

LCC Session

CanMEDS Competency:

Dr. Anne Niec

What will happen in this session?

Suggested Time 60 minutes.

Purpose of the session

1. To understand the importance of health advocacy
2. To understanding the meaning of and principles of advocacy
3. To see advocacy in action in our daily work

Background:

Vision of the Health Advocate Role:

Physicians responsibly use their expertise and influence to advance the health and well-being of *individual patients, communities and populations*

Royal College of Physicians and Surgeons of Canada

2008

Expectations of Advocacy

Health advocacy is an essential component of health promotion involving

- Understanding of the determinants of health (education, personal health practices, occupation, income, type of housing, social supports/services, genetics, culture, gender)
- Advocating at three level (individual, community, society)
- Using knowledge and influence in the health care system

Levels of Advocacy

Individual

- Identifying the health needs of the individual patient and looking for opportunities for advocacy, health promotion and disease prevention

Community

- Ability to describe the community served, identify opportunities for advocacy, health promotion and disease prevention, appreciate the possibility of competing interests between communities served and other populations

Society

- Identify determinants of the health of the population, including barriers to access to care and resources, identify vulnerable or marginalized populations within those served and respond appropriately

Royal College of Physicians and Surgeons of Canada 2005

Faces of Advocacy

In clinical setting: for investigations, navigating the health care system, modifying plans of care...

- In the community: to initiate prevention strategies, policy development, guidelines
- In the society: to invoke change by lobbying

**always between the physician and another individual (doctor patient, doctor-other professional, doctor-government)

***public accountability

Health Advocacy Competencies: The elements

- Advocacy for individual patients, populations and communities
- Health promotion and disease prevention
- Determinants of health, including psychological, biological, social, cultural and economic
- Fiduciary duty to care
- The medical profession's role in society
- Responsible use of authority and influence
- Mobilizing resources as needed
- Adapting practice, management and education to the needs of the individual patient
- Patient safety
- Principles of health policy and its implications
- Interactions of advocacy with other CanMEDS Roles and competencies

Exercise:

The background information is an opportunity for you to think about what advocacy is all about. The references and reading hopefully will give you further background information in order for you to use the scenario below (thanks to PIPER- inter-professional education) as a catalyst to analyze an approach to how you would support this family should this child have presented to our emergency department. Remember sometimes you get only one opportunity with a family – you need to determine how best to use that opportunity to either open up doors for further visits, investigations and inquiries or decide to deal only with the problem at hand and move this patient out, get another patient in. You decide which approach is more in keeping with advocacy!

Have a discussion about what approach do you take with this child and his family; what are the family's strengths; what possible community resources or supports could you put in place; how can you work with the family; discuss issues of food "food security" such as quality and quantity of their food/ housing/bullying/teen pregnancy/school supports (nutrition and health issues) etc. What can you do as a paediatrician recognizing they live in this community and recognizing that they live in one of the "zones" deemed poor in our community. Think and discuss your role from a clinical to community to a larger policy influencing one.

I suggest that you split into groups of twos to tackle a section of interest and come prepared to discuss with the group your analysis of the issues you chose to address and your advocacy role from the three levels noted above.

Scenario

Anita is a 35 y/o mother of 2 living in a low income housing neighbourhood in Hamilton. She is a homemaker with English as her second language. She is able to communicate, but it is difficult for her to understand other people when they speak too quickly, or use a lot of jargon. Her medical history includes: hypertension and a BMI of 33.

Today she took her 5 year old son to McMaster Children's Hospital ER accompanied by her daughter, (who speaks better English and can help translate if needed). He had been punched by one of the older boys in the neighbourhood because of his developmental delay; he fell on that arm and now he is complaining of a great deal of pain and is not willing to move his arm.

Over the past few months, Anita's daughter (16) started complaining of "*feeling sick all the time*", and she didn't want to go to school. She found out recently she was 28 weeks pregnant when she attended a walk-in clinic.

Anita's partner, Joe, is a 46 year old Hamilton native. He had been in an industrial accident 6 years ago and had to quit his job. He started drinking heavily and he started gaining weight. The family stress was creating more arguing at home. Anita had threatened to leave him and move back with her mother who had been very supportive after her first husband had left.

Joe started working for a trucking company loading and unloading international rigs, despite the fact that he had a limited tolerance for lifting. Although it paid well, he was constantly complaining about his sore back, and missed a lot of time from work. Two weeks ago, he lost his job.

Readings/Resources

1. Earnest M., et al. Perspective: Physician Advocacy: what is it and How do we do it? Academic Medicine, Vol. 85, No.1/January 2010- Attached
2. Dharamsi S. et al. The Physician as Health Advocate: Translating the Quest for Social Responsibility into Medical Education and Practice. Academic Medicine, Vol. 86, No. 9/September 2011-Attached
3. Gender and Health Collaborative Curriculum www.genderandhealth.ca
4. Women and Poverty Fact Sheet -Attached
5. **Hamilton's Vital Signs - Gap Between Rich and Poor**
www.hamiltonvitalsigns.ca/gapbetweenrichpoor.html
6. Code Red Report: <http://www.thespec.com/topic/codered>
7. Raising a Child in Hamilton: <http://www.hamiltonpoverty.ca/docs/HRPR-June12-06.pdf>
8. **How can Gender Analysis impact the work of Vibrant Communities?**
<http://tamarackcommunity.ca/downloads/gender/Tools.pdf>
It does this by:
 1. By helping us understand relationships between men and women. Gender Analysis does this by answering the following questions:
 - Q: What do men, women, adults, children and elders do, and where do they do it?
 - Q: Who has access to and control over resources and services, and who makes decisions in the community?
 - Q: What are the reasons behind these differences in gender?
 2. By helping us understand the impact of our poverty-reduction work on men and women, boys and girls.
 3. By helping us increase the capacity of our institutions and organizations to program for and consider gender equality.

Perspective: Physician Advocacy: What Is It and How Do We Do It?

Mark A. Earnest, MD, PhD, Shale L. Wong, MD, MSPH, and Steven G. Federico, MD

Abstract

Many medical authors and organizations have called for physician advocacy as a core component of medical professionalism. Despite widespread acceptance of advocacy as a professional obligation, the concept remains problematic within the profession of medicine because it remains undefined in concept, scope, and practice. If advocacy is to be a professional imperative, then medical schools and graduate education

programs must deliberately train physicians as advocates. Accrediting bodies must clearly define advocacy competencies, and all physicians must meet them at some basic level. Sustaining and fostering physician advocacy will require modest changes to both undergraduate and graduate medical education. Developing advocacy training and practice opportunities for practicing physicians will also be

necessary. In this article, as first steps toward building a model for competency-based physician advocacy training and delineating physician advocacy in common practice, the authors propose a definition and, using the biographies of actual physician advocates, describe the spectrum of physician advocacy.

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In 2002 the American Board of Internal Medicine, in its charter on medical professionalism, called for a “commitment to the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician.”¹ There was not an isolated entreaty. The American Medical Association (AMA) endorses a similar commitment: Physicians must “advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.”² Numerous authors have also argued for the importance of public physician advocacy and its place in medical professionalism^{3–8}; several specialty societies now include advocacy in their definitions of professional

responsibilities,^{9,10} and the Accreditation Council for Graduate Medical Education (ACGME) Pediatrics Residency Review Committee (RRC) now requires advocacy training and experience for all pediatric residents.¹¹

Despite widespread acceptance of a physician’s duty to advocate, the concept remains problematic because it remains undefined. Although the Pediatric RRC requires advocacy training, the committee does not define physician advocacy, nor does it delineate its scope or describe its competencies.¹¹ Others who have called for professional advocacy have likewise gone no further. In this article, we propose a definition and describe the spectrum of physician advocacy as first steps toward building a model for competency-based physician advocacy training and delineating advocacy in common practice.

requires working to address the root causes of the problems they face. Nevertheless, all physicians’ obligations to advocacy are grounded in their professional experience and expertise and their duty to their patients. Each physician’s obligation to advocacy must also include a recognition of the limits of his or her expertise (e.g., to expect an adult ophthalmologist to advocate children’s oral health needs is unreasonable).

We therefore build on the AMA’s endorsement² to propose the following definition of physician advocacy: Action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise.

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Defining Physician Advocacy

Physicians are well acquainted with their roles as advocates for the individual patient. Most, if not all physicians, have taken extra steps to ensure a patient receives a needed service. Physicians consider advocacy for an individual an accepted component of ethical practice, yet this alone does not meet the requirement for “public advocacy on the part of each physician.” Advocacy, according to this broader perspective, requires more than helping individual patients get the services they need; it

Physicians’ Unique Capacity for Advocacy and the Barriers That May Keep Them From It

Physicians are uniquely positioned to function as public advocates for health. They understand the medical aspects of issues better than any sector of society, and they are poised to observe and delineate the links between social factors and health. Public trust of physicians is very high; to the public, doctors are a credible source of information.¹² Given their social standing, physicians enjoy an unusual degree of access to policy makers, to local and national leaders, and to citizens; thus, they possess a great deal

of leverage in influencing public processes and priorities.

