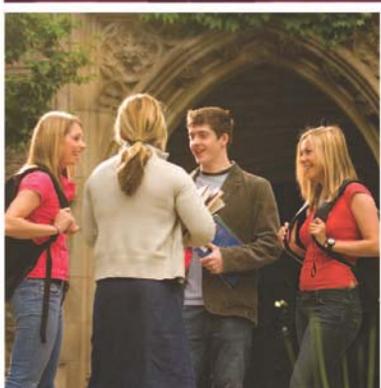




SUPPORTING NEIGHBOURHOOD-BASED
APPROACHES TO ADDRESSING POVERTY
CONCENTRATION AND ITS IMPACTS
ON HEALTH IN HAMILTON



EVIDENCE >> INSIGHT >> ACTION

Issue Brief:
**Supporting Neighbourhood-Based Approaches to Addressing
Poverty Concentration and its Impacts on Health in Hamilton**

6 October 2011

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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KEY MESSAGES

What's the problem?

- Poverty is a cause of poor health, child development and social outcomes.
- Poverty is spatially concentrated in Hamilton, making problems of poverty and health worse. Concentrated poverty can result in 'deprivation amplification' whereby the negative effects of poverty on individuals and families are magnified when these groups live in neighbourhoods with a high level of poverty. Moreover, it can be self-reinforcing, meaning that it is difficult for individuals, despite their best efforts, to escape the pattern of poverty.
- The inequalities in health between affected neighbourhoods in Hamilton are extremely large. But these inequalities are *avoidable*.
- More can be done to redress inequities between neighbourhoods.

What do we know (from available studies) about three viable options to address the problem?

- Option 1 – Coordinating local policy development and programming with a focus on neighbourhood-level approaches
 - There are numerous examples around the world of efforts to implement such a 'place-based' policy, such as Canada's Urban Development Agreements.
 - Evidence reviews show that locally based collaborations of appropriate institutions at the neighbourhood level can, in the long term, improve health and social outcomes.
 - One of the major challenges is to develop relations of trust and horizontal accountability across participating institutions.
- Option 2 – Targeting individual-based policy approaches at neighbourhoods with high concentrations of poverty, and advocating that other levels of government do the same
 - Most local activity is currently focused on reducing the *effects* of poverty on individuals, by providing resources through a broad range of services (e.g., job training) and other non-market mechanisms (e.g., food banks), and neighbourhood targeting of this activity has to some extent been the norm.
 - While evidence exists about the impacts of these resources on the lives of the individuals who receive them, we did not find specific evidence about the impacts of targeting them by neighbourhood.
 - Moreover, there is widespread agreement that reactive approaches, such as this one, are unable to address the root causes of a complex problem like poverty and poverty concentration.
- Option 3 – Reducing concentrated neighbourhood poverty and the social distance associated with it
 - Changing the composition of the groups living in or spending time in poor neighbourhoods is not a common approach to addressing place-based health and social inequalities.
 - The studies examining this option provided evidence both of intended benefits and of unintended negative consequences.
 - This option would be the most difficult option to implement and would take the longest time to achieve impacts, thereby requiring a sustained, long-term commitment by key institutions.

What implementation considerations need to be kept in mind?

- There are numerous barriers to overcome with some or all of these options:
 - lack of agreement among key local institutions on the objectives of initiatives to address poverty concentration, implementation strategies, monitoring and evaluation approaches, and timelines;
 - competing pressures that divert local institutions from a maximal contribution to the effort;
 - insufficient or delayed commitments by senior levels of government; and
 - difficulty of sustaining a long-term commitment to a coordinated approach.
- Four implementation strategies seem particularly germane to key local institutions, the first of which is engaging citizens and neighbourhoods in discussions about the optimal way forward.

REPORT

This issue brief was prepared in the context of great local concern about dramatic inequalities in health between neighbourhoods in Hamilton, which correspond closely with long-standing neighbourhood concentrations of poverty. There has been widespread awareness of the problem of concentrated poverty in Hamilton for a long time, but that concern has intensified since April 2010, when the Hamilton Spectator published a series of seven articles – called “Code Red: Where You Live Affects Your Health” – that documented significant concentrations of poverty in select Hamilton neighbourhoods, and showed the dramatic impacts on health.(1-8) The Code Red series reinforced the findings of a variety of other reports including the ongoing Vital Signs series and the findings of many reports by the Hamilton Social Planning and Research Council and other researchers.(9-11)

After the Code Red series was published, the findings were discussed at a community forum convened on 22 April 2010, where significant attention was devoted to the question ‘what next?’ Many local institutions have since begun to formulate a response to the question of ‘what next?’ including the City of Hamilton, which, among other responses, created and filled the new position of Director of Neighbourhood Development Strategies.(12) The Hamilton Community Foundation and other local institutions continued to support neighbourhood-based initiatives and also sponsored the production and dissemination of the latest Vital Signs report in November 2010, which provided further impetus to action on this topic.(9) The Social Planning and Research Council of Hamilton continued to produce neighbourhood-focused maps and reports to inform local activities.(10;11)

Eighteen months have now passed since the publication of the Code Red series and it seems an appropriate time to ask the question: what can key local institutions do individually and collectively to better support neighbourhood-based approaches to addressing poverty concentration and its impacts on health in Hamilton?

Box 1: Background to the issue brief

This issue brief mobilizes both global and local research evidence about a problem, three options for addressing the problem, and key implementation considerations. Whenever possible, the issue brief summarizes research evidence drawn from systematic reviews of the research literature, and occasionally from single research studies. A systematic review is a summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select and appraise research studies, and to synthesize data from the included studies. The issue brief does not contain recommendations.

