Rising Inequality, Declining Health

Health Outcomes And The Working Poor

Sheila Block

Wellesley Institute
advancing urban health

July, 2013

The Wellesley Institute engages in research, policy and community mobilization to advance population health.

Acknowledgements: Thanks to the Metcalf Foundation for its generosity in sharing its data.

Thanks to Maureen Miller, Brian Murphy, John Stapleton and Yue Xing for their comments on an earlier version of this report.

Copies of this report can be downloaded from www.wellesleyinstitute.com.

Rising Inequality, Declining Health | Research Paper

10 Alcorn Ave, Suite 300
Toronto, ON, Canada M4V 3B2
416.972.1010
contact@wellesleyinstitute.com

Wellesley Institute
advancing urban health

TABLE OF CONTENTS

TABLES

Rising Inequality, Declining Health

Health Outcomes and the Working Poor

Wellesley Institute
advancing urban health

Introduction

In a 2012 report, the Metcalf Foundation developed a new definition of working poverty. This definition is based on income, rather than hours worked, and excludes students and those who do not live independently. Applying that definition, the authors then used data from the Survey of Labour and Income Dynamics (SLID) and the Census to estimate how many people in Toronto were living in working poverty, where they were living and working, and to describe their family lives, education and age.[1]

This research found that 113,000 people were living in working poverty in the Toronto region in 2005, a 42% increase from 2000. The report findings indicate people living in working poverty:

- most commonly work in sales and service occupations;
- work a comparable number of hours and weeks as the rest of the working population;
- are overrepresented among immigrants; and
- are only slightly less educated than the rest of the working-age population.

This brief report builds on the Metcalf analysis to consider the impact of working poverty on self-reported health. How do people who are working and poor (working poor) describe their health? How does their health compare with others who are poor but are not in the labour force (non-working poor)? How does their health compare with those who are able to work and support themselves and their families (working non-poor)? Finally, how have these three groups' perceptions of their health changed over time?

The Impact Of Work On Health

The World Health Organization (WHO) Commission on the Social Determinants of Health stated that:

> Employment and working conditions have powerful effects on health and health equity. When these are good they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychological hazards – each important for health. In addition to the direct health consequences of tackling work-related inequities, the health equity impact will be even greater due to work's potential role in reducing gender, ethnic, racial and other social inequities.[2]

Work affects our health through a number of different pathways. One pathway is the impact of work on our health through our incomes. A report from Statistics Canada provides a stark Canadian example of the impact of income and income inequality on health. The difference in life expectancy between the bottom and the top deciles was 7.4 years for men and 4.5 years for women.[3] While these differences are striking, an equally important finding is that life expectancy increases with each and every decile. When health-related quality of life is considered, the gaps are even greater. Men in the highest income group had 14.1 more years of healthy living than those in the lowest income group. That gap between women in the

lowest and highest income groups was 9.5 years. Once again there is a gradient evident when comparing those in the middle of the income scale with those at the top.

The link between unemployment and ill-health has been clearly established.[4] However, the negative impact that work can have on health is not limited to unemployment. Precarious work has an impact on health both through Occupational Health and Safety (OHS) and through the employment relationship itself. In a review of the evidence in industrialized countries, the vast majority of studies found precarious employment was associated with a deterioration in OHS with respect to injury rates, disease risk, hazard exposures, and knowledge of OHS and regulatory responsibilities.[5] Of the 41 studies documenting the impact of downsizing and organizational restructuring, 36 found negative OHS outcomes.

The ill effects of precarious work are not limited to OHS outcomes. The concept of employment strain has been developed as a way of describing and documenting the connections that exist between health and the employment relationship itself; how people acquire work, how they keep work and how they negotiate the terms and conditions of work. Precarious work is associated with higher employment strain while more stable, standard working relationships are associated with less employment strain. For example, Canadian research shows higher risk of self-reported ill health and a greater incidence of working in pain among precarious workers compared with workers in similar jobs who are in more secure forms of employment.[6]

Together this evidence suggests that the working poor face elevated health risks both from lower incomes and working conditions.

