REGION OF OTTAWA-CARLETON | REPORT
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DATE 19 November 1998

TO/DEST. Community Services Committee

FROM/EXP. Committee Co-ordinator

SUBJECT/OBJET **TOWARDS A PUBLIC HEALTH APPROACH TO REDUCING CHILD POVERTY AND ENHANCING RESILIENCY**

REPORT RECOMMENDATION

For Committee discussion.

BACKGROUND

Councillor D. Holmes has requested that the above-cited position paper from the Ontario Public Health Association Child Health Workgroup, dated November 1998, be referred to the Committee for discussion.

The report is issued separately, and is respectfully submitted.

Approved by
M. J. Beauregard

REDUCING CHILD POVERTY/ ENHANCING RESILIENCY
A FRAMEWORK FOR ACTION

The following is a proposed framework though which the Ontario Public Health Association can take action to help reduce the incidence of child poverty and, by increasing resiliency, reduce the impact of child poverty.

1) MONITOR AND ASSESS

The OPHA should secure the resources to be able to:

a) monitor key organizations which do research into, and/or formulate policy about, healthy child development. These organizations, which are typically concerned with both health and social policy issues, include groups such as the Canadian Institute for Child Health, the Vanier Institute for the Family, the Caledon Institute, the Canadian Council on Social Development, the Canadian Institute for Advanced Research, Campaign 2000, Voices for Children and the Sparrow Lake Alliance;

b) assess the research/positions developed by these groups for application to public health initiatives. Particular attention should be paid to child health report cards, benchmarks for health development, and best practices guidelines and mechanisms;

c) identify and communicate local actions taken in response to municipal, province-wide and federal policies.

2) COMMUNICATE AND ENABLE

The OPHA should support effective public health programming and community action through the development of a child health resource centre to:

a) communicate key child development policy and research findings from the literature and key organizations to all public health units and governments;

b) build capacity in public health units by sponsoring best practices workshops and forums;

c) create an inventory of successful strategies and programs;

d) provide a forum for public health units to link with each other on child health issues

e) ensure that public health standards reflect requirements for resiliency programming that includes nurse home visiting to high risk families, early enrichment and community action.

3) NETWORK AND ADVOCATE

The OPHA should:

a) link with other organizations already advocating on behalf of children with a focus on the health dimension of relevant issues;

b) support research on policies and programs/practices that decrease poverty and enhance resiliency in children;

c) continue to collaborate with Campaign 2000 and Voices for Children and explore other potential partnerships for education and advocacy on child health;

d) advise governments and advocate for policies that enhance child and family health;

e) encourage governments to review the impact of new and existing policies on child health;

f) at the provincial level, seek partnerships with private sector organizations concerned about child health issues;

g) initiate a link with CPHA at the national level on child health action.

The OPHA Child Health Workgroup is committed to working to improve child health in Ontario, and is eager to work with the OPHA Board and other members to push forward the agenda outlined in this paper.

Towards a Public Health Approach to Reducing Child Poverty and Enhancing Resiliency

Ontario Public Health Association
Child Health Workgroup

November 1998

Ontario Public Health Association

ACKNOWLEDGEMENTS

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PREFACE

> *We have a choice. We as a society can either provide the supports hard-pressed families need to prepare their children for success in school and life, or we can avoid doing so, in which case we will pay later -- and much more with much less to show for it -- as we try to pick up the pieces of their developmental failure.* Paul Steinhauer, Sparrow Lake Alliance.

New research on the early years of child development and growing concern about child poverty have combined to push the state of Canada's children higher up the public agenda.

Over the past five years, many important reports on child health and development have been published by groups such as Campaign 2000, the Canadian Council on Social Development, the Canadian Institute for Child Health and the former (Ontario) Premier's Council on Health, Well-being and Social Justice.[1]

These reports have clearly identified an association between poverty and poor child health outcomes. As the Canadian Public Health Association stated in its 1997 report, Health Impacts of Social and Economic Conditions:

> Compared to their peers, poor children are disadvantaged in almost every way. The health effects of child poverty are not limited to childhood years, can last throughout a lifetime and often exact a huge toll in unrealized human potential and financial cost. . . . Among the health outcomes associated with poverty in children and youth are premature birth and low birth weight, increased risks of injury and stress, and the difficulty of forming secure and trusting relationships early in life.