The preparation of the issue brief involved five steps:

- 1) convening a Steering Committee comprised of representatives from key stakeholder groups and the McMaster Health Forum;
- 2) developing and refining the terms of reference for an issue brief, particularly the framing of the problem and three viable options for addressing it, in consultation with the Steering Committee and a number of key informants, and with the aid of several conceptual frameworks that organize thinking about ways to approach the issue;
- 3) identifying, selecting, appraising, and synthesizing relevant research evidence about the problem, options and implementation considerations;
- 4) drafting the issue brief in such a way as to present concisely and in accessible language the global and local research evidence; and
- 5) finalizing the issue brief based on the input of several merit reviewers.

The three options for addressing the problem were not designed to be mutually exclusive. They could be pursued simultaneously, or elements could be drawn from each option to create a new (fourth) option.

The issue brief was prepared to inform a stakeholder dialogue at which research evidence is one of many considerations. Participants’ views and experiences and the tacit knowledge they bring to the issues at hand are also important inputs to the dialogue. One goal of the stakeholder dialogue is to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. A second goal of the stakeholder dialogue is to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

Key concepts

There is a great deal of debate about the definition of poverty and how to measure it. Canada has no accepted definition of poverty or ‘poverty line.’ Statistics Canada has several operational definitions of poverty, but the most commonly used is the ‘low-income cut-off,’ which is defined as “income levels at which families or persons not in economic families spend 20% more than the average of their before tax income on food, shelter and clothing.”(13) While this notion focuses on the bare necessities to ensure subsistence, broader notions of the term poverty emphasize the resources needed for a person to participate in activities that are common in society, and to be socially included. The impact on social inclusion is described by Ross and Shillington in the following way: “someone who has so little that he or she stands out in relation to the surrounding community will rightly feel deprived.”(14)

Neighbourhood is another elusive term to define and operationalize. One of the widely accepted definitions, however, is that a neighbourhood is a “bundle of spatially based attributes associated with clusters of residences, sometimes in conjunction with other land uses.”(15) Also, communities of interest may define their geographic boundaries differently so neighbourhoods can have overlapping boundaries.

The percentage of people in a neighbourhood who have incomes below Canada’s low-income cut-off is a commonly used indicator of neighbourhood poverty levels. However, there is no accepted threshold at which a neighbourhood is said to have concentrated neighbourhood poverty. Instead, this issue brief uses the term to mean *relative* concentrated neighbourhood poverty (i.e., relative to other neighbourhoods).

In many instances, the term health is defined broadly, and that is the case in this brief. The World Health Organization (WHO) defines the term as “not merely the presence of disease or infirmity,” but as “a state of complete physical, mental, and social well-being.”(16) Health is also often considered not just a state, but also “a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.”(17)

Health equity and social equity are at the core of the problem addressed in this brief, however, it is valuable to define some terms related to equity/inequity and the related concepts of equality/inequality. The basic difference is that *inequality* refers to an unequal state of affairs - for example, health differences between groups -

Box 2: Equity considerations

A problem may disproportionately affect some groups in society. The benefits, harms and costs of options to address the problem may vary across groups. Implementation considerations may also vary across groups.

One way to identify groups warranting particular attention is to use “PROGRESS,” which is an acronym formed by the first letters of the following eight ways that can be used to describe groups†:

- place of residence (e.g., rural and remote populations);
- race/ethnicity/culture (e.g., First Nations and Inuit populations, immigrant populations, and linguistic minority populations);
- occupation or labour-market experiences more generally (e.g., those in “precarious work” arrangements);
- gender;
- religion;
- educational level (e.g., health literacy);
- socio-economic status (e.g., economically disadvantaged populations);
- and social capital/social exclusion.

The issue brief strives to address all citizens, but (where possible) it also examines whether and how existing data and research evidence give particular attention to:

- 1) poor and marginalized citizens who don’t live in neighbourhoods with high poverty concentrations; and
- 2) ‘middle’ neighbourhoods that have some worrying trends but don’t meet the definition of neighbourhoods with high poverty concentrations.

Many other groups warrant serious consideration as well (e.g., homeless people, new immigrants and people living with mental illness), and a similar approach could be adopted for any of them.

† The PROGRESS framework was developed by Tim Evans and Hilary Brown (Evans T, Brown H. Road traffic crashes: operationalizing equity in the context of health sector reform. *Injury Control and Safety Promotion* 2003;10(1-2): 11–12).

while use of the term *inequity* implies that such a state of affairs is unfair or unjust in some way.(18)

Health inequalities that exist between neighbourhoods in Hamilton are caused by social inequality. Health inequalities are different from health inequities. Health *inequities* are differences in people's health that are unnecessary, avoidable, unfair and unjust.(18) Such differences could be changed with appropriate and adequate action. People with low incomes are also more likely to be marginalized in other ways, including being a member of a minority ethno-racial group,(19) having a disability (physical or mental),(20) and suffering from addictions and mental health problems,(21) making health inequities multi-dimensional.

Local action to address poverty

For several years there has been a great deal of organized activity around the issue of city-wide poverty in Hamilton. This activity has necessarily touched upon concentrated poverty as well. Hamilton has a poverty rate above the provincial average,(22) and influential institutions such as the Hamilton Affordable Housing Flagship, Hamilton Community Foundation, Hamilton Roundtable for Poverty Reduction, and Social Planning and Research Council, have all been leaders in advocacy and programming in the area of poverty reduction. The Hamilton Spectator began its formal commitment to awareness-raising about poverty in Hamilton in 2005 with the launch of the 'poverty project.' The Spectator continues its leadership on this topic, notably with the publication of Code Red and also a pre-election poll in October 2010 about citizens' willingness to spend more money on poverty reduction: 80% supported the idea.(23)

A number of other prominent complementary foci have been present in the city, including the Hamilton Jobs Prosperity Collaborative, which has worked hand-in-hand with the Hamilton Poverty Reduction Roundtable to address the intersection between prosperity (attracting business investment, job creation and retention, etc.) and poverty. Other organizations included in such activities include the Hamilton Hive Young Professionals network and the Hamilton Chamber of Commerce.

