

**Income Inequity and Health:
Strategies for Action in Post-Pandemic B.C.
Through the Ethical Lens of Critical Social Justice**

March 2022

Submitted to The Minister of Social Development and Poverty Reduction,
Province of British Columbia, Canada

Submitted on behalf of the “Sylvia” Think Tank,
Vancouver, British Columbia, Canada

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“Sylvia” Think Tank: We are a self-funded diverse, intergenerational, and interdisciplinary group of academics, health care and social service practitioners, and community leaders involved in advocacy work who, over the past few years, have convened at the Sylvia Hotel in Vancouver. The first meeting was held in 2015.¹ Our mission is to mobilize knowledge and evidence to influence health, social and public policy, and praxis-oriented action to reduce disparities in income and health, and to improve the quality of life for British Columbians from diverse backgrounds and across all age groups.²

¹ The founders of the “Sylvia” Think Tank include Joan Anderson, Annette Browne, Heather McDonald, Patricia (Paddy) Rodney, and Sheryl Reimer-Kirkham. We thank those who laid the groundwork that has made initiatives such as this Brief possible.

² As noted above, the “Sylvia” Think Tank is comprised of a diverse group of academics, practitioners, and community partners, who speak from different social locations to address inequities in society. We refer to authors by the locations from which they speak, rather than by their credentials.

Acknowledgements

We acknowledge that the land upon which we conduct our work and live our lives is the traditional territory of the Coast Salish Peoples, specifically the shared ancestral, traditional, unceded and occupied territories of the Sk̓wx̓wú7mesh Úxwumixw (Squamish), Səlíl̓wətał (Tsleil-Waututh), and x̣ʷməθkʷəy̓əm (Musqueam).

We thank Heather McDonald, *Retired Health Director, Seabird Island Band*, for her important contributions to earlier discussions and drafts of this Brief; Shamshad Khan, *Associate Professor, Department of Communication, University of Texas at San Antonio*, Annette Browne, *Professor and Distinguished University Scholar, School of Nursing, The University of British Columbia (UBC)*, Sheryl Reimer-Kirkham, *Dean and Professor of Nursing, Trinity Western University*, and Merrilee Hughes, *Research Grants & KT Manager, School of Nursing, UBC*, for their thoughtful reading and valuable comments on earlier versions of this Brief.

We also thank the various people from the community who have contributed their knowledge and expertise to this Brief.

Executive Summary

The COVID-19 pandemic has riveted attention on the deep fault lines that exist globally and locally, as well as the physical and social suffering of people who continue to live on a low income, especially those who have experienced systemic discrimination. Ongoing documentation during the pandemic has shown that different population groups are disproportionately impacted. In this submission, we aim to contribute to the Government of B.C.'s long-term plan, as outlined in *Budget 2022*, to restore ground lost in this pandemic, and to work towards a more prosperous future, inclusive of all British Columbians.

Related policy action requires a comprehensive understanding of the lived experiences of diverse peoples of all ages, families, and communities, and the deployment of resources that are most relevant within each context. Governments should provide not only financial resources, but also resources that enable people to navigate complex social and health systems. Such policy action necessitates significant time, resources, and clinical expertise in social and health care planning, including the delivery of health and social services by professional groups, policy makers, and governments.

We hope that the following recommendations, constructed from experiences “on the ground,” might be useful strategies for action as the government moves forward in implementing its plan during this pandemic and thereafter to decrease income inequity and improve health in the Province of B.C. The recommendations build towards the right of all British Columbians to a dignified life, with all basic necessities of life adequately and equitably available to everyone (1).

Key Recommendations

We commend the Government of B.C. for the proactive initiatives outlined in *Budget 2022*. We provide recommendations that support implementation of the directions set in this Budget.

We recommend that the Government of British Columbia:

1. Commit to a **poverty reduction lens for all policies**, such that priority is given to policies that reduce income and social inequities across diverse populations, so that all people can experience their full potential. Policies should be inclusive of a living income for essential workers; comprehensive health, social, and educational services that are accessible and navigable; renewed public health services and mental health/substance use services, which were dismantled by COVID-19 and other cutbacks; and in-person resources to help citizens navigate government programs and supports. The goal is to restore ground lost in this pandemic, and to work towards a more prosperous future that is inclusive of all British Columbians.
2. Develop **British Columbia's child care system into a publicly funded and publicly managed** system of high quality, affordable, accessible, flexible and inclusive child care.
3. Engage with communities in developing programs and services to **overcome the barriers that children from low-income or otherwise insufficiently resourced households** may face. Such barriers may be experienced by, for example, Indigenous families; lone parent, immigrant and refugee families; and families supporting children living with disabilities. The goal ought to be that all children will be enabled to succeed in school, and achieve their full potential.
4. Invest in **intergenerational models of affordable community housing** (e.g., housing complexes) of mutual benefit to older adults at all income levels, as well as lone parent families living on a low income, and without extended family supports.
5. Prioritize resources and assistance that **enable families with persons with disabilities** (including infants, children, young adults, and older adults) **to navigate and access health, social, and educational programs and services** in a **timely manner**.
6. Provide sufficiently funded health care and social care resources for families and communities to enable **older adults to choose to age safely and with dignity at home or in respectful and well-resourced non-profit care environments**, regardless of family income.
7. Prioritize investment in jobs and skills training for an **inclusive and diverse workforce**.

