



**THE IMPACT OF POVERTY
ON THE HEALTH
OF CHILDREN AND YOUTH**

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When there is hunger while some have too much to eat, or when there is homelessness while some live in luxury, or when there is poverty in the midst of affluence, justice is not present (ISARC: 1998)

Introduction

This paper examines poverty as a determinant of health for children and youth in Canada. It will discuss how poverty, income security, food insecurity, involvement in the child welfare system, housing, Early Childhood Education and Care, public education, recreation and access to health services affect children's and families' health. A health promotion approach is used to facilitate the understanding that well-being must be viewed holistically, and within the context of life cycles and families as a unit within communities. Research has shown that there is a correlation between poverty and poor health status of children and families. Yet, existing policies are inadequate in addressing child poverty from a preventative and long term planning approach. The results are devastatingly clear. If action is not taken by all levels of government to address the social exclusion and ill effects on families' health, then the cycle of poverty will continue to have a negative impact on our communities.

International Commitments

While Canada agreed to fulfill a number of obligations when it signed the *International Covenant on Economic, Social and Cultural Rights* and other covenants such as *the Convention on the Rights of the Child* (1990) etc., ongoing lack of investment in critical community supports continues to occur. The lack of affordable social housing and Early Childhood Education and Care, increased numbers of families relying on food banks, increased numbers of individuals and families who are homeless, reductions to social assistance rates and limited access to education, physical recreational programs and health services are just a few examples of how Canada has neglected its responsibilities to ensure the health and well-being of children and families.

The existence and persistence of child poverty and homelessness in Canada over the past decades violates the *International Covenant on Economic, Social and Cultural Rights* (1976) which states everyone has the right to

- *Inherent dignity of the human person*
- *Adequate standard of living, including adequate food, clothing and housing*
- *Work and gain a living by work of one's own choosing*
- *Enjoy the highest attainable physical and mental health*
- *Education*

Despite these commitments, social exclusion continues to be a reality with the ill effects of poverty on the health and well being of children, youth, families and communities. Poverty is clearly linked to decreased human development, accessibility of services, involvement and engagement within community life. The rates of child and family poverty, including homelessness, must be addressed if Canada is to strive toward the goal of a socially inclusive and equitable society.

A Population Health Approach

A population health approach reflects the belief that health is more than the absence of disease. It includes physical, mental, emotional and spiritual well-being. Health and general well-being are affected by several social determinants including income, housing, quality education, and family dynamics. The population health approach recognizes that health is a capacity or resource rather than a state. This definition corresponds with the notion of being able to pursue one's personal growth and goals, and acquire skills and education (Frankish et al.: 1996). The broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health.

Population health may be defined as "the capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish et al.: 1996). Thus, the relationship between health and quality of life/social well-being should be viewed as reciprocal. Responses to poverty must be inclusive of the family life cycle and the experiences of intersecting oppressions (Frankish et al.: 1996). Affordable

housing and income security, including adequate employment and social assistance, are key for the health and social inclusion of children and their families.

Defining Poverty

Poverty is: *Not having breakfast sometimes; being afraid to tell your mom that you need new shoes; sometimes really hard because my mom gets scared and she cries; not being able to take swimming lessons; not getting to go on school trips; being teased about the way your are dressed;* (Grade 4 & 5 children- ISARC: 1998)

The effects of material poverty are very real for children and have implications on physical, emotional, mental and educational health and development. Although this is the everyday experiences for children and families living in poverty, statistically and for policy purposes, poverty is defined quite differently.

There is not an official poverty line; however, Statistics Canada does provide a Low income Cut-Off (LICO) each year. LICO's represent levels of income where people spend disproportionate amounts of money for food, shelter, and clothing. Each figure is produced and based upon family size, population and changes in the consumer price index (Statistics Canada: 1996 Census Data)

Low income Cut-Offs (LICO's) Before Tax, 2001					
Total Population of Community					
Family Size	500,000 +	100,000-499,999	30,000-99,999	Less than 30,000*	Rural
1	\$18,841	\$16,160	\$16,048	\$14,933	\$13,021
2	\$23,551	\$20,200	\$20,060	\$18,666	\$16,275
3	\$29,290	\$25,123	\$24,948	\$23,214	\$20,242
4	\$35,455	\$30,411	\$30,200	\$28,101	\$24,502
5	\$39,633	\$33,995	\$33,758	\$31,412	\$27,390
6	\$43,811	\$37,579	\$37,317	\$34,722	\$30,278
7 +	\$47,988	\$41,163	\$40,875	\$38,033	\$33,166

Notes: This table uses the 1992 base. Income refers to total pre-tax, post-transfer household income. (CCSD: 2002)

Rates of Poverty

Although poverty rates among children have decreased over the last four years, there are still more than 1.1 million (1,139,000) children living below the

low income-cut-off line in Canada. An estimated total of 16.5% of all Canadian children under 18 live in poverty, a figure which is substantially higher than the 14.4% figure in 1989 that prompted Parliament to commit to eliminate child poverty by the year 2000.

When the rate of poverty is analyzed according to age, the picture is much bleaker. For example, 17.8% of children in Canada under 6 years and 18.4% of children under 1 year of age are living in poverty according to 2000 Statistics Canada data (Campaign 2000).

In Toronto, the number of children living in these conditions increases each day. According to the City of Toronto's 2002 *Report Card on Children*, the number of children living in poverty across the city grew by 9% between 1995 and 1999 (Daily Bread Food Bank: 2002). There are over 50,000 children who rely on food relief programs every month in the Greater Toronto Area, a figure which represents a 15% increase since the election of the Ontario Provincial government in 1995 (Daily Bread Food Bank: 2002).