One of the important themes around poverty and prosperity in Hamilton has been the need to address early childhood development and inequalities in the start that children get in life. A large number of charitable, government and not-for-profit organizations deliver programs for children, and perhaps most importantly, as a result of the leadership of the Hamilton Poverty Reduction Roundtable, Hamilton has as its aspirational mantra to be "the best place to raise a child."(24)

Despite all of the excellent local work, the activities of one or more institutions may be inadvertently undermining the efforts of other institutions, and making the problem worse (or at least not improving it). In addition, there may be unnecessary duplication of effort and resources that signal an opportunity to rationalize and do more with the same resources.

Box 3: Mobilizing research evidence about the problem

The available research evidence about the problem was sought from a range of published and "grey" research literature sources. Published literature that provided insights into alternative ways of framing the problem was sought using the qualitative research "hedge" in MedLine. Grey literature was sought by reviewing the websites of a number of Canadian and international organizations.

Priority was given to research evidence that was published more recently, that was locally applicable (i.e., applicable to Hamilton, Ontario and Canada more generally), and that took equity considerations into account.

Attention given to poverty by senior levels of government and by international organizations

These local activities have resonance with provincial government priorities in several areas. Although the Ontario government has not historically been focused on neighbourhood-based concentrations of poverty, it does have important initiatives related to the problem at hand, including the provincial poverty reduction strategy,(25) the ongoing development of a mental health strategy, and a significant focus on select determinants of health, including education and disabilities. The government does not have a particular focus on health inequalities, although the enabling legislation for the new Ontario Agency for Health Protection and Promotion – now called Public Health Ontario – includes an emphasis on health equity.(26) Some preliminary work has taken place regarding the development of an integrated health and human services plan to address health equity with a whole-of-government approach within the province. This kind of initiative has the potential to facilitate efforts to address neighbourhood-based concentrations of poverty and its impacts on health.

At the federal level, the Canadian government has not historically focused on neighbourhood-based concentrations of poverty, although there are a few exceptions. Tripartite and multi-sectoral Urban Development Agreements, which seek to coordinate investment and action to tackle complex problems of distressed neighbourhoods, have existed in Vancouver and Winnipeg for 20 years (although they have expired and not been renewed by the current government), and they have also been struck in Edmonton, Regina, Saskatoon and Victoria. These agreements are implemented through Western Economic Diversification Canada, and have been the vehicle for several notable initiatives, including InSite (the supervised injection site in Vancouver), the re-development of a large vacant commercial space, and the the development of a significant amount of supportive housing. In Winnipeg, the Urban Development Agreement has resulted in a significant re-development of the downtown and a more coordinated approach to dealing with poverty among aboriginal people.(27;28)

Also at the federal level, the Canadian government has recently made a significant investment in the Mental Health Commission of Canada, and is engaged in demonstration projects in five cities to determine the impact of supportive housing for people with severe mental illness on social functioning and health outcomes. Several federal institutions have recently produced reports that address health inequalities (e.g., Chief Public Health Officer and Canadian Population Health Initiative),(29;30) at least some of which address healthy urban places. There is a longer history of Senate investigations and reports that focus on the impact of poverty on health and other social outcomes in Canadian cities (e.g., reports by Keon, Kirby and Eggleton).(31-33)

Internationally, the European Union and Organization for Economic Cooperation and Development (specifically its Territorial Policy Development Committee) have given some attention to concentrations of urban poverty, with a focus on its potential as an impediment to economic growth. Place-based policy frameworks have been adopted in a number of other jurisdictions, most visibly (for Canadians) in the United Kingdom, where the Labour government supported a number of area-based initiatives (e.g., Health Action Zones, New Deal for Communities), and now the Conservative/Liberal Democrat coalition is beginning to support ‘new localism’ through neighbourhood-based responses to its concept of a ‘big society’. Urban health was a focus for one of the global knowledge hubs of the World Health Organization’s Commission on the Social Determinants of Health (and the World Health Organization has also supported related domains such as the Healthy Cities Movement).

THE PROBLEM

There is a long-standing pattern of concentrated poverty and poor performance on a variety of health, child development and social indicators in Hamilton's lower city. Life expectancy, low birth weight rates, high school drop-out rates and child development outcomes all show a very disconcerting, large gap between Hamilton's poorest neighbourhoods and the rest of the city,(1-8) which is a reflection of concentrated poverty and its consequences. At the same time, there has been a renewed interest among Hamilton's major institutions and in the community at large to attempt to redress this. It is well-known that Hamilton has an overall poverty rate that is higher than the provincial average, but an added challenge to the problem in Hamilton is the concentration of poverty in several neighbourhoods in the lower city.(22)

Poverty is a cause of poor health, child development and social outcomes

There is now a large body of evidence that shows a strong relationship between an individual's socio-economic status and their health status.(34) It is widely accepted that the lower one's socio-economic status (whether measured by income, educational attainment, social class), the higher the risk of a wide range of poor health outcomes, across many different disease and conditions, including child development outcomes, accidents, injuries, suicides, most cancers, heart disease, stroke, mental illness and infectious diseases (for a summary, see the WHO Commission on the Social Determinants of Health(35)). The evidence for this relationship spans all affluent countries of the world, and more than a century of recorded history of the relationship between socio-economic status and health. Moreover, the relationship between income and health does not just apply to the poor – at all income levels, the higher one's income the better their health, suggesting that both absolute and relative poverty are important.(35)

