

Discourse

Poverty, Human Development, and Health in Canada: Research, Practice, and Advocacy Dilemmas

Dennis Raphael

Introduction

Canada's poverty rates are among the highest in the wealthy industrialized nations (Organisation for Economic Co-operation and Development [OECD], 2008). Despite the accumulating evidence that impoverishment is one of the greatest threats to human development, health, and quality of life, little progress has been made in addressing the incidence and effects of poverty (Raphael, 2007i). Much of this inaction has to do with the reluctance of government authorities to implement policies that will (a) reduce the extent of material deprivation experienced by Canadians, and (b) provide health supports and services to impoverished Canadians (Raphael & Bryant, 2006). Governments are assisted in their avoidance of these issues by the existence of conflicting models of poverty and its effects, the limiting of health-related research to traditional approaches associated with epidemiological and behavioural models of health and its determinants, and the difficulties associated with engaging in forceful health advocacy in increasingly conservative political environments (Raphael, Curry-Stevens, & Bryant, 2008).

These issues are especially important to health-care workers, as the presence of poverty (a) influences human development in all its spheres, (b) is a determinant of morbidity and mortality associated with a variety of disorders, and (c) shapes the ability of Canadians to access and benefit from health services (Raphael, 2007c, 2007g). Examination of these issues and how they could be addressed by health authorities, agencies, and advocacy groups suggests ways forward for researchers, health-care workers, and citizens concerned with maximizing human development and enhancing health.

Defining Poverty

There are two main conceptual issues related to poverty. The most widely discussed is definitional and concerns the distinction between absolute and relative poverty (Gordon, 2006). *Absolute poverty* can be defined as an inability to have one's basic human needs met. Starving people in the developing world and Canadians sleeping on the street or queuing up at food banks are the most common images of poverty in Canada (at least as evidenced by the comments of the hundreds of undergraduate students I encounter each year). *Relative poverty* can be defined as an inability to obtain the economic and social resources necessary to engage in the kinds of behaviour expected of members of a particular society (e.g., attending educational, social, or recreational events; maintaining a healthy diet; securing adequate housing; dressing appropriately for the seasons; buying gifts for special occasions) (Townsend, 1993). With both definitions, poverty entails material and social deprivation and an inability to participate in various societal activities (Pantazis, Gordon, & Levitas, 2006).

It is accepted among Canadian poverty researchers and international organizations such as the United Nations Development Program (UNDP), the United Nations Children's Fund (UNICEF), and the OECD that relative poverty — usually based on an individual or family income less than 50% of the median national income — is the most useful measure for ascertaining poverty rates in wealthy developed nations such as Canada (Innocenti Research Centre, 2005; OECD, 2008; UNDP, 2008). The use of such indicators finds Canada performing very poorly in terms of poverty ranking: 19th of 30 industrialized nations for adults, 21st for families with children, and 20th for children (OECD, 2008). Most poverty researchers in Canada apply relative poverty metrics (see below) for determining the presence of poverty (Williamson & Reutter, 1999).

The second conceptual issue is explanatory, and though less discussed it profoundly shapes the manner in which poverty is conceived and researched. The distinction here is between individual (liberal) and structural (critical) explanations for the existence of poverty (Wright, 1994). Individual explanations focus on the attributes of individuals and how these lead to poverty. According to these explanations, poverty results from a lack of education (on the part of individuals and groups), lack of motivation, the presence of physical or mental illness, or intentional dependence on the welfare or social assistance system (Raphael, 2007e).

Most enlightened researchers and health-care workers avoid motivational or dependence-type analyses. However, poverty is frequently attributed to illness or lack of education. Such analyses assume that if ade-

quate health promotion and care or adequate educational programs were available poverty rates would be reduced. They ignore the fact that society is organized such that vulnerable people (i.e., those with little education or with a physical or emotional affliction) end up living in poverty.

These individual analyses fail to acknowledge the fact that the structural organization of society shapes the extent and depth of poverty. Is it reasonable to assume that the parents of Scandinavian children — among whom the poverty rate is less than 5%, as compared to 15% among Canadian children — are profoundly more educated, motivated, and lacking in physical or mental illness than their Canadian counterparts (OECD, 2008)? Clearly, there has to be more to cross-national jurisdictional differences in poverty rates than the presence or absence of various individual characteristics. Nevertheless among health researchers in Canada there has been little conceptual analysis and research examining societal structures (e.g., wage structure; income and wealth distribution; provision of necessities such as child care, housing, and food as a basic right) as determinants of poverty rates and their subsequent effects upon health (Raphael et al., 2006).

