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1. What are health disparities?

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Impacts of Poverty on Marginalized Groups

Prologue
Health Disparity by Neighbourhood Income

- There were six low income neighbourhoods and six affluent neighbourhoods identified in Saskatoon
  - They were determined by the 2001 Census
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Health Disparity by Neighbourhood Income (2006)

In comparison to high income residents, low income residents in Saskatoon were:

• 1458% more likely to attempt suicide
• 1186% more likely to be hospitalized for diabetes
• 1389% more likely to have chlamydia
• 3360% more likely to have Hepatitis C
• 1549% more likely to have a teen birth
• 448% more likely to have an infant die in the first year
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Health Disparity by Neighbourhood Income (2007 & 2008)

In comparison to higher income children, Saskatoon children aged 10-15 years that are low income were:

• 180% more likely to have low self report health
• 200% more likely to be depressed
• 250% more likely to be anxious
• 190% more likely to have suicidal thoughts
• 41% more likely to have low self esteem
• 1140% more likely to be smoking already
• 200% more likely to be using alcohol already
• 1900% more likely to be using marijuana already
Chapter 1

What are health disparities?
Factors that Influence Our Health

An Uphill Battle

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healthy eating
physical activity
tobacco and substance use
income
education
social support networks
Health Disparities

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Our health – Life expectancy

Life expectancy at birth by neighbourhood income and sex, urban Canada, 2001

Q – population divided into fifths based on the percentage of the population in their neighbourhood below the low-income cut-offs.

Our health – Life expectancy

Life expectancy at birth by sex, Registered Indian and general population, Canada, 1980-2001

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Ratio of Age Standardized Hospitalization Rates Between Low and High SES Groups, Pan-Canadian, Regina, Saskatoon and Winnipeg

Source: Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada
Chapter 2

Why does this matter?
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Three truths about health disparities…

1. They are unfair or unjust.

2. They can and should be prevented.

3. Sooner is better!
Growing Up Well

Health trajectories are the pathways that individuals follow from a health perspective. These pathways evolve over time, and the directions taken are dependent on and shaped by individual actions, as well as by the circumstances and conditions that individuals experience throughout life.
What do children need for health?

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a) Income and Health

- 17.1% of Saskatoon residents live below the LICO (Low Income Cut-Off)
- 20.1% of the children under the age of 18 live below the LICO
- 26.3% of children aged 0-2 live below the LICO
**Socio-economic Status – Adequate Income**

**Estimated proportion of children, aged 0 to 11 years, living in low-income households, Canada, 1991 to 2006**

**Source:** Statistics Canada.

*Deciles refer to the division of families raising children in Canada into tenths based on their after-tax income.*

**Ratio of richest and poorest deciles, families raising children in Canada, 1976 to 2004**

**Source:** Yalnizyan, A. (2007).
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There’s more to poverty than meets the eye.

- Child poverty rates in Manitoba and Saskatchewan are the highest in Canada.
- Children who live in poverty are five times more likely than high income youth to drop out of school.

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b) Education and Health

In comparison to higher educated residents, Saskatoon residents with less than high school graduation are:

- 55% more likely to have diabetes
- 30% more likely to have suicide ideation
- 141% more likely to have heart disease
- 40% more likely to be daily smokers
Educational Disparity in Saskatoon

- Approximately 690 children below the age of 19 do not attend school in Saskatoon.
- 10.7% of all adults between the ages 20-24 do not have a high school diploma and are not in school.
- 48% of Aboriginal adults between 20 and 24 do not have a high school diploma and are not in school.
c) Early Childhood Development

Receptive vocabulary scores* of children, age 5, by household income levels, who were or were not read to daily, Canada, 2002-2003

**LICO** – Low-income cut off
*A score of 75 corresponds to the lower 5th percentile of the receptive vocabulary score distribution.

Early Childhood Development

In 2006, a national cohort of more than 100,000 children at the senior kindergarten-level in seven provinces (average age of 5.7 years) was assessed using the EDI:

- 28% were classified as “vulnerable” on at least one domain
- Aboriginal children had lower mean scores than non-Aboriginal children
- Children who had attended an organized part-time, pre-school, nursery school, or junior kindergarten had higher mean scores
d) Healthy environments

Westmount School, Saskatoon SK
Why does this matter?

“Reducing health inequities is, ...an ethical imperative. Social injustice is killing people on a grand scale.”

- Michael Marmot, 2008

www.freedommarchusa.org
BOX 3.2: INVESTING FOR HEALTH AND ECONOMIC RETURN, CANADA

A study in Canada shows that reducing health disparities has the potential for major economic benefits resulting from a reduction both in health-care needs and in the costs of lost productivity. Health-care spending in Canada is about 120 billion Canadian dollars per year (with the institutionalized population accounting for 26 billion Canadian dollars and the household population accounting for 94 billion Canadian dollars). The lowest income quintile of the household population accounts for approximately 31% of the 94 billion Canadian dollars, approximately double the utilization of the highest-income quintile. The study reported that if the health status and utilization patterns of those in the lower-income groups equalled those with middle income, significant savings on health-care costs could be possible.

In addition, the study reported that better health enables more people to participate in the economy. Reducing the costs of lost productivity by only 10-20% could add billions of dollars to the economy.

Source: Health Disparities Task Group, 2004
Growing Up Well

“One dollar spent in the early years is estimated to save between $3 and $9 in future spending on health, social and justice services.”

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Chapter 3

What can we do?
Evidence to Action – Research

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Evidence to Action – Community Consultation


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Evidence to Action – School Interventions

- School Health Committee formed in 2008
  - Discussed the disparity that exists in Saskatoon
  - Discussed possible interventions to address this disparity
  - Members included:
    • Principals and Community Coordinators
    • Public Health Nurses
    • Three Public Health Services Departments
    • School board representatives
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Evidence to Action – School Interventions

2. Physical activity programs
3. After-school activities
4. Health promoting schools
Impacts of Poverty on Marginalized Groups

ROAR (Resilience. Opportunity. Attitude. Reflection.)