CHILD POVERTY IN PROVINCES -2000		
	RATE	NUMBER
CANADA	16.5%	1,139,000
NF	26.2%	30,000
PE	13.3%	4,000
NS	17.6%	36,000
NB	15.4%	25,000
PQ	18.7%	293,000
ON	14.4%	391,000
MB	22.1%	58,000
SK	18.1%	44,000
AB	15.2%	112,000
BC	16.7%	146,000

(CCSD: 2002)

We can identify some groups within Canada who are at a higher risk of poverty including, female-lone parents, immigrants and refugees, racialized communities, Aboriginal peoples and persons with disabilities. *For many ethno-racial groups the child poverty rate is extremely high -- as high as 60% to 90%.* (Ornstein: 2000). At least 52.1% of all Aboriginal children in Canada are poor, with 12% of Aboriginal families being headed by parents under the age of 25 years (CCRF: 2001). Research has shown a positive link between some Aboriginal Peoples lower education levels and income to negative health status. For example, a national survey found that off-reserve Aboriginals reported

that their health was fair or poor 1.5 times more than non-Aboriginals (Congress of Aboriginal Peoples: 1998).

Recent immigrants are also experiencing high incidences of family poverty with a rate of 48% according to Statistics Canada 1996 Census Data. It appears that poverty rates for recent immigrants is steadily increasing with a difference of \$6, 200 less annual average earnings from 1980 to 2000 (Statistics Canada Census Data: 2001). The chart below demonstrates how poverty levels among both racialized and non-racialized immigrants have also increased substantially between 1991-1996.

Poverty Levels Among Immigrants Has Increased Between 1991-1996 (Toronto)	
Poverty Levels for Racialized Immigrants	↑ 11. 6%
Poverty Levels for Non-racialized Immigrants	↑ 4. 6%

This trend signals that recent immigrants who have children are facing systemic barriers to gaining adequate wages while competing against the rate of inflation and decreasing spending power.

Severely reduced social and economic investments to support families are not adequate to meet even the most basic needs. There is a clear connection between poverty and decreased accessibility, human development, involvement and engagement in community life, which leads to inadequate housing and food. All of these dimensions are critical for a socially inclusive and equitable society.

Income Security: Employment

"We need paying jobs, not volunteer jobs. We're here just like everybody else, to make a living." (Workfare Watch: 1998)

"I've called about jobs and had people say 'come down for an interview,' yet when I get there, I get the feeling they are surprised to see that I'm black because I sound like the average guy on the telephone. They've said 'Oh, the job has just been filled,' or during the interview they'll say that I'm overqualified or ask me questions like 'Are you sure you want to work at this type of job?'" (Perception: 2000)

Employment is an important link between increasing an individual's sense of citizenship, social inclusion, socio-economic mobility and being able to obtain the necessities of food, shelter, clothing etc. While recent economic growth has increased opportunities for employment many families, including those who have left social assistance, become the working poor. This is due to the minimum wage not being reflectivity inflation rates and being frozen in many provinces for at least five years.

Women continue to have an income gap, earning 70 cents for every \$1 paid to men while spending hours of time completing unpaid work related to child and elderly care and other household responsibilities (The Globe and Mail: March 12, 2003). Although this work assists families and the larger society socially and economically, women are often expected to reduce their working hours and receive even less pay in order to have time for family responsibilities.

WAGES REQUIRED TO REACH POVERTY LINE FOR FULL TIME, MINIMUM WAGE WORKERS IN ONTARIO (2002)				
Family Type	Full Time Market Earnings and Canada Child Tax Benefit	Low Income Cut -Off (LICO)	Hourly Wages Required to Reach Poverty Line	Hourly Gap Between Minimum Wage and Wage Needed to Reach LICO
1 Earner, 1 Child	\$15, 139	\$20, 651	\$11.30	\$4.45
1 Earner, 2 Children	\$17, 605	\$25, 684	\$14.11	\$7.26
2 Earners, 2 Children	\$30, 072	\$31, 090	\$8.54 x 2	\$1.69 x 2

Many racialized individuals also face racism and sexism within hiring and promotion processes. This results in highly educated racialized and immigrant communities being overrepresented in low paying, insecure and service orientated positions with little opportunity for advancement, union representation or wage increases. Consequently, many families are working full time far below the poverty line in jobs that are unstable, without security, benefits or flexibility for family related responsibilities.

Immigrants are also facing systemic barriers due to their foreign credentials not being recognized within the labour market. Yet, Canada emphasizes education and employability within immigration policies and entrance criteria. With a slow birthrate and aging population, Canada relies heavily on immigration for labour force growth. During the 1990's, immigration represented 70% of the total growth within the labour force. Yet, the lack of recognition of foreign credentials costs immigrant families and Canadian society billions of dollars.

It is estimated that improved learning/education recognition could increase salaries and spending power for immigrants by \$8,000 - \$12,000 per year (Bloom & Grant: 2001). Although recent immigrants (those who have arrived after 1990) are better educated, their earnings have deteriorated sharply compared to Canadian-born workers. For example in 2000, male immigrants who have been in Canada for one year earn on average 63 cents to every dollar that Canadian-born males make which is significantly lower than 72 cents to the dollar in 1980. Furthermore, the wage gap remains at 80 cents for those immigrants who have been in Canada for 10 years, down from 90 cents for each dollar that their Canadian-born counterparts earn (Statistics Canada Census Data: 2001).

A life cycle approach is needed to address family poverty, especially for immigrants and refugees who often require over 10 years to settle into Canadian society. Structural barriers such as limited spaces for foreign-trained professionals to become trained (e.g. doctors) need to be addressed so that immigrants and refugees are not segregated into employment for which they are over qualified. Thus, settlement, family orientated, employment and education programs need to be considerate, of and appropriate to the needs of immigrants and refugees and address the structural barriers within policies and planning.

