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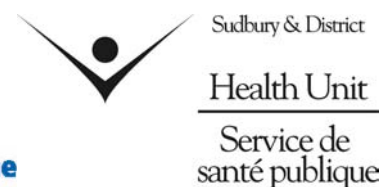
# Needs Assessment of Sudbury's Working Poor Population

Summary Report

A report from the

Working Poor Project Steering Committee  
Sudbury, Ontario

November 2005



## **Authors**

This needs assessment report was prepared by Michèle Parent with the assistance of Marie Laframboise and Maggie Delmege, and was based on documents from the Working Poor Project Steering Committee.

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This report is dedicated to low-wage workers, key informants and community organizations that collaborated with us on this study.

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## **EXECUTIVE SUMMARY**

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In December 2003, a partnership between Sudbury & District Health Unit staff, faculty from Laurentian University, and the University of Toronto was formed to create the Working Poor Project Steering Committee. The Working Poor Project's goal was to understand better the health and wellness issues of the working poor population in the City of Greater Sudbury (CGS). One main objective of the project was to engage low-income workers, together with other stakeholder groups, to achieve greater understanding of the population needs.

Poor working conditions characterized by low control and high demand are more prevalent in lower socioeconomic groups (Bosma et al., as cited in Siegrist and Marmot, 2004). The jobs of the working poor are typically low quality, temporary, low wage with few if any benefits (Lightman, Mitchell & Herd, 2003). Unstable jobs are associated with a variety of adverse health outcomes such as mental illness, physical symptoms and physical illness (Taylor, Repetti & Seeman, 1997).

The purpose of this study was to conduct a needs assessment of the working poor population in CGS. Specifically, the study investigated need as it pertains to the income, health and safety of the working poor population. Potential interventions to improve the health, safety and well-being of the population were also of interest.

### **Methodology**

We interviewed 23 key informants, talked to 65 low-wage workers in nine focus groups, examined trends using epidemiological data from Statistics Canada 2001 Census and the Canadian Community Health Survey (2000/2001), and reviewed the existing literature on initiatives for the working poor. The findings will assist the steering committee and stakeholders to develop projects and strategies to improve the health, wellness and safety of the working poor population. As part of the approval process, the Research and Ethics Committees of both SDHU and Laurentian University reviewed and approved the study components that involved human subjects.

Partners from different organizations in CGS were asked to help identify low-wage workers. Individuals self-selected to participate by reading advertisements, which were placed in several local prints and on bulletin boards where low-wage workers may be gathering. Because the focus group participants representing the Francophone and male sub-populations were relatively small, generalizations cannot be made across the entire working poor population in CGS; nevertheless, the total number of informants (65) provided a rich source of data.

Little information on access and interventions to improve health currently exists in the literature; this situation does not reflect the present population need. The results of this study highlight a strong need for improving access to programs that can impact job security. The need for education targeting low-wage workers, employers and their community was highlighted and several topics were suggested. The Steering Committee feels that the findings confirm some hypotheses, call some into question, and give rise to others, laying the ground for further investigation.

## Recommendations

Based on the findings, the Steering Committee has formulated recommendations on needs of the working poor population in CGS and interventions to improve their health, well-being and safety. The recommendations are meant to uncover ideas and provide guidance for improving the current condition of the working poor population.

- 1) Provide and advocate for opportunities for public education and awareness on the existence and needs of the working poor population.
- 2) Develop and improve access to evidence-based strategies and interventions that reduce health inequities and provide respectful and supportive environments for low-wage workers, using a population health approach with particular attention to six specific determinants of health (job security, physical environments, childhood development and care services, health benefits and services, income, and food security).
- 3) In light of the current trends observed in our community (increase of women as low-wage workers, increase of people working in low-wage jobs, increase of people experiencing poor employment conditions), continue to hear the voices of this often forgotten population, and encourage community initiatives that will improve the health, safety and well-being of low-wage workers.
- 4) Continue to implement health promotion protection, and safety programs focused toward the working poor population (e.g., physical activity, computer skills, nutrition classes, counselling, access to primary health care and life skills, WHMIS).
- 5) Develop a compendium of information on health promotion initiatives offered to the working poor population that is accessible, organized, communicated and disseminated to the people who require the information.
- 6) Work in partnership to implement policy changes, as a foundation for wide-spread change to the health, safety and well-being of the working poor population.
- 7) Extend research on the health, wellness and safety assets and needs of low-wage workers, in order to fill a gap in the scholarly literature. Of particular importance is research and evaluation related to *interventions* at the individual, workplace, community and social policy levels.

# Needs Assessment of Sudbury's Working Poor Population

## Summary Report

### INTRODUCTION

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The Sudbury & District Health Unit (SDHU) encourages a focus on the determinants of health in order to significantly improve health status and wellness in our communities. It is believed that ill health is not determined solely by what the individual does. Although lifestyle behaviours impact health, health is determined by complex interactions between individual characteristics, social and economic factors, and the physical environment. Strategies to improve health need to address the entire range of factors that determine health (Health Canada, 2002).

There are many definitions of determinants of health. The Sudbury & District Board of Health issued a determinants of health position statement in 2005 that uses the Public Health Agency of Canada categorization of the twelve major determinants: income and social status, social support networks, education, employment, working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture.

In keeping with a determinants of health approach, the SDHU Workplace Wellness Team provides health promotion services to at-risk groups within the context of the workplace to improve health status and wellness. The mission entails working with workplace communities to promote and protect health and prevent disease. To impact specifically on reducing chronic illnesses, the team develops and delivers a variety of health promotion strategies with the workplace community in the City of Greater Sudbury (CGS).

In March 2003, the team identified low-wage workers as a population of interest. Increasing numbers of low-wage workers were reported in CGS, as well as nationally. The problem was further complicated, in that despite continued efforts to reach these groups to provide services, they frequently remained hard to reach. Often workplaces that compensated workers with low wages were not able to provide sufficient time or resources for health promotion services at work. For example, a small convenience store owner could not spare or replace workers while they participated in health promotion activities. There was a pressing need to identify and understand the working poor population in CGS in order to plan, develop and provide health promotion services.

In December 2003, the partnership between SDHU staff (Health Promotion and Resources, Research, Evaluation and Development (RRED) Divisions), faculty from Laurentian University (School of Social Work, Department of Economics, Department of Sociology) and the University of Toronto (Health Communication Unit) was formed to create The Working Poor Project Steering Committee. The Working Poor Project's goal was to understand better the health and wellness issues of the working poor population in CGS. One main objective of the project was to engage low-income workers, together with other stakeholder groups, to achieve greater understanding of the population needs.

The first phase of the project began in January 2004 and included several planning sessions. At the onset, it was important to gather as many stakeholder groups as possible in a think tank. The event was organized to provide an opportunity for disseminating information on current project status with key stakeholder groups and to share knowledge that would be of interest to the Working Poor Project. Invitations requesting participation in this event were sent to over sixty different community groups and organizations. On February 23, 2004, Ms. Janet Gasparini, (Director, Social Planning Council and Sudbury & District Board of Health) opened the workshop, which brought together several individuals with knowledge of low-wage workers. Over thirty representatives from various groups and agencies participated. As a result, a report containing presentations on the working poor population and the health effects of poverty was produced and distributed widely in the community in June 2004. The Report of the Working Poor Workshop is also posted on the SDHU website.

Starting in April 2004, funding for different project components was sought. The Public Health Research Initiative Grant and funding from the Laurentian University Summer Student Placement program provided funds to support components of a needs assessment on the working population in CGS. A critical appraisal of the literature was completed. FedNor granted funding for a youth intern as research assistant to the project. As part of the needs assessment, key informant interviews were completed, presentations were developed and delivered on the working poor, and fact sheets were produced. On an ongoing basis, other sources of funding were sought throughout the project.

