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 l'Association pour la santé publique de l'Ontario
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Public Health Responds to the Challenge to Reduce Poverty and Enhance Resiliency in Children and Youth

**Position paper and resolution adopted by the
 Ontario Public Health Association (OPHA)**

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Submitted by: the OPHA Child Health Workgroup

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Resolution

WHEREAS there is increasing evidence of the importance of the early years of life to human health and development; and

WHEREAS it has been established that the single most important health determinant for children and youth is a caring family that has an adequate income; and

WHEREAS currently almost one in six children in Canada and Ontario, and one in three in Toronto, live in poverty, and that children and youth growing up in poverty continue to have fewer supports and opportunities needed for healthy development

THEREFORE BE IT RESOLVED THAT the Ontario Public Health Association (OPHA) support public health in engaging in effective strategies that reduce the amount and the impact of child and youth poverty, and also that public health strengthen its advocacy efforts by working collaboratively with relevant stakeholders to develop and communicate with a unified message regarding child poverty (see Table).

Table of Goals and Actions for OPHA (Child Health Workgroup) in Addressing Child Poverty 2004-8

| Goals | Actions |
|--|--|
| OPHA members become informed on economic and health issues, and articulate about the importance of addressing the determinants of health to achieve public health goals. | <i>Through multiple strategies possibly including provincial workshops in collaboration with provincial social planning councils, social justice networks, improve the number of public health practitioners with economic literacy and who have confidence to speak about the social determinants of health in an informed way.</i> |
| OPHA advocate for a more active role for Local Official Health Agencies in addressing income inequality and all other known determinants of health. This can be done both with monitoring the social determinants of health and intervening with those determinants. OPHA can coordinate this activity with the Public Dental Health initiatives. | <i>During any revision or restructuring consultation at all government levels, but especially provincially, OPHA participate with being present or writing briefs to support the improvement of policies and programs that address the determinants of health and child poverty, for more positive health outcomes.</i> |
| OPHA participate in Campaign 2000, (a coalition of over 85 National Partners) and support its activities in Ontario. | <i>A representative from OPHA participate in a liaison role with Campaign 2000, which is to include two-way communication and support for each other's advocacy to reduce child poverty in Ontario.</i> |
| OPHA advocate to the Federal, Provincial and local governments at each appropriate opportunity regarding the importance of reducing child poverty, as well as improving those policies which affect child health (e.g. housing, child care, employment insurance, etc). Specifically, OPHA influences the public health consultations planned by the Ministry of Health and Long Term Care as noted in "Operation Health Protection Blueprint." | <i>At every feasible opportunity (news items, health reports) the OPHA Child Health Workgroup provide brief responses through letters, op-eds, interviews, etc. to support changes in knowledge attitudes and action such that child poverty at the health outcomes are reduced.</i> |

Position Paper Executive Summary

This position paper is a revised version of the original position paper, *Towards a Public Health Approach to Reducing Child Poverty and Enhancing Resiliency* (1998). OPHA position papers require revision every five years, and although there has been some change on this issue in the last year, sadly child poverty has persisted for over 30 years in Canada. It is thought that continuing the efforts and increased public health involvement is required to see a significant reduction in child poverty.

The objectives established within the original position paper were ambitious, yet consistent with the urgency of matters at the time. How have we succeeded? The establishment of the Healthy Babies Healthy Children program the same year launched a key approach to providing supports to poor families. The workgroup provided support to the OPHA in its efforts to advocate that the Ministry of Health, in its Mandatory Program revisions, require boards of health to address poverty as a determinant of health. OPHA has participated with Campaign 2000, a National Coalition of over 85 organizations aiming at eliminating child poverty in Canada. There have been some small improvements in federal programs to support those who are poor. Recent developments are encouraging, such as when the federal government campaigned that they are committed to an early childhood education and care program.

However, much more needs to be done for the one in six children in poverty in Ontario, and one in three in Toronto, are at a disadvantage that will affect their health for a lifetime. As a society, we can pay now or pay later. The OPHA can show leadership and lend credible support to partners such that public health addresses poverty as a determinant of health with the following action outcomes in mind.

