

CASE 6

Reducing Poverty in Canada: Public Policies & Population Health

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INTRODUCTION

“Overcoming poverty is not a task of charity, it is an act of justice. Like Slavery and Apartheid, poverty is not natural. It is man-made and it can be overcome and eradicated by the actions of human beings. Sometimes it falls on a generation to be great. YOU can be that great generation. Let your greatness blossom.”

– Nelson Mandela

Walking around the downtown core of London, Ontario, Michelle often wondered how people, of all ages and ethnicities, living in such a privileged and developed nation filled with endless opportunities could end up on the streets, begging for money, emaciated and overcome by multiple addictive behaviours and chronic conditions. Time and time again she pondered about Canada, the beautiful and prosperous land she and her family had long prayed about and dreamt of immigrating to as a means to escape the political turmoil and instability of the Democratic Republic of the Congo (DRC). “How could this be?” she wondered. “What is the government’s response to such social and economic disparities?”

What was more alarming was her discovery of the fact that the issue of poverty (see Exhibit 1 for a definition of *poverty*) was nationwide, affecting over 3 million Canadians (Citizens for Public Justice, 2012; Statistics Canada, 2011). As a future public health professional and agent of change, Michelle embarked on a 10-week placement with the National Collaborating Centre for Healthy Public Policy in Montreal, Quebec (see Exhibit 2). She had the privilege of researching public policies (see Exhibit 1 for a definition of *public policy*) in the form of legislation, strategies, and action plans (see Exhibits 3 & 4) put in place by Canadian provinces and territories, with the exception of Alberta and British Columbia, in order to combat poverty and social exclusion (see Exhibit 1 for a definition of *social exclusion*).

In comparison to other modern industrialized nations or countries that have signed the Convention on the Organization for Economic Co-operation and Development (OECD) such as France, Germany, and the United Kingdom, poverty levels in Canada remained higher (Raphael, 2007; see Exhibit 5). The national cost of poverty was believed to surpass \$100 billion per year, or six per cent of the country’s gross domestic product (GDP), and had manifested through its impacts on the health care system, the legal and justice systems, the education system, and the country’s decreased economic productivity (Canadian Public Health Association, 2014). Due to an unequal distribution of resources and a higher proportion of

people working in low wage occupations, in Canada, population subgroups most affected by poverty were unattached adults, individuals with disabilities, women, children, those of Aboriginal descent, people of colour, single parents, and recent immigrants (Raphael, 2007; Canadian Centre for Policy Alternatives, 2011; CPJ, 2012; see Exhibit 6).

While collecting data on poverty reduction policies in Canada, Michelle was astonished to discover that among all the Canadian provinces and territories, British Columbia had the highest rate of poverty, accounting for twelve percent of its population or more than half a million people (CCPA, 2011; see Exhibit 7). Yet the province had no known plans, nor had it begun a public consultation process that would lead to the development and implementation of a poverty reduction policy.

POVERTY REDUCTION WITHIN THE INTERNATIONAL COMMUNITY: END POVERTY 2015 MILLENNIUM CAMPAIGN

Over the past decade, poverty reduction had been at the core of the global development challenge. Within the international development community, objectives set to reduce poverty served as not only the defining theme and overarching goal for the work undertaken by the most prominent aid organizations, but also as a source of motivation. At the wake of the millennium, Member States of the United Nations (UN) adopted the United Nations Millennium Declaration, thereby committing to the global partnership outlined in the blueprint document of the Millennium Developmental Goals (MDG). Of the eight MDGs, the first one aimed at eradicating extreme poverty¹ and hunger by half between 1990 and 2015 (UN, 2013). Although this goal was met in 2010, with the largest reduction occurring in East Asia and the Pacific, and China in particular, approximately 1.2 billion of the world's population was still considered to be extremely poor (The World Bank, 2010; UN, 2013).

With the main goal to eradicate extreme poverty and hunger globally to less than 15 per cent by 2015², through social media outlets such as Twitter, Facebook, YouTube and Flickr, the United Nations Millennium Campaign (UNMC) titled *End Poverty 2015* functioned to spur action from Member States' leaders who had committed to the realization of the MDGs in their jurisdiction. The campaign rested on three objectives: the reduction of those living on less than \$1 per day and those living in hunger, as well as increased stable employment (UNMC, 2014). Since its inception, the campaign attained its objectives by reducing the proportion of those living on less than \$1.25 per day by 600 million and a reduction of 23% in the global poverty rate between 1990 and 2008. However, the burden of poverty remained high on the global scale and the campaign continued to strengthen its efforts in order to produce results surpassing set goals and objectives (UNMC, 2014).

POVERTY REDUCTION IN CANADA

Over twenty years ago, in 1989, the Canadian House of Commons unanimously resolved to employ measures through which poverty would first be eradicated in Canadian children by the year 2000, followed by a plan to end poverty for all citizens (Campaign 2000, 2013). However, such goals were not met as approximately 1 in 7 Canadian children continued to live in poverty. Subsequent to the global financial markets collapse in 2008, the country went into a recession, leaving hundreds of thousands of families dependent on Employment Insurance and Social Assistance in the midst of rising costs of living (CPJ, 2012).

¹ Extreme poverty was defined as living with an income equating to less than \$1.25 a day (The World Bank, 2010).

² As the initial 23 per cent target had already been reached prior to 2015.

As cited by CPJ (2012):

“Without an anti-poverty strategy, the progress that Canada has made will erode, diminishing the life chance and opportunities of the poor, and undercutting Canada’s future prosperity” (p.1).

As a Member State of the United Nations, since 2000, Canada committed to the eight MDGs, of which poverty reduction was the first. However, it appeared as though most of Canada’s efforts in accomplishing these goals were geared towards international assistance to developing countries. Meanwhile, 3.2 million Canadians faced hardships associated with poverty and 100,000 children in British Columbia lived in families with extremely low-income (CCPA, 2011). In January 2001, Canadian Prime Minister Jean Chrétien highlighted social development and social inclusion at the forefront of his government’s agenda (Canadian Council on Social Development, 2014). Specifically, he mentioned:

“We are determined to help families break out of the poverty trap. To reverse the cycle of dependency. To help parents realize their hopes and their dreams for their children. We cannot afford the costs, moral, human and economic, of child poverty. We must find new and better ways to promote opportunity and to ensure that the basic needs of all are met” (CCSD, 2014, para. 2).

Months after this declaration, the government’s goal of deficit reduction led to severe cuts to Employment Insurance, federal transfers to the provinces, the elimination of the Canada Assistance Plan, and cuts in welfare incomes, as well as affordable housing programs and community-based services and supports (CCSD, 2014). In his report on poverty reduction policies and programs in Canada, David Hay of the Canadian Council on Social Development noted that the Canadian federal government was the least engaged member in discussions about solutions to poverty (CCSD, 2009).

DEFINING POVERTY

Unlike “health”, the term “poverty” was not ascribed an internationally recognized definition, deeming it to be a complex, multifaceted issue. Officially, the Canadian government did not have a definition of poverty (CCSD, 2009). In and of itself, poverty was continuously framed as a complex issue, primarily due to the difficulty in framing it as a social phenomenon, the unclear cause and effect relationships it has with other sociocultural determinants of health, the uniqueness of the experience of poverty among individuals, and its evolution over time, providing no right or wrong set of solutions to overcome it and the lack of an absolute measure that can be used to measure the success of poverty reduction efforts (Vibrant Communities Canada, 2014).

