Core Concerns:
A Discussion Document Regarding An Inner City Health Strategy for Hamilton

February 2008

Prepared by Hamilton Urban Core Community Health Centre
- an inner city health centre

71 Rebecca Street, Hamilton Ontario L8R 1B6
Phone: 905-522-3233 Fax: 905-522-5374
Website: www.hucchc.com

Acknowledgements

Special thanks to Maxine Carter, Jane Mulkewich and Lynn Simmons for their assistance with this initiative and for their contribution to this discussion document.

About Hamilton Urban Core
Community Health Centre

Founded in 1996, Hamilton Urban Core Community Health Centre provides primary health care services and programs in more than 15 languages to 10,000 registered clients who reside in the inner city of Hamilton, Ontario.

The Centre is the result of extensive community collaboration and the energy of service providers, community members, prospective clients, and health practitioners who shared a common vision for health services in the core. Responding to a compelling need, they worked together to imagine and create a first-rate health centre to deliver quality primary health care services, health promotion, education, advocacy, and outreach services.

The mission statement of the Hamilton Urban Core Community Health Centre is to provide the highest level of primary health care, education and advocacy, especially with those individuals who face barriers to improving their health and well being. In order to effectively fulfill this mission statement, Hamilton Urban Core is launching a strategy involving other community partners, service providers, policy makers and local residents to improve the health outcomes of people in the inner city who face multiple issues such as poverty and racism.

Hamilton Urban Core is a community-based health care agency primarily funded by Ontario's Ministry of Health and Long Term Care.

Preamble

The provincial government has created the health transformation agenda and introduced Local Health Integration Networks (LHIN) to provide the framework for renewal in health services and delivery. LHINs are described as "*local health organizations which will plan, integrate and fund local health services – including hospitals, community care access centres, home care, long-term care, mental health, community health centres as well as addiction and community support services – for a specific geographic area.*" *(George Smitherman, Minister of Health and Long-Term Care)*

LHINs are charged with the responsibility of ensuring that local health care needs are addressed through the delivery of appropriate quality health care and that barriers to accessing care are eliminated. LHINs are intended to provide stability and local accountability while government focuses on setting strategic directions and policy at the provincial level.

While we fully support the notion of improved efficiency in and accessibility to health services, it is our experience that individuals, families and communities who experience barriers in accessing health services are among the most marginalized and vulnerable in our community and their specific needs and health issues are often overlooked or excluded in planning processes. The Hamilton Niagara Haldimand Brant LHIN covers a large and populous area, and as an agency providing health care services to inner city residents in Hamilton, we want to ensure that these inner city needs are also articulated in planning efforts at the LHIN level. This discussion document is intended to draw attention to the health disparities that exist within our community and to serve as a catalyst for action by prompting the development and implementation of an inner city health strategy.

Introduction

The 2002 report to the *Prime Minister's Caucus Task Force on Urban Issues* noted that many cities in Canada are approaching crisis with the urban quality of life fast declining. Similar to other cities, Hamilton must grapple with a number of issues that impact the health and well-being of residents in the inner city.

In considering an inner city health strategy it is important to establish a working definition of health, health promotion and the determinants of health in order to enact an effective plan. In this discussion paper the definitions of health, health promotion and the determinants of health have been adopted as follows:

Health

A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. (The World Health Organization)

Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities." (Reference: Ottawa Charter for Health Promotion. WHO, Geneva, 1986)

Health Promotion

"Health promotion is the process of enabling people to increase control over, and to improve their health." (Reference: Ottawa Charter for Health Promotion. WHO, Geneva, 1986)

The Determinants of Health

Also known as the social determinants of health, the determinants refer to the range of personal, economic, environmental and social conditions that influence and impact upon the health of individuals and communities. The social determinants of health also determine the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment. The social determinants of health are about the quantity and quality of the variety of resources that a society makes available to its members. *(Reference Canadian Nurses Association Social Determinants of Health and Nursing, Summary of Issues)*

Generally, there is an assumption that health care and services are equally accessible to everyone within the community. While we fully endorse Canada's universal health care system we are also very aware that there is inequity and unevenness in access to these services and to health outcomes. This is why an inner city health strategy is critical.

It is also important to note that language is always evolving as new understandings emerge, and this is true around issues of inequity. For example, although the Canadian government has long used the terminology of “visible minority”, “racialized” and “minoritized” are newer terms that have evolved to make more explicit the active process of systemic marginalization of groups identified with these descriptors. The Ontario Human Rights Commission speaks to the term racialized and racialization accordingly:

“While biological notions of race have been discredited, the social construction of race remains a potent force in society. The process of social construction of race is termed “racialization.” The Report of the Commission on Systemic Racism in the Ontario Criminal Justice System defined “racialization “as the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life.”

