Increasing poverty threatens the health of all Canadians

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It is one of the greatest of contemporary social injustices that people who live in the most disadvantaged circumstances have more illnesses, more disability, and shorter lives than those who are more affluent.[1]

The profound improvements in Canadians' health in the past century are primarily due to advances in living conditions and physical and social environments. Improved health care also played a small (estimated at 10%) but important role. Yet, wide disparities in health continue to exist among Canadians and to persist despite access to health care.[2]

Lifestyle choices do not explain disparities in health. Lifestyle issues, such as tobacco and alcohol use, body mass index, and activity account for a rather small proportion of variation in mortality rates. The factors that actually account for most of the variation are called social determinants of health.[3] Health Canada lists these factors as income and social status, social support networks, education, employment and working conditions, and physical and social environments.

This editorial focuses on the health effects of poverty, which profoundly affect the presence and quality of many of these health determinants.[4]

Poverty and its effects on health

In this editorial, poverty is defined as living with a pretax income below the Low Income Cut-Offs established by Statistics Canada. These cutoffs—based on family and community size—identify people living in "straitened circumstances." To live in poverty means to lack the material resources that allow meaningful participation in society rather than to have enough merely to survive.[5]

By 1996, the Canadian poverty rate rose to 18%, and the children's rate reached a 17-year peak of 21%. In the wealthiest Canadian province, Ontario, the children's poverty rate rose from 11% in 1989 to 20% in 1996; 38% of Toronto's children now live below the income cutoffs. Latest figures indicate a slight improvement in national and provincial poverty rates.[6]

Canadians, Britons, and Americans in the lowest income groups have a higher incidence of a range of diseases and likelihood of death from illness or injury at every age.[7] Poor children in Canada have a higher incidence of illness and death, hospital stays, and injuries; more mental health problems; and lower levels of school achievement.[8] It is conservatively estimated that 22% of premature years of life lost in Canada can be attributed to income differences, about the same number attributed to heart disease or cancers.[9]

How does poverty affect health?

Poverty prevents people from achieving the prerequisites for health, such as shelter, food, warmth, and the ability to participate in society. Living in poverty also causes the anxiety and stress associated with uncertainty that can damage people's health. Lack of income precludes people from making the kinds of behavioural choices that support health.[1]

Poverty makes people vulnerable to material and social insults that accumulate over a lifetime. Periods during which people's health is especially vulnerable to these disadvantages include fetal development, childhood (where good nutrition and health would contribute to growth), entering the labour market, job loss or insecurity, and episodes of illness.[10] Those in poverty also lack control over life circumstances, a factor that predicts illness, and are distressed over their lack of material resources.[11]

The widening gap study

A recent British study[12] defined the parameters of poverty's influence on health. Using premature mortality rates (death before age 65) the 15 "worst health" and 13 "best health" constituencies in Britain were identified. The 1 million people in the worst health areas had a 2.6 greater mortality rate than those in the best health areas. Health

differences were seen as resulting from an accumulation of material disadvantages reflecting various economic and social life circumstances.

Striking differences in health were seen in rates of infant mortality, school failure, postschool qualifications, unemployment, disability, and long-term illness. A key finding was that the magnitude of health inequalities increased over time in response to increasing income disparities. Health differences systematically widened in Britain—paralleling increases in income inequality—over 20 years of Conservative party rule.

Findings that "Childhood and adult social circumstances make independent contributions to the risk of dying" indicate that the health consequences of children and families living in poverty will be manifest for the entire next generation in Britain.[13] To extrapolate, the magnitude of increases in child and family poverty in Canada poses substantial population health risks and threatens the viability of the health care system.

Social safety nets weaken as poverty increases

Poverty increases as social safety nets are removed. In Canada, government policies of reducing program spending, decreasing eligibility for benefits, and reducing amount of benefits served to both increase the incidence of poverty and remove the means by which those in poverty sustain themselves. Canada has been in the midlevel of nations in spending on social safety nets. The move toward reduced spending on services and supports coincided with an increase in levels of poverty.[14]

Poverty effects spill over to the whole population

The *British Medical Journal* editorializes: "What matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed the better the health of that society."[15]

Societies with higher poverty rates have higher mortality rates across the entire population. For example, after decades of rapidly increasing economic inequality, even the richest people in Britain now have higher adult male and infant mortality rates than the poorest people in Sweden.[16] Also, the richest people in economically unequal American communities have more health problems than the richest people in relatively economically equal communities.[17] This spillover effect is due to the weakening of social infrastructure and declines in social cohesion and civic commitment.