That being said, the only available definition of poverty was Statistics Canada’s definition for low income Canadians as those “living in straitened circumstances” (CCSD, 2009, p. 2). Within the Canadian scientific community, individuals living on low incomes or in poverty were classified as those at the bottom 20 per cent of the distribution or below the Low Income Cut-Off (LICO), the Market Basket Measure (MBM), and the Low Income Measure (LIM), as defined by Statistics Canada (CCSD, 2009; Raphael, 2007; see Exhibit 8). Due to a lack of national consensus on definitions of low income, LICOs were often used in relation to average household spending levels, LIMs in relation to median household income, and MBMs in relation to the cost of indispensable or “essential” goods and services. It is worth noting that these poverty measures were highly dependent on consumption levels, levels of income, and the costs of goods and

services. Particularly, LICO's were annually indexed to the consumer price index (CCSD, 2009), which Statistics Canada published per province monthly³.

Low Income Cut-Off (LICO) *(before and after taxes)*

The most commonly used measure of poverty and source of poverty rates in Canada was the LICO, developed by J. Podoluk of Statistics Canada in 1968. This measure provided "an income threshold below which a family will likely devote a larger share of income to the necessities of food, shelter and clothing than an average family would" (Raphael, 2007, p. 39; see Exhibit 9). The LICO was also the most used measure as it considered both relative poverty⁴ and how much a family spends on basic needs (absolute poverty⁵).

Market Basket Measure (MBM)

As a relative measure of poverty, the MBM estimated the required income for a family to purchase needed goods and services such as food, shelter, clothing, and basic social needs, primordial to their survival. Due to differing economies across provinces and territories, these governments had set locally-specific necessary goods and services, based on which they identified an income line. Human Resources and Social Development Canada (HRSDC) viewed the MBM as "falling somewhere between a subsistence standard of living and a more generous social inclusion basket" (CCSD, 2009, p.2)

Low Income Measure (LIM)

The LIM was a measure of the relative poverty, mostly used by the international community in relation to indicators of health and educational outcomes (Social Planning Council of Winnipeg, 2012). It ascertained income levels either before or after taxes necessary for families of certain sizes. When a family's income was less than the cut off amount, then they were determined to be living in poverty. As described by the CCSD (2009), the LIM "explicitly defines low income as being much worse off than average, and is calculated at one-half the median income of an equivalent household" (p.2).

SOCIAL INEQUALITY & SOCIAL EXCLUSION

The higher incidence of poverty among certain groups in comparison to others in such a developed country can be explained using two areas of study. The first is social inequality, which refers to "long lasting differences in power and resources among individuals or groups of people that influence the quality of their lives" (Raphael, 2007, p. 86). This social paradigm was first introduced by Karl Marx (1818-1883), who evaluated the formation and distribution of economic resources in capitalist societies among those of different social classes. Another proponent of exploratory frameworks on social inequality is Max Weber, who not only highlighted the importance of social class and economic processes, but the mechanisms through which power and influence are unequally distributed in society, ultimately leading to social inequality (Raphael, 2007).

The translation of such inequalities into the experience of poverty is explained by social exclusion, which is defined as "a multidimensional process, in which various forms of exclusion are combined: participation in decision-making and political processes, access to employment

³ See <http://www.statcan.gc.ca/tables-tableaux/sum-som/I01/cst01/cpis01a-eng.htm>.

⁴ Relative poverty relates to individuals' inability to carry out or participate in expected activities of a modern industrialized society such as accessing food, clothing, involvement in leisure or occupational activities, and participation in decision-making, civil, social and cultural life (Raphael, 2007).

⁵ Absolute poverty relates to a lack of basic human needs such as food, shelter, and education.

and material resources, and integration into common cultural processes. When combined they create acute forms of exclusion that find a spatial representation in particular neighborhoods” (Raphael, 2007, p. 86). Social exclusion had recently emerged as a primary concern within the public policy community and is centered on “outcomes of the differential access to resources (Raphael, 2007, p. 86-87). Social exclusion, also experienced by many citizens of India classified within the caste system, interacts with other determinants of health, producing poor health and lower quality of life (Ingole, 2014).

MEASURING INEQUALITY

Internationally, the World Bank attributed a Gini index or coefficient to countries, measuring “the extent to which the distribution of income (or consumption) among individuals or households within a country deviates from a perfectly equal distribution” (Raphael, 2007, p. 52). Cumulative percentages of total income versus the number of people receiving this income are plotted using a Lorenz curve. The Gini index⁶ is represented by the area between the Lorenz curve and a hypothetical line of absolute equality and is attributed a number between 0 (representing perfect equality) and 1.00 (representing perfect inequality). One of the arguments around the Gini-coefficient is that it is not cumulative of all population sub-groups within a society, such that “the total Gini of a society is not equal to the sum of the Ginis for its sub-groups” (The World Bank, 2011, para. 6). Similarly, when fluctuations in income distribution occur, the Gini-coefficient is also impacted irrespective of whether this occurs solely among the rich or the poor, or between the rich and the poor.

THE STRONGEST SOCIAL DETERMINANTS OF HEALTH

The World Health Organization (WHO) defined the social determinants of health as “‘the conditions in which people are born, grow, live, work and age’, as shaped by families and communities and by the distribution of money, power, and resources at global, national, and local levels and affected by policy choices at each of these levels” (Viner et. al., 2012, p. 1641) (see Exhibit 10). Viner et. al. (2012) recognized that national wealth, income inequality, and access to education constitute the strongest *structural determinants of health*. *Proximal or intermediate determinants of health* can be classified as circumstances of daily life, quality of family relationships and peer relationships, availability of housing, food, and recreation.

The experience of poverty could not be isolated, as it was intricately linked to individuals’ experiences with many other social determinants of health such as their early child development, educational attainment, employment, and access to health services. Poverty was known to have a myriad of ill-health effects, leaving children as the most vulnerable members of society. The inter-generational transmission of income and wealth asserted that children brought up by parents with higher income, wealth, and educational attainment were more likely to display higher cognitive functioning, educational achievement as well as a higher income and wealth (Raphael, 2007). When living within an optimum family income level, a child’s development was better supported, as they were more likely to be exposed to more material and social resources and to live in a neighbourhood characterizing positive social and physical environments (Raphael, 2007).

In the Findings from Canada’s National Longitudinal Survey, it was reported that “Canadian children whose family income is less than \$25,000 have a 47% greater chance of experiencing cognitive difficulties in school; a 45% greater chance of behavior problems in school; and a 41%

⁶ The World Bank sometimes expresses the Gini index as a percentage of the maximum area under the hypothetical equality line ranging from 1 to 100.

greater chance of scoring high on an overall vulnerability index than other children” (Raphael, 2007, p. 123).

In Canada, income disparities have been widening between urban and rural areas, certain groups, and between the very affluent and the poor (Lemstra, Neudorf, & Opondo, 2006; CPJ, 2012). Such disparities have left families living in poverty to suffer from social exclusion and a limited access to healthy foods, good housing, healthy neighbourhoods, and quality schools (Seguin et. al., 2012).

LINKING POVERTY TO HEALTH

Research has shown that the causes of poverty are comprised of a complex mix of factors at both the structural or institutional and individual level. Structurally, the social assistance system, skills and credential recognition, and cultural barriers are identified as risk factors; whereas a lack of skill-set, education, and literacy level identify as causes at the individual level (Raphael, 2007). An analysis of data obtained from the National Population Health Survey revealed that 73 percent of Canadians within the highest income brackets reported being in excellent health, in comparison to the 47 percent of Canadians with the lowest incomes who rated their health as high (Laurie, 2008).

Internationally, there existed a clear consensus concerning the ill-health effects of material and social deprivation. Poverty has continuously been framed as the best predictor of individuals’ health and quality of life (see Exhibit 1 for a definition), affecting behavioural risk factors such as nutrition, physical activity, and tobacco and alcohol use (Raphael 2007).