Although physicians seem to *endorse* the idea of civic engagement as a professional responsibility,^{13,14} there is less evidence that physicians *engage* in these activities. The limited evidence available shows that physicians are more likely to engage policy makers on issues affecting their own economic well-being^{7,15–18} and that, on the most basic measure of civic involvement, that is, voting, doctors vote less often than other professions or the even public at large.¹⁹ Others have observed that often a discrepancy exists between the professional values physicians endorse and the behaviors they demonstrate.¹⁴

Little empiric evidence exists to explain why physicians have not more fully embraced the role of advocate. A number of hypotheses might explain it. The gap between endorsing and engaging in advocacy may be illusory; because the attitudes cited are socially desirable, physicians may endorse them in polls without holding them very deeply. Maybe the admissions process for medical schools favors academic success to a degree that admissions committees admit too few service-oriented students. Medical training, which is long, intense, and isolating, largely removes physicians from the community while they attain clinical competence; perhaps these severed ties are too difficult to rebuild. Maybe the contrast between the competence and control physicians feel in a clinical setting and the uncertainty and ambiguity they experience in an advocacy role is too stark for most to overcome. Physicians have busy, demanding clinical lives—perhaps their time is too scarce. Doctors are trained to keep personal opinion and preferences out of the clinical encounter; they address religion and politics at the bedside with caution, if at all. Perhaps physicians tend to generalize this soft, interpersonal clinical boundary and become reluctant to engage in the processes required for effective advocacy. As one observer noted, leaving “the mountain of equipoise for the valley of advocacy” is difficult (John F. Steiner, MD, personal communication, 2000). An advocate’s agenda may at times conflict with the priorities of institutions to which he or she must be accountable; fear of political fallout may keep physicians, especially

those with more junior status, away from these activities; the culture of medicine and “hard” science may be the culprit as well. Few randomized controlled trials have tested community health interventions—much less public policy—and public decision making may often seem a chaotic and ill-informed process. Even our grammatical preferences may hold a clue here; perhaps a culture that so stubbornly clings to passive-voice-verb construction is simply averse to the proactive, declarative nature of advocacy.

Despite these barriers, doctors do engage in advocacy, and many are very effective in that role. Their real-life examples best demonstrate the broad range of physician advocacy.

The Spectrum of Physician Advocacy

Medical society affiliation: State health care reform

Dr. L became increasingly concerned about the lack of health insurance coverage available for his patients and the growing systemic inefficiencies in health care that he saw eroding access to and quality in health care. At a meeting of his state medical society he stood up, voiced his concerns, and made a motion that the members move comprehensive health care reform to the top of their agenda. His action redirected the meeting; 90% of the membership voted to suspend the planned agenda and take up his question. When the medical society convened its Physician’s Congress on Health Reform, he joined, and he has since contributed to the processes of health care improvement. The medical society is now providing leadership and advocating comprehensive health care reform at the state level, and Dr. L has taken a leadership role in the process.

Practice management: Coalition and board leadership

Dr. K reorganized his practice so that he could care for more uninsured patients. When the need grew so great that he was turning away large numbers of patients, he began researching local groups that were working to improve the plight of the uninsured. He volunteered his time with a statewide coalition working to bring about state health care reform. He ultimately joined the organization’s board and became one of the group’s leaders.

Parent education: School board advisor

Dr. B recognized an extraordinary rate of obesity among his school-aged patients while practicing in rural Washington. After discussing the issue with several families, he concluded that a contributing factor was the poor food choices found within the local schools. He decided to bring the issue before the local school board, requesting action on the children’s behalf. School board members agreed with Dr. B and felt empowered by his medical expertise to take action. They encouraged Dr. B to become a member of the board to follow this project to completion. On the basis of his commitment to these children, he agreed. His advocacy successfully effected changes in nutrition policy in the schools.

Policy advocate: Coalition building and leadership

Dr. L is a pediatrician who oversees a nonprofit practice. He cares for a largely uninsured and underinsured population. Frustrated by the lack of insurance for kids and the lack of action on the part of policy makers, he worked to build a coalition focused on expanding access to health insurance. He helped to organize a statewide coalition of 40 organizations interested in expanding health insurance coverage to all children. Dr. L uses his experience as a clinician to “tell the story” of why more kids need coverage. The collective advocacy and political capital of this newly formed coalition have effectively moved policy makers at a state level. Over the course of three years, the coalition outlined the necessary steps to cover all children in the state, and the members have, to date, successfully worked to pass several pieces of legislation leading toward that goal.

Patient advocate: A health care advisor for a policy maker

When Dr. S learned of a bill pending in the U.S. Senate that would adversely affect her patients, she called the office of her U.S. senator and spoke to the legislative aide who worked on health issues. The aide noted her concern and then asked her advice on another health-related matter. Dr. S spent several minutes offering a thoughtful opinion and left her number with the aide, offering to help in the future. Dr. S now meets quarterly with her U.S. senator and his legislative aide, and she has become a trusted advisor on health-related issues.

She uses the opportunity to advocate solutions to the needs she sees in her practice and community.

Hospital physician: Leader in injury prevention

Dr. R was sickened by the number of emergency department visits of children suffering injuries related to falls from high-rise windows. She sought a small grant to place window guards on apartment building windows in the surrounding neighborhood. When she demonstrated the dramatic decrease in injuries, the city council passed a law requiring protective guards on all high-rise windows. This initial effort led to a national change in laws promoting injury prevention from falls.

Patient advocate: Liaison to media and health reporter

Incensed by the injustice he saw in his daily care of patients without health insurance, Dr. M felt that change would come only if the public, too, could see what he saw. One particular patient's story seemed to perfectly illustrate some of the problems faced by the uninsured. With the patient's permission, he contacted a reporter who covered the story. Dr. M began gathering illustrative stories and pitching them to media outlets which then covered many of the stories. He also wrote and published frequent opinion pieces, editorials, and letters to the editor on health matters. In the process, he developed relationships with the local media and advocacy communities. He began coordinating his efforts with local health care advocates to link media coverage with their policy-change and organizing efforts. He also became an advisor on health matters to a number of local reporters.

Practice management: Reallocation of resources

Working in a hospital-based ambulatory care clinic, Dr. W recognized that the majority of her patients were not successfully accessing the social services they needed. When she voiced her observations, her colleagues confirmed her experience. Dr. W collected basic information documenting the magnitude and impact of these unmet needs. She then proposed a redistribution of social work services within the hospital to provide a full-time social worker to the clinic who would direct patients to social

services and assist them in overcoming barriers in accessing the services. This simple change dramatically improved access to social services for the clinic's patients and also led to the identification of a new layer of unmet patient needs. Dr. W is now organizing a system to facilitate legal referrals for patients to help them address many of the nonmedical barriers to health, such as housing and environmental risks.

Physician advocates—Discussion

The examples above illustrate some of the skills and competencies (e.g., identifying a problem amenable to advocacy, defining the problem and its scope, identifying and engaging strategic partners, developing a strategic action plan, communicating an effective message) necessary for effective advocacy. All of these physicians grounded their advocacy in their professional experience and work life. Each sought and developed critical strategic relationships that leveraged his or her own expertise and experience to achieve broader effect. In these examples, the physicians all acted locally—working with partners who served their own communities and institutions. None of these physicians changed jobs or moved. Most devoted only a few hours a month to their advocacy work. These examples illustrate the powerful effect physicians can have if they, as collaborators and leaders, strategically share their expertise with the community. They also illustrate the fact that every physician has a contribution to make and that, in all likelihood, a place exists in the physician's own community where those contributions would be both meaningful and welcome.

While each of these examples illustrates an instance of effective physician advocacy, each, to some degree, developed accidentally. None of these individuals received special training to take on these roles, and in many cases these physicians learned by trial and error the processes required to be successful as advocates. Because of the current paucity of formal physician advocacy training, successful physician advocacy tends to be exceptional.

Training Physician Advocates

If the profession of medicine considers advocacy a professional imperative, then advocacy must cease to be

exceptional. For this to occur, physicians and medical educators must become thoughtful and deliberate about training advocates. If left to chance, the charge to serve as public advocates rings hollow and will not be met. Furthermore, if advocacy is a professional imperative, its competencies must be well defined, and *all* physicians must meet them at some basic level—these competencies must not be relegated to a new specialty called “advocacy.” Whereas a minority of doctors practice cardiology, every physician must understand the circulatory system and its place in his or her clinical area of expertise. So it should be with advocacy.

What would medicine need to do to achieve this? What would advocacy training look like? We believe that sustainably fostering physician advocacy requires some modest changes to both undergraduate and graduate medical education while also developing advocacy training goals and opportunities for practicing physicians.