- OPHA members become informed on economic and health issues, and articulate about the importance of addressing the determinants of health to achieve public health goals.
- OPHA advocates for a more active role for Local Official Health Agencies in addressing income inequality and all other known determinants of health.
- OPHA is represented at and participates in the National Coalition of Campaign 2000, in Ontario.
- OPHA advocates to the Federal, Provincial and local governments at each appropriate opportunity regarding the importance of reducing child poverty, as well as improving those policies which affect child health (e.g. housing, child care, employment insurance, etc).

Introduction

The OPHA Child Health Workgroup revised its 1998 Position Paper on Child Poverty because child poverty has persisted and requires a new analysis and response. Our objectives in 1998 were ambitious. How have we done?

Over the last six years, OPHA supported the establishment of the Healthy Babies/Healthy Children (HB/HC) program, and helped those in Ontario delivering the program deal with some difficult issues in its startup. The HB/HC program accomplished the objective of supporting families by providing home visiting for families at risk.

The Mandatory Health Programs and Services Guidelines (1997) revision process also benefited from OPHA and Constituent Societies' input with respect to child poverty, but those changes never came to fruition in Ontario. All work on advocating for poverty came to a grinding halt in the late 1990's. OPHA and other groups' effectiveness were very limited in a time of conservative political leadership. OPHA has also been through much change in the last few years, and had limited capacity for advocacy. Despite limited effectiveness in advocacy within public health, some improvements in resources for the poor are noted, and OPHA was able to support these through participation in coalitions such as Campaign 2000.

For example, an increase in Employment Insurance benefits during parental leave was a positive contribution toward the child health workgroups' original objective of ensuring the provision of adequate unemployment insurance. The recent creation of the Ontario Ministry of Children and Youth Services may prove to be a good step in the direction of improving the coordination of policies relevant to child development.

The existence of an annual "report card" on the status of child poverty in Canada (by Campaign 2000) is also progress since 1998; this important resource provides updates and monitors the progress made toward the elimination of child poverty.

An enhancement to the National Child Tax Benefit is instituted. Due to the collaborative efforts and advocacy, the Ontario Provincial Government has decided not to "claw back" this enhancement to the tax benefit for those on social assistance. For the first time, poor families will benefit directly from the child benefits. Furthermore, the political climate shows encouraging signs, such as the government campaigning for a national early childhood education and care initiative.

Despite these trends, child poverty persists. The extent of Canadian children living in poverty has been referred to as the "structural rate of child poverty" (Freiler, Rothman, & Barata, 2004). This suggests the significance of the role of economic policy in the issue.

How Bad is Child Poverty In Canada and Ontario?

Child poverty in Canada is most commonly defined as children under the age of eighteen living in families whose total gross income (before taxes) is at or below the Low Income Cut-Off

(LICO) as defined by Statistics Canada, and whose family spends more than 55% of its income on food, shelter and clothing. (Campaign 2000, 2003, Statistics Canada, 2004).

Although the national rate of child poverty has been on the decline since 1997; as of 2001, one-in-six children under the age of eighteen were living in families where the total gross income failed to meet the LICO (Campaign 2000, 2003). Sadly, this is largely the same proportion of children living in poverty that has existed for almost 30 years in Canada (Freiler, Rothman, & Barata, 2004).

Clear associations between poverty and poor child health outcomes have been well documented in the literature. A Canadian Public Health Association (CPHA) report noted that;

“Compared to their peers, poor children are disadvantaged in almost every way. 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 ... “ (CPHA, 1997).

Child health advocates have recognized the impacts of poverty upon the early period of a child’s life (generally referenced as prenatal to six years of age), but it is known that socioeconomic status affects the health of older children and youth as well (Health Canada, 2002, Campaign 2000, 2003). Early nurturing throughout childhood is critical to the life-long health and well being of individuals.

Importance of Addressing Child Poverty During Early Development/School Years

Collective responsibility must be taken for the health of infants, young children, and youth. Social disadvantage places people on predictable health trajectories at sensitive points such as at birth, starting school, or during adolescence. (Hertzman & Wiens, 1996) and (Raphael, 2001).