Employment Insurance

Changes to Employment Insurance have resulted in fewer families being eligible for benefits. In fact 25% of individuals who are unemployed qualify for Employment Insurance compared to 75% in 1989 (Campaign 2000: 2002). Consequently, more families are forced to rely on social assistance when experiencing unemployment.

Social Assistance

"Life has become for many a vicious cycle of fear, hunger and exhaustion. So many families were terrified when the cuts came through. Mothers were heard screaming in the streets, 'How am I going to make it? What am I going to do?' These screams have not gone away. People just don't hear them anymore." (ISARC: 1998).

"In Ontario, families who are among the poorest of the poor are having the amount of their child benefit deducted from their welfare cheques" (ISARC: 1998).

More than 131,000 Ontario families with almost 230,000 children remained on social assistance in 2001. Children receiving social assistance today are experiencing increased depth of poverty as cuts to social assistance rates and inflation account for a 31% drop in rates (Campaign 2000).

As the following chart demonstrates, this dramatic cut to incomes places many families and vulnerable people at risk.

Average National Welfare Rates for Canada (Statistics Canada 2000 - Ten Provinces)				
	1991 Average	2001 Average	Average decrease in dollars	Average decrease %
Single Person	\$6,792	\$5,152	-\$1,640	-32%
Person with Disability	\$9,633	\$8,524	-\$1,109	-13%
Single Parent with One Child	\$12,241	\$9,936	-\$2,304	-23%
Two Parents with two children	\$16,537	\$13,041	-\$3,496	-27%

(National Council of Welfare: 2002)

The chart below demonstrates that cuts to social assistance are having a negative impact on families' ability to provide for their children. Women and children are most at risk due to barriers within the housing, labour and child care markets. Yet, these reductions of at least \$264 per month have been the breaking point for many families, leading to a loss of suitable housing, food insecurity and deeper depths of poverty.

Rates Before 1995	Basic Allowance/ Shelter Allowance	Maximum Total	Difference per month post 1995
Single Parent + One Child	\$569 / \$652	\$1, 221	
Couple + Two Children	\$781 / \$768	\$1, 549	
Rates After 1995:			
Single Parent + One Child	\$446 / \$511	\$957	- \$264
Couple + Two Children	\$612 / \$602	\$1, 214	- \$335

(Pay the Rent and Feed the Kids: 2003)

Even though some children have been removed from social assistance by the Ontario government, they are not necessarily removed from poverty. Many families with children have had their income drop and some have even entered into a state of homelessness. This is due to the removal of rent controls, elimination of new social housing, cuts to social assistance and increased costs of living.

Family Structure	Income	Average Market Rent
1 adult/1 child (0-12 yrs.)	\$957	\$866 – 1 bedroom
		\$1, 039 – 2 bedroom
2 adults/1 child (0- 12 yrs.)	\$1030	\$1, 039 – 2 bedroom
2 adults/2 children (0-12 yrs.)	\$1178	\$1, 224 – 3 bedroom

(Pay the Rent and Feed the Kids: 2003)

Research shows that the rate of homelessness has steadily increased, especially among families, children and youth. There are an estimated 6, 200 children staying in homeless shelters throughout Canada each night. This figure represents a 130% increase since 1988, a real state of disaster (National Council of Welfare Reports: 2002). An estimated 1000 children stay in emergency shelters each night in Toronto alone (Campaign 2000: 2003).

When families leave social assistance for employment their drug card and limited dental benefits are often terminated. This provides inconsistent access for families across Canada. Thus, many families who wish to gain employment are

worse off when costs such as medication, dental care and child care costs are accounted for. A survey by the City of Toronto reveals that almost 60% of people who left social assistance in 2001 reported no improvement to their financial situation (Daily Bread Food Bank: 2002). This is also reflected in the numbers of families that experience food insecurity.

Food Insecurity

"In the past couple of months I'd say I've gone days, weeks without food- like three or four days of the week I've gone without food...I only have so much and give my son the rest because he needs it, he's growing" (Workfare Watch: 1999).

Hunger is broadly defined as "the inability to obtain sufficient, nutritious, personally acceptable food through normal food channels or the uncertainty that one will be able to do so." If "the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain," then a condition called food insecurity exists (CCSD: 2000).

Since 1989 food bank use has increased by 90% and although children make up only one-quarter of the population, they comprise 41% (305, 047) of food bank recipients (Campaign 2000: 2002). However, this may be an underestimate as 59% of food bank recipients are families with children (CAFB: 2003). Over 40% of parents sacrifice their own food intake so that their children do not go hungry and approximately one-quarter of children will not have enough to eat at least once per week (Daily Bread Food Bank: 2002).

Studies indicate that Aboriginal peoples are four times more likely to report experiencing hunger in Canada. Basic foods such as bread, milk and cereal are scarce for many Aboriginal families for two weeks of the month (CCRF: 2001).

Among households headed by immigrants, food bank usage was at 49% for 2002. Moreover, for immigrants with at least some college or university education food bank usage has increased from 12% in 1995 to 59% in 2002 (Daily Bread Food Bank: 2003).

Clearly, food security and hunger have increased for families and children living in poverty. It has been established that material poverty is linked to

nutritional intake. Research shows that food recipients are disclosing fair and poor health at a rate that is approximately 31% higher than the general population (Daily Bread Food Bank: 2002).

After-rent incomes are almost half of what they were in 1993, which means that families have less money for food, clothing, medical needs and recreational learning activities. Thus, children who are living in poverty and experiencing food insecurity have fewer educational and developmental opportunities, and are at risk of developing hunger related symptoms such as an inability to concentrate, disciplinary problems, lower test scores, absences from school and serious health risks including limited physical, mental, social and spiritual growth. Children who are living in poverty are also at increased risk of being involved with the child welfare system.