In 2005, the needs assessment of the working poor population was completed. Data were collected from over sixty low-wage workers and twenty-three key informants. The findings will assist the steering committee and stakeholders to develop projects and strategies to improve the health, wellness and safety of the working poor population.

In 2005, a presentation on the needs assessment is scheduled at the Ontario Public Health Association Fall Conference. In addition, the Committee will host a symposium: *High Costs of Low Pay: Health, safety and wellness issues of low-wage workers*. The project outcomes for 2005 include increasing our own and our partners' awareness of the working poor population and ways to improve their health, safety and well-being.

This report presents information on the background and purpose of the project. A review of the literature is also provided. The needs assessment methods are described, and the findings and analysis are presented. In conclusion, several recommendations are presented, with a hope that they will guide research, education and practice.

## **BACKGROUND**

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In 2003, the Canadian Council of Social Development concluded that there is a growing polarization of income in Canada. The income of the wealthiest 10% of the population increased by 14%, while the poorest 10% only received a 1% increase. The population characterized as working poor has seen a decline in income. Further, young families whose major income recipient is aged 25-34 have seen their median wealth decrease by 36% compared to 4% in the average population (Morissette, Zhang & Drolet, 2002). During the 1990s, one of Canada's most prosperous decades, the overall number of Canadians living in poverty increased. For example, in 1980 there were 4.09 million, in 1990 there were 4.28 million, and in 2000 these numbers increased to 4.72 million people living in poverty in Canada (Canadian Council on Social Development, 2003).

Saunders (2003) states that dual-income households have displaced the single income breadwinner over the last 25 years. A change in the workforce has decreased the availability of full-time employment, and as a result increased numbers of workers are finding only part-time and temporary employment. Further, more individuals are required to work at two or more jobs. These trends leave numerous Canadians vulnerable to poor quality jobs characterized by working undesirable times, unstable employment, underemployment, exposure to involuntary layoffs and increased occupational risk (Saunders, 2003). With almost 2 million adult Canadians working for less than \$10.00 an hour, Saunders recommends that we must better understand the circumstances of low-income workers and strategies to improve their situation and health.

The term "working poor" refers to people who are employed and whose wages make up the main portion of the family's income but who are living below the poverty line (Urban Poverty Consortium of Waterloo, 2000). Mosisa (2003) refers to working poor as an individual/family who spent at least 27 weeks in the labour force (working or looking for work) and whose income fell below the poverty line. However, there is no official measure of poverty line in Canada, and multiple options exist (Ross, Scott, & Smith, 2000). Poverty lines are sometimes characterized as low-income cut-offs. Statistics Canada's Low Income Cut-Off (LICO) has been the most popular, yet the LICO is not without criticism (Ross et al., 2000). The LICO was developed in the 1960s and is a relative measure, which will go up as living standards improve, without necessarily reducing poverty. Because of these limitations, The Canadian Council on Social Development presented a new poverty measure called the market-poverty index (Schellenberg & Ross, 1997). The index combines the depth (how far below the poverty line) and rate (number of persons/families) of poverty comparing the results of the two data sets in time. At two points in time (1984 and 1994), the market-poverty measure identified more than 450,000 working poor families in Canada.

The problems associated with the LICO and other measures prompted the federal government, Human Resources and Development (HRDC) department to establish a taskforce in 1997. The HRDC developed a market-basket measure that combined both relative measures of income and measures of basic needs (Sarlo, 2003). Cubbin (2002), in a systematic review of the literature on socioeconomic status and injury, also suggests that no one measure should be employed; the use of multiple measures that would acknowledge the multifaceted nature of socioeconomic status is recommended.

Most of the working poor population are couples with children and more than half are part of dual income households (Ross, Scott & Smith, 2000). In 1998, about 5% of all persons employed earned minimum wage or less and of those, more than half are under 25 years of age. The adult over 25 years old category is mostly comprised of women earning minimum wage who are more likely to work part-time. The situation in CGS echoes that of other Canadian cities. In 2001, 38,775 women over 15 years of age worked in the CGS; of these, 55% worked part-time. The average yearly income for women working part time is \$16,081, and this is below the low-income cut-off for a one-person household (Census 2001, Statistics Canada). Although about 1/3 of minimum wage earners are married and tended to be younger (Ross, Scott & Smith, 2000), 14% are the sole adult providers in the family. The situation is amplified by the fact that low-wage work is unstable and these workers are most likely to suffer from involuntary layoffs (Urban Poverty Consortium of Waterloo, 2000).

The working poor have less access to extended family and community resources. They struggle to earn enough to support their family (Jenson, 2003). Foodbanks are finding the greatest increase in people who are hungry among the working poor. The working poor may not have access to full benefits and protections (e.g., extended medical insurance, dental plans, disability coverage, pension plans, job training and social services). They have less purchase power for telephone, hydro, childcare, transportation, food, accommodations, and clothing, and tend to work long hours, or part-time jobs (Saunders, 2003). The working poor have less education, fewer professional credentials, poor literacy or numeracy skills, outdated skills, and often face discrimination on basis of age, gender or race (Maxwell, 2002).

Statistical information for the population of CGS highlights the salience and scope of the current economic trends in the community. The average employment income in Sudbury is \$31,058. Among those who worked only part-time or part-year, the average employment income is \$20,450. The median total income of \$22,250 is more than \$2,000 lower than the Ontario average (Census 2001, Statistics Canada).

In studies on poverty, the neo-materialist approach is most often utilized (Raphael, Labonte, Colman, MacDonald, Torgerson, & Hayward, 2003; Evans & Kantrowitz 2002; and McLeod, Lavis, Mustard, & Stoddart, 2003). The model proposes that the effect of income inequality on health reflects a combination of negative exposures to risk factors, lack of resources and a systematic under-investment in social infrastructure. Raphael et al., recommend participatory action research projects that seek to address poverty issues. More regional and sub-regional analyses of exposure to health differentials, with emphasis on the lived experience of persons with low income is also recommended.

## **PURPOSE**

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The purpose of this study was to conduct a needs assessment of the working poor population in CGS. Specifically, the study investigated need as it pertains to income, health and safety of the working poor population. Potential interventions to improve the health, safety and well-being of the population were also of interest.

## **LITERATURE REVIEW**

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### **Social Determinants of Health**

In a commentary to The Globe and Mail on Friday, May 9<sup>th</sup>, 2003- Roy Romanow stated that the main factors that affect health are the same as those that affect society as a whole. The importance of the social determinants of health cannot be over-emphasized. The industrialized nations have experienced a dramatic improvement in health over the last century, which some have attributed to the improved access to and quality of the medical system. However only 10-15% of the increased lifespan seen in the developed countries is attributable to improved medical care (Raphael, 2003). Lifestyle differences have also been suggested to account for our increased longevity. Yet studies suggest that even lifestyle behaviours fill a small proportion of the health variation in populations.

The social determinants of health: 1) have a direct impact on health of individuals and populations; 2) are the best predictors of individual and population health; 3) structure lifestyle choices, and 4) interact with each other to produce health (Raphael, 2003, p. 36). The Canadian Population Health Initiative (2002) identified three areas for research on social determinants of health: 1) longitudinal policy assessment (both up-stream and down-stream, preventative and cross-sectional); 2) researchers talking to people living in poverty, bringing their experience into the mainstream of research and policymaking; 3) exploring the link between poverty and health at the population level, including the examination of pathways between poor health and socioeconomic status.

### ***Income and social status***

Money is the single most important determinant of health.

The amount of money that one has is the lead domino in a whole line of dominoes – the quality of your early childhood years, your education, the type of job you have, the kind of housing and community you live in, the type of recreation and fitness programs you have access to – all of which directly affect health, (Romanow, 2003).