Historically, both undergraduate and graduate medical education have focused purely on developing clinical competence. Advocacy training would require that training reliably occur in a broader context. Medical students and residents would gain a basic understanding of the world beyond the clinical encounter. Ideally, this would begin in undergraduate courses with instruction in both the determinants of health and the production of health from an ecological perspective. Residents would develop competence in the preventive and population health perspectives that relate to their specialty. Training in the theories and practices of both leadership and social and organizational change would be new areas for competency, but this training would be closely related to training in systems-based practice. Physicians-in-training would develop the interpersonal and leadership skills needed to work collaboratively in teams in order to participate in, develop, and lead groups and coalitions. They would practice basic skills in developing and delivering clear messages and using the media effectively. Training in the processes of policy making within trainees' own institutions as well as institutions in the community and the

government would also be necessary. Finally, students and residents would need the opportunity to practice these skills through service learning, and they would also need to see their mentors effectively use and truly value these skills.

For training like this to develop and thrive in academic medical centers, an infrastructure must be available to support it. Accrediting bodies like the Liaison Committee on Medical Education and ACGME must endorse advocacy competencies as necessary components of medical training. Just like any area of competence, some physicians must devote a significant portion of their time and effort to practicing the skills. Campuses would need to develop stronger, more productive partnerships with their communities. Deans and other administrators would need to encourage and reward faculty advocacy activities. Neither developing partnerships nor rewarding faculty advocacy is likely to occur if funding is not available to support advocacy. Although the National Institutes of Health (NIH) has recently begun to emphasize the importance of translational work,²⁰ to date there has been little investment in supporting translation from clinic to community. Advocacy is fundamentally a translational activity. The application of preventive strategies in populations, the practice of community-based participatory research, and the use of process improvement and outcomes research in community health are all methods that translate interventions from individual patient health to broader public wellness. Effective advocacy may require seeking resources and regulations from the same political bodies that fund medical schools and traditional research. These activities can become politicized, so academic institutions and practices must consider and prepare for the political ramifications of advocacy activities.

Although federal funders have not supported the activities we call advocacy in their funding priorities, private funders have. In a time of diminishing dollars from the NIH, the growing resources and influence of private health foundations represent an opportunity for advocacy activities. Many of these foundations espouse health promotion and the elimination of health disparities

as their highest priorities. They fund community-based organizations, and many would welcome productive partnerships between those organizations and the medical community, providing opportunities for funding and strategic partnerships.

The medical community itself could do much more to foster advocacy as an expression of professionalism. Attorneys have long recognized the importance of pro bono work. Many law firms allow their members to devote hours to community service as part of their practice. Medical practices could do the same, encouraging their physicians to offer their services as volunteers in the community for a few hours each month. Even small practices could afford this level of investment. Larger, multispecialty groups and staff-model organizations could even sponsor rotating fellowships, and doctors in the organization who have more ambitious goals could apply for funding to support a project that might involve a more significant time investment.

The advocacy training that is currently available to practicing physicians is largely available through professional societies. Often local, state, or specialty medical societies will offer some basic training in lobbying and will organize trips to the state capitol or to Washington, DC, for the opportunity to apply those skills. These efforts are valuable, though limited. Expanding the training and broadening the agenda to better include the concerns of those in the community while seeking broad partnerships with patient groups and community leaders and advocates would create robust new opportunities for physicians and their communities.

If advocacy is a core element of professionalism, it should not become the parochial concern of a subspecialty. If we intend to train physicians as advocates, we must create a home for these activities in academic medicine and in medical practice. Funding for advocacy research, training, and activities is required to make advocacy a sustainable activity. Successful advocacy is achievable with both a clearer understanding of its components and deliberate practice from committed physicians.

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Did You Know?

In 1970, faculty at Ohio State University College of Medicine and Public Health created the nation's first independent study curriculum for medical school education.

For other important milestones in medical knowledge and practice credited to academic medical centers, visit the "Discoveries and Innovations in Patient Care and Research Database" at www.aamc.org/innovations.

The Physician as Health Advocate: Translating the Quest for Social Responsibility Into Medical Education and Practice

Shafik Dharamsi, PhD, Anita Ho, PhD, Salvatore M. Spadafora, MD, MHPE, and Robert Woollard, MD, FCFP

Abstract

There is a growing demand for educating future physicians to be socially responsible. It is not clear, however, how social responsibility is understood and acted on in medical education and practice, particularly within the context of a growing desire to improve health care through an equitable and sustainable delivery system. The authors conduct a concept analysis, exploring the practical philosophical understanding of social responsibility and its implications for medical education and practice. The aim is to inform curricular development,

professional practice, and further research on social responsibility. The particular ways in which social responsibility is interpreted can either enhance or establish limits on how it will appear across the continuum of medical education and practice. A physician's place in society is closely tied to a moral sense of responsibility related to the agreed-on professional characteristics of physicianhood in society, the capacity to carry out that role, and the circumstances under which such professionals are called to account for

failing to act appropriately according to that role. The requirement for social responsibility is a moral commitment and duty developed over centuries within societies that advanced the notion of a "profession" and the attendant social contract with society. A curriculum focused on developing social responsibility in future physicians will require pedagogical approaches that are innovative, collaborative, participatory, and transformative.

The topics of social responsibility and social accountability are receiving increasing attention in medicine. There is a growing demand for educating future physicians to be socially responsible.¹⁻⁹ Medical schools worldwide are being told

that they can be "held to account by society" if they do not demonstrate that their education, research, and service activities are preparing future physicians with the capacity to respond to the "priority health concerns of the community, region, and/or nation they have a mandate to serve."¹⁰

to the social determinants of health and to the health care needs of people who are vulnerable and marginalized. This is not a new concept. Rudolph Virchow opined in the 19th century:

Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the answers for their actual solution.... The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction.²¹

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The quest for social responsibility and accountability is a long-standing attempt toward defining, vivifying, protecting, and upholding the social contract between medicine and society. It is an agreement that the medical profession will receive certain rights and privileges in exchange for service to society and the public good.¹¹⁻¹⁶ At the same time, there must be a realistic response to the pull toward the private interests of professionals.^{17,18} Similar concerns have emerged in other health care disciplines.¹⁹ A recent study on social responsibility in dentistry, for example, found that there is a belief among some dental educators, clinicians, and leaders in the profession that economic imperatives are dominant features affecting how dental education and practice are structured in society.²⁰

Within the context of society's priority health needs, medical education and practice need to be particularly sensitive

Several collective authorities such as the World Health Organization, the Accreditation Council for Graduate Medical Education (ACGME), and the Royal College of Physicians and Surgeons of Canada (RCPSC) have issued guidelines and accreditation standards around social responsibility in medical education and practice. The World Health Organization has provided a social accountability framework for medical schools highlighting the importance of working collaboratively with governments, health care organizations, other health professionals, and the public to meet society's priority health needs.²²

The ACGME in the United States followed by developing general competencies that address the “development of core professional attributes, such as altruism and social accountability, needed to provide effective care in a multidimensionally diverse society.” The identified aim is to prepare future physicians to be “responsive to the needs of patients and society that supersede self-interest.”²³

Health Canada followed by establishing a Steering Committee on Social Accountability of Medical Schools,²⁴ and the RCPSC responded by developing a framework of essential physician competencies to demonstrate a commitment to meeting “societal needs” through “better standards, better physicians, better care.”²⁵

These competencies provide a means through which to operationalize social responsibility in medicine. The competencies that deal with professionalism and health advocacy seem to align closely with social responsibility. They are intended to prepare future physicians across the broad range of specialties not just to respond to individual patient health needs as part of patient care but also to respond to the health needs of the communities they serve, to identify the determinants of health of the population, and to promote health at individual, community, and populations levels.²⁶ The American Medical Association adopted a declaration of professional responsibility that calls on all physicians to “advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.”²⁷

It has been over a decade since the formal adoption of competencies around health advocacy. Yet, how best to integrate them into medical education remains unclear, and little is known about how to effectively teach and assess learning in this area.^{28–31}

The purpose of this article is to examine the idea of “social responsibility” and its use in medicine. We believe that a practical philosophical understanding of the term would help to improve its integration into medical education and practice and provide a better understanding of how best to operationalize the physician’s role as health advocate. The particular ways in which a concept or phenomenon is interpreted can enhance or establish

limits on how the concept is conceived and acted on.³² Our aim is thus to encourage critical reflection.³³

We begin by exploring the practical philosophical understanding of social responsibility. We then explore the relationship between social responsibility and its implications for medicine’s contract with society. We end with suggestions on how to better operationalize the educational competencies designed to enable future physicians to meet their social responsibilities.

