TORONTO

STAFF REPORT
INFORMATION ONLY

Impact of Poverty on the Health of Children from Racialized Groups

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To:	Board of Health
From:	Medical Officer of Health
Wards:	All
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SUMMARY

Research has shown that children living in poverty have worse developmental outcomes than other children and poorer health both as children and later in life as adults. Evidence also shows that children from racialized groups experience higher than average levels of poverty. This report reviews available evidence on the impact of poverty on the health of children in racialized groups.

To date, Canadian research that directly examines the impact of poverty on the health of low-income children from racialized groups is lacking. However, given that more than three quarters of immigrant children in Toronto are in racialized groups, information about health outcomes for immigrant children can provide some insight into the impact of poverty on children from racialized groups. A selection of available health outcome indicators including low birth weight, immunization, child health status, breastfeeding, early child tooth decay, problems and access to health services reveal a complex mix of both positive and negative health outcomes. These patterns likely reflect the combined health impacts of poverty, racialization, and immigration.

There is clearly a need for better information in this area. New research initiatives, such as the New Canadian Children and Youth Study, will improve our understanding of the impact of poverty on the health of children from racialized groups. Toronto Public Health (TPH) will continue to collaborate with key partners to assess disparities in child health outcomes and will integrate these new findings into services and advocacy efforts to address the impact of poverty on child health.

Financial Impact

There are no direct financial implications arising from this report.

DECISION HISTORY

At its meeting on September 14, 2006, the Board of Health considered a report from the Medical Officer of Health on the "Impact of Poverty on Children's Current and Future Health". At its February 26, 2007 meeting, the Board of Health requested a report on the causes and impact of poverty on the health status of children in racialized groups for its April 16, 2007 meeting (1).
http://www.toronto.ca/legdocs/2006/agendas/committees/hl/hl060914/it001.pdf

ISSUE BACKGROUND

Addressing health disparities and the needs of vulnerable groups and ethno-racial communities, supporting immigrant and refugee settlement, and promoting the health of children, youth, and their families are all key goals of Toronto Public Health's Strategic Plan (2005-2009) (2). A particular area of concern is the significant number of families with young children living in poverty. Research has shown that young children growing up in poverty have worse health and developmental outcomes, on average, than other children. Children living in poverty are often exposed to risk factors/conditions that increase the likelihood of poor health, and children's early experiences with poverty continue to affect their health as adults (3). These issues were addressed in the September 14, 2006 Board of Health report "Impact of Poverty on Children's Current and Future Health". The focus of the 2006 report was on the impact of poverty on the health of children in general. It did not specifically examine the health of children from racialized groups.

COMMENTS

Ethno-Racial Diversity in Toronto

Toronto is Canada's largest and most ethnically diverse city. In 2001, forty-nine percent of Toronto's population were immigrants from over 200 countries. In 2001, the top countries of origin for immigrants to Toronto were China, Italy, Philippines, India, and the United Kingdom (4). For recent immigrants (arrived within 5 years of the 2001 census), the top countries of origin were China, India, Pakistan, Philippines, and Sri Lanka (5).

More than half of Toronto's children from birth to the age of 14 years were part of the visible minority population in 2001 (as defined by Federal Employment Act categories). The largest ethno-racial groups of children aged 0 to 14 years were South Asian (e.g. East Indian, Pakistani, Punjabi, Sri Lankan), Black (e.g. African, Haitian, Jamaican, Somali), and Chinese (6).

Data from the 2006 Census is in the process of being released and will be monitored by TPH for new and emerging trends.

Racialization of Poverty

Racialization has been defined as the "process by which racial categories are constructed as different and unequal in ways that lead to social, economic, and political impacts" (7) (p.10) as well as "health inequalities" (8) (p.13). Racialized groups refer to "non-dominant ethno-racial communities who, through the process of racialization, experience race as a key factor in their identity" (8) (p.13).

