Defining and measuring poverty: implications for the health of Canadians*

DEANNA L. WILLIAMSON and LINDA REUTTER

Department of Human Ecology and Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada

SUMMARY

This paper examines the implications that the conceptualization and measurement of poverty have for policies that aim to improve the health of Canadians. In recent years, poverty has been identified as an issue of policy importance within the health sector in Canada. Policy makers are recognizing that efforts to improve the health of Canadians are related to the development and implementation of policies that decrease the proportion of people who live in poverty. At the same time, the Statistics Canada Low-Income Cut-Offs (LICOs), which are the most commonly used tool for measuring poverty in Canada, are being called into question. One of the most frequently cited criticisms of the LICOs is that they are too high, and as such do not measure poverty. Critics who argue that the LICOs are too high disagree with the relative conceptualization of poverty which underlies the LICOs. In this paper, we discuss the LICOs, their underlying assumption that poverty is relative in nature, and the criticism that the LICOs are too high. In addition, we discuss the Sarlo/Fraser Institute poverty lines, which are based on the assumption that poverty is absolute in nature. The manner in which poverty is conceptualized and measured has implications for the types, characteristics and ultimately the success of policies that are developed to reduce poverty and its effect on health. We argue that the success of efforts to enhance the health of Canadians with a reduction in poverty depends on a commitment by policy makers to a relative conceptualization and measurement of poverty. We further contend that policy makers in the health sector cannot independently reduce poverty and its detrimental effects on health. The complex nature of poverty indicates the need for policy makers in the health sector to work collaboratively with their counterparts from a broad range of government and non-government sectors to develop an innovative network of social assistance, economic and employment policies that effectively reduce the proportion of Canadians who experience material and social deprivation.

Key words: Canada; healthy public policy; poverty and health; poverty definitions and measures

INTRODUCTION

In recent years, poverty has been identified as an issue of policy importance within the health sector in Canada. Increasingly, policy makers are recognizing that efforts to improve the health of the Canadian population are intricately linked to policies and programs that decrease both the number and proportion of Canadians who live in poverty (B.C. Office for the Provincial Health Officer, 1995; Federal, Provincial and Territorial Advisory Committee on Population Health, 1996; Régie Régionale De La Santé et Des Services Sociaux De Montréal-Centre, 1998). At the same time that poverty has begun to assume a position on health policy agendas, the manner in which poverty is commonly measured in Canada is being called into question. Recently, some economists (Sarlo, 1996; Anderson and Ibbott, 1998) and members of the media (Geddes, 1996; Coyne, 1997) have challenged the reliability and validity of the Statistics Canada Low-Income Cut-Offs (LICOs), which have been the most commonly used tool for measuring poverty.

*This manuscript is an expanded version of a presentation at the Parkland Institute First Annual Conference, Edmonton, Alberta, 6–8 November 1997.
in Canada for the past three decades. Some economists such as Anderson and Ibbott, and Sarlo, have argued that the LICOs are fraught with a broad range of methodological shortcomings (Sarlo, 1996; Anderson and Ibbott, 1998). Sarlo (Sarlo, 1996) and some members of the media (Geddes, 1996; Coyne, 1997) also have a fundamental disagreement with the conceptualization of poverty that underlies the LICOs. Whereas the LICOs are based on the assumption that poverty is relative in nature, critics such as Geddes, Sarlo, and Coyne conceptualize poverty as absolute in nature (Geddes, 1996; Sarlo, 1996; Coyne, 1997). Economists have proposed a variety of alternatives to the LICOs (Sarlo, 1996; Anderson and Ibbott, 1998). However, decisions about the best method for measuring poverty cannot be made until economists and policy makers reach an agreement about the more fundamental matter of determining what poverty is. So, while we acknowledge the broad array of methodological criticisms of the LICOs that have been detailed by economists, this paper focuses on the criticism that Sarlo (Sarlo, 1996) and others (Geddes, 1996; Coyne, 1997) have of the relative conceptualization of poverty in which the LICOs are rooted. The manner in which poverty is conceptualized, and subsequently measured, has significant implications for policies that aim to improve the health of Canadians by reducing poverty. The purpose of this paper is to discuss these implications.

