REDUCING THE COST
OF POVERTY
IN MEDICINE HAT
MOVING FROM CHARITY TO INVESTMENT

FEBRUARY, 2013
ACKNOWLEDGEMENTS

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This report should be cited as:

Our Funders:

This project is funded in part by the Government of Canada's Homelessness Partnering Strategy.
The opinions and interpretations in this publication are those of the author and do not necessarily reflect those of the Government of Canada.

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EXECUTIVE SUMMARY

As of 2010, 7,360 people in the greater Medicine Hat area were living in poverty, 2,590 of whom were children – representing a 10% poverty rate, and a 16% child poverty rate.

This report was commissioned by the Medicine Hat Poverty Roundtable as part of a community-based effort to reduce poverty in Medicine Hat. Fundamental to the Roundtable’s objective is the need to develop a different approach to addressing poverty. The aim is to move from a charity-based approach to an investment approach: from alleviating poverty to preventing and ultimately reducing poverty by addressing it at its roots. For the Roundtable, this means moving beyond addressing crises to preventing crises in the first place. It means ensuring that its citizens can access help before being destitute. And it means thinking about how moderate investments made now can lead to significant and long-term social benefit, financial savings, and economic growth down the road.

The Roundtable chose six priority areas on which to focus. They include: Living Wages, Affordable Housing, Recreation, Education, Transportation and Food Security.

This report provides information on poverty and social indicators in Medicine Hat; on the definition, causes, effects and indicators of poverty; and on the current state of the six priority areas. It is a starting point from which to develop a common understanding of poverty in the community, and from which to track progress in the future. This report accesses statistical data, current research, and qualitative data from key interviews with Medicine Hat residents to develop as representative a picture as possible.

Gender, work opportunities, wages, mental illness, addiction, disability, income support policies, bureaucracy, access to education, parenting, and immigration were factors found to be closely related to poverty in Medicine Hat. We also heard from residents that misconceptions exist about why people live in poverty. A common view is that poverty is related to individual choices. While individual choices have consequences in everyone’s lives – rich, poor, and middle-income – typically these alone do not lead to poverty.

Poverty derives from a mixture of complex and compounding factors, including:
• Individual vulnerabilities (education and skills, family life, personal confidence, social relationships);

• Community infrastructure (services and amenities, security, vibrancy);

• Systems (health system, education system, social services, the market economy and the justice system), and

• Societal biases (norms, attitudes, practices, and values) (United Way et al., 2012).

Poverty cannot be successfully reduced without addressing the full gamut of contributing factors.

Medicine Hat residents have a long tradition of giving time, money and energy in efforts to improve their community, and the progressive work and successes achieved in certain areas have been remarkable. These traditions are a tremendous resource that can be accessed in developing strategic collaborations and a plan to reduce poverty. Optimally the plan will identify strengths, weaknesses and opportunities across organizations and sectors, and set aligned goals and strategies.

This report will help inform the next stage of community conversations aimed at finding “made in Medicine Hat” solutions to poverty. Key findings in this report include:

• The great work achieved around access to recreation, which in other Canadian cities has been shown to help families move out of poverty.

• The strides several local business leaders have taken with regard to progressive human resources practices; the benefits of paying a Living Wage; and the opportunities, particularly in the retail and health sectors, around implementing Living Wages.

• The positive outcomes achieved in housing the homeless, and the steps that still need to be taken to increase the affordable housing stock, enforce quality-control in the rental market, create supportive housing, and develop mental health/addictions facilities.
• The success the public education system has had; the progress that is occurring in regard to post-secondary education; and the limitations that still exist with post-secondary programming and affordability.

• The collective energy that is building around community food programs and food security, which has helped build community and raise awareness.

• The steady progress that has been made with Medicine Hat Transit, and the opportunities to develop more flexibility within the system and more collaboration with other sectors.

Residents have expressed their commitment and confidence in reducing poverty in Medicine Hat. Their hard work and expertise, paired with research and precedents in poverty reduction, strongly indicate that this is an achievable goal. The sense of community is strong and there is a recognition that it “takes a village” to move the needle on poverty.

The Community Roundtable on Reducing the Cost of Poverty in Medicine Hat is inclusive and open to community members wanting to join this work. Please phone (403) 529-8316 if you are interested in becoming part of this work and/or receiving notification of Roundtable meetings.
POVERTY isn’t an easy subject to tackle. It’s a complex problem with interacting causes and effects, and everyone experiences it differently. It sometimes seems impossible to know where to start. Not only is it fundamentally possible to reduce poverty in our communities, it is deeply and broadly rewarding — personally, socially, and economically. Medicine Hat is already well on track by making a collective commitment to poverty reduction. It is recognized that solutions to poverty come from community change focused on economic and social inclusion, policy and systems change, and leveraging advantages for all. We don’t have to accept poverty in our communities. Medicine Hat has a long tradition of giving and rallying the community when it comes to poverty, and the creation of a Medicine Hat Poverty Roundtable builds on this tradition. The community came together to form the Medicine Hat Poverty Roundtable on June 2, 2011. Since that first meeting, the Roundtable has made great progress in developing a Framework for Change (see Appendix 1), identifying six priority areas for Medicine Hat, and identifying research needs. The Roundtable is eager to involve as many people from the community in Medicine Hat as possible to “work on cooperation rather than competition” (Roundtable Discussion, January 2012) and continues to develop community engagement strategies.

What quickly came up at community meetings was the need to implement a shift in approach in addressing poverty – of moving from charity towards investment in the future of Medicine Hat’s citizens. For members of the community, this translated to moving beyond addressing crisis situations, to thinking about how to prevent crises in the first place. How can the root causes of poverty be addressed, rather than the symptoms? How can Medicine Hatters get help before becoming destitute? How can residents earn more money, or see their living costs decreased? How can the community ensure residents have real choices in life, choices between good and better, rather than bad or worse? How can moderate investments create big savings in the health care system, the justice system, the educational system, the business sector, and communities?

Shifting to this approach means being more strategic and more collaborative. The creation of this report was one step towards this new direction. This report was commissioned by the Medicine Hat Community Housing Society, The Community Foundation of Southeastern Alberta, and The United Way of South
“People really care in Medicine Hat, and that’s growing – there’s a groundswell.”
- Medicine Hat Resident

Eastern Alberta, to provide background research on poverty in Medicine Hat. It is a starting point towards developing an informed, community-led poverty reduction strategy. A local research committee of community members from the Poverty Roundtable oversaw and guided this report, which was prepared by consultants from Vibrant Communities Calgary.

This report was compiled with relevant literature, statistical information about poverty in Medicine Hat, and interviews with 25 key informants from Medicine Hat who represent people living in poverty, community organizations, municipal and provincial politicians, and the business sector.

It includes figures on poverty in Medicine Hat against which future figures may be compared and evaluated, and potentially used as measures of success. It also explores definitions, measures, and effects of poverty. Lastly, it provides baseline information of the current state of the 6 priority areas identified by the community in Medicine Hat.

Over the course of putting together this report, it became clear that local representatives from every sector are invested in reducing poverty, and that addressing this goal in Medicine Hat is broadly deemed necessary and possible. In interviews, descriptions of poverty in Medicine Hat could be emotional. However, the overall consensus was that addressing poverty in Medicine Hat is a highly pragmatic exercise. It will require identifying what is working, what isn’t working, what is economically efficient, and where the community has the capacity to intervene.

Medicine Hat, other cities and the province are gaining traction on this issue. Community needs are being met with concrete action, the most recent of which is the extension of Special Transit hours by Medicine Hat transit on a trial basis.

The province has jurisdiction over crucial policies and programs in poverty reduction, and has seen unprecedented movement on poverty by the Government of Alberta. In February 2012, the Assured Income for the Severely Handicapped increase by $400/month, and capacity to earn more income without clawbacks increased. By April, Premier Alison Redford had committed to a 10-Year Plan to Reduce Poverty, and in late November 2012, it was announced that the next year will see increasing focus on the province’s 5-year plan to End Child Poverty. There is tremendous opportunity for
communities to engage the Province in conversation, and to work with the Province in developing local strategies for poverty reduction.

There is also tremendous opportunity to partner with other cities, and provide a unified voice on key issues. Poverty reduction conversations are occurring in cities across the province, and are in a variety of different developmental stages: from simple conversation to community-driven initiatives, to initiatives that are endorsed or driven by City Councils. We’re seeing numerous cities collaborating with each other through partnerships such as the Intercity Forum on Social Policy and Municipal Poverty Reduction Leaders. To have municipalities and the Province moving forward on poverty in concert is a great opportunity, with each party having different and complementary roles in addressing poverty.

To begin, it is crucial for Medicine Hat to be armed with information about poverty, to have as complete a picture as possible of poverty in the community of Medicine Hat, and to understand the current state and current perceptions of its 6 key priority areas – Living Wages, Housing, Recreation, Transportation, Education, and Food Security. So let’s get started!
This section provides an overview of poverty: the distinction between defining poverty, measuring poverty and the effects of poverty. Poverty is complex and as such, it will be important for the community to come together around a shared understanding of the issue before developing its strategies.

**Defining Poverty**

It is no small task to define poverty. It is important to narrow down some of the important components of poverty and the framing of the issue with a definition:

*Poverty is a lack of resources and opportunities to achieve a standard of living that allows full participation in the economic, social, cultural, educational, and political spheres of society (Vibrant Communities Calgary, 2012).*

While the definition above identifies a lack of resources as a key issue, it also specifies that a lack of resources can impact people’s ability to participate fully in their communities (Karelis, 2007). In other words, lack of physical resources can have important social and psychological effects.

By defining poverty in academic terms we would not want to diminish the actual experience of living without adequate resources. Very tangibly, living in poverty means making difficult choices every day between food, transportation, housing costs, childcare, and other basic necessities; not saving for the future; and spending disproportionate amounts of time and energy on meeting one’s basic needs.

**Measuring Poverty**

Determining a poverty measure is not a straightforward exercise. In Canada, we lack an agreed upon poverty line. There are three measures of low-income we use by proxy, as set by Statistics Canada (2011):

- **LICO = Low Income Cut Off** (represents an income threshold at which a family is likely to devote 20% more than the average family on basic needs)

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“Poverty is an ugly thing. Have you ever been hungry where you had no food and no way to get food? That is poverty, when you have no place to go but to food banks or soup kitchens”.

- Medicine Hat Resident

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**WHAT IS POVERTY?**
• LIM = Low Income Measure (50% of the median income in a geographical area, often used internationally)

• MBM = Market Basket Measure (disposable income compared to the cost of a basket of goods determined by geographical pricing)

While these measures will vary in the numbers of people experiencing low-income, they typically all follow the same trend line over time. Choosing a measure is simply a way to track progress and to identify the depth of the issue.