Because the relationship between income, or socio-economic status, and health exists for many diseases and conditions, it is thought to reflect in part an underlying vulnerability that expresses itself through different diseases and conditions (i.e., how the body responds to chronic, persistent stress, especially stressors associated with a lack of control over daily living circumstances). For example, stress undermines the immune system, making us more vulnerable to infectious diseases, and the endocrine system, affecting heart disease, stroke, fertility, obesity and other conditions.(36) Stress also affects brain and other aspects of development in children and functioning in adulthood resulting in mental illness and disability.(36) The relationship between poverty and poor health can also reflect material conditions, such as unhealthy housing.(37)

Poverty is spatially concentrated in Hamilton, making problems of poverty and health worse

The Spectator's Code Red report suggests that there is an added disadvantage to living in concentrated poverty. In other words, if one is poor and lives in a poor neighbourhood, this tends to be worse than being poor and living in a neighbourhood with a broader mix of incomes (although even in the former situation there can be positive outcomes associated with large numbers of poor people living in proximity to one another, one of which is the critical mass needed to sustain some social agencies). This impression is reinforced by a large body of evidence showing that characteristics of neighbourhoods often have an additive effect on health, over and above the characteristics of individuals that live in those neighbourhoods.(38;39) Being poor and living in a poor neighbourhood tends to be strongly associated with a variety of types of worse health outcomes, notably mental health, heart disease and healthy child development, than being poor and living in a more mixed-income neighbourhood.(40)

Concentrated urban poverty has been a significant social concern associated with urbanization and industrialization for hundreds of years, dating back to pioneering public health reforms in early industrialized England. In its current form, concentrated urban poverty is no longer as closely tied to concerns about the spread of infectious diseases from concentrated urban poor residents to the upper classes, as it once was. Instead, it is the way that the unjust nature of poverty and its effects on health is made visible, and for others it is enlightened self-interest that motivates their concern. The level of concern about concentrated urban

poverty has waxed and waned over the past 200 years, and here in Hamilton it has re-emerged. As we noted earlier, there is no accepted definition or benchmarks for concentrated poverty, however, Code Red and Vital Signs have provided vivid illustrations of the phenomenon.(1-9)

Concentrated poverty can result in what has become known as ‘deprivation amplification’,(41) whereby the negative effects of poverty on individuals and families are magnified when these groups live in neighbourhoods with high levels of poverty. Moreover, the spatial concentration of poverty and related social and physical isolation can be self-reinforcing, whereby it is difficult for individuals, despite their best efforts, to escape the pattern of poverty, poor social outcomes and poor health, other than under exceptional circumstances. Poverty and other forms of disadvantage tend to cluster together, so that people of colour, immigrants and people with both physical and mental disabilities also tend to be poorer.

The inequalities in health between affected neighbourhoods are extremely large.(1-8) But these inequalities are *avoidable*. In numerous other societies and cities, the magnitude of health inequality is considerably smaller, implying that it is clearly possible to achieve a more equitable outcome. Usually these societies are characterized by lower levels of income inequality, more generous family support programs, more extensive programs for early child development and greater supports for vulnerable and/or marginalized groups, including immigrants, people with disabilities (both mental and physical), and other minority groups.(42)

‘Community capital’ is central to the relationship between poverty concentration and health

One way of thinking about the means by which concentrated poverty magnifies the risk of poor health is through the lens of what has been called ‘community capital,’(43) which is an umbrella term for five other kinds of capital that a community may or may not possess at levels that permit it to thrive. These five types of capital are physical, economic, human, social and cultural. Although lower-income, marginalized neighbourhoods tend to have lower levels of such capital assets to draw upon as resources, they do have many strengths and assets that can be mobilized. Moreover, there is some evidence that these capital assets are associated with a variety of health outcomes.(44)

We define each of the five kinds of capital in turn, as well as how each can act as a mechanism through which poverty and poverty concentration can affect health:

- Physical capital refers to resources in a neighbourhood that are tangible and visible, and include land, buildings, streets, heritage architecture and natural features. For example, well-maintained, attractive streets with vegetation as well as public transportation connections may promote physical activity, thereby improving health, but similarly, poorly designed streets and traffic patterns may also be a hazard and a risk for injury or exposure to air pollution.
- Economic capital refers to the overall income levels of residents of a community, the investment by businesses in facilities that provide economic activity and job opportunities, as well as commercial and retail activity, which provides jobs, street life and valuable services to residents. These resources are valuable to the health of residents in a neighbourhood because they provide incomes to people, venues for social interaction, and resources that support their everyday lives (e.g., banks).
- Human capital refers to skills, knowledge, credentials, physical and mental capacity, and overall capabilities that residents possess that act as resources for their own lives. Human capital includes levels of early child development, educational attainment, and the acquisition of skills and credentials. Two aspects of human capital are of concern for neighbourhoods, both human capital *production* and human capital *retention*.
- Social capital refers to the social networks, which can bond similar people together collectively and act as a bridge between diverse people, with norms of reciprocity.(45) Social capital is known as a form of capital that is not limited by material scarcity, and it can be productive given that it also consists of “relationships, networks and norms that facilitate collective action.”(46)
- Cultural capital, according to Roseland, is “the product of shared experience through traditions, customs, values, heritage, identity, and history,”(43) and as such it is an important ingredient of social capital.

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Enhancing cultural capital demands attention to building place identity and image, as this is one of the ways that people come to have shared experiences, cultural knowledge, the arts, diversity, traditions and values, as well as social history.

The term *capital* is used quite deliberately to describe these phenomena, because these phenomena represent assets available to the community. Moreover, most forms of capital are enhanced by use, not depleted. Using the networks and relationships that comprise social capital for a collective purpose in a community, for example, can actually *enhance* that collective capacity for use in the future. This is also true of cultural capital, human capital, and some forms of economic capital and physical capital.