Detailed recommendations on page 16.

Introduction

The Human Face of Suffering

“... a range of contemporary critical theories suggest that it is from those who have suffered the sentence of history — subjugation, domination, diaspora, displacement — that we learn our most enduring lessons for living and thinking.” – Homi K. Bhabha (2 p172)

We, the “Sylvia” Think Tank Policy Group, are a self-funded, diverse, intergenerational, and interdisciplinary group of academics, health care and social service practitioners, and community leaders involved in advocacy work. Our mission is to mobilize knowledge and evidence to influence health, social and public policy, and praxis-oriented action to reduce disparities in income and health, and to improve the quality of life for British Columbians from diverse backgrounds and across all age groups.

This submission³ focuses on the severe disruptions in everyday life, multiple losses, and the experiences of suffering resulting from the COVID-19 pandemic, which was announced by the World Health Organization on March 11, 2020. It follows upon the Brief submitted to the Minister of Social Development and Poverty Reduction in 2018 (3), in which we focused on poverty as a major social determinant of health, and made recommendations to contribute to reducing poverty in this province. As well, a meeting was held in 2018 between members of the “Sylvia” Think Tank and the Minister, Deputy Minister, and Senior Staff to discuss the Brief. A follow-up virtual meeting was held in 2021 with the Deputy Minister and Senior Staff. We commend the Government of British Columbia for the initiatives to reduce poverty, launched between our first submission and now.

As noted in the Government of B.C.’s *Budget 2022* (4 p50), “The 2020 Annual Report [on poverty reduction] showed that, as of 2019, B.C.’s overall poverty rate had decreased 29 per cent and the child poverty rate decreased 58 per cent below 2016 levels, thereby exceeding the province’s legislated targets.” But the pandemic, alongside the ongoing overdose crisis (5) and the other unprecedented events in the province over the past two years, have presented major challenges. The pandemic, in particular, has riveted attention on the deep fault lines that exist globally and locally, as well as the physical and social suffering of people who continue to live on a low income, especially those who have experienced systemic discrimination, including racism⁴(6–9). As acknowledged in your British Columbia November 2020 Ministerial mandate letter (10), people who experience such discriminatory practices suffer the burden of financial hardships and health inequities. Duan (11), who studied the relationship between the COVID-19 pandemic and people

³ Our submission is the outcome of virtual meetings by the “Sylvia” Think Tank Policy Group during the pandemic. The voices included in its crafting are those of Indigenous peoples, and non-Indigenous peoples from Settler and Immigrant populations, including those who identify with histories of diaspora and displacement.

⁴ **Systemic racism** “is enacted through routine and societal systems, structures, and institutions such as requirements, policies, legislation, and practices that perpetuate and maintain avoidable and unfair inequalities across racial groups, including the use of profiling and stereotyping” (6 p8). **Anti-racism** “is the practice of actively identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism. It is more than just being “not racist” but involves taking action to create conditions of greater inclusion, equality and justice” (6 p8).

living in poverty in the B.C. context, emphasized that groups including women, seniors, people with disabilities, recent immigrants, poor children, youth, and BIPOC (Black, Indigenous, People of Colour) communities are more at-risk for COVID-induced poverty.

In this submission, we aim to contribute to the government's long-term plan, as outlined in *Budget 2022* (4), to restore ground lost in this pandemic, and to work towards a more prosperous future, inclusive of all British Columbians. We draw on past and ongoing research and scholarly work with Indigenous and non-Indigenous peoples (6,12–27), clinical practice, and community advocacy⁵ to illuminate the ways in which past histories and structural inequities shape the experiences of suffering, and to help us interpret and give voice to what we have been witnessing in this pandemic. Our recommendations, crafted through the ethical lens of critical social justice (13,26,28–30), are aimed towards a more equitable future in which people can experience their full potential. Critical social justice is a useful lens to “help us attend to the power imbalances that are often at the root of systemic, or structural, inequities” (13 p286). Through this lens, our recommendations are intended towards reducing these power imbalances, which are often rendered invisible (or purposefully overlooked) in everyday life; and, towards the empowerment of those who are made vulnerable by their histories and the circumstances of their lives. In so doing, we embrace our shared humanity, Truth and Reconciliation with Indigenous peoples, and a future where all people can thrive (2,6,14,18,31,32⁶,33,34).

To relay evidence of the increasing income disparities across different population groups during the pandemic, we have constructed three narratives of suffering—stories that convey a sense of urgency, as well as the need for compassionate and effective policy action. With these composite stories (“realistic stories based on multiple narratives” (35 p1)), we aim to convey how the COVID-19 pandemic has impacted groups disproportionately. These stories reflect the experiences of:

1. a new mother who identifies as Indigenous (*narrated by a non-Indigenous public health nurse conducting a postpartum visit*);
2. an intergenerational family new to Canada (*narrated by a COVID-19 contact tracer*); and,
3. an older adult entering long-term care (*narrated from the perspective of two nursing academics with expertise in health care ethics as well as the care of older adults*).