Table 1.1: Low Income Lines

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<tr>
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<tr>
<td>1 person</td>
<td>$19,941</td>
<td>$15,613</td>
<td>$19,161</td>
</tr>
<tr>
<td>2 people</td>
<td>$24,824</td>
<td>$22,076</td>
<td>$27,094</td>
</tr>
<tr>
<td>3 people</td>
<td>$30,517</td>
<td>$27,010</td>
<td>$33,187</td>
</tr>
<tr>
<td>4 people</td>
<td>$37,053</td>
<td>$31,225</td>
<td>$38,322</td>
</tr>
<tr>
<td>5 people</td>
<td>$42,025</td>
<td>$34,972</td>
<td>$42,844</td>
</tr>
<tr>
<td>6 people</td>
<td>$47,398</td>
<td>$38,251</td>
<td>$46,925</td>
</tr>
<tr>
<td>7 people or more</td>
<td>$52,770</td>
<td>$41,373</td>
<td>$50,700</td>
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Statistics Canada (2011), Tables 2-4 http://www.statcan.gc.ca/pub/75f0002m/2011002/tbl-eng.htm

The LICOs, MBM and LIM figures for Medicine Hat are listed in Table 1.1 above. These measures each have strengths and limitations – LICO, for example, is a national measure that accounts for the higher costs of living in large settlements (cities) over small settlements (towns, hamlets), but does not account for differences in costs, taxes, and public services geographically.

The MBM takes into account the cost of living with geographic sensitivity (typically by province), but it has been criticized for what it includes in its “basket” of goods and services. For example, Shillington and Stapleton (2010) note that the MBM used to include “five pairs of long underwear, but no computer access (p.7).” It now includes computer access, but no cell
These numbers are calculated by the Canadian Mortgage and Housing Company on a yearly basis. They represent the income threshold needed to afford a rental unit of varying size and by city. Affordable is defined as spending no more than 30% before tax income on housing.

Core Needs Income Threshold (CNIT)

While all of these measures are somewhat flawed, they do follow similar trends over time. We can be confident that they reflect trends in poverty, if not hard and fast numbers. They are positively correlated with the negative effects of poverty, and provide solid insight on which demographics are more likely to live in poverty. We primarily use LIM in this report due to its use by Statistics Canada for low-income data.

Measures of poverty can also be taken before tax and after tax, the difference between the two being whether or not income tax has been factored in. This paper uses after-tax measures to account for the re-distributive effects of taxation, which should make low-income earners better off relative to higher-income earners. We acknowledge, however, that taxation does not always benefit all low-income earners equally.

Poverty Indicators

Depending on the outcomes one hopes to achieve with poverty reduction initiatives, it is equally important to choose other indicators to measure progress in addition to poverty measures like LICO, LIM, and MBM. For example, if the poverty reduction initiative hopes to achieve better social inclusion for people living in low-income in Medicine Hat, one possible indicator to track might be the rates of use of recreation and other facilities by people in low-income over time.

Other indicators can demonstrate how people are faring in standard of living. The Core Needs Income Threshold (CNIT), for example, shows how much yearly income before tax would be needed to afford a safe place to live in a given city. Tracking the number of families making less than the CNIT is not straightforward, but could provide a useful barometer for the accessibility of safe, affordable housing.
Measuring Inequality

Measures of inequality are also increasingly important. We now know that a high level of inequality (income disparity) has negative effects for everyone in the community, no matter the income bracket (Wilkinson and Pickett, 2009). An often-used measure of inequality is the Gini coefficient and is readily available through Statistics Canada (see Figure 1.1).

Effects of Poverty

Poverty has many effects, which often interact and then exacerbate causes of poverty. This interplay of cause and effect is a large part of the reason poverty is so complex. For example:

A rundown apartment can exacerbate a child’s asthma, which leads to a call for an ambulance, which generates a medical bill that cannot be paid, which ruins a credit record, which hikes the interest rate on an auto loan, which forces the purchase of an unreliable used car, which jeopardizes a mother’s punctuality at work, which limits her promotions and earning capacity, which confines her to poor housing. (Shipler, 2004, p. 11)
This story is not terribly different from those we heard from Medicine Hat residents, where compounding circumstances led families and individuals to become more and more entangled in poverty. Circumstances included illness, disabilities, divorce, abusive relationships, lack of qualifications for advancement in employment, financial barriers to accessing education (including student debt), and bureaucratic barriers to accessing supports, among others.

Poverty is known to negatively impact quality of life, health and mental health, and social inclusion. The complicating factor is that these effects can also be causes of poverty. As such, it is never easy to say one thing was a cause of poverty and that the effects will be the same for all people in poverty (Phipps, 2003; Raphael, 2009). The causes and effects of poverty vary greatly, depending on individual circumstances and community strengths.

In addition to negative individual and community effects, poverty costs communities in real economic terms. A recent report showed that a cautious estimate of the economic costs of poverty in Alberta to health care, criminal justice, and lost economic opportunity is between $7.1 and 9.5 billion each year (Briggs and Lee, 2012).

Causes of Poverty

Identifying and describing causes of poverty is perhaps one of the most challenging endeavours in poverty reduction. There is no single cause of poverty and the reasons that poverty exists are often a complex interplay of individual vulnerabilities, community structure, systems, and societal biases (United Way of Calgary et al., 2012). This report will only briefly summarize these factors:

1. Individual vulnerabilities occur without opportunities and access to basic needs, education and skills, personal confidence and well-being, financial stability, and social relationships.

2. Community structure contributes to poverty if there is an absence of physical infrastructure, services and amenities, vibrancy, and safety.
3. Systems all around us have a huge impact on all of our lives. The way we structure our health system, education system, social services, market economy, and the justice system impact the prevalence and experience of poverty.

4. Societal biases include our norms, attitudes, practices, and values. These are often things we take for granted in a society without realizing how some may be excluded because of our own social biases.

You can note above that there are four clear and distinct categories of causes of poverty. Yet, the place where poverty reduction most often allocates its efforts is in individual vulnerabilities. Without a more balanced approach among all of the different levels, progress on poverty reduction will be very difficult to make. Focusing on individual vulnerabilities leads to common misconceptions about people living in poverty and efforts that inadvertently place blame on people living in poverty. This leads to incomplete solutions because it neglects the fundamental importance of the contexts in which individuals operate.

So how do we move forward on poverty reduction? The next section looks at some of the key factors in a poverty prevention and reduction framework, and the role communities can play within this.

“There is temporary help but there isn’t a whole lot that people can access that would help them get out of poverty”.
- Medicine Hat resident

“If you don’t address the causes, you’ll keep addressing effects.”
- Medicine Hat resident
Fundamental to the Roundtable’s discussions on poverty reduction in Medicine Hat is the need to make a change in approach: of moving from a charitable approach to an investment approach. The language is very important because it recognizes that charity typically provides temporary measures that respond to poverty crises, rather than contributing to permanent and lasting poverty reduction. The Roundtable has come together to suggest that moving the needle on poverty is possible, and to start the collaborative work needed to get there. It envisions leveraging the energy and resources that exist within the community to invest in solutions that will see a measurable change in poverty rates in Medicine Hat.

In addition to the human cost we know that our current approaches to poverty reduction – spending on temporary measures – are costing all of us economically across the province. A recent report suggests that the external costs of poverty in Alberta amount to $7.1 - 9.5 billion in the province, which encompass costs to the health care system, the justice system, lost tax revenue, and lost personal revenue (Briggs and Lee, 2012). It also suggests that we can choose to spend differently. We can choose to invest in poverty reduction efforts to address root causes, and reap long-term social benefits and significant long-term economic savings.

**Preventing Poverty**

Poverty reduction comes from addressing both poverty alleviation and prevention. The research is clear, however, that putting more resources and energy into poverty prevention is necessary in order to succeed at reducing poverty. This has typically been neglected across Canada (National Council of Welfare, 2011).

Based in our research, an effective overall prevention approach includes four components. It is:

1. Comprehensive – it addresses all facets of poverty to prevent citizens from falling through the cracks (Torjman, 2008)

2. Adaptive – it has monitoring, evaluation and feedback mechanisms (Torjman and Leviten-Reid, 2004)
“So far in Medicine Hat, lots of people are looking at how to help in the community, but we’re not looking at the causes of the problems.”
- Medicine Hat resident


“Early intervention – it is aimed at helping people before they are destitute, and at preventing the social conditions that contribute to poverty (National Council of Welfare, 2011)

Comprehensive approaches are critical to poverty reduction as well, because they acknowledge the complex, interconnected nature of poverty. They recognize, for example, that education, skills-building or mental health treatment are not likely to be effective without stable housing; or that educational and work opportunities for women are most improved by the availability of childcare; and so on.

A thorough framework for a comprehensive provincial approach to poverty reduction has been suggested by Sheri Torjman (2008). This approach includes 10 areas of intervention: affordable housing, early childhood development, education and literacy, training and employment, income supplementation and income replacement, disability income, creation of assets, social infrastructure, and place-based interventions. While this framework does not transfer directly to municipal and community projects – recognizing that communities, municipalities and provinces have different jurisdictions – it addresses the role that communities can play in collaboration with provinces within this framework. Some of these areas include place-based interventions, social infrastructure, training and employment, education and literacy, and affordable housing.

Early intervention might focus on providing help for citizens before they lose most of their assets. With regard to provincial Income Support, we know that Alberta Works provides help to individuals only once they are very vulnerable financially, making it more difficult for individuals seeking help to climb out of poverty. Research suggests this approach is more expensive for provincial governments: the deeper citizens fall into poverty, the longer they require support, and the more they are vulnerable to negative physical and psychological effects. This not only takes a personal toll, it adds pressure to the health care system (National Council of Welfare, 2011). On a larger scale, early
intervention could be aimed at preventing severe income disparity, with the effect of reducing the negative social impacts listed by Wilkinson and Pickett (2010), such as drug and alcohol abuse, obesity, violence, and poor academic performance.

Any effective prevention strategy must also tackle the often-contentious subject of judgement. Quite frequently, well-meaning initiatives embed judgemental practices within their poverty reduction efforts. A prevention approach, however, must suspend judgement for two main reasons:

1. There are proven psychological impacts of judgement including shame, and the effects of shame on behavior and mental wellness (Gray, 2009);

2. Evidence-based assessment, rather than judgement is a more effective lens.

Assessment is based on evidence and results, rather than on personal beliefs and therefore entails qualified people making informed, unbiased decisions. Evidence-based assessment leads to policies that are more likely to succeed while the use of judgemental policies has a high risk of failure. The “client-centered” model of healthcare and social services that has recently emerged not only provides an alternative to judgement, it goes beyond strict client-worker assessment models to address the balance of power within social services. The model focuses on service user empowerment, where solutions are developed co-operatively between worker and service-user. This approach has been used and documented primarily in the health care sector. The care resulting from this approach has been found to be more appropriate, more cost-effective, and more optimally used (Berwick, 2008; Institute of Health, 2001).

Transitioning to non-judgemental policies can be difficult because ideas of what is moral and good and fair can be emotionally tied. It requires trust that the new policies will work, even if in the interim they don’t feel right or fair. Transitioning to non-judgemental policies means embracing complexity, and embracing the idea that we may never be able to land on what is seen universally to be “fair”.

“There are programs but you have to realize that people in poverty are too proud to accept those sorts of things. Accepting charity is not easy”.
- Medicine Hat resident

Preventing and reducing poverty can only be successful if the community can embrace assessment, and suspend judgement.