While public health organizations often work with low income families, new research and awareness of the impacts of poverty on child health creates the opportunity for enhanced public health programming and advocacy.

The public health community can move on two fronts to address child poverty. It can, through advocacy and by participating in coalitions of concerned groups, push for measures that will reduce the incidence of child poverty. As well, it can enhance strategies to increase the resiliency of poor children. More specifically, it can take measures to protect child development and competence, thereby increasing the likelihood of resiliency (for example, by promoting home visiting of infants in high risk families; by increasing the pressure for more and better day care). It can also decrease the number of risk factors that undermine development and competence (for example, poverty; abusive and neglectful parenting; parental mental illness). In general, it is the predominance of protective factors over risk factors that encourages development competence and resiliency.[2]

This paper provides a context for considering child health and child poverty, outlines some of the health impacts of child poverty, lays out some possible goals for a comprehensive approach to child poverty, and proposes a public health analysis and response to the problem.

INTRODUCTION

In 1990, the National Council of Welfare was heralding a significant decline in child poverty over the years 1970 to 1988.[3] But things have changed.

Since 1989, child poverty levels in Canada have increased by 58 per cent[4] and more than one-fifth (about 21 per cent) of Canadian children live in poverty, according to "The Progress of Canada's Children 1997", a report from the Canadian Council on Social Development.

Poverty, along with unemployment and economic insecurity, deny equal life chances to children and threaten the social, emotional and spiritual health of families and communities.[5] But the last decade has also seen a significant increase in research into early child development, particularly neurobiological research, which has demonstrated the profound impact early deprivation has on optimal brain development.

This new research has thrown growing child poverty rates into stark relief, since it underscores how critically important early nurturing is to the life-long health and well-being of individuals. Advocates have recognized that the period from prenatal to age 5 can no longer be considered the private sphere of parents: that society must take collective responsibility for infants and young children.

The rise in child poverty is symptomatic of larger economic changes taking place in Canadian society, in particular increasing labour income inequality. But rising child poverty is also the consequence of public policy reactions to these larger economic changes.

The growing income gap has been attributed to the forces of globalization, the computer revolution and retrenching of companies, which increasingly opt to keep only a core of permanent staff, while increasing the pool of contingent workers. Until recently, government transfer payments buffered the impact of the increasing disparity in earned income, but recent cutbacks in unemployment insurance and social assistance payments are taking away this countervailing influence.

In 1989, Canada signed the United Nations Convention on the Rights of the Child. Canada committed itself to ensuring the safety and security of all Canadian children and to creating opportunities for each child to reach their full potential. However, as the child advocacy coalition Campaign 2000 has noted, the foundations of well being which sustained previous generations of families and young people are clearly eroding.

HEALTH IMPACTS OF CHILD POVERTY: THE EVIDENCE

Poverty can be seen as a political or economic problem, a social justice concern or an ethical issue.

But poverty is also a health issue; it has an enormous impact on health status. Most Canadians endorse the idea of equal access to health care, but equal access to health is not a reality in this country. Health is distributed unevenly in Canada, with poorer people dying sooner and being sicker than middle class people, who in turn die sooner and are sicker than wealthy people.[6]

According to the Canadian Institute for Child Health, the experience of poverty more than doubles many indicators of child ill health: the accidental death rate, low birth weight, infant mortality rate, school performance and psychiatric disorders -- all increase by at least two-fold.[7]

Poverty affects children's physical health, their mental health and their cognitive and social development. Poor families cannot afford nutritious food and safe places to live. The capacity of poor parents to provide a stimulating and nurturing environment for their children is undermined by the stress of responding to chronic poverty. But while child poverty is the focus in this position paper, any attempt to address the issue of child poverty must be addressed within context of the family.