Involvement in Child Welfare System

A recent study by the Children's Aid Society of Toronto and the University of Toronto (2001) reveals that inadequate or a lack of housing was a factor in children being placed in temporary care in over 20% of all cases during the year 2000, an increase by 60% since 1992. Over 11% of all children placed in temporary care had a delay in returning home due to a housing-related problem. The stress of poverty has been linked to some instances of abandonment, emotional or physical abuse. However, limited access to safe and affordable housing is affecting parents' ability to care for their children. For those children who have been entered into Children's Aid care, 29% of families did not have housing 'that was affordable now' and 21% of families did not have housing that was considered 'safe and appropriate to meet their physical housing needs' (Chau et al.: 2001).

Poverty clearly plays a role in the number of children who are placed into care with the Children's Aid Society. Parents who have children with disabilities often have little financial, social and health care support and may be forced to place their child into the care of Children's Aid Society. Yet, it is much more financially and socially viable for a child to remain with his or her family and receive at home and community based supports. The Metropolitan Toronto Children's Aid Society states that the cost for being involved with the care of a child within his or her own family may be under \$200 per month. Yet,

the cost of providing care outside of a child's own home is at least ten times as much at approximately \$2000 per month (Ontario Association of Social Workers 1996, Philp: 2001). All parents who have children with disabilities are struggling to provide the best life chances for their child. However, Aboriginal peoples face significant barriers and have a disability rate that is more than twice the national average (CCRF: 2001)

While there are extensive costs to placing a child into Children's Aid care, there are social and emotional short and long-term costs as well. These include depression, anxiety, behavioural issues and poor school attendance as presented in 44% of households with children being investigated (Philp: 2001). Emotional effects of being separated from a parent, especially a mother, can have long term consequences for children. Single mothers and their children are at particular risk with over half of all single mothers living in poverty (Chau et al.: 2001). Furthermore, the number of children who have been taken into temporary custody as a result of witnessing their mothers being assaulted increased by at least 870% between 1993-1998 (Trocme: 2001). With limited income supports, affordable regulated childcare, affordable housing and emergency shelters operating at full capacity, there are few options for women who are being assaulted and abused, leaving them and their children at risk of continued violence, poverty and involvement with the Children's Aid Society. Thus, shortages in affordable social housing and emergency shelters are closely linked to the number of children who are victims of prolonged violence and involvement with the Children's Aid Society.

Housing

"When poor people have to pay more in rent than they can really afford, what 'gives' is the budget for everything else, especially food" (ISARC: 1998).

According to Statistics Canada, housing is considered affordable if 30% of income is spent on housing costs. Even at a 30% spending rate, it is likely that some households will have inadequate funds available for other necessities such as food, clothing, and transportation. Households with children that must rely on food banks have just \$3.65 a day per person in their home for *all* living expenses (Daily Bread Food Bank: 2002).

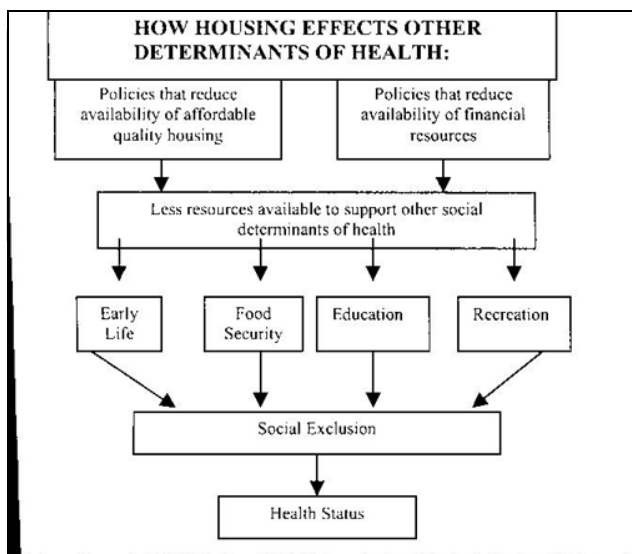
It is estimated that one in five Canadian households is deemed to live in ‘core housing need.’ This means that their housing is lacking in terms of number of bedrooms per family size, safety of the dwelling or payment of more than 30 % of household income on accommodation (Caledon Institute: 2003). Within Toronto, the Daily Bread Food Bank estimates that 60% of food recipients rate their housing as in poor condition. Approximately 25% of all households with children consisting of three or more people can afford only a bachelor or one bedroom apartment. In fact, families are frequently paying at least 50% of their income on housing for unsuitable, inadequate and overcrowded accommodation (Housing Again Website: 2002 & Daily Bread Food Bank: 2002).

The waiting list for subsidized housing in Ontario has reached up to 12 years (TDRC: 2003). In Toronto alone, there are at least 40, 000 children on the waiting list for affordable housing. The Ontario provincial government cancelled all new social housing units upon their election in 1995. The 1998 Tenant Protection Act 1998, removed all rent controls on new and vacant units and caused rents across Toronto to increase by 17% since its implementation (Daily Bread Food Bank: 2002). These changes have dramatically reduced access for those families and individuals that are living in poverty. Even though the demand for rental housing is increasing, 44% more rental units are being lost each year. Each year, more and more tenants are looking for fewer available units as the availability of affordable housing dwindles. By 2001, Ontario’s vacancy rate of 1.7% was still stuck far below the norm of 3% associated with a balanced rental market. Even though there was some improvement in terms of vacancy rates in 2002, virtually all openings are at the upper end of the rental market and far out of reach of the majority of households (Campaign 2000: 2003).