The recent inclusion of poverty as an issue on policy agendas within the health sector in Canada is likely associated, in part, with an increasing awareness among policy makers about the fundamental role that poverty plays in health and illness. Regardless of whether poverty is conceptualized as relative or absolute, the relationship between poverty and health is persistent and consistent over time and place (Feinstein, 1993; Reutter, 1995). People living in poverty have higher mortality rates, shorter life expectancies, and lose more years of life due to various diseases than do people who are not poor (Najman, 1993; Wilkins, 1995). Also, people who are poor rate their health status lower than those who are not poor (Adams, 1993; Manga, 1993; Millar and Beaudet, 1996). Also, compared to people who do not live in poverty, those living in poverty experience more chronic medical conditions along with symptoms of illness and disease, and they are more likely to have activity limitations (Hay, 1988; House et al., 1990; Statistics Canada, 1994; Roberge et al., 1995).

Research findings have also demonstrated the negative effect of poverty on the health of children. For example, the infant mortality rate is more than 1.5 times greater in low-income neighbourhoods in Canada than it is in the highest income neighbourhoods (Wilkins et al., 1991). In addition, children living in poverty are more likely than their non-poor counterparts to experience a variety of chronic medical problems such as diabetes, bronchitis, asthma, anaemia and psychiatric disorders, and they are more likely to have developmental delays, poor school performance and social impairments (Lipman et al., 1994; Canadian Council on Social Development (CCSD), 1997).

It is likely that the inclusion of poverty on health policy agendas also is related to an increasing awareness among policy makers about rising poverty rates in Canada. Using the LICOs, the overall poverty rate in Canada increased from ~15% in 1990 to ~18% in 1996, the most current year for which data are available (Centre for International Statistics, CCSD, 1997a, 1998a). Approximately 15% of Canadians living in families and ~40% of unattached individuals had incomes below the LICOs in 1996 (Centre for International Statistics, CCSD, 1998a). Furthermore, Canada has the second highest rate of child poverty in the developed world with 21% of children living in poverty in 1996 (Centre for International Statistics, CCSD, 1998b; National Council of Welfare, 1998). These poverty rates stand in stark contrast to Canada’s level of human development. For the past 5 years the United Nations has ranked Canada as number one among all countries in the world with respect to human development (United Nations Development Program, 1998). The United Nations evaluates human development by a composite index that comprises measures of life expectancy, educational attainment and real Gross Domestic Product (GDP) per capita. While Canada is number one in terms of overall human development, Canada was also rated tenth of 17 developed countries in the poverty index in 1998. According to the United Nations Development Program, the discrepancy between Canada’s overall human development rating and poverty rating indicates that human development is less evenly distributed in Canada than it is in nine other developed countries (United Nations Development Program, 1998). In short, the degree of poverty in Canada is greater than it ought to be in light of the country’s high level of development.
Considering the growing body of research findings that point to the pivotal role that poverty plays in health and illness, along with evidence that an ever increasing proportion of Canadians have incomes below the LICOs, it is not surprising that during the past 5 years, Federal and Provincial health departments and advisory bodies have begun to recognize that we will not see significant improvements in the overall health of the Canadian population unless efforts are directed toward the development and implementation of policies that reduce poverty. For example, the Federal, Provincial and Territorial Advisory Committee on Population Health identified the following set of priorities to improve the health of Canadians: meaningful work; adequate income; a reduction in the number of families living in poverty; and a more equal distribution of income than is currently the case (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996). At the provincial level, British Columbia has identified the reduction of poverty and income inequality as an objective that will positively contribute to the health of British Columbians (B.C. Office for the Provincial Health Officer, 1995). And, at a municipal level, the Montréal-Centre Department of Public Health has identified the reduction of health inequities related to poverty as a priority that is ‘essential to the progress of our society’ ([Régie Régionale De La Santé et Des Services Sociaux De Montréal-Centre, 1998) p. 69].