According to the Canadian Institute for Child Health (1997), the experience of poverty more than doubles many indicators of child ill health: the accidental death rate, low birth weight, infant mortality rate, poor school performance and psychiatric disorders – all increase by at least two-fold. Poverty affects children’s physical health, their mental health and their cognitive and social development. Poor families cannot afford nutritious food and safe places to live. The capacity of poor parents to provide a stimulating and nurturing environment for their children is undermined by the stress of responding to chronic poverty (Freiler, Rothman & Barata, 2004).

To improve health over the long term, emphasis must be placed on all critically sensitive periods during the life span, including the school years. Studies over the last two decades have found the sensitive factors operating during these periods have an independent predictive effect on adult disease and disability. Common environmental stresses and behaviour patterns experienced or learned in childhood and adolescence contribute significantly to the incidence and prevalence of disease later in life. Conversely however, patterns of healthy behaviour and stress management (learned early in life) contribute to health throughout life. This is true for a range of public health issues varying from injury, violence, bullying, teen pregnancy, obesity, tobacco use and mental health problems (Kendall, 2003).

Health Impacts of Child Poverty

The close relationship between child poverty and ill health has been acknowledged throughout the literature. The following points identify several known aspects of child poverty and health.

Indicators of Poor Health at Birth

- Low birth weight (LBW) is the most decisive indicator of poor health at birth and is closely linked with infant death, poor health during the first year of life, learning disabilities and long-term behavioural and social problems (Rachmalla, T., 1997).
- The LBW rate in poor neighbourhoods is greater than in wealthy neighbourhoods (Wilkins, Houle, Berthelot & Ross, 2000). LBW babies are at heightened risk of developmental delays, but those from higher income families are cushioned. (Rachmalla, T., 1997).
- Furthermore, LBW is later associated with poorer health in adulthood (Hertzman, 1999, in Keating).

Safety of Neighbourhoods

- Poor children are more likely to live in neighbourhoods where exposure to negative activity occurs (e.g. drug use/dealing, burglaries, violence etc.) than children from higher-income households (Ross & Roberts, 1999).
- “Children benefit from access to nurturing, stimulating, supportive, caring and safe environments. At present, access to these varies directly with SES.” (Kohen, Brooks-Gunn, Leventhal & Hertzman, 2002).

Risk of Disease related to Housing Conditions

- Children from poor families are greater than twice as likely to live in substandard housing as peers from higher-income families (Ross & Roberts, 1999).
- Poor indoor air quality in such conditions exposes children to carcinogens (namely benzene) and the risk of respiratory problems (Ross & Roberts, 1999).
- Low-income residences can also create situations that are not conducive to academic pursuits or leisure activities (Ross & Roberts, 1999).

Stress of Poverty

- Parents of low-income households are four times more likely to feel constantly stressed than parents of high-income households (Ross & Roberts, 1999). It has been shown that parents under chronic stress are more likely to be not as attentive, more harsh and

abusive with their children, than parents who are happy and feel in control of their lives (Ross & Roberts, 1999).

- “A body of evidence is now emerging which shows that health outcomes in adulthood reflect the accumulating influence of poor socioeconomic conditions throughout life. Adverse socioeconomic conditions in early life can produce lasting increases in the risk of cardiovascular disease, respiratory illness, and some cancers late in life.” (Shaw, Dorling & Smith, 1999, p. 216, cited in Raphael, D. (2001).

Association between Food Insecurity & Poor Health

- Thirty-nine percent of Canadian food bank clients in 2003 were children under 18 years of age. This is greater than their proportion of the overall Canadian population (25.9%). Furthermore, reliance upon foodbanks among low-income families has increased. Not surprisingly, food banks throughout Canada report that inadequate minimum wage and social assistance rates as well as expensive rent encompass the reasons for the increased demand for food banks (Orchard, Penfold & Sage, 2003).
- Inadequate nutrition can impact upon children’s ability to learn as well as to develop physically (Ontario Society of Nutrition Professionals in Public Health (OSNPPH) School Nutrition Workgroup Steering Committee, 2004). Sufficiently-nourished children and youth have greater chances of being better prepared to learn, participate in regular physical activity and to maintain their health as adults (OSNPPH, 2004).

