



# HORIZONS

ISSUE 2 • 2019

THIS ISSUE:

## Poverty AND Health

### Screening for Poverty Addressing the Root Causes of Ill-Health

*By Mike Bell*

Poverty and poor health are indisputably linked, and evidence to support this notion has been available for decades, in almost every country and jurisdiction across the planet. For many, these data are well understood and recognized. Yet as a province and region, we have been unable to address the ill-effects of poverty in a meaningful way.

**In Kingston**, the poverty rate has increased in the past the poverty rate has increased in the past 10 years. According to the 2016 census, 14.8 per cent of the Kingston population lived in poverty, compared with 11.1 per cent in 2006. This will surprise many, and we should all be saddened by the reality.

In this article, I hope to accomplish three things: 1) provide a brief overview of how and why poverty and health status are connected; 2) reflect on the current policy environment in Ontario, and how we have a great opportunity to focus on the social determinants of health; and 3) provide some practical program and referral options for busy health-care providers.

### Poverty and Health Status

The World Health Organization (WHO) has declared poverty as the single most important determinant of health. The Canadian Medical Association (CMA) graphic (Figure 1) supports this argument. Yet, despite such conclusive evidence, health-care discourse continues to focus almost entirely on our medical system. Deliberate dialogue connecting health status to financial status is lacking.

Health Quality Ontario (HQP) data also shed light on the negative health consequences of income disparity. Figure 2 illustrates that the poorer you are, the more likely you are to be hospitalized for conditions that are typically managed outside the hospital. Figure 3 is even more disturbing, demonstrating that the poorer you are, the younger you are likely to die. No further evidence is

required, and we must all acknowledge that addressing poverty is an essential way to improve the health of individuals and communities.

Another vital aspect of this debate is the impact of poverty on the family unit. If there is hope to break the cycle of poverty, and consequently improve health for our community, consider the living conditions of impoverished families. Children thrive on stability and predictability; an environment where parents are living with chronic poverty stress has a plethora of negative health consequences for the parents and children. Children in low-income families are at a higher risk of low birth weight, mental health problems, micronutrient deficiencies, asthma, and hospitalization. This environment has also been proven to lead to poor coping behaviours such as smoking, substance use, bad relationships, and more.

It is for these reasons and more that poverty itself has been declared an [Adverse Childhood Experience \(ACE\)](#)<sup>1</sup>. The significance of this reality, and its impact on the health-care system, must not be overlooked. Governments and health-care leaders must accept the challenge to work more upstream to address proven causes of ill-health.

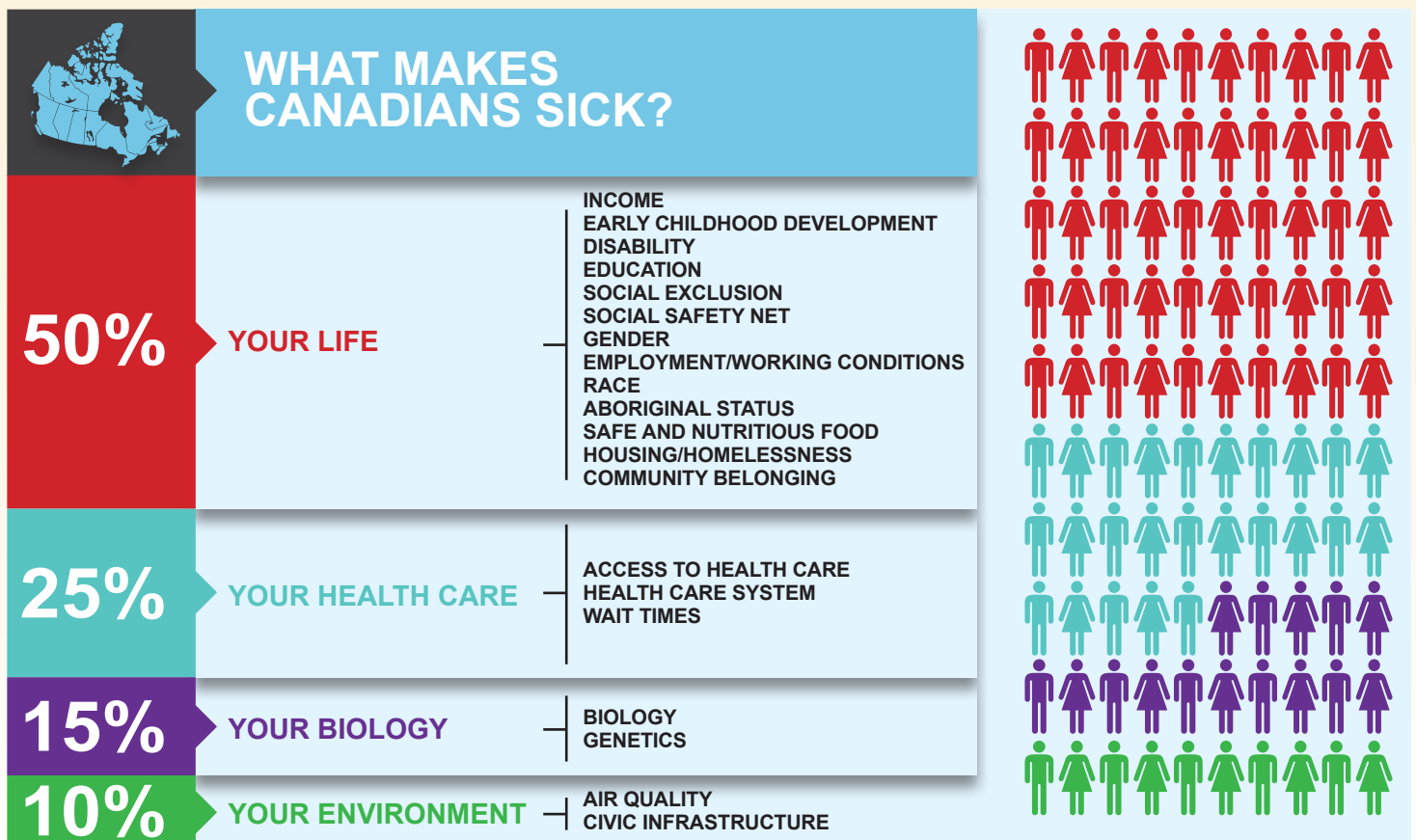


Figure 1: *Health Care in Canada: What Makes Us Sick?* (Canadian Medical Association)

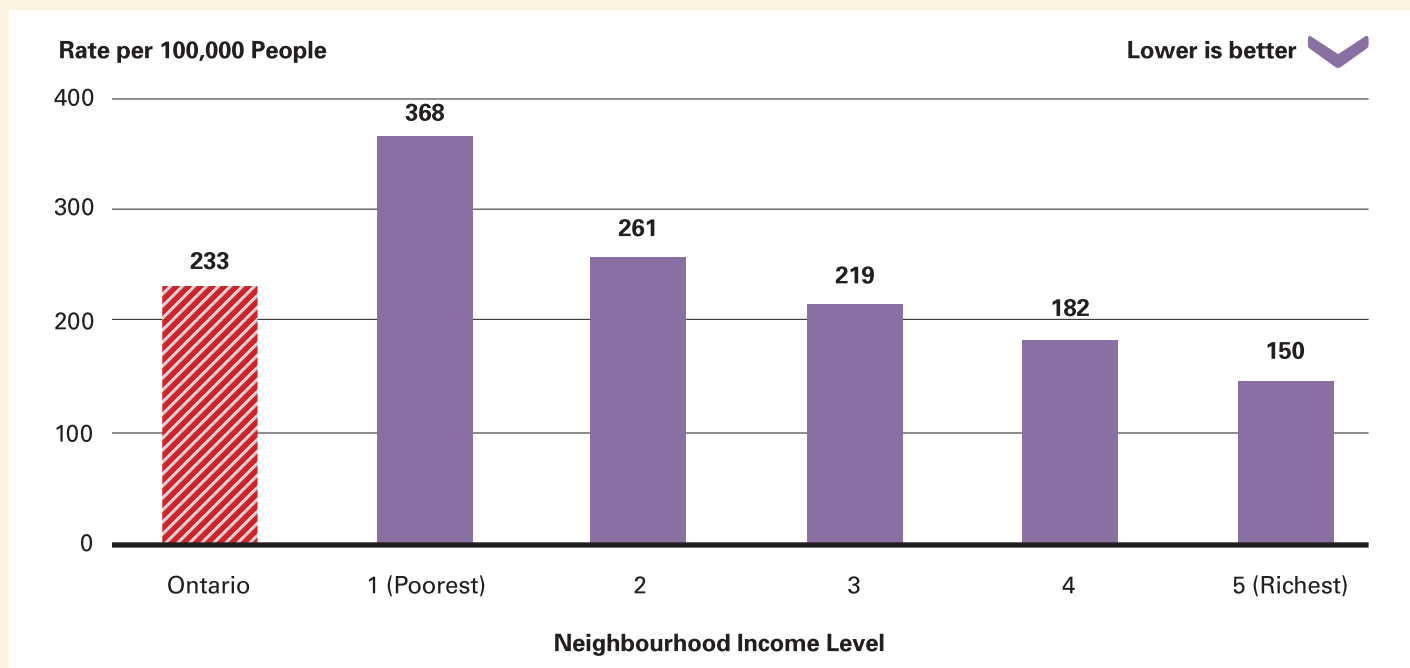


Figure 2: Hospitalization rate for ambulatory care sensitive condition, in Ontario, by neighbourhood income level, 2013/14.