In this paper, we argue that the success of efforts to enhance the health of Canadians by reducing poverty is dependent on a commitment by policy makers to a conceptualization and measurement of poverty as relative in nature. Furthermore, we contend that policy makers in the health sector cannot, on their own, ameliorate poverty and its negative effects. The complex nature of poverty points to the need for policy makers in the health sector to work collaboratively with their counterparts in sectors outside of health to develop a network of social assistance, economic and employment policies that effectively increase the proportion of Canadians who have adequate economic resources to meet food, shelter and clothing needs, and to participate meaningfully in society. Before we examine some of the main implications of conceptualizations and measurements of poverty, we briefly discuss two conceptualizations of poverty and the manner in which these conceptualizations are reflected in current and proposed measures of poverty.

**CONCEPTUALIZATIONS OF POVERTY**

While Federal and Provincial policy documents from the health sector increasingly identify the reduction of poverty as a means of enhancing the health of the Canadian population (B.C. Office for the Provincial Health Officer, 1995; Federal, Provincial and Territorial Advisory Committee on Population Health, 1996; Régie Régionale De La Santé et Des Services Sociaux De Montréal-Centre, 1998), these documents commonly fail to specify what is meant by poverty. This failure to define poverty can imply that it is a concept about which there is one generally agreed upon definition. However, this is not so. In fact, one of the most commonly cited criticisms of the LICOs stems from a more fundamental debate about whether poverty is absolute or relative in nature.

According to absolute conceptualizations of poverty, which are also referred to as physical subsistence definitions, poverty is the deprivation of economic resources that are required to meet food, shelter and clothing needs necessary for physical well-being (Ross et al., 1994; Sarlo, 1996). On the other hand, relative poverty is conceptualized as the deprivation of economic resources that are required for dignified participation in society (Reitsma-Street and Townsend, 1996), which is, in turn, necessary for not only physical well-being but also psychological and social well-being (Labonte, 1993; Wilkinson, 1996; Kawachi and Kennedy, 1997). According to such definitions, the degree of deprivation that prevents people from dignified participation in society is determined in relation to societal norms. As deprivation of economic resources increases, the less able people are to participate in society in a manner that is consistent with societal norms. Relative definitions assume that poverty is intrinsically tied to unequal distribution of income, or income inequality (Ross et al., 1994). Rising rates of relative poverty mean that increasing proportions of people are unable to engage in and feel part of life in their communities (Wilkinson, 1996). In short, absolute poverty is related to material deprivation, whereas relative poverty is related to both material and social deprivation.
MEASURING POVERTY: THE STATISTICS CANADA LOW-INCOME CUT-OFFS (LICOS) AND THE SARLO/FRASER INSTITUTE POVERTY LINES

The Statistics Canada LICOs have been used almost exclusively by researchers, policy makers and anti-poverty advocates to measure poverty in Canada during the past three decades. Statistics Canada uses complex econometric methods to calculate the LICOs (Anderson and Ibbott, 1998). For the sake of simplicity, these econometric calculations and techniques are not included in the description of the LICOs’ methodology that we summarize here. The LICOs are income levels at which families spend 20% more of their pre-tax income on basic needs (food, shelter, clothing) than the average proportion spent by Canadian families. The LICOs are calculated from data collected every 4 years by the Family Expenditure Survey (FAMEX). This survey provides detailed information about the expenditure patterns of Canadian families except for those living in the Yukon and Northwest Territories, and First Nations families on reserves. Using FAMEX data, Statistics Canada estimates the average family expenditure on food, shelter and clothing, which is expressed as a proportion of pre-tax income. The current estimate is 34.7% (Statistics Canada, 1992). With the addition of 20 percentage points, families with incomes below the LICOs spend at least 54.7% of their pre-tax income on basic needs. Average income levels where families spend 54.7% of their income on basic needs are then determined from the FAMEX data. These income levels, which are differentiated by family size and the population of the community within which families live, are the base year LICOs (the most recent of which is 1992). LICOS for the years in-between FAMEX surveys are calculated by adjusting the base year LICOs to reflect annual inflation rates (Ross and Shillington, 1989; Statistics Canada, 1992). The LICOs for 1996 are shown in Table 1.