Socioeconomic position determines the opportunities, stressors and resources accorded in life to individuals (Krieger, Williams & Moss, 1997). In a longitudinal study on income inequality, household income and health status, researchers found that low household income was consistently associated with poor health (McLeod, Lavis, Mustard & Stoddart, 2003). Based on data from the National Population Health Survey (1994, 1996 & 1998), which included 6,456 subjects representing 53 metropolitan areas, McLeod et al. (2003) concluded that apart from health status at baseline, household income was the best predictor of future health status. Research into strategies to address the needs of individuals reporting low household income is needed. Similar findings were reported by Hou & Chen (2003) in their study on low-income, income inequality and health of 8,862 subjects in Toronto, Ontario. Using data from the National Population Health Survey and Canadian census, Hou and Chen found that individuals with low-income status reported more chronic conditions. Self-perceived health status, an important independent predictor of onset of morbidity and mortality, was found to be lower in those with low-income status.

In a study of hospitalization rates in Manitoba, Roos, Burchill and Carriere found that 31% of the highest hospital service users came from the lowest 20% of household income (2003). The researchers recommended that policies should focus on the social conditions that lead to poor health, such as income.

Lantz et al. (1998) investigated cigarette smoking, alcohol drinking, sedentary lifestyle, relative body weight and the degree to which they explain the association between socioeconomic factors and all-cause mortality. The results demonstrated a strong association between education and income. Even when controlling for age, sex, race, urbanicity and education, the risk of mortality was still significantly increased for the lowest-income group. The authors concluded that reducing health risk behaviours is an important goal, yet the detrimental effects of low socioeconomic status on health would still persist. Research into a broader range of explanatory risk factors, including structural elements of inequality, is recommended. In Finland, Laaksonen et al., (2003) reported similar findings after conducting analysis of data representing 19,982 respondents to a nationwide health survey. They concluded that while education and occupation removed some of the health behavioural differences, smoking, minimal vegetable consumption, obesity, and use of saturated fats were all more common in those with lower income.

Holtgrave et al. (2003) examined relationships between individual-risk behaviour, income and rate of sexually transmitted infections (i.e. gonorrhoea, syphilis, chlamydia and AIDS). The researchers concluded that social capital is significantly predictive of some infectious diseases, and stress the need for further research into the association between income and health.

Low-income is a major barrier to protective health behaviours against chronic disease. Bell et al. (2001) examined compliance with diabetes care tasks in low-income patients in North Carolina. The authors measured specific health behaviours, such as glucose testing and blood pressure checks. The study's conclusions suggest that affordability of care was a significant barrier to compliance in low-income persons. In accordance with this, the Canadian Diabetes Progress Report (2003) recommends that strategies should be implemented to dissolve the burden of cost associated with diabetes-related complications. Erzen et al., (1997) examined the prevalence of asthma, bronchitis and airway obstruction in Winnipeg in light of average family income. Those in lowest income quintiles had greater prevalence of total respiratory morbidity than those in highest income bracket. Chen, Dales and Krewski (2001) found similar results in their study on combined effects of asthma and other factors on hospitalization rates. They concluded that age, gender and income increased the risk of overall hospitalization. The authors

suggested that higher income families could afford the medications and other associated costs of asthma and thereby attenuate the effects of chronic disease on their health.

Cardiovascular disease (CVD) is the leading cause of mortality among Canadians (accounting for 36% of all deaths) and costs \$20 billion annually (Raphael & Farrell, 2002). The relationship between income and CVD is purported to manifest through material deprivation, excessive psychosocial stress and adoption of unhealthy coping behaviours. The largest international study of CVD conducted by the World Health Organization (WHO) found that CVD rates between countries were not related to obesity, smoking, blood pressure or cholesterol level, while poverty, social unrest, and economic slowing were the best indicators and predictors of disease. Concurrently, Roux et al. (2001) studied 13,000 U.S. residents with no history of CVD and prospectively followed them for 9 years. They found that even when controlling for smoking, physical activity, diabetes, hypertension, obesity and cholesterol level, the lower income residents were much more likely to develop CVD. Thus, these studies exemplify that income plays a role in the prevention and treatment of specific morbidities. The studies also highlight the relationship between income and health behaviours.

### ***Employment***

The Institute for Work and Health (2002) acknowledged that little is known about work in general. The dearth of studies on work may explain why, in many of the current studies, there exists a lack of consideration of income, its distribution and health and safety. Employment and working conditions are Canadian social determinants of health which are not independent from, but in a dynamic relationship with all other determinants of health (Southwest Alberta Coalition on Poverty, 2003). Hallqvist et al., (as cited in Siegrist & Marmot) explored the effects of a disadvantaged workplace on the likelihood of myocardial infarction. Results indicated that accumulated periods of disadvantaged work experience increased the risk of heart attack. Choiniere, Lafontaine and Edwards also obtained similar results (2000). Hux, Booth, & Laupacis found an increased risk of diabetes among low-income Ontarians (2002). Twenty-three per cent of years of life lost for all causes mortality prior to age 75 in Canada could be attributed to low income (Statistics Canada, Wilkins et al., Health Reports. 2002). Bosma et al., (1998) as cited in Siegrist & Marmot, concluded that poor working conditions characterized by low control and high demand are more prevalent in lower socioeconomic groups. The jobs of the working poor are typically low quality, temporary, low wage with few if any benefits (Lightman, Mitchell & Herd, 2003). Unstable jobs are associated with a variety of adverse health outcomes such as mental illness, physical symptoms and physical illness (Taylor, Repetti & Seeman, 1997).

In a large scale study comprised of 8,273 men and women, job strain was consistently associated with poorer health (Ibrahim et al., 2001). The study findings demonstrated the effects of disadvantaged workplace on health. Mental illness, especially depression and anxiety disorders, are rising in number. In 2000 more than 30% of all disability work claims were due to depression and anxiety. The economic cost of mental illness is equivalent to 14% of corporate Canada's operating profits (Wilson et al., 2000). With the average worker spending half of their waking hours either at work or commuting to work (Hubbard & Workman, 2000) the workplace is a likely source of stress and is considered perhaps an effective venue for intervention.

Currently there are studies conducted in workplace settings to examine health outcomes, such as stress levels. Lewchuk et al. (Institute for Work and Health, 2002) are examining workplace organization and its effect on stress, pain, and blood pressure. The mounting evidence linking chronic work stress with acute disease and chronic illness such as coronary heart disease has been acknowledged (Taylor, Repetti & Seeman, 1997). Work and work-related stress are part of

the broader social environment in which we live and the policies we adopt to maintain order. Researchers have noted the importance of psychosocial factors (such as perceptions that the workplace was not socially supportive) along with the measured ergonomic exposures on the job since those play a significant role in workers' risk for a new episode of low-back pain (Kerr et al., 2001). In their analysis of the literature, Yen & Syme (1999) noted the evidence suggesting that the social environment, including the workplace, is associated with mortality and morbidity-independent of individual risk factors. They concluded that there is a need to develop prevention programs that focus on the environment and the structural processes therein, which can affect more people for longer periods of time than individual interventions.

The worksite can also be used as the primary avenue to influence individual risk-behaviour while enhancing occupational health and safety. In the WellWorks series of studies examining the rates of smoking among blue-collar workers, Sorensen et al., (2004) randomly assigned 15 manufacturing worksites to receive either a health promotion program or a social-contextual model of behavioural change combining health promotion with recommendations to decrease occupational hazards. The authors noted that in the socio-contextual group, the rate of people who quit smoking doubled. These findings are particularly salient since smoking rates in CGS are 8% higher than the Ontario average.

Over the past 30 years there has been a steady decline in manufacturing jobs and an increase in the service sector- especially in retail. This segment is characterized by low-wages, few benefits, poor working conditions, as well as high rates of part-time work; promoting widening income polarization (Gray, 2004; Morris, 1999). In CGS, the sales and service sector remains the largest employment category. This sector comprises 28% of total workers and is over-represented by women (Census 2001, Statistics Canada). Other studies examining the retail sector have demonstrated negative health effects. Peek-Asa, Erickson and Kraus (1999) analysed data from the American census on fatal occupational injuries (1992-1996) for the retail sector. Their results demonstrated that females, younger and minority persons working in retail were more likely to be killed on the job through violence than workers in any other industry/sector.