More can be done to redress inequities between neighbourhoods

As a result of the publication of Code Red, the City of Hamilton and its partners have taken preliminary steps to develop a more strategic and coordinated approach to neighbourhood development. A number of successful initiatives already exist and a number of institutions are engaged in activities that are also aimed at redressing the problems of concentrated neighbourhood poverty. That said, this is a complex, multi-dimensional problem that requires long-term commitments from relevant partners, and strategies for tracking results and ensuring horizontal accountability. There remain a number of challenges for the broad spectrum of stakeholders, at all levels, to collaborate and act in a more coordinated and strategic fashion.

More can be done, for example, in terms of greater coordination and integration of service delivery, program planning and policymaking. Mandated institutional responsibilities and vertical accountabilities often act as barriers to the coordination of health and human services programs, and of staff across institutions. Greater coordination could entail both the breadth (number of institutions involved) and depth (intensity) of collaboration. Another possible element of coordination is developing mechanisms for greater cross-institutional mutual learning from pilot projects (e.g., McQuesten neighbourhood project). This would allow for the application and adaptation of similar approaches to other areas, or scaling up to an appropriate level.

Another domain where more could be done is in cost- (and savings-)sharing arrangements, as there are few mechanisms for cost-shared, coordinated programs between institutions that could create more effective programs and policies and a net savings. Examples of such programs may include, but are not limited to: 1) coordination of hospital-based mental health services, innovative policing practices and supported housing for people with severe mental illness and concurrent disorders, in order to reduce hospital use and recidivism; and 2) coordination of recreational programming, school resources and social engagement for specific groups, such as youth, seniors or young parents.

Greater coordination requires careful attention to governance arrangements. There are no existing institutions that provide a governance structure that would maximize the synergies and minimize the contradictions among the activities of anchor institutions in Hamilton. Moreover, there are few mechanisms that provide feedback on the effectiveness of initiatives undertaken by individual institutions or groups to enhance future action. To be most effective, this would include a formal commitment to horizontal accountability among partners. Another major challenge is citizen engagement, as citizens are consulted but rarely engaged in local planning and performance measurement.

THREE OPTIONS FOR ADDRESSING THE PROBLEM

There are a number of different ways to approach the problem of concentrated neighbourhood poverty and its effects. To encourage discussion about the advantages and disadvantages of different strategies, three possible options are suggested: 1) coordinating local policymaking and programming with a focus on neighbourhood-level approaches; 2) targeting individual-based policy approaches at neighbourhoods with high concentrations of poverty, and advocating that other levels of government do the same; and 3) reducing concentrated neighbourhood poverty and the social distance associated with it.

The focus of each option is a broad policy approach, rather than specific programmatic content. In other words, each option is a ‘meta-policy’ that could define an overall approach for stakeholders in Hamilton to address this problem, with the specific elements of any initiative (policies, programs, strategies, etc.) to be determined in the future.

In this section, we focus first on what is known about these options and their strengths and weaknesses. In the next section we focus on barriers to adopting these options and strategies to overcome those barriers.

Option 1 – Coordinating local policymaking and programming with a focus on neighbourhood-level approaches

This option involves coordinating policymaking and programming for neighbourhood-based approaches, and for resource allocation and performance measurement more generally, to address poverty concentration (and its impacts on health) more effectively. Elements of this option might include:

- greater coordination of municipal policy development and other decision-making across sectors;
- greater prioritization within the resource allocation decisions of the municipal government and key local anchor institutions;
- greater coordination and targeting of programming across municipal government and other stakeholders;
- greater coordination and targeting of efforts to ensure access to or use of existing programs;
- greater emphasis on performance measurement and horizontal accountability;
- greater coordination of lesson-drawing from and scale-up of pilot projects; and

Box 4: Mobilizing research evidence about options for addressing the problem

The available research evidence about options for addressing the problem was sought primarily from two continuously updated databases containing systematic reviews, with one focused on public and population health focused interventions (<http://health-evidence.ca>) and a second focused on health system arrangements and implementation strategies within health systems (www.healthsystemsevidence.org). The reviews were identified by searching the databases for reviews addressing features of the options (first with poverty as a keyword to identify any ‘near perfect’ matches).

The authors’ conclusions were extracted from the reviews whenever possible. Where relevant, caveats were introduced about these authors’ conclusions based on assessments of the reviews’ quality, equity considerations, and relevancy to the issue. Otherwise, single studies were used, which introduces uncertainty about whether the studies provide only a partial or biased view of what is known.

Being aware of what is not known can be as important as being aware of what is known. When faced with an empty review, substantial uncertainty, or concerns about quality or lack of attention to equity considerations, primary research could be commissioned, or an option could be pursued and a monitoring and evaluation plan designed as part of its implementation. When faced with a review that was published many years ago, an updating of the review could be commissioned if time allows.

No additional research evidence was sought beyond what was included in the systematic reviews and single studies used. Those interested in pursuing a particular option may want to search for a more detailed description of the option, or for additional research evidence about the option.

- greater community engagement to inform the local planning (and evaluation) of programs and services and to enhance accountability.

There are numerous examples around the world of efforts to implement such a ‘place-based’ policy, and evidence reviews show that locally based collaborations of appropriate institutions can, in the long term, improve health and social outcomes.(47-50) Such a policy usually involves coordinating policymaking and programming among relevant stakeholders at the neighbourhood level. It can involve additional resource allocation to neighbourhoods where there is a greater concentration of poverty and locally led priority setting, but there is evidence of successful implementation both with and without additional targeted resources.(51) This kind of local approach has been argued to produce more appropriate policy and programs and better outcomes than top-down approaches to dealing with complex, entrenched, multi-stakeholder problems.(51)

Although local institutions may have limited mechanisms they can use to address poverty per se, they are not powerless to redress concentrated poverty and its effects. Certainly policies related to disability benefits and income supports, as well as unemployment and labour markets, are the responsibility of senior governments. Nevertheless, some of the issues related to concentrated poverty and its effects could be addressed by building synergies among institutions that already have an interest in and activities related to poverty in Hamilton. These institutions include the municipal government, school boards, higher education institutions, healthcare institutions, the Local Health Integration Network, social service providers, businesses, non-governmental organizations, foundations, collaboratives and roundtables. One of the major challenges is to achieve greater coordination between these institutions and create vehicles for them to develop synergies among their activities. Another challenge is to develop relations of trust and horizontal accountability, where answerability for horizontal programs occurs over and above hierarchical (vertical) chains of responsibility already in place within each of the participating institutions.