Poor Oral Health and Access to Dental Care

- Good oral health is particularly unattainable for children living in poverty in Ontario, as dental care is not covered by OHIP, unlike medical services. It has been demonstrated that those in lower socioeconomic groups report less visits to dentists, receive fewer preventative services, and usually only visit dental offices for emergency care (Newacheck & Halfon, 1988; Edelstein et al, 2000; Waldman et al., 2000).
- Furthermore, US-based studies conducted during the 1990’s found that children living in poverty experience a higher average number of treated and untreated infectious teeth than their peers living above the poverty level (Brunelle & Carlos, 1990, Brown et al., 2000). There is a need for the Ontario government to ensure the provision of necessary dental care for all children in Canada, regardless of income or supplementary/private coverage.

Association between Low-Income and Physical Inactivity

- Regular physical activity helps to reduce the risk of heart disease, hypertension, stroke, type 2 diabetes, osteoporosis, certain cancers and depression inactive (Craig, & Cameron, 2003). Being regularly active is an important part of healthy growth and development for children.

- Youth living in higher income families are more likely to be physically active (Craig, & Cameron, 2003). User fees for recreational facilities also create barriers to participation for poorer children (Canadian Council on Social Development, 1997).

Poor Academic Performance

- Poor children are more likely to experience a delayed development of vocabulary than peers from higher-income households (Ross & Roberts, 1999).
- Difficulty with mathematics has also been observed to lessen with an increase in family income (Ross & Roberts, 1999).

Inequity Influences Potential to Achieve Health

The rise in child poverty is symptomatic of larger economic changes occurring in Canadian society, in particular increasing inequity in labour income. Child poverty is the consequence of a widening disparity between the “have’s” and “have-not’s” in Canada (Freiler, Rothman, & Barata, 2004).

The growing income gap has been attributed to a few key factors; namely globalization, the information age/computer revolution and the free market capitalism/corporate expansion supported by conservative provincial and federal governments in Canada (Labonte, 2003). Previously, federal/provincial transfer payments buffered the impact of the increasing disparity in earned income, but cutbacks to employment insurance and social assistance in the 1990’s took away this countervailing influence. When the Child Tax Benefit was introduced, many provincial governments, including Ontario, “clawed back” the benefit by reducing social assistance payments.

But poverty is also a health issue; it has an enormous impact on health status (Phipps, 2003). Health status in Canada is linked to the traditional policy of social transfer payments, strong services and other policies that promote equalization of income. There is room for improvement; European citizens in countries, which have a more equitable distribution of income than Canada, live longer and healthier lives than Canadians. (Raphael, 2001) Most Canadians endorse the idea of equal access to health care, but equal access to health is not a reality in this country. Health is distributed unevenly in Canada, with poorer people dying sooner and being sicker than middle class people, who in turn die sooner and are sicker than wealthy people (National Forum on Health, 1997).

Policies and Programs that Make a Difference

There is well-established evidence that the health of children who live in poverty is being compromised in many ways. Poverty and income-inequality is now understood to have a similar, if not higher, risk ratio for many chronic diseases than “lifestyle” and behaviour (Canadian Institute for Advanced Research, 1997, Spencer, 2003).

What is the best public health response for prevention and protection of those affected and for promotion of child and youth health? Research evidence and experiences in other jurisdictions suggest we can reduce child poverty help children and their families minimize the disadvantages and health impacts associated with living in poverty.

“As part of this process of public education, we need to persuade the community to begin to look at children as the Europeans do – as a shared natural resource that represents society’s future – rather than as most North Americans do – as solely the responsibility of their parents.”