The United Nations states that “stable, affordable housing in a child-friendly neighbourhood is essential for healthy child development” (Daily Bread Food Bank: 2002). Yet, due to the housing crisis within Canada, especially within urban centers such as Toronto, many children are homeless and relying on emergency shelters for a roof over their heads. An estimated 1,000 children under the age of 12 in Toronto, and 6, 200 children in Canada are staying in homeless shelters each night. Families are one of the fastest groups of shelter users and the lack of

affordable and social housing means that employed and unemployed families are staying in shelters for longer periods of time. Homelessness increases families’ exposure to stress, instability, and illness and harmful effects on children’s development (TDRC: 2003).

The following flow chart demonstrates the linkages between structural and individual factors that lead to poverty. While housing is necessary for healthy child development and stability, the lack of affordable housing leads to other fewer resources, social exclusion and poor health status.



(Flow Chart from Bryant: Policy Options- 2003)

Neighbourhood segregation is also occurring whereby families of low incomes, including racialized communities and recent immigrants, are being forced to live in highly concentrated impoverished areas that are often unsafe and highly contaminated with environmental hazards.

Children are more vulnerable to hazardous environmental exposures because of differences in physiology, behaviour and developing organs that are sensitive to toxicants. If organ exposure to a toxicant occurs at a time of rapid cell multiplication this may alter the "programming" of susceptible organs such as the brain, which may have long-term consequences. The health implications of inadequate housing in environmentally hazardous neighbourhoods includes increased risk of asthma, cancer, lead poisoning, environmental tobacco smoke, birth defects and neuro developmental problems (CCSD: 2002).

Early Childhood Education and Care

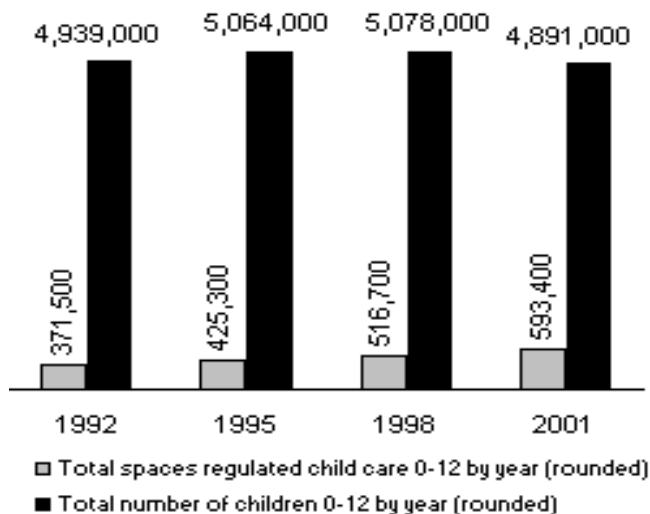
"I got a letter in the mail. I was due in the office on a Thursday, and I got the letter on a Wednesday to say that I was to show up at workfare the next day. My child is 3 months old now. I got a letter that said I have to find a babysitter so that I can do workfare" (Workfare Watch: 1999).

Education is closely linked to future risk of poverty and negative health status. Children should be provided with the best start in life possible through Quality Early Childhood Education and Care (ECEC) (Campaign 2000: 2003). Central to reducing child poverty is the need for social policies that recognize family poverty within a health promotion and life cycle context. Not only is regulated and quality ECEC central to child development and learning, it also provides more options for mothers who wish to participate in the labour market.

The importance of education, stimulation, loving interaction and attention during the first 5 years of a child's life has been widely recognized. For example, Dr. Mustard of the Canadian Institute for Advanced Research states *"brain development is fostered by nutrition and stimulation. By the time a child has reached age 5, most of the brain's wiring is complete; reversing poor development is difficult after this age. We need to build social cohesion to invest in children"* (City of Toronto Children and Youth Action Committee: 1998).

It is imperative that accessible ECEC be implemented now to address the limited opportunities that children and families living in poverty currently experience. More than 70% of young children in Ontario have mothers who are employed. Yet, only 12% of all children below the age of 13 have access to regulated child care. Furthermore, only 22% of all children enrolled in regulated child care have access to a fee subsidy which is essential for low and moderate income families (Campaign 2000: 2003). As a result, many families are forced to limit their involvement in the labour force or rely on unregulated child care that could pose threats to children's safety and development. This is due to varied quality of teaching and care within regulated and non-regulated child care facilities.

CHILDREN IN CANADA AND REGULATED CHILD CARE SPACES



Source: Friendly, M., Beach, J. and Turiano, M., *Early Childhood Care and Education in Canada: Provinces and Territories* 2001, 2002.

The social benefits of child care have also been established. For every \$1 invested in Early Childhood Education and Care there is a \$2 return in social benefits or savings (City of Toronto: 2003). However, since 1999 the Ontario government has cut base funding for Toronto's child care programs by \$11.8 million. The downloading of services onto the City of Toronto has crippled its resources and ability to sustain programs for families. In 2002 alone, the City of Toronto lost 1,616 spaces and will lose another 700 spaces (including 200 spaces for social assistance recipients) in 2003 as a result of inadequate funding. Yet, the demand for child care remains high with an average of 15,000 children on the waiting list a subsidized space (City of Toronto: 2003).

The lack of a federal Early Childhood Education and Care strategy is having detrimental effects on the health and financial sustainability of families. Many children are not receiving regulated, safe and stimulating education which could have long term effects on their health and social, economic and educational development. Furthermore, families are being forced to remain in poverty due to limit access to the labour market and inadequate social assistance rates. Universal, high quality and accountable Early Childhood Education and Care must be implemented nation wide with requirements on provincial governments to use funding provided for regulated, licensed and safe child care.

