

Health Impacts of Social and Economic Conditions: *Implications for Public Policy*



CANADIAN PUBLIC HEALTH ASSOCIATION
BOARD OF DIRECTORS DISCUSSION PAPER
March 1997

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of Social and
Economic Conditions:**
Implications for Public Policy



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Preface

The Canadian Public Health Association (CPHA) is a national, independent, not-for-profit, voluntary association representing public health in Canada with links to the international public health community. CPHA's members believe in universal and equitable access to the basic conditions necessary to achieve health for all Canadians.

CPHA's mission is to constitute a special national resource in Canada that advocates for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection, and healthy public policy.

CPHA and its members are concerned about the health of individuals and communities and the future of Canada's health and social services systems. Significant changes are occurring in these systems, changes which are challenging our understanding and expectations of health and well-being.

In February 1995, the CPHA Board of Directors identified health impacts of social and economic conditions and policies as a priority for action within the Association. A CPHA Working Group was established to guide the development of a Discussion Paper.

The Working Group, chaired by Sherri Torjman, included Doug Angus, Claudette Boyd, Susan Carter, Rick Edwards, Joan Feather, Pat Kerans, Fernand Turcotte and Reg Warren. This group brought together individuals working in social and economic policy development who have a broad range of experience in examining social and economic conditions in Canada. CPHA appreciates the expertise and time this group provided in the development of this paper. CPHA would also like to acknowledge the work of the external reviewers, contributors and CPHA staff in the preparation of this report.

This Discussion Paper explores various dimensions of the socioeconomic environment including income distribution, education, unemployment, systemic discrimination and violence. The paper identifies the health impacts of these dimensions and considers policy implications. These include changes to income programs and taxes, labour legislation, education and training programs, and social supports and services.

CPHA has developed this Discussion Paper for use by individuals and organizations in health and other sectors to raise awareness of the health impacts of social and economic conditions and to lay the foundation for discussion of the health impacts of specific public policies.

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Executive Summary

A growing body of evidence is providing direction for the development of policies to reduce health inequities in modern societies. The evidence points to the socioeconomic environment as a powerful and potentially modifiable health-determining factor and public policy as an instrument for changing this environment. To focus on the socioeconomic environment does not imply that other factors such as genetics, lifestyles or health care do not figure prominently in determining health status; rather, the new knowledge highlights a sector which, until recently, has not received much research attention from the epidemiological or health policy communities.

The new evidence offers additional proof of a direct and powerful link between the social environment and health. Poverty, unemployment, education, living and working conditions, families, friends, workplaces, social support and physical environments all significantly affect health. How or why this happens is as yet imperfectly understood, but sufficient evidence has accumulated that the relationship can no longer be denied.

Socioeconomic Status and Health Status

In virtually all societies, health status is directly related to social status. No matter the measure used, those with high incomes are usually healthier and generally live longer. Another dimension of this story can be found in the socioeconomic gradient in health. The evidence shows that a gradient exists in the rate of disease from the top of the social hierarchy to the bottom for almost every disease that has been studied, practically everywhere in the world. Higher-income people tend to live longer than lower-income people. Moreover, people on one rung live longer than those on the rung below them, on the entire socioeconomic ladder.

This variation in socioeconomic health is not due primarily to deprivation of food, clothing or shelter. The important factor in explaining health differences appears to be not so much the material conditions but rather the social meanings attached to those conditions. In modern societies, deprivation in social circumstances has become the major influence on health inequities.

Our discussion looks at the influence of the social environment on health inequities, but first explores how an evolving interpretation of 'conventional' determinants of health can shape our understanding of the links between the socioeconomic gradient and health:

- ▶ A review of current disease patterns and changes over time shows that focusing on individual disease risk factors is unlikely to significantly reduce health inequities.
- ▶ The socioeconomic environment plays an important role in influencing individual lifestyles.
- ▶ While genetics are an important determinant of health, their effects are strongly moderated by social and physical environments.
- ▶ Improvements in medical care, whether better access or new treatments, have little chance of reducing inequities in health.
- ▶ While health status may influence socioeconomic status in some circumstances, there is almost no evidence for discounting the influence of socioeconomic conditions on health inequities on these grounds.
- ▶ Per capita economic income growth is no longer as important a factor in determining overall health status as income distribution.
- ▶ Increasingly, attention is focusing on the health-enhancing influence of supportive environments.

Biological and Psychological Pathways

Many of the pathways between socioeconomic status and health are well documented. The path that leads from poverty to poor nutrition and on to infectious diseases and certain chronic conditions is generally well understood. New research, however, is shedding light on how the subtle and intangible effects of social and cultural environments can affect, through biological and psychological pathways, the health of individuals and populations. One of the keys to understanding the links between the external

environment and health status can be found in how humans and other primates respond to stress. A considerable body of research has been gathered which shows that the relationship between stress and health is ambiguous. Stress can be harmful to health, but on the other hand, stress can produce a positive response, or at least no negative reaction.

New research is also contributing to our understanding of the formative influence of early childhood environments on long-term health, well-being and competence. Yet the policy focus should not be on children alone. The conditions of adult life also exert a significant impact on health, well-being and competence.

Income Distribution and Poverty in Canada

While Canada has received international recognition for a positive social environment, poverty, and its associated health effects, remain a serious threat for many. An estimated one in three Canadians will experience poverty at some point in their lifetime.

Social programs have played a crucial role in narrowing the gap between high- and low-income Canadians, along with the income tax system, but many Canadians are just a divorce, an illness or a job loss away from being poor. But a job provides no guarantee against poverty. As national unemployment rates have climbed so have the number of working poor. Living in a family, on the other hand, can provide considerable protection against poverty.

In recent years, efforts have been made to focus national attention on the plight of poor children and youth. But in 1994, 1.4 million Canadian children under the age of 18, or almost 20 percent of all Canadian children, were poor. Women face a considerably higher risk of poverty than men, and have for some time. But for seniors during the past 15 years, the overall poverty rate has moved sharply downward, falling to a record low of 17.2 percent in 1994. Most people with disabilities are poor and of all population groups in Canada, Aboriginal peoples are the most economically disadvantaged.

The challenge for health-enhancing policy in times of deficit reduction is to maintain and, where possible, enhance the value of child

benefits, elderly benefits and other forms of income support for persons with disabilities and the unemployed. Other policy areas to be considered include removing disincentives to work for those receiving social assistance, and ensuring an adequate supply of affordable and accessible housing. Prenatal programs, both in the form of financial assistance and educational information, have been found to have a positive impact on health and well-being.

Education

The development of life skills through education and training increases opportunities for income and job security, and enhances life management potential, the ability to cope with change and a sense of control over life circumstances—key factors that influence health. In Canada, however, it is becoming clear that the organizational patterns of education and work that have served the country well over the past half century no longer will suffice in the face of rapid technological change and international competition. Canadians are becoming much better educated, but the education system does not always adequately prepare young people for the job market. Canadians are remaining in school longer than before but it is not clear they are acquiring the academic, teamwork and science and technology skills required to compete successfully in the global marketplace.

An emerging consensus is recognizing that job training must be an integral part of the Canadian labour market environment and a continuous, lifelong process. Nonetheless, labour market training is not a panacea for structural problems of underemployment or unemployment.

Employment

People with more control over their work conditions, fewer stress-related demands on the job and greater workplace social supports are generally healthier. When employees can use their skills and abilities in the workplace and when their work helps enhance their sense of self-esteem and achievement, they are, as a group, at lower health risk.

For many Canadian workers, however, structural changes in the Canadian economy are creating barriers that stand in the way of healthy work environments. The impact of the new,

restructured labour environments has been particularly severe for older workers. For some, overemployment is a significant problem, and for others, underemployment. Changing work patterns have created greater flexibility in the labour market and the nature of work itself is evolving. While the word 'employment' has frequently been limited to mean paid work, usually carried out on a regular basis, many other types of work are performed without pay, such as child and elder care, household chores and voluntary community work. Unpaid work may not figure in most economic calculations, but it is clearly of value to individuals and society.

Unemployment

Unemployment can significantly influence mental, physical and social health. The health effects of Canada's high unemployment economy, which has existed since the early 1980s with rates consistently higher than other industrialized countries, are potentially huge.

Unemployment affects some groups more than others. Older workers (aged 45 to 64 years), for example, often experience greater difficulty in getting back into the labour force. Youth is the other group most severely affected by high joblessness.

The health-associated policy implications of the education and work environments include the importance of lifelong learning, along with investments in education, on-the-job training and skills development. Other areas include the relevance of school and education policies to both students and employers and the problem of school drop-outs.

Supportive Social and Physical Environments

There are many social barriers in Canada that prevent or hinder access to the supportive environments that positively influence health and well-being. Many groups are without the social supports that could help them achieve even a portion of their full health potential. Others, such as some street and Aboriginal populations, live in conditions that are hazardous to health even by Third World standards.

Violence is a widespread social problem in Canada that affects the health and well-being of families, women, children, youth and seniors in

all economic, social, geographic, racial and cultural groups. Women are at higher risk of violence than men, while many children and youth are exposed to violence and abuse within their families. Adults may think violence in the home can be hidden, but the evidence shows most children are aware of spousal violence. Older Canadians are also not immune from violence.

Not all Canadians are able to share in the social, economic and health benefits associated with improved learning. For many, poor literacy skills create barriers to dealing with the simplest of everyday situations. Systemic discrimination is more prevalent in Canada than many would believe and can have a serious impact upon social conditions associated with health status. For many lesbians, gays and bisexuals, systemic discrimination based on sexual orientation is a major barrier to a supportive environment. Racism and discriminatory attitudes affect the social environment in which Aboriginal peoples and other visible minority groups live. Policy implications associated with a supportive social environment are strongly linked to human rights. People have the right to live and work in communities where they feel accepted, safe and secure and without this support, many groups will have difficulty achieving their full health potential.

Looking to the Future

A major challenge for the public health community and government will be to broaden the parameters of the health policy debate to include economic and social issues. The knowledge base for development and implementation of social and economic policies that could have a positive impact on reducing health inequities is in place. The next step will be to develop innovative policy tools that can translate this knowledge into action.

Section 1.0 Setting the Context

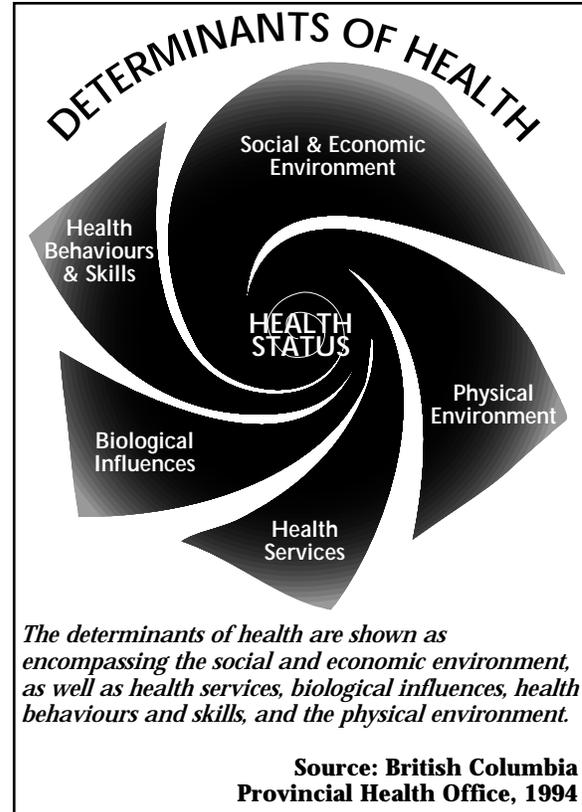
Introduction

Measured by almost any indicator, overall health status in Canada is among the highest in the world; yet wide inequities exist between groups. The health status of some Aboriginal populations, for example, approaches that of the poorest of developing nations, as does the health of many in the growing homeless population in major cities. But beyond these examples of extreme deprivation, the gulf between the health status of the poorest of Canadian society and those higher on the socioeconomic scale is wide, and in some instances, growing. Health inequities of this order have existed at least as far back as the beginning of this century in Canada and in major industrialized countries of the western world. These inequities have remained constant despite changes in disease patterns, advancements in medical care such as the discovery of penicillin, and more recently, the introduction of universal access to medical services and institutional care. Today, as a hundred years ago, the poor are much less healthy than those better off.

This situation, however, is not inevitable. There is a growing body of knowledge that can provide direction for developing policies to reduce health inequities in modern societies. The socioeconomic environment is a powerful and potentially modifiable health-determining factor and public policy is a key instrument to change the socioeconomic environment.

This direction in no way implies that other factors such as genetics, lifestyles or health care do not figure prominently in determining health status; rather, the new knowledge highlights a sector which, until recently, has not received much research attention from the epidemiological or health policy communities.

