Poverty, Income Inequality, and Health in Canada

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Abstract

An overview of the impact of poverty and income inequality on the health of Canadians is provided. Increasing poverty is seen to go hand-in-hand with increasing income inequality. Both poverty and income inequality result from governmental social and economic policy decisions. Poverty is also increased by weakening of social safety nets and other supports. Documentation is provided of the growing incidence of poverty and income inequality and how both of these impact upon the health of Canadians.

Poverty directly harms the health of those with low incomes while income inequality affects the health of all Canadians through the weakening of social infrastructure and the destruction of social cohesion. Recommendations for addressing increasing poverty and income inequality are provided. It is emphasized that reducing poverty and income inequality should be grounded in an approach that recognizes the importance of citizen participation and civic involvement.

Poverty, Income Inequality, and Health in Canada

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 (Benzeval, Judge, & Whitehead, 1995, p.1).

Overview and Purpose

The purpose of this paper is to consider the issue of poverty, income and health in Canada. This analysis is based on what are termed the social determinants of health (Marmot & Wilkinson, 1999; Wilkinson & Marmot, 1998). This literature links health outcomes to how societies are organized and resources allocated. And one of the most important societal factors related to health appears to be the degree of poverty present within a jurisdiction (Reutter, 1995; Haines & Smith, 1997; Warden, 1998). After considering the evidence concerning the incidence of poverty in Canada, I examine how poverty is linked to poor health. I will argue that the health consequences of the growing levels of poverty in Canada are profound and will be longstanding whatever efforts may eventually be made to reduce its incidence. Finally, I present means by which poverty could be reduced were the political will to do so present (Yalnizyan, 2000).

Why Be Concerned about Poverty and Health ?

It has been known for many decades that the profound improvements in health in Canada and other industrialized countries have primarily been due not to advances in medicine or health care but rather in the kind of societies in which we live. As one illustration, the most profound causes of the reduction of deaths from infectious diseases such as typhoid, influenza, and diphtheria were not implementation of immunizations or medical cures but rather improvements in general living conditions (McKinlay & McKinlay, 1987).

More recently, it has been hypothesized that lifestyle differences are the source of population differences in the occurrence of heart disease, stroke, and cancer. But careful studies have indicated that most of the variation among individuals in health cannot be accounted for by lifestyle factors alone (Marmot, 1986) suggesting that lifestyle issues are embedded within broader factors that predict illness and death.

What might these factors be?

The *Ottawa Charter for Health Promotion* (WHO, 1986) identifies prerequisites for health as being peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Health Canada (1998a) has outlined income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services as key determinants of health. British workers have identified the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport as key determinants of health (Marmot & Wilkinson, 1999; Wilkinson & Marmot, 1998). It is obvious that poverty is a key factor underlying whether these determinants of health can be attained.

> *Poverty can affect health in a number of ways. Income provides the prerequisites for health, such as shelter, food, warmth, and the ability to participate in society; living in poverty can cause stress and anxiety which can damage people's health; and low income limits peoples' choices and militates against desirable changes in behaviour.* (Benzeval, Judge, & Whitehead, 1995, p.xxi).

In this paper I focus upon poverty and its effects on health. Elsewhere I have examined the role that economic inequality plays in both creating poverty and weakening the social structures that support the health of all Canadians (Raphael, 1999; Raphael, 2001). The increases in poverty among Canadians demands that specific attention be devoted to the health effects of poverty. This exploration is assisted by Hurtig's (1999) and Townsend's (1999) recent volumes that brought together the most recent evidence concerning the incident and causes of poverty in Canada. Hurtig's analysis however, did not focus on the health consequences of increasing poverty and Townsend did not integrate

recent work on the health effects of poverty across the life-span. In this paper I draw upon numerous studies that document both the short and long-term health effects of poverty (Gordon, Shaw, Dorling, & Davey Smith, 1999; Pantazis & Gordon, 2000; Shaw, Dorling, Gordon, & Davey Smith, 1999).