A Concept Analysis of Social Responsibility

Concept interpretation inquiry³⁴ seeks to provide an account of reasonable and practical understanding of a concept in order to produce an unambiguous sense of its use or meaning. It is an attempt to move toward a less abstract use of terms. Informed by the Aristotelian idea of *phronesis*,³⁵ which is the notion of seeking understanding by applying critical, analytic reflection on everyday practices within a particular context, our concept analysis attempts to provide a thoughtful and practical account of social responsibility. Our aim is to enable concrete interpretations that can inform curricular development, professional practice, and further research. In the words of John Wilson,³⁶

Concept analysis gives framework and purposiveness to thinking that might otherwise meander indefinitely and purposelessly among the vast marshes of intellect and culture.

We begin our concept analysis with a focus on the term “responsibility.” In medicine, this term has different meanings and moral implications than it does in more general use. Physicians have a responsibility to make decisions and to take subsequent actions that have a foreseeable impact on the health and well-being of patients. This notion of role responsibility refers to the performance or fulfillment of the duties or sets of expected behaviors attached to a physician’s function as a medical practitioner. A responsible physician is one who is competent and who properly fulfills accepted or recognized commitments attached to that role. As a result, the practitioner is held to account for enhancing health, causing harm, or failing to prevent harm.

Role responsibility has a moral connotation as well. In following the Aristotelian notion of a virtuous person, a responsible person is required to recognize and do what is appropriate according to accepted moral norms. The idea of role responsibility is central to the moral fabric of medicine. The Hippocratic Oath, for example, pronounces physicians’ obligation to provide optimal medical care competently and humanely, with honesty, compassion, fortitude, authenticity, and fairness. Physicians are expected to uphold the identity and integrity of their profession not only by avoiding harm to their patients and promoting good health but also by avoiding behaviors that may compromise their moral obligations as members of the medical profession. Although a responsible physician is accountable for his or her actions through regulatory and legal means, the notion of responsibility in medicine is not motivated by a fear of liability or the expectation of reward. It is motivated by an internal moral commitment to certain core values such as excellence, integrity, respect, confidentiality, competence, altruism, fairness, human dignity, and compassion. In the words of Albert Einstein³⁷:

A man’s ethical behavior should be based effectually on sympathy, education, and social ties.... Man would indeed be in a poor way if he had to be restrained by fear and punishment and hope of reward after death.

The notion of social responsibility is integral to the physician’s role responsibility and corresponding relationship to society. It has been argued effectively elsewhere that in addition to patients who individually avail of the physician’s care and attention, the neighborhood, the community, and the nation are all, in essence, also the physician’s patients.³⁸ Hence, a physician’s professional and civic duties can be seen as complementary. The idea of social responsibility not only respects the important notion of individual rights but also concerns the fundamental point of how an individual, as part of the collective, can and ought to contribute toward the common good.

Many complex problems emerge within the various intertwined contexts of social, environmental, economic, and political settings and, thus, require not only individual responses but also collective reflections and coordinated responses. As individuals, we have various private and public interests, some of which conflict with each other. To be human, however, is to be social. We cannot define “the good life” separated from others; we can only live a good life in community. This is best captured by Arnold Toynbee,³⁹ a leading British historian of the last century:

Society is the total network of relations between human beings. The components of society are thus not human beings but the relations between them. In a social structure individuals are merely the foci in the network of relationships.... A visible and palpable collection of people is not a society; it is a crowd. A crowd, unlike a society, can be assembled, dispersed, photographed, or massacred.

The common good, then, is not just the common denominator. It is the recognition that the collective well-being is part of the individual good as well as individual responsibility. Social responsibility in this context emphasizes a social conscience and attention to systems of inequality, power, and privilege and working to eliminate social inequities and injustice in the interest of the common good. It connotes an ethic of care and trust beyond individualism, fear of liability, and private interests.

Social responsibility is about ensuring, protecting, and contributing to the collective welfare of society. It is also about choosing to contribute to the common good rather than being legislated to do it. It is unsettling and frequently unhelpful when principles, no matter how righteous they seem, are imposed as a matter of law. Social responsibility becomes meaningless when what is right and good ceases to be an ethical standard to be upheld but, rather, a matter of legal injunction to be enforced. A commitment to social responsibility is part and parcel of physicians' concerns and the core values of doctoring.

Nevertheless, the emergence of the idea of social accountability⁴⁰ in the medical literature indicates that medical schools should “expect to be held to account by society for what they do.”¹⁰ The emphasis

on accountability in this case appears in the literature as a concerned response to the shortcomings in the ways doctors are educated with respect to the relationship between medicine and society.

Our concept analysis thus prepares us to look critically at how we might expect physicians to behave in providing health care and how we might prepare them to be effective in that role.

Implications for Medicine's Contract With Society

There exists an implicit and yet undeniable relationship between the medical profession as such and the idea of social responsibility. The requirement for social responsibility in medicine is not a new idea. It is a moral commitment and duty developed over centuries within societies that advanced the notion of what constitutes a profession. Medicine, having accepted the status of profession in society, and the special social, moral, and political status that follows, has also accepted a fiduciary duty to behave altruistically—placing society's concerns before its own.⁴¹ In addition to obligations toward individual patients, therefore, society expects that physicians, both as individual providers and as a collective, will fulfill their enduring social responsibility. This is so particularly when dealing with issues around resource allocation, the social determinants of health, and inequities in health that result in avoidable differences in the incidence, prevalence, morbidity, and mortality that persist in society.

Codes of ethics for various health care professions therefore clearly recognize the power and obligations of their members that accompany entry into the profession. Those who hold the power to decide how health care resources are allocated and how health care professionals practice play a significant role in influencing the enormous disparities in health in the world today. Some have argued, therefore, that “it is not inequalities that kill people ... it is those who are responsible for these inequalities that kill people.”⁴²

Social problems that arise from issues such as unemployment, poor living conditions, crime, gender inequalities, discrimination, and social exclusion play a key role in shaping the health and well-

being of people.⁴³ The maintenance and restoration of health is therefore a collective societal concern. People who are rendered vulnerable because of a combination of social, economic, political, environmental, or biological problems find it increasingly difficult to protect their own needs and interests. Chronic vulnerability leads to worse health outcomes and higher rates of morbidity and mortality.⁴⁴ Medical systems that tend to focus largely on the individual relationship between the physician and the patient, with little attention to the doctor's role and responsibilities to society, will face difficulty serving vulnerable groups. For these reasons, the 1997 Jakarta Declaration on Health Promotion Into the 21st Century places a high priority on “social responsibility for health,” particularly within the context of equity-focused approaches to policy making.⁴⁵

Removing barriers to health requires the physician's responsibility to extend beyond the series of individual physician/patient encounters to the collective population—in Toynbee's terms, the “society”—in which those patients are embedded.

Implications for Medical Education

If physicians are thus called on to practice social responsibility throughout their careers, how are they to be assisted in developing the skills necessary to express that responsibility and the insights required to assess whether they are doing so? Although systems of peer review will be an ongoing requirement for professional behavior, a more fundamental commitment to critical self-assessment is the real foundation for effective practice and lifelong learning by an independent professional. However, the question of how to better prepare future practitioners for their roles other than clinical expert is regarded as one of the more pressing and challenging issues facing medical educators today.⁴⁶

This question is further complicated by concerns that some of the next generation of physicians hold negative attitudes toward patients with a low socioeconomic status.⁴⁷ Reluctance to address the needs of vulnerable populations is thought to be influenced by the fact that ever more medical

students and physicians come from privileged backgrounds and are socially distant from socioeconomic vulnerabilities.⁴⁸ Economic imperatives^{49,50} are believed to engender an increase in self-interest over social responsibility,^{51,52} resulting in an erosion of medicine's social contract and the ability of medical education to address these issues.¹³ Added to this are student concerns about debt load, its relationship to specialty choice, and the tensions between these forces and societal needs in the physician workforce.⁵³ Medical schools are also being asked to ensure that future students and faculty come from diverse cultural, socioeconomic, geographic, and academic backgrounds.

It is beyond the scope of this article to adequately address all of these issues. At the very least, the integration of health advocacy into medical curricula and accreditation standards provides a strong impetus for nurturing future physicians to be socially responsive.⁵⁴ Medical educators are recognizing that "if advocacy is to be a professional imperative, then medical schools and graduate education programs must deliberately train physicians as advocates."⁵⁵

It is nonetheless a difficult role to teach and evaluate—"it can be hard to teach messy real-world issues, but practitioners need to understand how these issues affect their patients and how to interact with, and ultimately improve, an exceedingly complex and fragmented system to provide good patient care."⁵⁶ In other words, it is not enough to simply tell medical students that health care practices and policies that fail to consider social determinants and ways of addressing related health disparities are unlikely to have the desired impact on health outcomes.^{57,58} Learning needs to take place within the context in which it will be applied. Topics such as professionalism, health advocacy, social determinants, and ethics must be taught in ways that help learners move from knowledge to practice, acquiring the necessary skills throughout their medical education. Just as in clinical learning, educators will have to provide students with opportunities to experience what this knowledge looks like in their hands. If medical students believe that what they

are learning will have little or no impact, they will quickly become disengaged.