Canadian mortality rates in 1991 were strikingly lower than those in the United States as was degree of income inequality.[18] But economic inequality and poverty are increasing in Canada. **Table 1**[19-21] shows the cumulative effects of various social policy orientations on population health by illustrating Canada's rank on a number of health determinants and outcomes compared with a nation with a market (United States) or welfare state (Sweden) orientation.

Table 1. United States, Canada, and Sweden rankings on various indicators of population health compared with other industrialized nations: *1 is most positive rating.*

MEASURE	CANADA	UNITED STATES	SWEDEN
Income inequality (1992)	11 of 18	18	3
Child poverty (1996)	17 of 23	22	1
Elder poverty (1990)	4 of 17	15	5
Wages (1996)	15 of 23	13	6
Unemployment (1996)	7 of 10	2	8
High school drop-outs (1996)	16 of 17	17	10
Youth suicide (1992 to 1995)	16 of 22	15	10
Youth homicide (1992-1995)	19 of 22	22	5
Infant mortality (1999)	10 of 29	17	2
Life expectancy (1999)	3 of 50	21	3

Data from UNICEF,[19] Miringoff and Miringoff,[20] and US Census Bureau.[21]

Physicians' responses to poverty

The *British Medical Journal* editorializes: "Doctors fought nuclear weapons, now they can fight poverty."[22] Public health practice usually limits itself to delivering programs to those in poverty.[23] One exception is the Montreal Medical Officer's report that stated, "Inequalities in health and well-being can be traced back to socioeconomic inequalities, that is to the harsh living conditions which marginalize so many of our fellow citizens, not only limiting their access to essential

goods, but depriving them as well of any meaningful role in social life."[24]

In 1995, the Canadian Medical Association's (CMA) Board of Directors stated, "Governments should give high priority to public policies that take account of the broad range of determinants of health, and proposed legislation should be routinely reviewed for any impact on the health of individuals and the community."[25] A number of resolutions were passed in CMA Council during the early 1990s regarding the health effects of poverty, but follow up with the CMA revealed little resulted from these motions.

The Canadian Paediatric Society recently called for government action to address poverty, also with little result: "The health problems associated with poverty include a greater likelihood of low birth weight, inadequate nutrition, poor school performance, injuries, disabilities, and even death. This all contributes to increased insecurity, stress and social isolation—all factors that have a profound impact on the emotional health of children."[26]

At St Paul's and Mount Saint Joseph hospitals in Vancouver, BC; St Michael's and St Joseph's hospitals in Toronto, Ont; and Montreal Children's Hospital in Quebec, family medicine has recognized the importance of poverty as a health issue. The Ontario College of Family Physicians reported on *Access to Health Care for the Marginalized: A Challenge for Family Medicine*,[27] and the College of Family Physicians of Canada was involved in the *Removing Barriers II: Keeping Canadian Values in Health Care*[28] initiative. These efforts could be supplemented if family physicians and their associations encourage further development of inner-city health care initiatives and develop models of care that better respond to people in poverty.

Focusing upstream

Family physicians and their associations can also help make policy makers aware of how their decisions can either increase or decrease poverty. They can encourage policy dialogue at local, provincial, and national levels on the health effects of poverty.

A range of policy options is available from Canadian and British sources on how to address poverty. The Canadian Growing Gap report[29] calls for restoring funding to social and health services, assuring a fair taxation system, and increasing financial and other supports to those in poverty. The British Acheson Inquiry[30] has many recommendations for reducing poverty. The main theme is monitoring the effects of government policy decisions to assess how they contribute to creating inequalities in resources among citizens.

Conclusion

In Canada, policy decisions are being made that affect the health of the population. Empirical evidence suggests looking to Scandinavian and other European nations for ideas on how to address health determinants, such as poverty. Yet our leaders seem to be looking to the United States for answers. Are family physicians in Canada prepared to join in these policy debates?[31]

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