Insufficient funds:

Poverty's effect on health

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The McMaster Health Forum strives to be a leading hub for improving health outcomes at the regional and provincial levels in Canada. Through problem-solving and discussion, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively.

CONTEXT

The World Health Organization states that "poverty is the single largest determinant of health".[1] Indeed, the relationship between poverty and health has been accepted for many decades, with the League of Nations Health Organization noting in 1933 that economic despair had created "the gravest dangers for health and the very existence of millions of people".[2] Although poverty is often thought of as an issue exclusive to developing countries, its impact is also felt in developed nations such as Canada. In the past decade, 9% of the Canadian population have been considered low-income citizens, translating to about 3 million Canadians living in relative poverty.[3] Low-income Canadians have a shorter life expectancy and suffer from more illnesses than Canadians with higher incomes regardless of age, sex, race, and place of residence.[4] To address the issue of poverty, the Canadian Government is currently conducting national case studies to inform a new federal poverty reduction strategy.[3] Throughout this process, it will be important to consider the unique challenges faced by specific groups. This article will highlight key challenges faced by low-income women - a group disproportionately affected by poverty - as well as policy options that could be considered within efforts to reduce poverty among low-income women.

GENDER WAGE GAP

The gender wage gap in Ontario is 14% in average hourly wages, 25% in average annual earnings for full-time workers, and 29% in average annual earnings for both seasonal and part-time workers.[5] Though these rates may help to characterize the gender wage gap in Ontario, they do not tell the entire story. It is critical to note that these rates vary significantly among different age groups, as well as among traditionally disadvantaged demographics, such as visible minorities.[5] For example, Indigenous women earn 18% less than Indigenous men and 36% less than non-Indigenous men in hourly wages.[5] Racialized women and women with disability earn 34% and 48% less than non-racialized men and men without disability, respectively, in hourly wages.[5] Women who identify with more than one marginalized identity are more severely affected by the gender wage gap, and thus deserve special consideration in the development and consideration of poverty reduction and health promotion policies.[6]

Structural reasons beyond the issue of equal pay for equal work contribute to women being disproportionately represented among Canada's low-income population. For example, no gender wage gap was reported between men and women who earn minimum wage per hour; however, more women than men hold minimum wage jobs.[5] Normative gender stereotypes and practices play a role in sustaining gendered workforce participation, and it is often the case that professions dominated by women offer less earning potential.[6]

Differences in the gender wage gap and overall income are important to address for many reasons, the most compelling being that the effects of these differences accumulate over time. Women earning less in employment incomes contribute to a gender pension gap

later in life, increasing the risk of older women falling below the poverty line after retirement.[5]

CAREGIVING

Caregivers are individuals who provide unpaid and ongoing care or social support to a family member, neighbour, or friend who is in need due to physical, cognitive, or mental health conditions.[7] Women have historically performed this service, and, as of 2012, the majority (53%) of caregivers in Ontario are female, with women spending more time providing weekly unpaid care than men.[8] Since Canadian Pension Plan (CPP) benefits are accrued through workforce participation, lower income compounded with time spent away from work has a larger effect on female caregivers. Unsurprisingly, many female caregivers report financial hardship as a result of their responsibilities.[9] At present, some financial support is provided to caregivers in Ontario through a federal tax credit or insurance benefits. However, these programs have limited public awareness, the application process can be cumbersome, and the benefits offered are not always sufficient.[10] In addition to increasing public awareness about existing financial programs supporting caregivers, another option to consider would be offering a means-tested income support (i.e., caregiver allowance) for caregivers who face financial burden. For example, Nova Scotia's Caregiver Benefit Program targets lower-income caregivers with a high-level of disability. Eligible caregivers receive $400 per month through the program.[11] However, little to no evidence has been published on this financial strategy, so its effects are unclear.[7]

WOMEN LIVE LONGER AND ALONE

In Ontario, life expectancy at the age of 65 is 21.7 years for females, compared to 18.7 years for males.[12] Male partners in Canada are also on average slightly older than females. When combined, these realities contribute to women over 65 being almost twice as likely to live alone compared to men (31.5% vs. 16.0%). Living alone negatively impacts health outcomes in both men and women.[13] For example, a study following 44,573 participants over four years found that living alone was associated with significantly higher mortality between the ages of 45 to 80 years.[14] Moreover, single older women were found to be more likely to experience financial challenges, with data indicating that 17% of women over 65 were low-income compared to 12% for men in the same age group.[15] Addressing the financial stability of single older women could involve a re-evaluation of the Guaranteed Income Supplement program payments (i.e., non-taxable benefit), which provide an allowance to low-income seniors. Alternatively, the Ontario health system and its sub-regions could consider policies or programs that target other negative consequences of living alone. For example, a medium-quality systematic review identified that social activities and groups where older adults were active participants are effective for decreasing the negative aspects of social isolation.[16] This may be a viable option, given that the Ontario government has emphasized the importance of civic engagement for older adults.[17]

CONCLUSION

Older single women, particularly those whose identities intersect with other marginalized populations, are overwhelmingly represented among Canada's low-income population. As Canada and the province of Ontario set their strategic priorities, it is imperative that future initiatives should engage with and support populations most burdened by poverty. In addition, poverty-reduction initiatives should reflect a nuanced understanding of heterogeneity among low-income populations. ■

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