One of the underlying assumptions of the LICOs is that the minimum standard of living in Canada ought to include more than is necessary for physical subsistence, and as such, the LICOs reflect the belief that poverty is relative in nature (Ross et al., 1994). The relative nature of the LICOs is also demonstrated by their relationship to the average proportion of income that Canadians spend on basic needs. With the exception of the United States, all developed countries use relative measures of poverty (Ross, 1997). Even though Statistics Canada does not describe the LICOs as poverty lines, the measures are viewed as such by most social policy observers.

During the past 5 years or so, the LICOs have been challenged by some economists (Sarlo, 1996; Anderson and Ibbott, 1998) and some members of the media (Geddes, 1996; Coyne, 1997). One of the most commonly cited criticisms seems to have arisen from the work of Christopher Sarlo (Sarlo, 1996), an economist with the neo-liberal economic think-tank, the Fraser Institute. Sarlo’s criticisms of the LICOs are rooted in his convictions about the nature of poverty (Sarlo, 1996). In contrast to most contemporary writers and researchers, Sarlo (p. 49) has conceptualized poverty as a state in which people lack ‘any item required to maintain long-term physical well-being’ (emphasis Sarlo’s). Sarlo’s chief criticism of the LICOs is that they are too high, and therefore do not measure poverty. Sarlo has challenged the LICOs with a basic needs approach to

| Table 1: Statistics Canada’s Low-Income Cut-Offs for 1996 in $ (1992 base) |
|------------------|------------------|------------------|------------------|------------------|
| Family size      | Community size   | Community size   | Community size   | Community size   |
|                  | 500 000–499 999  | 30 000–99 999    | <30 000          | Rural            |
| 1                | 17 132           | 14 694           | 14 591           | 13 577           | 11 839           |
| 2                | 21 414           | 18 367           | 18 239           | 16 971           | 14 799           |
| 3                | 26 633           | 22 844           | 22 684           | 21 107           | 18 406           |
| 4                | 32 238           | 27 651           | 27 459           | 25 551           | 22 279           |
| 5                | 36 036           | 30 910           | 30 695           | 28 562           | 24 905           |
| 6                | 39 835           | 34 168           | 33 930           | 31 571           | 27 530           |
| 7 +              | 43 634           | 37 427           | 37 166           | 34 581           | 30 156           |

Centre for International Statistics, Canadian Council on Social Development, 1997b.
measuring poverty (Sarlo, 1996). This approach, which has subsequently been adopted by the Fraser Institute, is based on the assumption that poverty is absolute in nature. The Sarlo/Fraser Institute approach to measuring poverty focuses only on the essentials that are necessary for physical survival, and it bears no relationship to either the average income of Canadians or the average proportion of income that Canadians spend on basic needs. The Sarlo/Fraser Institute poverty lines are determined by calculating the total cost of items that Sarlo considers to be necessary for long-term physical well-being (Sarlo, 1996). The most recent year for which Sarlo has calculated poverty lines is 1994 (Sarlo, personal communication, 1998). Table 2 shows estimates of the 1996 Sarlo/Fraser Institute poverty lines, which we calculated by adjusting the 1994 rates to reflect the 1995 and 1996 inflation rates. The Sarlo/Fraser Institute poverty lines are significantly lower than the LICOs shown in Table 1.