In a study comprising 6,311 retail workers, Johnston et al., (2003) examined lower back pain and its possible causes. Results indicated that high job intensity, dissatisfaction, scheduling demands, lack of influence and job security all increased the likelihood of reporting back pain. In another quantitative study of lower back pain, researchers found strong associations between job control, co-worker support, supervisor support, empowerment, physical demands, job satisfaction and workplace social environment on the incidence of lower back pain (Kerr et al., 2001). The authors concluded that interventions to modify the psychosocial work environment might reduce lower back pain experienced by retail workers.

### ***Physical environment***

Transportation is considered a major access barrier to the labour market. Blumenberg and Waller (2003) conducted a review of the U.S. literature to better understand the role of transportation on work. They found that there is a current decentralization of jobs away from the city centres to auto-oriented suburbs. Low-income families without vehicles must rely on fixed-route public transportation, which is ill suited for low-density long-run travel. Even in cities with excellent transit systems, the time required to access transportation, frequent and multiple stops, changeovers and delays frustrate transit users. Vehicles owned by low-income families tend to be older, less reliable and more apt to breakdown. Murakami and Young (1997) studied 4,721 low-income households and found that 26% did not have access to a vehicle, whereas

among those who did have a car, the vehicle were on average 11 years old (cited in Lambert, 1998). In 2002, 90% of all vehicles in the Sudbury Region were more than 5 years old (Financial Post Canadian Demographics, 2002).

### ***Education and literacy***

The level of education and one's literacy rate are closely related. Those with low literacy are denied access to higher-paying jobs, are more likely to live and work in dangerous environments, have a higher than average rate of occupational accidents, stress and unhealthy lifestyle practices (Movement for Canadian Literacy, 2002). In CGS over one third of the population has less than grade twelve education (Financial Post Canadian Demographics, 2002).

The growing gap in wealth seen in Canada highlights the importance to address the health, wellness and safety concerns of low-income workers. Drastic changes to the Canadian labour market have created jobs characterized by low-wage, few if any benefits and part-time hours. These market trends have produced a population of working poor who are both increasing in number and falling further behind. Low-wage workers disproportionately bear the burden of working undesirable times and increased risks for occupational injury (Hamermesh, 1999). Low-income is consistently identified as being detrimental to health, while the work and the work environment of low-wage workers is typically characterized by low-control and high-demand exacerbating the negative health effects. In the literature, researchers stress the need for further research and interventions to assist the working poor population.

## **METHOD**

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The method for this exploratory needs assessment incorporated various approaches, since little was known and few population-level statistics on working poor populations were available. Four main approaches were used, and reports developed by members and associates of the Steering Committee: individual interviews with key informants (Delmege, 2005), focus groups with representatives of the working poor population (Tilleczek, Delmege, Gregory, Lopes, Muise & Moreau, 2005), and reviews of existing epidemiological data (Comeau, Hohenadel & Snelling, 2004) and empirical findings (Gregory, 2004). Appendix A presents a summary of the methods used.

We interviewed 23 key informants, talked to 65 low-wage workers in nine focus groups, examined trends using epidemiological data from Statistics Canada 2001 Census and the Canadian Community Health Survey (2000/2001), and reviewed the existing literature on initiatives for the working poor.

### **Participants**

Committee members wanted to work with key informants who represented small businesses and community-based agencies. These stakeholders were united in their desire to see an improvement in the lives of low-wage workers in CGS. From a list of 97 agencies who partner with the workplace wellness team, 45 agencies representing various sectors were selected by the research team and invited via telephone, fax and/or emails to participate. A response rate of 51% was achieved.

Committee members conducted focus groups with low-wage workers and gathered diverse perspectives by including: men, women, younger/older workers, single parents Aboriginal people, Francophone persons, service and retail sector employees, and individuals with disabilities and diversity.

As part of the approval process, the Research and Ethics Committees of both SDHU and Laurentian University reviewed and approved the study components that involved human subjects.

### **Data collection instruments**

Interviews and focus groups were structured as a conversation-dialogue rather than a rigid question-and-answer format. The research assistant encouraged informants to go into depth on specific issues experienced by the working poor population and ways to improve their health, safety and well-being.

The questions guiding the interview process were designed to focus on four main areas: major challenges faced by the working poor population within the CGS; possible intervention strategies; ways to promote community awareness activities; and lastly, which term researchers should use when referring to the working poor population.

The assistant wrote responses and detailed notes on the questionnaire forms. Key informants who participated in individual interviews had many opportunities to contribute their opinions about issues of the working poor and solutions to improve the health, safety and well-being of the population.

The rationale for holding several focus groups was to give different types of participants the opportunity to share their opinions with peers and to participate in a group dynamic. Focus groups were open to all who wanted to participate and who met the eligibility criteria of being a low-wage worker. Everyone who participated signed a consent form. Researchers read the form to participants. Rides and childcare were offered to participants who required them, and a \$20.00 gift certificate was given to each participant as compensation for participating in the groups.

Focus group guiding questions were: 1) In what ways does a low paying job affect your health, safety, and wellness? ; 2) In your opinion, what factors related to your job or workplace would help your health, wellness and safety? ; and 3) what types of activities could improve your health, safety and wellness? These interviews were audio taped and transcribed verbatim. The facilitator wrote group summaries and all notes from note takers were typed. A total of 9 focus group sessions were held including 65 participants.

The steering committee wanted to gain a better understanding of the working poor population through reviews of existing epidemiological and empirical data for the working poor population in CGS. Statistics were taken from the Canadian Community Health Survey (2000/2001) and Statistics Canada Census (2001), focusing on characteristics and trends with respect to labour force participation and health status in the working poor population.

The review of the empirical literature focused on the identification of issues experienced by low-wage workers and potential initiatives to improve their health, safety and well-being. In total 1,175 abstracts and over 232 documents were retrieved with the assistance of a librarian, then screened for relevance by the research assistant. Fifteen descriptive reports regarding interventions targeted toward low-income workers were examined in more depth. In total, six initiatives were reviewed to better understand issues addressed, type of interventions, strengths, and weaknesses.

## **Limitations**

The challenge of identifying hard-to-reach low-wage workers was a limitation of the study. Partners from different organizations in CGS were asked to help identify low-wage workers they felt were hard-to-reach. Potential participants self-selected to participate by reading advertisements, which were placed in several local publications and on bulletin boards where low-wage workers might be gathering. Because the focus group participants representing the Francophone and Male sub-populations were relatively small, generalizations cannot be made across the entire working poor population in CGS. Nevertheless, the total number of informants (65) provided a rich source of data, and the Steering Committee feels that the findings confirm some hypotheses, call some into question, and give rise to others, laying the ground for further investigation.

## RESULTS

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### Sample

Individual interviews of 20 to 30 minutes were conducted with 23 key informants. Eighty-three percent of participants were female and the majority of participants (65%) were 41 years or older. The breakdown of organizations represented by the participants is in Table 1:

**Table 1: Participants by Organizations, Key Informant Interviews, 2005, Percentages**

Organizations	% Participants
Social Services	23%
Food Related Services	17%
First Nations Agencies	13%
Health Services: Mental	9 %
Health Services: Physical	9 %
Union Representatives	9 %
Child Resources	9 %
Employment	9 %
Activist	4 %
Arts	4 %
Francophone	4 %
Health Services: Mental	9 %

Note: Columns do not add up to 100% because participants were able to indicate more than one response.

Seven focus groups lasting 60-90 minutes were conducted with a total of 65 participants with an attempt to represent the following sub-groups of low-wage workers: Men, women, younger/older workers, single parents Aboriginal people, Francophone persons, service and retail sector employees, and individuals with disabilities and diversity.