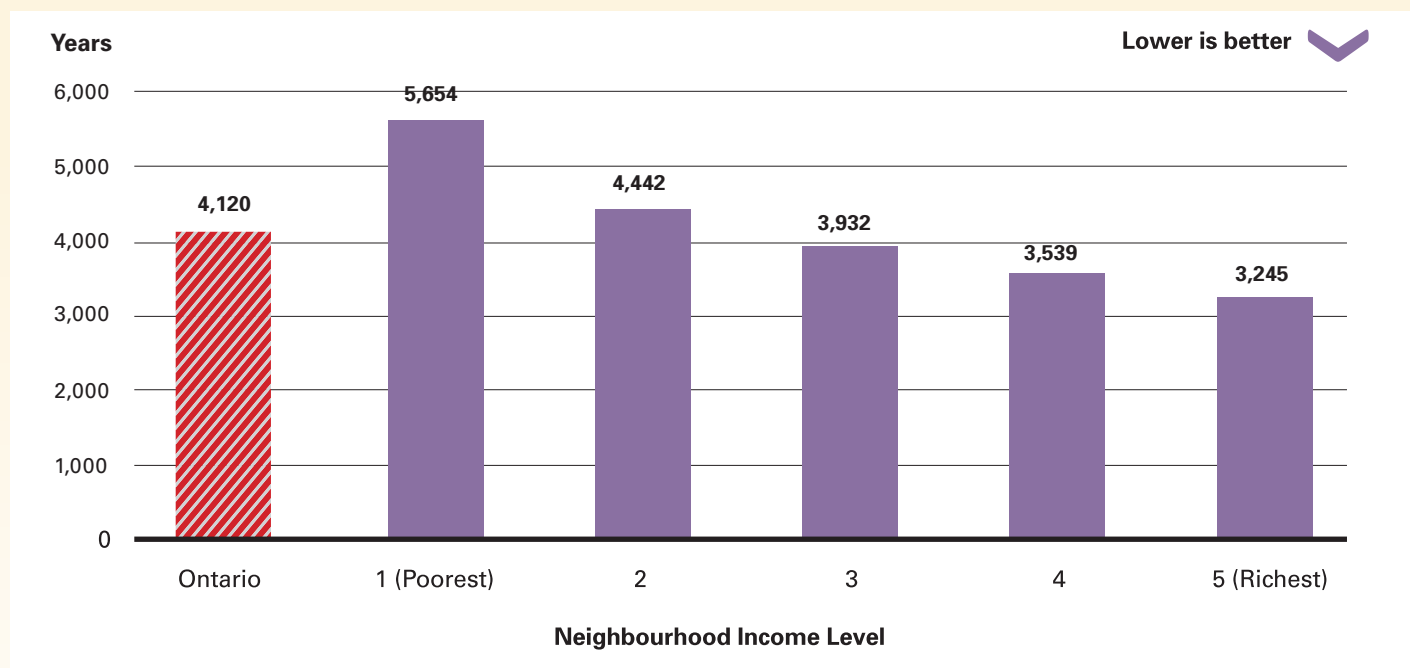


Figure 3: Potential years of life lost per 100,000 population, in Ontario, by income level, 2009-2011

Figures 2&3: Health Quality Ontario – [Income and Health: Opportunities to Achieve Health Equity in Ontario](#)



### Current Policy Context in Ontario

As described in a CBC analysis, *What You Need to Know about Ontario's New Model for Health Care*, Ontario is in the midst of the most significant transformation since the advent of Medicare nearly 50 years ago. According to the Ministry of Health and Long-Term Care, Ontario Health Teams (OHTs) have been presented as a new way of organizing and delivering services in local communities. Under OHTs, health-care providers (including hospitals, doctors, home-care providers, and community services) will work as one co-ordinated team — no matter where they provide care. The success of these teams will be measured by the Quadruple Aim, which prioritizes the following four metrics: patient experience, population health, health-care provider satisfaction, and value for money.

There will be many critical decisions along the way for OHTs, including where to start. Which initiatives would have the most success relative to the Quadruple Aim? There is a long list of meaningful topics.

Improvement efforts in health-care typically focus on a specific disease state or hospital-related issue (e.g., mental health, chronic obstructive pulmonary disorder, diabetes,

ED diversion, ending hallway medicine, etc.). These are all important topics, and thousands of health-care leaders across the province have put forth herculean efforts toward addressing them. These efforts must continue. However, when the WHO, CMA, HQO and others declare poverty as the single most important determinant of health, how will OHTs address this reality?

One factor is clear, a point that hospital leaders express frequently: solutions to ending hallway medicine and ED overcrowding will not be found in the hospital setting. Solutions are needed in communities, neighbourhoods, and homes. Ontario health networks provide an opportunity to build a modern system, a system that acknowledges social determinants as more important than medical determinants.

In summary, this short article contends that, in order to address the root causes of ill-health, a change in the prevailing health-care paradigm is needed. How can we act on the evidence that screening for poverty is just as important as screening for hypertension? We have an opportunity within OHTs to build a system that is more responsive and proactive than ever before.

Please find following a list of referral options:

<sup>1</sup> Other ACEs can include neglect, abuse, living with a parent who has a mental health issue, having an incarcerated parent, etc. The more ACEs someone experiences, the sicker they become. A proper review of ACEs is beyond the scope of this article, but for anyone interested, please reach out to KCHC physicians and staff who would be willing to host a conversation on this topic (regardless of size or type of group).

## REFERRAL OPTIONS

Acknowledging that the concepts I've discussed will not help a busy health-care provider support low-income patients today, there are a number of referral options patients may benefit from immediately. These are offered through Kingston Community Health Centres and partners. If interested, please call 613-542-2949, Ext. 5154.

**Practical Assistance.** This program offers advice and information referral, and connects individuals and families with resources within the community. Some of the most commonly sought-after areas of assistance include addressing rental and utility arrears, obtaining fuel and oil, applying for the Ontario Energy Support Program, and accessing emergency food programs and winter clothing, etc.

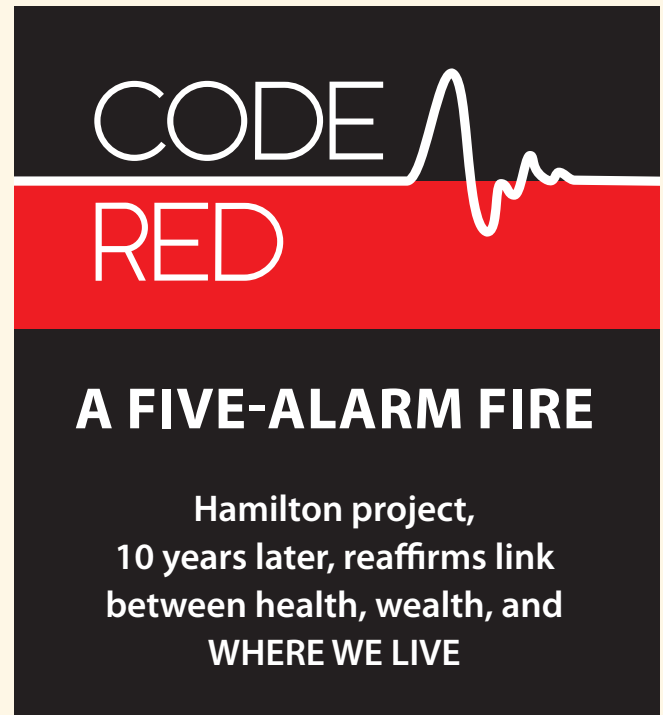
**Circles.** In partnership with Loving Spoonful and the City of Kingston, this program hosts weekly gatherings around meals to build community. The program gathers middle- and high-income volunteers to support families in poverty. Surrounded by people who have experience finding jobs, negotiating a lease, or managing credit card debt, people in crisis are more equipped to achieve long-term financial stability. This program launched in the US in 2004, and their data shows participants who complete the program achieved a 39-per-cent increase in income after six months and a 78-per-cent increase in income after 18 months.

**Pathways to Education** is a unique community-based program designed to increase high school graduation rates. It focuses on helping high school youth through tutoring, mentoring, financial support, and advocacy. Through the collective power of partnerships, Pathways to Education's innovative program is preparing youth for tomorrow and working to break a cycle of poverty. The program has helped more than 800 students in Kingston since 2010 and is now available in 21 communities across Canada.