There are programs but you have to realize that people in poverty are too proud to accept those sorts of things. Accepting charity is not easy.
- Medicine Hat resident
Shifting to an assessment approach can also raise legitimate questions around how organizations evaluate progress and remain accountable to funders. Asking service providers alone to devise these strategies is unrealistic and unfair. The sector must work in tandem with funders, service providers, researchers, and policy makers to jointly define and identify successful outcomes.

Working to solve poverty in ways that do not reinforce stigma or negative stereotypes can be challenging, but the Medicine Hat Roundtable is already on the right track by recognizing the importance of economic and social inclusion, policy and systems change, and leveraging advantages for all.

**Communities Reducing Poverty**

Community initiatives to reduce poverty are an invaluable part of creating positive change. Other communities have taken initiative and are seeing the results of their efforts. Vibrant Communities, for example, is a pan-Canadian “network or urban collective committed to substantially reducing poverty through multisectoral and comprehensive local action,” that has had chapter organizations in 13 cities. Since its inception in 2002, this model has yielded 164 poverty reducing initiatives, 1690 partnering organizations more than 300,000 poverty reducing benefits to nearly 200,000 households, and 35 substantive government policy changes (Gamble, 2010).

Research points to the notion that comprehensive approaches are likely to have greater success than isolated initiatives (Torjman, 2008). The Medicine Hat Roundtable’s coordinated approach with the six priority areas and shared goals is a very significant step in making progress. It is devising a way forward that reflects community and municipal jurisdictions, and that will complement provincial efforts.

Co-ordination with other levels of government is crucial in a comprehensive approach to close the cracks that people in poverty so often fall through. Communities are great at inclusion, engagement, and context-based strategies. These initiatives paired with support from all levels of government, who may have jurisdiction around key areas such as income supports, skills training and education, and mental health supports, among others, could have

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**Under the Vibrant Communities model there have been**

**164 poverty reducing initiatives**

1,690 partnering organizations & 35 substantive government policy changes
tremendous potential for change. It would be prudent for The Medicine Hat Roundtable to look for opportunities to collaborate with other municipalities and the province around shared goals, measures, and initiatives. Medicine Hat currently participates with Vibrant Communities Canada, the Inter City Forum on Social Policy, and the Action to End Poverty in Alberta Initiative.

The Roundtable has identified Living Wages, Affordable Housing, Recreation, Education, Affordable Transportation and Food Security as the six priority areas to work on. These areas are well within the community’s sphere of influence. They can be used to address some of the root causes of poverty by increasing the incomes of residents, and by making some essential services more affordable - meaning families’ incomes can go further. For now, let’s look at who lives in poverty in Medicine Hat, and why.
POVERTY IN MEDICINE HAT

Medicine Hat is well-regarded by its residents for its small-city feel, its outdoor recreational amenities, and its comparatively low property taxes and electricity rates (VitalSigns). Nonetheless, many of its residents struggle. As of 2010, 7,360 people in the greater Medicine Hat area\(^1\) were living below the low income cutoff of LIM, 2,590 of which were children – representing a 10% poverty rate overall, and a 16% child poverty rate (Statistics Canada).

This section pinpoints some of the critical issues in Medicine Hat around poverty: who lives in poverty, and why? It does so from the perspectives of residents with a range of expertise on poverty and social change, including people living in poverty, representatives from community organizations, municipal and provincial politicians, and leaders from the business sector. Federal, provincial and municipal statistics have also been utilized to support the feedback provided by residents. Using both interview data and statistics was crucial to developing an accurate picture of the issue, since statistics can miss things that interviews capture, and vice-versa.

Overall, poverty was related to the following issues:

- Lack of income
- Mental illness and addiction
- Disabilities
- Income support policies
- Work opportunities, employment income and Human Resources policies
- Access to education
- Parenting
- Bureaucracy
- Gender issues, particularly relating to parenting and work opportunities

Let’s find out why.

\(^1\) The greater Medicine Hat area refers to the Census Agglomeration of Medicine Hat – see page 27 (About the Data) for more details.
“People don’t choose to be poor, it’s not a character flaw. Poverty is related to life circumstances, to lack of opportunity, to trauma.”

- Medicine Hat Resident

**WHAT WE HEARD FROM RESIDENTS**

We heard from residents that misconceptions exist in Medicine Hat about people living in poverty. They expressed that there is misunderstanding about why poverty exists and the characteristics that are associated with those experiencing it. From the interviews conducted with numerous people living on low income in Medicine Hat, the words we would use to describe our interviewees are: resilient, brave, strong, generous, funny, determined, and hard-working. Not one person made any single life choice that led to living in poverty. In most instances a complex mix of bad luck, unsupportive social services and compounding challenges played into the individual situations. We can certainly say that while 7,360 Medicine Hatters live below the Low Income Measure, many more are vulnerable to poverty. As emphasized by one resident, “so many in Medicine Hat are one paycheque away from poverty.”

People experiencing poverty in Medicine Hat faced extremely tough choices, and at times lacked choice altogether. All those interviewed described working extremely hard to get by, and spent inordinate amounts of time trying to stay afloat or to get ahead. Living in poverty required considerable energy and time filling out paperwork, making connections, accessing food and taking care of children, other dependents, the household, and in many cases, neighbours.

Summarized below are some of the common themes we heard with regard to the challenges faced by those experiencing poverty. This section describes the perspectives of persons experiencing low-income and service-providers working directly with individuals living in poverty. Interviewees who were more removed from the sector expressed having less knowledge on the reality of poverty in Medicine Hat, and were beginning to think about solutions around the six priority areas. Common among them however was a desire to know more about poverty, which underlines the importance of this document as a tool to inform concrete plans and actions.

**Mental Health and Addiction**

Persons involved with the justice system and the social services sector, and persons with lived experience, all emphasized the role mental health and
"There is a lack of treatment centres for addiction in Medicine Hat, and that's a major weakness in the social fabric of this society. As is, residents have to go out of town, kilometres away from any family support."

- Medicine Hat Resident

If you're in day treatments for addictions, you lose income supports because you’re not looking for work.

- Medicine Hat Resident

addiction play when it comes to poverty, and lamented the lack of services available in Medicine Hat to address these illnesses. They did not suggest that everyone living in poverty struggles with mental health and addiction, but that those who do are exponentially more likely to struggle with poverty.

Residents reported mental health calls to the police as “going through the roof.” Some went as far as to say that addressing poverty in Medicine Hat without creating more infrastructure for addictions and mental health would be a losing battle. They further asserted that if not addressed, these illnesses would perpetually consume expensive resources in the police service, rather than being addressed as illnesses that require treatment. The latter approach, they suggested, would be much less expensive in the long run, even when accounting for people who may never be completely independent.

We heard from local experts that persons suffering from mental illness or addictions face compounding challenges within the social service systems. For example, being enrolled in rehabilitation programs means giving up income support through Alberta Works, because one is no longer actively looking for work. This can mean not having any security after rehabilitation is finished which, in turn, means people face choices between their mental health and their ability to feed themselves.

While we don't have data directly linking mental health and addictions to poverty in Medicine Hat, Alberta Health Services does link the two in Alberta. Their data shows that mental illness/addictions can be a cause of poverty as well as an effect of poverty (Alberta Health Services, 2011). This gives us some sense of the complexity of poverty, of the interactions of its causes and effects, and of its cyclical nature.

Disabilities

Persons with disabilities described struggling to make ends meet. Those on Assured Income for the Severely Handicapped noted some improvement in quality of life since the recent raise in AISH income, but those we spoke with were not lifted out of poverty.
“For now I depend on GST cheques and child support, and as I learn to cope with my disability, I hope I can get a home-based business off the ground.”

- Medicine Hat Resident

We heard about great employers and social enterprises providing and adapting employment for employees with a range of abilities. We also heard about the struggles of those with “invisible disabilities” within the workplace and within social services, which raised the issue of developing more awareness around a range of disabilities. We were told that because some disabilities, particularly mental disabilities, are not as obvious, they may keep people from succeeding in conventional workplaces, or even from being eligible for certain programs:

“It is difficult for people to understand “invisible” disabilities. Autism often isn’t obvious. It doesn’t directly affect your IQ scores. I am highly intelligent, so people assume I am highly employable. But autism means needing specific social and workplace supports to minimize particular stressors that make managing being autistic difficult. People with less visible disabilities often fall through the cracks - our needs don’t seem significant enough on paper, but can be very limiting in practice.” – Medicine Hat resident

Another significant issue is the struggle described by those who did not qualify for AISH, despite their disabilities. For example, not electing to take medical procedures with potentially crippling side effects could render someone ineligible for AISH. Similarly, having a physical disability that wasn’t considered disabling enough could prevent individuals from qualifying for AISH. We heard that a disability that prevents someone from working on a recurring basis, rather than on an every-day basis, might not meet AISH eligibility criteria. The unpredictable nature of these diseases interfered with being hired, keeping jobs, or searching for jobs.

Alberta Works, in the “Barriers to Full Employment” (BFE) category, was described as somewhat easier to qualify for, but provided less than half the income of a minimum wage full-time job. In addition, the experience of visiting the income supports office could be demeaning according to residents, to the extent that some individuals refused to use it. Medication covered through income supports was also described as limited. Users of Alberta Works described being covered only for cheaper drugs, which were not perceived as the most effective in treating their illness.

“AISH wouldn’t approve me unless I agreed to risky surgery for a sudden onset condition that prevented me from working. I have a young child to take care of, and can’t take those kinds of risks.”

- Medicine Hat Resident
Residents noted that it was difficult to acquire and maintain a case worker while on Income Support, and that it could feel like there was no one to provide support and advocacy for their individual situations. There was also concern that Income Support policy was being interpreted differently by offices throughout the province, and that Medicine Hatters were facing much more stringent guidelines.

Income Support was also noted for being available only in the most dire crises: “Why do we have to fail before we are allowed to succeed?” one resident asked. After falling into such difficult financial straits, it was described as exponentially more difficult to climb back out. The challenges of qualifying for Income Support and trying to emerge from poverty while on Income Supports are well-documented in the literature and within the social services community.

Job opportunities

Job opportunities were viewed as limited in Medicine Hat, particularly for women and single mothers. Most jobs available for those without post-secondary degrees were described as being in the service, retail and health care sectors, and were noted for their low wages. The two former sectors were also noted for their lack of flexibility with regard to work hours, thus making it more challenging for parents. In addition, many residents noted that these sectors rarely hired full-time and preferred part-time workers to avoid paying benefits. Again, this was a sticking point for people with children, particularly when Income Support and child tax benefits could provide stable income and more benefits, if not higher incomes.

Residents noted that many men work far from home in the resource sector, or were expected to move frequently to “follow the money.” “Families can't keep moving,” said one resident. This was definitely a topic of internal debate for many residents. Should existing local work pay better wages, or should residents be willing to move to find higher paying jobs? How could residents be encouraged to stay in Medicine Hat? How could sufficient incomes be ensured, without breaking the bank for small local companies? To what extent is this a role of governments, through models such as Guaranteed Annual Incomes?