⁵ Gail Bains has led advocacy work to improve the lives of people living with disabilities in a variety of roles (e.g., championing a cause, fundraising, working with agencies to develop resources). Helen Brown has been working to promote health equity with Indigenous peoples as an academic researcher through community-based participatory research and is a facilitator and champion for cultural safety and anti-Indigenous racism within nursing education and projects within health care and criminal justice systems. Ranjit Dhari has served on many community agencies, often as a volunteer and with cultural community groups, to raise awareness about what these communities experience with accessing resources, making communities aware of services available, making resources culturally appropriate (e.g., South Asian Covid-19 Task Force). Elder Roberta Price is the Lead Elder for Vancouver Coastal Health, the UBC Faculty of Medicine Family Practice Program and the UBC School of Nursing. Vera Radyo has worked with community agencies in advocating for and supporting early childhood development, women's issues, immigrant and refugees' issues, and international development. Brenda Sawatzky-Girling worked as a contact tracer during the COVID-19 pandemic, and works with First Nations communities on health and wellness planning.

⁶ In *Coolie woman: The odyssey of indenture* by Gaiutra Bahadur (32), attention is drawn to different histories of diaspora and displacement—which are often glossed over. These histories are shared by some of those who live and work in Canada. It will be important to recognize such histories, and to open up discursive spaces that will enable us to move towards a more inclusive, equitable, and socially just society.

Setting the context

Each story is a compilation drawn from multiple sources, including our academic research; clinical practice, including public health nursing and contact tracing; community engagement; engagement in advocacy work; and personal life experiences. These narratives are not published stories; they are blended from different experiences that we have had, or learned of, in different contexts working directly with people as well as drawing on other people's experiences, before and during the COVID-19 pandemic (35). To protect privacy, pseudonyms and altered details describe people, groups, places, and events. Finally, these narrative stories are not intended to represent all people in similar circumstances, or to imply that all individuals/families in these circumstances necessarily have similar strengths and challenges.

The Impact of COVID-19 on Indigenous Peoples

The first composite story we have constructed weaves together the experiences of a woman who identifies as Indigenous and is narrated from the perspective of a non-Indigenous nurse. This story draws on the expertise of an Indigenous Elder and two non-Indigenous nursing academics, one of whom is a former public health nurse. While the theme of this story, "Fear, mistrust, and immediate postpartum needs" depicts an Indigenous mother experiencing challenges, it also shows her resiliency. The story ought not to be seen as generalizable to *all* Indigenous women; we acknowledge the infinite diversity in Indigenous women's experiences, histories, needs, strengths, resources, and challenges.

Story 1: "Fear, Mistrust, and Immediate Postpartum Needs"

Gilda is a 27-year-old woman who identifies as Indigenous, and who is living in an urban setting having spent her life being raised by her grandmother on a rural reserve in Northern B.C. Gilda's mother was forced to attend Indian residential school, and Gilda and her siblings are estranged in the aftermath of trauma associated with residential schools and colonial-enforced poverty and displacement from ancestral homelands. Gilda is living in Vancouver and recently delivered her first baby in hospital and is now at home. Sarika, a public health nurse (PHN), in preparing for a first postpartum home visit to Gilda, reviews her chart and comprehensive health history that provides information about her life context. In doing so, Sarika recalls the importance of linking the social determinants of health with how poverty and trauma are continuous with colonialism and racism, and how these circumstances create immense barriers for women's access to safe, ethical, and humanizing perinatal care. Sarika reflects on the importance of connecting Gilda's move to an urban centre away from her grandmother and community as significant in assessing for social support during the early months of parenting her baby. Sarika also remembers the confirmation of mass graves on the sites of residential institutions across Canada in the summer of 2021 and how these ongoing traumas might impact Gilda and other new Indigenous mothers and their families.

During her pregnancy, Gilda was seen by a different PHN for one prenatal assessment. She was diagnosed with gestational diabetes on that visit, and was screened and determined to be at a high risk for postpartum depression. Due to PHNs being diverted to COVID-19-related services and programs (e.g., contact tracing and vaccine clinics), no additional

prenatal assessment or visits occurred during Gilda's pregnancy.

Gilda gave birth to her healthy baby and stayed for two nights in hospital. Gilda was intent on breastfeeding and experienced very common challenges during these early days, such as difficulty with positioning and latching. Notably, Gilda was discharged home without a Lactation Consultant referral or an infant feeding plan. Sarika visited Gilda one time at her apartment ten days after discharge and learned that Gilda was feeding her baby formula. Sarika attempted to assist Gilda with breastfeeding and yet together they were unable to successfully establish a latch. Sarika advised Gilda to rent or buy a breastfeeding pump and a nipple shield. During this time, post-partum services—including the breastfeeding clinic at the local health centre—were limited due to the pandemic. During the visit Gilda shared with Sarika that she was physically and mentally exhausted and did not have the strength, capacity, or support to inquire and locate the pump or shield, let alone seek out and access reproductive mental health resources. Gilda also shared that her partner, the baby's father, was on disability income assistance, and also that the geographical distance from their support systems on reserve were worsening her fears about social support and adequate income for their new family. However, Gilda showed her resilience when she discussed that she would connect with her grandmother by telephone.