**KCHC Dental Clinic** is a low-barrier clinic at 263 Weller Ave. that is open to those who have urgent dental needs but do not have adequate resources or private insurance to cover the cost. The clinic sees children, adults, and seniors.

**Want to screen for poverty in your practice?** Interested in screening addressing poverty during your next appointment? Consider [\*Poverty: A Clinical Tool for Primary Care Providers\*](#), offered by the Centre of Effective Practice.

*Mike Bell is CEO of Kingston Community Health Centres.*



*By Steve Buist*

In April 2010, we started a conversation in Hamilton with a project we called Code Red.

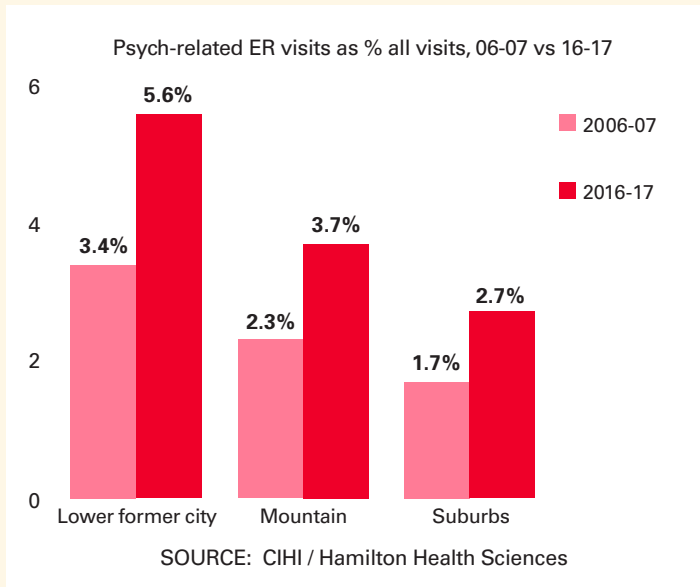
Using large data sets of health, social and economic information, we were able to map the health of Hamiltonians down to the level of neighbourhoods. From there, we were able to show the very strong connections that exist between health, wealth, and where you live.

It was a groundbreaking project and the results were shocking.

We showed there was a 21-year difference in lifespan between the best and the worst neighbourhoods in Hamilton. At the bottom end, we had a neighbourhood with an average lifespan of 65.5 years, something we'd expect to see in Third World countries.

We showed there was a 13-times difference in the rates of people showing up in the ER between the best and worst neighbourhoods. When it came to psychiatric-related emergencies, there was a 33-times difference in the rates between the best and worst neighbourhoods.

Time and time again, we showed huge gradients in health outcomes and the pattern was always the same. The places with the worst health outcomes were also the places with the highest rates of poverty, lowest incomes, and lowest rates of post-secondary education, while the best health outcomes were in the richest parts of the city.



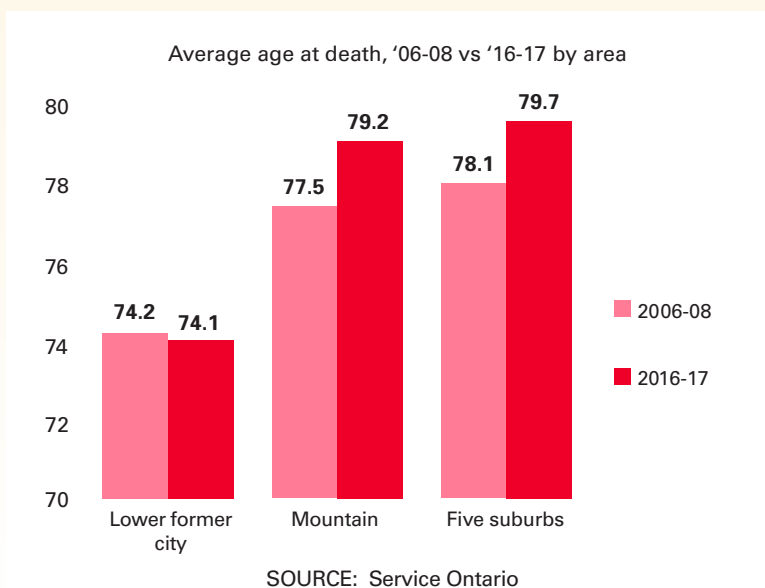
Not surprisingly, Code Red led to a lot of angst and introspection within Hamilton. But it also led to a lot of action and initiatives across a number of agencies, including the City of Hamilton, the hospital systems, McMaster University and Mohawk College.

In the fall of 2011, we published a second Code Red project that looked at the health of moms and babies. In a particularly hard-hit part of Hamilton’s inner city, we found that more than one in seven babies was being born to a teen mother. Meanwhile, in a part of neighbouring Burlington, one of the country’s most affluent cities, there had been 774 births over the same period and not a single one of them was to a teen mom.

In the fall of 2013, we published our third Code Red project, with a spotlight on cancer. We showed that while there’s some



*The places with the worst health outcomes were also the places with the highest rates of poverty, lowest incomes, and lowest rates of post-secondary education.*



randomness in who gets cancer, there’s a lot less randomness in who dies from cancer. The cancer mortality rate was 90 per cent higher in Hamilton’s inner city core than it was in Ancaster, the richest of the city’s five suburban communities. When it came to lung cancer, there was a 15-times difference in mortality between the best and worst neighbourhoods.

Now, a decade on from the original Code Red project and armed with updated health and socioeconomic data sets, we’re back with a simple question. Ten years later, what’s changed in Hamilton?

Sadly – horrifyingly – not much.

In fact, 10 of the 13 health variables we measured actually worsened over a decade. That’s despite years of action and the mobilization of resources to seek improvements.

A decade ago, there was a 21-year difference in lifespans between the best and worst neighbourhoods. Now the gap has grown to 23 years between best and worst. We now have one neighbourhood in Hamilton where the average lifespan is 64.8 years. That's worse than the ravaged African nations of Eritrea and Malawi.

In a large swath of Hamilton's inner city, the average lifespan declined by 1.5 years over a decade, from 72.7 years to 71.2 years. That's comparable to what's being seen in U.S. Rust Belt states and rural areas like Appalachia that are being devastated by the opioid epidemic. And in case you're wondering if it's a statistical anomaly, there are 68,000 people living in that part of Hamilton and the current average was based on more than 1,240 deaths.

We showed that people living in the lower part of the former City of Hamilton live five years less on average than those living on the Hamilton Mountain and nearly six years less than people living in Hamilton's five suburban communities.

We showed that the number of ER visits in Hamilton jumped by nearly 30 per cent in a decade even though the city's population only increased by about six per cent over the same period.

We showed evidence of what appears to be a mental health crisis in Hamilton. The proportion of ER visits for psychiatric-related emergencies jumped by nearly 60 per cent over the span of a decade. What's worrisome is that the number of psychiatric-related emergencies is rising across all parts of the city, rich and poor.

Addictions, particularly opioids, are certainly playing a role. There were 37 opioid-related deaths in Hamilton in 2014. In 2018, there were 122.

We showed that the number of hospital beds in Hamilton being taken up with patients who need to be in a different type of care facility has grown substantially in a decade. On an average day in 2017, there were 189 hospital beds in Hamilton out of commission because they were taken up with alternate-level-of-care patients. To put that in context, that's more beds than there are in Guelph General Hospital.

"We need to accept that this continues to be a five-alarm fire in terms of health outcomes and the way in which we're doing business," said Terry Cooke, president and CEO of the Hamilton Community Foundation.

The latest Code Red results are disturbing and discouraging.

They're also not entirely unexpected.

As *The Hamilton Spectator's* census project showed in 2017, social and economic factors have not improved over the past 10 years when areas of Hamilton are compared to each other.

When it comes to income, poverty, and education, there has been almost no movement in reducing the gaps between the best-performing and worst-performing neighbourhoods over the past decade.

Look, we recognize that 10 years is not a long enough period of time to change something as fundamental as population health. It means also changing social and economic factors, and that requires all three layers of government.

But while 10 years might not be long enough to see big changes, it's more than enough time to be concerned about the lack of progress we're seeing in Hamilton.

Read [A Five-Alarm Fire: Code Red, Ten Years Later](#).

For the complete series, visit [Code Red](#).

*Steve Buist, M.Tech., B.Sc., is an investigative reporter and feature writer with The Hamilton Spectator. He is the creator of the widely acclaimed Code Red project, which examines the connections between health, social and economic factors in Hamilton. He has won four National Newspaper Awards, been named Canada's Investigative Journalist of the Year three times, Ontario's Journalist of the Year five times, and winner of the world's top cancer-reporting prize by the European School of Oncology.*

CODE  
RED

Queen's Department of Family Medicine  
will host Steve Buist to present:

## ***A Five-Alarm Fire Code Red: Ten Years Later***

**Friday, November 22  
Noon to 1 p.m.**

**Kingston Frontenac Public Library  
130 Johnson St., Meeting Room 1**

All are welcome.  
Brown-bag lunch. No registration required.