Dr. Paul Steinhauer of the Sparrow Lake Alliance

Reducing poverty

Studies of the international and regional variability of child poverty rates demonstrate that the scope of poverty is modifiable, but there has to be an investment (Beauvais & Jenson 2003, Campaign 2000, 2003). UNICEF reports in 2000: “The countries that sit at the top of the child poverty league tables also sit at the high end of the social expenditure axis.” Canada has not yet done well in child poverty reduction – in three decades we haven’t succeeded despite an all-party commitment to end child poverty by 2000. Canada is third from the bottom in child welfare, in the ranking of 12 developed countries; at the same time we have successfully reduced the poverty of the elderly by 90% (Smeeding, 2003). The high number of children living in dire straits does not reflect Canadians’ values. Countries with the lowest levels of child poverty have the highest rates of social investment: we can pay now or pay later. (UNICEF, 1996).

“Child and family poverty is a structural problem that exists because the economy creates inequalities in resources and opportunities.....Unless the structural sources of child poverty are addressed, there will always be a new vulnerable group that ends up in poverty and replaces others for whom progress is being made (Freiler, Rothman, & Barata, 2004).” The persistence of child poverty in Ontario demonstrates that a strong economy and economic growth are insufficient to ensure poverty is averted. (Campaign 2000, 2003). Canada needs a comprehensive, long-term plan on reducing child poverty (for example, the U.K. has a 20 year strategy), that has participation from all levels of government (Campaign 2000, 2003, Rothman, 2004).

Transfer payments and social security policies are largely responsible for the difference in rates between Canada and other countries. For example, in Sweden the government assumes the responsibility for ensuring that single parents receive support payments. The government then reclaims the money from the support-paying parent. In Canada, more than 70% of female single parents live in poverty (Ross, Scott & Kelly, 1996). The government does not however pay support up front and social assistance payments to single parents are well below the poverty line. Clearly, public policy measures are levers that can raise or lower child poverty rates.

Two factors, the depth of poverty and the length of time poor, are showing effects such that poverty in older children and youth require attention, tracking and public response as well (Ross & Roberts, 1999).

Resiliency Factors

Fostering resiliency in children, families and communities is key because it strengthens the capacity to respond to multiple stressors. In the last 30 years, it has been demonstrated that several initiatives are effective in helping disadvantaged children and families reduce the negative outcomes associated with poverty. These initiatives address the many risk factors that undermine the development of resiliency, while promoting the development of protective factors in the personal characteristics of parent, children or both. There is good evidence that a supportive social environment can unlink children from the effects of disadvantage and economic deprivation (Power & Hertzman, 1999).

Early interventions to protect our many vulnerable children and youth “...will, more than any other single factor, influence their health, their mental health, their school achievement, their ability to control their aggression, and their future productivity as members of society (Steinhauer, 1995).” This does not mean that resources and interventions for later years are not also needed.

Inclusion and participation through broader interventions such as early childhood education and care, employment, housing, and community building are essential elements in the mix of strategies to adequately address child poverty. Children who belong to communities, whose parents belong to communities, and who participate in decisions affecting their lives are empowered. Childcare in quality licensed settings are required for positive child outcomes for working parents; 90% of Canadian families lack access to this care. (Toronto Charter, 2002).

More recently, initiatives have begun to address the protective characteristics in schools and communities in order to create supportive environments. There is an international movement towards comprehensive approaches to school-based health promotion that include formal and informal health education, health and social support services, supportive social environments and safe and healthy physical environments. These can have a greater impact on health and health-related behaviours of young people than health education alone. When professionals, service providers, parents and volunteers work collaboratively with schools and children, young people are surrounded with a community who cares about them. (Laforet-Fliesser & Mitchell, 2003)

Home visiting, centre-based enriched preschool programming and community action leading to participation and ownership are examples of strategies that have been used to increase resiliency. The implementation of the universal Health Babies, Healthy Children program in Ontario aims to increase confidence in parenting and child development outcomes in vulnerable families. In addition, the formation of the Ontario Early Years Centres across the provinces aims to increase parenting resources for parents. Public Health Units are mandated to provide population-based child and family health programs and provide early child development

programs to strengthen the health potential of children and families (Ontario Ministry of Health, 1997).