Public Education System

There is a strong association between education and positive health status. People with higher levels of education tend to be healthier. Early school leavers experience greater unemployment, lower incomes, poor health, and lower quality of life. However, funding cuts to public schools has resulted in fewer teachers and education specialists to address the barriers that some children and young adults face in elementary and high school. Furthermore, staff shortages reduce the amount of monitoring and security within schools, leaving children vulnerable to bullying and assaults by other students or strangers (Skinner: 2003).

Education provides one of the surest paths to increase a person's chance of full participation in society including secure employment. Although the trend for Aboriginal children attending school is increasing, there is concern for high levels of future poverty, as nearly 40% of all Aboriginal youth 18 to 20 year old have not completed high school and often have young families (Health Canada: 2002).

Clearly, if family poverty is to be addressed there needs to be a sharp change in the amount of support that public education receives from all levels of government. This is required if family poverty and negative health status are to be prevented and addressed.

Post Secondary Education

"What angers me more is that I will graduate with quadruple the amount of dept than students without children. OSAP is now considered income [by Social Services, and is thus subtracted from benefits], which I see almost as a punishment when you are trying to gain some independence and control in your life" (ISARC: 1998).

Children's future social and economic well-being is closely tied to the completion of high school and increasingly, university. Tuition fees for students have dramatically increased and now equate to 50% of college and university operating budgets.

A crisis is mounting in the lack of accessibility and quality of education in colleges and universities. Preliminary figures released by the Ontario Universities' Application Centre (2003) show that

there has been a 316% increase in the number of applications to universities since 1996. Yet, there is an estimated shortage of 7,000 - 10,000 spaces within colleges and universities to accommodate the double cohort of high school students in 2003 and increase of applications. Many universities have raised entrance and fee requirements which pose accessibility issues for those students who are struggling with poverty and have had numerous demands on their time and energy compared to other students.

The average tuition per year for a Bachelor of Arts in 2002-2003 was \$4,634, which represents at least a 150% increase in tuition fees since 1996. De-regulated programs such as law have increased tuition by more than 700% since 1996 in Ontario. This poses additional barriers for students from marginalized backgrounds (Canadian Federation of Students: 2003)

Increases to tuition fees, combined with greater expectations on extra-curricular activities and other entrance requirements have contributed to the growing evidence that lower and middle income students and those with learning difficulties/disabilities are being squeezed out from university and applying in lower rates.

For example, the Canadian Federation of Students (2003) states that there has been an 11% drop in recent years in the participation rates of students from family income backgrounds of less than \$50,000 in de-regulated programs of study such as law and medicine.

Education is one factor that is crucial to ending the cycle of poverty, and the process of deregulation will only continue to reproduce the class differences and barriers that are present in some professions.

Recreation

"Children probably spend more time in the average week in leisure, play and recreation than they do in school. Yet we marginalize it. Many people don't understand the importance of quality play, whether it's provided by a government agency, with the family, or just on the street. Access to quality recreational activities for all children is preventative public health" (Hanvey: 2001).

Participation in sport and physical activity is a health enhancement for children, families and communities. The safety, security and well being of local neighbourhoods may be dramatically affected when access to recreation and physical activity is limited (Donnelly: 2003 forthcoming). While research has shown that recreational activity is important to health promotion, it is becoming increasingly difficult for children to participate in exercise groups and organized recreational activity. Although, a lack of physical activity has detrimental economic and health effects, barriers such as user fees and expensive/inaccessible transportation are becoming a permanent reality.

The Canadian Council on Social Development (2001) conducted a study on how rising fees act as barriers to family access of social recreational programs within their communities. Participation was significantly lowered and limited by barriers relating to income.

The following chart demonstrates some of the barriers to participation that respondents in a Canadian Council on Social Development study (2001) experienced including; a lack of transportation, limited parental support due to work hours, the cost of equipment or lack of facilities.

Barrier	Number of respondents
Transportation	79
Family/ parental support	33
Social/ cultural	29
Equipment	28
Lack of facilities	17
Lack of awareness	10
Lack of volunteers	10

As the above chart demonstrates, respondents identified transportation as significantly impacting their participation. Many children and youth simply have no way of getting to a facility to participate in recreational programs. In some communities, there may be limited, unreliable or no public transportation service. More than half of the participants disclosed that user fees presented a moderate barrier to participation in aquatics, arts and athletics programs, and about 40% thought the fees restricted access to after-school and drop-in programs (CCSD: 2001). At least 20% felt that user fees presented a significant barrier to accessing athletic programs (CCSD: 2001).

The recent health report by Roy Romanow *Building on Canadian Values* (2002) states that in the year 2000, over half of children aged 5 to 17 did not meet recommended levels of physical activity as reported by the Canadian Fitness and Lifestyle Research Institute. However, physical inactivity has financial as well as health consequences for children and their futures. It is estimated that physical inactivity cost the health care system an estimated \$2.1 billion in 1999. If the prevalence of physical inactivity were to be reduced by 10%, \$150 million dollars would be saved within health care related expenses each year. Approximately 21, 000 lives were lost prematurely in 1995 because of physical inactivity (Romanow: 2002). Clearly, there are social, health and financial benefits to accessible recreational activities and programs.

Increasing physical activity and improving the health of children may be accomplished by supporting time devoted to physical education within schools, removing barriers such as user fees and privatized facilities and encouraging other community based recreation programs.

Accessing Health Services

"My daughters medication isn't covered under OW...she ended up in hospital because of...it's a breathing problem. I went to get it (medication) and welfare doesn't cover it"
(Broken Promises: Welfare Reform in Ontario)

"The government said that they wouldn't touch the disabled kids by [by cutting their mother's cheque] it was exactly what they did"
(Portuguese Community Inclusion Project (in progress))

A comprehensive approach to family and community health is imperative to provide children with the best start in life. However, limited access to health services and relevant programs means that a reactionary approach is frequently taken, often when the consequences are severe and could have been prevented with immediate and long term planning. The number of families who are forced to rely on emergency food sources, in a period of economic abundance is one example of the link between high costs of housing, food insecurity and health status. At least one-quarter of parents coming to food banks identify difficulty in accessing health care services,

especially medical services and prescriptions that have user fees (Daily Bread Food Bank: 2002).