Children in Toronto from racialized groups experience disproportionate levels of poverty. In 2000, 29% (51, 000) of all Toronto children from birth to age five years lived in low-income households (annual household income that falls below Statistics Canada's pre-tax Low Income Cut-Offs (LICOs). Seventy-six per cent of these low-income Toronto children belonged to a visible minority group (6).

Further analysis of census information indicates that poverty in racialized groups is concentrated in specific ethnocultural groups, in specific geographic communities, and has increased over time.

There is significant variability in the incidence of low income between different ethno-racial groups within the Toronto Census Metropolitan Area (includes the City of Toronto and 23 surrounding municipalities). In 2000, particularly high levels of poverty were reported for children under the age of 18 years for a number of ethno-racial groups, when compared to the prevalence rate of low income for children of European ancestry (10%). The level of poverty for people of African background was close to fifty percent (47.5%), while the rate for children from Arab and West Asian backgrounds was 35.7%, Caribbean 29.1%, South Asian 25.3%, South and Central American 25.1%) and East Asian 21.4%. The poverty rate for Aboriginal children in Canada was 25.8% (9).

Geographically, over half of the children in low income households from racialized groups live in just one quarter of the City's census tracts. The low income rate for children age 0-14 in racialized groups in these census tracts ranges between 47% and 85%. (10)

The concentration of poverty in children in racialized groups appears to be rising over time. The proportion of children aged 0-14 years from racialized groups living in low income households, increased from two thirds (67.2%) in 1995 to three quarters (74.9%) in 2000. (10)

Some of the contributing factors that have been cited for the higher rates of poverty among racialized groups include: over-representation of racialized groups in low paying and unregulated, temporary, and contingent work; lack of recognition of foreign credentials and international work experience; and racial discrimination in employment (11).

Health risks which have been described as stemming from racial discrimination include neighbourhood segregation in underserved areas with poorer quality housing; exposure to violence; educational streaming; racial/cultural stereotyping; unequal access to information; and discrimination in access to financial, social and health services (12, 13). In addition, the experience of discrimination and lack of access to culturally acceptable services are related to underuse of health services (14).

Disparities in Health Outcomes

While there is clear evidence that poverty has a detrimental impact on the health of children in general, and that children from racialized groups experience disproportionate levels of poverty, Canadian research that directly examines the impact of poverty on the health of low-income children from racialized groups is lacking.

In Canada, data on child health outcomes are not generally collected according to specific ethno-racial groups. However, some data is available based on mother's country of birth or the immigration status of the parent or child.

The examples of child health outcomes described below largely focus on immigrant children. Approximately 80% (79.4%) of immigrant children age 0-14 years living in Toronto in 2001 were from racialized groups and immigrant children are disproportionately living in low-income families. While they make up 18% of children age 0-14 years, they make up 30% of low-income households (10). Consequently, data on the health of immigrant children and their families can provide some insight into the health of racialized children.

For some health outcomes, immigrant children appear to have worse health outcomes than Canadian-born children and in others areas they appear to have better outcomes. This likely reflects the complex interaction between the health impacts of racialization, poverty and immigration.

Selected Canadian research is presented below using data from provincial databases, the Toronto Perinatal and Child Health Survey (PCHS), and National Longitudinal Survey of Children and Youth (NLSCY). The outcomes examined include low birth weight, immunization status, child health status, breastfeeding, early childhood tooth decay, emotional and behavioural problems, and access to health services.

1. Low Birth Weight

   In Toronto, there is considerable variation in singleton low birth weight rates. Mothers born in Latin America and the Caribbean had the highest singleton low birth weight rates while mothers born in North America had the lowest singleton low birth weight rates. Despite years of research investigating the impact of racial/ethnic differences on pregnancy outcomes, the true reasons for these differences are not clear, but it is has been suggested that factors such as socio-economic status,

nutritional deficiencies, stress, social support, behaviours, unplanned pregnancies and prenatal health care interact to influence pregnancy outcomes (15).