Poverty and Its Effects on Health

In this paper, levels of Canadian poverty are defined as the percentage of Canadians living with incomes below the *Low Income Cut-Offs* established by Statistics Canada (National Council on Welfare, 1998). These cut-offs are based on family and community size and identify individuals living in "straitened circumstances." Williamson & Reutter (1999) recently carried out a careful analysis of the usefulness of such cut-offs for defining poverty. Their analysis reached a conclusion that it is essential that poverty be defined not in terms of having enough material resources to merely survive, but rather having enough resources to participate in society in a meaningful way. Peter Townsend provides a useful definition of poverty as follows:

> *People are deprived if they cannot obtain, at all or sufficiently, the conditions of life – that is, the diets, amenities, standards and services – which allow them to play the roles, participate in the relationships and follow the customary behaviour which is expected of them by virtue of their membership in society. If they lack or are denied the incomes, or more exactly the resources, including income and assets or goods in kind, to obtain access to these conditions of life they can be defined to be in poverty.* (Townsend, 1993, p. 36).

By 1996, the poverty rate in Canada had risen to 18% from 16.6% in 1986 (Centre for International Statistics, 1998), and child poverty reached a 17-year peak of 21%. Child poverty has become a focus in Canada and by 1996, 1.5 million Canadian children lived in poverty, up from 934,000 in 1989 (Campaign 2000, 1998; Statistics Canada, 1998). The most recent statistics from the 1996 Census indicates that provincial child poverty averages ranged from a low of 18.5% in Prince Edward Island to a high of 26.2% in Manitoba.

Ontario, the wealthiest Canadian province in terms of Gross Personal Product, experienced an increase in child poverty from 11% in 1989 to 20.3% in 1996. These increasing poverty levels are well-publicized with national newspapers such as the Toronto Globe and Mail, carrying numerous reports documenting its increase (Little, 1996; Gadd, 1997; Mitchell, 1997).

No examination of the health effects of poverty can ignore the relationship between economic inequality and poverty. Societies that are economically unequal have higher levels of poverty. My re-analysis of data from the *Luxembourg Income Study* (Raphael, 2001) found that the relationship between degree of economic income inequality within a nation, as measured by the Gini index, with child poverty for 16 industrialized Western nations was strong, positive, and reliable (r=.77).

The effects of poverty on health have been known since the 19th century (Sram & Ashton, 1998). More recently, the issue was heightened by the publication in the United Kingdom of the *Black* and the *Health Divide* reports (Townsend, Davidson, & Whitehead, 1992). These reports documented how those in the lowest employment groups showed a greater likelihood of suffering from a wide range of diseases and having a greater likelihood of death from illness or injury at every stage of the life cycle. Updates on the incidence of and impact of poverty on health within Britain are available (Acheson, 1999; Gordon et al., 1999; Pantazis & Gordon, 2000; Shaw et al, 1999). Indeed, British work on poverty and health is the most advanced among industrialized nations and an excellent source of research ideas and potential courses of action.

Within Canada, Wilkins, Adams, and Brancker (1989) found individuals living within the poorest 20% of neighbourhoods to be more likely to die of just about every disease from which people can die of, than the more well-off. These included cancers, heart disease, diabetes, and respiratory diseases among others. In Canada, data on individuals' social status is not routinely collected at death, so Wilkins and his colleagues used residence census tracts to estimate socioeconomic income level. Even with the inevitable slippage that occurs since some poor people live in well-off neighbourhoods and vice versa, it was conservatively estimated that 22% of premature years of life lost to Canada could be attributed to income differences.

Within Canada, the most cogent presentation of the poor health and poverty association is the *Health of Canada's Children Report* (Canadian Institute on Child's Health, 1994) that documents the variation in health and well-being between poor and not-poor children. Studies summarized in that report defined being poor as receiving social assistance, while in others it was income below the Statistics Canada low income cut-off. Health differences were seen in the incidence of illness and death, hospital stays, accidental injuries, mental health and well-being, school achievement and drop-out, family violence and child abuse, among others. In fact, poor children showed higher incidences of just about any health-related problem, however defined.

A recent study by Ross and Roberts (1999) provides further evidence on the health effects of poverty upon children and families. Using a series of aggregated measures, they report that children in low-income families (annual income < $20,000) were twice as likely (25% compared to 12%) to be living in poorly functioning families as children in high income families (annual income >$80,000). The percentage of children identified as living in poorly functioning families also differed across the socioeconomic range. These differences were also seen for measures of chronic stress among parents, living in substandard housing, living within problem neighbourhoods, having less friendly neighbourhoods, and a very large number of other indicators of health and well-being. Finally, 50% of parents earning <$20,000 rated their children as not being in excellent health; the corresponding figures for those earning >$80,000 was 32%.