Understanding Self-Reported Health

Self-reported health (SRH) is a measure in which people are asked to rate their own health status. The most commonly asked question is "How is your health in general?" on a scale that ranges from excellent to poor.[8] Unlike other, more objective measures of health such as death, or clinically diagnosed chronic disease, or disability, SRH relies on a person's own assessment of their health. This personal assessment can often capture physical, psychological and functional aspects of health, as well as personal experiences and health behaviours.[9] A strong body of evidence suggests that self-reported health is a good predictor of death across age groups and cultures.[10-12] SRH is also a reliable predictor of long-term health outcomes such as disability and cognitive function. [13]

Although its simplicity and usefulness in measuring overall health status has been well established, SRH has some limitations. The reliance on people's own understanding and perception of what constitutes good or poor health may make the measure subject to a reporting bias.[14] This means that people can be selective about what they share and may under or over-report their health status for different reasons.

Population group differences can pose challenges especially when using SRH to assess social inequalities in health.[15] This measure is also affected by people's expectation of good health, which is affected by their social and cultural context.[15] For example, people with higher socioeconomic status more frequently report chronic illnesses while less educated people tend to underreport poor health.[15] The effect of income-related reporting differences on SRH has been observed in research from Europe.[20] In addition to socioeconomic variation in SRH, differences have also been observed between and within ethnic groups in their assessment of health, which can influence the validity of the SRH measure when examining health disparities.[21]

Despite these limitations, self-reported health is a useful, consistently utilized and easily understood

measure of overall health status. This is particularly true, as it relates to predicting mortality and morbidity. Since there is evidence that indicates the limitations of using SRH across socio-economic groups, there should be some caution in interpreting the results reported below.

Data

The Survey of Labour and Income Dynamics (SLID) is a survey of all individuals in Canada, excluding residents of the Yukon, the Northwest Territories, Nunavut, residents of institutions and Aboriginal people living on reserves.[22] The respondents for SLID are selected from the monthly Labour Force Survey (LFS) and share its sample design. Data are collected from survey participants as well as being extracted from administrative files. For each sampled household in SLID, interviews are conducted over a six-year period. Every year between January and March, interviewers collect information regarding respondents' labour market experiences and income during the previous year. Information on educational activity and family relationships is also collected at that time. The demographic characteristics of family and household members represent a snapshot of the population as of the end of each calendar year.

The data reported below are custom tabulations on self-reported health for the populations identified in the Metcalf study as working poor, working non-poor, and non-working poor. These cross tabulations were produced for Toronto, Ontario, and Canada from 1996 to 2009.

The Metcalf report defines working poverty as:

- After-tax income below the low income measure (LIM)
- Earnings of at least $3,000 a year
- Between the ages of 18 and 64
- Is not a student; and
- Lives independently

For persons aged 16 or older, the SLID survey asks, "What is your current state of health?" and respondents can select any of the following answers:

- Excellent
- Very good
- Good
- Fair

Differences In Self-Reported Health Across Income And Work Status: 2009

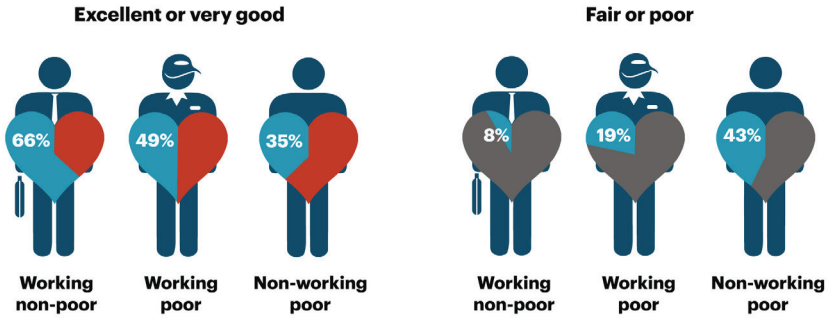
These data show a gradient in health: people who are working and are not poor have better self-reported health than those who are working and poor, and those with the worst self-reported health are those who are poor and not working. The Canadian data shows that 67% of people who were working non-poor reported their health as excellent or very good as compared with 53% of the working poor and 35% of people who were non-working poor. Similarly, 7% of people who were working non-poor reported their health as fair or poor as compared with 16% of people who were working poor and 39% who were non-working poor.

The Ontario data show that 66% of people who were working non-poor reported their health as excellent

or very good as compared with 49% of the working poor and 35% of people who were non-working poor. Similarly, 8% of people who were working non-poor reported their health as fair or poor as compared with 19% of people who were working poor and 43% who were non-working poor.