“There are different interpretations of policy among service providers, even between Lethbridge and Medicine Hat. People are not being treated the same way.”

- Medicine Hat Resident
To what extent is this a role of employers? These are questions that will require further dialogue in the community. Business leaders, residents, unemployed and underemployed people, politicians and local training and skills-building initiatives were all identified as key stakeholders in such a conversation.

**Parenting**

Parents are faced with tough decisions, particularly if they are single parents and particularly if they have limited employment opportunities. Should they stay at home with the children, collect Income Support, and ensure their children have medical benefits and a parent present in their lives? Should they work for low wages, pay for expensive childcare, fail to collect medical benefits, and experience low job security? The feared outcomes of losing a job included having to wait months before accessing benefits again, and putting their homes and children at risk in the meantime. Parents worried about losing their jobs because of a perceived lack of flexibility around family schedules and the need to respond to child illnesses. In addition, getting to work on time was described as challenging when using transit. Multiple transit trips involving dropping off the kids at daycare are time-management challenges not everyone has to face.

Finding higher paying jobs definitely improved the option to work. The ability to work from home and raise children simultaneously was also a positive option identified by some interviewees. These can be difficult to do, however, because oftentimes they required further education, which is both expensive and time-consuming. Accessing loans was described as difficult and in some cases, student loans were declined because of other small outstanding loans.

**Navigating the Systems**

Many residents talked about their frustrations in navigating the systems. The sheer amount of paperwork required, the number of trips required to visit multiple agencies, and the feeling of having to prove one’s poverty time and time again contributed to this sentiment. Feeling like workers were serving their organizations and government departments rather than addressing the individual needs of clients, and feeling that one’s needs did not always fit into programs’ systems of checkboxes were also common themes.

"There seems to be a breakdown in families, in communities, and not so much extended family. It means less support, less of a social net if things start to go wrong.”

- Medicine Hat resident

"The sector is really well connected – we all know each other and work well together.”

- Medicine Hat resident employed in the service sector
Many of these difficulties are being acknowledged more and more by non-profits and government agencies across Alberta, as well. This is likely an area where there is room and will to change and where Medicine Hat can contribute to current efforts. There has been a lot of discussion, for example, on solutions that “remove the red tape”. Some of the solutions may include developing “one-stop-shops” for those seeking services (so paperwork only has to be filled in once, rather than dozens of times), moving towards more client-centred approaches (approaches that recognize individual needs), giving more flexibility to social workers, who are typically highly qualified to assess the individual circumstances of a person’s case, and finally, changing the indicators of success in income supports, away from simply decreasing caseloads to more nuanced measures of success that reflect the complexity of success when it comes to poverty.

The strong connections amongst many service-providers in various agencies was noted as very positive in Medicine Hat. While some of the programs operated in “silos” that were hard to bridge for clients, workers could overcome some of these silos because of their personal relationships with each other. Several agencies were lauded for their great work in the community, as were individuals within these organizations. While resident interviews were typically aimed at constructive criticism for the community of Medicine Hat, there was a recognition that improvements could only build off the tremendous energy, quality work and tireless efforts of key persons and organizations within the community.

“There are too many doors to go to. We haven’t made it easy for poor people to access services. We need a Community Resource centre, where there are reps from everywhere, from a variety of agencies. People with complex needs tend to get bounced around a lot in the system.”
- Medicine Hat resident employed in the service sector

“Housing First is doing an amazing job.”
- Medicine Hat Resident
WHAT THE STATISTICS TELL US

As of 2010, 7,360 people lived below the Low-Income Measure within the Census Agglomeration of Medicine Hat (see textbox on page 27 for more on Census Agglomerations). Who are they? Why do they live in poverty? These are some of the questions we attempt to answer by looking at what the statistics say, and bolstering this with qualitative feedback.

Typically in Alberta and Canada, groups that are most often affected by poverty include women, children, aboriginal people, visible minorities, new immigrants and persons with disabilities. For aboriginal peoples, this can be traced back through years of discriminatory and abusive policies. For women, policy has not yet caught up with the modern-day realities of women in the work-force and lone-parent women. For new immigrants, non-transferable accreditations, English language skills, culturally relevant “soft skills” and discrimination may play roles. Persons with disabilities, including mental illnesses and addictions, may not be able to work, or may be able to work only part-time or periodically. All groups may be affected by low wages, particularly if access to education and skill-building are limited. While the impact of increased education and skill-building can be significant for poverty reduction, it is also limited by the job market. Regional rates of educational achievement can shift the job market, but retail, service, and other typically low-wage jobs will likely always be required at levels prescribed by the market (Heath, 2010). This means that as communities, we need to make some decisions on what we consider “fair” as pay for these positions.

While some demographic groups are affected by poverty more than others, it is important to emphasize that this does not reflect inherent qualities within these groups. Rather, as noted, it relates to political, historical and bureaucratic contexts.

According to the statistics we have gathered, those most notably affected in Medicine Hat are women, children, and low-wage workers. Of the 7,360 people living in poverty, 2,590 are children, 2,664 are adult women, 2,106 are adult men, and 190 are seniors (65+ years of age). Let’s take a look at how they are affected and why.
Data on Medicine Hat is available from several different sources in several different forms. For example, we use a great deal of data relating to the “Census Agglomeration” (CA) of Medicine Hat, which is larger than the City of Medicine Hat proper by 12,800 people. We use it because a significant amount of detailed and relatively recent (2010) data is available on this region.

Is the CA of Medicine Hat a reasonable region to consider for this paper? According to Statistics Canada (2012):

To be included in the CA, other adjacent municipalities must have a high degree of integration with the central urban area, as measured by commuting flows derived from census place of work data (Statistics Canada, 2012).

This is to say that the CA encompasses other areas that are highly connected to Medicine Hat as a source of work, but lie outside the geographic bounds of the City proper. This data thus provides information about the people you likely interact with on a day-to-day basis.

But what does this mean for the numbers in this report?

The outlying areas of Medicine Hat have lower poverty rates than the city of Medicine Hat. As such, the rate of poverty in the CA of Medicine Hat is lower than the city of Medicine Hat.

In sheer numbers, the CA overestimates the number of people living in poverty in Medicine Hat. To provide a sense of how much, here are some of the numbers from 2006 and 2011:

- 4,287 lived in low-income in 2006 in the City, compared with 4,977 in the CA
- Approx. 6,001 lived in low-income in 2011 in the City, compared with 7,281 in the CA

The data we rely on most heavily in this document is survey data from 2010 in the CA of Medicine Hat, simply because there is more information on poverty in this particular data set. The data is collected differently from the censuses, so we can expect minor differences among their numbers. We can be confident, however, that the trends reflected in the data will remain consistent - while the total number of people can vary depending on the low-income line used or the method of data collection used, the trends found within the data typically remain the same. Thus, it is reasonable to look at the 2010 data we have, and be confident that this data set accurately reflects trends in Medicine Hat.

While we rely a great deal on the 2010 CA data, we also draw from a variety of other reputable sources such as the 2006 Census, the 2011 Census, the 2011 National Household Survey, and various data from the Government of Alberta Office of Statistics and Information, themselves drawn from a number of different departments. This helps us paint a more detailed picture of poverty in Medicine Hat, but does have a few drawbacks. Not all of the statistics are taken from the same source, from the same year, or from precisely the same geographical boundaries (such as the City, the CA, and the “South Zone” of Alberta). We attempt to be clear throughout the document on the year and geography that our data refers to, which will help explain any discrepancies among the numbers. We will also make note of the rare times we cross-reference among different sources, which means that we are providing “informed estimates” rather than exact figures.
Women in poverty in Medicine Hat

The most striking finding from the Medicine Hat statistics is how much women are affected by poverty, and the implications this has within the community. Women account for 56% of all adults living in poverty in Medicine Hat. They experience deeper poverty than men, are more vulnerable to poverty, and women living in poverty have a significant ripple effect in the community.

Women are more vulnerable to poverty in Medicine Hat in some of the following ways:

- Women earn 48% of what men earn in the workplace in Medicine Hat (see Figure 3.1). For full-time workers only, this goes up to 60%, compared to 70% provincially. (Statistics Canada, 2006)
- When accounting for all sources of income – including government transfers and tax benefits – women bring home 56% of what men make after-tax (Ibid.)
- 31% of all working women in Medicine Hat earn less than $13/hour, accounting for 4,500 people (Statistics Canada, 2012)
- 75% of people earning less than $13/hour are women, (Statistics Canada, 2012). The majority are 25+ years of age, so low income earners are not primarily youths, as is sometimes assumed (Ibid.).
- In 2006, 57.8% of all single women not living with family members lived in poverty.
- Despite women having a higher rate of university degree completion than men, women have a lower rate of high school completion which makes improving their employment prospects more difficult (Statistics Canada, 2006).

Stay-at-home moms are penalized. When I got divorced, I didn’t have any assets. I didn’t have a house to sell, no RRSPs, I couldn’t get EI because I’d been a stay-at-home mom, and I didn’t have any recent job experience. I also have a disability, which means there are only so many hours of work I can do, and so many kinds of work I can do.”

- Medicine Hat Resident

1 Employee counts for those 25 years of age and less are suppressed by Statistics Canada in most categories because they are below the reliability threshold, which is 1,500 for this particular survey. Thus, we know that the vast majority of those making less than $11/hour and $13/hour are 25+ years of age, but cannot determine the exact percentage.
• 67% of all Alberta Works Income Support clients are women in Medicine Hat, accounting for 224 people, 85% of which are Expected to Work (Government of Alberta, 2012). This higher use of Income Support may reflect the compounding pressures of low wages, potentially inflexible workplaces and childcare responsibilities that women are more likely to face.

Women who earn low wages but do not currently live in poverty are typically dependent upon a spouse. Consequently family breakup typically has more negative impacts for women, and women may avoid leaving bad or dangerous relationships in order to avoid poverty for themselves and/or their children. Thus, the risk of poverty can be a factor in why some women do not flee abusive relationships, as suggested in resident interviews by persons with lived experience and professionals.

Because so many women earn low incomes, they also have a bigger ripple effect on the community when they are the primary income earners.

Figure 3.1: Median Earnings and Income, Men and Women, Medicine Hat and Alberta, 2005 (Statistics Canada, 2006)

Women who earn low wages but do not currently live in poverty are typically dependent upon a spouse. Consequently family breakup typically has more negative impacts for women, and women may avoid leaving bad or dangerous relationships in order to avoid poverty for themselves and/or their children. Thus, the risk of poverty can be a factor in why some women do not flee abusive relationships, as suggested in resident interviews by persons with lived experience and professionals.

Because so many women earn low incomes, they also have a bigger ripple effect on the community when they are the primary income earners.

“Rates of domestic abuse are very high in Alberta, but we’ve also gotten good at reporting domestic abuse in this province, compared to elsewhere. We’re raising awareness.”