How Does Poverty Affect the Health of Poor Adults and Children?

How can poverty-related health differences be explained? In recent British studies (Townsend, Davidson, & Whitehead, 1992) health differences were considered in four ways. Artifactual arguments have been dismissed as many studies have found that poverty usually does not result from poor health but is usually a precursor to it (Wilkinson, 1996). Lifestyle arguments suggested that poor individuals engaged in behaviours that essentially brought illness upon themselves by smoking, drinking to excess, and poor nutritional habits. These arguments, however, are not supported by studies that show that health differences remain even after these lifestyle factors are considered

(Marmot, 1986). Additionally, a lifestyle focus does not consider the societal conditions under which lifestyle differences occur (Travers, 1996).

Materialist arguments appear relevant to understanding of the health effects of poverty. In this view people living in poverty suffer actual material deprivations related to poor diet, housing, and sanitary conditions which contribute directly to poor health. The recent *Taking Responsibility for Homelessness* report (Golden, 1999) highlights some health issues related to the most extreme indicator of low income among Canadians, homelessness, and for those not yet homeless, grossly inadequate housing. Canadian studies have also documented the health-related impacts, including lack of control and feelings of hopelessness, that result from hunger and lack of food (Tarasuk, 1996; Tarasuk & Woolcott, 1994).

Two main schools of thought have emerged concerning the mechanisms by which economic inequality contributes to poor health.

- Kawachi, Kennedy and Wilkinson (1999), in the recently published collection of readings, *Income Inequality and Health,* emphasize psycho-social and social cohesion explanations for health inequities with less attention devoted to material deprivation issues and the role social policy decisions play in supporting health.

- The British authors of the *Widening Gap* however, explain socioeconomic differences in health in terms of how *"...the social structure is characterized by a finely graded scale of advantage and disadvantage, with individuals differing in terms of the length and level of their exposure to a particular factor and in terms of the number of factors to which they are exposed"* (Shaw, Dorling, Gordon, & Davey Smith, 1999, p.102).

The British workers emphasize 13 key critical periods of the life course during which people are especially vulnerable to social disadvantage. These include fetal development, nutritional growth and health in childhood, entering the labour market, job loss or insecurity, and episodes of illness, among others. Material disadvantage and the absence of societal supports during these key periods work against health.

The Widening Gap Study

A recent large-scale British study carefully defined the parameters of how poverty influences health (Shaw, Dorling, Gordon, & Davey Smith, 1999). Using premature mortality rates (death prior to age 65) the authors identified the 15 "worst health" and 13 "best health" constituencies in Britain. The one million Britons in the worst health areas of Britain had a 2.6 greater mortality ratio than the one million Britons in the best health areas. The authors then examined area differences on a wide range of health and socio-economic indicators. Their analysis took place within a life-span perspective whereby health differences were seen as resulting from an accumulation of material disadvantages that reflect widely differing economic and social life circumstances.

Importantly, the authors continued their consideration of how these health inequalities came about by drawing upon an extensive collection of research studies that relate material disadvantage to poor health outcomes. A key finding was that magnitude of health inequalities increases in apparent response to increasing disparities in wealth and income. Adding to the value of their volume is a systematic policy analysis by which government policies were seen as either helping to widen or narrow the health gap. Not surprisingly, analysis revealed that health inequalities had systematically widened in Britain over the 20 years of Conservative party rule.

A life-span perspective was used to document the profound differences in life situation between those living in the best and worst health areas. Striking differences were seen in rates of infant mortality, poverty, school failure, post-school qualifications, social class, unemployment, disability, long-term illness, and home and car ownership. Class and income differences within these areas are described. The authors argued that differences in material social and economic circumstances explained the observed health differences. They drew upon numerous additional studies that document the relationship of material conditions to health. In contrast to psychological arguments by which differences in relative status were seen as leading to poor health, they argued that socioeconomic indicators such as income, wealth, educational attainment and occupational group serve as indicators of material advantage that accumulate over the life-span. Evidence was presented

that material circumstances in early life were much more potent predictors of later health than social position during adulthood. Indeed, the authors state: "Health differences are primarily related to the lifetime material well-being of social groups, not to the psychological effects of positions within hierarchies."(p. 65).