Hence, medical students need to be part of a community of practice, working closely with their teachers and others in the health care system who share a common interest and desire to develop and advance an increasingly sophisticated and practical sense of social responsibility. In this way, students learn that they can indeed effect positive change in the lives of their patients, in the communities they serve, and at the level of health policy and health systems. The recent establishment of accreditation standards requiring service-learning opportunities in medical education enables pedagogical opportunities that can facilitate the kinds of community relationships that are required to promote innovative approaches to integrating health advocacy competencies into medical training.⁵⁹ Medical schools have yet to fully integrate service-learning as part of the training process and to fully espouse this aspect of social responsibility, particularly during residency training.⁶⁰

The few studies that have examined medical residents' attitudes toward health advocacy^{28–31,61} indicate that although it is generally acknowledged as part of the physician's social responsibility, residents find few meaningful opportunities to practice advocacy during training. Moreover, residency is experienced as a stressful time for trainees, with immense pressure to master clinical competencies, and few mentors available in the area of health advocacy to work with and to emulate. Trainees identify enthusiasm, compassion, openness, integrity, and good relationships with patients as attributes they seek in their role models.^{62,63}

Preceptors must model the behaviors they wish to see in future physicians. This can be done in several ways: (1) identify and become involved in advocacy activities that relate to your discipline, (2) apply evidence-based prevention and health promotion initiatives at the patient, community, and population levels, (3) identify and respond to factors outside the clinical encounter that influence health, (4) examine and respond to factors that result in barriers to care, and (5) take a scholarly approach to advocacy by encouraging and/or participating in research that contributes

to a better understanding of the issues at stake. These are only a few examples. Educators will need to work closely with learners to demonstrate in concrete ways how physicians' expertise and influence can help advance social responsibility in training and practice. We know that providing direct patient care is a powerful stimulus for learning, bringing together both cognitive and procedural knowledge as learners move from novice to expert clinicians through study and practice. The development of knowledge, attitudes, and skills pertaining to social responsibility can capitalize on this stimulus by actively involving learners in doing health advocacy.

A curriculum focused on developing social responsibility in future physicians will require pedagogical approaches that are innovative, collaborative, participatory, and transformative.⁶⁴ In practical terms, this means that medical schools, future physicians, and the communities they have a mandate to serve will need to work together to identify appropriate advocacy opportunities, collaborating on what specifically should be learned in areas of advocacy and why, how it can be best taught, and how learning should be assessed. Medical schools can begin by convening town hall meetings in their communities that provide opportunities for dialogue and discussion. Initial discussions can focus on how the curriculum can best foster opportunities for social awareness and responsibility. This also fosters the creation of a culture of social engagement. Postgraduate and undergraduate medical students can work together and help to prepare for the town hall by conducting literature searches and environmental scans, consulting with communities to identify priorities, exploring opportunities for partnerships with community-based organizations, and consulting with health authorities. Future physicians who participate actively in this process are more likely than those who don't to gain an increasingly sophisticated understanding of the issues, the relevance of social responsibility in medicine, and the importance of social accountability.^{65–77} This is also a worthy scholarly activity that has been well established.^{78–80}

Indeed, the social responsibility of medical educators and their institutions

calls on them to succeed in achieving this outcome by their students. This perspective has been confirmed at the global scale by the recently released Global Consensus on Social Accountability for Medical Schools.⁸¹

Concluding Remarks

Our concept inquiry into social responsibility opens various possibilities for further examination. We hope to have provided a point of departure for examining the different epistemological and ontological considerations for exploring how medicine might consider its social responsibility for addressing health determinants, health disparities, and the priority health needs of society. We have also aimed to provide practical direction for actions to animate an evolving consensus among medical schools and organizations that a different future must be crafted than that which currently appears to be unfolding. By so doing, we wish to advance the common good—a good to which all have equitable access.

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CRIAW FACT SHEET

CANADIAN RESEARCH INSTITUTE FOR THE ADVANCEMENT OF WOMEN Third Edition - 2005

Women and Poverty

Women and poverty are connected for many reasons. Various structural factors work towards making women more vulnerable to poverty, or to keeping them in poverty. Over the last decade, Canada has been moving towards a different model for its economy, drastically cutting social services. Despite seven years of budgetary surpluses, money is still not being channelled back into these social services and the depth of poverty (that is the gap between the average income of the poor and the amount needed to bring their income up to the level of the low-income cut off) is worsening¹. Canada has signed international agreements such as the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), but there still aren't adequate guarantees to protect women's rights in the country.

Women are also affected by poverty in different ways, depending upon their age, race, ethnicity, linguistic background, ability, sexual orientation, citizenship etc. Statistics provide some important indications of women's poverty in Canada, but experiences of poverty are much more complex than the picture created by numbers alone.

WHO IS LIKELY TO BE POOR?

A newborn child, just because she happens to be born female, is more likely to grow up to be poor as an adult. Women form the majority of the poor in Canada. One in seven² (2.4 million³) Canadian women is living in poverty today.

• **Women raising families by themselves:**

51.6% of lone parent families headed by women are poor⁴. With many of these families, financial support agreements with the non-custodial parent (usually the father) are either not in place or in arrears.⁵

• **Senior women:** Almost half (41.5%) of single, widowed or divorced ("unattached") women over 65 are poor⁶. While the poverty rates for all seniors have improved overall, there is still a large gap between men and women. The poverty rate for all senior women is 19.3%, while that for senior men is 9.5%⁷.

• **Women on their own:**

35% of women on their own under 65, live in poverty.⁸



This fact sheet was produced by the Canadian Research Institute for the Advancement of Women (CRIAW). You can obtain a copy on our website at <http://www.criaw-icref.ca>. Copies are also available from CRIAW at 151 Slater Street, Suite 408, Ottawa, Ontario K1P 5H3 Canada. Phone: (613) 563-0681 Fax: (613) 563-0682 Email: info@criaw-icref.ca. Aussi disponible en français.



• **Women with disabilities:** More women than men live with disabilities in Canada. Aboriginal people have twice the national disability rate⁹. Of all women with disabilities living in a household rather than an institution, and who had any income at all, those aged 35-54 had the highest incomes: an average of \$17,000, which is 55% of men with disabilities in that age range. Women with disabilities under 35 had an average income of \$13,000, and women with disabilities over 55 had an average income of under \$14,000. The more severe a woman's disability, the lower her income.¹⁰

• **Aboriginal women:** The average annual income of Aboriginal women is \$13,300, compared to \$18,200 for Aboriginal men, and \$19,350 for non-Aboriginal women.¹¹ 44% of the Aboriginal population living off reserve lives in poverty, but things are worse on reserve: Almost half (47%) of Aboriginal persons on reserve have an income of less than \$10,000.¹² Aboriginal women are also more likely than Aboriginal men to be trapped in low-paying jobs¹³, and because of the continuing effects of the Indian Act, they face insecurities related to housing, access to services and abuse both on and off reserve¹⁴.

• **Women of colour:** 37% of women of colour are low income, compared with 19% of all women. The average annual income for a woman of colour in Canada is \$16,621, almost \$3000 less than the average for other women (\$19,495) and almost \$7,000 less than that of men of colour (\$23,635).¹⁵

Women of colour are also overrepresented in precarious (part-time and temporary) work and often have to live in substandard, segregated housing. They are also more vulnerable to violence and other health risks¹⁶.

• **Immigrant women:** Education does not reduce the income gap between immigrant women and Canadian-born women. New immigrant women between the ages of 25-44 who have a university degree and who worked full-year, full-time earn \$14,000 less than Canadian-born women.¹⁷ This is partly because of overt racism, but also the structural racism of lack of recognition of foreign credentials and experience. New immigrant women, suffering from abuse, may have few options to escape this, if they are financially dependent on their male relative sponsors in Canada.

• **Lesbians:** There is little information about the economic status of lesbians. We only have isolated bits and pieces to go by, such as a Winnipeg study that found

that 14% of gay men over 65 reported incomes below the poverty line, compared with 42% of lesbian seniors.¹⁸

• **Migrant Women:** Migrant women who are often refugees or foreign domestic workers are also particularly at risk of poverty and exploitation, as they are often forced to work in unregulated or hidden employment. Women make up the majority of migrant workers from Asia and many work here to sustain their families back home. They are paid low wages, and despite the fact that they contribute significantly to the Canadian economy, they are not entitled to many benefits such as EI¹⁹.