Sarika left Gilda's apartment with a sense of not being able to do enough for Gilda; she wished she had more time to spend with this new mother, but also felt almost at the point of burnout from the extra hours and emotional toll of nursing during the pandemic. She reflected on Gilda's immediate needs related to postpartum recovery, newborn feeding and care, and the importance of being connected to family support and community agencies for mental health services, parenting support, income, and employment. Yet, Sarika knows that systemic racism experienced by Indigenous peoples within the B.C. health care system means that many stay away from care out of fear and mistrust of how they will be treated. Sarika reflected on the critical role that PHNs (such as herself) play in helping clients navigate barriers to accessing services, and how important it is to help clients tap into their strengths with regard to managing their lives, their health, and their family's well-being. Sarika also reflected on the critical need for more Indigenous nurses within the health care system to ensure culturally safe care and the integration of Indigenous approaches to health and well-being for mothers and infants. She also questioned the lack of prioritization of public health services to support women living within situations where material resources are lacking, poverty exists, and complex trauma histories endure.

Commentary

Indigenous peoples of B.C., such as *Gilda*, face ongoing barriers to health and social well-being directly stemming from historical and ongoing colonialism, including trauma associated with Indian residential schools, poverty, violence, racism and discrimination in the health care system, and displacement from ancestral lands (6,19). An equity approach to poverty reduction means targeting interventions towards those experiencing unfair and unjust barriers to health and well-being—treating *differences that matter differently*. This also requires working to address root causes of inequity such as those related to ongoing colonialism, both as advocates and allies alongside Indigenous peoples (36–38). It is critical to recognize that the very difficult experiences of many Indigenous families with institutions, including those in the health care system, often lead

people to avoid such interactions. Thus, policies to actively address underlying issues must be implemented to create trustworthy relationships with health care providers. Community-led and culturally safe⁷ services are needed that connect Indigenous women to resources to build on their strengths and cultural worldviews and practices within the context of parenting and mothering. Such approaches must necessarily include culturally safe and trauma and equity-informed (37,39,40) programs and services which are developed, implemented, and led by Indigenous health care providers to create safe and effective systems of perinatal care.

The Impact of COVID-19 on Intergenerational Families New to Canada

The theme of the second story we have constructed, “In very different shoes,” weaves together the experiences of an intergenerational family new to Canada that is having trouble making ends meet during the COVID-19 pandemic. A contact tracer working for the regional health authority narrates this story.

Story 2: “In Very Different Shoes”

In February 2021, Pritam, a 67-year-old South Asian man, received a call from a public health contact tracer, notifying him that because he had tested positive for COVID-19, he was required to self-isolate. The experiences of this man are similar to many newcomer families in B.C. who live in multigenerational families. For example, the phone number provided for contact tracing purposes belonged to Surinder, Pritam’s 36-year-old daughter-in-law. Surinder explained to Chris, the contact tracer, that the family had moved to B.C. 10 years ago and that her father-in-law, Pritam, spoke limited English; she then provided the contact tracer with Pritam’s direct cell phone number. The contact tracer called Pritam using a Punjabi interpreter via B.C. Provincial Language Services. Pritam explained that he and Surjit, his wife, both farmworkers, were exposed to COVID-19 in the shuttle van. The contact tracer relayed the public health information to Pritam and Surjit according to a prepared script, including that Pritam and Surjit were not allowed to work or leave their home for the 10-day isolation period because they were infected with COVID-19.⁸ Pritam emphasized that he was “feeling ok” and that his main concern was that he and Surjit needed to work—they could not afford to take time off.

Chris, the contact tracer, offered that Pritam could apply for the Canada Recovery Sickness Benefit. As Chris tried to explain how the benefit worked, he grew increasingly frustrated. The website URL was very long—and he realized that Pritam did not have or use the internet, so the website was irrelevant. Even with a phone number, Chris reasoned, how easy would it be for Pritam to access an interpreter for the call, and navigate the process? As a contact tracer, Chris had a heavy workload, and was unable to help each client

⁷ **Culturally safe care** is distinct from care defined as “culturally-based, informed, competent and/or sensitive care”; those approaches focus on cultural *differences* often conflated with ‘race’ or ethnicity. As per the First Nations Health Authority (39 para1), “Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.”

⁸ At the time that the interactions forming the basis of this story occurred, public health required people infected with COVID-19 (cases) to isolate for 10 days, and people exposed to COVID-19 (contacts) to isolate for 14 days.

navigate resources. In fact, it felt like it was doing more harm than good to suggest potential resources, and then to not be able to give any actionable information.

Because Pritam and Surjit had exposed their family members to COVID-19, all family members had to self-isolate within the home for 14 days. This meant that Surinder, their daughter-in-law who worked as a licensed practical nurse (LPN) in a long-term care home, could not go to work. Surinder worried that she may have infected the care home residents and that her older in-laws would get very sick with COVID-19. She especially worried about Deepa, Pritam's frail 91-year-old mother, who was vulnerable due to diabetes and kidney disease. For Surinder, balancing the needs of work, her in-laws, and her own children (including Ramandeep, her 6-year-old son with autism) was significantly more challenging during the pandemic. To make matters worse, Ramandeep's daycare for children with special needs had closed months before with no alternate supports provided. This meant that her husband, Lalli (Pritam's son), a real estate agent, had been bringing Ramandeep along to work with him. Surinder and Lalli were also disheartened with cutbacks to school-related services their son relied on, such as speech assessment. They were unsure what programs were available for their son and how to access them.