Using both the best and worst health reference groups identified above, as well as additional data from ongoing British studies, a disturbing picture was presented. From 1981 to 1995 standardized mortality rates for the best health areas decreased from 76 to 68 while rates in the worst health areas increased from 155 to 178. These changes paralleled changes in income distribution. The percentage of the British population with below half average income after housing costs increased from 8% in 1977 to 24% in 1995. Deprivation however, was focused: Child poverty levels in the poor health areas increased from 8% in 1981 to 25% in 1991 while in the best health areas the increase was from 4% to 10%.

The authors concluded that the key means of reducing inequalities in health was reducing inequalities in income and wealth. "Poverty can be reduced by raising the standards of living of poor people through increasing their incomes 'in cash' or 'in kind'. The costs would be borne by the rich and would reduce inequalities overall -- simultaneous reducing inequalities in health" (p. 169). They called for changes in tax structure, strengthening of services, improved equity in service delivery, and increasing payments through pensions, disability and social assistance. There appears to be widespread support for this among the British public, yet analysis of New Labour policies indicates that the political will for such action appears lacking.

This and other work suggests that *"Childhood and adult social circumstances make independent contributions to the risk of dying"* (Davey Smith & Gordon, 2000, p.142). Evidence is accumulating that poverty and deprivation during childhood contributes to poor health over the entire course of the life span even if an individual is removed from living in poverty subsequent to childhood. This would suggest that the health consequences of so many Canadian children and families living in poverty will manifest themselves for the entire next generation. And considering the magnitude of the increases in child and family poverty, such consequences are indeed frightening and pose direct threats to the sustainability of the health care system.

Additionally, increasing poverty frequently occurs in conjunction with the reduction of social safety nets (Raphael, 1999; Raphael, 2001). In Canada, government policies of reducing social safety nets, decreasing eligibility for benefits, and reducing the absolute level of these benefits have served to both increase the incidence of poverty and remove the means by which those living in poverty can sustain themselves. This shift has occurred in part as a result of the reorganization of the income tax system by which the well-off have had their tax rates decreased, providing less resources for governments to provide social assistance benefits and social services to those in need.

Canada has traditionally been in the mid levels of nations in spending on the social safety net (Hurtig, 1999); an important determinant of health for all individuals, but especially the poor (Bartley, Blane, & Montgomery, 1997; Montgomery, Barley, Cook, & Wadsworth, 1996). Canada had also been in the mid-level of percentage of tax revenues as a percentage of gross domestic product being allocated to services and supports (Smeeding, 1998). The move of Canada towards decreased spending on services and supports has occurred simultaneously with the increase in levels of poverty (Hurtig, 1999).

Policies that Create Poverty Spill-Over to the Whole Population

It is important to note that the changes in social and economic policy that have been associated with increasing poverty have the potential to negatively affect the health of all Canadians, not just those living in poverty. Wilkinson (1996) brought together much of the research showing that societies with greater poverty have higher mortality rates across the entire population. For example, after decades of rapidly increasing economic inequality, the most well-off in Britain now have higher death rates among adult males and infants than the least well-off in Sweden (Leon, Vagero, & Otterblad, 1992; Vagero & Lundberg, 1989). There are also findings that the well-off in economically unequal American communities have greater rates of health problems than the well-off in relatively equal communities (Lynch, Kaplan, Pamuk, et al., 1998). These findings have led the *British Medical Journal* to editorialize*:* "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" (British Medical Journal, 1996, p. 312).

Wilkinson (1996) argues that societies with greater economic inequality begin to "disintegrate"--that is, they show evidence of decreased social cohesion and increased individual malaise. These are all precursors of increased illness and death. Kawachi and Kennedy (1997) make the case that economic inequality contributes to the deteriorating of what has been termed social capital, or the degree of social cohesion or citizen commitment to society (Putnam, 1993). When the level of analysis is shifted to the societal level from the individual, the poverty and health relationship can be considered in terms of societal structures and public policy rather than as problems of individual health status and coping. For example, these kinds of analysis can help illuminate how differences in economic inequality between the USA and Canada may help explain mortality differences between the two nations (Ross et al., 2000).

Should Health Workers Consider Poverty as a Health Issue?

Considering the clear evidence that poverty leads to health problems, what has been the public sector response to it? A recent review considered the current state of Canadian health sector responses to poverty (Raphael, 2000). In Canada, the emphasis has been on viewing poverty as an individual issue rather than a problem to be addressed at the public policy level.

