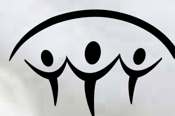
healthy futures

FOR BC FAMILIES

POLICY RECOMMENDATIONS FOR IMPROVING THE HEALTH OF BRITISH COLUMBIANS

SEPTEMBER, 2009



BC Healthy Living Alliance

working together to promote wellness and prevent chronic disease

Acknowledgements

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Introduction

British Columbians are among the healthiest people in the world.

British Columbia is a Canadian leader in health promotion and disease prevention and has the lowest rates of smoking and obesity and the highest rates of physical activity of any Canadian province. However, according to both short and longer term projections, BC and Canada will fall behind other world leaders in health status if no further action is taken. British Columbians want action because a healthy community provides a competitive advantage for economic success and future progress. Ultimately, nothing is more vital to our well-being than our health.

In 2005, the BC Healthy Living Alliance (BCHLA) submitted "*The Winning Legacy – A Plan for Improving the Health of British Columbians*" to the BC Government, which included twenty-seven recommendations. The BC Government rose to the challenge and BCHLA is pleased to see progress on many of these through policy and regulatory action. As well, a $25.2 million grant from the BC Government has enabled BCHLA to start the work on many of the recommendations through fifteen major initiatives. These initiatives support healthy living in four key areas, by improving opportunities for British Columbians to live smoke-free, be physically active, make healthier food and beverage choices and building leadership in health promotion at the local level.

BCHLA's initiatives also help to build capacity so that this work will be sustained in communities over the long-term. The results of these initiatives will undoubtedly provide guidance for future investments in health promotion and disease prevention — which are necessary to realize continuous improvement in the health of British Columbians and sustainability of our health care system.

The Social Determinants of Health

The creation of the Ministry of Healthy Living and Sport following on the success of ActNow BC has also been an important step forward. By introducing a "whole of government" approach to healthy living, barriers can be reduced between departments and new understandings developed among all ministries of the role they play in improving the health of British Columbians. The World Health Organization has recognized the model of ActNow BC for its inter-governmental approach to health promotion and recommended other jurisdictions consider this integrated practice.

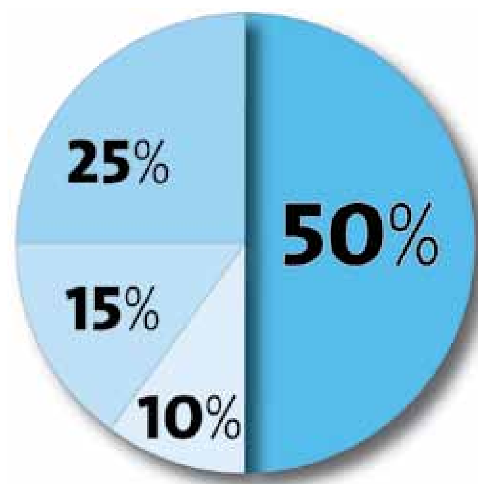
However, there are still significant challenges ahead if BC is to be a world leader in health status and chronic disease prevention. This is because despite BC's excellent average, there is still a large gap between the healthiest British Columbians and those who suffer from ill health. For example, we see major disparities between the health of those with lower incomes compared to those with higher incomes; Aboriginal peoples compared to non-Aboriginals and those living in more remote areas of the province compared to those in urban centres. It is apparent that to reduce the gap, traditional health services and lifestyle education and marketing by themselves will not be successful. The social determinants of health must be addressed because of their significant impact on chronic disease and health inequities.

In the fall of 2008 and spring of 2009, BCHLA brought together opinion leaders, local professionals and community activists from across the province to participate in a series of regional policy discussions on the social determinants of health. BCHLA heard from forum participants that there is great interest in developing a collaborative, multi-sectoral response to improve the social conditions and health outcomes of disadvantaged groups who experience a higher burden of ill health. There is a strong sense that the current economic downturn will have a greater negative impact on those groups already facing difficult circumstances and that an action plan must be developed to mitigate these impacts and to start building a healthier future for all.

The social determinants of health include the basic financial resources and supportive environments necessary for a healthy life.

Access to income, affordable housing, healthy food, education, early childhood development, and recreational opportunities influence our ability to make healthy choices and ultimately the state of our physical and mental health as well as life expectancy. In part, health inequities arise as the result of a concentration of risk factors within disadvantaged populations including the social conditions in which people live and work. It is clear that what are commonly known as the "social determinants" or "health inequities" must be addressed due to their significant impact on health. If action is not taken on the social determinants of health then targets for healthy living will be difficult to achieve and health inequities may actually increase.

Estimated Impact of
DETERMINANTS OF HEALTH
on Health Outcomes.



- Social and Economic Environment
- Health Care System
- Biology and Genetic Endowment
- Physical Environment

Graph reproduced from the Standing Senate Committee on Social Affairs, Science, and Technology, The Health of Canadians — The Federal Role, Volume One: The Story so Far, March 2001.

Chronic Disease and Disadvantaged Populations

Disadvantaged British Columbians have increased susceptibility to a broad range of chronic conditions and are more likely to be living with chronic illness.

For example, the rate of diabetes among those with low incomes is double those with high incomes and for heart disease it is almost double.[1,2,3] Relationships between social inequities and health outcomes are causal and bi-directional. Populations living in poorer social conditions have higher rates of chronic disease and through periods of ill health, individuals with chronic disease can lose the security of adequate income and social supports.[4]

While there are many groups that may not enjoy the full range of opportunities in society, for the purpose of this paper the focus is on populations in which the evidence demonstrates a greater risk for developing chronic disease and a reduction in life expectancy. There is significant evidence confirming that health inequities in BC are most pronounced among children and families living in poverty, the working poor, the unemployed/under-employed; those with limited education and/or low literacy, Aboriginal Peoples, new immigrants, persons suffering from social exclusion, the homeless and people with addictions and/or mental illness.[5,6,7,8] In addition to the concentration of risk factors for chronic disease within these disadvantaged populations there are also cross-linkages between certain social conditions and specific groups. For example, a new immigrant who is unable to find

permanent work is also likely to experience social exclusion, poverty and anxiety or depression as a result. Population health data clearly shows that there is an active gradient at work, as socio-economic status improves, so too do health outcomes.[9,10,11]

Addressing the complex range of issues that contribute to chronic disease and health inequities will require leadership from decision-makers to think in the long-term – beyond election cycles. BCHLA has reviewed the literature and sought expert opinion on what actions can be taken to address these health inequities in British Columbia so that this province can lead the way in healthy living for all citizens, particularly its most disadvantaged.