• **Low wage earners:** In Canada it is not enough to have a job to keep you out of poverty.²⁰ Most poor people do work full- or part-time.²¹ Poverty level wages are a particular problem for women. Women and youth account for 83% of Canada's minimum wage workers.²² 37% of lone mothers with paid employment must raise a family on less than \$10 per hour.²³

Women also make approximately 71%²⁴ of what men earn for full-year, full-time work. Education does not reduce the wage gap much: women with university degrees, employed full-year, full-time earned 74% of what men earned with university degrees.²⁵ The gap between what women and men (with University degrees) earn also widened between 1995 and 2000²⁶. In fact, in 1997, a man employed full-year, full-time with less than a Grade 9 education earned on average \$30,731, whereas a woman with a post-secondary certificate or diploma earned less for full-year, full-time work: \$29,539.²⁷ Women earn less than men even if they work in the same sectors or even in the same jobs. There are no occupations in which women's average earnings exceed men's, not even in female-dominated areas such as clerical work and teaching.²⁸ Canada has the 5th largest wage gap between women and men full-time workers out of world's 29 most developed countries. Only Spain, Portugal, Japan and Korea have larger wage gaps.²⁹

• **Women on welfare, and their children:** In 2001, 60% of single mothers relied on welfare at some point³⁰. 52% of Canada's social assistance recipients are made up of families with children³¹. One quarter (24%) of welfare families are headed by people with some form of disability.³² All welfare rates in Canada are far below the poverty line, ranging from 20% to 76% below.³³



WHAT IS POVERTY?

Statistics Canada's low-income cut-offs (LICO) represents the level at which people spend so much of their income on basic necessities that they live in very difficult circumstances. The LICO varies by family size and community. This definition of poverty is a matter of debate. Some say that we should measure poverty by the same standards as developing countries in which the majority of the population are struggling to survive. They claim that Statistics Canada's definition of low-income inflates the rate of poverty. In fact if anything, Statistics Canada's calculations underestimate the extent and depth of poverty because Aboriginal reserves, homes for the aged, prisons, and the Yukon, Northwest Territories and Nunavut are excluded from the data. Anyone who has spent any time in Vancouver's Downtown Eastside, the Jane-Finch corridor in Toronto, the North End of Winnipeg, the St. Henri district of Montréal, rural communities of New Brunswick, or some Aboriginal communities which don't have sewage systems or clean, running water, could not deny the existence of deep and persistent poverty within this abundant and prosperous nation.

WHY ARE WOMEN'S INCOMES LOWER?

There are simple structural reasons for women's lower incomes:

- **A Statistics Canada study found that the major factor in the wage gap is the presence of children, rather than age, marriage or education.**³⁴ Women are still expected to perform the majority of household chores and child care. In 52% of families in which both partners had full-time paid employment, the female partner was responsible for all the daily housework, in 28% the woman was mainly responsible, in 10% the chores were shared equally and in another 10% the man was primarily responsible.³⁵ Women are expected to cut down on their paid work, quit their jobs, take emergency leave from work, or refuse promotions, in order to care for children, elderly parents or in-laws, or disabled relatives. Men are not. This has a lifelong impact on a woman's wages, accumulation of pension benefits, and experience in her chosen occupation.³⁶ Largely because of the lack of balance and fairness in terms of women's and men's family responsibilities, the vast majority of part-time workers (70%) are women.³⁷ There is some change towards men progressively taking on more responsibility for child rearing, but women continue to be the primary care-givers.

- **Women are paid low wages for "women's work":** "Women's work", evolving from work that women are expected to do for free, such as caring for and teaching children, nursing the sick, preparing food, cleaning, serving others, managing a household, is not seen as skilled or valuable. 70% of women with paid employment are concentrated in a few female-dominated sectors: health, teaching, clerical, sales and service.³⁸

- **Cuts to social assistance in most provinces,** stemming from a federal withdrawal of billions of dollars in transfer payments and the elimination of most standards that guaranteed help for people in need.

- **Inadequate pensions:** Less than half of the Canadian population with paid work (39.6%) was covered by an employer pension plan in 2002³⁹. Of these, a minority were women.⁴⁰ The Canada/Quebec Pension Plans (CPP and QPP) are based on earnings, so women's lower earnings are reflected in the benefits, or lack thereof from this plan: The average man aged 65 to 69 gets a CPP/QPP benefit of \$533 a month, but the benefit paid to women in that age bracket is \$299 (56 % of what men get).⁴¹ Since women tend to earn less income during their lifetimes, it is also more difficult for them to save money through Registered Retirement Savings Plans (RRSPs). Government talks about CPP credit-splitting upon marriage breakdown as a way to alleviate the poverty of senior women, but this option is not mandatory and very few women know about it.

INTEGRATED FEMINIST FRAMEWORK:

We at CRIAW are working on situating our work within an Integrated Feminist Framework (IFF). This means that we attempt to include in our research and analysis, the lived realities of different groups of women as defined within categories: Aboriginal women, women of colour, women with disabilities, immigrant women, lesbians, bisexuals and transgendered women. In this analysis we also attempt to understand how institutions in society interact with these categories of women (as listed above) as well as with factors such as ethnicity, citizenship status, age, and class, to produce both oppression and privilege. We will further endeavour to understand how these categories themselves have been created and to what extent they actually reflect individual women's lived realities.



WHAT IS IT LIKE TO BE POOR?

- A single mother of one child in Ontario receives \$957 per month of assistance before deductions. Then she has to spend \$675 on rent, \$200 on groceries, and has \$82 left to pay bills (electricity, telephone, heat), laundry, transportation, school needs for her son, emergencies, aspirin, haircuts, clothing, sanitary napkins, soap, birthday or Christmas gifts, visits to grandma, repair or replacement of appliances, medical expenses not covered anymore by medicare, and anything else.⁴² She has to explain to her son why he can't go on school trips like the other kids, why he is teased for being dressed in old third-hand clothes, why he can't go to a friend's birthday party because there's no money for a little gift, why he can't participate in hot dog day at school because it costs money, why the milk tastes different because she's had to water it down, why by the end of the month they have to go down to the food bank because there's nothing left to eat. She has to cope with well-meaning higher income individuals who give her suggestions like buying in bulk when she has neither a car nor the financial means to buy large quantities. All of a sudden, how she spends her money and who she dates becomes everybody's business, and she is criticized if she splurges on a treat to relieve her depression or make her child happy. Being poor limits your choices and is not simply a matter of bad budgeting. Managing on a very low income is like a 7-day-a-week job from which there is no vacation or relief. Poverty grinds you down, body and soul.

If there is greater poverty among women than men, why are the majority of the homeless people on the streets men?

Only a small minority of homeless people panhandle on the streets. Homelessness is not always visible: Of the 26,000 people using emergency shelters in Toronto in 1996, half were in families and 5,000 were children.⁷⁰ Young homeless women are particularly vulnerable to being recruited as sex-trade workers in order to make ends meet. You may not see them on the streets during the day, but you see some of them at night. Most homeless people you never see at all. Homelessness is a complex issue resulting from poverty and lack of affordable housing, made worse by mental illness and addiction, and is particularly dangerous for women. It is not enough to just put a roof over a woman's head; this roof must also include a feeling of security and safety.⁷¹

- **Housing** is a major problem for poor women. In rural areas where families might own their own houses, they may not be able to keep them in a state of adequate repair. They may live with broken furnaces, ruptured pipes, rotten wood, cracked foundations, and have no capital funds to make windows and doors energy-efficient, no money even to replace the peeling paint, which further erodes their pride.

The urban poor, the vast majority of whom are renters, must move into the best housing they can get on a low income, which frequently means dilapidated apartments with dishonest or abusive slumlords, in high-crime areas, on loud streets or near environmental hazards. Women of colour and/or disabled women often have to deal with landlords who stereotype them, or refuse to rent to them. Overcrowded conditions lead to diseases such as tuberculosis which has re-emerged among the poor in Canada, as well as no quiet time or space for kids to do their homework. The urban poor tend to be transient, trying to find cheaper, better accommodation with good landlords. As a result, the lives of many poor people are disrupted through constant moving. Nearly 30% of poor children have changed schools three times before age 11, in contrast to 10% of better-off children.⁴³ Other factors such as hidden homelessness, where women are temporarily staying with friends, family, or a man, can mean that they might be subject to conflict or violence as well.⁴⁴

- **Attitudes about poverty:** Being poor erodes the spirit just as malnutrition erodes the body. It lowers self-esteem, so it becomes even more difficult to get out of poverty. When individuals are blamed for being poor, it takes attention away from the state of the economy and unemployment, the cycle of poverty and abuse for which helping services

are currently insufficient. The blame is often internalized, sometimes turning into self-abuse, increasing self-destructive coping mechanisms like smoking, over-consumption of alcohol and substance abuse. All of these issues affect both women and men. However, most low-income women are also responsible for children, and it hurts them deeply not to be able to provide a safe, quiet, stable home, nutritious food and at least a small fraction of what their kids' classmates take for granted. They may think they are bad mothers for conditions



that aren't their fault. Low-income women are also sometimes deemed to be "selfish" for wanting to have kids. By contrast, CEOs of Canadian corporations, whose average salary is \$703,000⁴⁵ (not counting stock options or benefits), do not seem to be called selfish for paying some of their employees less than a living wage just so that they can buy a second boat. It's a matter of perspective and lived realities.