# Tasked to Find Solutions

## How the City is addressing multiple societal challenges

*By Mary Rita Holland*

Eliminating poverty remains one of the most potent and persistent challenges we face in our community. So many of our children, families, and neighbours are vulnerable to desperate circumstances that can be caused in an instant by an unexpected layoff, family breakup, accident, or illness – or by ongoing cycles of poverty that span generations.

### Poverty Reduction

The City of Kingston is invested through its 2019-2020 Strategic Plan to foster healthy citizens and vibrant spaces, strengthen our economic development opportunities, and increase housing affordability. The City also recognizes

that poverty reduction and prevention is key to ensuring a stronger community. The value of ensuring income supports, food, clothing, and other daily essentials is extremely important, but so are preventative measures such as diversion from emergency shelters to safe, stable, affordable, long-term housing.

The City provides a number of services and supports related to income security, housing, and health benefits through the Housing and Social Services department, including Ontario Works financial assistance to cover basic needs, and health and dental coverage. Employment assistance is also provided through Ontario Works in order to help clients find, prepare for, and keep a job.

With the assistance of municipal, provincial, and federal government funds, the City is committed to strategizing



with community service providers to ensure a safety net is in place for residents experiencing challenging life circumstances. A few examples of how this is accomplished include the Rent Geared to Income Housing program, Portable Housing Benefits for survivors of domestic violence, and rent subsidies to assist in the maintenance of market rent tenancies.

## Housing and Homelessness Committee

In 2018, Housing and Social Services staff began the mid-point review of the City's [10-Year Municipal Housing and Homelessness Plan](#). The plan focuses on providing strategic direction and actions the City can undertake to eliminate homelessness and ensure residents have access to affordable housing. The environmental scan and needs assessment is now complete, and shows that over the last five years, there has been an increase in the number of residents in "core housing need," which represents the number of households paying more than 30 per cent of their gross income toward housing.

Shelter use has declined since the implementation of the housing and homelessness plan, but consultations with service providers suggest there is a need to end chronic homelessness through more supportive and transitional housing options. While Kingston is fortunate to have a variety of community agencies that offer supports to clients, many do not have the resources or property that would be required to enter into full-service transitional and supportive housing. This is a gap – and an opportunity for partnering – that has been identified through the early stage of the review.

## Mayor's Task Force on Housing

The [Mayor's Task Force on Housing](#) has been working since early 2019 to form a co-ordinated and practical set of recommendations to increase housing supply across the spectrum, considering market rent, affordability, and social housing. Co-chaired by Ted Hsu and councillor Mary Rita Holland, the task force includes members from the development sector; public health; and tenant, post-secondary, and Indigenous community members.

At the outset, the task force focused on understanding barriers to the development of housing in Kingston. A public consultation process sought input from community members with a variety of lived experiences seeking housing in Kingston, such as seniors, students, vulnerable populations, immigrants, and young professionals. The results of the task force consultation, similar to the housing and homelessness mid-point review, point to the issue of "affordability mismatch" – the limited supply of a range of affordable housing types. Further stakeholder consultation with employers, builders, and property owners is ongoing.

Over the past months, task force members have dug into some of the ongoing challenges involved in expediting multi-residential development in the city, including timelines for approvals, outdated policy that needs to be updated, and limited staff capacity. They have examined opportunities for collaborating across governments, private, and not-for-profit sectors, and reviewed the potential for "innovative approaches" including tiny homes, co-operative, and co-housing. Provincial legislative changes, and federal programs and priorities, have been woven into deliberations as housing policy gains more attention at

*The results of the task force consultation ... point to the issue of "affordability mismatch" – the limited supply of a range of affordable housing types.*

all levels of government.

The task force is currently working through members' recommendations, and is commissioning a third-party expert to conduct an analysis of the economics of building both market rate and affordable housing in Kingston. Final recommendations are expected by early 2020, and will be used to guide council in future decisions related to its strategic goal of reaching and maintaining a three-per-cent vacancy rate.

While the task force's final report will address ways of increasing the supply of affordable housing, ongoing work on issues of homelessness, housing affordability, and social housing will be addressed through the 10-year plan and staff at Housing and Social Services.

*Mary Rita Holland is a city councillor (Kingscourt-Rideau District) and a co-chair of the Mayor's Task Force on Housing. She is a PhD candidate and teaching fellow at the Queen's School of Kinesiology and Health Studies.*

# Perspectives & Aspirations

St. Vincent de Paul Society provides sense of belonging

By Judy Fyfe

As executive director for the St. Vincent de Paul (SVPD) Society of Kingston for the last seven years, I cannot stress enough how much I enjoy my work and the people we serve. Every day, I am encouraged by the generosity I witness.

We are a community of people that sees itself and operates as a big, somewhat dysfunctional, family. Our clients share their successes and struggles with us frequently. Many times, we hear their medical diagnoses before their immediate family does. There is an intimacy here that makes this a healing place for many, as we offer hugs along with the practical assistance for which we are known.

I believe the most important service we provide is a sense of belonging, and this is why so many share with us their own personal journeys in accessing health care. I am honoured to be trusted with some of the most personal and tender moments our clients have experienced. I convey just a few stories here, with the hope that they extend beyond the numbers, and face to face with those who need our help. *(All names have been changed to protect anonymity.)*



Photo courtesy the St. Vincent de Paul Society

## Gail

Gail had been a client of ours for many years. She disclosed to me on one of her visits that she had been diagnosed with cancer and had been given only months or weeks to live. She had not yet told anyone in her family. She needed to share it here first, to get perspective, before bringing it to her children.

Gail and I agreed that each day she was well enough, she would come to visit me so we would know she was OK. Over the next several weeks, she became weak and her tough exterior began to slip. On her

last visit to see me, she shared a lifelong secret: her story of childhood sexual abuse. It was hard to hear. Harder, still, for her to share. What if, perhaps decades earlier, she had felt safe enough to share and perhaps get support in dealing with her trauma? "What if?" is a painful question to ask. How can we as service providers create a space where it is safe to disclose and work through pain of this magnitude?

## Tracy

Tracy, in her early 40s, was a woman who struggled to smile. She had never had dental care as a child and

never developed healthy oral care habits, and she felt judged and ashamed of her teeth. She avoided conversation, and only smiled with her head down. The state of her teeth led many to accuse her of being a crystal meth user, which she was not.

Tracy retreated from life and became socially isolated, interacting only with her daughters. When a bad injury required her to leave her physically demanding job as a personal support worker, she became frustrated and couldn't move forward in life, as poor oral health made it difficult to secure employment. She knew she needed to get her life back on track, but was stuck.

We connected her with George Brown College in Toronto, where she was fitted for dentures. She found the necessary funds to buy them, but she had no way to get there. I drove her for her first visit and then the SVDP provided her bus fare to get to her remaining appointments.

Today, Tracy has a great smile and we rarely see her. She is no longer withdrawn from society; life has opened up for her.

### Peter

The society relies heavily on volunteers. For the last seven years, Peter mopped our floors, raked our parking lot, trimmed the trees and weeds, and did our heavy lifting for us, then hung around doing work outside until the last female staff member left for the day. He worried about the safety of his new "family members."

Full of life and vitality, Peter was a kind and generous man who had had a successful career working in a hospital in eastern Ontario. He did not share with me why he no longer worked, but I suspected he had fallen into addiction. Earlier this year, Peter overdosed. He was in a coma for several days and then he was gone. We still have not recovered from

the loss. We have lost many to the fentanyl crisis. The grief is piling up.

Looking back on Peter's death, I am moved to tears at the respect, care, and kindness he received from Kingston General Hospital staff, which they also extended to those of us who visited him to say goodbye.

### Christy

Christy is a middle-aged woman who has spent most of her life precariously housed and always in extreme poverty. She has a history of IV drug use and has been managing her addiction for years. When we sat for a cup of tea together, I could see she was not in good shape. I knew she had been in hospital, but I did not know why.

She disclosed that she had moved from Kingston to be closer to her new boyfriend, and she was optimistic that this would be a new start. Shortly after her relocation, the man she thought she was in love with drugged her and repeatedly and violently raped her, which left her suffering physically and mentally. It was horrendous to hear, and I do not know how she survived. During her recollection of the event, Christy did not

cry one tear, and I assumed she was still in shock.

This all changed as she began to tell me of her experience at the hospital. She was grateful for the care she received, except for one nurse. When she flinched as the nurse was trying to give her a needle, the nurse told her it was obvious Christy was used to needles and she needed to stop being difficult. At this point in the story, Christy began to sob. She was so crushed by the nurse's judgemental attitude during her most vulnerable state. Instead of the compassion she expected, she was made to feel she deserved her suffering because of her history with addiction.