### Gender

The data does not reflect our initial intention to conduct focus groups with men and women in relatively equal numbers. This was flagged during the course of the data collection. The statistical evidence suggests that there are more women than men in the working poor population. However, the under-representation of males in our sample leads to a less complete understanding of issues among male low-wage workers.

## **Language**

With respect to the language first learned at home and still understood, 65% reported English, 16% reported French, and both English and French were reported by 14%. Languages other than these were reported by a small number of participants. Relative to the CGS population, francophones are underrepresented.

## **Age**

Participants' ages ranged from 18 to 57 years. Over half of participants were under the age of 25. The data does not reflect our initial intention to conduct focus groups with low-wage workers both younger and older. Older low-wage workers were more difficult to reach and their underrepresentation is a limitation to the findings.

## **Statistics on low-wage workers**

There is a dearth of epidemiological data available on the working poor population in CGS. However, several trends in CGS were identified from the Canadian Community Health Survey (2000/2001), Statistic Canada Census (2001) and existing reports; those trends are listed below:

- The slowing of economic growth relative to Ontario as a whole
- The decline of Blue Collar industrial jobs and the rise of the Service Sector
- Increasing presence of women in the paid workforce
- Youth out-migration
- Levels of education continue to lag behind provincial averages
- Decrease in the participation rate of males in the labour force
- Increase in level of self-employment
- Increase in Aboriginal participation in region
- The average income of individuals in Northern Ontario is lower than the provincial average.
- The median income of individuals in Northern Ontario is lower than the provincial average.
- Differences in levels of income between Northern Ontario and Ontario are increasing.
- The average and median income of families in Northern Ontario is lower than the provincial averages.
- Differences in the income levels of families between Northern Ontario and Ontario are increasing.
- The average employment income of both full time workers and part time workers is less than the provincial average.
- Differences in the employment income levels of workers in Northern Ontario and Ontario are increasing.
- Resource dependent communities and suburb communities have the highest levels of income in Northern Ontario.
- 10% of people accessing food banks in Sudbury had a job (Suschnigg, et al., as cited in Nangia, 2003). These jobs were mostly part-time or casual in nature.

Other trends included:

- In many industries, the average employment income for females is lower than males. Low average employment income occurs most often in the Accommodation and Food Services Industry.

- Lone parent families in CGS have by far the lowest median family incomes. This is also the case provincially and nationally, yet CGS values are lower.
- The average employment income for females is lower than males for both full and part time category of work activity.
- Females have lower average employment income than males no matter what the education level. (Northern Ontario Local Training and Adjustment Boards, 2002)

## **Previous interventions with working poor populations**

Studies on the working poor population are in very early stages of development. Although none of the reported interventions found in the literature were evaluated for effectiveness, the needs addressed by six initiatives were reviewed to better understand low-wage workers, and those needs were: lack of health benefits; child care services; better housing; mental and physical health services; improved work spaces; food security; and transportation.

The sub-sections below each present a summary of needs assessment findings on population condition and interventions, each followed by discussion.

## **Needs Assessment: Condition of the working poor population**

The information is grouped into 2 clusters, low-wage worker responses and stakeholder responses.

### ***Low-Wage Workers***

“We used to eat ice cubes...it will take your hunger away with salt and pepper.”

“ ... the children will be kept home because there is no lunch available for them, and the oldest has to watch over the younger ones.”

“ ... when you're grocery shopping or whatever ... you can't afford real food. It's a balancing act. Do I pay the phone bill or do I buy a steak?”

Participants described their work environments as without security and low paying. Many mentioned that they were underemployed, overworked, had no sick time, no substitute workers even if they did have sick time, having to work shifts, and receiving little respect from employers. Participants also spoke about their living spaces and neighbourhoods. Many mentioned poor housing conditions, the expense of housing, and a lack of rent control. Participants also spoke about the systemic factors they faced in their daily lives, such as gaps in the health care system, a lack of communication about the programs that are available to help them, racism, discrimination, the problems of living in a consumer society, child support enforcement issues, and the costs of transportation.

“I had to turn down jobs because of people wanting me to work on Sundays. Transportation is a big factor. The buses on Sunday, you're always guessing when they are going to come.”

Given the contexts of low-income workers' lives, it is not surprising that they mentioned a host of ill effects on their health: stress (physical and mental), time constraints, food and income insecurity, and child health were most frequently mentioned.

Given the context of the work environments described above, participants mentioned a number of workplace safety issues, that they were experiencing. In relation to workplace, most often mentioned were the feelings of insecurity coming from little safety training and/or working under intense time pressure with too few employees. For example, the fear of robbery, insecure feelings, fatigue from long hours, accidents, double shifts or shift work, and having no safety equipment were mentioned.

**Stakeholders**

Participants described several challenges facing the working poor population. The most commonly reported challenges are listed in Table 2.

*“Hard to foster independence. Cost of living is too high to promote independence [among low-wage worker].”*

*“The challenges are: Basic necessities of life. i.e. rent, heat [and/or] hydro and food.”*

**Table 2: Major Challenges Facing the Working Poor Population, Percentages**

Major Challenges	Percentages
Financial Issues*	52%
Affordable Daycare	52%
Transportation	43%
Lack of Benefits	35%
Access to Health Services	26%
Access to Affordable Housing	26%
Food Security	26%
Temporary Jobs	26%
Stress	26%
Education	22%

Note: Columns do not add up to 100% because respondents were able to indicate more than one response.  
 \* Financial Issues: Included lack of money, poverty, minimum wage, low paying jobs, and insufficient welfare payments.

## Proposed interventions

In the following section, information about potential interventions for improving the health, safety and well-being of the working poor population is presented.

Ideas for activities or programs that might improve the health, safety and well-being of the working poor population, were grouped into 2 clusters: low-wage worker responses and stakeholder responses.

### *Low-wage workers*

Participants were asked about any ideas, activities or programs, which might help to overcome some of the negative issues associated with being a low-wage worker. Themes emerged which could be grouped into employer activities or systemic initiatives.

Employer activities were: Sick time; benefits; respectful workplace; flexibility; child care; employer training coverage/support (i.e. WHMIS, NORCAT, CPR); education; day shifts; stress management program; exercise breaks at work; extended business hours; staff meetings and better communication; paid holidays; and social time sponsored by work.

Systemic initiatives were: Unions, child care, transportation, universal/income-g geared subsidized child care, financial access to activities for kids (i.e. babysitting course, activities, sports), better communication/organization/access to programs that already exist, financial resources and time for leisure/recreation/education activities for adults, the gap between public/private sectors of work, raising minimum wage, easier access to loans and incentives for small business, drug plans and health benefits and government regulation of those who employ low income workers.

### *Existing programs*

Low-wage workers also mentioned numerous programs in which they had taken part and/or were aware. A list of those programs most often mentioned is provided in Table 3.

**Table 3: List of Programs Organized By Type of Service**

<b>Category</b>	<b>Name of Program Mentioned by Respondents</b>
Family Service	Cybermoms, PLAY (Human League), Pregnancy Care Centre, Ontario Early Years Program
Social Assistance	Ontario Works, Supplement for Working Families
Insurance	Employment Insurance (EI-UI), Trillium Drug Benefit Program, OHIP
Employment	Job Connect, Job Bank, HRDC, Occupational Resource Centre
Health & Safety	Workplace Health and Safety Training, Wellness Committee at Work

## Stakeholders

Participants provided information about ways to improve the health, safety and well-being of low-wage workers. Participant suggestions were organized into five categories and they are: Education, Benefits, Health Services, Policy, and Supports.

“We definitely need the EAP [Employment Assistance Program].”

“The [low-wage workers] are in a hamster wheel and there is no way to rise out without an education.”

“As workers/agencies: we can say what will work but the [low-wage worker] may not agree. They [low-wage workers] need ownership and employment.”