The important role of the socioeconomic environment as a health-determining influence has been recognized for some time. In 1974, *A New Perspective on the Health of Canadians* (the Lalonde Report) introduced the health fields concept, broadening the scope of health policy beyond health care, and this was followed by the



Achieving Health for All and the *Ottawa Charter for Health Promotion* documents in 1986. More recently, the Canadian Institute for Advanced Research population health framework, which has received wide international recognition, provided a conceptual model that includes the social environment.

What is new is a rapid growth in evidence that offers additional proof of a direct and powerful link between the socioeconomic environment and health status, and that opens up a new understanding of pathways between the social environment and physical and mental health.

This paper explores the issues around this subject, beginning with a discussion of evidence that is opening new doors to our understanding about the links between the socioeconomic environment and health status. We then review selected socioeconomic conditions in Canada, identifying key trends and directions and their potential impacts upon health status. We give special attention to poverty which data show is a powerful indicator of the lack of a supportive environment.

While we identify potential policy domains for future action, the focus of this paper is not on policy development. Our intent is to develop a basis to help the Canadian Public Health Association (CPHA) and others formulate advocacy positions on specific policies. The 1996 CPHA paper, “The Canada Health and Social Transfer and Health Equity in Canada”, is an example of the kind of advocacy position we have in mind.

“CPHA recognizes that inequalities in the health of different groups in Canada are often rooted in inequities in the opportunity to have access to or to benefit from a set of basic health prerequisites: food, shelter, work, education and income. The first priority of healthy public policy must be to ensure all Canadians have access to adequate amounts of nutritious foods, adequate housing, meaningful work and adequate income, and that all Canadians have basic literacy skills and health knowledge.” (CPHA, 1993)

CPHA recognizes the importance of public policy in translating knowledge into action. Public and private policies determine the kind of opportunities available in society and structure the range of choices that people can make (Milio, 1986). CPHA supports a positive role for public policy as an instrument for reducing health inequities and reaffirms that social justice and equity are essential to healthy public policy.

Throughout this discussion paper, a broad definition of health, one consistent with the *Ottawa Charter for Health Promotion* (1986), is implied. The *Ottawa Charter* notes that “health is a positive concept emphasizing social and personal resources, as well as physical capacities.” This broad concept of health accepts the definition first put forward by the World Health Organization (WHO) in 1947 and reaffirmed by the *Ottawa Charter for Health Promotion* and the *Achieving Health for All* framework in 1986. In short, health is more than the absence of disease or injury. Rather, health is a resource for daily living, associated positively with physical, mental and social well-being.

1.1 The Social Context

Social policies are changing in Canada in response to fiscal, demographic and trade pressures. In a recent paper, Torjman highlighted the evolution of social policy in Canada and strategic options for the future:

Much of the thinking that has shaped social policy in the past 50 years evolved in the postwar reconstruction era. This period was marked by three major influences: the ravages of the Depression and the determination to ensure that it was never repeated; the dramatic growth in the economy in the postwar period due primarily to technological and industrial advancement; and the role of Keynesian economics and its impact upon the public sector and government involvement in the economy.

The convergence of these forces resulted in an expanded role for government in the economy and a substantial investment in social programs. The major social programs that comprised the foundation of the welfare state—family allowances, Unemployment Insurance, Old Age Security, the Canada/Quebec Pension Plan, the Canada Assistance Plan, the Hospital Insurance and Diagnostic Services Act and the subsequent Medical Care Act—all were introduced in times of relative economic prosperity from the 1940s through the 1960s.

The model of social security that evolved in the postwar period was based on the conviction that government has a legitimate and necessary role to play in altering the unequal distribution of income, goods and services in the marketplace. Industrialization brought increased prosperity, but the private market could not, on its own, eliminate the risks to income from unemployment, low wages, illness, disability and old age. These risks and insecurities could not be borne by individuals or by private institutions alone; governments through social programs had a responsibility to protect and compensate citizens from earnings loss and income inadequacy.

The postwar vision was built on the ‘traditional’ two-parent, one-earner family—no longer the primary family structure in Canada. Another pressure on social programs is the aging of the

population, which will create demands on the pension system, social services and health care as the baby boom generation reaches old age. The social policy blueprint of the postwar era was also predicated upon a healthy economy and a labour market which provided relatively stable and secure employment.

Since the postwar vision, there has been a dramatic shift in the labour market with a rapid rise in the growth of nonstandard employment—i.e., work of a casual, contractual and part-time nature. Canada is experiencing earnings polarization, with growth in both lower-paid and higher-paid jobs and shrinkage of middle-income employment. High rates of unemployment have strained social programs.

The pressures on social programs from the changing labour market have been created to a large extent by government fiscal and monetary policies. The no-inflation, high interest rate policy of the Bank of Canada, in particular, contributed significantly to high unemployment by tightening the flow of cash available for business development. The high interest rate policy also increased the deficit by driving up the level of required interest payments.

Despite the rising pressures on social programs, they have done a remarkable job in contributing to economic and social well-being. Social programs are far more effective than most people realize in narrowing the gaps between high- and low-income earners. These programs provide a form of guaranteed income for seniors. Social programs have moved Canada away from cash-register medicine to a comprehensive health care system available to all. Social programs have helped build a national infrastructure of social services (Torjman, 1996: 3-24).

The range of social programs illustrates how we have been able to respond to changing needs and conditions by the creative use of public policy. We are no less creative today. The purpose of this document is to set the stage for discussion of effective ways to continue to use public policy to improve and protect the health of Canadians.

Section 2.0 Social and Economic Conditions

Introduction

The socioeconomic environment affects the health of populations. Poverty, unemployment, education, living and working conditions, families, friends, workplaces, social support and physical environments all significantly affect health (Frank & Mustard, 1994: 1). How or why this happens is as yet imperfectly understood, but sufficient evidence has accumulated that the relationship can no longer be denied.

2.1 Socioeconomic Status and Health Status

In virtually all societies, health status is directly related to social status. No matter the measure used—income, education, occupation or residence—those with high socioeconomic status are usually healthier and generally live longer (Frank & Mustard, 1994: 4). There are exceptions to this pattern—for example, breast cancer in developed countries today, or coronary heart disease earlier in this century—but these patterns of illness can be explained by differences in causal factors. Overall, the link between higher social status and better health status persists across countries and over time.

One of the best sources of historical information illustrating the link between health and socioeconomic status is the Black Report, which presented data from the U.K. Office of Population Censuses and Surveys showing an inverse relationship between mortality and socioeconomic class, across the entire population, that goes back to the beginning of this century (Hertzman et al., 1994: 69).

More recently, the Whitehall Study, which followed more than 10,000 British civil servants for nearly two decades, provides clear evidence of the relationship between socioeconomic factors and the health of the middle class (Frank & Mustard, 1994: 8). As in the larger population studies, the Whitehall Study found a higher risk of death from “coronary heart disease, strokes,

cancer, gastrointestinal disease, accidents, and suicides” among those lower on the civil service hierarchy (Frank & Mustard, 1994: 8). Over a 10-year period, the age-standardized mortality rates of people at the bottom were three times those at the top (Marmot & Mustard, 1994: 202).

There is, of course, a great deal of other evidence linking socioeconomic status and health. Thomas McKeown explored the major decline in mortality rates in the United Kingdom after 1840 (Frank & Mustard, 1994: 5). While his findings generated considerable controversy, a consensus has emerged on at least one conclusion: the overall, positive, health-enhancing influence of increased prosperity.

American data include the Kitagawa and Hauser study which showed that improving the overall health status of the US population between 1930 and 1960 has had little or even a negative impact on reducing health inequalities between classes (Frank & Mustard, 1994: 8). Other evidence demonstrates that higher status can have a buffering effect against both internal and environmental threats to health. One remarkable study, for example, showed that lower-class children are more likely to experience toxic effects from exposure to lead than higher-class children (Hertzman, 1994: 170). Another reveals that “severe pregnancy, labour, and delivery complications did not lead to impairment of the physical and psychological development of children from upper-class families in the way that they did for lower-class children” (Hertzman, 1994: 170).

2.2 Socioeconomic Gradient in Health

Another dimension of this story can be found in the socioeconomic gradient in health. The evidence shows that a gradient exists in the rate of disease from the top of the social hierarchy to the bottom for almost every disease that has been studied, practically everywhere in the world (Syme, 1994: 84). Higher-income people tend to live longer than lower-income people. Moreover, people on one rung live longer than those on the rung below them, on the entire socioeconomic ladder.

This variation in socioeconomic health is not due primarily to deprivation of food, clothing or

shelter (Hertzman, 1994: 168). It is possible but highly unlikely to conclude from the Whitehall studies, for example, that civil servants at the second highest grade have worse health than those at the highest grade because of worse housing, a poorer diet or more pollution. “It also seems unlikely that comfortable ‘middle class’ people in Britain are suffering from the effects of material deprivation” (Marmot & Mustard, 1994: 211).

The more important factor in explaining health differences appears to be not so much the material conditions but rather the social meanings attached to those conditions and how people feel about their circumstances and about themselves (Wilkinson, 1994: 70). In modern societies, deprivation in social circumstances has become the major influence on health inequities. We will look at the influence of the social environment on health inequities shortly, but first we explore how an evolving interpretation of ‘conventional’ determinants of health is shaping our understanding of the links between the socioeconomic gradient and health.

A review of current disease patterns and changes over time shows that focusing on individual disease risk factors is unlikely to significantly reduce health inequities. The socioeconomic gradient in health exists, independent of disease and risk factor patterns. Even if, for example, we managed to eliminate smoking and eradicate lung cancer, this cause of death would simply be replaced by another. The socioeconomic gradient in health would remain (Hertzman, 1994: 169). People lower on the income ladder would still have poorer health status than those above them, measured by all-cause mortality. In order to improve health equity, we should look beyond the direct connection between risk behaviours and particular diseases, such as smoking and lung cancer. Disease may simply be the pathway for other factors influencing the health of populations (Evans, 1994: 18).

Lifestyles

Focusing on lifestyles draws attention to freedom of choice and may foreclose debate about differences in the health status of populations. Some would say, if people choose a particular lifestyle, they are also free to accept the health consequences. Lifestyle programs that became popular following the 1974 Lalonde Report, *A New Perspective on*

the Health of Canadians, implicitly and perhaps unwittingly supported this argument.

Governments around the world, frequently with leadership from Canada, seized these programs with considerable enthusiasm as a way, some might say, to shift responsibility for health onto the shoulders of individuals. The programs were relatively inexpensive and “avoided challenging either the conventional world of work, income distribution, and control over the environment, or the conventional medical establishment” (Marmor et al., 1994: 223). Governments likely saw these programs as a way of reducing health care costs.

There is today, however, greater recognition that the socioeconomic environment plays an important role in influencing individual lifestyles. Both lifestyles and the social environment influence health. The chances of contracting cancer, for example, increase dramatically for people who smoke. But an individual’s ‘free choice’ and all lifestyle decisions are influenced by the socioeconomic environment.

Genetics

There is now considerable scientific evidence that while genetics are an important determinant of health, their effects are strongly moderated by the social and physical environments. Studies of migrant populations provide some of the best evidence of this relationship. The classic study in this area shows that Japanese who moved to California and adopted an American lifestyle have higher rates of coronary heart disease than those who maintained a more traditional Japanese lifestyle (Marmot & Mustard, 1994: 201). Their genetic makeup did not protect them from the disease patterns of their new, host country.

Animal studies also show the importance of the social environment. Work with rhesus monkeys has demonstrated, for example, that among animals with a negative, genetically inherited trait, (i.e., a ‘reactive personality’), those reared by a particularly nurturing mother fared best (Evans et al., 1994: 177). ‘Outside’ effects of the nurturing parent have a powerful influence on the impact of genetic makeup.

In short, genetics alone cannot explain differences in population health status. People are

born with genotypes that make them more or less vulnerable to disease. But how this vulnerability will play out during their lifetimes depends on their physical and socioeconomic environments.

Health Care

The evidence shows that improvements in medical care, whether better access or new treatments, have little chance of reducing inequities in health. Dramatic improvements in the extent, effectiveness, and accessibility of medical care have not reduced health inequalities between socioeconomic classes.

Moreover, medical care may not have played a major role in the most important health gains. McKeown has demonstrated that “the dramatic decline in deaths from particular infectious diseases over the nineteenth and early twentieth centuries occurred in the absence of any effective medical therapy.” And the health gains that occurred during this period were far from insignificant: life expectancy at birth increased roughly from 40 to 60 years in many now-developed countries (Hertzman et al., 1994: 69-70). McKeown’s work has generated considerable controversy about how much nutrition, child spacing/family size, housing and public sanitation contributed to this decline. But the limited role of medical care, at least, is clear (Evans, 1994: 10).

In the last 50 years, all developed societies have greatly expanded their health care systems. By the early 1970s, most (with the exception of the United States) had established financing systems that ensured virtually equal access to all citizens. Nonetheless, there is little evidence of a positive direct effect on reducing health inequalities. The goal of health equality for all citizens has not materialized despite universal access to health care.