“  
*There is an intimacy here that makes this a healing place for many, as we offer hugs along with the practical assistance for which we are known.*  
 ”



Photo courtesy the St. Vincent de Paul Society

**At the St. Vincent de Paul Society,** we find that kindness, patience, and well-designed service delivery creates less stress and goes a long way in keeping the peace. We do not book appointments for clients to access our emergency pantry. Appointments and timelines are stress producers to our clients, so we operate under a “first come, first served” model. We also do not require people to line up for services, as doing so creates anxiety for many. Instead, we have people shop in our WearHouse while they wait for their turn. We serve meals restaurant-style to create a less chaotic atmosphere. We address people by name when we can to make them feel comfortable and at home. We provide hugs when needed and encourage laughter. Together, these practices reduce tension and make service delivery incident-free, most of the time.

Our location, 85 Stephen St., has served us well for more than 50 years, but with our current numbers and the challenges our client group present, we clearly need to relocate and build to suit our unique needs, and we have been blessed to purchase the land needed to make this a reality. Our goal is to build a facility that will provide opportunity for other service providers to meet with our clients. Providing access

to preventative health care programming through partnerships with KFL&A Public Health and others interested in reaching those living in the Kings Town District is one of our goals.

Through a grant from the Ontario Trillium Foundation, we have conducted research into the needs of this community. We engaged a master of public health student to conduct focus groups to determine our clients’ health needs. She also accessed public health databases and compiled data on our district pertaining to disease rates, emergency room visits, and pregnancy rates, etc. This data will allow us to adapt our preventative program to the specific needs of those using our services.

Our goal is to create a facility that will meet this community’s needs, now and in the foreseeable future. We hope to help in the creation of a resilient Kingston by bringing people together from all socioeconomic backgrounds and offering the opportunity to learn together, serve together, and be a community together. In our togetherness, we will find our strength.

*Judy Fyfe is the executive director of the St. Vincent de Paul Society of Kingston.*

# The Cost of Eating Healthy

## Poverty Root Cause of Food Insecurity

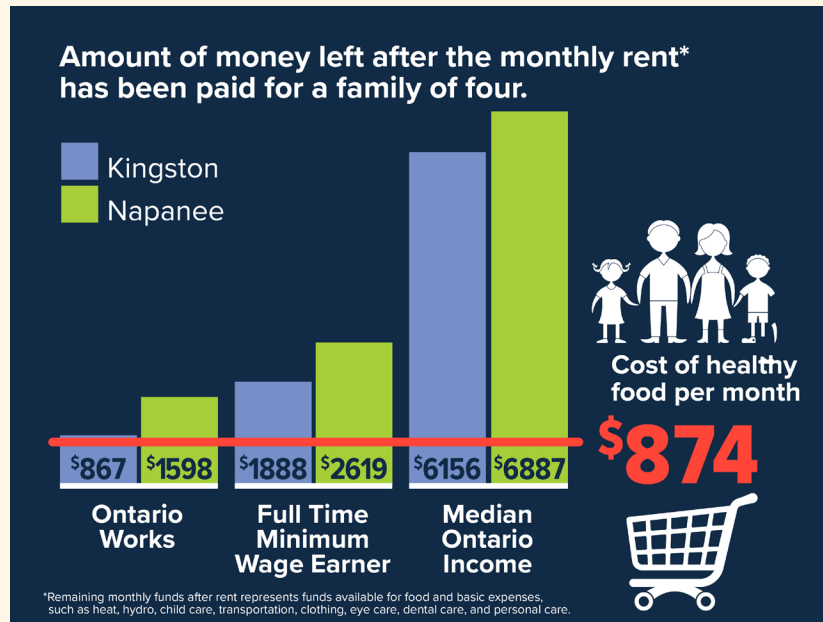
By KFL&A  
Public Health

Food is a basic human right. However, one in 10 households in the Kingston, Frontenac, Lennox and Addington (KFL&A) area experience food insecurity, meaning they cannot afford to buy the food they want and need for good health. Households on fixed or low incomes are often forced to compromise healthy eating in order to pay for other expenses.

When households experience food insecurity, the people living within them can experience negative health outcomes. Children who are hungry have an increased likelihood of developing depression and asthma later in life. Adults who are food insecure tend to experience poorer physical and mental health. This includes a propensity to develop chronic conditions such as depression, diabetes, and heart disease. Since food insecurity can cause individuals to compromise their food quality and/or quantity, these individuals often find it very difficult to manage their conditions.

The root cause of food insecurity is poverty. Therefore, income responses are needed to address this public health problem. Income responses are typically government policies that improve income security at a systemic level through income transfers, employment policies, pensions, tax exemptions/credits, and social assistance programs.

The Ontario Society of Nutrition Professionals in Public Health's Position Statement on Responses to Food Insecurity<sup>1</sup> states that food insecurity is an urgent human rights and social justice issue for local, provincial, and federal public policy agendas.



It also states that food charity is an ineffective and counterproductive response to food insecurity because it does not address the root cause – poverty<sup>1</sup>.

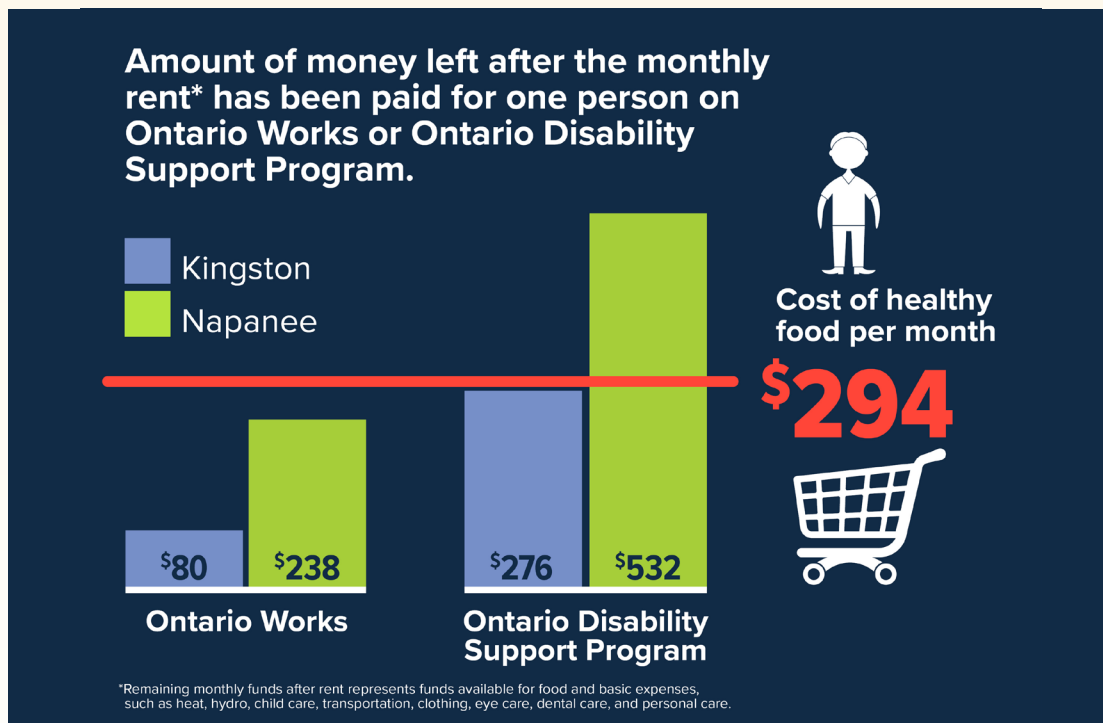
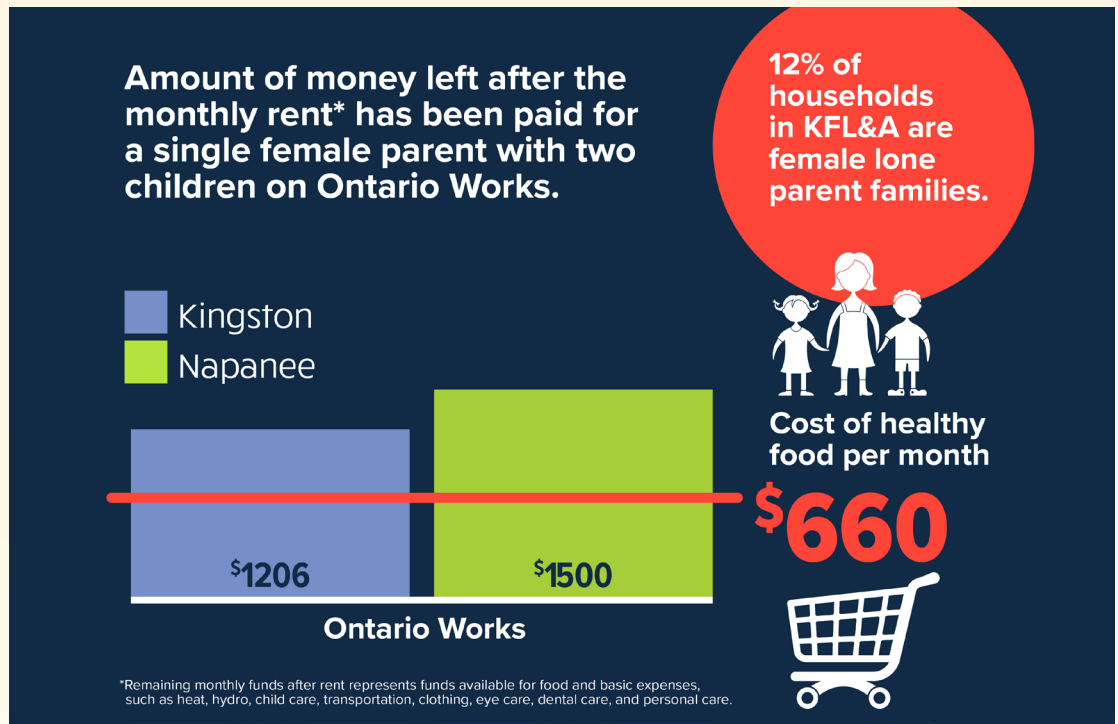
In their position statement and recommendations for addressing household food insecurity<sup>2</sup>, Dietitians of Canada suggests a comprehensive multi-pronged approach that incorporates

different income-based strategies building on current and potential social protection programs including:

- income protection for precarious employment and low wages;
- improved benefits for low-income households;
- increased social assistance and disability pension rates;
- investigation of the feasibility of a basic income guarantee;
- increased investment in subsidized, affordable, and stable housing options;
- actions to address the high cost of food in northern and remote regions.