Measuring Poverty

Internationally, poverty is usually indicated if individual or family income is less than 50% of the median national income. Statistics Canada's Low Income Measure (LIM) is the Canadian manifestation of this poverty measure (Raphael, 2007a). The more commonly applied Low Income Cut-Off (LICO) identifies whether an individual or family is experiencing the "strained circumstances" associated with spending significantly more than the average individual or family on basics such as food, housing, and clothing. The LICO can be calculated using either before-tax or after-tax income. Another commonly used measure is the Market Basket Measure (MBM) devised by Human Resources Development Canada (2003). All of these measures provide roughly comparable estimates of the incidence of poverty in Canada (Raphael, 2007a).

Poverty in Canada

The poverty rate in 2004, based on pre-tax LICOs, was 15.5% for all Canadians and 17.1% for children (Raphael, 2007k). The depth of poverty varied across the country, from 19.2% for adults and a whopping 23.5% for children in British Columbia, to 11.7% for adults and 10.8% for children in Prince Edward Island (Raphael, 2007k). Poverty rates for female-led families are exceptionally high in Canada (52.1%). As noted above, international comparisons place Canada 19th of 30 nations for

adult poverty and 21st of 30 nations for child poverty. Poverty rates are exceptionally high among recent immigrants of colour, Aboriginal Canadians, single adults, and people with disabilities (Raphael, 2007k). Women show higher rates than men and children show higher rates than adults.

Poverty and Its Effects on Human Development

A remarkably consistent body of evidence has accumulated concerning the detrimental effects of poverty on human development (however defined), health status, and quality of life (Raphael, 2007g). These effects are not limited to individuals but carry over into community well-being, as evidenced by issues of safety, crime, and community cohesion and solidarity (Raphael, 2007j). The various models of this process range from physiological models of stress and its impact on the immune, metabolic, and endocrine systems, to political economy models focused on the distribution of societal resources (Raphael, 2007h). Poverty is not only the primary determinant of children's intellectual, emotional, and social development but also an excellent predictor of virtually every adult disease known to medicine, including type II diabetes, heart disease and stroke, arthritis, a variety of respiratory diseases, and some cancers (Davey Smith, 2003). An emerging theme is powerlessness, both political and personal, as an important contributor to poor health due largely to the inability of individuals — especially those in the lowest socio-economic stratum — to influence the material conditions of their lives (World Health Organization, 2008).

In addition to the statistical evidence on the effects of poverty, an emerging body of research has put a human face to the material and social deprivation experienced by impoverished Canadians (Raphael, 2007d). Of particular value has been work documenting the social exclusion experienced by low-income Canadians (Reutter et al., 2009; Stewart et al., 2008) and children's experience of poverty (McIntyre, Officer, & Robinson, 2003; Robinson, McIntyre, & Officer, 2005). Such narratives illustrate the clear links between material and social deprivation and adverse outcomes.

Of particular relevance is the experience of impoverished Canadians with the health and social service systems (Raphael, 2007c). Interactions with government social service systems are especially problematic, characterized by stigma, shame, and sometimes even outright degradation. Interactions with community agencies and organizations are much more positive (Williamson et al., 2006). Interactions with the health-care system are generally positive, but there are significant issues related to

access to care and the affordability of medical and ancillary services (Schoen & Doty, 2004).

While there has been research into the effects of poverty on human development, health status, and quality of life in Canada, this work has been carried out by only a handful of researchers (Raphael et al., 2006). Contrast this situation with the research (and media) emphasis on medical treatment and epidemiological studies of behavioural risks, with their focus on the “holy trinity of risk” — tobacco use, poor diet, and lack of exercise (Canadian Population Health Initiative, 2004; Gasher et al., 2007; Hayes, 2007; Nettleton, 1997). More attention, both research and practical, on reducing poverty and its effects and on documenting the lived experience of poverty is sorely needed.