Some highlights from the literature demonstrating the close relationship between child poverty and ill health include:

- Women who suffer economic, social and educational deprivation are at a higher risk for having **low birth weight (LBW)** infants. The LBW rate in poor neighbourhoods is 1.4 times higher than in wealthy neighbourhoods. LBW is the most decisive indicator of poor health at birth and is closely linked with infant death, poor health during the first year of life, learning disabilities and long-term behavioural and social problems. LBW babies are at heightened risk of developmental delays, but those from higher family income are cushioned. It has been estimated that for every dollar spent on prenatal care in Canada, the government could save $3.38 spent caring for infants of low birth weight.[8]

- Children in the lowest income neighbourhoods are at greater risk of **dying from injuries**. Among children aged 1- 14 in urban Canada, death rates from fires, drowning, pedestrian motor vehicle crashes, suicide and homicide were 2 to 10 times higher among low income children than among those in the highest income group.[9]

- Children in the poorest families are almost twice as likely to live in **housing** that needs major repairs, compared to children from families in the highest income quintile. A variety of health problems from pneumonia and tuberculosis to increased infant mortality, suicides, mental hospital admissions and cancer deaths have been statistically associated with overcrowded living conditions.[10] Lack of space at home may be responsible for slowing down intellectual and physical/motor development and has been shown to be a factor in poor school performance.[11] Stable, adequate, housing is a critical precondition for breaking out of the poverty cycle.

- Evidence shows **prolonged stress** can seriously impair the immune system. Similarly, long-term stress can also cause permanent damage to brain function, including learning and memory.[12]

  lack of money affects the quantity and quality of food, and **an inadequate diet** prevents a child from properly developing physically, mentally and emotionally. Mild under nutrition "can lead to increased risk of infections, resulting in more frequent and more severe illnesses (and school absences) . . . Undernourished children are less physically active, less exploratory, less attentive and are more apathetic, irritable and tired."[13]

- While children of all income levels make the same average number of visits to physicians in Canada, this is not true of **dental care** in those provinces, including Ontario, which have no public dental program for children. Because of cost barriers, fewer poor children than non-poor children regularly visit a dentist in provinces like Ontario.[14]

- Two-thirds of Canada's children and youth are not active enough for their optimal health and development. The costs of many organized **physical recreation** activities such as hockey make them inaccessible to poorer children. User fees for recreational facilities also create barriers to participation for poorer children.[15]

- Poor children are much more likely to perform poorly at school. They generally have higher illiteracy rates and **lower academic achievement** scores that children from families with higher incomes. They often have poorer attendance records and have greater difficulty getting along with their teachers and peers. They suffer from more emotional and physical disorders.[16]

POLICIES AND PROGRAMS THAT MAKE A DIFFERENCE

We have cited significant evidence that the health of children who live in poverty is being compromised in many ways. But is there anything we can do about it? Research evidence and experiences in other jurisdictions suggest we can both reduce the scope of child poverty and help children to better deal with the disadvantages that are often associated with living in poverty.

Reducing poverty

First of all, the international and regional variability of child poverty rates suggests that the scope of poverty is modifiable, at least to a degree. Indeed, Canada's child poverty rate is "especially troublesome" when compared to other countries in the developed world, according to Towards Well-Being, Strategies for Healthy Children, the 1997 report of the federal Standing Committee on Health.

That report quotes a 1996 UNICEF report: "The rate of child poverty in Canada after government redistribution is four times the rate in Sweden, twice as high as in France and Germany, and 1.4 times the rate in Great Britain. Only in the United States is the rate higher than in Canada."[17] The figures are even worse when single parent households are considered. Canada's poverty rate for lone-parent families is almost eight times the rate in Sweden and almost three times the rate in France.[18]

Transfer payments and social policies are largely responsible for the difference in rates between Canada and other countries. For example, in Sweden the government assumes the responsibility for ensuring that single parents receive support payments. The government then reclaims the money from the support-paying parent. In Canada, where more than 70 per cent of female single parents live in poverty,[19] the government does not pay support up front and social assistance payments to single parents are well below the poverty line. Clearly, public policy measures are levers that can raise or lower child poverty rates.

Comments Dr. Paul Steinhauer of the Sparrow Lake Alliance: "As part of this process of public education, we need to persuade the community to begin to look at children as the Europeans do -- as a shared natural resource that represents society's future -- rather than as most North Americans do -- as solely the responsibility of their parents."