ABORIGINAL PEOPLES*

Within British Columbia, there are 203 First Nations groups distinct from one another in relation to their location and environment (urban, rural, and remote) with unique cultures, traditions and language. Aboriginal people experience gaps in their health outcomes as a result of a multitude of factors. According to the Provincial Health Officer's *Pathways to Health and Healing: 2nd Report on the Health and Well-being of Aboriginal People in British Columbia*, "a long history of colonization, systemic discrimination, the degrading experience of residential schools, and other experiences have led to adverse multi-generational health effects on Aboriginal families."[12] The report also measures social determinants and on every indicator shows that the risks are two to three times greater for Aboriginal people compared to non-Aboriginal people. It should be noted that the social determinants of health are viewed in a wide context from a First Nations perspective and includes lands, resources, culture and language.

In 2005, the First Nations Leadership Council†, Province of BC, and Government of Canada signed the Transformative Change Accord which acknowledged the significant gap to be closed in education, health, housing and economic opportunities for First Nations peoples over the next ten years.[13] In 2007 the *Tripartite First Nations Health Plan* was signed which calls for a collaborative and coordinated approach with First Nations' input and direction into the planning and delivery of programs and services, as well as policies and decision-making with Federal and Provincial Governments. This is an important process which needs to be carefully stewarded and adequately resourced in order to bridge the significant gap in health equity.

NEW IMMIGRANTS

There is a well documented pattern in which newcomers who exhibited excellent or good health characteristics when they first arrived often experience a decline in health following immigration. "Much of the literature reviewed suggests that determinants of health such as poverty and underemployment have a strong impact on health, particularly for immigrant women and children."[14] The prevalence rates of chronic conditions, including diabetes, increased from 37% among recent immigrants to 51% among long-term immigrants.

The stress of adjusting to a new country and culture is a significant factor, particularly for those who lack family support or community ties. Refugees fleeing war or oppressive regimes also commonly experience post-traumatic stress disorder and it can be very difficult for professionals whose sense of self identity and worth is tied to their profession to be unemployed for long periods or forced to take unskilled work.

CHILDREN AND FAMILIES LIVING IN POVERTY

The lack of resources and choices as well as social exclusion and stress created by poverty make it one of the most significant contributors to ill health. It is deleterious at all stages of life, but childhood poverty has been shown to have a negative affect on social and health outcomes that lasts across the life course. "As family income falls, the likelihood that children will experience problems increases. Rates of poor health, hyperactivity and delayed vocabulary development have been shown to be higher among children in low-income families."[15]

Reductions in access to, and increases in user fees for social services and recreation are particularly hard on lower income families with children—many of whom cannot afford to purchase these services.[16] "Nearly half of low-income families cite high costs as reasons for not participating in physical activities."[17] "Children are poor because their families are poor."[7] "There were an estimated 181,000 poor children in BC in 2006."[18] The current annual income of a lone-parent with a four-year-old child on welfare (including federal and provincial supports) is $16,383 a year—or $10,541 below the estimated after-tax

** In this report, Aboriginal Peoples refers to all First Nations, Inuit and Métis as well as others who self-identify as Aboriginal.*

† The First Nations Leadership Council is comprised of the political executives of the First Nations Summit, Union of BC Indian Chiefs and the BC Assembly of First Nations. The Council works together to politically represent the interests of First Nations in British Columbia and develop strategies and actions to bring about significant and substantive changes to government policy that will benefit all First Nations in British Columbia.

Chronic Disease and Disadvantaged Populations

poverty line. This level of family poverty is most acute in those families led by single mothers – over one third of whom live below the poverty line.[19]

THE UNEMPLOYED / UNDER-EMPLOYED

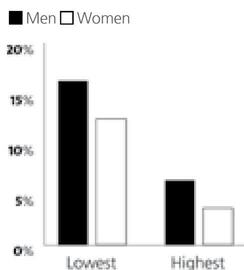
It has long been recognized that employment has a significant effect on the economy and also on the physical, mental and social health of individuals and their families. Almost a decade ago, the *Toward a Healthy Future: Second Report on the Health of Canadians* (1999) flagged the devastating effects of job loss, noting not only the loss of identity, but also the loss of social contacts and opportunities for personal growth. Not surprisingly, "unemployed people have a significantly reduced life expectancy and suffer significantly more health problems than people who have a job."[34] The proportion of "working poor" in BC is among the highest in Canada. Forty-six percent (46%) of low-income families and 57% of low-income unattached individuals in BC are "working poor".

MENTAL ILLNESS AND ADDICTIONS

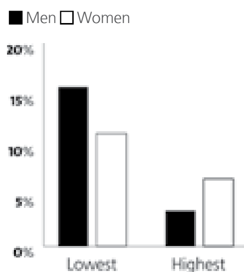
Mental illness is often defined as one of the five major chronic diseases along with cancers, cardiovascular diseases, respiratory disease and diabetes. Mental health and physical health are deeply intertwined. The BC Partners for Mental Health and Addictions Information explains, "emotional well-being also affects physical health through social relationships, behaviour, stress, accidents, suicide, coping strategies, and immune system functioning".[20] One in five British Columbians will experience a mental illness in their lifetime and "about 20% of people with a mental disorder have a co-occurring substance use problem."[21] People with mental illness and addictions "represent the most frequent category of billings by general practitioners" and are "one of the top categories of 'frequent users' of emergency room services".[20] Those with serious mental illness face many barriers including stigma and discrimination which limit access to education and employment thereby increasing their risk of poverty. Poverty in turn is known to exacerbate poor mental health; "losing stabilizing resources, such as income, employment, and housing, for an extended period of time can increase the risk factors for mental illness or relapse."[21]

> "One in five British Columbians will experience a mental illness in their lifetime and 'about 20% of people with a mental disorder have a co-occurring substance use problem.'"

Prevalence of
HEART DISEASE
in Relation to Household Income Levels in BC.



Prevalence of
DIABETES
in Relation to Household Income Levels in BC.



Data source: Statistics Canada Canadian Community Health Survey Cycle 3.1 Share File (2005).

CHRONIC DISEASE AND DISADVANTAGED POPULATIONS

PROPOSED ACTIONS

Aboriginal Peoples

- First Nations in BC should be afforded more control over health, social, education and justice policies and funding that disproportionately affect Aboriginal Peoples.
- All levels of government work with First Nations communities and educators to develop a plan to increase the rate of Aboriginal children graduating from high school to the same rates as non-Aboriginal children within ten years.
- All levels of government work with First Nations communities and leaders to set measurable goals and create a plan for increasing Aboriginal representation in the workforce in terms of full-time employment, management positions and professional workplaces.