It would be incorrect to conclude that medicine has had no effect on improving population health status over time. Medical therapies developed in the 1940s, for example, had a significant, positive impact on further reduction of mortality. Moreover, medical care has a legitimate role in relieving pain and suffering and restoring function. But in terms of relative contribution to reducing health inequalities, it is clear that other factors operating outside the medical care system have had a more important impact (Hertzman et al., 1994: 70).

More recently, a growing body of expert opinion is questioning the contribution of medicine to improving health status in modern societies. "A significant proportion of health care activity is ineffective, inefficient, inexplicable, or simply unevaluated . . ." (Evans & Stoddart, 1994: 39). Others claim that recent improvements in mortality in the United Kingdom have occurred largely as a result of the decline in deaths judged to be nonamenable to medical care (Marmot & Mustard, 1994: 209). More likely to cause human misery today are conditions such as underemployment, poverty, family and work stress, and discrimination that may be sensitive to interventions and structural changes outside the health care system (Hertzman et al., 1994: 82).

These arguments are not meant to minimize the importance of the essential caring services provided by many front-line workers in the health care system. Such caring functions are often essential to recovery from illness, are not always available through families or friendship networks and form part of the 'public goods' that help to foster a sense of fairness and community amongst Canadians. Indeed, our concern is that too much of the reduction in health care spending in recent years has been borne by these front-line caring professionals, rather than by reductions in ineffective and costly medical treatments.

If variances in material circumstances, lifestyles, genetic effects and health care cannot account for the socioeconomic gradient in health, the argument could be proposed that the statement has been improperly framed: health determines socioeconomic status rather than the other way around. Healthy people naturally would end up higher on the social ladder. Their better health helps them achieve and maintain higher socioeconomic status, while people with poorer health tend to have lower incomes. The evidence for this argument, however, is neither as strong nor as compelling as is the evidence that poverty and low status work lead to disease (Marmot, 1994: 209-210). At the same time, there is evidence that persons with disabilities, including chronic diseases, are ghettoized into lower-paying work and so we might conclude that poor health does lead to poverty. But this conclusion simply begs a larger ethical and policy question. If unhealthier people or persons with disabilities are less able to 'compete' for higher

paid jobs, should not the economic system that allocates such opportunities be changed to eliminate this discrimination? Why should our economic system cause ill people or those with disabilities to become poor?

Economic Growth or Income Distribution?

A relatively new body of research has shown that modern societies have passed a watershed in the relationship between economic development and health status. Per capita income growth is no longer as important a factor in determining overall health status as income distribution. Data compiled by Wilkinson and other researchers show that after a country achieves a Gross National Product (GNP) per capita annual income of approximately \$5,000 (in 1990 values), overall life expectancy depends more on the internal distribution of wealth than increases in income (Wilkinson, 1994: 62). The narrower the spread of income in a given society, the higher will be its overall health status.

In order to continue to reduce mortality, one of the greatest achievements of the last 150 years, improvements in GNP per capita alone will not do the job. The developed world has undergone "a transition from the primacy of material constraints to social constraints as the limiting condition on the quality of human life" (Wilkinson, 1994: 61). Using life expectancy as a barometer for health, "countries with the longest life expectancy are not the wealthiest but those with the smallest spread of incomes and the smallest proportion of the population in relative poverty" (Wilkinson, 1994: 67-68).

Recent economic development trends in developed countries show a consistent relationship between health status and income distribution. Between 1975 and 1985, for example, average life expectancy increased most quickly in those European Community countries in which relative poverty was growing at the slowest rate. Moreover, the gap in health status between upper and lower groups within some developed countries has widened in recent years during a time of overall improvement in mortality rates (Marmot, 1994: 200).

Between 1965 and 1990, life expectancy among all industrialized countries improved with no consistent link to income levels. Some countries

have increased their income levels with GNP per capita rates as much as twice those of others with no demonstrable impact on mortality rates (Wilkinson, 1994: 65). Japan best illustrates the relationship between narrow income spreads and improved overall health status. During this period, it jumped ahead of all other industrialized countries to take the lead in life expectancy, despite increased dietary fat intake and with higher than average smoking rates (Marmot, 1994: 199). There are many possible explanations for this dramatic decrease in mortality. But the most likely is a reduction in income spreads since 1970, now the most narrow of any country reporting to the World Bank (Wilkinson, 1994: 70). The most likely explanation for Japan's startling success is to be found in factors related to income distribution.

While Japan's health gains have been impressive, they must also be assessed in light of the ecological limits to economic growth. Japan has accomplished much of its prosperity and life expectancy gains only by imposing an enormous ecological 'footprint' on much of the rest of the world. The notion of an ecological footprint is that the lifestyles and prosperity of western societies rest primarily on control over the environmental resources of poorer nations (UBC Task Force, 1994). Given what is known about the devastating effects of environmental damage on public health, this suggests another reason why income distribution, rather than economic growth, is the more important health policy choice (CPHA, 1992).

Supportive Environments

While more attention has been paid in recent years to the influence of socioeconomic conditions on the health status of populations, there is still lack of clarity on what constitutes a supportive environment. At least part of the difficulty lies in the complexity of the subject. The interacting systems of social and cultural variables are not readily reducible to discrete entities whose contribution to health can be isolated and objectively measured. Nonetheless, there is sufficient data to open the door for more research. A key consideration in assessing the social environment is the influence of social and community ties on health status. The Alameda County Survey in California, for example, showed that "individuals without social ties were

found to be more likely to die from various causes than those with more intensive social contacts" (Corin, 1994: 94). Other studies support this conclusion. Still unresolved, though, is whether life expectancy is enhanced by the sheer number of contact persons or the quality of the social interaction. Some authors suggest that the number of contacts is important in a general, unspecified way while, in times of stress, the quality of interaction rather than the sheer number of potential social ties becomes more important (Cohen & Syme, 1985). At least one study seems to suggest that a 'traditional' way of life in Japan compared to modern North America has more positive health effects (Corin, 1994: 95). It would be wrong, however, "to assume traditional or stable societies always constitute a protective nest" (Corin, 1994: 115).

Research in Britain has found that rural life is not necessarily more conducive to health. Comparing psychiatric disorders in rural and urban settings, "a traditional way of life is a significant but complex influence on health in rural communities, simultaneously protective and debilitating" (Corin, 1994: 97). Other work also supports this conclusion.

Gender also seems to be an important component of a supportive environment. What is supportive for men might not always be so for women. A 1986 study of Navajo elderly showed that disruption of a traditional way of life, in this instance at least, had a positive effect for men but was consistently associated with hypertension for women (Corin, 1994: 105). Moreover, men appear to "rely significantly more on their spouses for support and intimacy, while women tend to rely on a larger span of social resources" (Corin, 1994: 130).

Other researchers have focused on the tension between certain social variables. Dessler, for example, in studies carried out in St. Lucia in the Eastern Caribbean, found that persons caught in the bind between high material lifestyle and low economic status experienced higher blood pressure (Corin, 1994: 104). This kind of 'lifestyle' stress translated into an adverse health reaction. Reactions to stress, however, are not always linear, as discussed in the next section on Pathways.

2.3 Biological and Psychological Pathways

Many of the pathways between socioeconomic status and health are well documented. The path that leads from poverty to poor nutrition and on to infectious diseases and certain chronic conditions is generally well understood—as is the biological pathway that links crowding to the transmission of infectious disease, or smoking to increased mortality.

New research and analysis, however, are shedding light on how the effects of social and cultural environments can affect, through biological and psychological pathways, the health of individuals and populations. But how does this happen in physiological terms? How is it that an individual's position on the social or economic ladder is somehow translated into disease or health?

The research shows that there is a biological path linking external stimuli and the systems of the body that determine health. The path joins various physiological systems that previously were thought to function more or less independently, transmitting information that ultimately has an impact upon health. At the extreme end of this pathway is the nervous system which provides an interface with the outside world. The nervous system, in turn, is linked to other body systems. Just how this happens is as yet imperfectly understood, but linkages between the nervous system and the immune system have been discovered at the cellular level.

The discovery of a biological link between the nervous system and the immune system is of major importance in understanding how social and economic conditions can affect health. There is now scientific evidence of a pathway from the external world to the immune system which plays a central role in guarding health.

One of the keys to understanding the links between the external environment and health status can be found in how humans and other primates respond to stress. A considerable body of research has been gathered which shows that the relationship between stress and health is ambiguous. While stress can be harmful to health,

Selye (1930) and others have demonstrated that stress can produce a positive response or at least no negative reaction (Hylton, 1994: 10). The link between stress and its effects is complex. Some of the most important work in exploring the nature of this relationship has taken place in animal experiments. While extrapolation to humans cannot be assumed, there is much to inform our thinking.

Not surprisingly, animal research shows that while the health effects of short-term stress can be both good and bad, the health effects of long-term, chronic stress are just plain bad. Chronic stress achieves its deleterious effects, it appears, by impeding the body's ability to carry on 'maintenance' operations. In the short term, stress in animals achieves the advantageous effects of preparing for the 'fight or flight' syndrome—e.g., increasing the heart rate, dilating pupils. While these activities are going on, however, the body shuts down maintenance operations, such as reproduction, growth and development, and learning from one's environment (Cynader, 1994: 162-163). Over the long haul, the animal that is continuously deprived of these functions will experience serious, negative health effects.

More important, then, than the actual experience of stress is the ability to turn off the stress response. Genetics undoubtedly play a role, but equally important is the social environment, and more specifically, the extent of control over the life situation. Animals lower on the social scale—those effectively under the control of those above them—experience more severe physiological effects to the same, adverse environmental conditions.

Other animal research provides convincing evidence of the biological pathway between sensory experience and the immune system. At least one set of animal experiments has confirmed the hypothesis that a gentle, supportive environment can have a positive effect on physical health (Marmot & Mustard, 1994: 210). Because the knowledge in this area is evolving rapidly, this information must be interpreted with caution.

Recent research, focusing more on individuals than populations, has shed light on the

psychological effects associated with low socioeconomic status and poor health. While many of these research findings are speculative, they point in the direction of a direct link between poverty and health. People at the bottom of a hierarchy who suffer more death and disease feel distressed by the unfairness of their situation. They internalize the unfair risk conditions they experience as aspects of their own 'badness' or 'failure,' adding to their distress. This situation is also more likely when the dominant social discourse on success is based on individualism and meritocracy, where people are presumed to succeed or fail purely on the basis of their own initiative or ability. This internalization leads to what psychological researchers have called learned helplessness (Seligman & Maier, 1967, Seligman, 1975) and policy researchers have called surplus powerlessness (Lerner, 1986).

Learned helplessness is a psychological construct that emerged from Seligman's and Maier's animal research in the 1960s (Seligman & Maier, 1967). Seligman has now coined another term, 'learned optimism,' to encompass the dynamic of learning how to develop positive self-images. Lerner (1986) argues that a similar phenomenon occurs with relatively powerless persons, i.e., persons living in risk conditions. He named this process 'surplus powerlessness,' a surplus created by, but distinct from, external or objective conditions of powerlessness. Individuals internalize this objective powerlessness and create a potent psychological barrier to empowering action. They "do not even engage in activities that meet their real needs. They begin to accept aspects of their world that are self-destructive to their own health and wellbeing, thinking that these are unalterable features of what they take to be 'reality'." Part of this internalizing process is isolation, removing oneself from active group participation because of low self-esteem and self-blame. Survey research affirms this process; poorer people internalize self-blame for their poverty, isolate themselves and set in motion a vicious circle in which peer support declines, self-blame increases and isolation worsens.

Lerner believed that specific group education could overcome self-blame while improving health status and health behaviours. His research involved blue collar workers experiencing occupational stress. Persons in the experimental

occupational stress groups demonstrated statistically significant improvements in the predicted direction on all of the measures used compared to controls. The key construct, self-blame, decreased significantly as social support behaviours among stress group participants improved. That stress groups took place under union sponsorship may have been an important factor. Many stressors are embedded in the structure of work; actions to remedy this problem require an organized, political effort. Unions, through their collective bargaining, afford individual workers an opportunity to take collective actions on the 'structural' elements of work (i.e., the risk conditions of work) while the stress groups improved social support and coping behaviours.

2.4 Early Childhood Environments

New research is contributing to our understanding of the formative influence of early childhood environments on long-term health, well-being and competence. Some of the particularly innovative work involves the linkages between the environment and personality development. Animal studies have shown that the quality of sensory information provided to an animal during its early stages can have a profound impact on how the nervous system develops. An information-rich early environment affects neural development positively, better equipping the organism for later life and lifelong learning.

The discovery of physiological links between external stimuli and development of the neural system has profound implications for health. But perhaps equally important is the negative effect of stress on lifelong learning capacity. Just as evidence shows prolonged stress can seriously impair the immune system, long-term stress can also cause permanent damage to brain function, including learning and memory (Cynader, 1994: 162-163). Prolonged stress can result in elevated levels of circulating cortisol which kills off neurons that 'are most ready to learn,' thereby adversely affecting brain function. The good news is that animal studies show early nurturing can provide long-term protection against such effects later in life.