Many of these initiatives share similar goals: enhancing parenting capacity, fostering healthy child growth and development, (including a healthy birth weight), reducing rates of child maltreatment, improving children's social and coping skills and cognitive development, increasing access to community resources and developing supportive and participative communities. Effective programming involves identifying both the risk and protective factors in children, families and communities that contribute to, or undermine the development of resiliency, and then identifying effective interventions in the research literature that impact on these factors.

Two examples of resiliency initiatives, in which public health played a key role are provided here. Many school-centred protective factors seem to be associated with resilience and future success in dealing with life's challenges. These are: success in school socially and/or academically; positive engagement with peers; supportive and positive peer dynamics. Programs promoting stability in the home, school and community settings, with an emphasis on continuity and a sense of safety in relationships between youth and non-youth have been shown to foster resilience in adolescents. The fostering of resilient qualities in children and youth offers a positive approach to reducing risk for health-related problems while helping achieve what it is that we want to achieve - responsible, caring, competent adults. (Kendall, 2003)

In a child's early years, initiatives that help babies to be born healthy, help infants to develop security through the appropriate care of a primary caregiver, and help toddlers and preschoolers to grow up in a stimulating and nurturing environment, have been shown to help children become more resilient (McCain & Mustard, 1999).

Reducing Child Poverty/Enhancing Resiliency: Setting Goals

The Ontario Public Health stakeholders must understand the connection between poverty and health, for children and others. Health inequities are avoidable and are now being recognized by researchers and health workers as important to have a greater impact on illness-reduction efforts. In order to have a significant impact on the health status of Ontarians, they must support a broad social and political agenda to create conditions that both reduce poverty and increase resiliency. Public health in Ontario, along with municipal governments must begin to lend support to the following directions established by the Coalition of Partners (over 85) of Campaign 2000 (see Table One below).

Table One: Goals for Eliminating Child Poverty in Canada

- Increase availability of good jobs at living wages, raise minimum wages and provide better protection through Employment Insurance.
- Create an effective child benefit system that provides enough income support to keep working parents, including single parents, out of poverty that is not clawed back from social assistance recipients.
- Build a universally accessible system of quality early childhood education and care to support optimal early development of children and to enable parents to work or receive training.
- Expand affordable housing significantly to end adult and family homelessness and enable parents to raise their children in healthy community environments; and
- Renew the national social safety net through the new Canada Social Transfer, with increased federal funding and improved accountability for provincially delivered social services, including social assistance.
- Reinvest in a public education system to allow for comprehensive school health initiatives and community programs, including increased access to affordable post-secondary education.

Sources:

Campaign 2000. (2003). *Honouring our promises: meeting the challenges to end child poverty and family poverty – 2003 Report card on child poverty in Canada*, Toronto: author.

Campaign 2000. (2003). *Child poverty persists. Time to invest in children and families. 2003 Report card on child poverty in Ontario*. Toronto: author.

These initiatives are consistent with the directions selected by the Canadian Centre for Policy Alternatives (Beauvais & Jenson, 2003, 1998), the Canadian Public Health Association (1997, 1995), the Federal/Provincial/Territorial Advisory Committee on Population Health (1996), the National Forum on Health (1999), the Registered Nurses Association of Ontario (1998), National (US) Association of County and City Health Officials, (Bhatia, 2003) and many others.

Since the first version of *Towards a Public Health Approach to Reducing Child Poverty and Enhancing Resilience* OPHA position paper (1998) Canadians have seen some success in addressing child poverty. There are changes in the Federal/Provincial transfers (the new Canada Social Transfer, in particular). There is enhancement in early childhood programs in Ontario, particularly with the home visiting services for families who qualify for the Healthy Babies Healthy Children services. From these efforts and the social investment of the Federal Government since 1999, there has been a slight reduction in child poverty (from one in five to one in six), back down to the level of 16% nationally – the same as 30 years ago. Yet, still one in three children in the City of Toronto live in poverty. Thus, these efforts have not gone far enough. Comprehensive approaches are shown to be protective during economic downturns and contribute to overall stability (Ross, 2003). Table Two lists the broad-based Social Investment Strategies that are required to have a significant impact on the lives of millions of Canadian Children.

