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Poverty and Near Poverty of Injured Worker Respondents to the RAACWI Injured Worker Health Survey (Cycle 1): Health and Social Status Comparisons to Non-poor Injured Workers

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Project abstract

Recent national and provincial reports documenting the relationship between poverty and health are alarming. Poverty is associated with poor health, and sometimes with problems around health care access. Furthermore, these reports note that poverty and health influence one another, such that poor health influences the continuing risk of living in economic insecurity and poverty; and economic (in)security influences opportunities for health. These reports have differentiated the opportunities for health and health care among different income groups – with a particular focus on the poorest of the population; and with conceptual differences made between labour market poverty and social assistance poverty. However, to the best of our knowledge, there has been little systematic study of the poverty of injured workers in Ontario or elsewhere. The RAACWI health survey of injured workers includes questions about employment, income and sources of income of injured workers with permanent partial impairments (injured workers awarded NEL awards following a workplace accident), along with detailed questions on health status, health care utilization and health care deficits. In this proposed sub-study, we intend to conduct a secondary analysis of the RAACWI longitudinal health survey, so as to report the level of poverty and near poverty (and to distinguish labour market poverty from social assistance poverty), and the associated social (labour market location, employment status, income sources, family status) and health characteristics of injured workers living in, near or out-of poverty. With a sample of ~450 persons, the survey will provide a unique opportunity to begin to document the risk of poverty that many more injured workers across Canada and elsewhere may face.

Literature review

Several recent reports from diverse sources have documented the extent and of and consequences of poverty for the well-being of individuals and populations (WHO, 2008; Lightman et al., 2008; Laurie, 2008; Community Social Planning Council of Toronto, 2009). (Of course, these do not report new findings; socio-economic inequality and poverty have long been understood as among the key social determinants of health). In these reports, it is evident that poverty is a complex condition resulting from social-structural or institutional as well as individual characteristics. For example, a nation's or other jurisdiction's labour policies and regulations, income and tax policies, occupational health and safety legislation, social insurance policy such as EI, and social assistance, housing, education and health care policies all influence opportunities for economic security and risk of poverty for individuals and groups living within that jurisdiction. An individual's personal capital (education, formal skills training) and their negative or positive experiences in a competitive labour market –

formed by the structural context - influence current and future opportunities for economic security and risk of poverty. And, of course, broad global economic downturns and upturns determine the capacity of autonomous jurisdictions to support its citizens, and the relevance of individuals' labour market and educational opportunities. Individuals, families and social groups are particularly reliant on the presence and adequacy of the social safety net within their jurisdiction to buffer the impact of those downturns on their lives. As noted in the WHO report (2008) "inequity in the conditions of daily lives is shaped by deeper social structures and processes; the inequity is systemic, produced by policies that tolerate or actually enforce unfair distribution of and access to power, wealth and other necessary social resources" (WHO, 2008: 109).

In Canada, poverty rates have remained relatively unchanged since 1989 (Campaign 2000, 2007). Persistently high poverty rates are evident in specific groups: female-headed single parent families; new immigrants and new immigrant families, racialized families, First Nations individuals and families living both in and outside of First Nation communities; and persons with disabilities (Campaign 2000, 2007). Human Resources Development Canada (2003) reported that for working aged adults with disabilities, employment rates – one of the key factors protecting groups and individuals from poverty - were only 51% in 2001. In Ontario, Laurie (2008) reports similar trends in poverty, such that Ontarians with disabilities, Ontario's children, Aboriginal Ontarians, single parents and new Canadians experienced the highest rates of poverty in this province in 2005.

The costs of poverty are broad and far reaching, as Laurie (2008) asserts, reflected in remedial (related to health care and crime), intergenerational and opportunity costs. The economic costs of poverty in Ontario have been estimated at 5.5% to 6.6% of Ontario's GDP, costing the federal and provincial governments at least 10 to 13 billion dollars; and costing every household in Ontario from \$2,299 to \$2,895 every year (Laurie, 2008: 4).

A key cost to governments, taxpayers, and to individuals and families living in poverty is ill-health burden of poverty. Recent documentation of the general and specific health costs of poverty is alarming. Examining national data, Lightman et al., (2008) documented health inequalities among income groups across a range of chronic conditions and health measures. The authors found that the poorest one fifth of the Canadian population have more than double the rate of diabetes and heart disease, a sixty percent greater rate of having two or more chronic conditions, more than three times the rate of bronchitis, and almost double the rate of arthritis or rheumatism, as compared to the richest one fifth of the population. The poor experience major health inequalities in rates of disabilities, mental and behavioural disorders, circulatory conditions, and chronic conditions, according to this report. The poorest quintile group were reported to be significantly less likely to have access to a regular physician, to spend more time as overnight patients in health care institutions, and to report having greater levels of unmet health care needs than those Canadians in the highest income quintile group (Lightman, et al., 2008).

In Ontario in 2005, social assistance recipients had significantly higher rates of poor health and chronic conditions, compared to the non-poor, for 38 out of 39 health indicators including disability, stress, diabetes, heart disease, migraines, chronic bronchitis, asthma and arthritis and rheumatism. Suicide attempts were 10 times higher among social assistance recipients compared to the non-poor (Community Social Planning Council of Toronto, 2009). The social assistance and working poor groups were significantly more likely to report they didn't have access to a family physician; and were less likely to have accessed various preventive health measures than the non-poor in Ontario (Community Social Planning Council of Toronto, 2009).