Other psychosocial data indicate that early interventions can positively affect health and

well-being throughout a person's lifetime. Long-term follow-up of children in an early enrichment program in an inner-city US ghetto, for instance, showed that at age 19 the intervention group was much better off than the control group in terms of education, contact with the criminal justice system, employment and teen pregnancies (Hertzman et al., 1994: 71). Early childhood interventions also buffer against the negative effects of reactive personality, perinatal stress, growth retardation and other conditions (Evans, 1994: 20).

Yet the policy focus should not be on children alone. The conditions of adult life also exert a significant impact on health, well-being and competence. In fact, the so-called 'window' for childhood interventions may not close as early for humans as other primates. Adults can and do learn new languages, for example, although it may be more difficult for them than children. In short, both early childhood experience and the cumulative effects of lifelong experience have an important impact on human well-being (Hertzman, 1994: 174-177). This factor is of major significance in developing appropriate health-enhancing policies.

Section 3.0 Social and Economic Conditions in Canada

Introduction

The relationship between socioeconomic conditions and health is powerful and pervasive, and operates across the full spectrum of society, over time, and across national boundaries. Many Canadians are at risk of poor health because of socioeconomic factors.

3.1 Income Distribution and Poverty

Income Distribution

Social programs are far more effective than most people realize in combatting the growing inequality that threatens Canada's economic health and social stability. The gap between high-income and low-income Canadians has widened in recent years in terms of their shares of income from the market—i.e., employment, investments, private pensions and other private sources. But social programs and a progressive income tax system help reduce dramatically this 'market income' gap. Families in the highest-income group have 22 times greater a share of market income than those in the lowest-income category. The gap between well-off and poor families narrows to five times after income security benefits and the income tax system are factored into the equation (Battle & Torjman, 1995: 3). Income security benefits include: the Child Tax Benefit, Employment Insurance, welfare, workers' compensation, and the various programs that comprise the retirement income system.

But substantial cuts to certain programs in recent years raise serious questions as to their continued ability to reduce the growing gaps in market income. Employment Insurance (formerly Unemployment Insurance) has been scaled back significantly since 1990. There have been sizable reductions in some welfare programs throughout the country, especially since the introduction of the Canada Health and Social Transfer which removes billions of dollars in federal cash transfers to the provinces. The income security programs which have played such a crucial role

in protecting low-income Canadians are themselves becoming increasingly vulnerable.

Poverty

Few Canadians are immune from poverty and many are just a divorce, an illness or a job loss away from being poor.¹ An estimated one in three Canadians will experience poverty at some point in their lifetime (NAPO, 1994: iv). In 1994, 17.1 percent of Canadians, more than 2.1 million individuals, were poor, with the highest provincial poverty rate in Quebec (20.5 percent) and the lowest in Prince Edward Island (11.2 percent) (Statistics Canada, November 1995: 17).

Working Poor

A job provides no guarantee against poverty. In 1994, a total of 373,000 families and 430,000 unattached individuals in Canada were classified as working poor (National Council of Welfare, Spring 1996: 70). The working poor are family heads and single individuals between 15 and 64 years of age living below the poverty line, who receive at least half of their total income from employment.

As national unemployment rates have climbed so have the number of working poor. Between 1981 and 1991, when the jobless rate increased dramatically and real wages fell, the number of working poor households in Canada rose by 30 percent for families and 57 percent for unattached individuals (Ross, Shillington & Lochhead, 1994: 76).

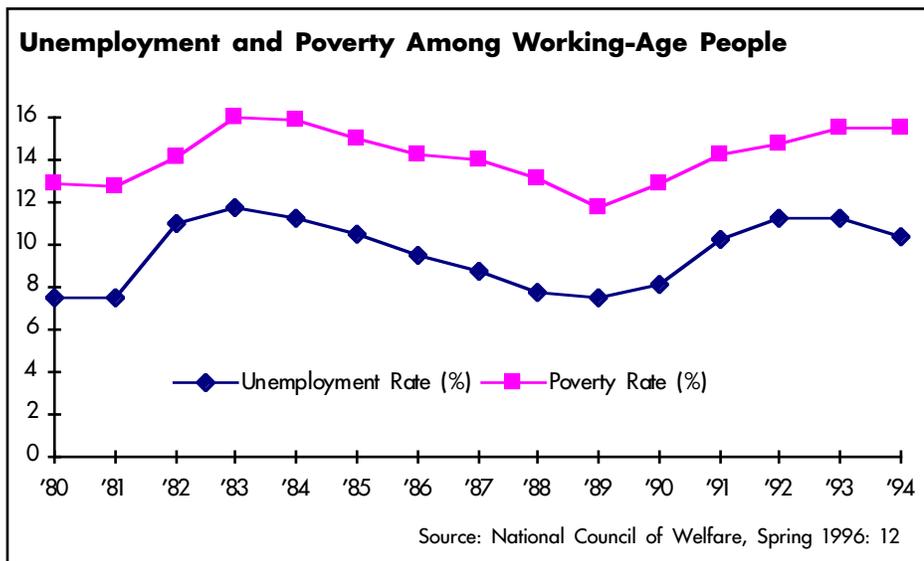
There has been a growth in recent years in non-standard work (which tends to be low paying and often of short duration). The resulting decline in purchasing power has been exacerbated by the dropping real value of the minimum wage. In 1976, it was possible to have a minimum-wage job and not be poor; by 1992, minimum-wage incomes had fallen to between 55

and 83 percent of the poverty line (National Council of Welfare, Autumn 1993: 36). By 1994, a single parent earning the average minimum wage at a full-time job would have an income of only 55 percent of the poverty line. At that wage, she or he would have to work 74 hours a week to lift the family out of poverty (Campaign 2000, 1994).

Children and Youth

Being born poor in Canada can mean not having enough food to eat, living in inadequate housing, not having warm clothing in winter, and not having access to the social supports and recreation facilities that are key to a child's growth and development.

In recent years, efforts have been made to focus national attention on the plight of poor children and youth. In 1989, Parliament passed a resolution to move towards the eradication of child poverty by the year 2000, but five years later a Statistics Canada report showed that little progress had been made. In 1994, 1.4 million Canadian children under the age of 18, or almost 20 percent of all Canadian children, were poor, the highest level recorded by Statistics Canada since it first began publishing this information in 1980 (Statistics Canada, 1994: 15). At the provincial level, Newfoundland has the highest rate of child poverty; Prince Edward Island has the lowest. The poverty rate for children living with single mothers has remained at approximately 60 percent for the last 15 years, five times the poverty rate for children in two-



parent families (National Council of Welfare, Spring 1996: 73, 17).

Children and youth who leave home without resources, voluntarily or not, encounter severe poverty risks. While the data recording the numbers of street children and youth in Canada are not comprehensive, there is a consensus among community workers that there are more children and youth living on the street and they are younger than in the past. The vast majority of young people (84 percent) living on their own have incomes below the poverty line (Statistics Canada, March 1994: 5).

**HEALTH IMPACTS
Children and Youth**

Compared to their peers, poor children are disadvantaged in almost every way (Offord, 1991: 10). The health effects of child poverty are not limited to childhood years, can last throughout a lifetime, and often exact a huge toll in unrealized human potential and financial cost. Poverty is strongly associated with lower health status in children (CICH, 1994: 113). Among the health outcomes associated with poverty in children and youth are premature birth and low birthweight, increased risks of injury and stress, and the difficulty of forming secure and trusting relationships early in life.

Among expectant mothers, low income and inadequate nutrition (a result of not having enough money to buy healthy food) can affect fetal growth and increase the risk of having low birthweight babies (Montreal Diet Dispensary, 1994: 2). Low birthweight can lead to infant death or increase the risks of cerebral palsy, autism and learning disabilities (WHO, 1994: 21). Poor children and youth are at greater risk than non-poor children and youth for injuries, the largest single cause of death for this age group (CICH, 1994: 128).

Poor children are also more likely than non-poor children to engage in riskier behaviour, including smoking and taking drugs, and to suffer from alcohol-related

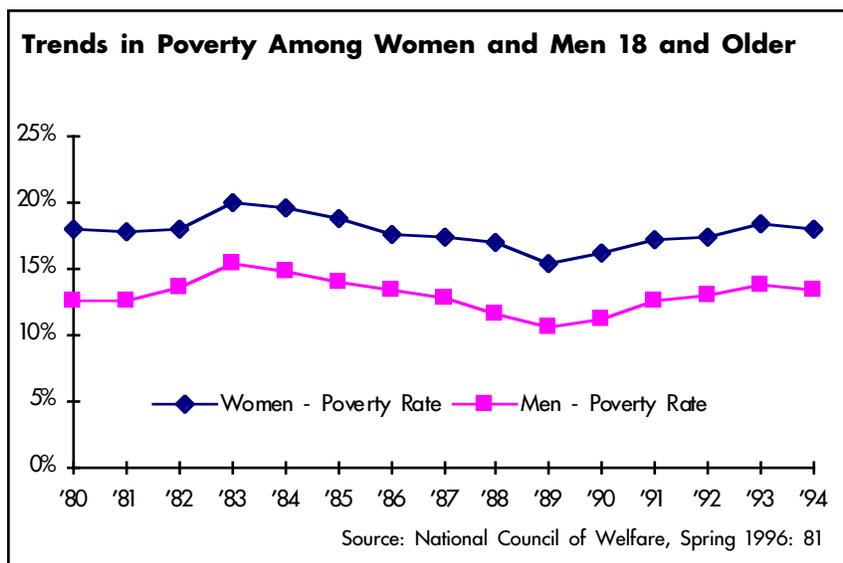
problems. Among sexually active youth, poor teens are less likely to use birth control, or to use condoms as protection against sexually transmitted diseases (Ross et al., 1996: 16-18).

As they develop and grow, poor children are at increased risk of developing psychosocial problems. They are much more likely to perform poorly at school and to suffer chronic health problems. Stresses can often lead to life-threatening decisions. Over the past 40 years, there has been a dramatic increase in the rate of youth suicide. While there does not appear to be a direct link between socioeconomic status and suicide risk, income or lack of income is considered to be a contributing factor, along with other factors such as unemployment and stressful life events (Health Canada, 1994: 13).

Families

Living in a family can provide considerable protection against poverty. The poverty rate for families in 1994 was approximately one third that for unattached people and has been at least that much lower for the last 15 years (National Council of Welfare, 1994: 14).

The protection against poverty that family life provides, however, depends very much on the structure of the family. Families with a second source of income are much less likely to be poor than sole-earner households. The second income source can come from wages or pensions. Either way, families with two-income earners at the



head have poverty rates dramatically lower than single-parent families.

In 1994, out of an estimated eight million families in Canada, more than a million, or 13.7 percent, were poor, a rate that has remained relatively constant over the last 15 years. Of all families, those with very young parents are at greatest risk of being poor. In 1991, 83 percent of all families headed by a person age 15 to 19 had incomes below the poverty line; families led by single women age 15 to 19 had an extraordinarily high incidence (93 percent) of poverty (Statistics Canada, March 1994: 5).

HEALTH IMPACTS

Families

The impact of poverty on the health of families is well-documented. Poor families are much more likely to live in overcrowded conditions, experience parental unemployment, disturbed family relationships and parental psychiatric disturbance (Offord, 1991: 9-10). Households with the lowest incomes have, on average, the lowest health levels. This relationship is particularly strong among adults aged 45 to 64 (Roberge et al., Summer 1995: 19).

Low income can lead to increased stress, including stress from inability to improve family circumstances and parental frustration with not being able to provide adequately for children. While physical abuse and neglect are often linked with poverty, most poor families manage to provide a suitable environment despite difficult conditions (Ministry of Health, Quebec, 1992: 31).

The fulfillment of personal needs contributes to a sense of well-being and satisfaction that can provide a buffer against some health problems (Health Canada, Spring 1995: 2). Informal supports also have a positive impact on health for all families. People living in families, and those who have more social contacts, tend to live longer than those with fewer social relationships. Married people, for example, live longer than people who are alone and have never married (Premier's Council on Health Strategy, 1991: 8).

Women

Women face a considerably higher risk of poverty than men. Since 1980, the poverty rate for

women has been at least four or five percentage points higher than men. In 1994, 2.7 million women, or just under 20 percent of all Canadian women were poor. The poverty rate for men, by contrast, was 15 percent. In the same year, women represented almost 60 percent of all poor Canadians (Statistics Canada, November 1995: 25-27).

An examination of the relationship between women's roles in society and poverty status in eight industrialized countries—Australia, Canada, Germany, Italy, the Netherlands, Sweden, the United Kingdom and the United States—shows that while marriage and work reduce the risk of poverty for women in all countries, motherhood increases the chances of being poor (Keating & Mustard, 1993: 92). For many married women, the only shield from poverty is their partner's income. Women are more likely than men to have no personal income—e.g., earnings from work or investment income. In 1993, 12 percent of women, compared to only five percent of men, had no personal source of income (Statistics Canada, 1995: 8). Should the partnership break down, or their partner die or become unemployed, these women and their families face a high risk of being poor (National Council of Welfare, 1990: 3).