New Immigrants

- Increase accessibility of language training programs to enable immigrants to learn English and for those with some English to increase their proficiency to levels that enable them to function effectively in the workplace, take courses at post-secondary institutions and/or enter into licensing programs.
- Increase skills bridging programs to upgrade professional or technological skills and improve coordination between employers, apprenticeship bodies, licensing associations and service providers – making it easier for immigrant trades people and professionals to Canadianize their skills and credentials while also increasing opportunities to change careers.
- Provide additional supports to settlement counsellors in order to improve their clients' integration and chances for success in BC.
- Ensure that the settlement of refugees includes the identification and treatment of mental health issues and support to overcome trauma experienced prior to immigrating to Canada.

Mental Illness and Addictions

- Ensure the delivery of a comprehensive approach to prevention, promotion and early intervention - across the lifespan and across mental health/illness and addictions spectrums.
- Develop a province wide seamless continuum of care through cross-Ministry integration, improved information sharing systems and better integration of services.
- Develop a long-term, consolidated, comprehensive, Interagency Social Housing System for hard to house individuals; including those living with mental health problems and addictions.

A Framework for Action and Accountability

79%

of British Columbians support

A provincial action plan with targets and timelines to improve the health of disadvantaged citizens

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

As well as an ethical imperative for action there is also a strong economic rationale.

Chronic disease arising from persistent inequities is a costly economic drain in terms of lost productivity, foregone tax revenue, reduced consumer spending and higher public expenditures. Strong and sustainable social programs can enhance economic competitiveness by supplying vital social infrastructures—health care, a skilled and knowledgeable workforce, resilient families, and healthy and secure societies—that bestow competitive advantage.

Specific targets, an action plan and designated leadership are required to reach the goal of a healthier BC for all.

In striving towards this goal, the province should review policies throughout government with respect to their impact on the reduction of inequities in health and strengthening chronic disease prevention. Population based health promotion and disease prevention strategies that take an integrated approach to the risk factors are needed in conjunction with broader measures to improve social conditions for disadvantaged British Columbians.

With the right supports for children and their families, the impact of the returns will be realized over the next 10 to 20 years. By supporting conditions in which today's and tomorrow's children can aspire to healthier lives, it should be possible to reduce the burden of chronic disease, lessen the load on the health care system itself and slow the growth rate of health care spending.

It is important to note that other provinces have adopted or are in the process of adopting Poverty Reduction Strategies which would not only reduce the number of children and families living in poverty but would have as anticipated outcomes, improved health for their citizens. Quebec was the first to move in this direction and has already seen results. Newfoundland has more recently implemented such a strategy and Nova Scotia and a number of municipalities are also in the process of developing poverty reduction strategies. In May 2009, the Ontario legislature gave unanimous consent to Bill 152, the *Poverty Reduction Act*. "The legislation requires Ontario to set a new poverty reduction target and plan of action at least every five years and to consult regularly on its progress with key stakeholders."[22] Manitoba also announced their poverty reduction strategy in May, 2009. The Manitoba strategy emphasizes four pillars: safe, affordable housing in supportive communities; education, jobs and income support; strong, healthy families and accessible, coordinated services.[23]

BCHLA has identified the following priorities and actions that if addressed, will increase the health of BC children and the families that support them.

POLICY GOAL

Rates of chronic disease and health outcomes for British Columbians of lower socio-economic status are dramatically improved, and the gap between low socio-economic status groups and those with higher socio-economic status is significantly narrowed.

A FRAMEWORK FOR ACTION AND ACCOUNTABILITY

PROPOSED ACTIONS

- **Targets:** The BC Government should commit to reducing the burden of chronic disease by addressing health inequities with the establishment of targets for improving health outcomes of British Columbians of lower socio-economic status. A good start would be to establish the following targets:
  - By 2017, a 50% reduction in the number of children and their families living in poverty[‡] ; and
  - By 2017, an improvement of 20% in the health status of children in BC (0 to 16 years) as measured by infant mortality, morbidity, premature mortality, and healthy weights and reduction in risk factors which contribute to childhood disease and ill health[§].
- **Planning:** The BC Government should establish a plan that will lay out specific actions that will be undertaken in order to meet the targets to reduce health inequities. While it is now possible for all government proposals and policies to be subjected to health impact assessments, this should be expanded to address the impact of all proposals and policies on inequities in health.
- **Investment:** The BC Government should allocate funding to implement policies and actions planned to achieve the targets. Investments in the key areas outlined in this report, together with a strong public health infrastructure are necessary to raise the health outcomes of the least healthy in this province.
  - In addition to broad measures that will improve social conditions for disadvantaged British Columbians, it is recommended that the BC Government invest in the 'Six Percent Solution', adding an additional three percent of current health dollars to public and population health approaches to prevent chronic disease and lessen the load on the health care system.
- **Responsibility:** The BC Government should assign a minister with responsibility for coordinating inter-ministerial efforts to meet the targets to reduce health inequities. Intersectoral action and coordination is a necessity in effective policy development and implementation.
- **Measurement:** The BC Government should put in place surveillance mechanisms for measuring and reporting to the public on the progress in meeting the targets.

‡ This target aligns with the target promoted by Campaign 2000. Campaign 2000 is a cross-Canada movement to build awareness and support for the 1989 all-party House of Commons resolution to end child poverty in Canada by the year 2000. There are over 120 national, community and provincial partners actively involved in the work of Campaign 2000.

§ The BCHLA Coordinating Committee determined that a realistic target for improving health equity among BC children should be established at a Social Determinants of Health Workshop held on February 15, 2008. This target was ratified on May 22, 2008.

Early Childhood Development and Care

It is clear that a child's early experiences and development establish a foundation that will impact school readiness, educational achievement and high school completion which ultimately contribute to employment and income security.

With emotional, social and cognitive aptitudes, come the skills for securing material resources and the conditions for a healthier life.

Longitudinal studies have demonstrated that disadvantaged children who participate in quality early childhood development programs have significantly better outcomes.[25] A 2005 study of the costs and benefits of universal preschool in California noted that for disadvantaged children, quality childcare can lead to the participants staying in school longer, earning higher wages later in life and committing fewer crimes.[26]

In the short term, children who participate in quality early childhood development and care are provided healthy food choices and physical play in smoke-free environments. This health-promoting environment gives children from all backgrounds the opportunity to develop healthy behaviours from positive role models. Quality childcare programs also deliver positive impacts to the family through reduced stress and increased opportunities to pursue employment or education and training, thereby increasing the resilience of the family.