- Medicine Hat Resident

A couple family consists of

- a couple living together (married or common-law, including same sex couples)
- living at the same address with or without children (Statistics Canada, 2013)
The following details exemplify this ripple effect in Medicine Hat:

- In couple families with just one income-earner, female breadwinners not only make substantially less than male breadwinners, their median incomes consistently fall below the LIM (Figure 3.2). This accounts for 1,617 - 3,233 people living in poverty. For more information on Median Incomes, see Appendix 3.

- At least 33% of single parents live in poverty, and 80% of single parents in Medicine Hat are women (Statistics Canada, 2010; Statistics Canada 2011). This accounts for approximately 816 families living in poverty.

- 75% of single mothers with children under the age of 6 live in poverty, and children under the age of 6 have a higher likelihood of living in poverty (Statistics Canada, 2006)

- More than 2/3 children living in poverty have single parents, which accounts for 1,770 children

- If 80% of these children have single moms, then roughly 55% of all children living in poverty have single moms, accounting for 1,416 children.

In our interviews, all of the women living on low-income took it upon themselves to help their ailing parents or other relatives, as well as their neighbours, some of whom were struggling even more than the women interviewed. It is thus important to note that the ripple effect of women living in poverty goes beyond just the nuclear family.

**Roughly 55% of all children living in poverty have single moms, which accounts for 1,416 children**

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3 More than half of female breadwinner couple families (525) make less than LIM, which accounts for approximately 1617 people. We know the number of female breadwinner families with 3+ children, but can only estimate the number of people in this family type. We use the average number of people in couple families with 3+ children – 4.5 – to estimate this.

4 In the city of Medicine Hat (as opposed to Census Agglomeration) this rate was higher at 38.5% in 2006.

5 This estimate assumes that because 80% of single parents are female 80% of children with single parents have single moms. Our research suggests that single moms on average have more children than single dads, but we do not have hard numbers on this for Medicine Hat, so this is a rough estimate.
At least 33% of single parents live in poverty. 
80% of single parents in Medicine Hat are women.
Why are women more prone to low incomes?

Based on data from the interviews, some of the difficulties faced by female parents may relate to conflicts between the schedules of young children and a lack of flexibility in the workplace, particularly in low-wage workplaces. Low incomes may also relate to the inadequacy of child benefit income for lone-parents and one-income families, particularly when 2 or more children are involved. Research from Vancouver has shown that these families face more difficulty breaking even (Richards et al., 2010). Figure 3.3 shows how the incomes of different family types measure up to the LIM and whether they fall short or above the LIM on a per person basis. Note that median incomes for single parents, most of whom are women, are only slightly above the LIM, and that 33% of single parents live under the LIM.

Women in Medicine Hat are much more likely than men to earn low wages, a difference that is far more pronounced than the provincial statistics. For example, if we look at those earning $13/hour and less, 75% of this group are women in Medicine Hat, compared with 62% provincially (Statistics Canada, 2012). Figures 3.1 and 3.2 provide more evidence of income inequality among men and women, even when women are the primary earners. This suggests that higher-wage employment opportunities for women are more limited. Interviews and data suggested that retail and health sector employment accounted for much of the available work for women with limited post-secondary education, and that significant barriers to educational attainment existed. These barriers included having to obtain costly pre-requisites, such as the GED (high-school diploma equivalent), the cost of post-secondary education, the availability of student loans, pre-existing debts, and childcare costs.

Men and Poverty in Medicine Hat

In 2010, 2,106 men lived in poverty. Men are more likely than women to experience poverty related to the realities of living in a resources and light-industry economy. We can account for many of the men statistically, but it is important to note that several of the following categories overlap - for example, one can be a single-parent and on Alberta Works. Men living in poverty include the following:
• 1,700 men earn less than $13/hour and are in poverty or vulnerable to poverty (Statistics Canada, 2012);

• 90 low-income single male parents live in poverty (informed estimate, Statistics Canada 2010, Statistics Canada 2006);

• 108 men living in poverty were on income supports as of September 2012 (Government of Alberta), with 69% Expected to Work;

• 840 were on AISH as of October 2012, and we can assume that the majority of them live in low-income households (Government of Alberta, 2012b)

• 620-1,240\(^6\) low-income males live in couple families with a female single-earner, illustrating the ripple effect of lack of opportunity among women (Statistics Canada, 2010b);

• 330 men were on employment insurance in July 2012 in Medicine Hat, which is 6% higher than provincial usage rates (Statistics Canada, 2012b)

**Why do men experience poverty?**

There are approximately the same number of men as women on AISH, and significantly fewer men on Alberta Works. Above and beyond AISH, poverty among men seems to be most highly related to low-income work, to unemployment, and to living in households with women as the primary earners. Statistics and qualitative data provide some explanation for this. Men are less likely than women to continue with post-secondary education in Medicine Hat and in Alberta in general, in part because this is not required for well-paying jobs in the energy sector. Interviews suggested that because of the boom-and-bust cycle of the sector, men may find themselves unemployed, at which point finding jobs for similar pay becomes much more difficult with less education. This could explain why, compared to provincial numbers, those in Medicine Hat make proportionally more use of EI.

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\(^{6}\) Estimate based on tabulations from CANSIM tables 111-0015 and 111-0020. StatsCAN getting back to me re: more conclusive numbers.
When speaking about employment and poverty, it is important to note that the working poor are an often overlooked demographic, and can be among the most vulnerable in economic crises. As Peter Faid (2009) explains:

*In the province today, jobs may be more available, but as the cost of living rises, working Albertans who do not qualify for health, housing and other subsidies are often worse off than welfare recipients. As a result, the working-poor in Alberta tend to be the first to be hurt and the last to get help.* (p.24)

This is important to keep in mind given the number of low-wage workers in Medicine Hat, which is among the highest rates in Alberta (Public Interest Alberta, 2012). This also helps us understand why so many single parents do not work. While income supports and child tax benefits may not provide very high incomes, they do provide benefits and some stability regardless of the marketplace.

“On income supports, you get $750/month if you’re lucky. You can’t pay the most basic bills with that.”
- Medicine Hat Resident

250 companies in the region that supply goods and services to the oil and gas sector
17.5% of men employed in oil and gas
12.6% of men employed in agriculture, forestry, fishing and hunting
17.3% of women employed in health care & social assistance
14.1% of women employed in retail

Statistics Canada Census, 2006
Unemployment

Unemployment is another important contributing factor in poverty. Unemployment\textsuperscript{7}, which is measured for Medicine Hat and Lethbridge combined, was at its highest in the spring of 2010, going up as high as 7.5% and then sitting at 5.1% as of August 2012 (Statistics Canada, 2012c). This puts unemployment numbers at 3,713\textsuperscript{8}, and as of July 2012, 1,090 Medicine Hatters were on employment insurance. Untracked are the people not qualified for income supports or those who choose not to access them, despite being unemployed or unable to work due to illness or injury. Individuals who have chosen not to pay employment insurance dues while self-employed, but have limited or no savings, are particularly vulnerable should they find themselves unable to work.

Approximately 60% of those on employment insurance are women\textsuperscript{9} (Statistics Canada, 2012) in Medicine Hat. The disparity between men and women is lower in Medicine Hat than Alberta averages, which could signify that men in Medicine Hat face more challenges than elsewhere in the province when it comes to employment. Again, this reflects what we heard in interviews in relation to the boom-bust dynamic of the natural resource sector in Alberta.

Income Support and the Poverty Trap

Income supplements or replacements are provided in Alberta by Assured Income for the Severely Handicapped (AISH), which is a long-term income-replacement program, and by Alberta Works, which is a shorter-term program designed to help people through periods of temporary crisis. People receiving Alberta Works may then fall within two categories: Expected to Work and Barriers to Full Employment.

\textsuperscript{7} According to Statistics Canada, unemployed persons “persons who, during the reference week, were without work, had actively looked for work in the past four weeks, and were available for work. Those persons on layoff or who had a new job to start in four weeks or less are considered unemployed.” Interestingly, “employed person” include those performing unpaid family work, even though they would not qualify for employment insurance.

\textsuperscript{8} Figure represents the Medicine Hat Census Agglomeration. For the City of Medicine Hat (census subdivision), the unemployment estimate would be closer to 3060.

\textsuperscript{9} Averaged over one year, July 2011-July 2012

“I had to drop out of high school to support my family. I took courses later on to improve my skills, but still only got minimum wage jobs, and now I have student loans to pay on top of it all. I couldn’t pay them back on minimum wage, and the government hasn’t forgiven them. Until I pay them back, I can’t get another student loan.”

- Medicine Hat Resident
Persons in these programs nearly always find themselves living in poverty. Persons living on AISH, for example, make $19,056/year if they do not have additional income, and number 1,650 people in Medicine Hat (for annual numbers, see Figure 3.4). Those on Income Supports can make as little as $583/month (Government of Alberta, 2012d), which after rent leaves nearly nothing for other expenses – not enough to buy a bus pass, food, clothing, hygiene products, medications, etc. As of October 2012, 332 people were on Income Support through Alberta Works in Medicine Hat.

It is also worth mentioning that not all persons requiring financial assistance such as AISH or Alberta Works receive the help they need, for a number of reasons. At times, the rules associated with Alberta Works and AISH fail to serve the unique needs of individuals. We saw this in interviews with Medicine Hat residents; who at times would benefit from and qualify for help do not seek it out.

Questions still exist around why the Alberta Works "Barriers to Full Employment" (BFE) category was almost cut in half as of November 2011 in Medicine Hat, as seen in Figure 3.5. For more detailed caseload levels, see Appendix 5. One might expect the Expected to Work (ETW) category to decrease along with a substantial effort to increase employment opportunities for those on
Alberta Works, or for AISH numbers to go up with a decrease in BFE cases, which has not occurred. The recorded decrease is incongruous and should likely be investigated by the community.

**What are the ripple effects of those living on AISH?**

Most people receiving AISH are single persons. From our interviews, we heard that marrying often disqualified individuals from AISH. This means having to cover many expenses related to their disabilities on the incomes of their spouses. There are some individuals on AISH with families, including 102 single parents, 97 couple families with no children, and 42 couple families with children (Government of Alberta, 2012b). We do not know how many of these families live in poverty, but can assume that the majority of single parents on AISH, as well as their children, are struggling.
What are the implications of Living on Income Supports?

Climbing out of poverty while on Income Support is often described as challenging. This was captured by Medicine Hat residents, and is documented within the literature, and it comes back to the rules and policies of provincial Income Support, which we’ll attempt to summarize here.

To qualify for income supports in Alberta, one can own a house, a vehicle and have $5,000 in RRSPs; but one must not have more than $583–1,166 in available cash (i.e. in a chequing or savings account.) In other words, users must lose their savings before getting help. Once on income supports, one can make $230/month at work on top of the $583/month typically provided by the program. Beyond this, there is a significant disincentive to work because 75 cents on every dollar earned is “clawed back” by the province (Stapleton, 2012; Government of Alberta, 2012d). This makes it exceedingly difficult for people to position themselves to succeed.