Resiliency

Poverty is often believed to be solely responsible for the poor developmental outcomes in children. But new research is showing that while economic disadvantage has an important association with poor life chances for children,[20] it is also associated with psychosocial disorders -- frequently clustered in poor families -- that can have even more devastating effects on outcomes for children, dramatically increasing the developmental risks for the children involved. There is good evidence that a supportive social environment can unlink children from the effects of disadvantage and economic deprivation.[21]

Interventions to protect the roughly one third of our children and youth who are currently falling short of their potential must be focused in the early years of a child's life, since " the quality of care that children receive, particularly in the crucial first year of life, will, more than any other single factor, influence their health, their mental health, their school achievement, their ability to control their aggression, and their future productivity as members of society." [22]

In the last thirty years, the research community has demonstrated that several initiatives have been effective in helping disadvantaged children and families to reduce the negative outcomes associated with poverty. These initiatives address the many risk factors that undermine the development of resiliency, while promoting the development of protective factors in the personal characteristics of parents, children or both. More recently, initiatives have begun to address the protective characteristics in schools and communities in order to create supportive environments. Home visiting, centre based enriched preschool programming, and community action leading to participation and ownership are examples of strategies that have been used to increase resiliency.

Many of these initiatives share similar goals: enhancing parenting capacity; fostering healthy child growth and development including a healthy birth weight; reducing rates of child maltreatment; improving children's social and coping skills and cognitive development; increasing access to community resources and developing supportive and participative communities.

REDUCING CHILD POVERTY/ENHANCING RESILIENCY: SETTING GOALS

The Ontario Public Health stakeholders need to help to develop and support a broad social and political agenda to create conditions that both reduce poverty and increase resiliency. They should lend support to the following macro goals, which are a synthesis of recommendations from a variety of reports and organizations including Campaign 2000, The Canadian Centre for Policy Alternatives, The Canadian Public Health Association, the Federal/Provincial/Territorial Advisory Committee on Population Health, the National Forum on Health, and the Registered Nurses Association of Ontario. [23]

GOALS 1: Increase equity and reduce child poverty

Strategies:

- change the tax structure so that single earner families are not placed at a disadvantage
- enhance the child benefit
- government to pay child support and seek reimbursement from paying parent

GOAL 2: Support families

Strategies:

- high quality, affordable child care arrangements available to all parents who need them
- family friendly work environment: parental leave, flex work arrangements, on-site child care, reduced work hours, job sharing
- nurse home visiting program for mothers in high risk families

GOAL 3: Invest in education, health and welfare

Strategies:

- create a national social investment fund to replace the Canada Health & Social Transfer program and provide dedicated funding with national standards in areas such as health, education and income support[24]
- ensure universal junior kindergarten
- devote 1 per cent of federal government revenues for programs to support the development of children
- secure a comprehensive, integrated, coherent system of services that offers equal access to flexible, multi-functional quality services for all young children from birth to age six, and for their parents who elect to utilize it.

GOAL 4: Economic and labour policies that protect children

Strategies:

- set targets/plans for "good jobs" (e.g. fair pay, decent working conditions)
- cut unemployment in half
- provide adequate unemployment insurance
- pass legislation requiring that all overtime work hours , above a designated threshold, be paid at 1 1/2 times the regular rate

GOAL 5: Adequate housing

Strategies:

- renew financial support from federal and provincial governments for social housing and co-op housing units

GOAL 6: Make child development a priority policy area

Strategies

- improve policy coordination/collaboration, for example through a provincial health minister designated for children or an increased mandate for the Minister Without Portfolio Responsible for Children
- Implement a community-based public planning process to support children 1 to 3 years old

- Establish national standards and indicators for child health and social support and services, for example a "Well Street Index", which is a list of 11 measures of how children are faring, including the low birth weight rate, percentage of children arriving at kindergarten who are not ready to learn and length of waiting lists for subsidized days care [25]
- initiate annual progress report
- set national goals

A PUBLIC HEALTH APPROACH TO CHILD POVERTY

Public health practitioners are well placed to bring a health perspective to the issue of child poverty. Our main focus is of course the prevention of ill health, and poverty crosses over many of the issues identified in the Ontario mandatory programs. Many public health departments already work directly with families affected by poverty, and are also well connected with community groups and organizations in a position to take action to improve child health (policy makers, schools, parent, businesses). With expertise and knowledge about the broad determinants of health, public health workers can increase the legitimacy of action on poverty-related concerns and early childhood interventions. Finally, public health workers offer increasing skills in community organizing and animation

Public health workers also face significant barriers in taking action on child poverty. Above all, there is the sensitivity and awkwardness of a publicly-funded body engaging in policy advocacy and political action. Moreover, in part due to the shift in funding to the local level and changes to the Mandatory Core guidelines, there is pressure to focus on programming, rather than on community action and advocacy.