The call for a comprehensive early childhood development and care system comes from a broad range of sectors including business leaders, economists, academics, as well as educators and provincial, federal and international organizations.[27,28,29] Dr Clyde Hertzman, UBC Professor, Director of the Human Early Learning Partnership and Team Leader of the *World Health Organization's Global Knowledge Hub on Early Child Development*, argues that because the majority of vulnerable children live in middle class neighbourhoods, a strategy to provide universal access is favourable over targeted approaches.

Early childhood development and care is an excellent investment for government. According to the 2000 Nobel Laureate in economics, Dr. James Heckman, in terms of return on investment in human capital, the earlier the intervention the higher the return. One study shows a 10-fold return on every dollar invested in 0 to 3 year olds. In the Canadian context it is estimated that one dollar invested in early childhood development generates two for the economy.[30]

According to UNICEF, Canada has achieved only one benchmark out of ten for minimum standards in early childhood education and care. UNICEF's benchmarks, which are based on a summary of international research, include a requirement for parental leave at 50% of salary for at least one year, available to the self employed and a portion specifically reserved for fathers. Seventy percent of Canadian mothers work in the labour-force and yet until children reach Kindergarten there are few quality early education and care spaces available. In BC, there are spaces in childcare centres for 5% of children under three years and just over 30% for children between the ages of three and five.[32] UNICEF suggests that there should be subsidized, regulated childcare spaces for 25% of children under three and subsidized, accredited early education services for 80% of four year olds.[31]

Universal childcare is not impossible or even beyond our means to deliver; Quebec provides quality daycare to families for $7.00 a day, achieving six out of ten of the benchmarks set by UNICEF.[31] British Columbia should explore a similar model of high quality, affordable early education and care for families. This should also include professional training, wages and benefits for early childhood educators and childcare workers to ensure career development and sustainability in this field.

"Positive conditions during childhood not only support child health but have long lasting effects on health and the development of disease during adulthood. Healthy child development is influenced [and in turn influences] other determinants of health such as income, housing and food security."[33] If British Columbia focuses its energies on children today, there is hope that this generation of children may actualize their full health and developmental potential as adults.

> "...it is estimated that one dollar invested in early childhood development generates two for the economy.[30]"

80% of British Columbians support improving childcare through subsidies and additional childcare spaces.

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

Early Childhood Development and Care

POLICY GOAL

All children in British Columbia from birth to five years of age have access to comprehensive early childhood development and care with all levels of government contributing to achieve this goal.

EARLY CHILDHOOD DEVELOPMENT AND CARE

PROPOSED ACTIONS

- Extend parental leave benefits to cover the period of birth to 18 months to enable both mothers and fathers to be with infants during their earliest period of development and encourage employers to provide top-ups to the current benefits available under Employment Insurance.
- Provide comprehensive, quality and affordable early childhood development, parenting, pre-natal health and family wellness services and programs ensuring that priority is given to those neighbourhoods and communities with the highest numbers of vulnerable children. Universal childcare delivered by early childhood educators should be considered as the ultimate goal.
  - Employ the Early Development Instrument – that has been used in school districts across BC to assess the state of children's development at Kindergarten – to identify priority neighbourhoods for phasing in programs and areas for further expansion in successive waves. Prorate charges according to family income ensuring that fees are very small or waived for low income families.
  - Provide affordable pre- and after-school programs for all children from the age of four with appropriate hours to meet the needs of working parents.

  - The Federal and Provincial Governments continue to support Aboriginal Head Start programs in BC for Aboriginal children from birth to six years of age.
- Coordinate the identification of learning and developmental disorders utilizing an integrated approach involving primary care and public health professionals as well as childcare providers and other community resources. Work with parents to ensure appropriate remediation can be provided as early as possible.
- Reinvest in childcare capital and operation funding to provide incentives for the creation of more quality childcare spaces.
- Increase training spaces and remuneration for early child educators and childcare workers, providing incentives for people to pursue, stay and value these careers and reduce turn-over.

Education and Literacy

Education, literacy and training are acknowledged as vehicles for transcending low socio-economic circumstances including health status.

"There is strong evidence that those who graduate from high school show significantly better health and family functioning than non graduates."[34]

The relationship between education and income is so well established that educational attainment is used as a proxy measure of socio-economic status when more complete measures are lacking.[36] The unemployment rate for youth with no more than a primary school education is four times the rate for young people with a university education.[35] Parent's education levels also are strongly related to the school readiness of children.[7] "Despite these strong associations, graduating from high school is rarely considered a public health priority."[36]

British Columbia's public education system already makes considerable effort to engage disadvantaged students and encourage high school completion and post-secondary education. But if British Columbia is to overcome health inequities due to poor socio-economic status, then support for interventions that will increase educational opportunities for disadvantaged youth need to be strengthened.

Beyond high school, basic literacy skills are needed by all citizens and yet, seventeen percent (17%) of British Columbians have low literacy. "There is a large income penalty for Canadians with low literacy scores. Among Canadians with the lowest level of prose literacy, 47% lived in low-income households, compared with 8% among Canadians with the highest levels of prose literacy."[7] Literacy skills enhance employment opportunities as well as a person's ability to use and understand written and verbal communication and thereby participate in society. There is a significant body of research that suggests that those who do not read daily, lose literacy skills as they age especially if they are employed in fields that don't require them to read.

84%

of British Columbians support

increasing education grants or loans available to lower income families

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

Education and Literacy

POLICY GOAL

All British Columbian youth including those from the most disadvantaged backgrounds are able to access and successfully complete educational programs to the highest level possible and the rates of low literacy in BC are significantly reduced.

82% of British Columbians support

creating programs to reduce drop-out rates

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

EDUCATION AND LITERACY PROPOSED ACTIONS

- Support a culture of health in schools, ensure healthy schools policies are supported with resources and integrate the knowledge of experts.
- Commit and fund additional human resources to support the early identification of students who may withdraw from their education prior to graduation. Provide intensive individualized instruction including the use of tutoring and mentoring programs delivered by teachers interested and trained to work with at-risk students. Provide opportunities to make up work via summer and night school and correspondence.
- Integrate the delivery of child and youth assessment and support services to address substance abuse, teen pregnancy and young parenthood, suicide prevention, counseling and other mental and physical health issues into schools in consultation and coordination with the school and school district administrators, school psychologists and social service / public health agencies.[39]
- Ensure all professionals working with Aboriginal and immigrant students have a proven level of cultural competency and access to training.

- Work with First Nations communities and educators to develop a plan to increase the rate of Aboriginal children graduating from high school to the same rates as non-Aboriginal children within ten years.**
- Increase support for low-income students to pursue post-secondary education and vocational training opportunities by building on the BC Grant, the BC Loan Reduction Program and extending support for students in one-year training programs.
- Review and strengthen support for adult basic education training.
- Encourage literacy programs particularly in the workplace.