The debate about increasing poverty has been raised primarily by the social development sector rather than the health sector. This is surprising since Canada has been a world leader in the development of theory related to health promotion and the "new public health" (Lalonde, 1974; Epp, 1986). Nevertheless, while the health-related effects of poverty appear to be known to many health professionals, with few notable exceptions, health responses are usually limited to the delivery of ameliorative programs to those living in poverty. While federal, provincial, and public health associations document poverty as a determinant of health (CPHA, 1993; 1996; 1997; Health Canada, 1998a; 1998b), discussions of the role that government policies play in creating poverty and its impact upon health have been, for the most part, isolated from health sector discourse and practice.

One exception to this tendency was the City of Montreal's report *Social Inequalities in Health* where the director of public health presented an

extensive discussion of the role that social inequalities, specifically economic resources, played in determining the health of Montrealers. "In actual fact, today's socioeconomic context dictates our leading questions: What influence do living conditions, social environment and, more importantly, social inequalities have on health and well-being" (Lessard, 1997, p.vii).

There is detailed analysis of the latest figures showing increases in poverty in Montreal, and the association of level of income with numerous indices of health and well-being. Specific chapters are devoted to early childhood, youth, adults, and those over 65 years of age. In each case, there is presentation of income data, the relationship of these data to health status, and means suggested for ameliorating the effects of low income upon health. As part of the section, *Why Make an Issue of Poverty?*, it is stated:

> *For anyone interested in public health, social inequalities in health must be a major concern. But we know that the solution is not to invest more in the health system or in new technologies. These inequalities must rather be met head-on; and well-targeted actions must be undertaken to ensure that they will not become worse.* (Lessard, 1997, p. 20).

In the report's final chapter, *Counteracting Poverty and its Consequences,* avenues of action open to the Department of Public Health were outlined. These actions included monitoring, research and evaluation, transmission of knowledge, regional programming, and strategic action. Concerning strategic action, this includes keeping decision-makers and the public informed of the department's concerns about social issues important to the health and well-being of residents. Of significance for the practice of public health in North America is the introductory statement to this final chapter that reflects the orientation of the entire report:

> *Having scanned the health and well-being of Montrealers from one end of the life cycle to the other, we note the important role played by poverty. 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.* (Lessard, 1997, p.60).

Policy Options

If the health sector were to highlight policy options to reduce poverty, what would some of these policy options look like?

In Canada, the *Growing Gap* report (Yalnizyan) recommended the following ways to close the gap between rich and poor:

- *Employment Gap:* create a better distribution of working time; provide publicly needed goods and services; adopt procurement policies; improve access to capital; ensure high quality, low cost education and child care; enforce employment equity legislation; undo the bias in the tax system; and enact a review investment mechanism with teeth.

- *Value Gap*: join a union, support a union, form a union; raise minimum wage to a living wage; call for 'maximum salaries', improve pay equity, and demand better corporate behaviour.

- *Income Gap*: supplement low wages; restore and improve income supports; and a provide a guaranteed minimum income.

- *Common Goods Gap*: make housing more affordable; create a system of universally accessible, high quality child care system; restore the health of the health system; expand universal health provisions; improve public education and access to higher education; enhance parks, libraries and community services.

- *Wealth Gap*: reinstate the inheritance tax; review family trust provisions; and prevent increased concentration of ownership.

British researchers have recommended strong government action to close the widening health gap. In the volume the *Widening Gap*, Shaw, Dorling, Gordon, and Davey Smith (1999) make three main points in their discussion of how to narrow the health gap.

- The key policy that will reduce inequalities in health is the alleviation of poverty through the reduction of inequalities in income and wealth.

- There is widespread public support for poverty reduction in Britain and the government has pledged to eliminate child poverty by 2020.

- Poverty can be reduced by raising the standards of living of poor people through increasing their incomes in 'cash' or 'in kind." The costs would be borne by the rich and would reduce inequalities overall -- simultaneously reducing inequalities in health.

In a follow-up volume *Tackling Inequalities*, Pantazis and Gordon (2000) provide detailed policy prescriptions for addressing health inequities in Britain. Also in Britain, the *Acheson Independent Inquiry into Inequalities in Health* (Acheson, 1998) outlined 39 sets of recommendation that provide a rich source of ideas for reducing health inequities. These recommendation appear to be relevant to Canada and are presented under the following headings. One example of each type of action is presented.