Research and Interventions to Ameliorate the Effects of Poverty

Significant effort goes into ameliorating the effects of poverty on human development, health status, and quality of life. This work is carried out by those working in the health-care and public health systems; community agencies; and the education, social work, police and justice, housing, and nutrition sectors. Diderichsen, Evans, and Whitehead (2001) outline a model comprising various levels of intervention aimed at addressing the effects of social stratification whereby the layer at the bottom experiences poverty and its effects. In this model, societal characteristics structure human development and health. Public policies shape the extent of social stratification within a society. Stratification results in many individuals at the bottom being exposed to the most adverse living circumstances — those associated with problematic human development, poor health status, and inferior quality of life.

Interventions can take place on many levels. One can respond to the problems by directing attention to the end of the sequence and setting up new and improved health, social service, justice, and police systems. Currently, many of Canada’s policy responses to poverty are focused on such efforts. Further upstream, one can attempt to decrease the vulnerability of impoverished people by enhancing their coping skills: *We will not improve your living conditions but we will attempt to provide you with the skills needed to cope with the deprivation associated with adverse living conditions.* While there is some evidence showing their effectiveness, these interventions do little to address the source of the afflictions: poverty. The emphasis is on making exposure to adverse living conditions more palatable through the targeting of services. The extent to which these services can achieve success, considering the unfavourable living circumstances of impoverished people, is open to debate.

Interveners can also move still further upstream and attempt to reduce the negative conditions to which impoverished people are exposed. This could include the provision of universal affordable child care, health and social services, and educational and recreational opportunities that are viewed as entitlements rather than as user-paid options. This decommodification of resources, services, and benefits has been the direction taken in many nations to reduce the detrimental effects of social stratification in general and the effects of material and social deprivation associated with poverty in particular. Canada scores very low on these indices of decommodification (Coburn, 2006).

Perhaps the most efficacious means of reducing the effects of poverty would be to provide monetary resources to people so they will not experience poverty in the first place. This would take the form of employment that pays a living wage, social assistance and disability benefits raised to health-sustaining levels, and transfers to citizens on the basis of both universal entitlement and identified needs (Raphael, 2007f). In many European countries this is the approach that has proved the most successful. The structural analysis of poverty that is implied in this approach — and in related research — is rarely employed in the Canadian health sector.

Research and Interventions to Eliminate Poverty

There is increasing recognition that the determinants of the incidence of poverty have more to do with the making of public policy than with the altering of human characteristics (Alesina & Glaeser, 2004; Rainwater & Smeeding, 2003). How it is that poverty has been virtually eliminated in the Nordic nations while remaining at consistently high levels in Canada and the United States? Indeed the OECD reports that, over the past decade, income inequality and poverty have increased more in Canada than in most other developed countries (OECD, 2008). In addressing the above question, analysts have been focusing on economic and political systems as the primary determinants of poverty.

The workings of our economic and political systems and the societal discourses that are used to justify their approach have been nicely organized by two Canadian sociologists, Saint-Arnaud and Bernard (2003). Building upon Esping-Andersen's (1990, 1999) insights regarding various forms of the welfare state, these authors provide a narrative that succinctly sums up the relationship between systemic differences in poverty rates and the development of different ways of addressing citizen security in terms of public policy. Saint-Arnaud and Bernard identify four types of welfare state: *liberal*, *social democratic*, *conservative*, and *Latin*.

The United States, Canada, and the United Kingdom are *liberal* welfare states. Of the four types, the liberal welfare state provides the least

support and security to its citizens. Despite the persistence of the United States as a welfare state outlier, characterized by striking shortcomings in the provision of security to its citizens, the public policy profiles — and poverty rates — of both Canada and the United Kingdom have consistently been found to be closer to those of the United States than to those of European welfare states, where citizens are assured of more security and support (Bernard & Saint-Arnaud, 2004). In liberal welfare states the dominant ideological inspiration is liberty and the dominant institution is the marketplace. The result is minimal government intervention in the workings of the marketplace; indeed such intervention is seen as providing a disincentive to work and as breeding “welfare dependence.”