On this income, people end up having to spend all of their time and income trying to cover their basic needs, rather than having sufficient income to invest in their future. Investments for the future can include simple things, like being able to afford transit passes to get to job interviews, or being able to buy personal necessities such as denture glue, hearing aid batteries and clothing that makes one more employable. Investments may also include expensive or time-intensive activities, such as pursuing further education and building skills, or addressing past trauma, mental illness, or addiction.

This approach to Income Support seems counter to the intended outcomes of the program, which is meant to help people temporarily through tough times until they can get back on their feet. Rather than spring-boarding people out of poverty, the program is more likely to inadvertently trap people in poverty. Essentially, not investing enough in people during hard times depresses their ability to climb out of poverty (Stapleton, 2012; Karelis, 2007). Not only is this frustrating personally for those experiencing poverty, it is much more expensive in the long-run. People end up depending on programs for longer and are more likely to experience negative health impacts related to low income, which also puts pressure on the health care system.

“Alberta Works, with its earning exemption of $230 a month, allows someone to make minimum wage for 24 hours a month before it reduces [earnings] by 75 cents on the dollar.”
- Stapleton, 2012, p. 2
New Immigrants and Refugees

It is difficult to pin down immigrant demographics in Medicine Hat. The new immigrant population, according to local experts, is subject to much in- and out-migration, so the population numbers change often. In addition, census data relies on self-identification as a new immigrant, as well as on citizens understanding the census. These are factors to consider when quoting the 2006 Census, which states that 740 people were new immigrants (had immigrated within the past 5 years) in the CA of Medicine Hat in 2006. This accounts for 1.1% of Medicine Hatters.

In addition to the limited reliability of immigrant population figures, there is no available census data on poverty among immigrants. Saamis Immigration Services Association in Medicine Hat, however, works closely with new immigrants and refugees and has a wealth of expertise and data to lend on the topic. The number of people coming through their doors has been on the rise since 2009, from 87 in 2009, to 101 in 2010 to 109 in 2011. The majority are refugees, accounting for 63.3% of their clients in 2011 (Saamis Immigration Services Association, 2012). Other immigrants come as “family class” immigrants, which means they’ve been sponsored by a family member, or “economic class” immigrants, who come to work.

Refugees coming into Canada receive Income Support for their first year in Canada or until they are independent. Their incomes in Alberta depend on family size, and range from $700/month for a single person – well below half of LIM – to $1600/month for families of 7 or more. Similar to Alberta Works clients, they are able to keep up to $350/month in work earnings for an individual, and then their income is deducted dollar for dollar.

According to local experts, we can safely assert that both new immigrants and refugees struggle financially upon coming to Medicine Hat. Within couple families, both adults typically work in entry-level jobs for minimum wage or close to minimum wage in service, manual labour and health care. All clients coming through SAAMIS immigration apply for subsidized housing, and it is roughly estimated that 90% are still in subsidized housing 3 years later.
It was noted that education in Medicine Hat has improved in the last decade in terms of ESL services and employment programs for ESL learners, with the development of programs such as “Connection”. There is a gap, however, for professionals trying to access the courses required for professional accreditation in Canada. Often, professionals end up moving to bigger cities to pursue this goal.
POVERTY AND THE COMMUNITY AS A WHOLE

Poverty affects us all socially, economically and personally. Richard Wilkinson and Kate Pickett, authors of *The Spirit Level* (2009), show us that income inequality affects us in very measurable ways, and at every income level. In fact, they argue that income inequality has a higher negative impact on social factors than poverty. Their research correlates hard data from around the world with nine different impacts: community life and social relations, mental health and drug use, physical health and life expectancy, obesity, educational performance, teenage births, violence, imprisonment and punishment, and social mobility.

Because of the strong correlations, the nine impact areas can be considered as indicators of progress with regard to inequality and poverty. Using them as indicators at the city level requires some caution. Wilkinson and Pickett correlate the nine impacts with inequality at the national level, not at the municipal level. As such, we don’t know if municipal impacts would be most affected by inequality at the local, provincial or national level. It would thus be wise to keep track of inequality at each of these levels of geography. With this in mind, it may be useful for Medicine Hat to choose several indicators from each of the 9 areas, several of which are listed in Appendix 2, and track them over time.

The following graphs, Figures 3.6 to 3.10, have pulled out a few key indicators where a marked difference exists between Medicine Hat (or South Zone) data and Alberta-wide data. We can see for example, that the average Medicine Hatter has lower perceived life stress than the rest of the province, and a greater sense of community (Figures 1.8 and 1.9), indicating positive results. On the other hand, we see that there are more people seeking mental health services per capita than provincially. This could indicate that more Medicine Hatters experience significant mental health issues, or it could indicate that more Medicine Hatters seek help, or with no addictions centre in Medicine Hat, it could be a result of persons with addictions seeking help through psychiatric services. We can’t know why Medicine Hat has a higher rate than in Alberta, but we can track the use of mental health services over the years to see how it changes as other factors change – poverty rates, income inequality, employment opportunities and perceived quality of employment. It is worth noting that in other Canadian cities that have achieved more income equality,
decreases in the use mental health services have been observed, so this is likely a good indicator to track (Forget, 2011). This same approach can be applied to child intervention caseloads and high school achievement rates – again, it is worth tracking several indicators from each of the nine areas in order to develop a picture of how Medicine Hat is faring, overall, as a community.

These indicators give us a sense of how a community is doing, but what can we do to make communities better? This is the question that drives the next six sections, each of which focuses on a priority area identified by the Medicine Hat community: Living Wages, Affordable Housing, Affordable Transportation, Recreation, Education and Food Security. All six were considered strategic areas of intervention at the community level, where there is potential to reduce poverty and/or its negative effects. Following the tables below, the proceeding chapters describe ways in which these areas can contribute to poverty reduction, the current state of the priority areas in Medicine Hat, and opportunities for future action.

Figure 3.6: Physical Health Indicators, Per 100,000 population, Medicine Hat and Alberta, 2011 (Canadian Community Health Survey Data, 2011)
Child intervention caseloads in Medicine Hat have decreased from 304 in 2009/10 to 260 in 2011/12.

“...The hospital is not designated or well-equipped to hold people with mental illnesses who have been remanded. They end up having to be taken to Calgary to be remanded there, which is really time- and resource-intensive.”

- Medicine Hat Resident
Figure 3.9: Community Life and Social Relations Indicators, Medicine Hat and Alberta, 2011 - 2012 (Canadian Community Health Survey Data, 2011)

Figure 3.10: Grade 9 Achievement Rates, Medicine Hat and Alberta, 2011 - 2012 (Government of Alberta, 2012d)
A Living Wage is one way in which communities can ensure that their citizens make enough to survive and provide a buffer for crises.

Living Wage is the amount of income an individual or family requires to meet their basic needs, to maintain a safe, decent standard of living in their communities and to save for future needs and goals and devote quality time to friends, family and community. (VCC, 2012)

It is also fundamentally an investment that an employer makes in an employee. Why an investment? We know that there are real and measurable financial costs to businesses, to the government, and to taxpayers – as well as social costs in our communities, when our neighbours live in poverty.

It is important to note that there is a distinction between a Living Wage and Living Income. Living Wage refers to income earned from employment; it does not refer to a form of guaranteed income support for people who may be under or unemployed or who cannot be employed full-time.

In addition, while Living Wages are important, so are good general business practices. Living Wages should not be seen as a replacement for benefits, flexible work places, or supportive Human Resources policies but rather as one part of a healthy workplace. Interviews with people from Medicine Hat made this point very clearly: that while wages are one key factor in a work-place that contributes to a good standard of living, so too are other practices that benefit both businesses and the community.

What are the Benefits of a Living Wage?

Paying a Living Wage recognizes that employees are the most valuable assets in a workplace. Not only does it keep employees out of poverty, it can improve employers’ bottom line by boosting productivity, reducing employee turnover, decreasing training costs and providing a key marketing tool. In fact, the Living Wage is among the top Corporate Social Responsibility initiatives when it comes to improving customer loyalty and corporate income. Paying Living Wages also boosts local economies by increasing local spending, and contributing to healthier communities (Reich, Hall and Jacobs, 2005; London Economics, 2009; Aaronson et al., 2008; CCPA, 2009; Cascio, 2006; VCC, 2012).
On the other hand, low incomes are associated with high stress, poorer health, more interaction with the justice system as victims and perpetrators, and more work absenteeism – all of which have very measurable costs to business, government, and taxpayers (Briggs and Lee, 2012; CCPA 2009).

Living Wages Improve the Bottom Line

Barclay’s Bank, accounting giant KPMG and the San Francisco Airport all reported seeing huge decreases in employee turnover, ranging from 50-87%,
when they implemented Living Wage policies as part of new HR strategies (KPMG, 2012; SERTUC; Reich, Hall and Jacobs, 2005). For the airport this resulted in thousands of dollars in savings per employee in recruiting and training costs. Calgary’s Community Natural Foods saw similar benefits resulting in a sharp increase in productivity that far exceeded the increase in salary costs, with an overall benefit to its bottom line. In other words, Living Wages made its business operations less expensive. These businesses have also successfully leveraged their Human Resources policies in marketing campaigns.

Where has Living Wage Gained Traction?

The concept of the Living Wage has been used in many Canadian municipalities, including New Westminster, Vancouver, Calgary, and Hamilton. In most cases, their activities involve voluntary initiatives; in Calgary, for example, Vibrant Communities Calgary provides a “Living Wage Leader” designation as a Corporate Social Responsibility initiative. Rather than using a voluntary measure, New Westminster set a Living Wage of $19.14/hour as the minimum for all City employees.

The Living Wage also has a long history in the U.S. and in the U.K. It was recently prominently featured in the London Olympics where the Olympic Delivery Authority included a Living Wage clause in all of its sub-contracts. The Holiday Inn soon joined them becoming the first hotel chain to implement a Living Wage policy. These policies follow in the footsteps of other major corporations in the UK with Living Wage policies, including Barclay’s Bank, HSBC, Price Waterhouse Coopers, and the London School of Economics.

How is the Living Wage Calculated?

This report uses the Living Wage for Families (LWF) methodology developed by the CCPA, which calculates a wage allowing two income earners to support a family of four. This methodology assumes the following scenario:

- 2 parents working full-time
- 2 children aged 4 and 7
• 1 parent taking evening courses at a local college

• Family members are healthy, with no special needs, including dietary, medical or other

• Costs of living include transportation, health benefits, food, housing, clothing, and “other” expenses

• Rental housing (not ownership)

• Taxes, tax rebates and government benefits, namely child tax benefits.

A detailed account of the calculation can be found in Appendix 4. In simple terms, the calculation can be described as such.