Overall, exposure to COVID-19 raised serious questions for this intergenerational family: Who was going to provide meals and groceries? Finances were tight—to order take away or bring in each meal for this family for 10 days would be expensive. How were they going to manage care for the child with autism? How were they going to protect their vulnerable (frail elderly) family members from contracting the virus? How were they going to care for family members who developed severe COVID-19 illness?

Commentary

Reflecting on the interactions with *Pritam's* family, the conversations stuck with Chris, the contact tracer, as he tried to imagine being in this position. This composite story highlights the issues that essential workers face, and the need not only for services and systems that are more readily available and easier to navigate, but also, paid time off from work when sick. For example, *Pritam* might be unable to navigate access to the Canada Recovery Sickness Benefit. It cannot be assumed that all individuals from immigrant families have people who can translate and navigate services and systems on their behalf. While intergenerational ties can provide an important source of instrumental and emotional support (notwithstanding frictions and psychological stressors) (15,16,25), this family was made vulnerable by life circumstances. Immigrants often fill low-paying jobs in the Canadian labour market, and subgroups of immigrants who are most likely to be overqualified (compared to non-immigrants) include people who immigrated recently, who are older, female, or who have lower levels of familiarity with English or French (11,41).

The Impact of COVID-19 on Older Adults

We turn now to the third composite story. The theme “After rent and utilities, there's not much left for Anne,” is narrated from the perspective of two nursing academics with expertise in health care ethics as well as the care of older adults. The story includes reflections on the vulnerability of older adults, including the impact of COVID-19.

Story 3: “After Rent and Utilities, There’s Not Much Left for Anne”

Anne is a 79-year-old woman, a Settler Canadian of Scottish descent, who is living alone on a government pension in a small apartment in a town in the interior of British Columbia. She has been widowed since her husband died suddenly of a heart attack twelve years ago. Anne has three adult daughters (and five grandchildren) living in Saskatchewan. She has longstanding hypertension, but is unable to gain access to a primary physician, and attends a local urgent care clinic when she needs a prescription refill for her blood pressure pills. Anne feels that she has developed a good rapport with Felicia, the Nurse Practitioner who works in this clinic, but she does not have the bus money or physical energy to attend the clinic regularly to see Felicia.

Over the past month, Anne started noticing some memory changes as well as occasional periods of dizziness, so she went into the urgent care clinic for a check-up. During her visit the Nurse Practitioner checked her blood pressure, which was elevated, and ordered follow-up tests, including tests for Anne’s memory changes. While waiting for these appointments, Anne was becoming more distressed. With the contact restrictions of COVID-19, she was feeling lonely and depressed in her small apartment, particularly as one of her closest friends had died in the past year. Her daughters were far away pursuing their own lives. Friends in her age group had problems of their own with chronic illnesses and loss of mobility. They too were feeling isolated. Furthermore, Anne was having difficulty “making ends meet.” After rent and utilities, she had very little left over for food. She couldn’t afford the rising food prices, and started to go to the local food bank, which she could walk to from her apartment.

Unfortunately, one day on a walk to the food bank, Anne tripped and fell on a broken piece of sidewalk. She lay on the ground in pain until a passerby found her 30 minutes later. Anne was transported by ambulance to the closest hospital, and she was diagnosed with a hip fracture. Her post-operative recovery was slow, and over the course of her hospitalization she had episodes of delirium which were not recognized or treated, as the staff at the hospital were overwhelmed with COVID-19 patients. COVID-19 also meant that Anne had minimal access to rehabilitation for her hip fracture while in hospital.

Anne expressed to the hospital social worker that she was eager to return to her apartment once she felt better. However, on further assessment, the health care team was concerned about her safety returning to the apartment. Given her lack of mobility, and her overall fragility, their judgement was that it was not safe for her to be on her own. The assistance that could be provided through the publicly funded system was not sufficient for the level of care that Anne needed at this time. Furthermore, she did not have the financial resources for private services that would allow her to remain in her apartment. She and her husband had lived a frugal life on a limited income, and what resources they had went to raising their daughters. Anne had been a “stay at home mother” and her husband’s job did not carry pension benefits. This meant that after his retirement, they lived on their government pensions. None of her daughters were in a position to provide financial support or move to B.C. to look after her. The hospital discharge planning team was therefore anticipating that Anne would need to be transferred to a long-term care facility, which left Anne feeling anxious and depressed, because being in “her own space” was very important to her.

Commentary

The narrative above regarding *Anne* illustrates the significant challenges facing many seniors in B.C. (42). According to the most recent Census data available, B.C. has the highest seniors' poverty rate of any province or territory in Canada (43). The Conference Board of Canada (44 para3) notes that: "Elderly poverty is both a social and a fiscal problem that will be exacerbated as higher percentages of populations in developed countries move into the over-65 demographic." We also know that older adults (and especially widows such as *Anne*) living alone are most at risk for poverty, which jeopardizes their ability to access health care and to remain in their own homes (44,45). Estimates indicate that one in three B.C. senior women living alone are poor, compared to senior men (46). Widows over the age of 75 are particularly vulnerable because pensions have traditionally been linked to employment (44). While older adults who are living alone on a low income or are impoverished in old age are not without agency, as *Anne's* story illustrates, they can face profound challenges. Fortunately, societal attention to the quality of care and support available to older adults has increased dramatically as a result of the COVID-19 crisis (27,47). For example, the B.C. Senior's Advocate (47) continues to warn of the serious impacts of COVID-19 outbreaks in long-term care homes, which have often been associated with inadequate sick leave for staff, reduced registered nurse staffing, and shared rooms. It has become evident that the Healthy Aging and Wellness Working Group's (48) three key mechanisms to pursue a new vision for the promotion of healthy aging remain highly relevant:

1. *supportive environments*: developing policies, services, programs, and surroundings that support healthy aging across all settings;
2. *mutual aid*: people supporting each other emotionally and physically, and sharing resources, ideas, information, and experiences; and,
3. *self-care*: people making choices and acting in the interest of their own health (ppvii-viii).