**POLICY IMPLICATIONS RELATED TO THE CONCEPTUALIZATION AND MEASUREMENT OF POVERTY**

The manner in which poverty is conceptualized and measured has two significant implications for policies that aim to enhance the health of Canadians by reducing poverty. First, the conceptualization and measurement of poverty will determine the number of Canadians who are identified as living in poverty, which will shape the perceptions of policy makers about the extent of poverty in Canada. These perceptions may subsequently influence the efforts of policy makers to reduce health inequities that are associated with poverty. Poverty rates that are calculated from measures that conceptualize poverty as absolute in nature include only those people who are deprived of the economic resources necessary to meet food, shelter and clothing needs that are necessary for physical well-being. Conversely, poverty rates derived from the application of measurement tools that assume that poverty is relative in nature include people identified by absolute measures plus people who are deprived of the economic resources necessary to meet their needs for psychological and social well-being. Accordingly, relative measurement tools result in higher poverty rates than do absolute measures. While the LICOs indicate that almost one in five Canadians (18%) lived in poverty in 1996 (Centre for International Statistics, CCSD, 1998a), the Sarlo/Fraser Institute poverty lines point to a poverty rate of <2% (Sarlo, 1996), thereby suggesting that poverty is virtually non-existent in Canada. This perception could, in turn, lead policy makers to erase poverty from their agendas.

The conceptualization and measurement of poverty also has implications for the types, characteristics, and ultimately the success of policies that are developed to reduce poverty and its detrimental effects on health. Poverty-reduction policies that are based on the assumption that poverty is absolute in nature will narrowly target Canadians who experience material deprivation. In contrast, anti-poverty policies that assume that

<table>
<thead>
<tr>
<th>Province</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland</td>
<td>7603</td>
<td>10 629</td>
<td>13 658</td>
<td>16 334</td>
<td>18 604</td>
<td>20 866</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>6745</td>
<td>9646</td>
<td>13 115</td>
<td>16 168</td>
<td>18 355</td>
<td>20 536</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>6966</td>
<td>9890</td>
<td>13 079</td>
<td>16 469</td>
<td>18 625</td>
<td>20 782</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>6766</td>
<td>9495</td>
<td>12 470</td>
<td>15 051</td>
<td>17 253</td>
<td>19 447</td>
</tr>
<tr>
<td>Quebec</td>
<td>6437</td>
<td>9274</td>
<td>11 950</td>
<td>14 756</td>
<td>16 900</td>
<td>19 036</td>
</tr>
<tr>
<td>Ontario</td>
<td>7664</td>
<td>10 849</td>
<td>14 157</td>
<td>17 506</td>
<td>19 578</td>
<td>21 644</td>
</tr>
<tr>
<td>Manitoba</td>
<td>6607</td>
<td>9876</td>
<td>13 318</td>
<td>16 548</td>
<td>18 675</td>
<td>20 796</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>6042</td>
<td>9184</td>
<td>12 300</td>
<td>15 149</td>
<td>17 317</td>
<td>19 479</td>
</tr>
<tr>
<td>Alberta</td>
<td>6581</td>
<td>9402</td>
<td>12 437</td>
<td>15 066</td>
<td>17 087</td>
<td>19 102</td>
</tr>
<tr>
<td>British Columbia</td>
<td>8238</td>
<td>11 403</td>
<td>15 247</td>
<td>18 589</td>
<td>20 825</td>
<td>23 055</td>
</tr>
</tbody>
</table>

Sarlo, 1996.

This table shows the estimates of the 1996 Sarlo/Fraser Institute poverty lines, which we calculated by adjusting Sarlo’s (1996) 1994 rates to reflect the 1995 and 1996 inflation rates (Statistics Canada, 1998).
Poverty is relative in nature will target not only people who are unable to meet their food, shelter and clothing needs but also those Canadians who experience social deprivation. Policies guided by absolute conceptualizations and those guided by relative conceptualizations will likely both utilize some common means for reducing poverty, examples of which include income assistance along with in-kind benefits such as subsidized housing and food vouchers. The amount of cash and in-kind benefits that result from policies that assume an absolute conceptualization of poverty will, however, be much less than benefits that result from policies that are based on the assumption that poverty is relative in nature. Unlike policies that narrow equate poverty with material deprivation, policies that are based on a relative conceptualization will likely result in the provision of benefits that cover the costs of transportation, recreation, entertainment and medications in addition to the costs of food, shelter and clothing.