When it is necessary to describe people collectively, the term “racialized person” or “racialized group” is preferred over "racial minority", "visible minority", "person of colour" or “non-White” as it expresses race as a social construct rather than as a description based on perceived biological traits.

When referring to minoritized groups we are speaking about groups that are actively systemically disadvantaged and oppressed in relation to a more privileged and or dominant group. While minortized groups are usually smaller in numbers in relation to a more privileged and/or dominant group, it is the associated systemic oppression that “minoritizes” them.

Hamilton – The Community Context

Hamilton is one of the most diverse cities in Ontario and in Canada. With a population of approximately 500,000 Hamilton is the one of the largest receiving centers for immigrants and refugees and a popular choice for many secondary migrants. Approximately 40% of the population identifies as being born outside of Canada and there over 52 of the main language groups represented in the area. In close proximity to Six Nations, the largest reserve by population in Canada, Hamilton also has a significantly high number of Aboriginal people living in the city.

The Social Planning and Research Council’s report *“Incomes and Poverty in Hamilton”* notes that poverty rate in Hamilton is 20% with the highest incidence being in the inner city areas (Wards 3, 4 and 5) with pockets of low incomes or poverty found elsewhere in the city.

In the past three to five years there is a notable increase in the number of individuals and families who are homeless or at high risk of becoming homeless. Added to that is the growing prevalence of mental illness and mental health issues.

Reports on health status and health outcomes also note that there are increased rates of sexually transmitted infections, substance abuse, environmental illnesses, and chronic disease such as diabetes, heart disease and asthma in Hamilton.

It must be pointed out that within each of these areas there are populations that experience multiple barriers to health and social services and are differentially impacted by the social, political, economic, psychological and emotional determinants of health. For example within the 20% poverty rate found in Hamilton, racialized communities, Aboriginal people, immigrants and refugees experience an even higher rate of poverty as evidenced in the following statistics:

<u>Poverty Rates in Hamilton</u>

General population	20%
Recent immigrants and refugees	52%
Aboriginal peoples	44%
Visible minorities	37%
People with active limitations	30%
Seniors over 75	29%
Children under 12	25%

This is of particular importance as "*poverty has been shown to be a cause of poor health and also limits access to both preventive and remedial health care*". *(Dr. D. Wasylenki, Psychiatrist-in-Chief, St. Michaels's Hospital).* In other words – poverty makes people sick! Poor health is linked to living in poverty and any redress must effectively consider this as a key determinant of health.

In addition, a significant number of immigrants and refugees choose Hamilton as their home. Many are unable to communicate in English and experience tremendous difficulty in accessing a complicated system of services. However, there is not a uniform commitment on the part of service providers (e.g. hospitals, long-term care facilities, mental health agencies, social service agencies and others) of ensuring client accessibility through the use of professional cultural interpretation. This results in significant differences not only in access to services but also in health outcomes.

There are many other examples that illustrate the inequities experienced by immigrants, refugees, Aboriginal peoples, racialized and minoritized communities and others who are disadvantaged and marginalized that are not noted in this

brief outline but must be considered in the discussion and development of the strategy.

These varied experiences and realities related to accessing health and health related services demonstrate the need for a focused strategy that will encompass the broad range of issues and complexities found in the inner city. The American College of Physicians notes that "*Physicians treat patients' symptoms, but not until after diagnosing the disease that causes the symptom. Similarly, we must find ways to improve delivery of health care in the inner cities while addressing the underlying causes of poor health such as poverty, homelessness, violence*" and isolation, cultural incompetence and discrimination.

Forging an Inner City Health Strategy

The Inner City Health Strategy is a pioneer initiative designed to create strategic alliances, community initiatives, and a supportive body of research with the objective of influencing local, provincial, and federal policy and funding decisions. By these means, we hope to make a material difference in the lives and health outcomes of those living in poverty, or with too-low incomes, and to effect positive change in the inner core of Hamilton and other Ontario cities.

Poverty and Racism – Co-Determinants of Health

While much has been written about the significance, importance, and effects of poverty (or socio-economic status), as well as gender status, on health outcomes very little has been produced on the role of racism, and even less on the significant inter-relationships of poverty and racism.