Table Two: Social Investment Strategies

- set targets/plans and policies for “good jobs” (e.g. fair pay, decent working conditions, increase minimum wage), reduce unemployment through training opportunities
- create family friendly work environments: expand those eligible for parental leave, flex work arrangements, on-site child care, reduced work hours, appropriate remuneration for overtime, job sharing
- expand employment insurance eligibility
- change the tax structure so that single earner families are not placed at a disadvantage
- enhance child benefits nationally and provincially, stop the claw back
- dental and other health benefits for children of the working poor (continue benefits for those on assistance)
- government to pay child support and seek reimbursement from paying parent
- make high quality, affordable early education and care available to all parents who need them, expand the subsidy
- ensure universal junior kindergarten, better resources for comprehensive public school programs
- implement a comprehensive community-based public planning process to support young children and facilitate a smooth transition between preschool and school
- Stabilize and enhance the HBHC program funding to strengthen BF duration and reduce PP adjustment disorders (both enhance resiliency)
- create healthy school environments: support comprehensive school health approaches
- design the new Canada Social Transfer such that dedicated funding exists with national standards in social services, education and income support
- renew financial support from federal and provincial governments for existing and new social housing and co-op housing units, Ontario to stop downloading social housing costs to municipalities
- continue to support the advocacy work and the distribution of the annual report card on Child Poverty in Canada (and Ontario) by Campaign 2000
- lobby such that international trade agreements include safeguards for social programs, enhance social development, and protect human rights

Sources:

Campaign 2000, (2003), Hyndman and Telford (2003), Beauvais & Jenson (2003), Ross (2003)

A Public Health Approach to Child Poverty

In addition to the support of the above macro initiatives, it is time for public health to apply population health approaches to poverty as the key determinant of health for all, especially children. Many public health staff work directly with families affected by poverty, and are also effectively connected with community groups and organizations which could also be in a position to take action to improve child health (policy makers, schools, parents, businesses). Increasing inequities in income will continue to contribute to overall disease rates, limiting the impact of other protection and promotion efforts and increasing costs to the health systems.

Within the realm of public health practice, expertise and knowledge about epidemiology and the broad determinants of health increases the legitimacy of action on poverty-related concerns and early childhood interventions. Public health workers also offer resources and skills in community organizing and animation. These can all be applied to addressing poverty as the root cause of ill health especially for children, just as this same knowledge, these resources and similar skills are applied to physical activity, tobacco use prevention, etc. in addressing other risk factors for chronic diseases. Poverty and income-inequality is now understood to have a similar if not higher risk ratio for many chronic diseases (Canadian Institute for Advanced Research, 1997).

Hyndman and Telford (2003) identified six components and goals for a public health response to income inequalities, and OPHA is wise to select actions as opportunities arise, and create opportunities for those strategies that are needed (see Table Three).

Table Three: Public Health Response to Income Inequalities

Education:

Foster individual, organizational and community understanding of the health impact of poverty and what can be done to alleviate it.

Capacity Building:

Provide individuals and communities with the skills, resources and opportunities to take appropriate action to alleviate the health impacts of poverty.

Research and Knowledge Development:

Carry out a comprehensive program of research and knowledge development that monitors the health impacts of poverty at the community level and informs the development of initiatives to meet the health needs of low-income people.

Organizational Change:

Enable organizations to create environments that alleviate the health impacts of poverty and reduce poverty for clients and employees.

Advocacy:

Influence decision-makers to support programs and policies aimed at reducing poverty and increasing equitable access to the determinants of health.

Policy Change:

Guide the development of local, provincial and federal policies addressing the social and economic conditions contributing to poverty.

Source: Hyndman & Telford (2003)

Public health workers face significant barriers in taking action on child poverty. Many believe that addressing poverty is not the jurisdiction of public health, just as some once thought that advocating for reduced speeds on highways was not within the realm of public health practice. There are challenges (e.g. political) and limitations (e.g. skills) for a publicly funded body to engage in policy advocacy and political action. Furthermore, negative attitudes and misconceptions about the poor undermine such action and advocacy, and require complex approaches (Reutter, Harrison & Neufled, 2002; Edwards, 1999).