• **Lack of Privacy:** Women who are poor, on social assistance and working themselves to the bone trying to make ends meet for their children and themselves are often subjected to assaults on their privacy. As a recipient of social assistance, a woman is asked to sign broad information release forms. Anyone with access to social service files can then call up *all* her personal financial information. This makes women feel as though they are being monitored and policed at every step. Women on social assistance can also feel that they are at the mercy of the discretionary powers of their social assistance officers.⁴⁶

• **Child custody and access:** Struggling to sort out legal and financial responsibility for their children can mean that many single mothers are caught in the justice system for many years. This is financially draining, physically and emotionally exhausting and if their former partner was abusive, it is also unsafe. The mother and child can then be at risk of abuse by the ex-partner. Often, professionals in the system encourage the woman to provide broader access rights for the ex-partner, even though it may be unsafe.

WHAT EFFECT DOES THE POVERTY OF WOMEN HAVE ON SOCIETY, ON WOMEN?

• **Child poverty:** Children are poor because their parents (mainly their mothers) are poor. More than one million children live in poverty in Canada.⁴⁷ Poverty is strongly linked to poor health and poor school achievement.⁴⁸ School performance has been found to be the best and most stable predictor of adult involvement in criminal activity.⁴⁹ By keeping women poor, we are also keeping children poor, making them sick, sabotaging their future, contributing to crime, and perpetuating the cycle of poverty.

• **High health care and income security costs:** There is a clear link between low income and poor health.⁵⁰ Poverty increases reliance on health services, and

this drives up health care costs. For example, many senior women have spent many years caring for children and family members for free. This means they have not made a lot of income during their lives, and so their pensions are lower and their resulting high rates of poverty also drive up their health care costs. This is an unsustainable system.

• **Higher crime:** Only a minority of poor people turn to crime to supplement their income. However, a long-term study has shown that the most frequent criminal offenders came from the poorest families with the worst housing. Low family income, measured when the child was 8 to 10 years, was seen as a predictor of general social failure at age 32.⁵¹ Studies have revealed that most female offenders are women with low levels of education, few job skills, no economic resources, living alone in extremely poor conditions, and unable to support themselves.⁵²

• **Democracy eroded:** Women cannot become involved in decision-making structures in equal proportions to men when they remain primarily responsible for child-rearing, when they are economically disadvantaged by their caregiving role, and when they have fewer economic resources to run for office. An important perspective is lost, which may affect the direction and priorities of the country as a whole.

• **Health:** Acute and chronic ill health, susceptibility to infectious and other disease, increased risk of heart disease, arthritis, stomach ulcers, migraines, clinical depression, stress, breakdown, vulnerability to mental illness and self-destructive coping behaviours are also common impacts of poverty on women.⁵³ Women also face increased vulnerability to violence and abuse, as poverty traps and limits their choices.⁵⁴

WHAT CAN WE DO ABOUT IT?

• **Adequate Income:** Establish a minimum wage that reflects the actual cost of living. Ensure access to job training without heavy financial burdens, bureaucratic hassles and rules that make no sense. Canada is more prosperous than all European countries in terms of per capita Gross Domestic Product (GDP), but spends less on social security and other income support measures (including Employment Insurance (EI) and welfare) as a share of GDP.⁵⁵

• **Economic Measurements:** In society, we measure progress and prosperity by economic growth.⁵⁶ Other



aspects such as natural and social resources and unpaid and voluntary work are not formally considered in measurements of progress. We measure what we value. Until women's work is valued and societal attitudes around this change, it will not be measured as part of a healthy, caring society. We need to encourage the use of alternative economic measures such as the *Genuine Progress Index* which includes 22 social, economic and environmental parts to measure our progress.⁵⁷

• **Recognition of unpaid work:** Workplace practices and government policies, programs and legislation that support women and men in their family responsibilities are essential.

• **Re-establish basic standards:** In 1996, the federal government replaced the Canada Assistance Plan (CAP) with the Canada Health and Social Transfer (CHST). In 2004 the CHST was further divided into the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). The CHT was recommended by the Romanow Commission, but the CST was created by default from the leftovers of the health fund. The CST includes post-secondary education and social transfers. However, there has been little public discussion about exactly how these social transfers to the provinces will be spent.⁵⁸ In addition to cutting millions of dollars for health, education and social services in the past decade, the federal government has also removed standards that guaranteed support for people in need. The CAP funded shelters for abused women, group homes for people with disabilities, and a wide range of services for people in need, as well as social assistance income. All this has been drastically cut back, as the federal government has abandoned most of its responsibility for the national problem of poverty in Canada.⁵⁹ Current block transfers to the provinces contain no funds specifically earmarked for social assistance or poverty reduction.

• **Decent, affordable housing:** Provide rent-geared-to-income subsidies to make existing housing affordable and capped at market values or less. Create additional affordable housing through rehabilitation and new construction. There is a waiting list of 96,000 for subsidized housing in large Canadian urban centres.⁶⁰ More than 68% of poor families with children live in unaffordable housing.⁶¹ The market will not solve this problem, as decent, affordable housing is not profitable.

• **Child care:** Lack of affordable, good quality child care keeps many women from finding full-time, well-paying work. In Metro Toronto alone, 16,000 families are on the waiting list for child care. One third of these parents (over 5,000) could take a job tomorrow if they had child care.⁶²


There is also a danger of child care becoming privatized. This would make it too expensive for most parents to afford, and not necessarily accountable to regulatory standards. Under the North American Free Trade Agreement (NAFTA) if we don't keep child care in the not-for-profit sector, we could face challenges from large commercial childcare chains who want to come to Canada and who put profits before quality child care, as experience has shown in Australia.⁶³ The government needs to live up to its promises of national child-care and ensure that it is accessible, affordable, high quality, publicly funded and regulated, and not-for-profit.⁶⁴

Not only is child care necessary if parents are to provide an adequate income for their family, but children attending good quality, regulated child care are also more likely to do better at school.⁶⁵

• **Social Services:** Ensure access to social services, including health care, child care, mental health care and substance abuse treatment.

• **Tax relief for the poor, not for the rich:** Having to pay income tax starts well below the poverty line. How can you pay for food, decent housing, bills, personal needs, transportation, clothing, repairs, dental work and other medical costs not covered by public insurance, occasional entertainment, savings for education, retirement or appliances, financial obligations such as student loans or supporting other family members, *and taxes* on \$8,500-12,000 per year? Yet thousands of low-income women are put into this bind while high income people get a tax break that allows them to take an extra vacation overseas. The general corporate tax rate in Canada has declined from 28% in 2000 to 21% in 2004.⁶⁶

• **Unionization:** Unionized women earn 92% of what unionized men make. Non-unionized women earn up to 80% of what their male counterparts make.⁶⁷ The benefits of unionizing and incorporating labour standards are obvious.



• **Equality between and within women and men**, which honours and respects women's perspectives, paid and unpaid work, and values/priorities, is key to eliminating the feminization of poverty. Equality cannot be achieved by a one-off initiative or any one of the solutions listed here in isolation. The poverty of women is a part of systemic, structural inequality and it requires a systemic response that deals with poverty and gender inequality at its roots, including inequality within different groups of women.

The legal recognition of same-sex couples as common-law partners, allows them to have the same rules around child support, adoption and pension benefits⁶⁸. The legal recognition of same-sex marriage within the whole of Canada would provide further equality, including rights of being considered next of kin, and rights around inheritance and succession etc. This would grant lesbian couples the same human rights as heterosexual couples.

EMPLOYMENT INSURANCE: In 1997 the federal government radically cut the Unemployment Insurance program. The name was changed to Employment Insurance (EI), the criteria for qualification were made much more strict and benefits were reduced. The result was that the number of people covered by EI fell from almost 80% in the late 1980s, to around 30% in the late 1990s.⁷²

Previously, to qualify for UI/EI (and maternity benefits) a person needed 12-20 weeks (at 15 hours), but after the new rules, the requirement was changed to up to 700 hours (which is 20 weeks at 35 hours per week or 46.6 weeks at 15 hours per week and depending on the regional rate of unemployment).⁷³ The benefits were no longer based on weeks, but on hours of work. Some public pressure forced the government to change the required number of hours to 600 in 2001. At the same time though, the government eliminated the National Training Act and 39 employment programs especially those geared to women.⁷⁴

For parental leave, although it is now possible to get up to 50 weeks through the EI program, only a minority of women qualify. Ten thousand fewer women are now able to access EI maternity benefits than prior to the change.⁷⁵ Even if women do qualify, the benefit level is 55% of their insurable earnings, and not all their earnings - such as contract labour - may be insurable. People may receive a maximum of \$413 in weekly earnings for maternity or EI benefits. In many cases it may not even cover rent. There is also an enforced two-week waiting period for benefits with no income, just when a pregnant woman or new mother needs income most. By comparison, Norway's system of parental leave grants a choice between 42 weeks with *full wage replacement* or 52 weeks at 80% of salary.⁷⁶

PRECARIOUS EMPLOYMENT: In Canada, 34% of the workforce over the age of 15 is involved in non-standard work, which includes part-time employment, temporary employment, own account self-employment, and multiple job holding.⁷⁷

More women than men are involved in precarious work. In 2003, more than 28% (2 million) of women in the workforce worked less than 30 hours per week at their main job, compared with 11% of men.⁷⁸ Statistics from 2001 also reveal that women's participation in the paid workforce was only 59.7% compared with men's 72.5%.⁷⁹

People who are employed in precarious jobs don't always have protection under labour codes or collective bargaining agreements. Being forced to work on contract and/or part-time is becoming more and more common in the Canadian economy. A recent study shows that the wages of newly hired employees have dropped substantially, relative to other workers. From 1989 to 2004, the number of all recently hired private sector employees who had a temporary job, rose from 11% to 21% (see <http://www.statcan.ca/Daily/English/050126/d050126a.htm>).