In sum, the cash and in-kind benefits that result from poverty-reduction policies that are based on an absolute conceptualization of poverty will be available to a smaller proportion of Canadians and will be of less monetary value for recipients than benefits that result from policies that assume poverty is relative in nature.

Table 3: Summary of social assistance incomes in Canada by household type, 1996

<table>
<thead>
<tr>
<th>Household type</th>
<th>Range of provincial social assistance incomes ($)</th>
<th>Mean social assistance income ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single employable</td>
<td>2709 (Newfoundland)–6809 (Ontario)</td>
<td>5410</td>
</tr>
<tr>
<td>Disabled person</td>
<td>6698 (New Brunswick)–11 759 (British Columbia)</td>
<td>8697</td>
</tr>
<tr>
<td>Single parent, one child</td>
<td>10 793 (Alberta)–13 700 (British Columbia)</td>
<td>12 315</td>
</tr>
<tr>
<td>Couple, two children</td>
<td>13 359 (New Brunswick)–18 076 (Ontario)</td>
<td>16 679</td>
</tr>
</tbody>
</table>


Minimum wage policies in Canada are implicitly rooted in the assumption that poverty is absolute in nature. Table 3 summarizes information from the National Council of Welfare (National Council of Welfare, 1997–1998) about provincial social assistance incomes for four household types: single employable persons; disabled persons; single-parent families with one 2-year-old child; and two-parent families with two children (10 and 15 years of age). Comparison of the social assistance incomes presented in Table 3 to the LICOs shown in Table 1 indicates that the amount of money provided by social assistance programs in all provinces across Canada falls below, and in some cases far below, the LICOs. With few exceptions, provincial social assistance incomes coincide more closely with the Sarlo/Fraser Institute poverty lines (Table 2) than with the LICOs. This seems to provide some support for the position taken by provincial social services departments that social assistance programs are intended to provide only the basic necessities of life (National Council of Welfare, 1997).

Similar to the cross-Canada variation in social assistance incomes, Table 4 shows that minimum wage rates in Canada range from a low of $5.25 per hour in Newfoundland to a high of $7.20 per hour in the Yukon (Human Resources Development Canada Labour Program, 1998). Table 4 also includes estimates of the yearly incomes of...

1It is important to note that the social assistance incomes for the Northwest Territories are higher than any of the provinces (National Council of Welfare, 1997–1998). However, comparison of social assistance incomes from the Northwest and Yukon Territories to the LICOs is not appropriate because the data that are used to calculate the LICOs are not collected from families living in either of the territories. Similarly, the social assistance incomes from the territories cannot be compared to the Sarlo/Fraser Institute lines because Sarlo (1996) did not calculate poverty lines for either of the territories.
people who work full time (40 h per week) at the minimum wage. These yearly incomes range from ~ $11 000 to $15 000 per year.

Comparison of the yearly incomes shown in Table 4 to the Sarlo/Fraser Institute poverty lines (Table 2) suggests that the minimum wage may, for the most part, allow Canadians who are employed full time and who live in families with fewer than three members to meet basic food, shelter and clothing needs that are necessary for physical well-being. However, with the exception of Quebec, Ontario and Saskatchewan, a yearly income derived from full-time minimum wage employment falls short of even the Sarlo/Fraser Institute lines for families with three or more members.

Furthermore, it is evident that both social assistance and minimum wage incomes prevent some Canadians from experiencing meaningful participation in society. People who depend on social assistance programs and minimum wage employment often are unable to afford activities and services that are considered to be ‘norms’ within Canadian society. Some of these activities and services include transportation, dental care, prescription medications, eye glasses, education, insurance and recreational activities (Family Service Association of Edmonton (FSAE) & Income Security Action Committee (ISAC), 1991; ISAC, 1994; Ross, 1997; Williamson and Drummond, 1998). Nearly half of poor families in Canada cite the cost of physical recreation as a barrier to their children’s participation in physical activities (Canadian Council on Social Development, 1997).