There is a slightly different pattern for Toronto. The data showed a much smaller health gap between the groups of people who are poor. This was the case both for those who reported their health as excellent or very good, and those who reported their health as fair or poor. Fourty-four percent of the working poor and 45% of people who were non-working poor reported their health as excellent. Twenty-five percent of people who were working poor and 31% who were non-working poor reported their health as fair or poor. The differences in self-reported health between those who were poor and those who were not were similar to Ontario and Canada. In Toronto, 8% of people who were working non-poor reported their health as fair or poor and 65% rated their health as excellent in Toronto. Given the very small sample size, the Toronto data should be treated with caution, and particularly when there is a deviation from the national and provincial trends.

Self Reported Health: Ontario



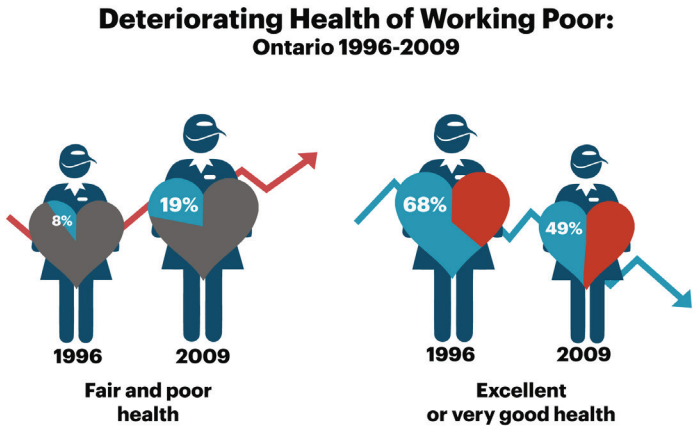
These relationships between working poverty and health differ from those in research by Myriam Fortin comparing health outcomes and behaviours for working poor and welfare poor Canadians.[7] Using 2005 data from the Canadian Community Health Survey, she found, on a number of measures including changes in self-reported health, the working poor were generally as healthy as the non-poor. It showed that 9.7% of working poor persons rated their health as poor or fair as compared with 27.6% of welfare poor and 7.3% of non-poor. The author concludes that 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.

Differences in the definition of working poverty might account for the differences in Fortin's results as compared to the data reported here. The Metcalf definition captures a broader low-income population, as it is based on minimum earnings of $3,000 or more, rather than on the minimum of 910 hours worked used in Fortin's research. At the same time, the exclusion of those who do not live independently narrows the population of working poor in the Metcalf definition. Further, the use of data from different surveys might also contribute to the differences in results.

Changes In Self-Reported Health Over Time: 1996-2009

For those who are working and make enough to support themselves and their families (working non-poor), there has been stability in self-reported health over the 13 year time period. Across the three geographies, Canada, Ontario, and Toronto, the shares of this population reporting excellent or very good health ranged between 64% and 74% over the entire period. There is a slight downward trend in the share of people who reported that their health has been excellent or very good. However, this downward trend has been accompanied by an increased share of those who report their health as good, those who report their health as fair or poor remain consistently between 4% and 8% of this population (see Tables 3, 6, 7).

Over the period, there was a more pronounced drop in the share of working poor who reported their health as excellent or very good in both Canada and Ontario. It dropped from 64% to 53% in Canada and from 68% to 49% in Ontario. Similarly, there was a sharp rise in the share of the working poor who saw their health as fair or poor, from 9% to 16% in Canada, and from 8% to 19% in Ontario (see Tables 1, 4). Year to year variability in the data for working poor and non-working poor in Toronto, most likely a result of small sample size, prevented meaningful comparisons over time.



Across Canada, there was also a downward trend in the share of the non-working poor who reported their health as excellent and very good, or good. The share that reported their health as excellent or very good dropped from 40% to 35% over the period. At the same time, the share reporting their health as good fell from 29% to 26%. The share that reported their health as fair or poor rose from 31% to 39%. The Ontario data shows the share reporting their health as excellent or very good falling from 43 to 35% over the period. The share that reported their health as good fell from 28% to 22%. The shares who reported their health as fair or poor increased from 29% to 43% (see Tables 2, 5). However, the greater year to year variability in this Ontario data suggests that this last comparison overstates the shift in the numbers reporting their health as poor or fair.

Implications

The Metcalf Foundation report made an important contribution both in defining working poverty and shedding light on the experience of those whose work does not provide sufficient income. The data reported here shed further light on the health of those who are working but who do not make sufficient incomes to support their basic needs and are, therefore, living in poverty. The data show a gradient in health outcomes. Those who have sufficient incomes have better self-reported health than those who do not. They also show that health outcomes for people living in poverty have deteriorated along with labour market conditions. The data suggests that deteriorating labour market conditions and rising income inequality has been accompanied by the rising inequities in health outcomes.