You can help address this local human rights issue by learning more about the impact of food insecurity on health; advocating for solutions that will ensure secure and healthy food for all; and sharing this information with your peers, colleagues, and partner agencies.

*This article was adapted from the KFL&A Public Health Report titled [The Cost of Eating Healthy, 2018](#). (See references and resources, next page.)*



## Resources

- [The Cost of Eating Healthy, 2018](#) (KFL&A Public Health)
- [Poverty: A Clinical Tool for Primary Care Providers](#) (Centre for Effective Practice)

## References

1. [Ontario Society of Nutrition Professionals in Public Health: Position Statement on Responses to Food Insecurity](#), 2015 Nov [cited 2018 Oct 18].
2. [Dietitians of Canada: Addressing Household Food Insecurity in Canada: Position Statement and Recommendations](#), 2016 May [cited 2018 Oct 18].

# Climate Change and Housing

## Bold Action Critical to Protect World's Most Vulnerable

*A large wildfire in Northern Ontario threatens Pikangikum First Nation, July 2019. Photo courtesy Trav G Peters/Facebook*

By Tara Kainer

From *The Tyee* to *The National Post*, *Globe & Mail*, *Huffington Post* and *The Star*, journalists describe the housing situation in Canada as a “crisis.” Foreign investment, speculation, low interest rates, inadequate supply, and higher construction costs have all led to a dramatic spike in the cost of housing, leaving even those who earn reasonably good incomes struggling to afford home ownership or rentals.

In Kingston, the affordability crisis is acute. At 0.6 per cent, the vacancy rate is the lowest in Ontario. Forty-eight per cent of renter households spend 30 per cent or more of their income on housing, and a tenant needs to earn an hourly wage of \$23 to rent a two-bedroom apartment in a province that has frozen the minimum wage at \$14 an hour.

Add climate change, described by the Centre for American Progress (*A Perfect Storm*, August 1, 2019) as “an affordability housing crisis multiplier” into the mix, and the situation worsens, particularly for our most vulnerable citizens. For them, the combination of the high cost of living and the lack of affordable housing exacerbates the impacts of extreme weather events.

At play are not only the devastating effects of climate disasters including floods, hurricanes, wildfires, severe cold, heat waves, and ice storms, which are increasing in frequency and severity, but also rising

inequality. With the concentration of income and wealth among Canada’s top 20 per cent – who own about 67 per cent of our total wealth – while the bottom 20 per cent of households own less than one per cent, we have a wealth gap that Oxfam calls “obscene” (*Public Good or Private Wealth*, January 2019).

Globally, the wealth gap is preposterous. According to a report Oxfam published in January 2017 to mark the annual meeting of political and business leaders in Davos, Switzerland, “Eight men own the same wealth as the 3.6 billion people who make up the poorest half of humanity.” This inequity penetrates to those most likely to experience the worst and first climate impacts: low-income communities and those experiencing homelessness.

Unlike many homeowners and those of affluent means, the disadvantaged lack housing that is stable, affordable, and as able to withstand disastrous events. They are more likely to live in isolated and under-resourced neighbourhoods with poor environmental conditions and shoddy infrastructure. While the hurricane rages or wildfires spread and officials issue directions to stay inside or leave town to avoid smoke, or retreat to roofs to escape flooding, those without homes and vehicles have few, if any, options.

As bad as the consequences of the extreme weather event itself might be, the aftermath is worse. Hurricanes Katrina in New Orleans, Maria in Puerto

Rico, and most recently Dorian in the Bahamas, illustrate how those displaced or experiencing homelessness desperately scramble to find shelter while inequities in disaster response systems favour wealthier households and nations. Those displaced by extreme weather – which globally numbered a record seven million in the first half of 2019 (*The New York Times*, September 12, 2019) – are likely to be cut off from basic needs including clean water, electricity, and food. They may lack access to transportation, telecommunications, and medical aid.

Rents skyrocket due to the sudden supply shortage of housing, and damaged affordable housing stock is more often demolished than rebuilt, forcing the homeless to seek shelter in shattered homes and makeshift tents and structures unfit for human habitation. People already disadvantaged are most likely to die in a disaster or live to suffer the consequences of physical and mental illnesses including cholera, West Nile virus, post-traumatic stress disorder, anxiety, and depression.

The reality that some people will feel the effects and health impacts of a changing climate more than others, causing perhaps the most significant threat to democracy and public health this century will experience, prompted Philip Alston, the United Nations’ special rapporteur on extreme poverty and human rights, to coin a term: climate apartheid. He has warned that climate change “threatens to undo the last 50 years of development, global health, and poverty reduction,” leading to a new era where “an over-reliance on the private sector” could enable “the wealthy to pay to escape overheating, hunger and conflict while the rest of the world is left to suffer” (*UN News*, June 25, 2019).

Alston predicts that unless we take immediate action, by 2030 climate change will push an additional 120 million people worldwide into poverty, food insecurity, forced migration, disease, and death. “Perversely,” while the 3.5 billion people living in poverty are responsible for just 10 per cent of greenhouse gas emissions compared to the richest 10 per cent being responsible for half, the world’s poorest will bear the brunt of climate change and have the least capacity to protect themselves.

The remedy for climate apartheid, Alston argues, is to make “deep structural changes in the world economy,”

to “decouple from fossil fuel production” and transition to a green, sustainable economy, while providing a fair and stable safety net for workers who temporarily lose their jobs in the interim – policies the Green New Deal and basic income address.

“A robust social safety net will be the best response to the unavoidable harms that climate change will bring,” he reasons. States should take the opportunity to fulfil “long-ignored and overlooked economic and social rights, including social security and access to food, shelter, healthcare, and decent work (UN Report). Moreover, the trillion-dollar investment needed to avert climate apartheid will be far smaller than the eventual cost of doing nothing (*The Guardian*, September 10, 2019).



*Eight men own the same wealth as the 3.6 billion people who make up the poorest half of humanity.*



In countries as affluent as Canada, climate apartheid manifests itself more often, although not always, as climate gentrification instead. The term refers to those who have the means to retreat from floods, storms, heat waves, wildfires, and other climate vulnerabilities and move to safer areas, “bringing soaring property and rental values with them” (Oliver Milman, *The Guardian*, September 25, 2018). A pattern of climate gentrification is taking hold across the United States, Milman notes, with Flagstaff, Arizona, for example, being inundated by climate refugees.

“We don’t mind people moving to Flagstaff at all,” says Coral Evans, Flagstaff’s mayor, in Milman’s article. “But about 25 per cent of

our housing is now second homes. The cost of living is our number one issue. We don’t talk much about what climate change means for social justice. But where are low-income people going to live? How can they afford to stay in this city?”

What climate gentrification underscores, Janna Levitt and Drew Adams argue in *Why Zoning is Key to Combatting Climate Change (AZURE Magazine*, September 2019), is that “Climate action cannot be divorced from the social dimensions of sustainability and opportunities to make more equitable cities.” Turning to policy that originated as a means of protecting human health and well-being, they propose zoning as the remedy. “To more effectively combat climate change, it is past time that we rethink this pervasive regulatory instrument that affects every aspect of our built environment.”





*Kashechewan First Nation community on James Bay in Northern Ontario during a flood in May 2014. Photo courtesy Kashechewan First Nations Communications*

Fadi Masoud, University of Toronto Assistant Professor of Landscape Architecture and Urbanism, stresses the wisdom of understanding our relationship to geography and working with, rather than against, natural landscapes.