HEALTH IMPACTS

Women

Income level has a direct impact on the health of women, including effects on nutrition, prevention and treatment of illness, risk behaviours (e.g., smoking), stress and mental health. It is virtually impossible to consider the health impacts of poverty on women separately from health impacts on families and children. Many poor single mothers became disadvantaged as a result of a chain of events beginning with early pregnancy, the stresses of raising a child with few informal supports, and limited access to work opportunities due to a lack of affordable child care (National Council of Welfare, 1995: 32).

Poverty also affects prevention and treatment of illness. Women's income levels are directly linked to preventive cancer screening measures. Twenty-five percent of women with low incomes reported they had never performed a breast self-exam, compared to only 12 percent of women

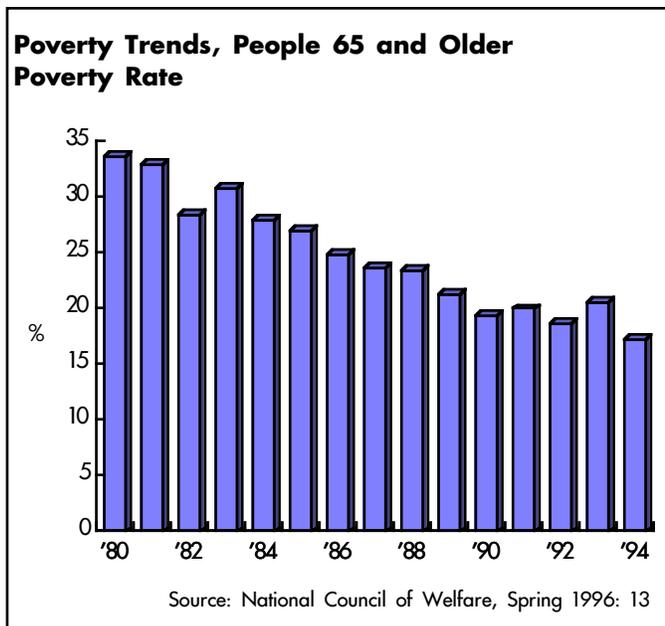
with high incomes. Comparable figures were also reported for mammograms. While breast cancer is more common among women with higher socioeconomic status, poor women have a lower chance of survival, due perhaps to later diagnosis (Mitchell & Sear, 1995: 5). Similar findings exist for other preventive measures. Women with low incomes are less likely than women with high incomes to have regular pap smears, and poor women have a higher incidence of death from cervical cancer (Angus & Turbayne, 1995: 51).

Data on smoking provide an example of the higher incidence of risk-taking behaviours among women who are poor. Women who are poor are 1.6 times more likely to smoke than women with higher incomes (Jensen, 1994: 31). Many poor women often see cigarettes as one of the few luxuries in their lives. But the price is high. Solid links have been established between smoking and cervical cancer, menstrual disorders, early menopause, osteoporosis, and risks to pregnancy and fetal health (National Clearinghouse on Tobacco and Health, 1993: 3). Moreover, smoking is the leading cause of death among Canadian women, with more than 15,000 women dying annually from tobacco-related causes. Lung cancer is overtaking breast cancer as the leading cause of cancer deaths for women.

There is a strong link between women's economic circumstances and their mental health. Poor women seeking help for mental health concerns are more likely to receive intrusive physical treatments, particularly psychotropic medications, rather than psychotherapy. These women continue living in stressful conditions, reliant on medication and with limited supports (CMHA, 1989: 5).

Seniors

During the past 15 years, the overall poverty rate for seniors in Canada has moved sharply downward, falling to a record low of 17.2 percent in 1994. The rate has dropped with such speed that, despite a rapid increase in the overall population of seniors, the actual number of poor seniors was significantly lower in 1994 than in 1980. In 1994, 567,000 seniors in Canada were poor (National Council of Welfare, 1994: 13).



Social programs that provide income have been responsible for reducing the number of poor seniors in Canada. These programs include federal Old Age Security (OAS), the Guaranteed Income Supplement (GIS), the Spouse's Allowance, the Canada/Quebec Pension Plan and income supplements provided by five provinces and the territories. (OAS and the GIS are to be replaced in 2001 by a new Seniors Benefit). As a result of these overlapping benefits and programs, couples over 65 are the least likely to be living at or below the poverty line (National Council of Welfare, 1995: 31).

Elderly benefits show clearly how an appropriate policy package can reduce poverty and inequities. The overall decline in poverty, however, does not mean most seniors are now comfortably off. Even the combined OAS/GIS maximum falls below the poverty line. Many have been lifted just barely above the poverty line by the various income programs; instead of being poor, they are now simply near poor (Ross, Shillington & Lochhead, 1994: 119).

Older single women are more likely than older single men to be poor. Because women tend to live longer than men, many older women are widows without access to the complete basket of pensions and supplements couples can share. When the women were younger, many did not have a steady attachment to the labour force or access to job-related pensions.

HEALTH IMPACTS

Seniors

Seniors are healthier and better educated today than in the past. Most are in good health, and despite temporary or permanent health problems, 65 to 70 percent retain their autonomy and do not require special services (Quebec Ministry of Health, 1992: 107). While the health impacts discussed below are relevant to all seniors, the impact is greater for poor seniors because many lack the necessary financial and social supports. When poverty is combined with frailty, the impact on health can be immediate and debilitating (SP Research Associates, 1989: 16).

People who are better off financially tend to live longer, healthier lives while those with less money and social status are more likely to develop health problems. This relationship is particularly strong for seniors: the poorest seniors tend to have the most activity limitations—conditions caused by illness or disease which restrict the kind or amount of home, work or leisure activities they can do. For many seniors, these limitations result from lifelong exposure to stress, such as low incomes, poor job opportunities, and inadequate food, shelter and social supports. Other seniors, by contrast, are poor because their functional limitations made it difficult for them to find well-paying work (National Advisory Council on Aging, 1996: 1-4).

There is still a bias linking old age with disease, worthlessness and incompetence and this bias may influence the medical treatment that seniors—particularly older women—receive (Rochon Ford, 1990: 26).

People with Disabilities

The World Health Organization defines disability as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (WHO, 1980). The 1991 Health and Activity Limitation Survey (HALS) found that 4.2 million Canadians, or 15.5 percent of the population, reported some level of disability for six months or more that restricted or limited their ability to perform an activity within a range considered normal. The survey also found that the incidence of disability rises with age; 27.7 percent for those individuals 65

and older, and 36.7 percent for those 75 and older (HALS, 1991).

Causes of disabilities differ for men and women. In 1991, accidents were the primary cause of disability for men (28 percent), compared to illness or disease for women (32.4 percent) (HALS, 1991). Multiple disabilities are common: more than half (53 percent) of disabled people reported more than one disability (HRDC, 1994: 30). The vast majority of people with disabilities live in households, not institutions (HRDC, 1994: 30). Caring for children with disabilities at home can create further financial hardship for a family, particularly if a parent must quit work and stay home to provide that care (CCSD, 1996: 11).

Most people with disabilities are poor. Finding a job has traditionally been more difficult for people with disabilities. Unemployment rates are high: 40.7 percent for women and 57 percent for men. But there are signs this pattern may be changing: between 1986 and 1991, there was an increase in the rate of employment among persons with disabilities—particularly among women (HRDC, 1994: 3-4). Finding employment, however, does not guarantee economic security. People with disabilities, particularly women, are concentrated at the low end of the income scale. In 1990, the average annual employment income of people with disabilities was \$22,100, more than \$3,000 below the average employment income of people without disabilities (Boyd & Norris, Autumn 1995: 14). Many people with disabilities also incur higher costs which insurance and health plans do not reimburse.

HEALTH IMPACTS

People with Disabilities

The 1990 Health Promotion Survey found that upper middle- and upper-income Canadians with disabilities are more likely to be successful in coping with their activity limitation than those less well off. There is also a positive relationship between education levels and the ability to cope with activity limitations (Stephens & Fowler, 1993: 266).

The presence of children with disabilities within a household can create stress and financial difficulties. In the absence of appropriate supports, not always in the form of formal

services, it is not unusual for a parent to leave a job in order to provide the required care. Reduced income and stress, coupled with the lack of supports and services, can create a cycle of disadvantage (CCSD, 1996: 11).

Aboriginal Peoples

More than one million people—or 3.6 percent of Canada's total population—are of Aboriginal origin (Statistics Canada, March 1993: Table 1). Aboriginal peoples include status and non-status Indians living on and off reserve, as well as Métis and Inuit peoples. The Aboriginal population in Canada is diverse: social and economic conditions vary from one community to another. But despite the variation, Aboriginal peoples are the most economically disadvantaged group in Canada. Unemployment is a major problem. In 1991, the Aboriginal unemployment rate was 25 percent, about 15 percent higher than the national rate (Standing Committee, July 1995: 7). In some communities, unemployment is as high as 90 percent. Less than one-quarter of Aboriginal women living on reserves have jobs, compared to 50 percent of all Canadian women (Alberta Health, 1994: 29). In 1991, 13 percent of Aboriginal people of working age (15 to 64) reported no earned income, compared to nine percent of the Canadian population (Standing Committee, July 1995: 6). An average of 29 percent of all Aboriginal people reported receiving social assistance.

Poverty is widespread. Almost half (47.2 percent) of Indian families on reserves live below the poverty line, triple the overall poverty rate for Canada (Oberle, 1993: 1). In 1990, more than half of adult Aboriginal people reported annual incomes below \$10,000, while only six percent reported annual incomes of \$40,000 or more. Other problems include inadequate housing, especially on reserves where the numbers of Aboriginal people living in substandard housing is much higher than off the reserves. Many houses are overcrowded, in need of major repairs, lacking a bathroom, and lacking central heating (Young et al., 1991: 5).

H E A L T H I M P A C T S

Aboriginal Peoples

Aboriginal people have lower health status and lower life expectancy than the overall Canadian

population. This difference is reflected in higher rates of infant mortality, injury, tobacco use and chronic diseases. Poor social conditions—lack of jobs and access to a clean water supply, physical and social isolation, substandard and crowded housing, and a loss of cultural identity—all contribute to poor health.

Morbidity and mortality rates of Canada's Aboriginal populations are high; the mortality rates of both groups exceed those of the least developed countries. The Aboriginal infant mortality rate is almost twice that of the Canadian population and the mortality rate of Inuit babies even higher.

The incidence of chronic diseases such as arthritis/rheumatism, diabetes and tuberculosis is higher among Aboriginal and Métis peoples than the general population (Kinnon, 1994: 8). In 1991, 31 percent of Aboriginal adults reported being told by a health professional that they had a chronic health problem, while three percent reported having tuberculosis. Among the total population, the incidence of tuberculosis was one percent (Statistics Canada, June 1993: 4).

In 1991, 67 percent of Aboriginal people 15 years of age and older identified unemployment as a social problem in their community. Alcohol, drug and sexual abuse, and suicide and family violence were also identified as key social problems (Statistics Canada, June 1993: 1). A recent study found links between socioeconomic factors—such as unemployment, illiteracy, multiple forms of abuse and low housing standards—and solvent abuse. For many, solvents are not the drug of choice but are simply more readily accessible and affordable than the alternatives (Health Canada, 1995: 3). In 1991, the incidence of alcohol, drug and substance abuse and deaths due to accidents and violence reached epidemic proportions among Aboriginal populations (Drew, 1992: 163).

Aboriginal suicide rates are four times the Canadian average. The reasons for this are complex and derive in large part from personal experiences such as economic disadvantage, high unemployment, loss of identity or cultural dislocation, and physical, emotional or sexual abuse (Health Canada, February 1995: 5).

Inadequate housing can create health problems, especially for Aboriginals living on reserves.

Those living in inadequate housing on reserves often develop asthma or arthritis and also experience higher hospital admissions for pneumonia, burns, intestinal and skin infections, and respiratory, skin, and eye diseases (Young et al., 1991:25).

Policy Implications: Income Distribution and Poverty

While poor families derive most of their income from paid work, many single parents and seniors receive substantial financial support from government transfers such as child benefits, social assistance and pensions. Without this support, overall income for the poor would drop substantially. The effect of government transfers is clearly demonstrated in the case of seniors. In the past 15 years, poverty rates for seniors have moved sharply downward, thanks to the variety of programs that comprise the retirement income system. The challenge in times of deficit reduction is to maintain and, where possible, enhance the value of child benefits, elderly benefits and income support programs for persons with disabilities and the unemployed.

Other policy areas to be considered include removing disincentives to work for those receiving social assistance, and ensuring an adequate supply of affordable and accessible housing. Prenatal programs, both in the form of financial assistance and educational information, have been found to have a positive impact on health and well-being. Every dollar spent on prenatal care can save an estimated \$3.38 in the cost of medical care for low birthweight infants (Walker, 1991:58).