**Living Wage for Families, for a healthy family of four with 2 income-earning parents and 2 children, aged 4 and 7**

\[
\text{Combined Income for 2 parents} = (\text{Expenses}^1 + \text{Taxes}^2) - \text{Tax Benefits}
\]

\[
\text{Living Wage for Families} = \$13/\text{hour/parent}
\]

---

1 Expenses include food, clothing, transportation, shelter, health benefits, and “other” costs. Food, clothing and “other” expenses come from 2011 Market Basket Measure (MBM) data for a city of 30,000 - 99,999 in Alberta. “Other” expenses include a long list of products including, but not limited to, cleaning and hygiene products, a landline telephone, and they now include a household computer but not a cell phone. Transportation, shelter and health benefit expenses are local figures. For a detailed list of items and expenses, see Hatfield et al. (2010)

2 Tax calculations use latest Alberta tax forms and online Canada Revenue Agency calculators
It is significant that the LWF recognizes that the well-being of citizens is a responsibility that lies not only with employers, but with governments and communities as well. It does this by accounting for child tax benefits (provincial and federal initiatives), the cost of a transit pass (municipal), and the cost of housing and other expenses (CCPA, 2009). Thus, as progressive social policies are implemented, the Living Wage has the potential to decrease accordingly. The Living Wage can also be decreased to account for employer contributions to staff education and benefit plans.

This methodology is conservative, based on “bare bones budget without the extras many of us take for granted (Richards et al., 2010, p.5).” It also does not account for those who cannot work 35 hours/week, such as persons with disabilities, nor does it account for single parents, who would require higher incomes to get by. A single parent with one child for example, would have to make closer to $19/hour in Medicine Hat to have the same purchasing power. Given some of the limitations of the LWF methodology, it is important to acknowledge the role of other government-provided safety nets, such as child tax benefits, that can help make up the difference for some families.

It is worth noting that the LWF methodology has been tabled as the standard in the development of a national framework for a Living Wage, through a pan-Canadian Living Wage network convened by the Tamarack Community. Thus, in using the LWF, the Medicine Hat community may have the opportunity to join an initiative that is already gaining momentum across Canada. More on the benefits and drawbacks of the LWF and other methodologies are described in Appendix 6.

**Living Wage Figures for Medicine Hat**

Medicine Hat’s Living Wage comes to $13/hour, which means that a family of 4 is considered to make sufficient income when **two adults make $13/hour each**. If we apply this methodology to other family types, we find that $13/hour is also enough to sustain a healthy single person, but due to Alberta’s tax rates and benefits, is not sufficient for single parent families. Again, this underlines the importance of adapting supportive policies, such as child tax benefits, accordingly.

“Moms need flexible hours, and this isn’t available in lower paying jobs.”
- Medicine Hat Resident

“I can’t get by on a minimum wage, even with two people earning a minimum wagel.”
- Medicine Hat Resident
Who benefits from a Living Wage in Medicine Hat?

Increasing wages in Medicine Hat to Living Wages has the potential to impact the lives of the 6,100 full-time and part-time employees making less than $13/hour – 21% of all workers in Medicine Hat.

Increasing wages to Living Wages can particularly improve the lives of women and adults 25+:

- The vast majority of employees making less than $13/hour are 25+ years of age\(^3\)
- 73% of those making less than $13/hour are women (4,500 people)
- 31% of all female employees make less than $13/hour,

Low wages are also over-represented, percentage-wise, among part-time employees:

- 83% of all workers work full time, 17% part-time
- 17% of full-time workers make less than $13/hour (4,000 people 25+)
- 44% of part-time workers make less than $13/hour (2,100 people 25+)

It is important to note that this data does not tell us whether part-time workers wish to work part-time or can afford to work part-time; nor does it tell us whether part-time employees are working multiple jobs, and in so doing, working full-time hours or more. These are important factors that our interviews have encouraged the community to take into consideration.

There is some evidence, based on provincial data rather than on Medicine Hat data, that the sectors that have the highest rates of low income include retail,

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\(^3\) Employee counts for those 25 years of age and less are suppressed in most categories because they are below the reliability threshold, which is 1,500 for this particular survey. Thus, we know that the vast majority of those making less than $11/hour and $13/hour are 25+ years of age, but cannot determine the exact percentage.
construction, health care and administration (McIntyre et al, 2012; McIntyre, 2010). Interestingly, retail and health care are the top employers for women in Medicine Hat, and in interviews, these were the sectors in which residents reported experiencing low income.

**What Residents Said:**

Residents stated that many employers, particularly in the retail sector, hired part-time employees rather than full-time employees in order to avoid providing benefits. Some of these residents worked several part-time jobs, and others wished they could work full-time, both for the extra income and for the benefits. As such, they highlighted the idea that implementing a Living Wage is only one piece of a broader Human Resources strategy to help address poverty in Medicine Hat. On the other hand, another resident felt that working extra jobs was simply par for the course until you could land a higher-paying job.

One resident felt that the Living Wage should account for home ownership, which would encourage residents to stay in Medicine Hat and lay down roots; and, in doing so, invest in the community as long-term, contributing members. Others felt it is difficult to determine which expenses should be included in a Living Wage, citing it as a subjective figure that is subject to lifestyle choices.

Others wondered about the role of education in helping individuals qualify for higher-paying jobs, potentially outside of Medicine Hat. They also weighed this against the importance of keeping residents in Medicine Hat and building local higher-paying employment opportunities. They felt Medicine Hat should focus on changing the job market, rather than on wages in the existing market. In addition, however, they felt that assisted living incomes should increase to bring those with barriers to employment to the poverty line.

Some felt that a Living Wage put too much onus on small, independent businesses, and one suggestion was to consider a Guaranteed Annual Income as an alternative. In this model, anyone making less than a given yearly income.

“On top of benefits and bonuses, [our company] provides reimbursement for 75% of the cost of online or evening courses, and contribute to employee scholarship funds. We also make sure to provide raises every 3 months.”

- Medicine Hat Resident and employer
We need living wages so parents can pay the bills, pay for childcare, education, and do some budget planning.”
- Medicine Hat Resident

(likely something close to the poverty line) would be topped up⁴. While investigating the Guaranteed Annual Income was not the purpose of this report, it is a policy tool that has certainly gained attention in recent years. Prominent among its proponents are Senators Art Eggleton and Hugh Segal.

**KEY QUESTIONS MOVING FORWARD**

1. How can the benefits of paying a Living Wage be shared broadly with employers in Medicine Hat?

2. What would it take to see Living Wage implemented? What incentives could be used? In policy? Through voluntary initiatives?

3. How can local business leaders be supported to share best practices in Human Resources with others?

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⁴This has been successful in various places, including in Dauphin, Manitoba, in the 1970s, when a Guaranteed Annual Income (GAI) was implemented as part of a pilot project. The policy resulted in lower usage of the health care system and its associated costs, and it only saw a drop in employment among young adults, who chose to continue their studies rather than join the workforce. Nova Scotia, which implemented several policies paralleling a GAI, actually saw welfare caseloads drop as a result. A GAI tries to ensure that no citizen becomes destitute, that no citizen is left without choices, but is set low enough that it provides a significant incentive to work (Forget, 2011; Nova Scotia, 2008).
Affordable housing is understood as consuming no more than 30% of a family’s income, including utilities. Fundamental to an understanding of affordable housing in Canada is that it is also adequate and suitable housing. It is safe, clean, and meets the needs of its residents with regard to space (Pomeroy, 2001). According to the Canada Mortgage Housing Corporation (2011), many families in subsidized housing end up paying disproportionate amounts of their income on housing.

Stable, safe and uncrowded housing is critical to childhood development, including social, psychological, and academic performance (McFarlane, 2001; Shillington, 2001; Evans et al., 2001; Hwang et al., 1999; Cooper, 2001; Child and Youth Health Network for Eastern Ontario, 2003; CMHC, 2011; Evans and English, 2002). These benefits are correlated with future income, future literacy, and future interaction with the justice system (National Council of Welfare, 2000; CCPA, 2009). Housing is one of the basic needs required for people to be securely employed, to consider investing in themselves, to raise children healthfully, and to start thinking about getting ahead, rather than getting through the day.

**Current Situation in Medicine Hat**

While the vacancy rate in Medicine Hat has increased over the last several years – up to 7.5% as of August 2012 due to new construction (City of Medicine Hat) – the waiting list for affordable housing numbered 340 households as of June 2012 (see Table 5.1). This tells us that not everyone in Medicine Hat can afford the existing stock. Why? Typically, being unable to afford housing can be traced back to income (Garrett et al., 1994), it can relate to intensely competitive housing markets, which is not the case in Medicine Hat; and it can relate to a lack of affordable and suitable options for those on low incomes. So let’s take a look at how Medicine Hat is doing on affordable housing and its relationship to income.

In Medicine Hat, average housing rental prices have stayed fairly consistent since 2009, now sitting at $695/month for a two-bedroom apartment. If this monthly rent represented 30% of an annual income, that annual income would be $27,800 – well above the LICO, LIM and MBM for 1 and 2 people. This tells us that those below the low income lines, as well as those slightly above them,
may be struggling to make ends meet in Medicine Hat; and we know that they represent many more than the 340 on the Affordable Housing waiting list. For example, of the families who would be in the market for a 2-bedroom apartment alone, 1,140-1,640 families fall below the $27,800 mark (Statistics Canada, 2010).

Affordable housing in Medicine Hat is provided primarily by the Medicine Hat Community Housing Society (MHCHS), in two ways: by providing units owned by the MHCHS for long-term and transitional housing, and by providing rental supplements. These strategies are funded both municipally and provincially.

In 2010, the total housing portfolio of the Medicine Hat Community Housing Society numbered 1,021 units, including the 555 units in Table 5.1 owned by the MHCHS. The cost of renting these units is $430/month for 1-bedroom

Table 5.1: Medicine Hat Community Housing Association Affordable Housing Waiting List, February 2013

<table>
<thead>
<tr>
<th>Size of Home</th>
<th>No. of Households on Waiting List</th>
<th>No. of Units MHCHS Current Housing Stock</th>
<th>No. of Wheelchair Accessible Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 bedroom</td>
<td>179</td>
<td>16 bachelor 270 1-bedroom</td>
<td>46</td>
</tr>
<tr>
<td>2 bedrooms</td>
<td>93</td>
<td>90</td>
<td>2</td>
</tr>
<tr>
<td>3 bedrooms</td>
<td>38</td>
<td>139</td>
<td>3</td>
</tr>
<tr>
<td>4 bedrooms</td>
<td>6</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>5 bedrooms</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Special Needs</td>
<td>allocated through community agencies</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>316</strong></td>
<td><strong>555</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>

Medicine Hat Community Housing Society, 2013

1 Assuming this includes couple families without children, couple families with one child and single parent families with one child.
2 1,140 families make less than $25,000, and 1,640 families make less than $30,000.
“The rental subsidy is hugely important. I want to avoid moving into community housing. I don’t want to move my kids, give up the dog, lose my neighbours. We need to enhance the subsidy program.”
- Medicine Hat Resident

units, $540/month for 2-bedroom units. When benefiting from rent subsidies, recipients pay 30% of their income, leaving the remainder of the rent to be subsidized. There will be 32 new units added to this stock in 2013, which will be owned by the City of Medicine Hat, and managed by the MHCHS.

It is worth mentioning that being on a waiting list for affordable housing impacts families. According to the CMHC, not only does this prolong the physical and economic vulnerability of applicants, it contributes to psychological distress (including powerlessness and stress), which manifests as academic underachievement for children in school. Medicine Hat’s investment in new units shows responsiveness to the current need for more affordable housing. Ensuring that low-income earners are suitably housed should continue to be a priority.