For those children who have a severe illness or disability such as autism, the financial cost to providing comfort and care may amount to thousands of dollars each year. Many parents cannot afford this and are often faced with difficult decisions that impede their career, social relationships, finances, own health and child's development.

Health and social services must also be appropriate to the cultural and linguistic barriers that many families face. It has already been demonstrated that racialized communities and immigrants/ refugees often face extensive discrimination that leads to poverty, employment and housing segregation and general social exclusion.

Consequences: Oral Health

"I am very self-conscious about my teeth. I'm also very ill about it. I have not eaten solid foods for many years because minimum wage jobs don't pay to get your teeth fixed. The welfare system in the town that I spent last winter in outright refused to help unless it was an emergency. Well, they're black, they're broken, they're poisoned and I can't eat solid foods. If I can't eat solid foods then I can't eat healthy. They didn't take that seriously. Down here, as soon as the interviewer saw the blackness where my teeth are supposed to be, she mentioned the possibility of dental benefits after three months on the system, and of course they cut me off after two. Even if someone talked about an extension of the benefits for this reason, cut me off the income sure, but fix my teeth" (Workfare Watch: 1999).

Research within the health sector has revealed that oral health contributes to chronic disease including low birth rate of babies and heart disease. The dental health of children clearly reflects the dental health of their mothers. It is for this reason that oral care needs to be treated within a family context from the time of birth and be mindful of the health of the family as unit whose members are not exclusive of one another.

For families who receive social assistance, dental care is covered on a discretionary basis set by each municipality. For example, in Toronto recipients of welfare only receive emergency care (i.e. extractions). Low income children who are in need

of dental treatment are entitled to urgent care through the Children in Need of Treatment (CINOT) program, which is administered by Toronto Public Health. CINOT is situated within each health unit throughout the city and children are only seen through the school system. *Thus, health care professionals are reporting that children often already have cavities by the time they have started school due to the lack of preventative and continuing treatment available for families with low incomes.* While parents who meet the financial criteria for urgent dental care for their children may be able to obtain limited treatment through the CINOT program, any medicine (e.g. for tooth pain) or follow up non-urgent care is not covered and becomes the financial burden for parents who are already living in poverty (Toronto Public Health: 2003).

Clearly, oral health needs to be more accessible for low income families and funded from a life cycle, socially inclusive and health promotion perspective. Current conditions are inadequate and poor oral health affects children's and adults physical, mental and emotional well being. Unhealthy teeth and gums not only cause pain but are also linked to children's poor concentration, sleep disturbances, behavioural problems in school, low self esteem, difficulty eating, fewer friends, chronic illness (including heart disease) and fewer opportunities for employment as adults (Toronto Public Health: 2003).

Consequences: Physical Health

Poverty has negative consequences for the immediate and long-term life chances of children. Being born prematurely and too small are high risk factors that often result in many serious health complications or even death. Approximately 5.7% of babies have low birth weights - a decisive indicator of poor health at birth. Low birth weight babies are two to three times more likely to have heart problems, high blood pressure and diabetes as adults. The number of low birth weight and pre-term babies born has not diminished since the mid 1980's (Health Canada: 2003).

A relationship has been found between low birth weight and poverty, and with high risk behaviour such as cigarette smoking, alcohol and drug use which are often coping mechanisms and forms of self medicating. A disproportionate number of low birth weight babies come from low income households and

have limited access to food, prenatal care and vitamins, and increased risk of stress and other poverty related factors. Poor children are also less likely to live in safe neighbourhoods and are disproportionately exposed to environmental contaminants.

Poverty during childhood also poses increased risk of lower functioning vision, hearing, speech, mobility, dexterity, and cognition. Social, physical and cognitive development may be impaired affecting educational and employment opportunities (Campaign 2000: 2003). As previously discussed, lower levels of education have also been linked to lower incomes as adults, repeating the likelihood of poverty within the life cycle.

Children who are abused or witness abuse are also at increased risk of prolonged exposure to physical and other injuries, as poverty limits the choices of parents who wish to leave unsafe situations. The fact that emergency shelters are operating at full capacity and many agencies have had funding losses results in many women remaining with an abusive partner. The cycle of poverty is also repeated, as many children will leave an abusive home as youth, thus becoming homeless and facing significant barriers to social inclusion. Clearly, the relationship between poverty and exposure to abuse has grave consequences in every aspect to the personal and community health of children and their families in the short and long term.

Consequences: Emotional and Mental Health

"For a while there was almost one suicide a week in my reserve, it is so common place now that it hardly even shocks a person. Looking at the people and hearing all the stories, it is like there is no hope left. So many of our people are suffering. One of the most recent examples and closest to my heart is a month ago, my little cousin tried hanging herself. Luckily my little brother stopped by for a visit, found her and resuscitated her. She was taken to emergency and then put in the psych ward; she was released the following day"
(Aboriginal Youth Network Website: 2003).

Emotional health is closely linked with mental, physical and spiritual well being. The consequences of poverty on children's and families' health are

multi-faceted and cannot be compartmentalized into exclusive categories of physical, mental or emotional health. The factors discussed in this paper of limited safe and secure housing, a lack of sufficient, nutritious food, unemployment, declining access to public education and health services and racism/discrimination intersect with one another and negatively affect health in a similar fashion (Workfare Watch: 1999).