Individual Approaches

Numerous elected officials, health care and public health officials failed to recognize that poverty is indeed a health issue, as health issues associated with those living in poverty are often attributed to their risk behaviours. On the other hand, health care and public health officials often modulated the importance of poverty as a public health issue due to their fear of menacing governments who control their status and funding. The individual perspective asserts that individual biomedical risk factors such as hypertension, excess weight, cholesterol, and behavioural risk factors such as lack of physical exercise, type of diet, and tobacco or alcohol use are the major cause of the poor health conditions experienced by people living in poverty. This approach further affirms that to promote health among those living in poverty, these risk factors must be modified either by medical interventions or by changes made by the individuals leading them to make healthier choices.

Travers (1996) states:

“Individualism assumes that the current social system provides sufficient and equal opportunity for individuals to move within the social system according to their abilities. Within this ideological construct, poverty results from the individual’s failure to seize the opportunity or to work sufficiently hard within the current social structure; it is not a reflection of inadequacies and inequities within that social order” (p. 551).

Material and Social Deprivation

Deprivation is defined as “a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which the individual, family or group belongs” (Townsend, 1987, p. 125). Material deprivation refers to scarcity of

goods and conveniences within a modernized environment and social deprivation is associated with individuals' inability to form meaningful relationships within family, the workplace, and the community (Raphael, 2007). Exhibit 11 shows a model depicting the relationship between social structures and health status in terms of well-being, morbidity, and mortality, affected by positive and negative material factors. This model, however, does not account for the interaction of the determinants of health and their correlation with health outcomes. Conditions of work and the state of social environments are framed by the existing social structure. The degree of power one has and their ability to influence societal structures are determined by their conditions of work and their wages such as those of lower paying jobs have less political influence and receive little government attention because of their lower class and status. The highlighted psychological factors and health behaviours also affect the work and social environments, including the social structure. Those who may be experiencing high levels of stress due to their experience of living in poverty are more likely to experience unpleasant work and social environments, inhibiting their coping and managing skills to a great extent (Raphael, 2007).

National Anti-poverty and Income Security Policies in Canada

The Constitution Act, 1982⁷, section 36, addresses the federal and provincial governments' commitment to "promoting equal opportunities for the well-being of Canadians" and "providing essential public services of reasonable quality to all Canadians." Existing federal policies and programs aimed at reducing poverty and supporting low-income families are geared towards providing benefits for children and families, seniors, and employment. These include seniors' benefits (e.g. pensions), child and family benefits, social assistance programs, employment-related benefits (e.g., employment insurance, maternal/paternal leave, sickness, disability and injury benefits), minimum wage regulations, employment training, community economic development, early childhood care and education, and home and nurse visiting (CCSD, 2009).

Over the last three decades, trends based on the before-tax LICO have fluctuated between 15 to 20 percent and those based on the after-tax LICO fluctuated between 10 and 15 per cent, signifying a decrease in levels of poverty (see Exhibit 8). However, such fluctuations have been majorly attributed to changes in the business cycle, such as employment rates, as well as changes in levels of taxes and income transfer programs such as pensions and child and family benefits (CCSD, 2009).

PLAN OF ACTION

Despite the existence of these national programs for reducing poverty and supporting low-income families, the proportion of Canadians living in low income situations remained high (see Exhibit 5). After retrieving all the existing poverty reduction legislation, strategies and action plans in Canada (see Exhibit 3 & 4), Michelle employed a validation process with stakeholders within responsible government ministries to ensure that her synthesis adequately represented the provincial policies (see Exhibit 12 for the validation questionnaire distributed). Not all the policies in Canada can be said to contain internationally recognized categories that can ensure the success of poverty reduction strategies (see Exhibit 13). In the case of Saskatchewan, the government preferred using the term "approach" rather than "strategy" in referring to its poverty reduction efforts, recognizing that these efforts possess some of the qualities of a formal strategy (e.g. guiding values, objectives). When referring to Saskatchewan's actions, the guiding

⁷ *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 36.

document should be referred to as a poverty reduction policy or a policy reduction approach.

Regarding provinces that had neither launched legislation nor a strategy, government representatives were contacted to inquire on the next steps that are anticipated. In Alberta, extensive consultation processes had taken place and the department of Human Services expected to present a policy formulation to government in the fall of 2014. In BC, two bills (Bill M216 and Bill S216) had been proposed but neither were approved.

POVERTY IN BRITISH COLUMBIA

As of 2011, the overall rate of poverty and the child poverty rates in BC based on the LICO before tax were estimated at 15.6% and 18.6% respectively, being the highest rates in Canada (Canada Without Poverty, 2011). Particularly, between 2010 and 2011, the poverty rate among female-led single parent families increased from 20.1 to 49.8 percent. Recently, a coalition of 400 members and 400 organizations, consisting of community and non-profit groups, faith groups, health organizations, First Nations and Aboriginal organizations, businesses, labour organizations, and social policy groups, was developed in order to create a unified voice advocating for a poverty reduction plan in BC. Aside from being one of the wealthiest provinces in the country having the highest rate of poverty, it was believed that BC needed a poverty reduction plan because the situation had remained unchanged for the past eight years in the midst of rising living costs, posing threats to population health and the well-being of children, with increasing inequality, housing challenges, and crime.

As in many parts of Canada, most of those living in poverty in BC lacked access to supplementary insurance through their place of work and thus, were unable to access and afford private health care costs. For those already living in poverty and suffering from a chronic illness, access to services such as dental and vision care, and rehabilitation services such as physiotherapy, played a fundamental role in the management of their conditions and the prevention of further deterioration. Numerous studies have also shown that those living in poverty are more likely to use public health care resources. In BC, “the poorest 20 percent, or ‘quintile,’ of families used a greater share of health care resources than any other group on the income ladder” (CCPA, 2011, p. 6). The CCPA had estimated that “if poverty reduction initiatives reduced health care use for families in the poorest 20 per cent to that of the next quintile, it would save BC’s public health care system 6.7 per cent of total spending each year” or “an equivalent of \$1.2 billion in annual provincial health care spending” (CCPA, 2011, p. 7).

HEALTHY PUBLIC POLICY

In his 1974 report, the Honourable Marc Lalonde affirmed recognition by the provincial Governments of the importance of physical and mental wellbeing for a quality of life aspired to by Canadians. However, he further acknowledged that “the health care system is only one of many ways of maintaining and improving health” (Lalonde, 1974, p. 5). Raising the general standard of living was identified as an important factor for increasing the “number of illness-free days in the lives of Canadians” (Lalonde, 1974, p. 5).

A decade later, the Ottawa Charter for Health Promotion established *Building Healthy Public Policy* as its first priority area for Health Promotion Action, with the overall goal to “achieve Health for All by the year 2000 and beyond” (WHO, 2010). The WHO report highlighted that “health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them” (p. 3). By definition, public policy refers to “a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems” (Raphael, 2007, p. 24). Healthy public policy refers to public policy capable of fostering supportive environments, and enabling individuals to lead healthy

lives (Green & Tones, 2010). In essence, decision makers in both the public and private sectors were tasked with the implementation of policies and practices characterized by a “commitment to social equity, recognition of the important influence of economic, social, and physical environments on health, facilitation of public participation, and cooperation between health and other sectors of government” (Green & Tones, 2010, p. 254).

STRATEGIES FOR REDUCING POVERTY & SOCIAL EXCLUSION

Due to the complex and deeply rooted nature of poverty and social exclusion, developing solutions was an equally complex task, requiring multiple and well-developed policies and program interventions. The New Policy Institute and the Poverty Alliance (MacInnes, Bushe, Kelly, & McHardy, 2014), reported on several reasons why strategies and action plans addressing poverty reduction and social inclusion were extremely helpful as they:

- Highlight existing initiatives, exposing gaps and providing future direction for action;
- Serve as an education tool to raise awareness of poverty and social exclusion’s complex nature and why prioritizing its elimination is beneficial to the community at large;
- Demonstrate government commitment to the issue of poverty and social exclusion as they aim to make it a priority;
- Offer the opportunity to associate national or provincial targets to local activity, as well as facilitate co-ordination and consensus building among internal and external stakeholders; and
- Enable governments to assess their progress and identify areas of improvement.