*** This recommendation is aligned with the Transformative Change Accord: First Nations Health Plan to close the gap in education between First Nations and other British Columbians within ten years.*

Income Security

Sufficient income allows access to adequate housing, nutritious foods, safe communities and participation in recreational, educational and cultural opportunities as well as other essentials for a healthy life.

Inadequate income limits the security of these basic living conditions for individuals and families and that insecurity can create tremendous stress which also contributes to ill health.[37]

In the years of British Columbia's booming economy there were record low unemployment rates; however, between 1998 and 2004, 25% of British Columbians experienced low income and 10% of British Columbians were in low income for three or more of six years.[41] Now in the face of what are said to be the worst economic conditions of this generation, it is critical that there are supports for the most disadvantaged who tend to be the first and worst hit in times of economic decline.

Inadequate family income can take a substantial toll on the health of children and establish a negative trajectory for life-long health outcomes. Compared to other provinces, British Columbia has the highest percentage of children living with inadequate family incomes. In 2005 15% of BC children were living in low-income families.[38] Low incomes among female lone-parent families are even more common at 31%. A higher proportion of the Aboriginal population have low incomes and are lone parents compared to the non-Aboriginal population.[12]

Benefits targeted to low income families with children can help to break the cycle of disadvantage.[39] A simulation of the prospective

85% of British Columbians support *adjusting income assistance and the minimum wage annually to account for the rate of inflation*

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

Income Security

80%

of British Columbians support

increasing the child tax benefit and supplement to $5100

79%

support increasing the minimum wage

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

impact of an increase to $5100 in the federal Child Tax Benefit and Supplement paid to low income families would result in a 37% reduction in the rate of child poverty based on the Low Income Cut-Off rates.[40] However this would only occur if low income families are able to receive the full amount of the benefit and this is not presently the case.

Income assistance rates should adequately support those who are experiencing financial emergencies or face barriers to income through long–term unemployment. The rate increase introduced in April, 2007 was a step in the right direction. BC can build a stronger system of support for persons with disabilities, special needs, children at risk, and seniors by ensuring that income assistance rates are based on and keep pace with the actual cost of living.

British Columbians employed full time should earn enough to afford healthy basic needs including safe, adequate shelter, healthy food, household amenities, childcare, clothing, transportation and recreation. The proportion of employed people living in poverty in BC is among the highest in Canada. Forty-six percent of low-income families are "working poor" and among unattached individuals, the number climbs to 57%. For those moving from income assistance to employment in BC, two-thirds remained in low income and on average were poorer than they had been on income assistance.[41] The cost of living has gone up by 14% since 2001, the last time the minimum wage was raised to $8.00 an hour.[42] At this rate, someone working full time for 50 weeks in a year would make $16,640 per year, an amount which makes healthy life choices difficult to achieve.

POLICY GOAL

All British Columbians have sufficient income to provide a healthy life for their children and families with all levels of government coordinating their policies and programs to achieve this goal.

INCOME SECURITY

PROPOSED ACTIONS

- Establish a Poverty Reduction Strategy including the following:
  - Raise the minimum wage to a level that allows British Columbian families to purchase healthy foods, secure decent housing and pursue recreational opportunities.
  - Structure marginal tax rates and benefits so that low wage earners are not penalized for working rather than relying on income assistance.
  - Index income assistance rates and the minimum wage to the rate of inflation annually.
  - Increase the National Child Tax Benefit and Supplement provided by the Federal Government to $5100 per child.†† Ensure that this benefit is delivered in addition to income assistance and that for low income families, other benefits are not reduced to off-set this increase.

†† The recommendation to increase the National Child Benefit Supplement to $5100 is aligned with recommendations by Campaign 2000 and a policy option proposed by the Provincial Health Services Authority to increase food security in BC. It is based on a simulation conducted by Campaign 2000 that projected a 37% decline in the child poverty rate were a $5100 child benefit paid to all low income families (based on 2007 dollars).

Housing

Housing is one of the most basic requirements for health.

When people spend excessive amounts of income on housing, fewer resources are available for other health essentials.[43] Studies suggest affordable housing improves health outcomes by freeing up resources for nutritious food and other essentials. It also reduces stress, exposure to allergens, neurotoxins and other dangers as well as provides the stability that enables patients with chronic diseases to access and maintain the level of care they need.[43]

The BC Government has demonstrated its commitment to the issues of affordability and homelessness with the provincial housing strategy, *Housing Matters BC*. Considerable progress has been made with the expansion of programs such as the *Rental Assistance Program, Homeless Outreach Program*, and with an increase of funding for emergency shelters to operate 24/7 in addition to the $80-million investment for 996 new units of supportive and affordable housing.

These efforts are to be commended and yet the need remains high. In 2008 there are still 11,000 households on the wait list for subsidized units with BC Housing.[44] According to Statistics Canada, nearly half the renters in BC spend more than one third of their income on rent and the low vacancy rate (1.1%) gives them few choices for improving their housing situation.[45] Spending excessive amounts of income on housing also reduces resources available for other determinants of health such as food and recreation.

From a public health perspective, perhaps the most acute manifestation of the housing issue relates to homelessness. The homeless population in Vancouver increased between 2002 and 2005 and half of these persons were not staying in emergency shelters but living outside.[46] There are an estimated 10,000 to

Housing

12,000 homeless people in BC with mental health and/or substance abuse issues.[47] Homeless people have a range of chronic health problems due to their extreme poverty, lack of stable housing and exposure to the elements on the street. They are less likely to receive adequate medical care and more likely to draw upon emergency medical services.[48]

There is a strong economic rationale for transitioning the homeless into supportive housing. A 2001 study prepared for the Office of Housing and Construction Standards under the Minister Responsible for Housing reported that the annual cost of providing services to a homeless individual ranged from $30,000 to $40,000 on average. The annual costs for providing government services to an individual in similar circumstances but provided with supportive housing ranged from $22,000 to $28,000 per person per year.[49]

POLICY GOAL

All British Columbians have access to safe, affordable housing.