Yet, the racialization of poverty represents a daily reality for Ontario's inner city health centres, and for the low-income clients they serve.

For inner city populations, the pernicious effects of poverty represent a significant health barrier. Critical as it is as a determinant of worse health outcomes, poverty alone does not explain – and, indeed, denies - the lived reality for the tens of thousands of residents who are also affected by racism. Therefore utilizing it as a single indicator will not produce social and health policies, strategies, workable solutions or best practices to measurably enhance prospects for inner city residents; indeed, precious health care dollars and resources will continue to be allocated to "feel good" solutions and partial remedies that will have less than an optimal effect on outcomes for the populations in need.

Racialized people are two or three times as likely to be poor than other Canadians. In Canada's urban areas, the spatial concentration of poverty or residential segregation is intensifying along racial lines. (Galabuzi)

Clearly a relevant Inner City Health Strategy requires that poverty and racism (or the racialization of poverty as some propose) not only serve as the co-determinants of health but that there must also be an understanding that poverty and racism are at the same time structural and political.

There is a hesitation or a willful blindness to recognize that poverty and racism exist, and as outlined below, much of the debate in Canada has centered on ways to measure poverty and ways to measure racism, rather than focusing efforts on ways to mitigate the effects of poverty and racism.

The connections between poverty and racism can be made on the basis of the empirical evidence (that racialized peoples experience greater rates of poverty), on the historical legacy (that racialized peoples were denied property rights or employment rights and in some cases were themselves considered property), or by comparing the similar mechanisms that contribute to poverty and racism (mechanisms such as a refusal to recognize that they exist).

First, there is the empirical evidence, that racialized communities and Aboriginal communities experience significantly greater rates of poverty. For example, in May 2006 the United Nations Committee on Economic, Social and Cultural Rights stated the following:

> *"The Committee is concerned that, despite Canada's economic prosperity and the reduction of the number of people living below the Low-Income Cut-Off, 11.2 per cent of its population still lived in poverty in 2004… The Committee also notes with particular concern that poverty rates remain very high among disadvantaged and marginalized individuals and groups such as Aboriginal peoples, African Canadians, immigrants, persons with disabilities, youth, low-income women and single mothers."*

Poverty

In Canada, social assistance levels are clearly set at or below levels associated with absolute poverty. The dominant view is that living on government benefits should be so unpleasant as to motivate individuals to join the workforce. This approach makes living conditions extremely difficult for those who must rely on such benefits.

The Debate on How to Measure Poverty

The low income cut-offs or LICOs of Statistics Canada are by far the most widely used measure of poverty in Canada. Despite this, Statistics Canada has consistently maintained that it does not regard the LICOs as poverty lines, presumably because the federal government does not want to give official recognition to poverty. The low income cut-offs or LICOs mark income levels

where people have to spend disproportionate amounts of their incomes on food, shelter and clothing. In 1998, the federal government introduced a new approach to measuring poverty, called the Market Basket Measure or MBM. The MBM estimates the cost of a specific basket of goods and services assuming that all items in the basket were entirely provided for out of the spending of the household. Some people believe that the MBM is too high and some believe it is too low, but no matter how poverty is measured, it will not change the situation of poor people in Canada. Whether we use the MBM or the LICO, it is clear that too many Canadians live in poverty.

The LICOs allow us to see how deep in poverty or how very far below the cut-off some people live. All measures of poverty are relative. The issue is not so much about measurement as it is about values. How poor and excluded are we willing to allow some people to be in our wealthy society? Questions about poverty measurement are often used to distract attention from what is really important, such as trends, which tell us whether we are doing better or not, and patterns, which tell us what circumstances make some people more vulnerable to poverty.

Poverty rates can vary a great deal depending on government policies and priorities. For example, poverty rates of lone-parent mothers vary from 47% in the USA and 40% in Canada to 25% in France and an amazingly low 3% in Sweden.

Also, politicians and policy-makers continue to make political decisions about children living in poverty. For example, the Hamilton Roundtable on Poverty has decided to focus on child poverty. However it remains true in Hamilton and across Ontario that single employable people have by far the least adequate incomes, no matter what poverty line we look at. Although families on social assistance spend significantly more than the recommended 30 percent of their income on housing, single employable people on social assistance simply cannot afford an apartment on their own.