DEVELOPING A STRATEGY FOR BC

Upon completion of her studies, Michelle came across a job posting in the policy branch of the BC Ministry of Social Development and Social Innovation, which had recently unveiled a ten-year accessibility strategy, targeted at individuals living with disabilities. With the knowledge she possessed on poverty reduction policies in Canada, especially with her experience at the NCCHPP, the Deputy Minister in charge requested that Michelle lay out a poverty reduction strategy for BC. The Deputy Minister stated that this task was of great priority as “if there is no long-term vision, no plan, no one accountable for carrying out the plan, no resources assigned and no acceptable measure of result, BC will continue to be mired in poverty for generations”. Within a limited time period, she had to develop a plan ensuring a sustained decrease in the high rate of poverty in BC, contributing to economic, social, and health development of the province.

Seeing the work done by the BC Poverty Reduction Coalition and other organizations in advocating for government support in the creation and implementation of a provincial poverty reduction plan in BC as a first step, Michelle joined forces with them in developing the plan. Knowing all the health, social and economic benefits that could result from such a plan, and the great opportunity this presented, Michelle was deeply submerged in comparing Canadian provincial and territorial policies, as well as those developed in Sweden and the UK in order to develop a plan that would not only guarantee her employment, but also one that would become a reference for the rest of the country.

EXHIBIT 1
Glossary of Terms

Health

“Usually defined as the absence of disease. When used in this manner it is best described as health status. Defined broadly by the World Health Organization (WHO) as the ability to have and reach goals, meet personal needs, and cope with everyday life. The WHO argues that health requires the following prerequisites: peace, shelter, education, food, income, a sound environment, and social justice. While these definitions are primarily focused at the individual, quality of life is focused on the larger community and society” (Raphael 2007, p.24).

Poverty

Gordon & Townsend (2000) define poverty as “the condition whereby individuals, families, and groups lack the resources to obtain the type of diet, participate in the activities, and have the living conditions and amenities which are customary, or at least widely encouraged or approved, in the society to which they belong. Poverty can be considered in terms of absolute poverty, whereby individual and families do not have enough resources to keep “body and soul together”, or relative poverty, whereby they do not have the ability to participate in common activities of daily living” (Raphael 2007, p.24).

Public Policy

“A course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems. Policy is a course of action that is anchored in a set of values regarding appropriate public goals and a set of beliefs about the best way of achieving those goals. The idea of public policy assumes that an issue is no longer a private affair.” (Raphael 2007, p.24).

Quality of Life

“A holistic construct that views individual and community human well-being in relation to immediate and more distant environments. It looks at both broad societal indicators and the lived experience of people. Concretely, quality of life is the extent to which individuals and communities are able to enjoy the important possibilities of life. Their ability to do so is influenced by public policies that develop and maintain a vibrant local economy; protect and enhance the natural and built environment; offer opportunities for the attainment of personal goals, hopes, and aspirations; promote a fair and equitable sharing of common resources; enable residents to meet their basic needs; and support social interaction and the inclusion of all residents in community life” (Raphael 2007, p.24).

Social Exclusion

“A multi-dimensional process, in which various forms of exclusion are combined: participation in decision-making and political processes, access to employment and material resources, and integration into common cultural processes. When combined they create acute forms of exclusion that find a spatial representation in particular neighbourhoods” (Raphael 2007, p.86).

Welfare State

“Governmental structures that assure the components of citizenship: meeting basic needs, providing resources for participation in society, and minimizing forces that systematically exclude citizens from these activities” (Raphael 2007, p.24).

EXHIBIT 2

The National Collaborating Centre for Healthy Public Policy

In the year 2005-2006, the Canadian government opened a funding portfolio for six national collaborating centres for Public Health focusing on different priority areas in public health and located in distinctive regions across Canada. These centres work to increase the use of scientific knowledge within Canadian public health practices and policies, through activities centered on the identification of knowledge gaps and building sustainable networks with researchers, practitioners and policy makers.

In the context of the National Collaborating Centre for Healthy Public Policy NCCHPP, which is hosted by the Institut National de Santé Publique du Québec (INSPQ), public policy is defined as “a strategic action led by a public authority in order to limit or increase the presence of certain phenomena within the population”. Milio (2001, p. 622) further suggests that healthy public policy improves the conditions under which people live: secure, safe, adequate and sustainable livelihoods, lifestyles, and environments, including housing, education, nutrition, information exchange, child care, transportation, and necessary community and personal social and health services.

Organizational goal: to reach various public health actors interested in promoting healthy public policies.

The centre operates under **two main objectives:**

1. Bridging gap between decision makers and public health actors.
2. Seeking to make resources and tools from political science, policy analysis, sociology and other social sciences available to public health actors in order to apply them to Canada's public health realities.

Source: NCCHPP, 2010.

EXHIBIT 3
Provincial & Territorial Legislation to Combat Poverty in Canada¹

Province/Territory	Name & Type of Policy	Date adopted	Public consultation/engagement process	Primary Objective
Quebec	<i>An Act to Combat Poverty and Social Exclusion (R.S.Q., c. L-7)</i>	December 13, 2002	Yes	“...[T]o guide the Government and Québec society as a whole towards a process of planning and implementing actions to combat poverty, prevent its causes, reduce its effects on individuals and families, counter social exclusion and strive towards a poverty-free Québec.”
Ontario	<i>Poverty Reduction Act (S.O. 2009, Ch. 10)</i>	May 6, 2009	Yes	“...[T]o establish mechanisms to support a sustained long-term reduction of poverty in Ontario.”
New Brunswick	<i>Economic and Social Inclusion Act (SNB 2010, c E-1.105)</i>	April 16, 2010	Yes	“...[B]y 2015, New Brunswick will have reduced income poverty by 25% and deep income poverty by 50%, and will have made significant progress in achieving sustained economic and social inclusion.”

¹ See http://www.ncchpp.ca/141/publications.ccnpps?id_article=279 for document published in 2009 by the NCCHPP. The updated version of this document has not yet been published.

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Province/Territory	Name & Type of Policy	Date adopted	Public consultation/engagement process	Primary Objective
Manitoba	<u><i>The Poverty Reduction Strategy Act (C.C.S.M. c. P94.7)</i></u>	June 16, 2011	No	"...[A]ddress the various needs, including the need for quality, accessible education that develops knowledge and skills; training that prepares persons for employment; income supports opportunities; income supports for persons who are unable to fully participate in the labour market; affordable housing; supportive and safe communities; and supports for strong and healthy families."
Nunavut	<u><i>Collaboration for Poverty Reduction Act (Snu 2013, c 12)</i></u>	May 16, 2013	Yes (Public Engagement Process)	"...[T]he purpose of this Act is to affirm in law the commitment of the Government of Nunavut to participate as a partner with Nunavut Tunngavik Inc., Inuit organizations, other governments, non-government organizations and businesses on the Nunavut Roundtable for Poverty Reduction to implement The Makimaniq Plan and the five year poverty action plan in a manner consistent with Article 32 of the Nunavut Land Claims Agreement."