“We should advocate/fight for health benefits through government for everybody, welfare or not, including the [low-wage worker] regardless of how much you make or where you work. It should be available for everyone.”

### I. **Education:**

- i. **Community:** Community wide awareness of working poor (Walk a Mile in my Shoes); reducing stigma.
- ii. **Employer:** Awareness of Working Poor Population (Walk a Mile in my Shoes); Flexible Shift Structure; Safe Workplace i.e. adequate ergonomics, safe workplace culture.
- iii. **Employee:**
  - i) **Life skills:** addiction cessation; life skills: i.e. budgeting, computer skills; yoga classes; nutrition classes; cooking classes; employee rights (i.e. unions); stress management; understanding the process for getting copies of government documents, e.g., birth certificates; registering to vote and voting in elections; immunization; job retention skills; ‘ownership’ i.e. having a voice within the community as opposed to having another group speak on your behalf; job training; awareness of existing services; knowledge of local marketplace (i.e. trade programs, career management)
  - ii) **Wellness:** Sudbury & District Health Unit health fairs; proper safety equipment
  - iii) **Health & Safety:** Workplace Hazardous Materials Information System (WHMIS); Industrial Accident Prevention Association (IAPA)

II. **Benefits:**

Prescription medication; glasses; dental; Employee Assistance Program; universal daycare (on site); employees having WSIB coverage and subsequent access to benefits should they have an accident while at work; Incentive Programs i.e. Compensation Days or Float days; In house Wellness Plans; Group Insurance Plans.

III. **Health Services:**

Physicians; elder care; primary care; trained social workers; professional counselling

IV. **Policy:**

Increased minimum wage; affordable daycare; affordable and sustainable transportation (at the CGS level); affordable housing; economic viability; Ontario Works i.e. a complete overhaul; stop the claw back of the National Child Tax Credit; employer accountability; access to reduced bulk necessities i.e. toiletries, foods, fruit; increased Mental Health services; government policy for helping out the working poor; food security; Guaranteed Adequate Income Plan; universal income; life long public health programs (from Healthy Babies Healthy/Children across the lifespan); local level community centres; education (i.e. equal access, mandatory grade 12 education, co-operative education in high school).

V. **Supports:**

- i) **Employer:** offer education opportunities
- ii) **Employee:** peer support; parental relief; financial institutions (i.e. banks offering lines of credit, affordable banking services) investing in working poor; Community kitchens; free recreational activities: i.e. hockey, skating; community gardens; clothing bank; Safe child baby equipment; transportation (being able to access the services), networking among programs in place: i.e. coalitions, Chamber of Commerce, city councillors, small business; ongoing research.

### **Additional interventions described in the literature**

The implementation of programs, initiatives, and interventions to improve the health, safety and well-being of the working poor population, are in their very early stages and are currently being made available to a very small number of a large and ever growing population of low-wage workers. Although, none of the reported interventions found in the literature were evaluated for effectiveness, six initiatives were reviewed to better understand ways to help low-wage workers (see Appendix B).

## DISCUSSION

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The descriptions arising from the interviews offer rich insight about the working poor population. Low-wage workers desire an acknowledgement from society of their struggles due to income and their contributions to the labour force. The experience of the working poor population suggest that more than the quantity of income and weeks of work should be considered; the full range of the experience of health, safety, living, and working conditions for low-income workers are suggested as important characteristics of the population.

“I worked in that [place of employment] myself and I know how hard it is. How sick they make you [feel]. It has to change. There are a lot of people who are desperate there. You can’t abuse that feeling of desperation from people. You have to treat them with respect.”

“I enjoy my work but there’s always this safety issue ... being robbed four times in the last year doesn’t really help either ... ”

The nature of low-wage work was characterized as low paying and lacking security. Their work at times often had health and safety issues, (i.e. lack of training, fear of robbery, fatigue from long hours, etc.) The home environments for low-wage workers were not optimal either.

“She [the baby] was peeling [the floor tiles] up and chewing on them and we couldn’t give her a bath there because the bath tub had chunks missing out of it”

Participants described living in poor housing conditions (i.e. poor security, peeling floor tiles, flooding, drunk neighbours), which are expensive and lacking in rent control. External factors affecting low-wage workers ranged from lack of funds to pay for prescriptions, eyeglasses, doctor appointments, encountering racism, lack of health care benefits at work, and societal pressure to live beyond their means.

“You more or less have to get better by yourself or, like, do without. You really avoid going to the doctors because you know it’s going to be over a hundred dollars [for prescriptions and doctor fees]. So you don’t go to the doctors.”

“... a lot of times lower paying jobs are very hard on your body, like serving, cashier, construction, they are very labour intensive.”

“Stress alone causes health problems. Being stressed for a long period of time will cause stomach aches, ulcers, all kinds of things.’

Discussion also arose around the health effects that low-wage workers have to deal with on a daily basis. They suffer from mental and physical stress, gastric problems, headaches, chronic fatigue, high blood pressure, sleeplessness, time pressures (i.e. never enough time for themselves or their families) and food insecurity. The ill-health effects also affected their children's health and well-being. Low-wage workers worried about having enough funds for childcare, babysitters, providing school lunches, providing new clothing and saving funds for post secondary education.

“I would like to have enough money to be able to save, buy RRSPs, [and] send my children to university.”

“You feel powerless without money.”

In conclusion, the current condition of the working poor population highlights the impact of specific determinants on their health. The results from interviews demonstrated that most importantly employment (i.e. job security), physical environment (i.e. where people live), early childhood development and care, access to health services, and income affect the health of low-wage workers in CGS. The literature further supports food security as another significant determinant of health for this population. Considering current trends (increase of women as low-wage workers, increase of people working in low-wage jobs, increase of people experiencing poor employment conditions) observed in our community, several determinants of health could be addressed with health promotion strategies to improve the health safety and wellbeing of low-wage workers.

Possible initiatives to alleviate and/or eliminate some of the daily issues facing low-wage workers were suggested, ranging from employer-led (for example, the provision of adequate training WHIMIS, NORCAT, CPR) to policy change (for example unionization, childcare, transportation, universal/income geared subsidized childcare, education for children, minimum wage, small business financing, health benefits, and drug benefits).

Little information on access and interventions to improve health currently exists in the literature; this situation does not reflect the present population need. The results highlight a strong need for improving access to programs that can impact job security. Another major highlight was a need for education for low-wage workers, employers and their community and several topics were suggested as crucial.

## RECOMMENDATIONS

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Based on the findings, the Steering Committee has formulated recommendations on the needs of the working poor population in CGS and interventions to improve their health, well-being and safety. The recommendations are meant to uncover ideas and provide guidance for improving the current condition of the working poor population.

The investigation of needs as they pertain to income, health and safety of the working poor population, and potential interventions to improve the health, safety and well-being of the population were of interest in this study. The following recommendations are based on the findings of the needs assessment:

- 1) Provide and advocate for opportunities for public education and awareness on the existence and needs of the working poor population.
- 2) Develop and improve access to evidence-based strategies and interventions that reduce health inequities and provide respectful and supportive environments for low-wage workers, using a population health approach with particular attention to six specific determinants of health (job security, physical environments, childhood development and care services, health benefits and services, income, and food security).
- 3) In light of the current trends observed in our community (increase of women as low-wage workers, increase of people working in low-wage jobs, increase of people experiencing poor employment conditions), continue to hear the voices of this often forgotten population, and encourage community initiatives that will improve the health, safety and well-being of low-wage workers.
- 4) Continue to implement health promotion protection, and safety programs focused toward the working poor population (e.g., physical activity, computer skills, nutrition classes, counselling, access to primary health care and life skills, WHMIS).
- 5) Develop a compendium of information on health promotion initiatives offered to the working poor population that is accessible, organized, communicated and disseminated to the people who require the information.
- 6) Work in partnership to implement policy changes, as a foundation for wide-spread change to the health, safety and well-being of the working poor population.
- 7) Extend research on the health, wellness and safety assets and needs of low-wage workers, in order to fill a gap in the scholarly literature. Of particular importance is research and evaluation related to *interventions* at the individual, workplace, community and social policy levels.