Pursuit of the initiatives above signals the growing awareness of, and attention to, the growing care and support needs of older adults in B.C. and beyond (27,49).

The Impact of COVID-19 on Women and Children

Following from the three stories above, we focus here on the issues that are surfacing for women and children. Living on a low income or in poverty increases the challenges of life and the ability to cope with them. Around the world, women make up almost 70 per cent of the health and social care workforce, and thus have borne a higher risk of infection and a greater proportion of job loss from the COVID-19 pandemic (45). Women in early and mid-life who are living on a low income or in poverty often need to balance work outside the home, childcare, care of elderly parents, and doing the housework. Many of these women are essential workers. The conditions described in earlier studies—such as low paid jobs without benefits and pension structures (12,44)—often contribute to women being less able to look after and care for themselves in ways that would promote health or manage chronic illness, and is one of the drivers of poverty in old age, such as in the case of *Anne*.

In the first story, we see a young woman, who is Indigenous, struggling with a newborn baby, in a fragile mental state, and possibly experiencing post-partum depression. *Gilda* had little energy to seek mental health services and even if she had, she may not have felt safe and there might have been few culturally safe resources to support her. In the second story, the women in the South

Asian family have the challenges of caring for a child with autism and also caring for a frail 91-year-old grandmother. The family was significantly challenged during the pandemic when *Ramandeep's* daycare for children with special needs had closed months before with no alternate supports provided. School-related services their son relied on, such as speech assessment, were cut back. In the third story, the challenges older women face, especially those living on a low income, come into stark focus. The resources that would enable many older adults to age with dignity in the setting of their choice, are not readily available. These examples profile health promotion and disease/injury prevention services dismantled by COVID-19 and other cutbacks; in particular for childbearing families, including maternal/newborn and early childhood programs, young adults, and older adults (50).

We know, from previous research, that what happens in childhood affects a person through life. Renowned UBC researcher, the late Clyde Hertzman and colleagues demonstrated that early childhood development plays a critical role in a person's health and welfare throughout their life, affecting everything from scholastic success to employment to physical health (23). In study after study, Hertzman's research teams demonstrated that poverty, inadequate social support, stress and lack of stimulation before age five can impact a person's life over the long-term, right through until old age (21). In fact, many adult health problems have their roots in early childhood: obesity, depression, heart disease, type 2 diabetes, and others. Hertzman and his team showed that children's environments—from the intimate circle of the family to the neighbourhood and broader social and economic contexts—impact the health and well-being of all children.

Good quality child care is a great equalizer. It can provide otherwise disadvantaged children with opportunities to succeed in school and in life. Child care is also important for women and groups who have lost jobs and income during the pandemic, and want to return to work. Prior to the pandemic, child care was seen as important. During the pandemic, the provincial government declared child care to be an essential service.

The pandemic served to highlight that B.C. needs a publicly funded and publicly managed system of child care. We commend the provincial government for its commitment to the \$10/day child care plan as an important vehicle to enable children to be adequately cared for when their caregivers are in the workforce. The \$10/day pilots have been shown to be extremely successful. In Greater Vancouver, for those not participating in the pilots, child care fees can be \$1,200/month to over \$2,000/month for infant care. Cost is not the only factor, as child care is often difficult to find. This creates barriers for low and middle-income families to enter the workforce and retrain, and creates stress on families. We are pleased with the federal-provincial agreement announced July 8, 2021 to implement \$10/day child care in B.C. within five years, and with the *Budget 2022* commitment to cut average child care fees in half by the end of 2022 for children under the age of six in licensed child care. We also commend the province for increasing the wage top-up of child care workers and the commitment to move child care programs into the Ministry of Education and Child Care by 2023.

According to a pan-Canadian advocacy organization, "Child care serves not only children and families, it is an essential component of equality and social justice and a necessary pre-requisite to job creation, economic renewal and growth" (22 para7).

From Evidence to Action

SUMMARY and RECOMMENDATIONS

Living on a low income or in poverty, one of the central themes in the stories constructed above—exacerbates the challenges of life and the ability to cope during this pandemic. *Gilda's*, *Pritam's* and *Anne's* stories highlight the significant difficulties in **navigating systems** to access the resources that governments and related agencies put in place to help those who needed them most. Clearly, some systems are not designed for those who do not have access to, or are challenged by technology, and who are not fluent in Canada's official languages. These challenges not only hampered people's ability to access the financial resources made available during the pandemic, and to follow the public health measures that would keep them safe, but also had consequences for their families, and their communities. The stories also highlight the potential for burnout and moral distress many health care and social care providers have experienced during the COVID-19 pandemic.