EXHIBIT 4
Poverty Reduction Policies (Strategies & Action Plans) across Canada, by Province and Territory²

Province/Territory	Policy	Date launched	Target	Areas of Intervention
Quebec	<u><i>The Will to Act, The Strength To Succeed, National Strategy to Combat Poverty and Social Exclusion</i></u>	August 2002	To progressively transform Quebec over a ten year period (by 2013) into one of the industrialized societies with the least poverty, according to recognized methods of international comparison.	<ul style="list-style-type: none"> • Early child development • Family programs • Training and employment • Housing • Income security • Social integration • Place-based initiatives
	<u><i>Quebec's Combat Against Poverty: Government Action Plan for Solidarity and Social Inclusion 2010-2015</i></u>	June 2010	To progressively provide all citizens with the conditions required for them to live with dignity and with a sufficient standard of living according to international standards, while respecting our society's ability to absorb the costs thereof.	<ul style="list-style-type: none"> • Early child development • Community empowerment • Housing • Family programs • Income security • Training and employment • Social integration • Place-based initiatives
Ontario	<u><i>Breaking the Cycle: Ontario's Poverty Reduction Strategy</i></u>	December 2008	To reduce the number of children living in poverty by 25 per cent over the next five years (2015).	<ul style="list-style-type: none"> • Early child development • Family programs • Housing • Training and employment • Review of social assistance

² See http://www.ncchpp.ca/141/publications.ccnpps?id_article=279 for document published in 2009 by the NCCHPP. The updated version of this document has not yet been published.

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Province/Territory	Policy	Date launched	Target	Areas of Intervention
New Brunswick	<u>Overcoming Poverty Together: The New Brunswick Economic and Social Inclusion Plan</u>	November 13, 2009	To reduce income poverty by 25% and deep income poverty by 50% by 2015.	<ul style="list-style-type: none"> • Place-based initiatives • Social and economic inclusion • Social assistance • Transportation alternatives • Introduce early learning and childcare Act • Prescription drug program • Develop a comprehensive housing strategy • Social enterprise and community investment funds • Training, education and volunteer opportunities
	<u>Overcoming Poverty Together: The New Brunswick Economic and Social Inclusion Plan 2014-2019</u>	May 16, 2014	To reduce income poverty by 25% and deep income poverty by 50%.	<ul style="list-style-type: none"> • Community development, communication, Networking and volunteerism • Child & youth education • Adult education • Participation in labour market and business activity • Food security • Housing • Transportation
Newfoundland and Labrador	<u>Reducing Poverty: An Action Plan for Newfoundland and Labrador</u>	December 6, 2006	To transform Newfoundland and Labrador from the province with the most poverty to the one with	<ul style="list-style-type: none"> • Aboriginal programs • Justice system supports • Housing • Income security

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Province/Territory	Policy	Date launched	Target	Areas of Intervention
Nova Scotia	<u>Preventing Poverty, Promoting Prosperity, Nova Scotia's Poverty Reduction Strategy</u>	April 3, 2009	None identified	<ul style="list-style-type: none"> • Early child development • Education • Employment training programs • Review of Income Assistance program • Income security for families • Early child development • Service coordination • Advocate for national anti-poverty strategy and national housing strategy
Manitoba	<u>All Aboard: Manitoba's Poverty Reduction Strategy</u>	May 21, 2009	None identified	<ul style="list-style-type: none"> • Family programs • Housing • Training and employment • Income support • Service coordination
	<u>All Aboard: Manitoba's Poverty Reduction and Social Inclusion Strategy</u>	May 2012	None identified	<ul style="list-style-type: none"> • Early childhood development • Family programs • Housing • Training and employment • Place-based initiatives • Opportunities for youth

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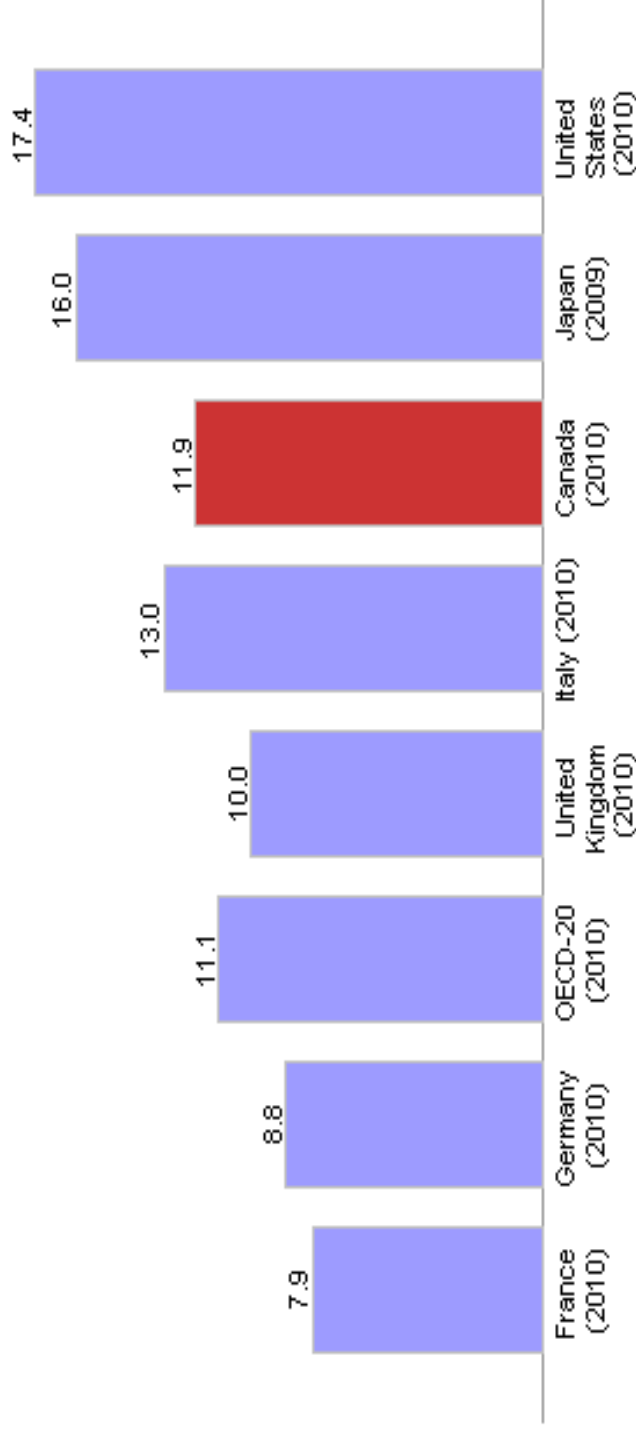
Province/Territory	Policy	Date launched	Target	Areas of Intervention
Nunavut	<u><i>The Makimanig Plan: A Shared Approach to Poverty Reduction</i></u>	November 30, 2011	None identified. However, the Nunavut Roundtable for Poverty Reduction identified their vision as "our land, Nunavut, and each of our communities, free of poverty."	<ul style="list-style-type: none"> • Collaboration and community participation • Health and wellbeing • Community and economic development • Education and skills development • Housing and income support • Food security • Childhood development • Parenting skills and family planning • Removal of the welfare wall
Prince Edward Island	<u><i>Social Action Plan to Reduce Poverty</i></u>	May 2012	Specific target not identified. However, "the Social Action Plan will work to strengthen our programs, sharpen our focus, and improve the way we provide services in order to reduce poverty in this province."	<ul style="list-style-type: none"> • Housing • Income support • Supports for persons with disability • Employment supports and services • Family supports and services • Seniors
Saskatchewan	<u><i>From Dependence to Independence: Actions and Investments for Saskatchewan's Most Vulnerable People</i></u>	Summer 2012	None identified.	<ul style="list-style-type: none"> • Housing and emergency shelters • Education and skills training • Early childhood development and childcare • Community inclusion