The outcomes of this ideological persuasion in the United States, Canada, and the United Kingdom are meagre benefits provided to social assistance recipients, weak legislative support for the labour movement, underdeveloped policies for assisting those with disabilities, and a reluctance to provide universal services and programs. The services and programs that do exist are residual — intended to provide the most basic needs of the most deprived. Of the developed nations, Canada ranks among the lowest in terms of public spending on infrastructure in general and on families, pensions, early childhood education and care, and supports for persons with disabilities. Also, Canada’s social assistance rates are among the lowest in the world (Raphael, 2007b). The end result is very high poverty rates (Innocenti Research Centre, 2005, 2008).

The opposite situation prevails in *social democratic* welfare states. The ideological inspiration for the central institution of these nations — the state — is equality, the reduction of poverty, and full employment (Saint-Arnaud & Bernard, 2003). The government’s responsibility is not seen as limited to meeting the most basic needs of the most deprived. Rather, the organizing principle is universalism in terms of social rights. Denmark, Finland, Norway, and Sweden best exemplify this form of the welfare state. Governments with social democratic political economies are proactive in identifying social problems and issues and in promoting the economic and social security of their citizens.

The social democratic welfare state is associated with the virtual elimination of poverty, gender and class equality, and regulation of the market in the service of the people (Esping-Andersen, 1999). Public policy is directed at supporting programs that serve to reduce social inequality, such as child care, services for those with disabilities, programs that address racism and homophobia, job training, and support for education (Swedish Ministry of Health and Social Affairs, 2002; Swedish Ministry of Industry Employment and Communications, 2004a, 2004b; Swedish National Institute for Public Health, 2003).

Even welfare states that are considered *conservative* (e.g., France, Germany, Netherlands) or *Latin* (e.g., Greece, Italy, Portugal) generally ensure a level of social security that is superior to that provided by liberal welfare states (Bambra, 2004; Esping-Andersen, 1999; Navarro & Shi, 2001). In conservative and Latin welfare states, the ideological favouring of social stability, wage stability, and social integration is expressed through the provision of benefits based on insurance schemes covering a variety of family and occupational categories. These well-organized benefit schemes are directed towards the primary wage earner, with less concern for the promotion of gender equality than is found in social democratic welfare states.

Faced with evidence of these distinctions and their importance for measuring social and health inequalities, what can researchers and workers in liberal political economies do to increase their understanding of poverty and its effects and develop means of addressing these issues? There is clear evidence — supported by the Canadian experience — that poverty-reducing policies are more likely to develop when social democratic parties are in power or are part of minority governments along with other political parties (Raphael, 2007e). Critical analyses of ideological and political barriers to poverty reduction, though rarely conducted in Canada, appear to be a fruitful area of research activity.

More importantly, advocacy for poverty-reducing policies not only must continue but should be clearly related to human development, health, and quality of life. Evidence shows that such advocacy is favourably received by the Canadian public, if not always by our elected representatives (Reutter, Harrison, & Neufeld, 2002; Reutter, Neufeld, & Harrison, 1999). Many health researchers and workers have told me personally that raising such issues can be a “career-threatening move.” Whether or not that perception is accurate, it must be addressed and, if appropriate, responded to strongly by the health-care community. Recommended actions are those that focus on addressing the social determinants of health (e.g., income, housing and food security, social inclusion/exclusion, early childhood development, and access to health care) (Campaign 2000, 2008; Canadian Association of Food Banks, 2004; Raphael, 2008). Research is needed to look into why such efforts have so far proved to be relatively ineffectual.

Conclusion

There are many fruitful areas for research into poverty and its effects on human development, health, and quality of life. These include careful, theoretically driven analyses of statistical databases to identify the determinants of human development, health status, and quality of life (Raphael

et al., 2006). Inquiry into the lived experience of poverty and barriers to/access to health care is also needed (McGibbon, 2008). We need more critical analyses of the economic, political, and social barriers to the implementation of public policies that address poverty. There is resistance within much of the health sector to the idea of such analyses, yet the carrying out of these kinds of research and the dissemination of the findings are essential, as is the implementation of recommendations resulting from these analyses. To date there has been some excellent work done to research the structural determinants of poverty and the means by which both poverty and its adverse effects might be ameliorated. Further efforts are needed.