## CONCLUSION

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In conclusion, it was a privilege for the Steering Committee to engage in a needs assessment of the working poor population in CGS. Considering the results from this study, the Committee has already undergone several exercises to plan future steps, and will be seeking support to advocate for and implement the recommendations. In-depth discussions led to prioritizing dissemination of findings through fact sheets, articles, and scientific presentations such as the Ontario Public Health Association Conference in the Fall 2005. In addition, we are holding a conference in CGS where study participants, stakeholders, steering committee members and academic experts will be brought together. The Committee will present the report, *Needs Assessment of Sudbury's Working Poor Population* to inform and contribute further knowledge for practice, education and research. The report will also be made available to needs assessment contributors and to the public at [www.sdhc.com](http://www.sdhc.com).

## References

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- Bell, R.A., Camacho, F., Goonan, K., Duren-Winfield, V., Anderson, R.T., Konen, J.C. & Goff, D.C. (2001). Quality of Diabetes care among low-income patients in North Carolina. *American Journal of Preventive Medicine*, 21(2), 124-131.
- Blumenberg, E. & Waller, M. (2003). The long journey to work: A federal transportation policy for working families. *The Brookings institute series on transportation reform*.
- Canadian Council on Social Development. (2003). *Census shows growing polarization of income in Canada*. Retrieved from <http://www.ccsd.ca/pr/2003/censisincome.htm>
- Canadian Diabetes Association. (2003). *Diabetes Progress Report 2003*. Author.
- Canadian Institute for Health Information. (2003). *Canadian population health initiative. Poverty and health: Links to action*. Author.
- Chen, Y., Dales, R. & Krewski, D. (2001). Asthma and the risk of hospitalization in Canada. *Chest*, 119, 708-713.
- Choinière, R., Lafontaine, P., and Edwards, A.C. (2000). Distribution of cardiovascular disease risk factors by socioeconomic status among Canadian adults. *Canadian Medical Association Journal*, 162: 13 – 24.
- Erzen, D., Carriere, K.C., Dik, N., Mustard, C., Roos, L.L., Manfreda, J. & Anthonisen, N.R. (1997). Income level and asthma prevalence and care patterns. *American Journal of Respiratory Critical Care Medicine*, 155(3), 1060-1065.
- Evans, G.W. & Kantrowitz, E. (2002). Socioeconomic status and health: The potential role of environmental risk exposure. *Annual Review of Public Health*, 23, 303-331.
- Financial Post Canadian Demographics. Sudbury Region. (2002).
- Gray, M. (2004). The social construction of the service sector: Institutional structures and labour market outcomes. *Geoforum*, 35(1), 23-34.
- Hamermesh, D.S. (1999). Changing inequality in work injuries and work timing. *Monthly Labor Review*, Oct, 22-30.
- Health Canada (2002). Towards a Common Understanding: Clarifying the Core Concepts of Population Health. A Discussion Paper Cat. No. H39-391/1996E ISBN 0-662-25122-9.
- Holtgrave, D.R. & Crosby, R.A. (2003). Social capital, poverty, and income inequality as predictors of gonorrhoea, syphilis, Chlamydia and AIDS case rates in the United States. *Sexually Transmitted Infections*, 79(1), 64-64.

Hou, F. & Chen, J. (2003). Neighbourhood low income, income inequality and health in Toronto. *Health Reports*, 14(2), 21-34.

Hubbard, J.R. & Workman, E.A. (2000) (ed.). *Handbook of Stress Medicine: An Organ Systems Approach*. Florida: CRC Press.

Human Resources Development Canada. (2003). *Understanding the 2000 low-income statistics based on the market basket measure*. Document # SP-569-03-03E. Applied Research Branch-Strategic Policy.

Hux J, Booth G, Laupacis A. (2002). *The ICES Practice Atlas: Diabetes in Ontario*. Institute for Clinical Evaluative Sciences and the Canadian Diabetes Association.

Ibrahim, S.A., Scott, F.E., Cole, D.C., Shannon, H.S. & Eyles, J. (2001). *Women's Work, Health and Quality of Life*. Toronto: The Haworth Press.

Institute for Work and Health. (2002). *Workplace Studies*. Retrieved from <http://www.iwh.on.ca/archive/pdfs/area2SAC02.pdf>.

Jenson, J. (2003). Redesigning the Welfare Mix for Families: Policy Challenges. Ottawa: Canadian Policy Research Networks, 6.

Johnston, J.M., Landsittel, D.P., Nelson, N.A., Gardner, L.I. & Wassell, J.T. (2003). Stressful psychosocial work environment increases risk for back pain among retail material handlers. *American Journal of Industrial Medicine*, 43, 179-187.

Kerr, M.S., Frank, J.W., Shannon, H.S., Norman, R.W., Wells, R.P., Neumann, W.P., Bombardier, C. & Ontario Universities Back Pain Study Group. (2001). Biomechanical and psychosocial risk factors for lower back pain at work. *American Journal of Public Health*, 91(7), 1069-1075.

Krieger, A., Williams, D.R. & Moss, N.E. (1997). Measuring social class in US public health research: Concepts, methodologies, and guidelines. *Annual Review of Public Health*, 18, 341-78.

Laaksonen, A., Prattala, R., Helasoja, V. & Lahelma, E. (2003). Income and health behaviours. Evidence from monitoring surveys among Finnish adults. *Journal of Epidemiological Community Health*, 57, 711-717.

Lambert, T.E. (1998). The poor and transportation: A comment on Marlene Kim's "The working poor: Lousy jobs or lousy workers?" *Journal of Economic Issues*, 32(4), 1140-1142.

Lantz, P.M., House, J.S., Lepkowski, J.M., Williams, D.R., Mero, R.P. & Chen, J. (1998). Socioeconomic factors, health behaviours, and mortality. *Journal of the American Medical Association*, 279(21), 1703-1708.

Maxwell, J. (2002). *Smart social policy: "Making work pay"*. Ottawa: Canadian Policy Research Networks.

McLeod, C.B., Lavis, J.N., Mustard, C.A. & Stoddart, G.L. (2003). Income inequality, household income, and health status in Canada: A prospective cohort study. *American Journal of Public Health*, 93(8), 1287-1293.

Morissette, R., Zhang, X. & Drolet, M. (2002). Are families getting richer? *Canadian Social Trends, Statistics Canada. Catalogue No. 11-008*.

Morris, M. (1999). Inequality in earnings at the close of the twentieth century. *Annual Review of Sociology*, 25, 623-657.

Mosisa, A. (2003). A profile of the working poor, 2001. U.S. Department of Labor Bureau of Labor Statistics. Report #968.

Movement for Canadian Literacy. (2002). *Literacy and Health: Making the connection*. Retrieved [www.literacy.ca/govrel/connect.htm](http://www.literacy.ca/govrel/connect.htm) Occupation – 2001 National occupational classification for statistics, class of worker and sex for labour force 15 years and over, for Canada, provinces, territories, census metropolitan areas and census agglomerations, 2001 census – 20% sample data. Ottawa: Statistics Canada, February 11, 2003. 2001 Census of Canada. Catalogue number 97F0012XCB01018.

Nangia, P., Dilenardi, S., and Gasparini, J. (2003). *Social Profile of Greater Sudbury, 2003*. Sudbury: Social Planning Council of Sudbury.

Peek-Asa, C., Erickson, R. & Kraus, J.F. (1999). Traumatic Occupational fatalities in the retail industry, United States 1992-1996. *American Journal of Industrial Medicine*, 35, 186-191.