Although social assistance and minimum wage policies that are implicitly based on an absolute definition of poverty may be cost saving in the short term, research findings about the relationship between income inequality and health suggest that such policies are short-sighted. A growing body of research, which was pioneered by Richard Wilkinson in the UK (Wilkinson, 1996), provides increasing evidence that the health of populations is negatively influenced by both the proportion of people who live in physical subsistence poverty and by income inequality, or relative poverty. Studies comparing health status indicators among industrialized countries have revealed a positive relationship between income equality and the health of populations. That is, industrialized countries with the most equal distribution of income (e.g. Japan and Sweden), and consequently the lowest levels of relative poverty, are the healthiest (Wilkinson, 1996). Additional evidence from the United States suggests that the differences in health status among states can also be explained by the positive relationship between equal income distribution and health (Kennedy et al., 1996; Kaplan et al., 1996; Lynch et al., 1998). Similar findings across regions in Spain have also been reported (Navarro, 1997).

The negative relationship between income inequality, or relative poverty, and health can be explained, in part, by the contribution that a variety of psychosocial factors such as connectedness, meaningfulness and control, make to health (Labonte, 1993). There is a growing body of evidence that people who participate in community life (Wilkinson, 1996; Kawachi and Kennedy, 1997), who have purpose and meaning in life (Antonovsky, 1987), and who have a sense of control over their working and living conditions (Mirowsky and Ross, 1989; Syme, 1991; Wallerstein, 1992), are healthier than people who are isolated and who lack a sense of control, self-efficacy and self-esteem. Quite simply, the opportunity to participate ‘economically, politically, socially, culturally and with dignity in their community’s activities’ [(Forum Directors Group, National Forum on Family Security, 1993), p. 2] is a fundamental determinant of health. Thus, as income inequality, or relative poverty, becomes more pronounced in a society, the health of increasing proportions of people is jeopardized by the lack of both personal control (Mirowsky and Ross, 1989; Wallerstein, 1992) and social support networks (Belle, 1982; Auslander, 1988;

Table 4: Minimum wage rates and annual incomes for adult workers in Canada, 1998

<table>
<thead>
<tr>
<th>Province/territory</th>
<th>Hourly rate ($)</th>
<th>Annual full-time income ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland</td>
<td>5.25</td>
<td>10 920</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>5.50</td>
<td>11 440</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>5.50</td>
<td>11 440</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>5.40</td>
<td>11 232</td>
</tr>
<tr>
<td>Quebec</td>
<td>6.90</td>
<td>14 352</td>
</tr>
<tr>
<td>Ontario</td>
<td>6.85</td>
<td>14 248</td>
</tr>
<tr>
<td>Manitoba</td>
<td>6.00</td>
<td>12 480</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>6.00</td>
<td>12 480</td>
</tr>
<tr>
<td>Alberta</td>
<td>5.65</td>
<td>11 752</td>
</tr>
<tr>
<td>British Columbia</td>
<td>7.15</td>
<td>14 872</td>
</tr>
<tr>
<td>Yukon Territory</td>
<td>7.20</td>
<td>14 976</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>6.50</td>
<td>13 520</td>
</tr>
<tr>
<td></td>
<td>7.00 (remote areas)</td>
<td>14 560</td>
</tr>
</tbody>
</table>

Evidence about the relationship between income inequality, or relative poverty, and health makes it clear that policy efforts to enhance the health of Canadians by reducing poverty will be most effective if they increase the proportion of Canadians who are able to participate in society. The development and implementation of such policies are rooted in a commitment by policy makers to the assumption that poverty is relative in nature. If, on the other hand, policy makers adhere to an absolute conceptualization and operationalization of poverty, resulting policies will aim only to ensure that Canadians' most basic food, shelter and clothing needs are met. Even though such policies are better than having no policies and programs that aim to reduce poverty, policies that are based on an absolute conceptualization of poverty are incompatible with evidence about the crucial role that meaningful participation in society plays in health (Labonte, 1993; Miller, 1995; Wilkinson, 1996; Kawachi and Kennedy, 1997). Moreover, there is evidence to suggest that, if psychosocial factors such as connectedness and control are ignored, physical health will also be undermined.