“Mother Nature will always win in the end,” so instead of building walls to keep out floodwaters, for example, it’s more effective to restore and enhance natural defences such as wetlands and marshes. Decrease impervious surfaces like parking lots and asphalt to let water flow naturally, turn parks and sports fields into flood plains, build green roofs to absorb rainwater, build only on high ground (CBC Radio, Ontario Morning, September 6, 2019). Levitt and Adams add, “As we preserve higher ground for added density, through tools like inclusionary zoning (municipal planning policy that requires a given share of new construction be affordable), so, too, can we preserve it for those without means to escape the impacts of climate change” (*AZURE Magazine*).

On March 5, 2019, the City of Kingston became the first Ontario municipality to declare that climate change is an emergency requiring an urgent and strategic response. The Climate Smart Kingston Commission convenes monthly to strategize, plan, and implement the goals of Kingston’s Climate Action Plan. While a climate adaptation plan for Kingston is underway, Environment Director Paul MacLachy reported in email correspondence (August 27, 2019) that the City currently provides “support for property owners wishing to improve the resilience of their properties.”

Ruth Noordegraaf, Manager, Housing and Childcare, pointed to the City’s work to improve energy efficiency and noted that service managers have the discretion

to direct funds to improve infrastructure. Solar panels as well as geothermal heating and cooling systems are being installed in some recent building projects. Kingston received \$20 million in federal gas tax revenues this August to separate storm water and sanitary sewer lines and also to repair and strengthen shoreline damaged by high water (*The Kingston Whig-Standard*, August 29, 2019). On the housing front, in February this year, Kingston Mayor Bryan Paterson created a task force mandated to increase the supply of a diverse range of housing for all residents in our city.

Research makes clear that climate vulnerabilities compound already existing inequalities that compromise public health. Local policy makers who implement progressive and equitable housing policies that invest in resilient infrastructure and strengthened building codes will help to protect the supply of affordable housing as well as public health and well-being in the face of extreme weather.

Given that severe weather in 2018 caused \$1.9 billion in insured damage while governments paid three times that to recover broken infrastructure (media release, Insurance Bureau of Canada, January 16, 2019), bold action simultaneously addressing housing and climate change policies towards the goal of building liveable communities will in the long-run save both money and lives.

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*Tara Kainer is employed in the Justice, Peace & Integrity of Creation Office of the Sisters of Providence of St. Vincent de Paul and is a member of Kingston’s Task Force on Housing.*

# Moving People from Poverty to Possibility

*By the United Way of KFL&A*

As all health professionals know, it's hard for children and adults to focus on learning or employability when they are hungry. Helping people move from poverty to possibility is one of the key pillars of the United Way of Kingston, Frontenac, Lennox & Addington (KFL&A).

Working closely with agencies and partners, the United Way funds programs that support people who live in poverty — some below the poverty line, and others working a number of jobs to make ends meet. Additionally, the United Way looks at root causes to address social issues in the region.

Food security is an issue that is part of any poverty-reduction initiative. Ten per cent of households in the KFL&A area live with food insecurity, not knowing if there will be enough food the following week or month.

Research demonstrates that children from families who are not sure where their next meal may come from are more likely to have lower math scores and repeat a grade, among other challenges. Community agencies continue to work on this issue. The Food Sharing Project, for example, which feeds 16,000 children in 90+ schools across the region, recognizes that children who are hungry are unable to learn. Through the project, children in schools get breakfast, lunch, or healthy snacks, with United Way funding going towards healthy, nutritious food.

"We fill the gap that children have when they come to school hungry, and they can't solve problems well and they can't learn," said Brenda Moore, Food Sharing Project chair. "They just do not do well at school. They can't take advantage of all school has to offer them without being fed properly, and that's what we do with the Food Sharing Project."

In addition to feeding kids at school, a number of agencies work together to provide healthy meals to the hungry. Agencies like Martha's Table, St. Vincent de Paul



Photo by Bernard Clark

*After receiving assistance from the United Way's Early Years program, Jaz Jenner now helps others in similar situations.*

and Outreach St. George serve meals to people who are homeless or disenfranchised. Last year, more than 38,000 meals were served by these agencies, who work closely with the United Way and community partners to help people live with hope, dignity, and a sense of belonging. The Elizabeth Fry Society's Women Empowered program provides a safe, gender-specific space for women who may be homeless, in conflict with the law, hungry, or who just need somewhere to go.

Working toward a healthier, more connected community, Loving Spoonful provides programs and champions policies affecting food security, poverty, social inclusion, and community health. Their work includes food-reclamation programs, delivering fresh, healthy produce to more than 40 agencies and 18 Fresh Food markets in the area and providing cooking programs to help increase food security.

"Food security is the major worry for me after the bills are paid," said Shelley Forbes, a Loving Spoonful program participant. "At the free cooking classes we are able to meet as a group, to learn, share, prepare, and enjoy nutritious food. We learn how to substitute ingredients for food we have on hand or that is more cost-efficient. We enjoy food and friendship in a safe, positive environment and we get food and recipes to take home."

Early Years programs are also important, with programs and services offered through Kingston Community Health Centres for families with children from birth to six. The program helps families with pre- and postnatal support, parenting and cooking programs, early learning, and one-on-one individual support. All services are free, with transportation and childcare provided, if needed. Jaz Jenner is an example of how this program can make a big impact:

*“At 21, I was living on the streets, using drugs, and had little support. I learned I was pregnant, and a social worker told me about a program that helped new and expectant mothers and I started going. I didn’t have a lot of money and I was really relieved that I could get a taxi chit and food when I went. I couldn’t afford a lot and the program provided fresh, healthy food. I knew it was important to my baby’s growth and development. I signed up for every group available to me, and one-on-one support. Staff helped me apply for housing and disability financing, and answered my questions. I began to feel more confident and that I could be the parent I wanted to be. Through the program, I grew as a person and they helped me find a job. I was able to become clean and drug-free and find stable housing. I now have three healthy children and help others in similar situations.”*

Another resource that can be used to address food insecurity is 211. It is an easy-to-remember, free, non-emergency help line that connects callers to a full range of community, social, government, and health-service information. Sixty per cent of callers are individuals who live below the poverty line. Referral specialists answer 211 calls 24/7. The service is confidential and multilingual, available in 150 languages.

Many other United Way-funded programs offer meals as part of their holistic approach to reaching people who

need help: One Roof Youth Hub partners with agencies to provide food, a safe space, and support for youth who are homeless or at-risk; Pathways to Education offers educational support, but also basic needs support; and Kingston Youth Shelter and Home Base Housing offer shelter, housing supports, and programs.

With all of these programs in mind, the United Way and the City of Kingston, in partnership with the Community

Foundation for Kingston & Area, KFL&A Public Health, a number of agencies and food providers, and representatives from local school boards and unions established a food access advisory committee. Discussions centred on providing a local sustainable solution to address food access and its root causes, and making Good Food Stands available at local schools. In August 2018, the Good Food Stand pilot project launched in five locations throughout KFL&A.

In its first year, Good Food Stands were visited 1,600 times, with more than 5,300 kilograms of healthy and fresh food sold at affordable prices. The program continues to work with many community partners to find solutions and provide services that are accessible to residents and that offer access to affordable, healthy food in a setting that is free of prejudice and discrimination.

The goal of all these programs is to provide and improve food security in our community, but also to work to create awareness among community members and help them see

that increasing food access has a positive impact on the entire community. Together, we can move people from poverty to possibility.

To learn more about programs funded by United Way KFL&A, to donate, and to learn about the impact of a donation, visit [unitedwaykfla.ca](http://unitedwaykfla.ca).

## Impact of your Local Love

United Way KFL&A helped more than 53,000 people locally last year.



**38,000** meals were served by local soup kitchens like Martha’s Table, Outreach St. George’s, and the St. Vincent de Paul Society.



**13,800** people benefitted from reclaimed produce and had increased access to healthy food because of the Loving Spoonful.



**581** people had access to affordable produce in their own neighbourhood because of Good Food Stands.



**16,000** students had nutritious snacks and meals at school because of the Food Sharing Project.



**910** parents struggling with managing on a low income participated in prenatal, infant, and parenting groups because of Early Years programs.

One in Seven Ontarians  
Live in Poverty

# Basic Income Social Program

## It's time for bold political leadership

By Elaine Power

On July 31, 2018, recently elected MPP and then Minister of Children, Community and Social Services Lisa Macleod rose in the Ontario Legislature and announced the cancellation of the Ontario Basic Income Pilot (OBIP) project, which had been running for a little more than a year. In doing so, she broke Premier Doug Ford's campaign promise from a few months earlier that a Conservative government, if elected, would continue the pilot. Macleod's move stunned anti-poverty activists and pulled the rug out from the approximately 4,000 participants who had signed a three-year contract with the Ontario government and had been receiving their cheques.

In a scathing [editorial](#), *The Globe and Mail* called the cancellation deceitful, because of the broken campaign promise; callous, because participants had planned their lives for three years around receipt of the basic income; anti-scientific, because the pilot included a detailed research evaluation plan that would not be finished; wasteful, because the cancellation consigned the research data to the garbage; and vindictive, because no justification was given. There was wide media circulation of news conference images of Macleod in front of a sign that appeared to say "Live in Poverty<sup>1</sup>," which was taken as further evidence of the new government's cruelty.