• To enhance and strengthen resilience and self-esteem (ROAR-S)
• To increase understanding of children’s developmental needs and promote relationships (ROAR-F)
• Population: grade 6 classrooms in five low-income neighbourhood schools in Saskatoon
• 11 week program, 1 hour each week
• Small groups for caregivers (2 sessions per school)
• Started in March 2010 - Ending in June 2010
• Partnered with Public School Division and CPHA
• Funded by PHAC’s Innovation Strategy
• Evaluation administered in June 2010
Physical activity programs

- To increase exposure to physical activity opportunities and increase physical fitness
- Population: grade 6 classrooms in five low-income neighbourhood schools in Saskatoon
- Physical activity programs unique to school
- Fitness challenge at beginning and end of program
- Partnered with Public School Division
- Evaluation administered in June 2010
Impacts of Poverty on Marginalized Groups

After-school programs

- To improve students’ self-esteem, school performance, and behaviour
- Population: 216 students in ten low-income neighbourhood schools in Saskatoon
- After-school programs unique to school
- Partnered with United Way and School Boards
- Evaluation administered in 2009/2010
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Health promoting schools

• To have healthier weights among children and families
• Population: 20 urban and rural complex-needs schools in 4 school divisions
• Co-leadership model between health and education, including alignment of partner priorities and outcomes
• Funded by PHAC
• Started in 2010 (Phase I)
• Phase II to begin in 2012 (expanded sites)
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Evidence to Action – Raising Awareness

1. Social marketing campaign
2. School curriculum toolkit
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There’s more to poverty than meets the eye.

- Child poverty rates in Manitoba and Saskatchewan are the highest in Canada.
- Children who live in poverty are five times more likely than high income youth to drop out of school.

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- Canadians with disabilities face 53% higher unemployment rates.
- In Saskatchewan, 7 out of 10 long-term social assistance clients have a disability.

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There's more to Poverty than meets the eye

- A golden retirement does not exist for many older Canadians.
- More than one quarter of seniors live at or near the poverty line.

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Impacts of Poverty on Marginalized Groups

- Almost half of low-income households include at least one working adult.
- Full-time minimum wage pays under $20,000 per year - almost $16,000 below the poverty line for a family of four.

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School Curriculum Toolkit
“Health inequalities are fundamentally societal inequalities that we can overcome through public policy, and individual and collective action.”

-Dr. David Butler-Jones
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Total family policy generosity and child poverty in 20 countries, circa 2000.

Net benefit generosity of transfers as a percentage of an average net production worker's wage.
The poverty line is 50% of median equivalized disposable income.
AUS = Australia; AUT = Austria; BEL = Belgium; CAN = Canada; FIN = Finland; FRA = France;
GER = Germany; IRE = Ireland; ITA = Italy; NET = the Netherlands; NOR = Norway; SWE =
Sweden; SWI = Switzerland; UK = the United Kingdom; USA = the United States of America.
Examples of Evidence-based Options

a) Set measurable goals to reduce poverty
e.g.
• Reduce poverty in children from 20% to 2% in five years
• Reduce poverty in all residents from 17% to 10% in 5 yrs

• In Ireland, a target was set to reduce poverty from 15 to 10%. Within 4 yrs, the rate fell to 5%. The target was achieved by goal setting coupled with increases in social assistance payments, educational initiatives and employment programs.
b) Ensure no child lives in poverty
e.g.
• Parents with children on social assistance should have their shelter allowances and adult allowances doubled – to raise children above the LICO. For example, a lone parent with 2 children receives $725 per month from Social Services for shelter, food, clothing, etc.
• Prioritization of children was a key strategy in poverty reduction plans in UK, Sweden and Quebec
Examples of Evidence-based Options (continued)

c) Create a Child Poverty Protection Plan
   • With Canada Pension Plan, only 6% of seniors live in poverty instead of 58%

Various funding options are available, such as:
   • Exempting 500,000 residents, $6 from every worker and $5 from every business per week would fully fund a national Child Poverty Protection Plan. This plan would bring every child $1 above the poverty line.
Epilogue
Closing the Gap in a Generation

1. Improve the conditions of daily life.

2. Tackle the inequitable distribution of power, money, and resources.

3. Measure, evaluate, educate, build capacity, and raise awareness.
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Fair Society, Healthy Lives


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Addressing Health Inequalities

1. Social investment
2. Community capacity
3. Inter-sectoral action
4. Knowledge infrastructure
5. Leadership
What can teachers do?

- Reduce income disparities
- Strengthen social capital
- Support public schooling
- Reduce disparities for disadvantaged students
- Educate students about the impacts of inequity and social injustice
- Increase access to early childhood education and postsecondary school education for all
- Provide for community control of schools and Aboriginal students on reserve
- Provide life-long learning opportunities for parents and adults
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What can we do?

• Support ongoing research - e.g. costs of poverty vs. interventions, relative contributions of various determinants, identifying disparities in urban and rural areas and in specific risk groups, monitor public support
• Support evaluation of interventions being tried (for sufficiency and effectiveness)
• Promote regular reporting on progress - report cards, serial health disparities reports to monitor situation
• Promote mechanisms that allow or encourage inter-ministerial solutions
• Become aware, and educate politicians about the causes and solutions
• Adopt what has worked in other provinces, or work together with other provinces to collectively ask for federal policy changes
• Change what you can in your own sphere of influence (home, school, workplace, neighbourhood, community, etc.) - locally, provincially, nationally, globally