Two key examples of such initiatives are the United Kingdom’s New Deal for Communities and Canada’s Urban Development Agreements. The lessons available from the research evidence are similar for both examples.(51;52) The jurisdictional fragmentation that the Vancouver Urban Development Agreement sought to overcome is striking: 12 federal departments, 19 provincial ministries or agencies and 14 municipal departments, in addition to private sector, not-for-profit and community partners.(51)

As part of this option Hamilton could establish an Urban Development Agreement (or similar) place-based collaborative governance structure to address concentrated poverty and its effects. This may or may not include senior governments. The governance structure could then oversee the key elements of the option as described above.

We did not find any systematic reviews addressing particular features of this option, however, we did find a number of studies addressing some of the features (Table 1). In addition to the insights derived from these studies, deliberations about this option would need to draw on the tacit knowledge, views and experiences of policymakers and stakeholders. If time allowed, a focused systematic review could be conducted.

Table 1: Summary of key findings related to Option 1 - Coordinating local policymaking and programming with a focus on neighbourhood-level approaches

Category of finding	Summary of key findings
Benefits	<ul style="list-style-type: none"> • Participants report greater freedom to take risks than in a strictly vertical accountability structure • Coordination occurs with respect to a specifically defined, complex problem and across many stakeholders • Mutual learning takes place among stakeholders over a sustained period of time, allowing for more substantial coordination • Horizontal accountability increases(51) • Approach is flexible in terms of the issues that can be addressed (e.g., the United Kingdom’s New Deal for Communities addressed a spectrum from education, employment and health to crime and safety, housing and the physical environment, and community development)(53)
Potential harms	<ul style="list-style-type: none"> • Participating institutions may be distracted from other core functions • ‘Success’ would mean gentrification and displacement of poor and marginalized citizens • The absence of a sustained, long-term commitment from key local institutions and other levels of government may breed cynicism and defeatism among stakeholders and the community at large • Poor and marginalized citizens who don’t live in neighbourhoods with high poverty concentrations would not benefit • ‘Middle’ neighbourhoods that have some worrying trends but don’t meet the definition of neighbourhoods with high poverty concentrations would not benefit(54)
Costs and/or cost-effectiveness in relation to the status quo	<ul style="list-style-type: none"> • Main costs are interaction costs, however, these may be offset by savings from better coordination and by reduced duplication in activities among the partners
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the option were pursued)	<ul style="list-style-type: none"> • Applicability of some case examples is difficult to determine, particularly in situations where extraneous forces may undermine local efforts (e.g., provincial policies regarding mental health services, schooling and urban planning)
Key elements of the policy option if it was tried elsewhere	<ul style="list-style-type: none"> • Ingredients of successful efforts to establish governance structures for place-based, collaborative partnerships can include:(51) <ul style="list-style-type: none"> ○ Resource sharing ○ Leadership ○ Community involvement ○ Mutual learning ○ Horizontal accountability ○ Power sharing and decision rule of unanimous consent ○ Careful, collaborative identification of strategic directions and priority actions
Stakeholders’ views and experience	<ul style="list-style-type: none"> • Mainly positive, with participants reporting greater results than would have been possible without implementation of this option(55;56)

Option 2 – Targeting individual-based policy approaches at neighbourhoods with high concentrations of poverty and advocating that other levels of government do the same

This option involves targeting individual-based policy approaches at neighbourhoods with high concentrations of poverty (where there is local discretion to do so) and advocating for the federal and provincial governments and select stakeholders to target their poverty-reduction and related individual-based policy approaches at neighbourhoods with high concentrations of poverty, or to allow more flexibility for local stakeholders to do so. Elements of this option might include:

- greater compensation in funding arrangements for the higher needs for programs in neighbourhoods with high concentrations of poverty (e.g., supportive housing and education); and
- increased generosity in individual-based programs that reach citizens in neighbourhoods with high concentrations of poverty.

Most local activity is currently focused on reducing the *effects* of poverty on individuals, by providing resources through a broad range of services (e.g., job training, child care supports and health behaviour modification programs such as those targeted at reducing smoking) and other non-market mechanisms (e.g., food banks). Evidence indicates that this kind of activity can have a significant impact on the lives of the individuals who receive such resources.⁽⁵⁷⁾ Moreover, using neighbourhood concentrations of poverty to identify people in need of additional services that could improve their circumstances is a common approach to the issue of place-based health and social inequalities. The reasons for it being commonly used include ease of implementation, frequent successes in achieving satisfactory ‘reach’ in targeted neighbourhoods and in targeting limited resources to the highest need groups (i.e., those affected by deprivation amplification), and economies of scale for service providers working with a target group that is spatially concentrated. An important caveat is that a minority of low-income people actually live in neighbourhoods that are characterized by high concentrations of poverty.

While neighbourhood targeting of individual-based policy approaches has been the status quo in Hamilton for some time, the trend in the city has been to see the continued concentration of poverty, with negative consequences for child development, educational, social and health outcomes^(1-9;58). On the other hand, more targeting of these policy approaches could offer some benefit.

Reviews addressing the targeting of individual-based resources by neighbourhood specifically suggest that reactive approaches, such as this one, are unable to address the root causes of a complex problem like individual poverty, concentrated neighbourhood poverty or the factors that lead to its reproduction.⁽⁵⁵⁾ Although it is not reviewed here, it is likely that there is evidence that these programs aimed at individuals are making a difference to the well-being of those who receive them. In addition to the insights derived from these studies, deliberations about this option would need to draw on the tacit knowledge, views and experiences of policymakers and stakeholders. If time allowed, a focused systematic review could be conducted.

