
Insured	15.7	Not healthy, insured	—
Not insured	34.7	Not healthy, not insured	—

Source: Statistics Canada, National Population Health Survey, cycles 1-6.  
<sup>1</sup> Population limited to persons aged 15 years and over whose employment status is known.

age, low income seems to be a precursor to poor health, *but to a lesser degree than unemployment*. The worst combination is being unemployed and poor; almost one-third of the unemployed poor reported a decline in health over an eight-year period, compared with about one-tenth of the working nonpoor (table 3).

With respect to poor health being a precursor to low income, it seems that it is not so much being ill as lacking health insurance coverage that leads to low income (table 4). However, this result has to be interpreted with caution. The fact that individuals with supplementary insurance are less likely to experience low income may have more to do with the characteristics of this population (for example, they may be in more stable employment or more forward-looking than other individuals) than whether they have supplementary insurance.

**H**ere I come back to the initial question: Is low income more often a precursor to or a consequence of poor health? Knowing that over a 10-year period Canadians are almost twice as likely to experience low income than poor health, we can conclude that in a given year the poor health outcomes of those living in

low income are, in most cases, due to experiencing unemployment, low income or a combination of both prior to the period of observation rather than to a pre-existing health condition.

The working poor are generally as healthy as non-poor working-age Canadians and much healthier than other poor persons, both in a given year and over the longer term, although, like other poor persons, they are more likely to experience food insecurity and to have a lifestyle that is detrimental to their health. In comparison, poor Canadians who do not work as much or do not work at all, the welfare poor, have the worst health outcomes of all working-age Canadians. With respect to the connection between income and health, results indicate that low income seems to lead to poor health, but to a lesser degree than unemployment.

These findings have some implications for policies and programs. They suggest that:

- Encouraging Canadians who do not have work limitations to join the labour market makes a lot of sense, because it should increase their chances not only of escaping

poverty, but also of staying healthy over the longer term.

- Reducing poverty could improve the health of financially worse-off Canadians, but it would also be desirable from an economic perspective as the poor health of those with low incomes puts a strain on Canada's health care system.
- Providing coverage for prescription medication and other expenses to the working poor could help lower the "welfare wall" so that individuals on social assistance are encouraged to join the labour market, but it could also persuade the working poor to stay in work while improving their financial conditions and health.
- Welfare-poor Canadians deserve special attention as they have far worse health outcomes and a much weaker attachment to the labour market than other poor persons, two conditions that put them at higher risk of being trapped in poverty for many years.

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