Despite the barriers, public health must strive to take a two-pronged approach to tackling the health impacts of child poverty: decrease exposure to child poverty and enhance the resiliency of poor children. The latter approach, traditionally practised by public health, is more accepted as a mandate of public health.

1) Decreasing exposure to poverty

Advocacy for healthy public policy and practice. The research base in public health strongly suggests that while a balance of initiatives is necessary, policy change is a key factor in promoting health goals. From the Ottawa Charter to more recent OPHA discussions[26], the importance of a strong public health involvement in advocating for government policy and programming supportive of the health of our communities has been growing.

Effective advocacy involves a number of activities:

- *policy analysis:* monitoring of current and proposed policies [illegible] assessing their effects on health of populations, in this case children:

- *policy development:* researching, proposing [illegible] marketing feasible and effective policies and programs, often in collaboration with policy makers at different levels of government;

- *raising awareness:* educating communities about policies and programs and their actual and potential health impacts;

- *community action:* enabling community members to identify and advocate for policy priorities;

- *coalition-building:* bringing together key stakeholders from various sectors to advocate for healthy policies.

There may also be a role for the development of guidelines within the health department so that individuals understand the role they may play in advocating for changes to government policies.

Unfortunately, the current Mandatory Health Programs and Services Guidelines (December 1997, Ministry of Health) do not directly identify advocacy on child poverty as a role of public health. However, they do allude to poverty as a "barrier" to equal access of public health programs. Moreover, the program standards for the mandatory guidelines do establish objectives which are clearly tied to poverty-related policy issues. For example, one objective is to increase the percentage of children who meet physical, cognitive, communicative and psychosocial development milestones by school entry. Others include reducing the low birth weight babies (under 2500 g) to 4 per cent by the year 2010, and reducing the prevalence of dental diseases in children and youth.

2) Increasing resiliency in poor children, families and communities

Fostering resiliency in children, families and communities is key because it strengthens the capacity to respond to multiple stressors. Public health units spend resources on programming that develops resiliency in children, families and communities. What differs, however, is the amount of resources spent and the types of strategies implemented. How should public health be investing their resources and energy?

Evidence tells us that effective resiliency programming involves identifying both the risk and protective factors in children, families and communities that contribute to, or undermine the development of resiliency, and then identifying effective interventions in the research literature that impact on these factors.

In a child's early years, initiatives that help babies to be born healthy, help infants become securely attached to a parent or primary caregiver, and help toddlers and preschoolers grow up in a stimulating and nurturing environment have been shown to help children become more resilient.

There are two rigorously evaluated and well known initiatives that focused on enhancing protective factors in children and parents. David Olds' [27] Elmira home visiting project used nurses to provided intensive home visiting over a two year period, using a structured, yet flexible curriculum, with multiply disadvantaged families. Results from Olds' study indicate that in a 15 year follow-up study of primarily white families, among women who were low-income and unmarried, in contrast to those in a comparison group, those provided with a nurse home visitor had: 55% fewer verified reports of child abuse or neglect and 70% fewer maternal arrests by self report. The study has since been replicated in Memphis Tennessee and Denver, Colorado with similar benefits among program participants.

The second initiative, The High/Scope Perry Preschool Project [28] provided an enriched half day curriculum based preschool program to children living in a disadvantaged area in Ypsilanti, Michigan. The centre based programming was augmented with home visits to help parents' provide a cognitively and socially stimulating environment at home. The children enrolled in the original High/Scope Perry Preschool program have been studied for 27 years and the latest findings reveal long term benefits for the children, now adults, and for society. When compared with a control group, children who attended the preschool had 50% fewer arrests and convictions, the teen pregnancy rate was 42% lower, twice as many had never been on welfare over the past ten years, and 33% more graduated from high school. The estimated savings by age 27 for each $1.00 spent on the program was $7.16.

Clearly, well designed initiatives can promote resiliency in disadvantaged children and families. In Ontario, there are several innovative programs underway that focus on promoting protective factors in families, schools and communities. Although their results are not yet available, several appear to be increasing social cohesion in disadvantaged communities.

When planning resiliency programming, public health practitioners should target initiatives to all people living within a disadvantaged community. As well, initiatives should be derived from, and respond to, a clear analysis of the problem they are intended to address; they should be based on research, but be flexible enough to adapt to the needs of the population; and they should have an accountable and evaluative component. [29]

APPENDIX

Key Informants

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