Gilda's story emphasizes the importance of always considering the role of history and context in promoting equitable and safe care for all childbearing women. Within the context of *Gilda's story*, the history of colonialism—that continues today—reveals how *Gilda's* life has been impacted by forced assimilation that has displaced many Indigenous people from homelands, families, and their culture (6,19). *Gilda's* move to Vancouver means she is a long way from the familiar support of her grandmother, and their Indigenous birthing and parenting teachings. An equity approach to poverty reduction means working to address root causes of inequity, such as those related to ongoing colonialism, both as advocates and allies alongside Indigenous peoples (36–38). For *Gilda*, this means the PHN *Sarika* may help *Gilda* build on her strengths by advocating for community supports within the urban setting, and potentially setting up virtual visits with her grandmother and Elders. There is the need to ensure that services are culturally safe and trauma and equity-informed (37,39,40), and where possible be designed, implemented, and led by Indigenous health care providers to create safe and effective systems of care.

Pritam's story highlights the issues faced by essential workers, like farmworkers, many of whom live in intergenerational families. As a society, we cannot function without essential workers as we have learned throughout the pandemic and the multiple “unprecedented” events over the past two years. Yet, many essential workers, some of whom are women and immigrants, live on a low wage. These people experienced higher risks of viral exposure in their work environments or while commuting to/from work when compared to people who were able to work virtually from home, and bore the brunt of COVID-19 infections across Canada (51,52). Most essential workers cannot afford to quit or take leaves from their jobs to “stay home” even when they might have felt it necessary to protect themselves and loved ones, as loss of income would worsen the slide into deeper poverty. When they had to go to work regardless, childcare was often an issue, as we saw with *Surinder* and *Lalli*, *Pritam's* daughter-in-law and son. Thus, the links between poverty and health status move in more than one direction—they affect each other in mutually reinforcing ways. A fair or living income for essential workers would not only reduce their stress and enable people to provide support for their families, but it would also serve to increase staff retention and reduce fragmented service provision in some institutions, such as long-term care facilities.

Anne's story exposes the food insecurity that older people living on a low income experience (53). It also highlights the lack of resources in the community that would enable older people to choose where they would like to live towards the end of their lives. In our Western society, values of youth, power, “productivity,” and wealth predominate. The emphases on these values result in widespread devaluing of older people, who are no longer seen as “productive,” wage-earning members of society. The concomitant ageism generates a lack of respect, and undermines the dignity of those made vulnerable by attitudes to the aging process. The challenges that have been exposed during this pandemic (47,54,55), together with the increasing number of older adults in the coming years (42), will require a more positive attitude towards aging, innovative solutions with regards to housing, and a great deal of empathy and compassion as we move forward.

The ethical lens of critical social justice, through which this submission and recommendations have been developed, entails addressing income and other inequities on the basis of careful attention to the complex context of people's lives (13,26,28–30). Critical social justice includes initiatives such as a fair wage, paid time off from work when sick, access to different services that are navigable by those for whom these services are intended, including childcare, support for families, and resources that would enable older adults to age and die with dignity in the setting of their choice. It also includes adequate resources for those who are experiencing vulnerabilities due to disabilities, and other systemic barriers and life situations. Ethical and socially just practices entail **recognizing and eliminating systemic discriminatory practices** wherever these practices exist.

Related policy action therefore requires a comprehensive understanding of the lived experiences of diverse peoples of all ages (children, youth, adults, and older adults), families and communities, and the deployment of resources that are most relevant within each context. It is not only financial resources that are needed, but also those resources that would enable people to navigate (or be guided by knowledgeable people through) complex social and health systems. In addition, in-person resources, such as live telephone answering service, are essential access points for many citizens seeking information from government agencies. Such policy action necessitates significant time, resources, and clinical expertise in social and health care planning, including the delivery of health and social services by professional groups, policy makers, and governments.

We hope that the following recommendations, constructed from experiences “on the ground,” might be useful strategies for action as the government moves forward in implementing its plan during this pandemic and thereafter to decrease income inequity and improve health in the Province of B.C. We advocate for all levels of government to continue to: work collaboratively alongside local non-profit organizations; engage people from each of the community agencies and population groups (in particular, Indigenous peoples, people living on a low income, people new to Canada, families with persons with disabilities, and older adults) in providing collaborative input and leadership into the implementation of these recommendations; and, finally, to integrate appropriate accountability measures.

Recommendations

We commend the Government of B.C. for the proactive initiatives in *Budget 2022*, which we believe, when implemented will help us move towards a more equitable and socially just society. Our recommendations are aimed to restoring ground lost in this pandemic, and a more prosperous future that is inclusive of all British Columbians.