89%

of British Columbians **support**

increasing investment in affordable housing

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

HOUSING
PROPOSED ACTIONS

- The provincial government should work together and coordinate the efforts and investments of non-profit organizations, the private sector and other levels of government to ensure a full spectrum of housing for those in need, including affordable housing, supportive housing, social housing, emergency and transition housing.
  - Create a youth homelessness prevention strategy to eliminate youth homelessness including the creation of affordable, supportive housing options for at-risk and homeless youth.
  - Develop a long-term, consolidated, comprehensive, interagency Supported Housing System for hard to house individuals; including those living with mental health problems and/or addictions.
  - Ensure that emergency, transition and affordable housing meet the needs of specific populations including women and children fleeing violence, families, seniors, youth and those with mental health problems and addictions.
  - Consider purchasing abandoned or neglected multifamily and apartment buildings to renovate and transfer the title from the provincial government to non-profit housing authorities.
  - Develop a national housing strategy and allocate additional and sustained federal spending for affordable housing.
- The Government of Canada, and Province of BC should provide resources to implement the Memorandum of Understanding signed with the First Nations Leadership Council to work together to develop a comprehensive approach to improve housing for First Nations communities, individuals and families both on and off reserve.
- Adjust the Income Assistance shelter rates so they are based on reasonable market rental costs.
- Provide adequate follow-up support and housing for those leaving institutional care.

Food Security

Affordable, healthy, local and culturally acceptable food makes a difference to our individual health, the resilience of our community and the integrity of our environment.

Evidence shows vegetables and fruit have a protective effect against the development of chronic disease and that even a one-serving-per-day increase is linked to a 20% reduction in all causes of mortality.[50] In BC, as in other provinces, there are pronounced differences in healthy eating which are linked to the social and economic determinants of health.

Although the issue is complex, the social gradient is in play and can help to predict populations with the highest risk for unhealthy eating, obesity and food insecurity.[9] Among those with a university degree, 53% of women and 37% of men follow a healthy diet (as indicated by fruit and vegetable consumption). Among those with secondary school or less, the rates fall to 38% of women and 32% of men.[51]

A similar pattern emerges for obesity with rates increasing from 15% of women and 18% among men with university degrees to 30% of British Columbians with less than secondary education. The World Health Organization notes that obesity is often most prevalent in the poorest socio-economic sectors. "There is abundant evidence that energy-dense, nutrient-poor foods are

chosen because they are cheap, produced safely, widely promoted and readily available".[52]

It is difficult to think that there are families experiencing food shortages and hunger in British Columbia and yet according to Canadian Community Health Survey, in 2005 some 116,104 British Columbians were 'food insecure without hunger'. Another 53,480 persons were food 'insecure with moderate hunger' and 13,442 were 'food insecure with severe hunger'.[53] An over sampling of off-reserve Aboriginal people indicated that one in three off-reserve Aboriginal households were experiencing food insecurity and that just under half of these households included children.[54]

Accessing healthy, affordable food can pose a significant challenge to those on low or fixed incomes. In 2007, it cost a family an average of $715 a month to purchase a basic healthy food basket in BC — an increase of 9% since 2006. At this amount, a family of four on income assistance would need to spend 42% of their income to buy a healthy food basket.[55] In 2006, 76,514 British Columbians sought assistance from charitable food banks – 36% of whom were children.[56] The primary source of income for food bank recipients are income assistance (42%), disability income supports (22%) and employment (12%).

In many low income neighbourhoods, the relative shortage of grocery stores makes access to a variety of healthy foods challenging and often groceries are more expensive in these areas when compared to stores in more affluent neighbourhoods.[57] Studies in Edmonton and Toronto have shown a higher concentration of fast food outlets in low income neighbourhoods.[58,59] Whether this is true in BC communities remains to be verified; however, there is evidence that where there are higher numbers of fast food outlets per population there are also increased rates of obesity, mortality and admissions for acute coronary syndromes.[60,61] A mixture of planning and zoning measures along with other incentives and disincentives should be explored to ensure all communities have easy access to healthy foods while limiting the proliferation of energy-dense, nutrient-poor foods.

Access to healthy, affordable food is even more challenging to remote, rural and Northern residents, many of whom are First Nations. The limited food supply and transportation system leaves many citizens in these communities with few choices in fresh produce that are often expensive and of poor quality. The Province's creation of a task force to develop strategies to get fresh produce to remote communities in 2008 was a positive step. The recommendations by the representatives from remote communities and farmers were anticipated to begin addressing this pressing issue and BCHLA looks forward to seeing how their implementation will impact regional food security.

Resources such as community gardens and farmers markets not only increase the availability of local food, they also create opportunities for community development and facilitate a better connection between residents and their food sources. However, in BC local food sources are unevenly distributed throughout the regions.[62] First Nations stewardship and access to traditional territories will increase the availability of environmentally safe traditional food sources.

For people who live in poorer neighbourhoods, getting to stores where they can buy the healthy food they want is a challenge because of safety, distance and transportation issues.

" I know how to buy good fruits and vegetables, but there aren't any stores like that in my neighbourhood. "

– Elaine, age 50

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

POLICY GOAL

All British Columbians have access to a safe, healthy, sustainable and culturally appropriate food supply.

FOOD SECURITY

PROPOSED ACTIONS

- Support initiatives that increase supplies of local, healthy, sustainable and safe food for all with particular focus on rural and remote communities and others for whom access to food is difficult.
- Adjust Income Assistance support rates to account for the actual cost of fresh and healthy food.
- Recognize First Nations interests with respect to stewardship and access to lands and waters from which traditional diets are sustained.
- Ensure access to quality drinking water. Priority should be given to remote First Nations communities with all levels of government working together to address this issue.
- Strengthen the Agricultural Land Reserve legislation to prevent the destruction of arable land and loss of agricultural land to development pressures.
- Provide tax incentives to encourage local agricultural production and apply disincentives for those using agricultural land for residential use only. Provide resources and capacity building opportunities that assist First Nations to farm available farmland on reserve.
- Review agricultural policies with input from small scale producers to ensure that policies promote local food production and direct purchasing from consumers.
- Review provincial legislation that limits the use of traditional foods in First Nations daycares, schools and elders facilities.

Supportive Environment

How communities are planned and built can impact the health outcomes of the citizens who live there and their ability to make healthy life choices.

Density, affordability, connectivity and the relative mix of land uses within a community determine how far and by what means citizens are required to travel to meet their everyday needs.[63] Collaborative social planning processes can improve the social inclusiveness of communities as well as maximizing the impact of investments made by all levels of government to address the complex social issues faced by communities.

Local governments have a leadership role to play in determining the sustainability, health and overall livability of a community. Faced with multiple challenges, in some cases growth, in some cases declining populations, all communities must respond to the various needs of their citizens. Through their planning and land use powers, community leaders make decisions that will determine the types of services, amenities, recreation, transportation and housing options available. But they cannot do it alone. In partnership with the provincial government, some programs have been put into place to assist local governments address a diversity of demands such as reducing greenhouse gas emissions, improving public and environmental health, revitalizing town centres, encouraging physical activity and building age/access friendly communities.