2. Immunization

   Data from the Ontario Health Insurance Plan (1997-2000) for urban children in Ontario indicate that less than 70% of two year olds were fully up-to-date with routine immunizations. Children from families with a lower socioeconomic status were less likely to be up to date on their immunizations. However, children of immigrant mothers were more likely to be up to date on their immunizations than children of non-immigrant mothers. Children whose mothers were from Asia had the highest rates of coverage while children from industrialized nations and Latin/Central America had the lowest rates (16).

3. Child Health Status reported by Parents

   Parental report of child health is one indicator of overall child health status. The 2003 Toronto Perinatal and Child Health survey (PCHS) found that parents of children aged six years or younger who lived in low income households were three times more likely to report their children to be in poorer health compared to those who did not live in low income households. The survey also found that parents not born in Canada were almost twice as likely to report their children in poorer health compared to parents who had been born in Canada, after accounting for household income. Differences in immigrant parents' rating of their children's health status were also found based on the length of residency in Canada, with 21% of recent immigrants (in Canada for 10 years or less) reporting their children to be in poorer health compared to 13% of non-recent immigrants (in Canada for 11 years or more) (6).

4. Breastfeeding

   The PCHS (2003) found that Toronto mothers born outside of Canada were more likely to initiate breastfeeding compared to mothers born in Canada. As well, mothers who were recent immigrants (in Canada for 10 years or less) at the time of the child's birth were more likely to report that they breastfed their child than non-recent immigrants (17).

5. Early Childhood Tooth Decay (ECTD)

   The PCHS (2003) found that children born outside of Canada were slightly more likely to have visited a dentist within the last year and also less likely to have never been seen by a dentist (Toronto Public Health, 2006). However, these same children were three and a half times more likely to be diagnosed with ECTD than children born in Canada (17).

6. Access to Health Services and Other Social Supports

Kobayashi, Moore, & Rosenberg (1998) examined the use of formal and informal supports and services by the parents of immigrant and non-immigrant children. They used data from the first cycle of the NLSCY (1994/1995). Families from the most recent immigrant groups living in larger cities and families with the lowest proficiency in English or French had the least access to both formal and informal networks. These findings suggest the importance of identifying and addressing barriers to formal and informal supports (18). A recent literature review by Access Alliance Multicultural Community Health Centre identified several barriers to accessing health care. These included financial, cultural, linguistic, and geographic barriers as well as those related to discrimination and lack of legal status (8).

Some researchers studying the health of immigrant and refugee children have characterized the literature on the health of racialized children as being "riddled with paradoxes, inconsistent results and unanswered questions" (19) (p.21). They attribute this to a lack of consideration of the broad range of factors that influence the health and well-being of immigrant and refugee children and their families. Some of these factors include immigrant versus refugee status, age at migration, gender, family characteristics, visible versus non-visible minority status, social support, receiving country's attitudes, and resettlement practices (19).

Data on the health of immigrant children should be interpreted with caution when seeking an understanding of the relationship between poverty, race and health. While most immigrant children in Toronto are members of racialized groups, many non-immigrants are also members of the same groups, and their experience of the impact of poverty on health may differ from that of immigrants.

Improving our Understanding

In order to address the data and research gaps identified throughout this report, TPH will continue to seek new information and opportunities to collaborate with key partners. These efforts will focus on assessing disparities in child health outcomes at the local, provincial, and federal levels and seeking research and evidence to improve our understanding of the relationship between income and health (and its mediators) for children.

The New Canadian Children and Youth Study (NCCYS) will be an important source of data. A longitudinal survey will address the under-representation of immigrants and refugees in the NLSCY. It will focus on the health and development of approximately 4,500 immigrant and refugee children from 17 different ethno-cultural communities living in six Canadian cities. It will attempt to address the interplay of individual characteristics, pre and post migration stressors, and individual and social resources that influence child health (19). Access to health services and discrimination will also be addressed. Analysis of data from the first cycle is currently underway and will be used to inform future service planning and delivery.

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SIGNATURE

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