“Single employable people are frequently vilified by governments and are invariably forced to subsist on incomes far below Canada’s unofficial poverty lines… People with disabilities on welfare have not fared much better. In 17th century England, they were labeled the “deserving poor” and were supposed to be treated better than the “undeserving poor” under the country’s Poor Laws. In 21st century Canada, people with disabilities are all too commonly treated as undeserving by most provincial and territorial welfare systems and subjected to harsh treatment by welfare… Families with children are the focus of much flowery government rhetoric, but most governments go out of their way to deprive families with children who have the bad luck to be on welfare. The worst examples of this are the claw back mechanism in the National Child Benefit.”

It is disappointing that provincial governments continue to set welfare rates at levels that simply do not allow any welfare recipient to maintain the most basic standard of living.

Social assistance or welfare is the income program of last resort in Canada. It provides money to individuals and families whose resources are inadequate to meet their needs and who have exhausted other avenues of support. The welfare systems in each province have complex rules that regulate all aspects of the system, including eligibility for assistance, the rates of assistance, the amounts of other income recipients are allowed to keep, and the way in which applicants and recipients may question decision regarding their cases. Across Canada, welfare officials have some degree of discretion in deciding whether certain households qualify for special assistance. Discretion is both a strength and a weakness of the welfare system. On the one hand, welfare recognizes the fact that individuals may have ongoing or one-time special needs for which they require assistance. On the other hand, a person with special needs may be considered eligible for extra assistance by one welfare worker, but not by another.

The Cost of Poverty

There are many indicators of the human cost of poverty, from low birth-weight babies and increased illness to family disintegration and young lives lost to homicide or suicide. Designing public policy means making decisions about what a society can afford in terms of money – how much a program will cost compared to its benefits – in order to set priorities.

One of the difficulties with measuring the cost of poverty is that economic and social policies have historically developed on different tracks, without recognizing how interdependent they are. In very basic terms, economic policy has concerned itself with money and social policy with people. The result is often that many activities may contribute to economic growth, but not to well-being.

The health field provides a key example of how reducing and preventing poverty in the first place is more cost-effective than paying for its consequences.

Canada devotes a very large share of its wealth, effort and attention to trying to maintain or improve the health of the individuals that make up its population. These massive efforts are primarily channeled through the health care system, despite evidence that income, employment and social status would have a greater positive effect.

For example, the Hamilton Community Foundation report of December 5, 2007 noted that over 16,000 people access food banks every month, with almost half being children. Nearly 400 people stayed in emergency shelters on any given night in the city of Hamilton. Twenty percent of families who rent their

accommodation spend more than half of their income on shelter and teeter on the brink of homelessness.

Racism

The Ontario Human Rights Commission in its description of racism notes "the social construction of race remains a potent force in society with real consequences for individuals. At the institutional or systemic level, racism is evident in organizational and government policies, practices, and procedures and 'normal ways of doing things' which may directly or indirectly, consciously or unwittingly, promote, sustain, or entrench differential advantage for some people and disadvantage for others."

Context of Racism and Inequities in Canada

- Historic policies/legislations set the framework for systemic racism in Canada.
- Racism is the use of power to exclude racialized people and Aboriginal/First Nations from equal participation in society.
- Racism is determined not by intent but by impact on racialized and Aboriginal/First Nations.
- Racism can be conscious or unconscious; intentional and unintentional
- Underlying all discrimination is the use of power to oppress or exclude
- Racialized groups, Aboriginal people and recent immigrants have been identified as some of the most marginalized in Canada (Galabuzi)
- Racialized groups account for 13.5% Canadian population
- Immigrants account for 18% of Canada's population and 25% of Hamilton's population
- 27% of people living in Ontario are born outside Canada compared to 18% in Hamilton.
- Immigration accounts for approximately 85% of Hamilton's population growth and that percentage could rise to 100% over the next couple of decades

The Debate on How to Measure Racism

More of the debate has centered on how to measure racialized people, rather than trying to measure racism itself. Even where racism is criminal, police agencies across Canada do not have consistent or standard methods of measuring hate crimes based on racism. The Ontario Human Rights Commission reports relatively low rates of complaints based on racism, and of those complaints that come forward to the Commission, relatively low rates of successfully proving cases of racism. It is a negative feedback cycle, where politicians and decision-makers (who are white and do not experience racism) do not believe that racism is a serious or widespread problem and therefore do not

institute effective methods of measuring racism, and because there are no effective methods of measuring racism, politicians and decision-makers continue to believe that racism is not a serious or widespread problem. However, racism continues to have a major impact on the health of racialized people.