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Province/Territory	Policy	Date launched	Target	Areas of Intervention
Yukon	<i>A Better Yukon for All : Government of Yukon's Social Inclusion and Poverty Reduction Strategy</i>	November 2012	To reduce the number of people who experience social exclusion and poverty, while improving the lives of people currently experiencing them.	<ul style="list-style-type: none"> • Sexual assault and family violence supports • Mental health and addictions programs • Services for children and youth with Autism Spectrum Disorder • Services for low-income neighbourhoods and communities • Early childhood development • Housing • Employment
Northwest Territories	<i>Government of the Northwest Territories Anti-Poverty Action Plan: Building on the Strengths of Northerners</i>	February 2014	None identified.	<ul style="list-style-type: none"> • Early childhood development • Family programs & Food Security • Access to mental health services • Community capacity • Education and training • Housing & Community development • Social programs • Partnerships • Public safety

EXHIBIT 5
Low Income Rates within Industrialized Nations

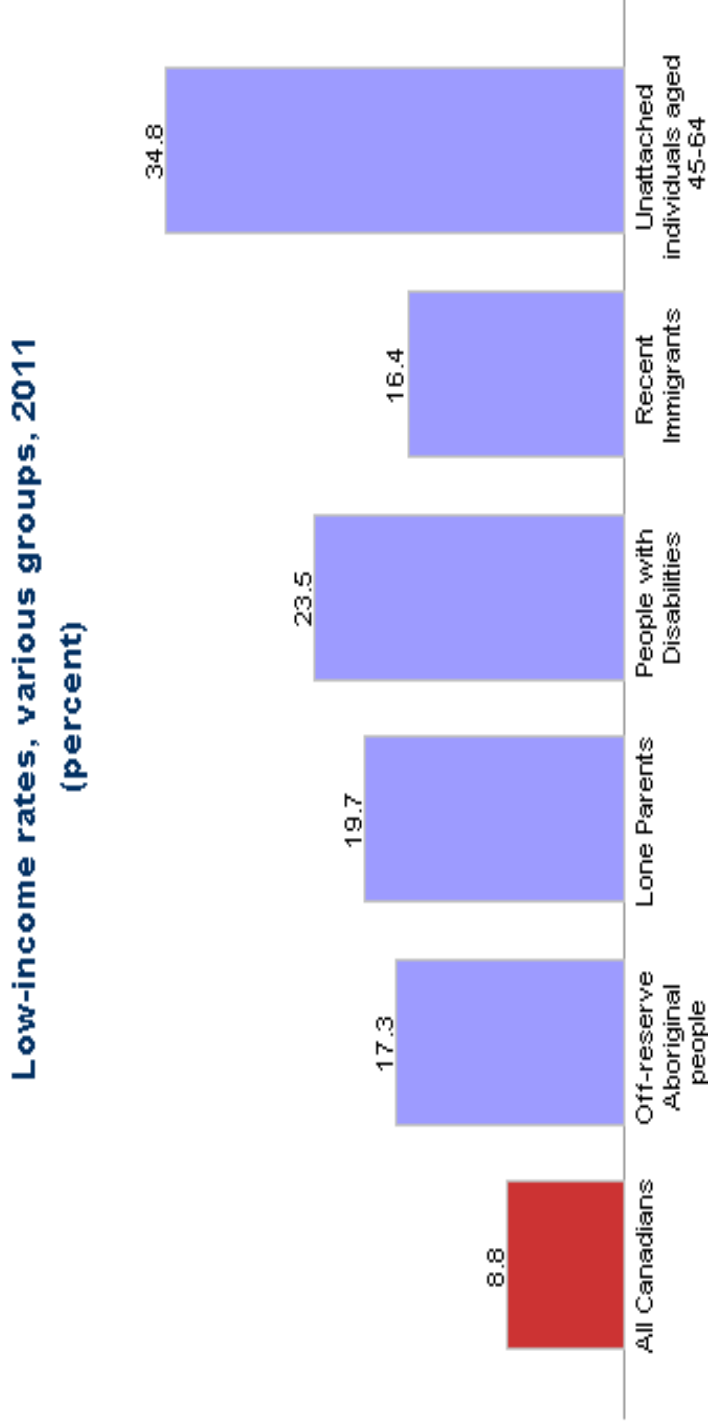
Low-income rates, G7 countries and OECD, 2009-2010
(percent)



Note: Based on an OECD measure similar to after-tax [LIM](#).

Source: OECD Income Distribution Database (via www.oecd.org/social/income-distribution-database.htm) [cited July 10, 2013].

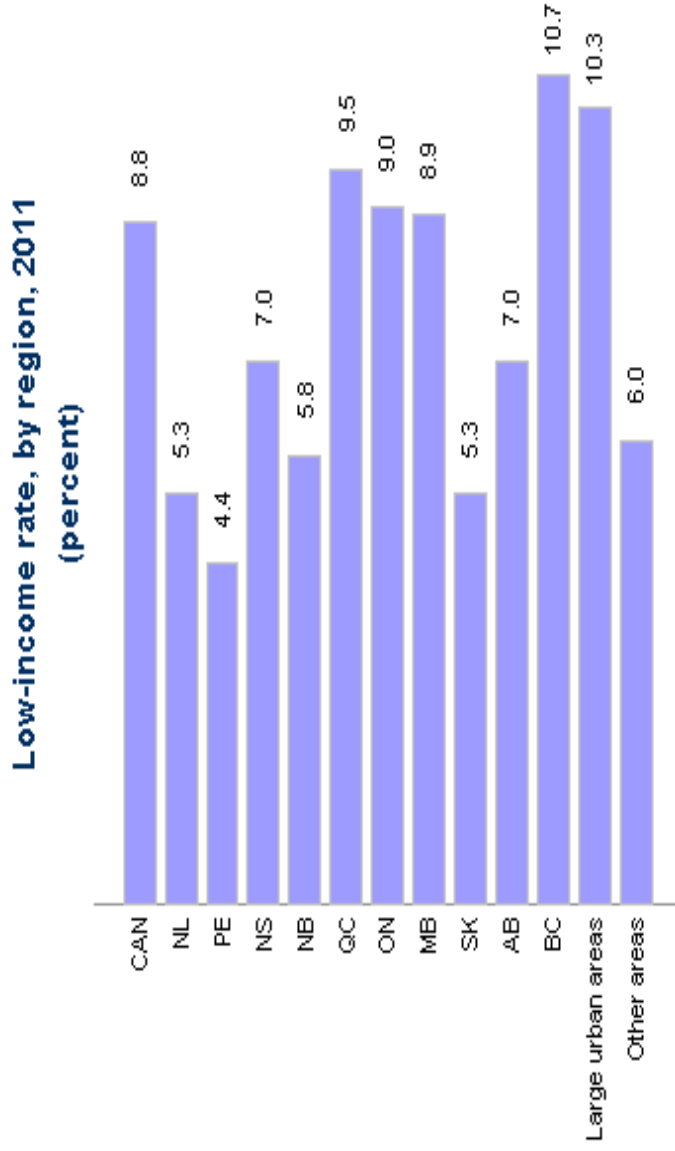
EXHIBIT 6
Population Subgroups Most Affected by Low Income



Note: Based on after-tax [LICOs](#).

Source: Statistics Canada calculations based on Statistics Canada. *Survey of Labour and Income Dynamics*. Ottawa: Statistics Canada, 2013.

EXHIBIT 7
Low Income Rates by Region



Note: Based on after-tax LICOs. The category "Large urban areas" includes the 20 largest Census Metropolitan Areas (CMAs). For the list of areas included in the category 'Large urban areas', see large urban areas. The category 'Other areas' includes all other urban areas as well as the rural communities in Canada.

Source: Statistics Canada. *Table 202-0802 - Persons in low income families, annual, CANSIM (database)*.