Table 1: Working Poor in Canada

Working Poor			
	Excellent + Very Good	Good	Fair + Poor
1996	64%	27%	9%
1997	64%	26%	10%
1998	68%	23%	9%
1999	62%	27%	11%
2000	57%	31%	12%
2001	55%	29%	16%
2002	57%	31%	12%
2003	59%	29%	11%
2004	58%	29%	13%
2005	58%	28%	13%
2006	52%	33%	15%
2007	55%	29%	16%
2008	53%	33%	14%
2009	53%	31%	16%

Source: Statistics Canada. 2013. Special Tabulation, based on Survey of Labour and Income Dynamics.

Table 2: Non-Working Poor in Canada

Non-Working Poor			
	Excellent + Very Good	Good	Fair + Poor
1996	40%	29%	31%
1997	35%	30%	34%
1998	39%	26%	35%
1999	38%	26%	36%
2000	36%	27%	37%
2001	34%	26%	40%
2002	35%	26%	39%
2003	31%	30%	39%
2004	31%	29%	40%
2005	34%	28%	37%
2006	30%	30%	41%
2007	27%	32%	40%
2008	29%	29%	42%
2009	35%	26%	39%

Source: Statistics Canada. 2013. Special Tabulation, based on Survey of Labour and Income Dynamics.

Table 3: Working Non-Poor in Canada

Working Non-Poor			
	Excellent + Very Good	Good	Fair + Poor
1996	73%	21%	6%
1997	73%	22%	5%
1998	72%	22%	5%
1999	71%	22%	7%
2000	68%	25%	7%
2001	67%	25%	8%
2002	70%	24%	6%
2003	70%	24%	6%
2004	69%	24%	6%
2005	68%	25%	6%
2006	68%	25%	6%
2007	67%	26%	7%
2008	69%	25%	6%
2009	67%	26%	7%

Source: Statistics Canada. 2013. Special Tabulation, based on Survey of Labour and Income Dynamics.

Table 4: Working Poor in Ontario

Working Poor			
	Excellent + Very good	Good	Fair + Poor
1996	68%	24%	8%
1997	70%	20%	10%
1998	70%	21%	9%
1999	65%	24%	11%
2000	52%	34%	13%
2001	50%	25%	24%
2002	56%	28%	16%
2003	55%	32%	12%
2004	54%	28%	18%
2005	56%	30%	14%
2006	49%	33%	18%
2007	57%	27%	16%
2008	50%	34%	16%
2009	49%	32%	19%

Source: Statistics Canada. 2013. Special Tabulation, based on Survey of Labour and Income Dynamics.

Table 5: Non-Working Poor in Ontario

Non-Working Poor			
	Excellent + Very good	Good	Fair + Poor
1996	43%	28%	29%
1997	38%	23%	39%
1998	39%	22%	39%
1999	44%	21%	35%
2000	36%	24%	39%
2001	38%	24%	38%
2002	38%	22%	40%
2003	32%	29%	39%
2004	31%	26%	43%
2005	32%	28%	40%
2006	24%	29%	47%
2007	29%	27%	44%
2008	26%	29%	45%
2009	35%	22%	43%

Source: Statistics Canada. 2013. Special Tabulation, based on Survey of Labour and Income Dynamics.

Table 6: Working Non-Poor in Ontario

Working Non-Poor			
	Excellent + Very good	Good	Fair + Poor
1996	72%	22%	6%
1997	72%	23%	5%
1998	72%	22%	5%
1999	72%	21%	7%
2000	67%	26%	7%
2001	66%	27%	8%
2002	70%	24%	6%
2003	69%	24%	7%
2004	69%	24%	7%
2005	66%	27%	7%
2006	67%	26%	7%
2007	66%	27%	7%
2008	68%	25%	7%
2009	66%	26%	8%

Source: Statistics Canada. 2013. Special Tabulation, based on Survey of Labour and Income Dynamics.

Table 7: Working Non-Poor in Toronto

Working Non-Poor			
	Excellent + Very Good	Good	Fair + Poor
1996	70%	24%	6%
1997	72%	24%	4%
1998	73%	23%	4%
1999	74%	21%	5%
2000	67%	27%	6%
2001	67%	27%	7%
2002	69%	25%	6%
2003	69%	24%	7%
2004	68%	25%	7%
2005	65%	27%	8%
2006	65%	27%	8%
2007	64%	28%	8%
2008	67%	27%	6%
2009	65%	27%	8%

Source: Statistics Canada. 2013. Special Tabulation, based on Survey of Labour and Income Dynamics.