Because the rate of poverty rises with unemployment, job creation and adequate Employment Insurance payments are crucial. The availability of personal supports for long-term care and independent living is another policy area which could have a significant impact on poverty, especially for persons with disabilities who often face higher living and disability-related costs. Personal supports could help many persons with disabilities enter or re-enter the labour market.

Wage standards as a means to ensure income adequacy should be considered. At present, minimum wage pays less than poverty-level

incomes. Both the level of minimum wages and their indexation are important. Labour legislation in the form of pay equity, employment equity and the provision of associated benefits is critical.

Taxation policy also affects income distribution. Possible policy changes include a more progressive income tax system, indexation of tax credits and tax brackets, the treatment of special needs and increased deductions for charitable giving. Wealth taxes and capital gains taxes represent important sources of revenue for income redistribution. Canada is the only OECD country, other than Australia and New Zealand, that does not have a wealth tax.

3.2 Education, Skills Development and Work

The organizational patterns of education and work that have served Canada well over the past half century no longer will suffice in the face of rapid technological change and international competition. If Canada is to continue in a position of generating sufficient wealth that equitable income distribution and redistribution are possible, the structural changes that are reshaping the economy will have to be reflected in new approaches to education and work.

While the Canadian workforce is considerably better educated than a quarter century ago, there is growing recognition of our serious literacy problem. Labour market restructuring is also making clear the need for lifelong learning and job training for the technology skills required by the new economic opportunities generated by international trade and communications/information technologies.

Learning is a lifelong activity that includes both organized and unstructured processes. Informal education begins long before entry into a formal learning setting and includes knowledge and skills gained through family and community activities. Formal education includes not only all forms of organized learning such as pre-school, elementary, secondary school, college and university, but apprenticeship programs and other forms of skills development. The development of life skills through education and training increases opportunities for income and

job security, and enhances life management potential, the ability to cope with change and a sense of control over circumstances—key factors that influence health (Marmot, Fall 1994: 210; B.C. Ministry of Health, 1994: 31).

Education

On average, Canadians are becoming much better educated. In the last 20 years, the percentage of the population that completed public school has more than doubled and the proportion of people completing at least some post-secondary education has increased by 15 percent (Stephens, 1995: 33).

While Canadians have been spending more time in school, the demand for educated workers has been steadily increasing. Employers who previously hired Grade 8 graduates are now more likely to require at least high school graduation, if not some post-secondary education, and more and more jobs require individuals who can work in teams and have high literacy, numeracy and computing skills (Offord, 1994: 18). Forty-five percent of new jobs created in the 1990s will require more than 16 years of education and training, substantially up from the 1991 level of 25.4 percent (HRDC, March 1994: 11).

Whether the education system adequately prepares young people for the job market of today, however, is another matter. Canadians are remaining in school longer than before but it is not clear they are acquiring the academic, teamwork and science and technology skills required to compete successfully in the global marketplace.

At present, however, higher educational attainment in almost any area of study, while not guaranteeing work or an adequate income, does improve chances for employment. In 1994, single individuals with some public school education had poverty rates at least four times those of single individuals with university degrees (although 21.4 percent of single individuals with university degrees had incomes below the poverty line in 1994) (National Council of Welfare, Spring 1996: 42).

Canada's education system, then, while making some progress, faces serious challenges in

equipping the labour force for the new high-technology job market of the 1990s and early 21st century in the face of international competition. Yet these challenges come at a time when funding for all levels of education has been cut dramatically.

Skills Development

Despite the importance of training and other active labour market measures, there are limits to what they can accomplish. One of the fundamental principles of labour market training and adjustment is that they should lead eventually to stable, long-term employment. But this type of work may not be available in the new economy.

Labour market training is not a panacea for underemployment or unemployment (Betcherman, 1994: 43-44). Nevertheless, a consensus is emerging that job training must be an integral part of the Canadian labour market environment and a continuous, lifelong process (Verma, 1992: 17). Skills development programs have not received the level of support they have in other countries.

HEALTH IMPACTS

Education and Skills Development

A large and growing body of Canadian data, supported by international research, shows a direct link between education and skills development, and health status (Stephens, 1995: 33). One of the strongest confirmations of this relationship is found in the link between self-reported health and educational attainment. In the 1994-95 National Population Health Survey, for example, 20 percent of respondents with less than high school education rated their health as excellent, compared with 36 percent of university graduates (Statistics Canada, 1995: 8). Similar results were reported in the 1990 Ontario Health Survey, with 80 percent of people with primary education reporting health problems compared to 69 percent of those with some post-secondary education (Warren, 1994: 14).

The earlier discussion (Section 2.0) established the relationship between economic status, as measured by education and other factors, and health. The evidence pointed to the important influence of a supportive environment. As one aspect of a supportive environment, education can improve 'health literacy'—the ability to gain

access to information and services to keep individuals and their families healthy (SPHA, April 1994: 6). A decision to leave school early also has an impact on both the individual and society. For the individual, the consequences range from loss of self-esteem and lower self-worth to disadvantages in the labour force and subsequent levels of income (Brannigan & Caputo, 1993: 35). Societal impacts, quite apart from reduced potential for economic performance, include the extraordinary loss in human potential and capacity for development.

Extensive Canadian evidence shows that awareness of health risks increases with formal education. The results of 10 provincial Heart Health surveys found that Canadians with more than 11 years of formal education were better informed about the causes of heart disease than those with 11 or fewer years of education. However, knowledge of risk factors was limited even among those with higher education (Health Canada, 1995: 10-14).

The Canadian data are not limited to awareness and knowledge. Education has also been linked to disease prevalence and risk factors nationwide. People with 11 or fewer years of education, for example, have been found more likely to have at least one major cardiovascular disease risk factor than those with more than 11 years of education (Health Canada, 1995: 10).

Literacy

Not all Canadians are able to share in the social, economic and health benefits associated with improved learning. Poor literacy skills create barriers to dealing with the simplest of everyday situations. As many as 42 percent of all Canadians have weak reading skills; approximately the same proportion has difficulty reading documents and performing arithmetic functions (Statistics Canada, Backgrounder 1995: 7).

Workers with poor literacy skills are particularly vulnerable to layoff and displacement, and once unemployed, they may find it exceedingly difficult to find new jobs. From 58 to 64 percent of unemployed Canadians possess low literacy skills (Statistics Canada, 1995: 26). More than a third of Canadian workers possess only marginal reading skills; those most at risk of job loss work in 'older' industries, such as agriculture, mining,

manufacturing and construction, where employment has declined and literacy tends to be lowest.

H E A L T H I M P A C T S

Literacy

The association of low literacy skills with poor health is well documented (OPHA, 1993: 1). While low literacy can affect health directly—e.g., the effects of misreading prescription information—more often poor literacy skills serve as an indicator of other negative, health-influencing conditions. Psychosocial effects that have been linked with low literacy skills include stress and diminished self-confidence; the resulting low self-esteem often makes it difficult to seek employment or to socialize (OPHA, 1989: 27).

The psychological and social impacts of low literacy can also increase the risk of physical health problems. People with low literacy skills are less likely to engage in preventive health measures and tend to smoke more, have poor nutrition, drink more coffee and engage in regular physical activity (OPHA, 1989: 24-25).

Most health information is provided in both written form and through verbal communications between individuals and providers. Much of the available health education literature requires a level of reading ability that makes it inaccessible to a large proportion of the population in greatest need of health information (Michielutte et al., 1992: 251).

Employment

The impact of the new, restructured labour environment has been particularly severe for older workers. A Statistics Canada survey found that approximately 45,000 older workers left the labour force during the recession of 1990-1992 due to lay-offs; in the vast majority of cases their positions were eliminated, leaving no opportunity for re-call (Schellenberg, 1995: 12). Others have taken advantage of financial incentives in the form of buy-out packages and opportunities to receive pension benefits prior to age 65.

The age at which employed men leave the labour force has dropped dramatically. Men used to remain in the labour force until they reached

retirement age (65 years or older). But the numbers of men aged 55 to 64 in the labour force has decreased at a rate of 10 percent each decade since 1974.

As the creation of permanent jobs has slowed, a defining characteristic of the new labour market has been the growth of part-time work, i.e., less than 30 hours per week. While the number of people working part-time increased slowly in the 1970s, there was a big jump during the 1981-1982 recession. But not all employees who have a permanent, full-time job wish to work longer hours—overemployment is a significant problem. During times of downsizing and lay-offs, employers frequently maintain production at previous or higher levels, while increasing demands on remaining workers. For employers paying hourly wages, compensation for overtime tends to be less expensive than hiring additional staff. Salaried employees are generally not paid overtime.

In 1985, almost 30 percent of working Canadians reported that they would prefer to work fewer hours, with a proportionate decrease in their pay (Osberg, 1988: 12). But in the current economic climate, with its high levels of unemployment and competition for work, most workers do not feel secure enough to demand or accept shorter work hours (Donner, 1995: 141).

While some Canadians are concerned about overemployment, others are worried about underemployment. In recent years, the number of Canadians working part-time who would have preferred full-time employment has risen substantially (Krahn, 1995: 36). One explanation could be that part-time jobs seldom offer employment benefits (i.e., extended health care and family leave) and generally pay less, particularly on an hourly basis.

Changing work patterns have created greater flexibility in the labour market. Once considered the norm, working 9 a.m. to 5 p.m. Monday through Friday is becoming increasingly rare—30 percent of workers do not have regular daytime hours and 25 percent do not work a regular schedule (HRDC, December 1994: 16). Self-employment is also increasing in today's economy as more people, and particularly older people, work (voluntarily or otherwise) for themselves.

As the economy continues to undergo structural change, the nature of work itself is evolving. While the word 'employment' has frequently been limited to mean paid work, usually carried out on a regular basis, many other types of work are performed without pay, such as child and elder care, household chores and voluntary community work. Unpaid work may not figure in most economic calculations, but it is clearly of value to individuals and society. The annual monetary value of work done in the home, including the time and energy it takes to care for family members, would be \$374 billion or 43 percent of GNP in 1992 (Statistics Canada, *The Daily*, December 1995).

HEALTH IMPACTS Employment

Apart from injury risks and threats from the physical environment, some work situations are better for health than others. People with more control over their work conditions, fewer stress-related demands on the job and greater workplace social support are generally healthier (FPTAC, 1994). When employees can use their skills and abilities in the workplace and when their work helps enhance their sense of self-esteem and achievement, they are, as a group, at lower health risk (Marmot & Mustard, 1994: 205).

There are many other stress-inducing factors in the workplace, some of which are associated with lack of control. Workload, monotony, boring repetitive tasks, worries about non-work-related situations, physical hazards, and job insecurity are all potential stress inducers. Others include conflicts with co-workers and clients, unreasonable deadlines, over- or underemployment, harassment and the lack of feedback on performance (Geran, 1992: 14). Low income mothers in the paid labour force often must manage home responsibilities without the resources available to higher income families. The economic, social and personal costs of stress-related work disorders are immense. Measuring only the direct, employment-related health costs, at least \$3 billion are lost annually as a result of sickness, absenteeism, tardiness and fatigue (SPHA, 1994: 7).

Canada does not have a strong track record in the case of occupational health and safety.

Occupational injury rates in Canada have been rising at a time when rates in most other OECD countries have declined (ACPH, 1994). In 1993, there were more than 423,000 time-loss work injuries in Canada (Stephens, 1995: 240).

The increased incidence of work injury is reflected in the budgets of Workers' Compensation Boards across the country. These have almost doubled in the last 20 years. Only some of this growth can be accounted for by a rise in the number of conditions that have become eligible for benefits.

Men are about two-and-a-half times as likely to be injured on the job as women, which may result from the predominance of males in industries such as forestry, transportation and construction. Forestry has, by far, the worst injury record of all industries in Canada. Most injuries occur among younger workers.

While there are now well-developed occupational health and safety systems at the provincial, territorial and workplace levels, increasingly protection is being undermined by threats to job security. The right to refuse dangerous work is an important component of occupational health and safety, but a lack of alternative employment can pressure some workers to stay in dangerous situations.

Unemployment

Canada has had a high unemployment economy since the early 1980s, with rates consistently higher than other industrialized countries. Unemployment as defined by Statistics Canada includes those persons in the labour force who are not working and have been actively seeking work in the four weeks previous to the collection of data. This definition does not include discouraged workers (who, while available for work, have given up looking), nor underemployed workers (who work part-time but would prefer full-time employment). Thus, the rate generally used in Canada to measure unemployment underestimates the real unemployment level. In 1995, the official unemployment rate never dipped below 9.5 percent, indicating that over 1.4 million Canadians were unemployed (Dumas, 1996: 2). However, the unofficial unemployment rate is

closer to 15 percent or 2.3 million unemployed Canadians (Jin et al., 1995: 530).