References

- Alesina, A., & Glaeser, E. L. (2004). *Fighting poverty in the US and Europe: A world of difference*. Toronto: Oxford University Press.
- Bambra, C. (2004). The worlds of welfare: Illusory and gender blind? *Social Policy and Society*, 3(3), 201–211.
- Bernard, P., & Saint-Arnaud, S. (2004). *More of the same: The position of the four largest Canadian provinces in the world of welfare regimes*. Ottawa: Canadian Policy Research Networks.
- Campaign 2000. (2008). *Family security in insecure times: The case for a poverty reduction strategy for Canada. 2008 report card on child and family poverty in Canada*. Toronto: Author.
- Canadian Association of Food Banks. (2004). *HungerCount 2004. Poverty in a land of plenty: Towards a hunger-free Canada*. Toronto: Author.
- Canadian Population Health Initiative. (2004). *Select highlights on public views of the determinants of health*. Ottawa: Author.
- Coburn, D. (2006). Health and health care: A political economy perspective. In D. Raphael, T. Bryant, & M. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness, and health care* (pp. 59–84). Toronto: Canadian Scholars' Press.
- Davey Smith, G. (Ed.). (2003). *Inequalities in health: Life course perspectives*. Bristol: Policy Press.
- Diderichsen, F., Evans, T., & Whitehead, M. (2001). The social basis of disparities in health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya, & M. Wirth (Eds.), *Challenging inequalities in health: From ethics to action* (pp. 12–23). New York: Oxford University Press.
- Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton, NJ: Princeton University Press.
- Esping-Andersen, G. (1999). *Social foundations of post-industrial economies*. New York: Oxford University Press.
- Gasher, M., Hayes, M. V., Ross, I., Hackett, R. A., Gutstein, D., & Dunn, J. R. (2007). Spreading the news: Social determinants of health reportage in Canadian daily newspapers. *Canadian Journal of Communication*, 32(3), 557–574.

- Gordon, D. (2006). The concept and measurement of poverty. In C. Pantazis, D. Gordon, & R. Levitas (Eds.), *Poverty and social exclusion in Britain: The Millennium Survey* (pp. 29–70). Bristol: Policy Press.
- Hayes, M., Ross, I. E., Gasher, M., Gutstein, D., Dunn, J. R., & Hackett, R. A. (2007). Telling stories: News media, health literacy and public policy in Canada. *Social Science and Medicine*, 54, 445–457.
- Human Resources Development Canada. (2003). *Understanding the 2000 low income statistics based on the Market Basket Measure*. Ottawa: Author.
- Innocenti Research Centre. (2005). *Child poverty in rich nations, 2005. Report card no. 6*. Florence: Author.
- Innocenti Research Centre. (2008). *The child care transition: A League table of early childhood education and care in economically advanced countries*. Florence: Author.
- McGibbon, E. (2008). Health and health care: A human rights perspective. In D. Raphael (Ed.), *Social determinants of health: Canadian perspectives*, 2nd ed. (pp. 318–335). Toronto: Canadian Scholars' Press.
- McIntyre, L., Officer, S., & Robinson, L. M. (2003). Feeling poor: The felt experience of low-income lone mothers. *Affilia*, 18(3), 316–331.
- Navarro, V., & Shi, L. (2001). The political context of social inequalities and health. *International Journal of Health Services*, 31(1), 1–21.
- Nettleton, S. (1997). Surveillance, health promotion and the formation of a risk identity. In M. Sidell, L. Jones, J. Katz, & A. Peberdy (Eds.), *Debates and dilemmas in promoting health* (pp. 314–324). London: Open University Press.
- Organisation for Economic Co-operation and Development. (2008). *Growing unequal? Income distribution and poverty in OECD countries*. Paris: Author.
- Pantazis, C., Gordon, D., & Levitas, R. (Eds.). (2006). *Poverty and social exclusion in Britain*. Bristol: Policy Press.
- Rainwater, L., & Smeeding, T. M. (2003). *Poor kids in a rich country: America's children in comparative perspective*. New York: Russell Sage Foundation.
- Raphael, D. (2007a). Canadian perspectives on poverty. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 27–54). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007b). Canadian public policy and poverty in international perspective. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 335–364). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007c). Interactions with the health and service sector. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 173–203). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007d). The lived experience of poverty. In *Poverty and policy in Canada: Implications for health and quality of life* (pp. 145–172). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007e). The politics of poverty. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 303–334). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007f). Poverty and future of the Canadian welfare state. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 365–398). Toronto: Canadian Scholars' Press.