As well, there is an urgent requirement to support those most in need within communities. Enhanced social supports are required to address these challenges. This includes improved access to: health, social and community services, healthy and affordable food, and safe, affordable, quality housing. For others in need it may mean access to economic capital and resources that facilitate employment or training and education opportunities. Supports that enhance the built environment by expanding transportation options and increasing access to enjoyable spaces for physical activity and recreation provide universal benefits to the community as a whole.

POLICY GOAL

All British Columbians can live in safe, healthy and supportive communities.

In poor neighbourhoods, safe outdoor spaces are scarce, discouraging outdoor physical activity. This is a particular challenge for kids, who "exercise through play" (e.g. playing "tag" with friends).

"There is no playground near my house."

– Serena, age 9

Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research)

SUPPORTIVE ENVIRONMENTS

PROPOSED ACTIONS

- Continue to support collaboration with local government to provide communities with resources that develop healthy and inclusive communities through an integrated approach to social, physical, environmental and economic planning and development.

- Ensure communities have universal services which will have the greatest impact on healthy child development. Support the expansion of the community-based "neighbourhood hub" as a way to deliver community services. This has been recommended as a 'best practice' for communities whose population is large enough for this type of facility.
- Provide resources for communities to audit and design or retro-fit their communities according to age-friendly guidelines.
- Create and expand successful evidence-based programs for active and healthy aging and living.

Transportation

photo: www.pedbikeimages.org /Dan Burden

Transportation has a direct impact on one's ability to access health promoting services including essential community amenities such as grocery stores, schools, recreation facilities, health care and employment.

The lack of public transportation service to rural and remote residents in BC is seen widely in those areas as a barrier to healthy food choices and healthy living overall.

According to the Canadian Institute for Health Information, "access to prevention, early detection, treatment or support services… make good health status even more difficult to achieve in rural or remote areas… People living in rural communities generally need to travel longer distances, and often on more dangerous roads, for work, shopping and other reasons. Not surprisingly, injuries and death due to traffic accidents are much more common in rural areas."[64]

Public transportation is a basic amenity that provides multiple benefits for all but is particularly necessary for those who do not own or are not able to drive their own vehicle. This includes people on limited incomes, those with physical impairments or disabilities, youth and some seniors. Transportation systems relate directly with the built environment and how our communities are planned. It can be difficult for people on low incomes who have to choose lower housing costs at the expense of transportation options.

In addition to public transit, walking and cycling options should be built into communities. As universally accessible infrastructure, walking and cycling facilities support healthy living among the population as a whole and are of particular benefit to the disadvantaged since they are free and promote social integration.

POLICY GOAL

All British Columbians have adequate transportation to access the services and amenities they need to live a healthy life.

TRANSPORTATION

PROPOSED ACTIONS

- Increase investments in public transit – emphasize projects that maximize ridership while meeting local and regional needs.
- Encourage the development of hubs with higher density housing, shops and services to facilitate transit for the surrounding community (transit oriented development) in areas where the density is considered too low to deliver efficient regular transit service.
- Establish a task force to explore innovative public transportation systems that can serve rural and remote populations and others with mobility challenges.
- Continue to support local governments to create complete, connected communities with shops, services, food and employment accessible by transit systems and pedestrian and cycling infrastructure.
- Invest in active transportation, 7% of all infrastructure funding allocated to urban transit, road and other transportation construction, should be set aside for Active Transportation infrastructure (e.g., bicycle facilities, walking trails/paths, sidewalks, signals, signage and traffic calming measures).
- Explore ways to improve transportation to health services including prevention, primary, treatment and tertiary services for rural and remote residents that are unable to afford transportation.

Conclusion

Together, we can build a healthier future for BC Families.

There has been much discussion of policy interventions that are promising for alleviating health inequities. There is, however, very little research measuring the efficacy of policies on long-term health outcomes of those populations that are negatively affected by the social determinants of health. Much of the literature on policy options focuses on those that have been proven in other jurisdictions or appear to be effective at mitigating the negative effect when specific determinants are not met, such as early childhood development, affordable housing, income security, food security and improved education outcomes.

Clearly, no single policy will be effective in itself. What is required is an integrated approach that will deal with the complex problem of health inequity from various angles. This necessitates the participation of multiple sectors, including multiple levels of government, the non-profit, education, and private sectors as well as representatives from affected communities. Government not only needs to engage with external partners but also work more effectively internally by increasing cross-ministerial cooperation and integration.

British Columbia cannot wait for the perfect longitudinal study to take action. At this juncture, it is imperative to move ahead and pursue the policies that combine the most promising evidence with support from the citizens of British Columbia. If action is not taken now health care costs will be significant and the human costs will be immeasurable. But with an action plan, timeline and commitment a difference can be made. Together, we can build a healthier future for BC Families.

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Appendices

NAMES OF ORGANIZATIONS THAT PARTICIPATED IN BCHLA'S 'HEALTHY FUTURES FOR BC FAMILIES' POLICY DISCUSSIONS

OCTOBER 2008 – MARCH 2009

1. ACT - A Conscious Thought
2. ActNow BC
3. Affiliation of Multicultural Societies & Service Agencies of BC (AMSSA)
4. Alzheimer Society of BC
5. Back of a Napkin Strategies Inc
6. BC Alliance on Mental Health & Addiction Services
7. BC Association of Family Resource Programs
8. BC Association of Pregnancy Outreach Programs
9. BC Cancer Agency
10. BC Childrens' Hospital Foundation
11. BC Coalition of People with Disabilities
12. BC Confederation of Parent Advisory Councils
13. BC Dental Association
14. BC Healthy Communities
15. BC Lung Association
16. BC Medical Association
17. BC Naturopathic Association
18. BC Network for Aging Research
19. BC Nurses Union
20. BC Paraplegic Association
21. BC Pediatric Society
22. BC Principals and Vice-Principals Association
23. BC Recreation & Parks Association
24. BC School Trustees Association
25. BC Soccer Association
26. Building Opportunities with Business
27. Bulkley Valley District Hospital
28. Business Council of British Columbia
29. Canadian Cancer Society, BC & Yukon Division
30. Canadian Centre for Policy Alternatives
31. Canadian Diabetes Association, Pacific
32. Canadian Mental Health Association
33. Canadian Policy Research Networks
34. Cariboo Chilcotin Métis Association
35. Carrier Sekani Family services
36. Central Vancouver Island Multicultural Society
37. Centre for Healthy Living and Chronic Disease Prevention, UBC Okanagan
38. Chemainus First Nation
39. Child Development Centre
40. Child Health BC
41. City of Courtenay
42. City of Cranbrook
43. City of Dawson Creek
44. City of Fort St. John
45. City of Nanaimo
46. City of Prince George
47. City of Terrace
48. City of Vancouver
49. City of Williams Lake
50. Community Development Institute
51. Community Futures Fraser Fort George
52. Context Research
53. Coty Services
54. Council of Canadians, Kamloops Chapter
55. Covenant House
56. Cowichan Social Planning
57. Dietitians of Canada, BC Region
58. Directorate of Agencies for School Health BC (DASH)
59. District of Chetwynd
60. District of Mackenzie
61. District of Sparwood
62. District of Tofino
63. Dze L K'ant Friendship Centre
64. First Call: BC Child & Youth Advocacy Coalition
65. First Nations & Inuit Health