For example, in the health care sector, the effects of racism often take the form of:

i) Language interpretation not systemically recognized
ii) Lack of cultural sensitivity in service delivery
iii) Absence of cultural competencies (policies and operations)
iv) Systemic barriers to access of health services
v) Inadequate funding for community health services
vi) Inadequate funding for research and treatment of certain conditions
vii) Poor representation at the staffing level

Racism is too often narrowly defined as individual acts. Systemic racism and more subtle forms of racism are ignored. Historically, the dominant culture in Hamilton has assumed that the way to deal with racism is to celebrate the city's racial diversity, but this does not challenge the structures of power which work to maintain white dominance.

A Canadian example of the economic costs of inequality and social exclusion was provided in the Report of the Royal Commission on Aboriginal Peoples. The costs associated with the economic marginalization of Aboriginal people were estimated at $7.5 billion in 1996. Of this, $5.8 billion was estimated as the cost of foregone production because Aboriginal people are not able to fully participate to their potential in the economy and $1.7 billion for extra expenditures or remedial programs to cope with social problems.

There are increasing reports across Canada from researchers and community organizations regarding the racialization of poverty. Strong indicators point to the fact that poverty disproportionately impacts racialized and Aboriginal peoples. Numerous studies show that those who are racialized or Aboriginal fare the poorest in Canada.

The Racialization of Poverty

What do we mean by the racialization of poverty? The Colour of Poverty Campaign has developed a series of fact sheets in which they describe the racialization of poverty as:

"Racialized communities experience ongoing, disproportionate levels of poverty. In other words, people from ethno-racial minority groups (communities of colour) are more likely to fall below the LICO and to have related problems like poor health, lower education and fewer job opportunities, than those from European

backgrounds, while it is possible for anyone to experience low income and reduced opportunities, individual and systemic racism plays a large role in creating such problems. Discrimination means that they are less likely to get jobs when equally qualified and are likely to make less income than their white peers. It means they are more likely to live and work in poor conditions, to have less access to healthcare and to be victims of police violence."

In a presentation n Social Exclusion, Race and Immigration as Social Determinants of Health (October 2007) Grace-Edward Galabuzi notes:

The Racialization of poverty represents a disproportionate and persistent experience of low income among racialized groups

- It is linked to the process of the deepening social exclusion of racialized and immigrant communities.
- A key contributing factor is the concentration of economic, social and political power in fewer hands that has emerged as the state has retreated from its regulatory role in the economy.
- The experience of poverty includes powerlessness, marginalisation, voicelessness, vulnerability, and insecurity.
- The various dimensions of the experience of poverty interact in important ways to reproduce and reinforce social exclusion
- Racialized people are two or three times as likely to be poor than other Canadian

He further notes:

- In 1995, the rate for racialized children under six living in low income families was 45% – almost twice the overall figure of 26% for all children living in Canada.
- In 1996, while racialized groups members accounted for 21.6% of the urban population, they accounted for 33% of the urban poor.
- In 1996 36.8% of women and 35% of men in racialized communities were low-income earners, compared to 19.2% of other women and 16% of other men.
- In 1998, the family poverty rate for racialized groups was 19% compared to 10.4% for other Canadian families.

The Foundation of an Inner City Health Strategy

While there is a formal rural and northern health policy/strategy, an urban health or inner city health policy or strategy has not been implemented at regional or national levels. This is not to say that cities or communities have not developed plans to address the specific health needs of their populations rather it is a comment on the absence of what we think to be important public policy given that approximately 80% of the population lives in urban areas.

Two examples of inner city plans are found in Toronto at St. Michael's Hospital and in Ottawa with the Inner City Health project.

St. Michael's Hospital has developed the Inner City Health Research Unit (ICHRU). The mandate of ICHRU is *"To improve the health of inner city populations through a program of applied, clinical and health services research. Particular emphasis is placed on addressing the needs of disadvantaged groups within a broad health determinants framework."* In addition to building knowledge and engaging in research the ICHRU has identified engaging a wide variety of disciplines, organizations and communities to address the health needs of inner city populations as one of their key goals. Their clinical programs engage in active outreach to hostels and shelters for the homeless to ensure access and support to individuals.

Ottawa's initiative known as the Inner City Health Project identifies providing *"health maintenance and health care services to homeless people in the region commensurate with need and in a comprehensive and integrated fashion that is flexible, individualized, efficient and effective"* as their mandate. The Project also incorporates 10 guiding principles that speak to how the project will carry out its mission.