Unemployment affects some groups more than others. Older workers (aged 45 to 64 years), for example, often experience greater difficulty in getting back into the labour force, and are more likely than other age groups to abandon their job search, believing that no suitable employment is available (Schellenberg, 1995: 12). Women, Aboriginal peoples, persons with disabilities and visible minorities all experience higher unemployment and have lower incomes than most Canadians. These groups face systemic barriers to entering or re-entering the labour force, thereby limiting their occupational choices (CLFDB, 1994: 10).

Youth is the group most severely affected by high joblessness. In 1995, the unemployment rate for youth (aged 15 to 24) was more than five percent above the national average (Dumas, 1996: 6). The duration of youth unemployment has also increased (CMHA, 1992: 39). In fact, the duration of unemployment has increased for all workers.

H E A L T H I M P A C T S

Unemployment

Employment can significantly influence mental, physical and social health (CPHA, July 1996). Paid work provides not only money, but also a sense of purpose and identity, social status and connectedness, and opportunities for personal development and growth. There is a strong link between the loss of these benefits and adverse health outcomes (CPHA, July 1996).

Many studies have shown an association between unemployment and increased mortality rates. The most commonly-studied causes of death are cardiovascular disease and suicide. The editor of the *British Medical Journal* noted that "the evidence that unemployment kills—particularly the middle-aged—now verges on the irrefutable" (CPHA, July 1996).

The unemployed are also more likely to develop physical and mental disorders. An examination of the 1978–79 Canada Health Survey results found unemployed Canadians reported worse levels on seven of 12 measures of self-reported health status: psychological distress, anxiety or

depressive symptoms, short-term and long-term disabilities, and the number of current health problems, hospitalizations, and visits or phone calls to physicians. Moreover, households with lower education and incomes are most likely to suffer job or income loss independent of the unemployment rate. Thus, existing inequalities in society, rather than general economic conditions, may be strong determinants of adverse health consequences (D'Arcy, 1986).

Most research has focused on male wage earners and looked at women primarily as spouses of jobless men. However, Canada Health Survey results indicate that unemployed women had, on average, worse levels of anxiety, depression and self-rated health status, and made more visits to physicians (D'Arcy, 1986).

Unemployment affects more than just the individual; spouses, children and others in the family network can also suffer adverse effects. In one British study, parental unemployment doubled the risk of young children being admitted to hospital; poverty was an important determinant (Jin et al., 1995: 17). Children whose parents are unemployed may lack access to basic necessities such as adequate food and clothing, may suffer depression or other illnesses, and may exhibit behavioural problems or have difficulty coping at school (Kirsh, 1992: 5).

Considerable research has been undertaken on the health-care and other social costs of unemployment. According to one estimate, the total annual cost of health care attributable to the unemployment level in March, 1993—officially 12.3 percent—was \$845 million. The economic impact on society was \$109 billion in lost wages, profits, and taxation revenue, unused human resources and the lack of additional work generated through employment (CPHA, July 1996).

Policy Implications: Education, Skills Development and Work

Policy makers need to examine the importance of lifelong learning, along with investments in education, on-the-job training and skills development. These components can not only

enhance the ability to cope in a changing workplace; they can also improve an individual's sense of capability and self-esteem. All these factors affect health, and, in turn, a healthy and productive workforce. Learning begins at birth, and early childhood education programs to compensate for the effects of poverty are one aspect of lifelong learning. Other areas include the relevance of school and education policies to both students and employers, the problem of school drop-outs and literacy policies.

On-the-job training, one feature of a healthy workplace, is another factor. This form of training can do more than just target narrow ranges of skills for particular job slots. It can also focus on language and literacy, life skills and portable work skills that can be used, within or outside a given company.

Health and safety education is crucial. Full employment is another factor, along with the issue of personal meaning and security for those unable to find employment. Technical competence is important in the changing world of work, as is creativity and the ability to use written information at work and in daily life. The availability of high quality child care is a major issue for low income parents in the paid labour force.

3.3 Supportive Social and Physical Environments

In all societies, there are barriers that prevent or hinder access to supportive environments that can positively influence health and well-being. Canada has received international recognition as a leader in the quality of social environment enjoyed by its citizens, but all segments of the population do not share equally in this achievement. Many groups are without access to the social support that could help them achieve even a fraction of their full health potential. Others, such as some street and Aboriginal populations, live in conditions that are hazardous to health, even by Third World standards.

In this section, we examine some barriers to supportive environments and their associated health effects. This is not meant to be a comprehensive listing; the intent is to focus on selected areas to illustrate the nature of the

challenge and identify policy domains for future action.

Homelessness

Adequate, secure shelter is one of the most basic of human needs, but for many Canadians, homelessness seriously harms their health and well-being. Despite a number of enumeration attempts in the last few years, no one knows for sure just how many Canadian citizens are homeless. The Canadian Council for Social Development Survey undertaken in 1986 estimated that between 130,000 to 250,000 people did not have homes or had housing that was grossly inadequate (Begin, 1994: 1). According to the Toronto Coalition Against Homelessness, approximately 25,000 people were homeless in Metropolitan Toronto in 1996, double those in 1984 (Toronto Coalition Against Homelessness, 1996).

The modern concept of homelessness goes well beyond living without a roof over one's head. The United Nations General Assembly for the International Year of Shelter for the Homeless (1987) recognized two kinds of homeless people: those who have no homes, and those whose homes do not meet basic standards including adequate protection from the elements; access to safe water or sanitation; secure tenure and personal safety; access to employment, education, and health care; and affordable prices (Begin, 1994: 2).

The homeless include people who are on the street and require refuge for a night, such as runaways; those in crisis who need shelter for a limited period, such as women who have left abusive husbands; and those who are without shelter for financial or other reasons (SARC, 1988: 68-69). The homeless also include persons who, due to the difficulty of finding affordable housing, live in substandard accommodation.

The face of homelessness has changed dramatically over the last few years. It used to be associated with images of middle-aged, socially marginal alcoholic men sleeping on park benches, in doorways or under bridges. The homeless now include able-bodied young people lacking marketable employment skills, runaways, the elderly, discharged psychiatric patients, women and children who have fled domestic

violence, families and single mothers on social assistance, and the working poor who cannot find adequate and affordable housing (Begin, 1994: 1). Increasingly, families with children are included among the homeless and the population itself, like the Canadian population, is aging.

While the underlying causes of homelessness are complex, a consensus has emerged that homelessness is related to unemployment and lack of affordable housing rather than factors linked to individual failure (Begin, 1994: 1).

HEALTH IMPACTS

Homelessness

The homeless suffer poorer health status on almost any measure. They experience greater vulnerability to respiratory diseases, bacterial and viral infections and are likely to suffer from poor circulation in the legs, leading to swollen legs and feet, and eventually cellulitis, skin breakdown, and ulceration (Dennis et al., 1991: 819). Frostbite or hypothermia is a serious threat to people living on the streets in Canadian winters, especially those who are very young or very old (WHO, 1989: 14).

The physical health problems faced by the homeless are often compounded by mental health problems. Elements of daily life for the homeless, such as a lack of privacy, the "uncertainty of shelter, excessive noise, the struggle for survival, the fear of crime and other threats to physical security, squalor, physical discomfort and the ugliness of the surroundings are frequent sources of psychological stress." (WHO, 1989: 10).

Families that are homeless and living in temporary shelters can experience special health difficulties. For instance, mothers and children who stay in one room for more than eight hours a day have been found to be prone to diarrhea and vomiting (Smith, 1989: 17). Chest infections, which are "the most common cause of death in children between the ages of one and fourteen years" are a special risk for children of homeless families (Furley, 1989: 14). Moreover, children who are less likely to be immunized or receive preventive health care and who live in cramped areas with other children are at increased risk of contracting viruses and diseases (Furley, 1989: 16; Smith, 1989: 17).

Generally speaking, homelessness in childhood can contribute to forms of ill-health that are not apparent until later years (Furley, 1989: 6). An increased incidence of hospital admission, as well as higher mortality and morbidity in later life, has been associated with poor housing in childhood (Furley, 1989: 6). Delays in childhood development have been found, particularly in speech, learning, walking and normal weight gain (SARC, 1988: 69).

Pregnant women who are homeless are twice as likely to “experience difficulties in pregnancy, and three times more likely to be admitted to hospital during pregnancy than their housed counterparts” (Smith, 1989: 17). These women are also much more likely to give birth to low birthweight babies and to experience postnatal and clinical depression (Smith, 1989: 17). The homeless over age 65 have higher rates of tuberculosis than younger homeless individuals; the former are also vulnerable to osteoporosis (especially women), diabetic foot ulcers, arthritis and dental problems (Rich et al., 1995: 48).

These health problems are intensified by both the under-availability of health services to homeless people, and their under-use. Many family doctors resist listing the homeless as patients and some hospitals refuse specialist services to persons with no fixed address. Not surprisingly, many homeless people finally seek medical attention in hospital emergency departments (Smith, 1989: 60-62). For others, the stigma of homelessness can prevent them from seeking medical attention.

Violence

Violence in Canada is a widespread problem that affects the health and well-being of families, women, children, youth and seniors in all economic, social, geographic, racial and cultural groups. Violence includes acts that are random and spontaneous as in a lashing out in rage, as well as systematic, planned acts calculated to overpower and control. Violence touches each of us and takes more forms than physical blows or wounds. It includes sexual assault, neglect, verbal attacks, insults, threats, harassment and other psychological abuse that can have more serious consequences for the victim than physical injury. Another significant form of violence is the abuse of trust or power by persons in positions of authority (CPHA, 1994: 11).

Women

Women are at higher risk of violence than men. Women experience higher rates of physical and sexual assaults by partners or acquaintances (i.e., date rape) and are more subject to psychological abuse. An estimated 25 percent of young women in high school have experienced date rape (Mercer, 1987).

Other studies suggest that family violence affecting women is more common in Aboriginal communities than in other communities. Aboriginal people do not approach the problem in terms of an offender-victim relationship; rather, they see the need for social healing directed to the entire community and network of family and friends surrounding those whose lives have been affected by violence (Health Canada, 1993: 2).

For women who are assaulted, isolation is a fact of life. For immigrant and refugee women, in particular, this isolation is compounded by language and cultural barriers—in some instances racism—and the fact that many of these women are far away from their friends and extended families (MacLeod & Shin, 1990: 7).

Some women in abusive situations find themselves ostracized for reporting the violence. There is little help available in the area of culturally sensitive and appropriate protection services. Moreover, certain immigration laws have actually increased the vulnerability of women to violence. For example, a woman sponsored under the Immigration Act who is abused by her partner and reports the abuse can find herself facing deportation rather than receiving protection. In cases where children are involved, she can be deported without them (National Action Committee on the Status of Women, 1993: 55).

Children and Youth

Many children and youth are exposed to violence and abuse within their families. Adults may think violence in the home can be hidden, but most children are aware of spousal violence (Statistics Canada, 1994). At least half of the children of women who have been attacked by male partners have witnessed the assault.

Children are also themselves the victims of abuse and neglect, although the absence of national

statistics makes it difficult to develop a national picture of the problem. What is known is that the majority of all violent crimes (43 percent) against children are sexual in nature and that sexual assaults are more often perpetrated on young girls than boys (Statistics Canada, 1995: 1).

There is a general public perception, encouraged by media reports, that violent youth crime is increasing dramatically and has reached crisis proportions. Yet most youth crime is property-related and is not violent (Department of Justice, 1996).

Literature in this field has identified child poverty, school failure and other blocked opportunities for youth as major risk factors for young males becoming persistent offenders (MacLeod, 1993: 1). Criminologists generally accept that potential for persistent offending increases as more families live below the poverty line; more children experience school problems and drop out, and more families fail to provide consistent care for children. The relationship between poverty and crime, however, is complex and unpredictable. The vast majority of poor people do not become criminals, and not all criminals come from impoverished backgrounds. Poverty nonetheless tends to exacerbate many of the other risk factors associated with delinquency (Department of Justice, 1996).

Seniors

Older Canadians are not immune from violence. But as the problem of elder abuse has only recently come to public attention, there are few statistics on its prevalence. Even available figures are likely to be understated as victims of abuse are reluctant to seek help (National Clearinghouse on Family Violence, 1993: 1). However, one study estimates that approximately 98,000—or four percent of seniors 65 years of age or over—suffer some form of elder abuse (Podnieks et al., 1989: 54).

The physical abuse of seniors includes assaults, rough handling or sexual abuse and the withholding of physical necessities such as food, personal care, hygienic care or medical care. Verbal assaults, social isolation, lack of attention or denying seniors a chance to be involved in decision-making are all forms of psychological abuse. Many seniors may be vulnerable because

of frailty, poor health, or financial or emotional dependency on their abusers.

H E A L T H I M P A C T S

Violence

All forms of violence have damaging short- and long-term effects on mental, physical and spiritual well-being. Victims of violence may experience extreme guilt and self-blame, acting-out, delinquent behaviour, self-abusive behaviour and suicidal tendencies. Over the longer term, victims may exhibit poor self-esteem, depression, difficulty in interpersonal relationships, feelings of isolation and stigma, and a tendency toward re-victimization (National Clearinghouse on Family Violence, 1990: 2; 1993: 2-3).