Finally, the Mandatory Health Programs and Services Guidelines [MPSG] (Ontario Ministry of Health, 1997) focuses public health into program “silos,” rather than on population health, community action and advocacy for all. The lack of resources to implement the MPSG also limit Boards of Health to tackle emerging health issues and quickly and adequately respond to evidence-based approaches, with scarce funding and easily-outdated directives.

The MPSG (1997) do recognize poverty as a “barrier” to equal access of public health programs. One objective in the MPSG is “to increase the percentage of children who meet physical, cognitive, communicative and psychosocial developmental milestones by school entry.” Others objectives include reducing the low birth weight babies (under 2500 g) to 4% by 2010, and reducing the prevalence of dental diseases in children and youth. Each of these health outcomes are directly influenced by income in families, but addressing poverty is not yet listed as a key strategy in the Guidelines. The consultations noted in *Operation Health Protection...* (Ontario Ministry of Health and Long -Term Care, 2004) offer an excellent opportunity to address these specific limitations but also the overall strategy of addressing poverty as a determinant of health.

Even with existing systemic and resource barriers, public health must take a broad approach to reducing the level of poverty and addressing the health impacts of child poverty. This will decrease exposure to child poverty and continue to enhance the resiliency of poor children.

Advocacy for Healthy Public Policy and Practice

The research base in public health strongly suggests that while a balance of initiatives is necessary, *policy change is a key factor in promoting health goals*. From the Toronto (2002) and Ottawa Charter (1985) to the Jakarta Declaration (1996) and OPHA strategic review (2003), the importance of a strong public health movement advocating for government policy and programming supportive of the health of our communities has grown.

Effective advocacy for policy improvements involves describing the problem (such as in this position paper) followed by a number of activities:

- assess community capacity and readiness
- complete a policy analysis (monitor current and proposed policies and assess their effects on the health of children in preschool and school periods)
- develop policy options stemming from goals and objectives, often in collaboration with policy makers at different levels of government

- identify key decision-makers, raise awareness
- enable community members to identify and advocate for policy priorities
- build support for policy by, for example, educating communities and leaders about policies and programs and their actual and potential health impacts
- rewrite/revise the policy as needed, continue until adopted (The Health Communication Unit, 2004)

OPHA Takes Action

The OPHA can show leadership and lend credible support to partners such that public health addresses poverty as a determinant of health - to both prevent ill health and to limit impact on health (prevention and protection) - with the following action outcomes in mind.

- OPHA members become informed on economic and health issues, and articulate about the importance of addressing the determinants of health to achieve public health goals.
- OPHA advocates for a more active role for Local Official Health Agencies in addressing income inequality and all other known determinants of health. This can be done both with monitoring the social determinants of health and intervening with those determinants. OPHA coordinates this activity with the Public Dental Health initiatives.
- OPHA is represented at and participates in the National Coalition of Campaign 2000, in Ontario.
- OPHA advocates to the Federal, Provincial and local governments at each appropriate opportunity regarding the importance of reducing child poverty, as well as improving those policies which affect child health (e.g. housing, child care, employment insurance, etc). Specifically, OPHA influences the public health consultations planned by the Ministry of Health and Long Term Care (2004), as noted in *Operation Health Protection: an action plan to prevent threats to our health and to promote a healthy Ontario*.

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Regarding resolutions, position papers and motions:

Status: Policy statements (resolutions, position papers and motions) are categorized as:

Active, if:

1. The activities outlined in the policy statement's implementation plan have not yet been completed; or
2. The policy statement addresses an issue that is currently relevant to public health in Ontario.

Archived, if:

1. The activities outlined in the policy statement's implementation plan have been completed; or
2. The policy statement addresses an issue that is not currently relevant to public health in Ontario or is not based upon the most current evidence. The statement remains the position of the OPHA until a new statement is adopted that effectively reverses or essentially negates all or major elements of an earlier statement. In this instance, the former supersedes the latter

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