Appendices

66. First Nations Health Council
67. Fraser Basin Council
68. Fraser Health Authority
69. Frog Hollow Neighbourhood House
70. Gold River Interagency Committee
71. Harris House
72. Health and Wellness Advisory Committee (HWAC)
73. Heart & Stroke Foundation of BC & Yukon
74. Heartland Foods and Farm Tours Cooperative
75. Hiiye'yu Lelum (House of Friendship) Society
76. Hong Kong Bank of Canada
77. Human Early Learning Partnership, University of British Columbia
78. Immigrant and Multicultural Services Society
79. InspireHealth
80. Institute of Health Economics
81. Interior Health Authority
82. Ismaili Council for BC
83. James Bay Community Project
84. Jessie's Hope Society
85. John Howard Society
86. Kaien Anti-Poverty Society (KAPS)
87. Kamloops United Church PIT Stop program
88. Kamloops YMCA-YWCA
89. KidSport Canada
90. Ki-low-na Friendship Society
91. Kitimat Child Development Centre Association
92. Ladysmith Children First Family & Friends Society
93. Laichwiltach Family Life Society
94. Learning Disabilities Association of BC
95. Lelum Aboriginal Friendship Centre & Safer Nanaimo Working Group
96. LUSH Valley Food Action Society
97. Malaspina University-College
98. Measuring Up the North
99. Métis Commission for Children and Families, White Buffalo Aboriginal Health Society and Resource Centre
100. Michael Smith Foundation for Health Research
101. Ministry of Children & Family Development
102. Ministry of Community Development
103. Ministry of Environment
104. Ministry of Health
105. Ministry of Healthy Living & Sport
106. Ministry of Housing and Social Development
107. MOSAIC
108. Move More Eat Well Committee
109. MS Society of Canada (BC & Yukon Division)
110. Nak adzli' Health Centre
111. Nanaimo & Ladysmith Public Health
112. Nanaimo RCMP
113. Nechako Valley Community Services Society
114. Nicola Valley Institute of Technology
115. Nisga Valley Health Authority
116. North Peace Community Resources Society
117. North Savings Credit Union
118. Northern Health Authority
119. Northern Lights College
120. Northwest Community College
121. Nutrition and Diabetes Education
122. Office of Workplace Health and Sustainability | UBC Okanagan
123. Opposition Critic for Health, New Democratic Party of BC
124. Osteoporosis Canada, BC Division
125. Peace River Regional District
126. PeerNetBC
127. Phoenix Transition Society
128. Portland Hotel Society
129. Power of Friendship AHS
130. Prince George Brain Injured Group
131. Prince George Chamber of Commerce
132. Prince George Hospice Society
133. Princess Royal Family Centre
134. Project Friendship Society
135. Provincial Health Services Authority

136. Public Health Agency of Canada, BC/Yukon Region
137. Public Health Association of BC
138. Queen Charlotte Health
139. Qwallayuw Aboriginal Head Start
140. Reach Clinic
141. Regional District of Nanaimo, Recreation and Parks
142. Runners of Compassion
143. S.U.C.C.E.S.S
144. Saanich Neighbourhood Place
145. Safer Nanaimo Working Group
146. School District No. 020 (Kootenay-Columbia)
147. School District No. 027 (Cariboo-Chilcotin)
148. School District No. 057 (Prince George)
149. School District No. 060 (Peace River North)
150. School District No. 068 (Nanaimo-Ladysmith)
151. School District No. 072 (Campbell River)
152. School District No. 079 (Cowichan Valley)
153. School District No. 087 (Stikine)
154. School District No. 092 (Nisga'a)
155. School of Child & Youth Care, University of Victoria
156. Service Canada
157. Sik-e-dakh Band
158. Skidegate Health
159. Smart Growth BC
160. Smithers Community Services Association
161. Snuneymuxw First Nation Health Centre
162. Social Planning & Research Council of BC (SPARC)
163. Sooke Family Resource Society
164. Sooke Region Community Health Initiative
165. Spirit Lodge Prince George
166. Sport BC
167. St. James Community Services Society
168. Success by Six North Peace
169. Sugar Cane Elder
170. Telkwa Community Initiatives Society
171. Terrace Make Children First Network
172. The Salvation Army
173. The Stroke Recovery Association of BC
174. Tillicum Lelum Aboriginal Friendship Centre
175. Town of Ladysmith
176. Town of Lake Cowichan
177. Town of Montrose
178. Thompson River University Nursing Program
179. 2010 Legacies Now
180. Union of BC Municipalities
181. Ulkatcho Health
182. United Way
183. University of British Columbia, Department of Educational & Counselling Psychology & Special Education
184. University of Northern BC
185. Urban Development Institute
186. Vancouver Board of Trade
187. Vancouver Coastal Health Authority
188. Vancouver Foundation
189. Vancouver Island Health Authority
190. Vancouver Island University
191. Variety - The Children's Charity
192. Village of Canal Flats
193. Village of Hazleton
194. Village of Queen Charlotte, North West Regional Hospital District
195. Virtual Cardiac Rehabilitation Study
196. W.E. Graham Community Services
197. Wachiay Friendship Centre
198. Williams Lake & District Chamber of Commerce
199. Woman's Contact Society
200. YMCA of Greater Vancouver
201. Young Parents Support Network
202. YWCA Vancouver

Appendices

PHOTOS

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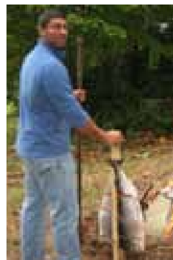
Page 8: Aboriginal Team BC, photo by Dionne Paul



Page 21: Smoking salmon for community gathering, photo by Dionne Paul

Page 22: BCHLA initiative: Karen newcomers enjoy Al Anderson Pool with the support of CARL project funded through a Community Capacity Building grant

Page 23: BCHLA initiative: Karen newcomers introduce Langley youth to cane ball with the support of CARL project funded through a Community Capacity Building grant

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