PAY EQUITY: Pay equity is a basic human right, enshrined in various international conventions and treaties. The principle of pay equity ensures that there is no discrimination in wages based on gender. The Canadian Human Rights Act and the equality provisions in the Charter of Rights and Freedoms support pay equity, and yet, women in Canada still only earn 71% on average of what men earn.⁹⁰ In some provinces, such as Newfoundland and Labrador, women's average income has been as low as 62.4% of men's.⁹¹

The fight for pay equity has involved three important but different aspects. One of these is the idea of equal pay for equal work. This means comparing jobs done by men and women, where the job is the same or basically the same, to see if there are differences in wages between men and women. The second, equal pay for work of equal value compares different jobs that are considered "male" or "female" to reduce the wage gap. Finally, pay equity laws refer to programs and laws that attempt to achieve pay equity proactively, that is, a complaint should not be needed to achieve the goal.⁹²

While there is legislation in the Canadian legal system to protect pay equity, women still dominate in traditionally female occupations which tend to be lower paying and precarious. Recently, the fight for pay equity suffered a severe blow. The Supreme Court had decided that the government of Newfoundland and Labrador discriminated against members of the Newfoundland Association of Public Employees (NAPE) (within the health care system) in 1991, as it withheld retroactive pay equity payments. However, the Supreme Court also ruled that this was justified, given the province's fiscal situation.⁹³ The message here was clear: women's equality is not as important as the economy.

In 2001 the federal government appointed a Task Force on Pay Equity and adopted some recommendations made by this task force. CRIAW, along with a number of other women's organizations, provincial pay equity coalitions, and the Canadian Labour Congress, is working on a Pay Equity Campaign to pressure the federal government to implement the recommendations of the Task Force on Pay Equity. For information on the Pay Equity Network see: <http://www.nawl.ca/lob-pay.htm>. Employment equity is also important. For example, Aboriginal women in workplaces covered by federal employment equity laws earned \$33,310, 87% of their female colleagues⁹⁴, as opposed to the below-poverty level average annual incomes of most Aboriginal women, and the even larger wage gap with women in Canada.

CHILD BENEFITS: The House of Commons passed a unanimous resolution in 1989 to end child poverty by the year 2000. Ironically, the rate of child poverty rose between 15% and 18% in the decade that followed.⁸⁰ While some decrease had been noted in 2000-2001 in rates of child poverty,⁸¹ Canada continues to have one of the highest rates of child poverty out of other industrialized countries, at a rate of 15.7%.⁸² Tackling child poverty requires a comprehensive approach that includes the strengthening of different social policies such as employment insurance, maternity benefits, social assistance and housing. The federal government has made a commitment to increase the Canada Child Tax Benefit (CCTB) to a maximum of \$3,243 for one child by 2007.⁸³ However, national organizations and groups call for an amount of up to \$4,900 annually.⁸⁴ The CCTB is a base monthly benefit provided to families with children under the age of 18. The National Child Benefit Supplement (NCBS) is a supplement provided to low-income families with children.⁸⁵

For families on social assistance, the increased amount they received in the NCBS has been clawed back dollar for dollar from their social assistance payments, by the majority of provinces.⁸⁶ This is because the NCBS is considered income by many provinces. The policy is based on the stereotype that poor people don't want to work, so it provides an "incentive" to work by forcing people, especially women, to watch their children go hungry.

The money that is taken away from families is what the government calls a "saving" which is supposed to be reinvested into programs that benefit low-income families with children.

Support for children on welfare has actually declined with the CCTB though. Estimates based on clawbacks to the NCBS show that only 66% of poor families with children benefited from the federal child tax during 1998 and 1999. Approximately half (57%) of poor single-parent families were allowed to keep their supplement.⁸⁷



GLOBALIZATION AND WOMEN'S POVERTY: Globalization can be seen as a set of processes which in part facilitate the easier flow of materials, products, services, cultural symbols and practices and communication between groups of people, communities and nations.

While on the one hand these processes bring people closer together, their speed and intensity also create problems. For instance, trade is emphasized within globalization, as the way in which people's lives all over the world will be improved.⁸⁸ While trade is pushed, the social safety net provided by the government is also eroded. This means that wealth continues to accrue to the already powerful and privileged, while the traditionally disadvantaged groups, such as women (particularly marginalized women), fall deeper into poverty or become more vulnerable to poverty.

World economic markets are merged through free trade agreements. Governments are then forced to reduce corporate taxes to make their countries and cities more 'competitive' (to invite foreign investment), while taking necessary funds away from social programs. Having spent their money on corporations, governments can no longer afford to pay for essential services such as health and child care. Private for-profit companies are then allowed to come in as service providers. The essential services provided by these companies are usually too costly for low and middle income families.

These are the effects of international trade agreements such as the North American Free Trade Agreement (NAFTA) and the Canada-US Free Trade Agreement (FTA), which are simply described as cross-border trade, but they actually interfere in many areas of our lives, such as policy on education, health, and employment. Although the government is supposed to be transparent in its working, the details of these free trade agreements are decided in secret.⁸⁹

Sometimes NGOs and faith based organizations come in and fill the gap in services created by the government. Most often, though, government funding for these groups is cut and the door is opened to multinational corporations. However, standards that regulate costs of services, and worker's conditions and salaries, are not enforceable upon these multinational corporations.

The push for 'small government' also means that the power to regulate business and to tax corporations is lost. Without these accountability measures, the poorest are often most exploited, either because they cannot afford basic essential services any more, or because they are forced to work for these multinational companies at minimum wages (or below) and with inadequate or no benefits.

Again, women (particularly marginalized women) are much more adversely affected by these government actions than are men, in part because women are forced to shoulder greater responsibility for child rearing and because women occupy more precarious jobs. Women's higher vulnerability to poverty also means that they rely on the social safety net more than men.

As governments shrink under the pressure of globalization, women's access to social services, employment and benefits also shrinks.

WHAT YOU CAN DO

- **Contact** your political representatives and ask them what specific measures they will take to reduce/eliminate poverty among women from the list above. Ask them to set real poverty reduction targets and timetables, and make this issue a top priority. Follow up with them to see if they have kept their word.
- **Support** organizations that advocate and provide services for poor people, including advocacy organizations, shelters, food banks, women's organizations, and international development organizations which take gender into account in economic development programs.⁶⁹ Support living wage and minimum wage campaigns.
- When you hear someone saying "all people on welfare are..." **challenge** the assumption. At no time is it valid to make assumptions about an entire group of people on the basis of the actions of a few individuals. Write letters to the editor when media engage in poor-bashing.
- Look for **fair trade** clothes and other products. Make sure your money does not go toward the exploitation of women in the garment or agricultural industries. For more info: Ten Thousand Villages network www.villages.ca.
- **Support or establish** laundry co-operatives, bulk-buying groups, a housing co-op, a free after-school program, a fund that would allow girls to participate in organized sports and other activities, a store that sells fair trade clothing and goods.
- **Ask** about the wages and working conditions for women at your local businesses, and support the ones that pay and treat women well.
- If you have non-union paid employment, look into **unionizing** your workplace, or promoting better labour standards. Recruit a group of co-workers to persistently press your workplace for more flexible options for people with family responsibilities. Find out what your rights are.
- If you are a man, **do your fair share** of housework and child care, and talk to other men about the value of this work. Treat all the women and men in your life with equal respect. Translate your words into action by joining initiatives such as the White Ribbon Campaign http://www.whiteribbon.ca/about_us/#1
- Get any group you belong to, such as a workplace, place of worship, union, book club, support group, bowling team, etc. to **take action** on poverty in general and poverty among women and children in particular, in your own community and around the world.
- If you are living in poverty, **take heart**. You are an incredibly strong and competent person to survive these unfair and degrading conditions. You are not alone.

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