EXHIBIT 8
Canadians Experiencing Low Income Between 1980 and 2006

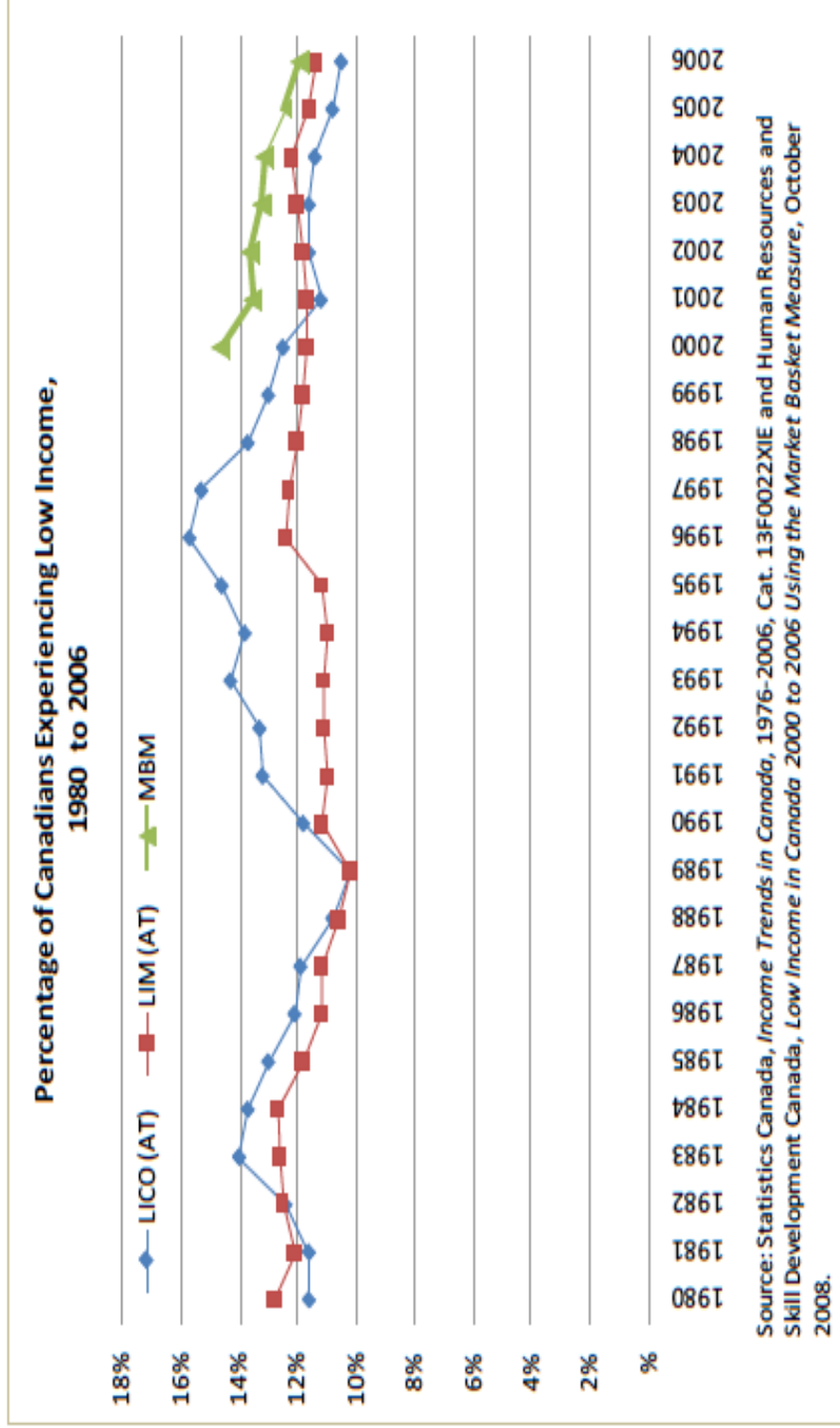


EXHIBIT 9
Trends in Low Income Cut-Offs Between 1976 and 2006

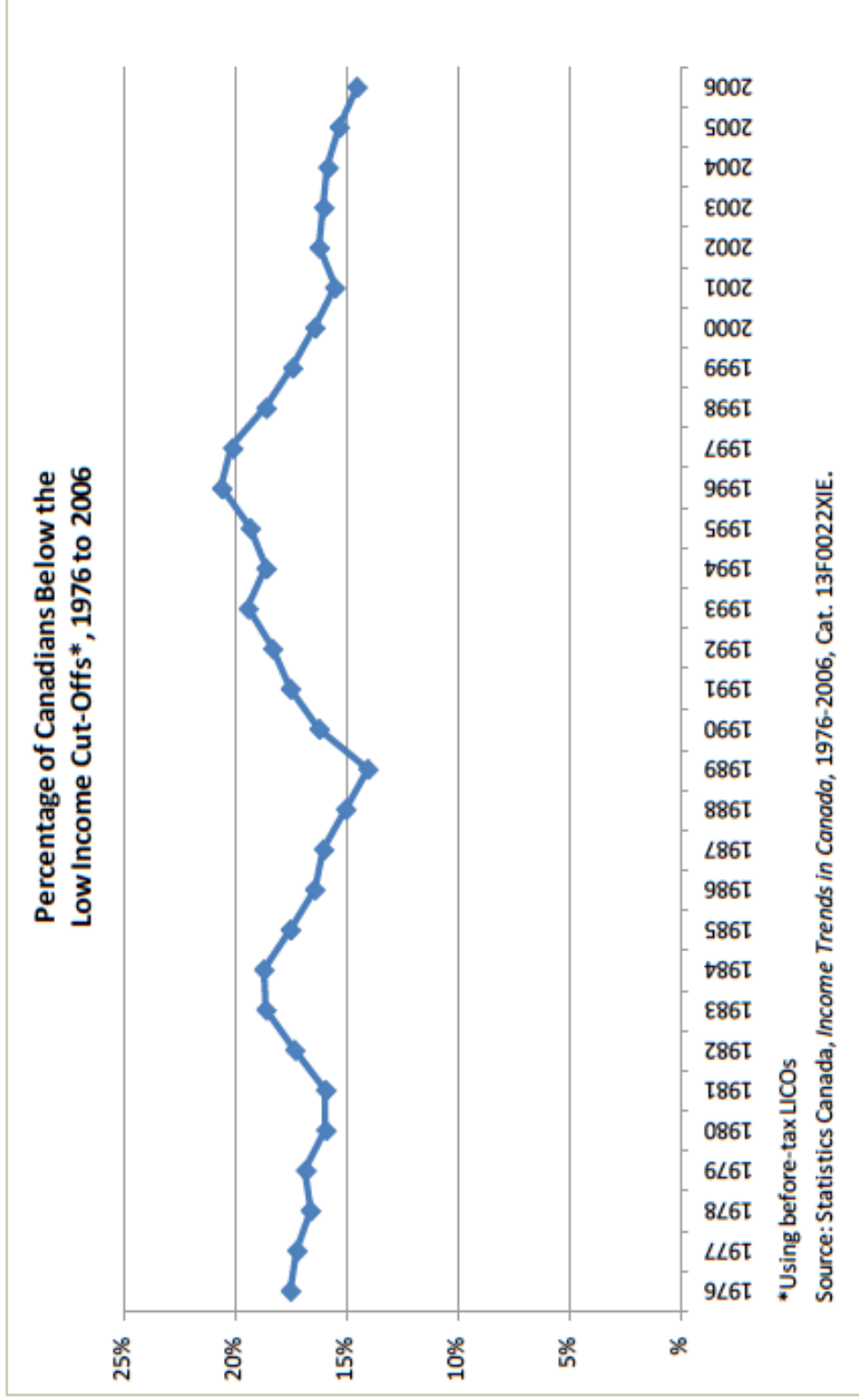


EXHIBIT 10
The Social Determinants of Health

Structural Determinants	Proximal/Intermediate Determinants
Income and Income Distribution	Early Childhood Development
Education	Food Security
Unemployment & Working Conditions	Social Exclusion
Social Safety Network	Aboriginal Status
Health Services	Gender
	Race
Physical Environment (Housing)	Disability

Source: Mikkonen & Raphael, 2010 (for a detailed explanation of each determinant see Association of Faculties of Medicine in Canada, n.d.).