The OBIP cancellation was poorly organized, with no believable rationale given for the cancellation<sup>2</sup> and no plan for its conclusion when the announcement

was first made. Under fierce public pressure, the Ford government eventually extended participants' payments until March 31, 2019. Project participants reported that they got their information about the cancellation from the media. Their letters pleading for the government to reconsider and requests for meetings were never answered. It became apparent that Ford's campaign slogan "For the People" was not about the people participating in the Ontario Basic Income Pilot.

The Basic Income Canada Network (BICN) and academic researchers have set out to rescue what data they can from pilot participants, though the scientific rigour of the original evaluation design has been lost. BICN's [analysis](#) of its survey of more than 400 OBIP participants showed important effects of the basic income, even though the amounts of money provided to OBIP participants were well below the Low Income Cut-Off (LICO)<sup>3</sup>. With their extra money, participants made wise choices such as paying down debt, buying health aids and services such as glasses and dentistry, enrolling in educational programs, and so on. Most were able to make healthy food choices, and more than one-quarter stopped using a food bank. Participants reported dramatic decreases in levels of stress and anxiety, giving them more self-confidence, with the reduction or elimination of medication. They also described increased social connection and decreased social isolation resulting from an enhanced capacity to socialize with family and friends, participation in community programs, and volunteering.

The BICN report also shines some light on the devastating effects of the cancellation. Participants reported that their anxiety and health problems returned. Some had to reverse their plans to return to school, and those who had moved into better housing were left with a lease they couldn't afford.

For at least a few participants, their time on the Basic Income Pilot was enough to help them stabilize their finances and to thrive. In a CBC news [article](#), Luis Segura, co-owner and operator of a healthy food restaurant in Lindsay, said he and his wife, Leanna, probably wouldn't have qualified for additional funds under OBIP, had it continued. Working long hours at their restaurant, and with four small children, the money from OBIP reduced their stress levels and helped them pay for daycare and before-and-after school care.

Other participants, who banked on three years of OBIP income security, were left much worse off after the cancellation. Four Lindsay participants have launched a class-action [lawsuit](#) against the Ontario government, alleging the promise of three years of funding amounted to an enforceable contract and the government was negligent in stopping the payments.

Perversely, the cancellation of the OBIP drew considerable attention to the topic of basic income and its potential to ensure income security for Canadians, and fuelled the fire of activists' determination. Had the government allowed the pilot to run its course, it may have faded into the history books, like Canada's last [basic income experiment](#), MINCOME, in the 1970s.

While the premature OBIP termination is certainly a setback, momentum around basic income continues

to grow nationally and internationally. In September 2019, the Canadian Centre for Economic Analysis released a [report](#) showing that Canada's basic income for children, the Canada Child Benefit, not only kept hundreds of thousands of kids out of poverty, but has also generated about \$139 billion in economic activity since 2016, almost \$2 for every dollar invested. British Columbia has set up an [expert panel](#) to examine the role of basic income in providing income security. And in Prince Edward Island, an all-party [special committee](#) will examine poverty in the province and bring forward recommendations for a fully costed basic income pilot.

Other provinces interested in setting up and running a pilot can certainly learn from the work done in Ontario.

In the United States, [Andrew Yang](#) has made basic income a central plank in his campaign to become the Democratic nominee for president, and is educating Americans about the potential of basic income to address income insecurity from job losses related to technological advances. The Basic Income Earth Network (BIEN) [website](#) features basic income activism and projects in countries around the world, including India, Scotland, and Spain. Earlier this year, the World Health Organization Regional Office for Europe published a [report](#) about the potential for basic income to address health inequities.

As momentum continues to build, it is only a matter of time before a basic income social program is

“*The OBIP cancellation was poorly organized, with no believable rationale given for the cancellation and no plan for its conclusion when the announcement was first made.*”

implemented – and a question of where. Canadian advocates dream of a national basic income that would be our 21st century version of Medicare – a social program that helps define us as Canadians and is impossible to imagine living without. There is already a solid evidence base supporting the efficacy of an adequate basic income, especially related to its positive health effects, and its affordability in a country as rich as Canada<sup>4</sup>. The primary missing piece is bold political leadership.

*Elaine Power is an associate professor in the School of Kinesiology & Health Studies at Queen’s University. For 15 years, she taught HLTH 101, the Social Determinants of Health. She conducts research on food in conditions of poverty and ways that community food programs can facilitate political advocacy to ensure adequate income for all. Elaine is a founding member of the Kingston Action Group for a Basic Income Guarantee and is working on a book about basic income.*

<sup>1</sup> The full sign read “One in Seven Ontarians Live in Poverty” but almost no images showed the full sign. The image of the mean-spirited Macleod continued to circulate for months afterward.

<sup>2</sup> On different occasions, government spokespeople claimed that it was going to cost too much to run the pilot; it wasn’t working properly, with a high dropout rate; and that it discouraged people from seeking employment. None of these claims were supported by the available evidence.

<sup>3</sup> OBIP provided up to \$16,989 per year for an individual, 75 per cent of the Low Income Cut-Off (LICO), plus an additional \$5,000 per year for people with disabilities. Couples received up to \$24,027 per year.

<sup>4</sup> For a summary of the evidence to support a basic income program in Canada, see health economist and basic income advocate Evelyn Forget’s book, *Basic Income for Canadians: The key to a happier, healthy, more secure life for all*.

## EDITOR’S NOTE: Update on trans care in Kingston

Since publication of our fall 2018 issue of *Horizons*, which focused on [LGBTQ+ Health](#), more options for transition-related health care have become available for gender-diverse patients in the Kingston area.

Queen’s Family Health Team (QFHT) now has a half-day per week gender-diversity clinic, run by Dr. Meghan Wilson and incorporating Queen’s family medicine residents. This clinic focuses on the patient’s medical care as related to gender transition. Patients at this clinic may also have other primary health-care needs addressed. In addition, nurse practitioner Heather Geddes began operating a full-time trans clinic out of the Kingston Community Health Centre (KCHC) on Weller Avenue in May 2019. A full-time social worker will soon be joining her there. The KCHC clinic is focused solely on supporting gender transition; primary care is not provided.

In addition to these two new clinics, Dr. Ashley Waddington continues to operate her trans clinic at Kingston Health Sciences Centre (KHSC) one-half day per month.

These three clinics operate co-operatively; a referral to any clinic may result in the patient being booked into the next available appointment with the provider most suited to meeting the patient’s specific needs. Patients may self-refer, or be referred by any provider.

Self-referrals can be made by calling 613-542-2949, Ext. 1166, or a form can be picked up at KCHC at 263 Weller Ave. Provider referrals may be faxed to KCHC at 613-542-7657. Referrals are reviewed by nurse practitioner Geddes at the KCHC and distributed to one of the three clinics. Referrals sent to Dr. Waddington at KHSC (fax 613-548-1330) or Dr. Wilson at QFHT (fax 613-544-4352) are also triaged in this manner.

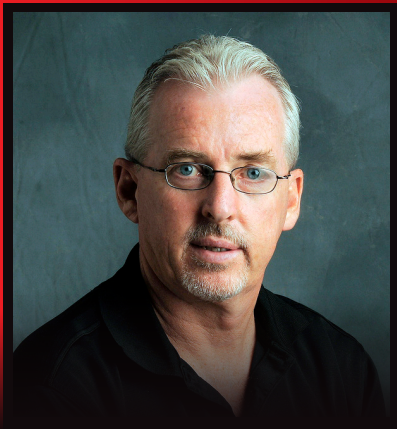
The current wait time for new referrals is now approximately one month, which is a significant improvement over last year, when waits could exceed one year. These clinics welcome all gender-diverse patients.

*Horizons is published twice annually by Queen’s Department of Family Medicine on behalf of its Global Health program. Opinions expressed in this publication do not necessarily reflect those of Queen’s Department of Family Medicine or Queen’s University.*

# CODE

# RED

## TEN YEARS LATER A Five-Alarm Fire



## Health, Wealth and Social Determinants

### **Steve Buist, M.Tech., B.Sc.**

Investigations Editor  
*The Hamilton Spectator*

Steve Buist, creator of the highly acclaimed and national award-winning Code Red series on health outcomes, will share his groundbreaking analysis of how the social determinants of health have been directly measured in Hamilton, Ontario. The shocking results – from staggering differences in birth weights to cancer mortality rates and life expectancy – expose inequities pervasive in neighbourhoods across Canada.

With updated health and socioeconomic data sets, Steve's research reveals that a decade after the launch of the original Code Red project, 10 of the 13 health variables measured have actually worsened — a scenario the Hamilton Community Foundation calls "A Five-Alarm Fire."

**Friday, November 22, 2019**

**Noon to 1 pm**

Kingston Frontenac  
Public Library  
130 Johnson St.  
Meeting Room 1

All are welcome.

Brown-bag lunch.  
No registration required.