- Raphael, D. (2007g). Poverty and health. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 205–238). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007h). Poverty and health: Mechanisms and pathways. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 239–268). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007i). *Poverty and policy in Canada: Implications for health and quality of life*. Toronto: Canadian Scholars' Press.
- Raphael, D. (2007j). Poverty and quality of life. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life* (pp. 269–302). Toronto: Canadian Scholars' Press.
- Raphael, D. (2007k). Who is poor in Canada? In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life*, (pp. 59–84). Toronto: Canadian Scholars' Press.
- Raphael, D. (Ed.). (2008). *Social determinants of health: Canadian perspectives*, 2nd ed. Toronto: Canadian Scholars' Press.
- Raphael, D., & Bryant, T. (2006). Maintaining population health in a period of welfare state decline: Political economy as the missing dimension in health promotion theory and practice. *Promotion and Education*, 13, 236–242.
- Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy*, 88, 222–235.
- Raphael, D., Labonte, R., Colman, R., Torgeson, R., Hayward, K., & Macdonald, J. (2006). Income and health research in Canada: Needs, gaps, and opportunities. *Canadian Journal of Public Health*, 97(Suppl 3), S16–S23.
- Reutter, L., Harrison, M. J., & Neufeld, A. (2002). Public support for poverty-related policies. *Canadian Journal of Public Health*, 93, 297–302.
- Reutter, L., Neufeld, A., & Harrison, M. (1999). Public perceptions of the relationship between poverty and health. *Canadian Journal of Public Health*, 90(1), 13–18.
- Reutter, L., Stewart, M., Veenstra, G., Love, R., Raphael, D., & Makwarimba, E. (2009). Who do they think we are anyway? Perceptions and responses to poverty stigma. *Qualitative Health Research*, 19(3), 297–311.
- Robinson, L. M., McIntyre, L., & Officer, S. (2005). Welfare babies: Poor children's experiences informing healthy peer relationships in Canada. *Health Promotion International*, 20(4), 342–350.
- Saint-Arnaud, S., & Bernard, P. (2003). Convergence or resilience? A hierarchical cluster analysis of the welfare regimes in advanced countries. *Current Sociology*, 51(5), 499–527.
- Schoen, C., & Doty, M. M. (2004). Inequities in access to medical care in five countries: Findings from the 2001 Commonwealth Fund International Health Policy Study. *Health Policy*, 67, 309–322.
- Stewart, M., Reutter, L., Makwarimba, E., Veenstra, G., Love, R., & Raphael, D. (2008). Left out: Perspectives on social exclusion and inclusion across income groups. *Health Sociology Review*, 17, 78–94.
- Swedish Ministry of Health and Social Affairs. (2002). *Welfare in Sweden: The balance sheet for the 1990s*. Stockholm: Author.

- Swedish Ministry of Industry Employment and Communications. (2004a). *Innovative Sweden: A strategy for growth through renewal*. Stockholm: Author.
- Swedish Ministry of Industry Employment and Communications. (2004b). *The Swedish government's national plan for gender equity*. Stockholm: Author.
- Swedish National Institute for Public Health. (2003). *Sweden's new public health policy*. Stockholm: Author.
- Townsend, P. (1993). *The international analysis of poverty*. Milton Keynes: Harvester Wheatsheaf.
- United Nations Development Program. (2008). *Human development report 2008. Capacity development: Empowering people and institutions*. Geneva: Author.
- Williamson, D. L., & Reutter, L. (1999). Defining and measuring poverty: Implications for the health of Canadians. *Health Promotion International*, 14(4), 355–364.
- Williamson, D., Stewart, M., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., et al. (2006). Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy*, 76(1), 106–121.
- World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: Author.
- Wright, E. O. (1994). The class analysis of poverty. In E. O. Wright (Ed.), *Interrogating inequality* (pp. 32–50). New York: Verso.

Dennis Raphael, PhD, is Professor of Health Policy and Management, York University, Toronto, Ontario, Canada.