Based on research, observation and lived experience the critical elements of an effective inner city health strategy must include:

i) The definition of an "inner city health centre" as a centre spatially located in the inner city, whose majority client base are homeless, under-housed, low or no income residents, and who represent racialized and/or the most marginalized populations;

ii) Recognition of poverty and racism as central co-determinants of health;

iii) Recognition of poverty and racism as structural and political;

iv) Recognition of the need for immediate and aggressive action.

It is important that the development of any strategy or method directed at improving the delivery of health care, and health or health related services must also address the underlying causes of the health disparities and inequities experienced most predominantly in the inner city.

The objectives of the Inner City Health Strategy are:

1. To improve health outcomes for inner city clients
2. To improve the delivery of health care and health related services and supports, with particular focus on those who are the most marginalized and

vulnerable within the community as well as those who have been historically excluded
3. To affect public policy in order to facilitate system changes
4. To identify service gaps and unmet needs including the identification of new services or service delivery approaches where necessary;
5. To actively engage in research and information gathering to support the strategy;
6. To promote cultural competency in service environments
7. To provide a basis for the establishment of broader networks

Where Do We Go From Here?
Next Steps in the Creation of an Inner City Health Strategy

On March 6, 2008, Hamilton Urban Core will convene the first Inner City Health Strategy think tank session with the goal of identifying a critical path to support the development of the Inner City Health Strategy.

Utilizing the foundation elements outlined in this document, the Inner City Health Strategy will operate from a common understanding of strengths; recognizing that while it is important to identify gaps, the strategy will acknowledge the positive strengths of the services and populations in the inner city, and develop a climate of confidence in being able to achieve goals and visions.

Summing Up

Throughout the world, racialized and socially disadvantaged people have less access to health resources, get sicker and die earlier than people in more privileged social positions. These unfair gaps are growing in spite of an era of unprecedented global wealth, knowledge and health awareness. By far the greatest share of health problems is attributable to broad social conditions. Yet, health policies have been dominated by disease-focused solutions that largely ignore the social environment. As a result, health problems persist, inequities have widened, and health interventions have obtained less than optimal results. At the same time, there is evidence that policy, action and leadership to address the social dimensions of health can improve health and access to health care.
(Public Health Agency of Canada)

Bibliography

British Independent Inquiry into Inequalities in Health (the "Acheson report") Such assessments would provide the basis for projecting how well legislative efforts are targeted to address both the racial/ethnic and class dimensions of disparities.

Raphael D. (2001).

Mark Fraser, Senior Social Planner

From increasing poverty to societal disintegration: How economic inequality affects the health of individuals and communities*, in H. Armstrong, P. Armstrong and D. Coburn*

(Eds.). Unhealthy Times: The Political Economy of Health and Care in Canada*. Toronto: Oxford University Press,*

Grace-Edward Galabuzi, Ryerson University, Social Exclusion, Race and Immigration as Social Determinants of Health, presentation to McGill Institute of Social and Health Policy, October 25, 2007

Health Disparities By Race And Class:Why Both Matter by Ichiro Kawachi, Norman Daniels, and Dean E. Robinson

Raphael, D. (2007a). Addressing health inequalities in Canada: Little attention, inadequate action, limited success. In (eds.) Health promotion in Canada. Toronto: Canadian Scholars' Press. In A. Pederson, I. Rootman, M. O'Neill & D. S. (Eds.),
Health Promotion in Canada: Critical Perspectives. Toronto: Canadian Scholars' Press.

Raphael, D. (2007b). The politics of poverty. In D. Raphael (Ed.), *Poverty and Policy in*

Canada: Implications for Health and Quality of Life. Toronto: Canadian Scholars' Press.

O'Hara, P. (2006). *Social Inclusion Health Indicators: A Framework for Addressing the Social Determinants of Health*. Edmonton: Edmonton Social Planning Council.

Navarro, V. (Ed.). (2007). *Neoliberalism, Globalization, and Inequalities: Consequences for Health and Quality of Life*. Amityville NY: Baywood Press.

Navarro, V., Borrell, C., Benach, J., Muntaner, C., Quiroga, A., Rodrigues

Murphy, B., Roberts, P., & Wolfson, M. (2007). High Income Canadians.

Perspectives onLabour and Income(September), 5-17.

Navarro, V. (2004). The politics of health inequlities
Association of Ontario Health Centres. (2007). *Taking Action on the Social Determinants of Health*. Toronto: Association of Ontario Health Centres.

Chronic Disease Alliance of Ontario. (2007). *Primer to Action: Social Determinants of Health*.

Toronto: Chronic Disease Alliance of Ontario.