The relationship of poverty and physical and mental health is of particular concern when one considers those persons living with chronic health conditions and disabilities. We would include in this group those persons with ongoing permanent impairments resulting from or following a workplace injury. Recent research indicates that injured workers frequently suffer further physical and mental health declines after an initial workplace injury (Lippel, et al., 2007; Ballantyne, 2001), a process described by Ballantyne as "injury cascading." Other studies have shown that workers who are unable to return to work, or who experience persisting employment instability following a workplace injury often experience mental health consequences: a decreased sense of well-being and self-worth, depression, anger, role disruption and powerlessness as well as social problems such as



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marital and family stress, financial strain, and substance abuse (Ballantyne, 2001; Beardwood *et al.*, 2005; Cacciaccaro & Kirsh, 2006; Franche *et al.*, 2003; Gamborg *et al.*, 1992; Kirsh & McKee, 2003; Lippel *et al.*, 2007; MacEachen *et al.*, 2004; Stone, 2003; Stone *et al.*, 2002). Thus, the poverty of injured workers who become alienated from the labour market, and from their family and other social networks is a type of social (as well as economic) poverty, characterized by social isolation and social exclusion more generally (see Reid, 2007; Kawachi, *et al.*, 1997).

Interest to community

Our needs are to have a skilled data analyst assist us in the proposed sub-study involving the RAACWI health survey of injured workers, Cycle 1. Ms. Becky Casey, a graduate student at McMaster University, has been assisting with data cleaning and the creation of poverty variables, and with analysis of the data. In terms of community involvement, we will seek the input from a panel of injured workers as to the best way to present our findings, and the panel's input will be co-ordinated by Pat *****, co-applicant, and RAACWI-community member who has been a partner in the design of the RAAWCI injured worker health survey, from its inception. Pat has promoted the need for specific research on the poverty of injured workers, and has scanned the publicly-accessible literature, listened attentively at conferences she has attended, and taken every opportunity she found to ask researchers and politicians about the availability of poverty-related research on injured workers. I would seek Pat's involvement in leading a community review panel to consider the report or articles that we will prepare from our study; and to consider the knowledge mobilization and report transfer/translation to relevant groups.

Project bibliography

Ballantyne P. 2001. "The workplace safety and insurance board pre-1990s claims unit study. Final report." Institute for Work & Health.

Beardwood B, Kirsh B, Clark N. 2005. "Victims twice over: The perceptions and experiences of injured workers." *Qualitative Health Research*, 15: 30-48.

Cacciaccaro L, Kirsh B. 2006. "Understanding the mental health needs of injured workers." *Canadian Journal of Occupational Therapy* 73(3): 178-187.

Community Social Planning Council of Toronto. (2009) Sick and Tired: the Compromised Health of Social Assistance Recipients and the Working Poor in Ontario.

Campaign 2000 (2007) 2007 Report Card on Child and Family Poverty in Canada. Family Services Association of Toronto. ISBN 1-894250-50-8

Franché R-L, Mustard C, Krause N, Hepburn G, Breslin C, Kosny A, *et al.* 2003. "Summary of the return-to-work pilot study." Institute for Work & Health document, Toronto, Canada.

Gamborg BL, Elliott WS, Curtis KW. 1992. "Chronic disability syndrome." *Canadian Family Physician*, 37: 1966-1973.

Human Resources Development Canada. (2003) Disability in Canada: a 2001 Profile. Ottawa: Human Resources Development Canada.

Kawachi, I. *et al.*, Women's status and the health of women and men: a view from the States. *Soc Sci Med* 1999; 48: 21-32.

Kirsh B, McKee P. 2003. "The needs and experiences of injured workers in Ontario: A participatory research project." *Work*, 21: 221-231.

Laurie N. (2008) The Cost of Poverty: An Analysis of the Economic Cost of Poverty in Ontario. Toronto,



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Ontario: Ontario Association of Food Banks.

Lightman E., Michell A. and Wilson B. (2008) *Poverty is Making Us Sick. A Comprehensive Survey of Income and Health in Canada.* Toronto, Ontario.

Lippel K., Lefebvre MC, Schmidt C, Caron J. 2007. *Managing claims or caring for claimants: effects of the compensation process on the health of injured workers.* Research Report UQÀM Service aux collectivités Université du Québec à Montréal.

MacEachen E, Kosny A, Ferrier S. 2004. "Exploring the experiences of injured workers outreach services: achievements, issues, and community needs." Report to the Workplace Safety and Insurance Board.

Reid, Colleen (2007). "Women's health and the politics of poverty and exclusion." Chapter 7 in *Women's Health in Canada. Critical Perspectives on Theory and Policy.* Morrow M, Hankivsky O, Varcoe C (Eds.) Toronto: University of Toronto Press.

Shillington, R. (1999). *What Should be the True Definition of Poverty?*
<http://www.shillington.ca/poverty/ts012999.htm>

Stone SD. 2003. "Workers without work: Injured workers and well-being." *Journal of Occupational Science*, 10(1): 7-13

Stone SD, Hill ME, Kawchuk K, Lefrancois E, Maki K, Mantis S, Pilato B. 2002. "Connecting for change: Injured workers in Northwestern Ontario and the effectiveness of peer support." Final Report submitted to the Workplace Safety and Insurance Board (Ontario).

World Health Organization (2008) *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* Geneva, Switzerland.

Published works on the project

There are no published works to date.



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