Issues relating to anxiety, poor body image, loneliness, depression, eating disorders, substance abuse, alienation from peers and family, and mental illness exist for many children and youth and may present themselves as behavioural, social, family and educational conflicts. Children in low income families are prone to low self-esteem and associated mental health difficulties. Depression, frustrations and anger are frequent emotions and consequences to mental health that families living in poverty experience. Research has consistently shown that recipients of social assistance suffer from dramatically higher levels of depression, and other mental health problems, than the general population (Workfare Watch: 1999).

Although experiences of low self-esteem, anger, self-doubt, frustration, hopelessness, bullying, aggressiveness, depression and suicide ideation may be recognized by professionals, children are increasingly at risk due to educational, health and social service funding cuts (Campbell: 2000, CCRF: 2001). Without intervention, suicide rates among children and youth may continue to rise. Already, experiences of racism, high unemployment rates, isolation, abuse, disempowerment and colonialism are taking their toll on Aboriginal children and youth. Aboriginal youth are five to six times more likely to attempt suicide than non-aboriginal youth (Campbell: 2000 & Health Canada: 2003).

Immigrants and refugees also have to contend with a variety of stressors, including economic circumstances, feelings of isolation and discrimination. They often lack familiarity with the institutions of their new country, including the school system, health and social services. These stressors may jeopardize physical and mental health and the educational success of children. With immigrant families facing barriers of de-skilling, unrecognized credentials, job segregation and low pay, many parents are forced to work longer than average hours to make ends meet. The result of family poverty

means that there is less time and involvement for family centred activities and parents often rely on children to care for siblings, grocery shop and cook, find employment and translate during appointments (Omidvar and Richmond: 2003). However, research has also shown that immigrant families often have stronger family units and relations which offer invaluable informal supports and stability needed for a child's mental health. Yet it is also important to note that these informal support systems may be tested with longer/inconsistent working hours and intergenerational and cultural conflicts as a result of the immigration process (Human Resources Development Canada: 1998).

Consequences: Short and Long Term Health

This paper demonstrates that the short and long term effects of child and family poverty are devastating. Without a preventative and holistic health promotion approach, health related issues become prolonged with exposure to poverty. For example, low birth weights, anaemia, lack of dental care, chronic ear infections and decreased physical, social and educational development are all short term effects associated with child poverty (CCRF: 2001).

However, poverty is also correlated with food insecurity, inadequate housing, poor access to health services, decreased access to Early Childhood Education and Care and prolonged exposure to

violence and stress (CCRF: 2001 & Daily Bread Food Bank: 2002). All of these factors affect a child's health, development and school related behaviour/learning. Children who are living in poverty are not only more likely to leave school early, but also to have lower levels of employment and to become involved in smoking and drinking as a long term coping mechanisms.

Malnutrition, limited access to medicine and exposure to environmental hazards decrease an individual's physical, emotional and mental defence mechanisms. Children who are living in poverty are at an increased risk of asthma, cancer, lead poisoning, neuro-developmental problems and other illnesses. Thus, the effects of poverty are clearly detrimental to the short and long term health of children, families and communities (CCRF: 2001).

FAMILY INCOME AND CHILD OUTCOMES					
	INCOME RANGES				
PER CENT OF CHILDREN WITH:	Less than \$20,000	\$20,000 to \$39,999	\$40,000 to \$59,999	\$60,000 to \$79,999	over \$80,000
Lower functional health	13.4%	8.6%	8.1%	8.3%	5.1%
Above average hyperactivity scores	63.6%	53.8%	52.9%	52.5%	45.8%
Delayed vocabulary scales	30.2%	18.5% (\$20,000-29,999)	17% (\$30,000 to 39,999)	12.1% (over \$40,000)	
Low math scores		20.6% (<\$40,000)	15.2%	12.2%	11.1%
Infrequent participation in organized sports	69.2%	53.3%	39.2%	31.2%	21.6%
16-19 year olds not employed and not in school	15.6%	8.3%	5.6%	4.8%	3.6%
Source: Prepared by the Canadian Council on Social Development using the National Longitudinal Survey of Children and Youth, 1994-1995					

Building Strong and Healthy Communities

"If the government could do one thing to improve my situation, it should take away my fear of not being able to fend for myself. Help me to work in the community in a way which I could direct myself, using my past and present experiences to help others" (ISARC: 1998).

Clearly, a multi-level and comprehensive approach is necessary to reduce family poverty and its negative effects on family and community health. However, for this to occur, health policy and initiatives need to be created and implemented from a holistic, preventative and life cycle framework. Jurisdictional boundaries should not stand in the way of all levels of government working with communities to build an inclusive society.

The following areas need more attention and action:

- Canada desperately needs new affordable housing and low income families need protection against sharp rent increases, evictions and discrimination. Emergency shelter beds and supportive services for at-risk and homeless individuals and families are also needed to provide survivors of family violence with options and address the health hazards of inadequate housing and homelessness.
- Social assistance needs to provide adequate income security that reflects the actual cost of living in each community.
- The Canada Child Tax Benefit should be significantly increased for all low, modest and middle income families and should not be clawed back from families receiving social assistance.
- Quality licensed Early Childhood Education and Care needs to be available to all families in every community across Canada.
- Public education system needs to address the wide range of children's educational and developmental needs.
- Post secondary education fees should not be a barrier to the participation of students from all socio-economic backgrounds.
- All families should have access to medication, complete and preventative dental and health services throughout the life cycle.
- Systemic barriers that place certain groups at higher risk of poverty and homelessness including, women, immigrants and refugees, racialized communities, Aboriginal peoples and persons with disabilities should be addressed.
- Health care and social service policies should be approached from a preventative, holistic, less fragmented and culturally sensitive framework.
- International Conventions, Human Rights and the principles that foster an equitable and socially inclusive society should be upheld