EXHIBIT 11
Relationship Between Social Structures & Health Structures

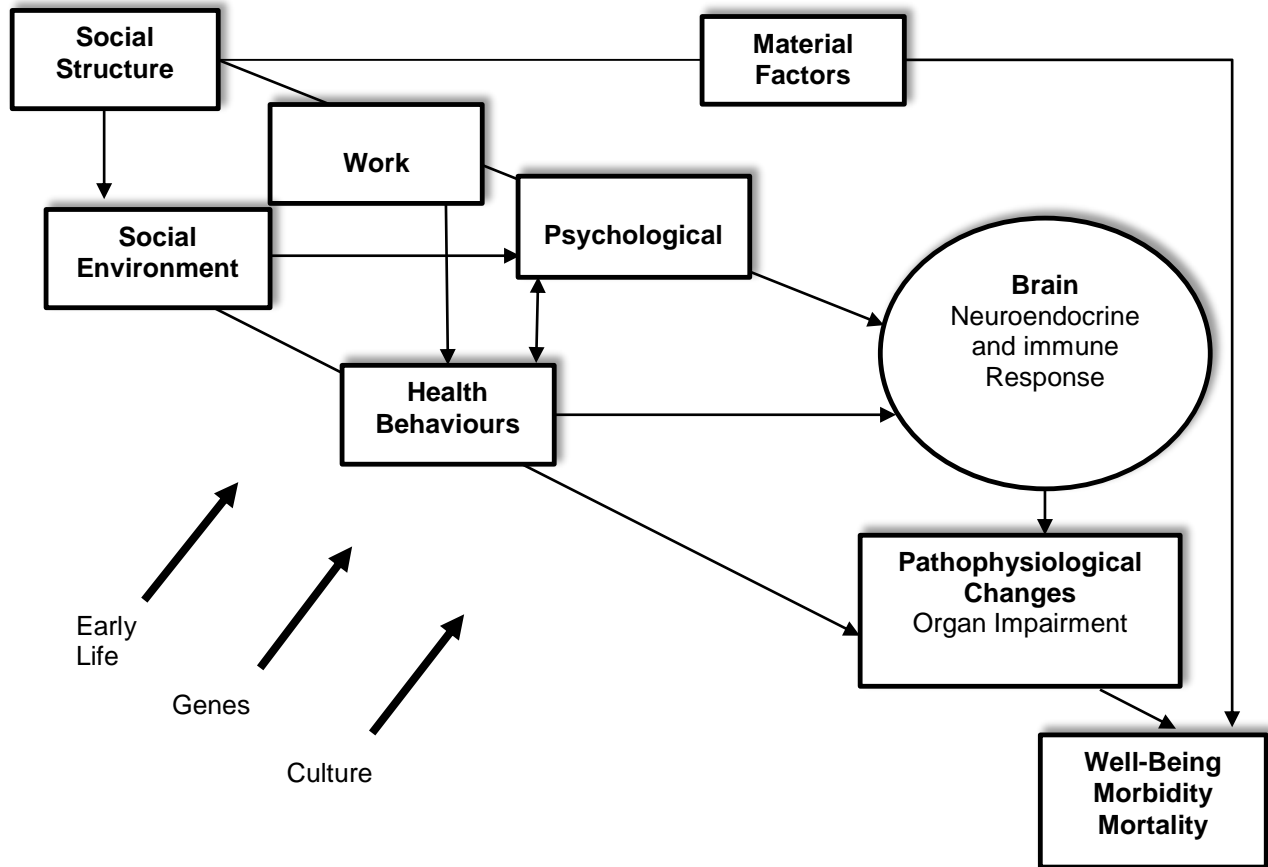


Figure shows how the organization of society influences the living and working conditions we experience that then go onto shape health. These processes operate through material, psychosocial, and behavioural path-ways. At all stages of life, genetics, early life, and cultural factors are also strong influences upon health.

Source: Raphael, 2007, p.242 (by permission of Oxford University Press).

EXHIBIT 12
NCCHPP Validation Questionnaire



Centre de collaboration nationale
sur les politiques publiques et la santé

National Collaborating Centre
for Healthy Public Policy

Document: “Comprehensive policies to combat poverty across Canada, by province and territory”

1. Is the presented information complete?
2. Is there something missing from this document that should be added?
3. Are the relevant facts well-presented? Are they clear?
4. Are there any changes that you would suggest for further clarification/elaboration of the contents?
5. Are there other pertinent resources you would suggest the readers be guided to?

Thank You!

EXHIBIT 13

What Makes a Strategy More Likely to Succeed?

- ***Political commitment***
 - A high level of commitment from politicians and civil servants, providing impetus and leadership to the strategy.
- ***Responsibility and accountability***
 - Less successful strategies often have misconstrued terms of responsibility and accountability for delivery. The establishment targets and timelines provides evidence of such accountability.
- ***Links to economic policy***
 - Anti-poverty policies developed alongside an economic policy have more buy-in
- ***Institutional arrangements***
 - Establishing dedicated institutions or other systems of governance facilitates the development process, while offering security against changes in political leadership
- ***Co-ordination (the all government approach)***
 - Tackling multi-faceted issues such as poverty requires high levels of inter-governmental co-ordination
- ***Implementation***
 - A developed strategy must be put into practice, however there remains large gaps between what is set out in the plan and what is delivered, particularly when moving from the national/provincial scale to local delivery
- ***Involvement of external stakeholders***
 - External stakeholders are a vital source of information and assistance to be involved in the development and implementation of the strategy
- ***An effective monitoring and review system***
 - Performance monitoring is essential for maintaining momentum and ensuring government objectives are being met and are revised as needed. Evaluation of the plan also shows government accountability.

Source: MacInnes et. al., 2014.

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INSTRUCTOR GUIDANCE

Reducing Poverty in Canada: Public Policies & Population Health

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Amardeep Thind, MD, PhD (Professor, Western University)

BACKGROUND

The case is aimed at providing students with an overview of the burden of poverty in Canada and the effects of poverty on the health of Canadians. It exposes students to the various definitions of poverty, as well as its measures, including the Gini index, which is an internationally recognized measure of income distribution used to assess overall inequity. While it is challenging to define poverty and identify its multifactorial root causes, the link between poverty and ill-health is stronger. The case exposes students to existing federal, provincial and territorial policies and plans aimed at reducing poverty and supporting low income families. It asks the student to focus on the development and implementation of an innovative poverty reduction plan in British Columbia, one of the Canadian provinces without a provincial poverty reduction strategy.

OBJECTIVES

1. Understand the various measures used to assess poverty.
2. Tease out the links and pathways between poverty and health.
3. Develop a poverty reduction strategy for British Columbia.

DISCUSSION QUESTIONS

1. How is poverty assessed?
 - a. What are the limitations of each method?
2. What are the links between poverty and health?
 - a. What are its direct and indirect effects?
 - b. How does one impact the other and vice-versa?
3. What key elements should a poverty reduction strategy for British Columbia contain?
4. What are the essential elements for a knowledge translation strategy for the implementation of this poverty reduction strategy for British Columbia?

KEYWORDS

Poverty – measurement; healthy public policy; knowledge translation; reduction strategy.