References

1. Stapleton J, Murphy B, Xing Y., *The Working Poor in the Toronto Region: Who they are, where they live, and how trends are changing*, Toronto: Metcalf Foundation, 2012.
2. Commission on Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health*, Geneva: World Health Organization, 2008.
3. McIntosh CN, Fines P, Wilkins R, Wolfson MC., *Income disparities in health-adjusted life expectancy for Canadian adults, 1991 to 2001*, Health Reports, 2009;20(4).
4. Employment Conditions Knowledge Network, *Employment Conditions and Health Inequities: Final Report to the WHO Commission on Social Determinants of Health*, Geneva: World Health Organization, 2007.
5. Michael Quinlan, Mayhew C, Philip B., *The Global Expansion of Precarious Employment, Work Disorganization, and Consequences for Occupational Health: A Review of Recent Research*, International Journal of Health Services, 2001;31(2):335-414.
6. Lewchuk W, De Wolff A, King A, Polanyi M., *The Hidden Costs of Precarious Employment: Health and the Employment Relationship*, In: Vosko L, editor, *Precarious Work: Understanding labour market insecurity in Canada*, Montreal: McGill-Queen's University Press; 2005, p. 141-62, 397-8, 409-53.
7. Fortin M, Myriam F., How (Un)Healthy Are Poor Working-Age Canadians, Policy options, 2008;29(8):71.
8. Lindeboom M, van Doorslaer E., *Cut-point shift and index shift in self-reported health*, Journal of Health Economics, 2004;23(6):1083-99.
9. Simon JG, De Boer JB, Joung IMA, Bosma H, Mackenbach JP., *How is your health in general? A qualitative study on self-assessed health*, The European Journal of Public Health, 2005;15(2):200-8.
10. Burström B, Fredlund P., *Self Rated Health: Is it as good a predictor of subsequent mortality among adults in lower as well as in higher social classes?* Journal of Epidemiology and Community Health.,2001;55(11):836-40.
11. DeSalvo K, Bloser N, Reynolds K, He J, Muntner P., *Mortality prediction with a single general self-rated health question*, J Gen Intern Med, 2006;21(3):267-75.
12. Idler EL, Benyamini Y., *Self-rated health and mortality: a review of twenty-seven community studies,* J Health Soc Behav 1997;38(1):21-37
13. Bond J, Dickinson H, Matthews F, Jagger C, Brayne C., *Self-rated health status as a predictor of death, functional and cognitive impairment: a longitudinal cohort study,* Eur J Ageing, 2006;3(4):193-206.
14. Johnston DW, Propper C, Shields MA., *Comparing subjective and objective measures of health: Evidence from hypertension for the income/health gradient*. Journal of Health Economics. 2009;28(3):540-52.
15. Tubeuf S, Jusot F, Devaux M, Sermet C., *Social Heterogeneity in Self-Reported Health Status and Measurement of Inequalities in Health*, Paris: IRDES, 2008.
16. d'Uva B, van Doorslaer E, Lindeboom M, O'Donnell O, Chatterji S., *Does Reporting Heterogeneity bias the Measurement of Health Disparities?* Rotterdam: Tinbergen Institute, 2006.
17. Jylhä M, Guralnik JM, Ferrucci L, Jokela J, Heikkinen E., *Is Self-Rated Health Comparable across Cultures and Genders?,* The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 1998;53B(3):S144-S52.
18. Huisman M, van Lenthe F, Mackenbach J., *The predictive ability of self-assessed health for mortality in different educational groups*, International Journal of Epidemiology, 2007;36(6):1207-13.
19. Singh-Manoux A, Dugravot A, Shipley MJ, Ferrie JE, Martikainen P, Goldberg M, et al., *The association between self-rated health and mortality in different socioeconomic groups in the GAZEL cohort study,* International Journal of Epidemiology, 2007;36(6):1222-8.
20. Etilé F, Milcent C., *Income-related reporting heterogeneity in self-assessed health: evidence from France*, Health Economics, 2006;15(9):965-81.

21. Bombak AE, Bruce SG., *Self-rated health and ethnicity: focus on indigenous populations*, 2012.
22. Statistics Canada, *Survey of Labour and Income Dynamics (SLID)*, Ottawa: Statistics Canada, 2012, Available from: http://www.statcan.gc.ca/pub/75f0011x/2012001/method-eng.htm.