SUMMARY AND CONCLUSIONS

Recent criticisms by Sarlo (Sarlo, 1996) and others (Geddes, 1996; Coyne, 1997) of the relative conceptualization of poverty on which the LICOs are based, provide an opportunity for economists, members of the media and policy makers in the health sector to talk about the ‘best’ way to define and measure poverty. This kind of debate can be valuable not only in terms of revisiting and clarifying assumptions about the nature of poverty, but also in terms of examining the implications that the conceptualization and measurement of poverty have for policies that aim to enhance the health of Canadians. However, this discourse can also shift the attention of policy makers from the matters at hand, which are the high rate of relative poverty in Canada, the negative influence that poverty has on health, and the need to develop policies that reduce health inequities that are related to poverty. The addition of poverty as an issue on policy agendas within the health sector has been a long time coming. Canadians, particularly those living in poverty, can ill afford the consequences that will occur if efforts to reduce poverty are side-tracked and discredited by criticisms that relative measures, such as the LICOs, do not measure ‘real’ poverty.

In addition, the success of policy efforts by the health sector to improve the health of Canadians will be hampered if policy makers in the health sector allow themselves to be convinced that poverty is absolute in nature. If policy makers are committed to improving the health of Canadians, it is not good enough to reduce the proportion of Canadians living in poverty by simply redefining poverty as absolute and subsequently lowering the poverty lines. Instead, there is a need to develop a broad range of policies that effectively increase the proportion of Canadians who are able to meet their basic needs and participate meaningfully in society. Evidence about the relationship between income inequality and the health of populations, along with findings about the manner in which a variety of psychosocial factors influence health, leaves little doubt that relative conceptualizations and measurements of poverty ought to guide the development of policy.

Poverty is a complex phenomenon that has detrimental effects on the health of individuals who live in poverty and on society as a whole. Poverty is intricately rooted in a network of social, economic and political factors and conditions, which extend far beyond the control of the health sector. Yet, efforts to enhance the health of Canadians are intimately linked to the reduction of poverty. So, while policy makers in the health sector are recognizing the fundamental role of poverty reduction in their endeavours to improve the health of Canadians, the ability of these policy makers to enhance health through poverty-reduction efforts is restricted because the reduction of poverty depends on a network of social assistance, economic and employment policies and programs that are outside the mandate of the health sector.

Although policy makers in the health sector alone cannot develop and implement policies that reduce the proportion of Canadians who experience material and social deprivation,
policy makers in the health sector can attempt to influence the development of such policies by advocating the use of a relative conceptualization and measurement of poverty by policy makers in other sectors. If efforts to enhance the health of Canadians are to be advanced beyond their current status as words on paper, policy makers in the health sector must take responsibility for initiating the development of intersectoral partnerships that comprise a broad range of government sectors, non-governmental organizations, the private sector and communities. Though the challenges associated with the establishment of such partnerships are formidable, they are not insurmountable. Considering Canada’s high level of overall development, there is little doubt that as a collective, Canadians have the human and material resources that are needed to reduce poverty and the detrimental effects that it has on the health of individuals, communities and society as a whole. Thus, it seems that in years to come, further improvements to the health of Canadians will depend more on political will than a need for knowledge or money (Draper, 1997; Régie Régionale De La Santé et Des Services Sociaux De Montréal-Centre, 1998; United Nations, 1998).

ACKNOWLEDGEMENTS

We would like to thank Jerry Kachur for his discerning comments and provocative questions which helped us to clarify our ideas and arguments as we worked on this paper. In addition, we appreciate the feedback and suggestions for improvement that Anne George provided about an earlier draft of the paper.

Address for correspondence:
Deanna Williamson
Department of Human Ecology
302 Human Ecology Building
University of Alberta
Edmonton
Alberta
Canada
T6G 2N1
E-mail: deanna.williamson@ualberta.ca

REFERENCES