Raphael, D. (2003). Addressing the Social Determinants of Health in Canada: Bridging the Gap Between Research Findings and Public Policy. *Policy Options*, March, 35-40.

Raphael, D., Labonte, R., Colman, R., MacDonald, J., Torgerson, R. & Hayward, K. (2003). *Income, health and disease in Canada: Current state of knowledge, information gaps, and areas of needed inquiry*. Institute of Population and public Health.

Raphael, D. & Farrell, S. (2002). Income inequality and cardiovascular disease in North America: Shifting the paradigm. *Harvard Health Policy Reviews*, 3(2).

Romanow, R. (2003, May 9). It helps to be rich. *The Globe and Mail*.

Ross, D.P., Scott, K.J. & Smith, P.J. (2000). *The Canadian Fact Book On Poverty*. Canadian Council on Social development.

Roux, A.V., Merkin, S.S., Arnett, D. & Chambless, L. (2001). Neighbourhood of residence and incidence of coronary heart disease. *The New England Journal of Medicine*, 345(2), 99-106.

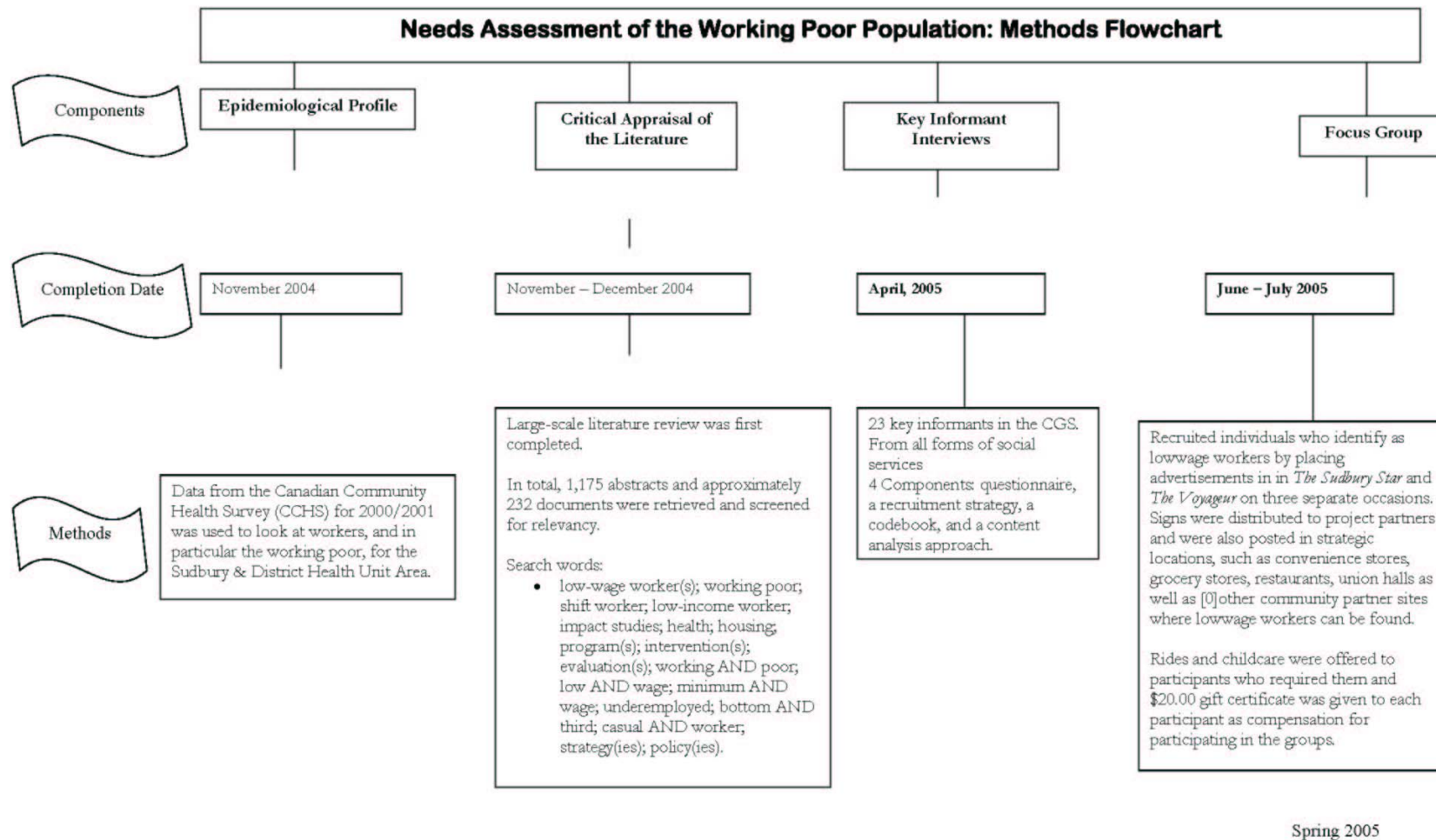
Roos, N., Burchill, C. & Carriere, K. (2003). Who are the high hospital users? A Canadian case study. *Journal of Health Service Res Policy*, 8(1), 5-10.

Sarlo, C. (2002). Poverty and the federal government. *Fraser Forum*, 27-28.

- Saunders, R. (2003). Defining Vulnerability in the Labour Market. Document # 25148. Work Networks.
- Schellenberg, G. & Ross, D.P. (1997). Left poor by the market: A look at family poverty and earnings. Canadian Council on Social Development.
- Siegrist, J. & Marmot, M. (2004). Health inequalities and the psychosocial environment – two scientific challenges. *Social Science and Medicine*, 58(8), 1463-1473.
- Sorensen, G., Barbeau, E., Hunt, M.K. & Emmons, K. (2004). Reducing social disparities in tobacco use: A social-contextual model for reducing tobacco use among blue-collar workers. *American Journal of Public Health*, 94(2), 230-239.
- Southwest Alberta Coalition on Poverty. (2003). *The cost of poverty in our communities*.
- Suschnigg, C., Alexander, L. & Carter, L., et al. (2003). *Dependence on Food Banks: Greater Sudbury 2003*. Sudbury, ON: Laurentian University.
- Taylor, S.E., Repetti R.L. & Seeman, T.E. (1997). Health psychology: What is an unhealthy environment and how does it get under the skin? *Annual Review of Psychology*, 48, 411-447.
- Urban Poverty Consortium of Waterloo Region. (2000). *Let's talk about poverty* [Fact Sheet #5].
- Wilson, H., Joffe, R.T. and Wilkerson, B. (2000). The unheralded business crisis in Canada: Depression at work. *GPC 2020 Series on Mental Health and the Economy*.
- Yen, I.H. & Syme, S.L. (1999). The social environment and health: A discussion of the epidemiologic literature. *Annual Review of Public Health*, 20, 287-308.

# Appendix A

## Methods Flow Chart



## **Appendix B**

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### **Community-Level Initiatives**

#### ***Initiative 1: Waterloo Opportunities 2000 (OP2000)***

Community-based multi-sectoral poverty reduction project in Waterloo Region, Ontario. Targets the working poor populations.

#### ***Initiative 2: The Church Health Centre of Memphis***

Provides primary health care to working poor individuals at no-cost.

#### ***Initiative 3: Greater Baton Rouge Community Clinic***

Created to provide affordable primary health care to low-income workers.  
Virtual clinic providing preventative health care services to vulnerable workers.

#### ***Initiative 4: Ottawa-Carleton Small Business Health Project***

Partnership to provide affordable and accessible health promotion services to small businesses.  
Conducted needs assessment surveys to ascertain health-related needs.

#### ***Initiative 5: The Toronto Windfall Clothing Support Service***

Distributes new donated clothing to over 80 social services agencies.

#### ***Initiative 6: South West Alberta Coalition on Poverty 2003***

Regional group of individuals, community organizations, agencies, and businesses working together to reduce poverty and its effect on children, families and communities.