Table 2: Summary of key findings from systematic reviews relevant to Option 2 – Targeting individual-based policy approaches at neighbourhoods with high concentrations of poverty and advocating that other levels of government do the same

Category of finding	Summary of key findings
Benefits	<ul style="list-style-type: none"> • Greater compensation in funding arrangements can translate into greater availability of services, which in turn would likely make a difference to outcomes for individuals in need who receive them in the target neighbourhoods, particularly if the services included prenatal programs, parenting classes, childcare subsidies, job skills training, drug and alcohol treatment, mental health treatment, smoking cessation, health education, youth recreation, rehabilitation, micro-credit, rent bank/housing assistance programs, etc. • Similarly increased generosity of existing individual-based programs would likely make a difference to outcomes for individuals in need who receive them in the target neighbourhoods
Potential harms	<ul style="list-style-type: none"> • People with need for services outside target neighbourhoods are unaffected • Does not address root causes of neighbourhood poverty concentrations, and may just perpetuate the problem • May induce residential mobility among people in need to areas with greater services, thereby worsening the concentration of poverty(59) • Poor and marginalized citizens who don't live in neighbourhoods with high poverty concentrations would not benefit • 'Middle' neighbourhoods that have some worrying trends but don't meet the definition of neighbourhoods with high poverty concentrations would not benefit(54) • This option is already part of the status quo to some extent, and to reverse it may cause harm to individuals in obvious need
Costs and/or cost-effectiveness in relation to the status quo	<ul style="list-style-type: none"> • Costs are likely to be high, and are already high
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the option were pursued)	<ul style="list-style-type: none"> • Applicability of some case examples is difficult to determine
Key elements of the policy option if it was tried elsewhere	<ul style="list-style-type: none"> • There are no agreed-upon elements to such a policy approach, other than the geographical targeting of disproportionately higher levels of service/resources
Stakeholders' views and experience	<ul style="list-style-type: none"> • Widespread dissatisfaction with such approaches for their failure to address root causes, and concerns about meeting the needs of people outside such areas

Option 3 – Reducing concentrated neighbourhood poverty and the social distance associated with it

This option involves reducing concentrated neighbourhood poverty and the social distance associated with it. Elements of this option might include:

- policies that increase the ‘social mix’ in neighbourhoods with high concentrations of poverty, such as:
 - incentives (and removal of disincentives) for more affluent citizens and for businesses to move into neighbourhoods with high concentrations of poverty, and for poor citizens to move out of these neighbourhoods;
 - inclusionary zoning policies, which create favourable conditions for (or require) construction of new affordable housing in conjunction with new development;
 - fair-share housing policies for social housing, supported housing, halfway houses, etc.;
 - policies that affect socio-economic concentrations in schools, such as ‘constrained choice’ policies;
 - other policies and initiatives to encourage social mix (and reduce social distance) in the context of employment, recreation, early child development, arts and culture, public transportation and other domains;
- policies that raise overall incomes of lower-income households, such as;
 - at the local level, ‘living wage’ policies adopted by employers in the city; and
 - at the provincial and federal levels, changes to eligibility and rates for social assistance, employment insurance, disability pensions, and income assistance for seniors.

Changing the composition of the groups living in or spending time in poor neighbourhoods is not a common approach to the issue of place-based health and social inequalities. We did not find any systematic reviews addressing this option, however, we did find a number of studies relevant to this option (Table 3) to inform deliberations about this option. The studies provided evidence both of intended benefits and of unintended negative consequences. Moreover, the studies suggest that this option could be the most difficult option to implement and could take the longest time to achieve impacts, thereby requiring a sustained, long-term commitment by key institutions. It is also worth noting that the second option element listed ‘policies that raise overall incomes of lower income households’ is an initiative that could also be pursued in the context of option 1, but it sits in option 3 because it does not *necessarily* require a high degree of sustained coordination and integration among local institutions, or with senior levels of government. In other words, this option element could be achieved with a one-time policy decision, and does not necessarily depend on a longer, deeper engagement among institutions.

Table 3: Summary of key findings from systematic reviews relevant to Option 3 – Reducing concentrated neighbourhood poverty and the social distance associated with it

Category of finding	Summary of key findings
Benefits	<ul style="list-style-type: none"> • The major benefit of both types of policies is that they tackle the root causes of concentrated poverty
Potential harms	<ul style="list-style-type: none"> • Increasing the social mix can only happen slowly and the risk of displacement of low-income households is significant <ul style="list-style-type: none"> ○ Moreover, inclusionary zoning has produced mixed results; in some cities land has been preserved for affordable housing, but no building capital is available(60;61) ○ Fair share housing policies can have major political risks(62) • Additional costs of initiatives to raise incomes of low-income people (which is also part of option 2) may necessitate cutbacks and behavioural responses elsewhere, thereby diminishing the net impact <ul style="list-style-type: none"> ○ At the local level, for instance, adoption of living wage policies may result in job losses or stagnant job growth, which will affect low-wage workers(63-68) ○ At other levels, improvements to government income-assistance benefits, in the absence of new resources, may result in cuts to non-cash benefits that are differentially used by low-income households (e.g., medical benefits, job training, etc.) ○ Also subject to the ‘welfare trap’ – the value of higher wages still does not exceed the value of benefits that people receive while on social assistance(69)

Costs and/or cost-effectiveness in relation to the status quo	<ul style="list-style-type: none"> • Costs will depend on the specific mix of initiatives undertaken
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the option were pursued)	<ul style="list-style-type: none"> • If implemented, careful monitoring required to capture both intended and unintended effects
Key elements of the policy option if it was tried elsewhere	<ul style="list-style-type: none"> • None identified through available studies
Stakeholders' views and experience	<ul style="list-style-type: none"> • None identified through available studies

IMPLEMENTATION CONSIDERATIONS

In considering what challenges may be faced in trying to pursue one or more of the options – or which may surface later – it is helpful to consider these difficulties in relation to five levels: citizens, neighbourhoods, service providers, organizations and systems. A list of potential barriers to implementing the options is provided in Table 4 (on the next page). We found few empirical studies that helped to identify or establish the importance of these barriers(51;53) so we have listed those that were identified in a range of sources (not just empirical studies) and we have not rank ordered them in any way.