- *General Recommendations*: We recommend that as part of health impact assessment, all policies likely to have a direct or indirect impact on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities.

- *Poverty, Tax and Benefits:* We recommend further reductions in poverty of women of child-bearing age, expectant mothers, young children and older people should be made by increasing benefits in cash or in kind to them.

- *Education*: We recommend the provision of additional resources for schools serving children from less well off groups to enhance their educational achievement. The Revenue Support Grant formula and other funding mechanisms should be more strongly weighted to reflect need and socioeconomic disadvantage.

- *Employment:* We recommend further investment in high quality training for young and long-term unemployed people.

- *Housing and Environment*: We recommend policies which improve housing provision and access to health care for both officially and unofficially homeless people.

- *Mobility, Transport, and Pollution:* We recommend the further development of a high quality public transport system which is integrated with other forms of transport and is affordable to the user.

- *Nutrition and the Common Agricultural Policy*: We recommend strengthening the CAP Surplus Food Scheme to improve the nutritional position of the less well off.

- *Mothers, Children, and Families:* We recommend an integrated policy for the provision of affordable, high quality day care and pre-school education with extra resources for disadvantaged communities.

- *Young People and Adults of Working Ages:* We recommend measures to prevent suicide among young people, especially among young men and seriously mentally ill people.

- *Older People*: We recommend policies which will further reduce income inequalities, and improve the living standards of households in receipt of social security benefits.

- *Ethnicity:* We recommend that the needs of minority ethnic groups be specifically considered in the development and implementation of policies aimed at reducing socioeconomic inequalities.

- *Gender:* We recommend policies which reduce the excess mortality from accidents and suicide in young men. Specifically, improve the opportunities for work and which ameliorate the health consequences of unemployment.

- *The National Health System*: We recommend that providing equitable access to effective care in relation to need should be a governing principle of al policies in the NHS. Priority should be given to the achievement of equity in the planning, implementation, and delivery of services at every level of the NHS.

Conclusion

Does the health sector have a role in raising the issue of how poverty and income inequality affect health? It appears, at times, that the answer to that question depends more on the values being expressed by institutions concerned with health than by the research evidence. From an evidence-based perspective there is no doubt that poverty and income inequality are the key determinants of the health of Canadians.

It is also clear that the current policy directions of governments -- which should be the subject of critiques by health institutions -- clearly threaten the health of Canadians. Indeed, I have argued elsewhere that the Canadian traditions of peace, order, and good government are threatened by increasing poverty and economic inequality (Raphael, 1999).

Examining and responding to the health impacts of poverty and income inequality can be justified as being part of the mandate of health institutions. But such examinations also need to consider the values associated with civil society and health promotion and the notion of shared responsibility. These values provide a framework and justification for implementing actions to reduce poverty and income inequality.

This should not be a difficult task since such notions are consistent with the beliefs of most Canadians. For example, Reutter, Neufeld, & Harrison (1999) found that a majority of Albertans were aware that poverty led to poor health. Similarly, the view that health was influenced by the context in which people lived received more endorsement than life-style arguments.

Therefore, it is important to remember that the “new public health”is as much about values of participation, enablement and empowerment, equity, and social justice (Raphael & Bryant, 2000). As attempts are made to address the causes and health impacts of poverty and income inequality, such efforts must be rooted within the communities in which we live. There is an emerging literature indicating that action to improve health will be most effective when the participation and understandings of citizens are incorporated into such actions (Williams & Popay, 1997).

The importance of carrying out local citizen involving activities are described in volumes such as *Community Organizing and Community Building for Health* (Minkler, 1995) and *People-Centred Health Promotion* (Raeburn & Rootman, 1997).

Such ideas have seen application in community-based Canadian efforts such as the Pathways to Building Healthy Communities in Eastern Nova Scotia (PATH, 1999) and the Community Quality of Life projects in Toronto (Raphael, et al., 1999). There, community members identify and act upon social determinants of health by drawing upon their experiences and developing critical understandings of how societies operate.

Armed with these understandings, citizens can identify policy issues that become the basis of efforts to influence government actions. There is a role for governments and health institutions to play in such efforts. At the city, provincial, and national levels, governments and health institutions can support citizens in examination and discussion of the importance of the social determinants of health.

It is in these sorts of undertakings that the health sector can draw upon and apply traditions of civic involvement and participation to create effective action to reduce poverty and income inequality and improve the health of Canadians.

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