We recommend that the Government of British Columbia:

1. Commit to a **poverty reduction lens for all policies**, such that priority is given to policies that reduce income and social inequities across diverse populations, so that all people can experience their full potential, and inclusive of the following:
 - a. a living income for essential workers to increase staff retention and reduce fragmented service provision; with paid sick time off work (number of days to be agreed upon across different jurisdictions);
 - b. investment in affordable and accessible housing for young adults and families to allow them to live in the communities in which they work;
 - c. provision of comprehensive health, social, and educational services that are accessible and navigable by those who are challenged by inequities related to language, age, computer literacy and access, disabilities, special needs, mental health and substance use issues, and other related factors;
 - d. restoration of the public health services and mental health/substance use services which were dismantled by COVID-19 and other cutbacks; in particular health promotion and disease/injury prevention for those needing them, including childbearing families, maternal/newborn and early childhood programs, young adults, and older adults; and,
 - e. restoration of in-person resources (e.g., live telephone answering service, in addition to online and automated voice messages) to help citizens navigate government programs and supports.
2. Develop **B.C.'s child care system into a publicly funded and publicly managed** system of high quality, affordable, accessible, flexible and inclusive child care:
 - a. transition existing child care programs to \$10/day sites;
 - b. address the chronic shortage of child care spaces by expanding public and non-profit child care spaces through infrastructure investments;
 - c. expand school age child care (before and after school) on elementary school grounds;
 - d. give priority to expanding culturally-safe Indigenous child care developed by or in collaboration with Indigenous communities;
 - e. ensure access to child care for new immigrants, refugees and other populations that are vulnerable as a result of their circumstances;
 - f. expand training opportunities to ensure highly trained early childhood educators meet the growing needs; and,
 - g. ensure early childhood educators are paid a fair wage, based upon their experience and qualifications.

3. Engage with communities in developing programs and services to **overcome the barriers that children from low-income households or otherwise insufficiently resourced households** may face. Such barriers may be experienced by, for example, Indigenous families; lone parent, immigrant and refugee families; and families supporting children living with disabilities. The goal ought to be that all children will be enabled to succeed in school, and achieve their full potential. Successful schooling is foundational to closing the gap between well-off people and those living in poverty. Children should have access to:
 - a. free transit passes or access to a school bus;
 - b. nutritious breakfast and lunch in schools;
 - c. inclusion-based programming for school activities;
 - d. after school programs that provide social and educational experiences for students who do not get them at home;
 - e. teachers with the required resources to help children from low-income households who need extra support in the classroom; and,
 - f. mentoring programs and financial aid to foster post-secondary progression for children from low-income families.

4. Invest in **intergenerational models of affordable community housing** (e.g., housing complexes) of mutual benefit to older adults at all income levels, as well as lone parent families living on a low income, and without extended family supports. Such housing would include daycare facilities for younger children, and the resources to meet the needs of older adults, with built-in opportunities for children of all age groups to interact with older adults. Rents should be on a sliding scale according to income, to prevent ghettoization along the lines of age, race, and income. The expected outcomes are to:
 - a. provide opportunities for children to interact with “grandparent” figures to increase intergenerational social skills, empathy, emotional intelligence, social support networks, and a sense of community belonging and responsibility;
 - b. increase cognitive engagement in older adults and prevent social isolation and cognitive decline;
 - c. increase social support networks for lone parent families, and improve mental health;
 - d. provide safe and affordable communities for older adults and lone parent families without family support networks; and,
 - e. decrease “crisis management” of older adults, and families, and the associated human suffering and financial expenditures.

5. Prioritize resources and assistance that enable **families with persons with disabilities** (including infants, children, young adults, and older adults) **to navigate and access health, social and educational programs and services**. Enable people of all ages with disabilities and complex health challenges to access the services they need **in a timely manner**, and to **seamlessly transition** into educational systems, skills training, the job market, and retirement.
 - a. for infants with potential disabilities, early diagnosis is a priority. Services should occur within one to two months (as soon as possible), with the goal that these individuals can be as high functioning as possible; and,

- b. for children and young adults with known disabilities, future health, social, and educational program and service needs are usually anticipated. The goal is a smooth transition, without waiting lists or obstacles, into these programs and services. Particularly important is the transition from 18 to 19 years of age, when many families are not able to provide proper care for their young adult children because they already have full time jobs.
- 6. Provide sufficiently funded health care and social care resources for families and communities to enable **older adults to choose to age safely and with dignity at home or in respectful and well-resourced non-profit care environments**, regardless of family income. Older adults and their caregivers should have access to:
 - a. greater allocation of resources (including those living with dementia/Alzheimer's disease) to allow them to be cared for by trained support staff at home;
 - b. more hours and consistent scheduling of home support that also provides respite to caregivers;
 - c. better links between home care, assisted living, and long-term care services, with frequent client assessments to ensure that home supports are sufficient, with facilitated transitions between services if required;
 - d. health care assistants who earn better wages and have job security, that allow for consistent support to families (instead of support staff changing all the time that can be confusing for aging adults); and,
 - e. not-for-profit, integrated housing complexes, that provide a continuum of care from independent living, assisted living, long-term care, and end-of-life care, to enable people to age and die in place, if they so wish.
- 7. Prioritize investment in jobs and skills training for an **inclusive and diverse workforce**, in particular:
 - a. Indigenous-led, solidifying partnerships between industry and provincial, federal and First Nation governments;
 - b. people whose jobs are made obsolete by global concerns such as the COVID-19 pandemic or the transition away from fossil fuels;
 - c. immigrants and refugees, as well as resettlement programs, to foster integration into Canadian society; and,
 - d. adults with intellectual and developmental disabilities to build capacity to function in society.

These recommendations build towards the right of all British Columbians to a dignified life, with all basic necessities of life adequately and equitably available to everyone (1).

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