Taking each option separately, these challenges are more or less important. For option 1, the major, overarching implementation challenges are commitment and coordination. Experience with the Urban Development Agreements in Canada and similar initiatives in the United Kingdom (e.g., New Deal for Communities) suggests that strong commitments are needed from partner organizations, and one of the most challenging commitments required is for participating organizations to engage in horizontal accountability at least partially at the expense of vertical accountability. Experience with Urban Development Agreements also suggests that citizen and community engagement have been a challenge in the past. Finally, there is no evidence that a collaborative partnership to tackle a problem as complex as this one can be successful with only local participation. On the other hand, this does not necessarily mean it is impossible, however, its capacity may be constrained.

Option 2 involves relatively less complex implementation challenges, but shares the need for involvement of senior levels of government, and a commitment of significant resources from those levels of government. The essence of option 2 is to use neighbourhoods to target people in need of individualized services, however, this approach does little to solve the root causes of the problems, and therefore would need to be linked to other, more structural initiatives. There are also some important equity concerns as this option raises concerns about reaching all those in need, as it involves providing services to individuals in need, and may exclude people in need who do not live in targeted neighbourhoods.

Finally, option 3 has different implementation challenges for its possible elements. Efforts to create social mix within services and programs offered by institutions in Hamilton could achieve the goal of creating social mix and bridging social distance quite quickly (e.g., mixed school and recreation programs), however, such initiatives are also the most politically risky and controversial. On the other hand, it is arguably less controversial to infuse lower income neighbourhoods with housing opportunities for middle- and upper-income households, but it will certainly be much slower to achieve substantial levels of residential social mix. Note that the idea of infusing middle- and upper-income neighbourhoods with affordable housing opportunities for low-income people is very controversial, so such a strategy is challenging to implement. Transportation and accessibility to services is also a significant challenge to achieving greater social mix in programming. Paradoxically, community engagement will be challenging because the social distance that already exists means that different groups have misconceptions about one another, leading to resistance to social mix, thereby perpetuating the problem.

Four implementation strategies seem particularly germane to key local institutions:

- engaging citizens and neighbourhoods in discussions about the optimal way forward as well as a broader array of stakeholders about the strength of support for making the optimal way forward a cross-institutional priority;
- reaching agreement about the overarching objective(s) of an initiative to address poverty concentration, implementation strategies (including the engagement of senior levels of government), monitoring and evaluation approaches, public reporting of results, and timelines;
- working collaboratively to design the specific elements of the initiative (e.g., policies and programs); and
- working through in their respective institutions the changes needed to both deliver on specific elements of the initiative and to ensure that their institution will sustain their commitment over the long term (e.g., by including it in their own strategic plan, committing to report publicly on their contributions each year over the timeline of the initiatives).

Table 4: Potential barriers to implementing the options

Level	Option 1 – Coordinating local policymaking and programming with a focus on neighbourhood-level approaches	Option 2 – Targeting individual-based policy approaches at neighbourhoods with high concentrations of poverty and advocating that other levels of government do the same	Option 3 – Reducing concentrated neighbourhood poverty and the social distance associated with it
Citizens	<ul style="list-style-type: none"> • Lack of citizen engagement • Cynicism among lower-income, politically engaged groups 	<ul style="list-style-type: none"> • Resistance among poor and marginalized citizens who don't live in neighbourhoods with high concentrations of poverty (and those who speak for them) 	<ul style="list-style-type: none"> • Lack of citizen engagement • Resistance among higher-income, politically influential groups, particularly those who want all services close to home
Neighbourhoods	<ul style="list-style-type: none"> • Lack of neighbourhood engagement 	<ul style="list-style-type: none"> • Resistance among 'middle' neighbourhoods that have some worrying trends but don't meet the definition of neighbourhoods with high poverty concentrations 	<ul style="list-style-type: none"> • Lack of neighbourhood engagement
Service providers	<ul style="list-style-type: none"> • Resistance to devoting time and energy to the difficult task of coordination • Turn-over and other factors that make long-term commitments difficult to sustain 	<ul style="list-style-type: none"> • Difficulties associated with reaching many citizens that are most at risk • Lack of interest among senior governments 	<ul style="list-style-type: none"> • Transportation options that hinder the coming together of people who are currently segregated from one another • Lack of knowledge about what initiatives will create a social mix as efficiently and ethically as possible
Organizations	<ul style="list-style-type: none"> • Lack of familiarity with the horizontal accountability demanded by this option (as opposed to the vertical accountability with which they're familiar) 	<ul style="list-style-type: none"> • Lack of consistency with the priorities of many key local institutions 	<ul style="list-style-type: none"> • Stagnant property market hinders efforts to engage developers
Systems	<ul style="list-style-type: none"> • Senior governments are not actively supporting this approach despite their involvement having been key to past successes (e.g., Western Regional Economic Development) 	<ul style="list-style-type: none"> • Constrained fiscal position of the provincial and federal governments which hinders opportunities for new funding • Lack of engagement by the federal government in areas of provincial or municipal jurisdiction 	<ul style="list-style-type: none"> • Many factors affect where institutions are based and where services are provided

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