The effects of violence often depend on the life situation of the victim. Family violence frequently begins or escalates during pregnancy or the post-partum period. Two well-documented adverse outcomes are low birthweight and spontaneous abortion (Modeland et al., 1995: 4-9). Childhood trauma and sexual violence can manifest themselves through substance abuse and self-abusive behaviour or eating disorders such as bulimia and anorexia. Victims of rape and child abuse are more likely to become dependent on drugs and alcohol and are more likely to attempt suicide (Canadian Panel on Violence Against Women, 1993: 36-37).

Research on spousal abuse suggests that witnessing violence against one's mother increases the likelihood that a female child will, as an adult, be involved in an abusive relationship herself, and that a male child will, as an adult, be violent towards his spouse (Department of Justice, 1996). Child witnesses to violence often suffer from low self-esteem and a lack of self-confidence, feel fearful and vulnerable, and may have feelings of guilt and responsibility for their mother's suffering (Jaffe, Wolfe & Wilson, 1990; Hughes, 1986). Child witnesses may also come to believe that violence is an acceptable way for men to relate to women and to resolve conflict (National Clearinghouse on Family Violence, 1992: 1; Ristock, 1995). Serious behaviour problems are 17 times higher for boys and 10 times higher for girls who have witnessed battering (Wolfe et al., 1995).

It is often extremely difficult for people to recover from the effects of violence. A recent Canadian Mental Health Association study identified important attitudinal and structural barriers to healing (Ristock, 1996):

- ▶ willful ignorance surrounding abuse: “don’t ask, don’t tell;”
- ▶ feelings of shame, guilt and despair;
- ▶ stigma and blame associated with being a victim;
- ▶ myths that violence is a function of the victim’s social group;
- ▶ support services which deter victims from seeking help;
- ▶ physically inaccessible buildings and linguistic and cultural barriers;
- ▶ inconsistency in dealing with issues of violence.

The negative impact of violence affects not only the individual but the community and society. Both levels of damage must be addressed in order to create true healing.

Systemic Discrimination

Systemic discrimination is more prevalent in Canada than many would believe. It can affect a wide range of minority groups and have a serious impact upon social conditions associated with health status. This section focuses on minorities that have traditionally experienced systemic discrimination.

Sexual Orientation:

Lesbians, Gays and Bisexuals

For many lesbians, gays and bisexuals, systemic discrimination based on sexual orientation can be a major barrier to a health-enhancing, supportive environment. Popular television shows, magazines and movies have recently demonstrated ‘acceptance’ of sexual minority lifestyles in portrayals of the lives of lesbians, gays and bisexuals, but this apparent change belies a much deeper level of discrimination and homophobia that runs throughout Canadian society—in the home, schools, the workplace, the legal system and the health care system. To be openly gay, lesbian or bisexual in Canada still means running the risk of losing one’s job or custody of one’s children, experiencing open or implied hatred, or in some instances, physical violence.

Homosexuality is still seen as deviant, despite the vast majority of scientific opinion that same-sex orientation is not a choice, nor is it something that can be changed (Simpson, 1994: 11). Public support for lesbian, gay and bisexual rights is mixed; in 1995, Canadian support for equal rights was 67 percent, down from 80 percent in 1990 (Holland, 1996: 3).

Schools often ignore issues of sexual orientation, implicitly supporting negative stereotypes (Holland, 1996: 10). “For those children who reveal their same-sex attraction, school often means a place for verbal and physical abuse from teachers and fellow students, and other homophobic practices that undermine their ability to learn and frequently cause them to drop out of school altogether” (Uribe & Harbeck, 1992: 14).

Despite some positive indications of change, the currents of systemic discrimination identified by the Parliamentary Committee on Equality Rights more than 10 years ago continue to run deep. Important social and legal challenges that remain include: barring the right to fire someone because s/he is lesbian, gay or bisexual, and expanding the definition of spouse as partners of the opposite sex, thus granting gays and lesbians access to spousal, tax and other benefits. Progress has been made, but Canada still has a long way to go before gays, lesbians and bisexuals can take their place openly in society without fear of discrimination.

H E A L T H I M P A C T S

Sexual Orientation

For many gays, lesbians and bisexuals, homophobia is a barrier to high quality and appropriate health care. Respondents to a Project Affirmation survey provided stories of being sexually assaulted, misdiagnosed and subjected to verbal abuse that they attributed to their sexual orientation. Project Affirmation notes: “Lesbian, gay and bisexual [health care] consumers face an important choice in deciding whether or not to tell their doctors of their sexual orientation. They may choose to come out, hoping to receive more comprehensive and appropriate services in issues connected with their sexuality, their partners, or other circumstances in their lives. However, if they come out and the reaction is negative, consumers may fear that this will negatively affect their treatment” (Project Affirmation, 1996: 24-31).

The following examples illustrate some specific health barriers, concerns and conditions experienced by gays, lesbians and bisexuals.

- ▶ Homophobia and heterosexism effectively isolate many gay and lesbian youth from familial and cultural support (Magnuson, 1992: 14). As a result, suicides among lesbian, gay and bisexual youth are more frequent than among the general population.
- ▶ While hate crime statistics do not provide an accurate picture of the violence and abuse experienced by gays, lesbians and bisexuals, the figures do indicate the seriousness of these crimes. Violent crimes against gays and lesbians involve a greater degree of injury than the average assault (Roberts, 1996).
- ▶ Internalized homophobia, or self-hatred, can be one of the reasons for not practising safer sex all of the time, exposing gays, lesbians and bisexuals to more sexually transmitted diseases (Canadian AIDS Society, 1995: 1).
- ▶ Lesbians, gays and bisexuals have been denied involvement by hospital personnel in significant decisions regarding their partners.
- ▶ A survey of 33 Canadian fertility clinics showed that 19 refused to provide services to lesbians (Holland, 1996: 4).

Diverse Multicultural Society

Prior to World War II, most immigrants to Canada came from Europe. In the last few decades, most newcomers have arrived from non-European countries, adding to the nation's cultural and ethnic diversity. Today, a large proportion of immigrants belong to visible minority groups.

This shift in immigration is expected to continue and will dramatically alter the demographic make-up of the country. By the year 2007, the percentage of visible minorities is predicted to increase to 17.7 percent of the Canadian population. At the turn of the century, approximately one-half of the Toronto and two-fifths of the Vancouver population will be made up of visible minorities. Montreal, Edmonton, Calgary, Winnipeg and Windsor can expect one-fifth to one-quarter of their

populations to be visible minorities (Samuel, June 1992: 4-5).

Certain negative social and economic conditions have a disproportionate impact on visible minorities. For example, unemployment and underemployment are generally higher among visible minority communities. Many immigrants and refugees who have foreign educational, professional and trade credentials find their qualifications are not recognized in Canada (House of Commons, 1995: 25).

Language can present a barrier to full participation in society. The lack of facility in one official language or the lack of social supports in languages other than English and French can cause social isolation, create difficulties integrating into Canadian society, result in a lack of privacy as information is communicated through an interpreter, and prevent the communication of important information. The inability to function in either English or French can also be an obstacle to receiving needed medical care and services.

HEALTH IMPACTS **Diverse Multicultural Society**

Different cultural health beliefs and practices may be barriers to visible minorities, immigrants and refugees using Canadian health services. Some cultures view health issues differently, e.g., mental health problems, physical disability, female genital mutilation, birth control, abortion, sexual assault, and physical and mental abuse. Many cultures believe and practise less intrusive health care, such as the use of traditional medicines and herbal remedies, massage and acupuncture. There may be a different appreciation of privacy and modesty for cultural and religious minorities (Ministry of Health, Ontario, 1993: 4). In the case of breast and pelvic examinations, for instance, some immigrant women may not wish to present for examinations, especially to a male doctor.

Visible minority women who are poor may feel trapped in abusive relationships as there are still few programs and services that are accessible and appropriate to them. Immigrant and refugee women, and seniors who depend on their husband or family's immigration status to be in Canada, must rely on their cultural community

for most, if not all, of the social support. They can find it extremely difficult to leave abusive relationships.

There is a long history of racism and discriminatory attitudes towards Aboriginal peoples and other visible minorities in Canada. According to the 1988 Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, “the basis for much of the mental health problem in Canada is a moderate, systemic racism throughout our society. To be sure, it is not as blatant or as extreme as in the past. Even so, the racism that lingers is still powerful enough to place visible minority people under the pressure of always being on watch for the hard edge of prejudice and discrimination.”

Policy Implications: Supportive Social and Physical Environments

The human rights domain encompasses policies that have a major influence on supportive social and physical environments. People have the right to live and work in communities where they feel accepted, safe and secure. Without this support, many groups will have difficulty achieving their full health potential.

Communities are a major component of the human rights policy domain. They can provide safe environments, support the rights of citizens, and enable their members to share information to increase their sense of awareness and acceptance. To achieve this level of security, it is essential to develop supportive communities. Income tax provisions to support voluntary organizations within communities should also be examined.

Other policy areas include services for the homeless to provide safe shelter. Causes of

homelessness, including unemployment and the lack of affordable housing, should also be examined, and policy makers need to consider ways to ensure that individuals and families can have their essential needs for shelter, privacy and security met. Those in crisis, for example, women fleeing abusive spouses, need emergency shelter. Poor Canadians require high quality, affordable housing. Decision makers should take steps to help those who are experiencing family violence by ensuring the presence of support measures such as transitional housing.

Community agencies and organizations need to examine their biases and how these affect the services they provide. Some organizations are starting to address discrimination on the basis of sexual orientation. Health care professionals are recognizing the particular needs of gays, lesbians and bisexuals, workplaces are offering same-sex benefit plans, and in some jurisdictions, the number of police hate-crime units available to investigate reports of violence and harassment against sexual minorities is being increased. In some provinces, landmark legal decisions are being made regarding the rights of lesbians and gays to receive bereavement leave and adopt children.

Within the school system, there is a growing awareness of the problem of discrimination and its links with violence. Increasingly, educators are identifying issues such as racism, homophobia and sexism as key elements leading to violence, and are working with students to encourage more tolerant attitudes. Culturally sensitive services and access to these services are important. A related issue is the need for services to help immigrants now settling in Canada. Policies governing access to French and English training for immigrants should be improved along with hiring practices for immigrants by industry and the professions.

Section 4.0

Looking to the Future

Economic and social conditions clearly have a powerful and pervasive impact on health. Our understanding of this relationship is incomplete as yet, and likely will remain so for some time, but knowledge has advanced sufficiently to begin to shape the policy development process.

One of the clearest directions to emerge from the data concerns income distribution. The evidence shows conclusively that reducing relative poverty and narrowing income distribution are likely to have a much greater effect on improving well-being than increasing aggregate wealth. A strong, healthy economy is required to generate the wealth required for effective redistribution policies. But this redistribution is crucial; we now know that in modern, wealthy societies, well-being is associated more with relative income than growth in overall, average wealth.

The evidence also speaks persuasively to the powerful influence of the social environment on health. Modern, industrialized societies appear to have passed a watershed in reducing health inequities. Social factors associated with supportive environments are equally as important as material conditions in determining health. In developed countries, the quality of the social fabric has become of predominant importance in determining health status and the quality of life. In effect, good health is ultimately a reflection of societal values.

A major challenge for the public health community will be to broaden the parameters of the health policy debate to include economic and social issues. As pressure builds for more cost/benefit assessments of currently funded health care activities, a broader range of potentially health-enhancing public policies must be included in the analysis. Mechanisms must be put in place to evaluate the health impacts of public policy, particularly in the face of reduced fiscal resources. Public health must assume a leadership role in advocating for social change.

The knowledge base for development and implementation of social and economic policies that could have a positive impact on reducing health inequities is in place. The next step will be to develop innovative policy tools that can translate this knowledge into action.

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Note: A more detailed bibliography on issues related to this discussion paper is available on request from CPHA.

Appendix C Endnote

- 1 There are two basic approaches to defining poverty. The absolute or subsistence approach is based on the belief that a measure of poverty can be established by setting out the essentials required for basic survival. An absolute measure is usually determined through a 'market basket' approach in which the basic requirements for daily living are itemized and costed.

The relative approach to poverty, by contrast, takes into account social as well as physical well-being. It establishes poverty lines in relation to average income or living standards; poverty is defined more broadly as inequality rather than lack of the basic necessities of life.

Although there is no official measure of poverty in Canada, we use Statistics Canada's low income cut-offs in this report because they are the best known and most widely employed of all available poverty measures. The low income cut-offs are a somewhat complicated mixture of the absolute and relative approaches to defining poverty. The low income cut-offs are absolute in that they are based on expenditures on the basic necessities of food, clothing and shelter. They are relative in that they are set at income levels where people have to spend substantially more than average on the necessities of life.