Funding for rental subsidies, as opposed to community housing, was described as limited in resident interviews, and this was identified as a weakness. Both low income-earners and social service workers indicated that rental supplements allow families to stay in their homes thereby reducing unnecessary distress to children and adults (particularly for those with special needs), allowing them to keep their pets, and avoiding the ghettoization of poverty. Rental subsidies encourage more mixed neighbourhoods, residents said, which can mitigate the cycle of poverty and the disruption involved in moving. This is feedback that may be worthwhile discussing with the province, which partners with the MHCHS and the City of Medicine on affordable housing.

It is important to emphasize that while the term “affordable” is often used, housing should also encompass standards of safety and suitability. Interviews with Medicine Hat residents indicated that private rental properties do not always meet these conditions, and that accountability for landlords needs to be strengthened to minimize the exploitation of low-income tenants.

Both community members and the MHCHS (in its Community Service Delivery Plan 2012) emphasized the urgency of investing in local “permanent supportive housing”, meaning housing for persons who may never achieve full independence, and who require regular visits from community or social workers. The lack of such housing, according to the MHCHS, will impede success towards the 5-Year Plan to End Homelessness.
Progress in other areas towards the 5-Year Plan, however, has been very encouraging with regard to addressing homelessness, decreasing shelter usage, using the Housing First approach, creating the Rapid Re-Housing program, and developing relationships with landlords and property management companies through the Landlord Roundtable Meetings. For example, between 2009-2012, 161 participants successfully graduated from Housing First programming, and 574 people who were homeless or on the verge of homelessness were housed over 2009/2010. The MHCHS’ Community Service Delivery Plan and the Year 2 Progress Report on the 5-Year Plan to End Homelessness are both great additional resources on the progressive and successful work that Medicine Hat has done on housing and homelessness.

**Income and Housing in Medicine Hat**

Comparing income to the cost of housing gives us a good sense of whether people are able to cover their costs. One useful indicator is the Core Needs Income Threshold which is established annually by the Canada Mortgage and Housing Corporation, Alberta Municipal Affairs for each municipality in Alberta. They state that “incomes equal to or less than CNIT are said to have insufficient income to afford the on-going costs of suitable and adequate rental units in their area” (City of St. Albert, 2012). In other words, the CNIT estimates the annual income needed to afford housing in a given city by number of bedrooms.

Looking at Figure 5.2 we see that the CNIT for a 1-bedroom is higher than the low-income measures for one person. Similarly, the CNIT for a 3-bedroom is higher than the LIM for 4 people, and so on. This tells us that those making slightly above the LIM in Medicine Hat are still struggling. Of those in the market for 2-bedroom housing in Medicine Hat, 1,640 families, or 3,460 people, would fall short of the Core Needs Income Threshold.

```
<table>
<thead>
<tr>
<th>House size</th>
<th>Req'd income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor</td>
<td>$19,500</td>
</tr>
<tr>
<td>1 bedroom</td>
<td>$25,000</td>
</tr>
<tr>
<td>2 bedrooms</td>
<td>$30,000</td>
</tr>
<tr>
<td>3 bedrooms</td>
<td>$43,000</td>
</tr>
<tr>
<td>4 bedrooms</td>
<td>$47,000</td>
</tr>
<tr>
<td>5 bedrooms</td>
<td>$50,000</td>
</tr>
</tbody>
</table>
```

Alberta Municipal Affairs, 2012

“Housing is very expensive here – I couldn’t get a place. It is $500-$600/month just for a room. I’m on the wait list for affordable housing, and it’s a year wait. Trailer court rentals go for $480/month, but there aren’t many available in town.”
- Medicine Hat Resident

“We desperately need more supportive permanent housing, with daily visits from workers.”
- Medicine Hat Resident
What Residents Said:

Residents expressed that Medicine Hat has a range of housing options that respond to crises, from short-term shelter at the Salvation Army to transitional shelters, such as Phoenix House, Musasa House, Miwasin and the McMan Centre. Some pointed out that there was a gap, however, when it comes to supportive housing options for people requiring some form of daily care, whether to address skill-building, disabilities or mental health issues, including addictions.

In addition, residents mentioned that qualifying for low-income housing was not always straightforward, which could indicate a need for more simplicity and transparency in the application process, and potentially for flexibility around persons with extenuating circumstances who might otherwise fall through the cracks. Waiting lists were also seen as simply frustrating.

Residents far preferred housing subsidies to community housing, and saw it as a better way to stay in their neighbourhoods, maintain stability for their children, avoid the ghettoization of poverty, and to keep their pets. They also suggested requesting more funding from the province in order to boost the Medicine Hat Community Housing Society’s capacity for housing subsidies.

Residents felt that home ownership was more affordable in Medicine Hat than in other cities for middle-income earners, but anything outside of community housing or subsidies was unaffordable for low-income earners. The segregation of communities along income lines was also a theme within resident interviews, but for some, there seemed to be a sense that this was changing in some areas – that communities were becoming more mixed along the boundaries.
“For those below the poverty line, subsidies are required, and we need to ensure quality of housing – it varies from household to household. We need to implement standards and accountability for landlords.”

- Medicine Hat Resident

### KEY QUESTIONS MOVING FORWARD

1. **How can the incomes of Medicine Hatters be increased so that there is less need for affordable housing?**

2. **What would it take to implement and fund supportive housing?**

3. **How can the city and province support and implement greater rent subsidies?**

4. **How can the affordable housing stock in Medicine Hat be increased quickly?**

5. **What role can the province play in increasing this housing stock?**
Mounting evidence shows that access to recreation for children can mitigate the impacts of low-income, not only for children, but for their parents as well. As used by Sheri Torjman, recreation is a “broad concept that includes formal sport, active living such as walking and hiking, and activities such as cultural dance (2012, p.3).” Recreation often encompasses physical places, such as recreation centres, sports fields and walking trails, as well as programming around activities that are often physical in nature and contribute to well-being and social connectivity.

According to Torjman, the benefits of recreation include decreased boredom, which is associated with hopelessness, loneliness and depression; improved social skills; and having an equalizing effect on social, physical and academic competence, where children on low-income do as well as their peers. Without access to recreation, these competencies drop (Torjman, 2012).

Perhaps the more surprising result to come out of studies on recreation is the impact that affordable recreation services for children may have on parents. In a study where single mothers were offered a bundle of health-related services, parents whose children had access to recreation had a 10% greater chance of moving away from a dependence on social assistance, and 20% of parents whose children received recreational services exited social assistance after 1 year (Ott et al., 2006; Torjman, 2012). Parents reported having more money because they were spending less on their children’s recreation, and spending less on their personal use of health and social services.

The authors found that subsidizing recreation actually paid for itself. Children with subsidized recreation showed a decreased use of specialist services aimed at emotional/behavioural problems, of social workers, day care services, and “other” providers. These savings also covered the costs of the family counsellors and subsidized childcare that were offered alongside of subsidized recreation. Thus, a moderate investment in recreation led to savings down the line: a financial “break-even” in children’s services, a financial surplus for parents, and a marked social benefit or “surplus” for families and communities.

These beneficial impacts are interesting in relation to what we heard in resident interviews. On one hand we heard that organized sports, such as soccer, were very expensive, and on the other hand, that soccer can be one of the
cheapest sports – all you need is a ball. This points to the difference between organized sport and pick-up sports. When considering the pros and cons of organized and pick-up sport, it is important to consider the factors that relate to poverty. In addition, it is important that children are not segregated according to socio-economic backgrounds – that sports allow them to feel a sense of belonging to the same community. Whether this is achieved through organized or pick-up sport is not relevant on its own, but organized sport is currently the norm, and thus currently offers a higher sense of belonging.

Accessing recreation is important for adults as well as children. Recreation improves health outcomes and provides opportunities for social inclusion and connectedness (Wellesley Institute, 2012). Developing policies that remove barriers to recreation - such as cost, transportation, infrastructure, lack of information, and stigma associated with socio-economic status - can have very beneficial effects for people living on low-income and for communities on the whole. As will be discussed in other priority areas, universal programs are effective at removing barriers associated with social stigma, as are programs that exercise discretion when providing subsidies.

Access to Recreation in Medicine Hat

A number of programs exist in Medicine Hat that increase access to recreation for those with low-incomes, for both children and adults. They include the Jump Start Program, Kid Sport, the YMCA, the Elm Street School, Gear Up Sports (a Lions’ Club initiative), the Kinsmen Club and the North Flats Neighbourhood Association for children in the Flats neighbourhood. Residents in Medicine Hat described several of these programs very positively; in fact, the only drawback seemed to be that not all low-income parents interviewed knew about the programs.

The JumpStart program is a collaborative initiative by the YMCA and Canadian Tire providing subsidies for youths ages 4-18. In 2011, JumpStart helped 280 children cover the costs of a wide variety of sports programs and camps (see Table 6.1). Funding is available to cover fees, equipment and transportation, but with the exception of lacrosse equipment, only program fees were provided in 2011. Qualifying for the program is largely trust-based: parents can indicate how much they

“Many activities are reasonable [in price] but then transportation costs on top of activity costs are too much. You can either go somewhere or pay for something but you can’t do both”.

- Medicine Hat Resident
KidSport also helps families pay registration and equipment fees associated with organized sport for children, providing up to $300/child/year, and they organize community events, such as the Red and White Day with the Calgary Stampeders. In 2011, they funded 207 children across 17 different sports, for a total of $44,000 disbursed. They note that demand keeps rising every year by 5%-10%. Eligible families include those in which parents earn low incomes, are unemployed, or are on AISH or income supports.

Table 6.1: Assistance Provided to Children and Youth in Medicine Hat by JumpStart, 2011

<table>
<thead>
<tr>
<th>Total Individuals helped</th>
<th>280</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>146</td>
</tr>
<tr>
<td>Male</td>
<td>142</td>
</tr>
<tr>
<td>Age 4 - 8</td>
<td>115</td>
</tr>
<tr>
<td>Age 9 - 13</td>
<td>115</td>
</tr>
<tr>
<td>Age 14 - 18</td>
<td>50</td>
</tr>
<tr>
<td>Total Disbursement</td>
<td>$36,439.80</td>
</tr>
<tr>
<td>Avg. Cost per Child</td>
<td>$130.14</td>
</tr>
</tbody>
</table>

For adults, the Family Leisure Centre and the Crestwood Recreation Centre provide a 50% discount to those with low-income. As seen in Table 6.2, uptake of this program has been increasing steadily. The Family Leisure Center also offers special rates to all users on specific days or for specific time periods, such as Terrific Tuesdays, Last Hour and Non-Prime Time rates.

Additionally, the Kinsmen Club provides funding for free skates and swims at City owned rinks and pools throughout the year. Free skating times occur weekly at each of the arenas from September to April and free swims occur at the each of the outdoor pools weekly in June, July and August. These times are

“Recreation can be expensive, but there are good sports programs. My kids do two sports each through KidSport.”

- Medicine Hat Resident
published weekly in the Medicine Hat News and are on the City of Medicine Hat website. Universally free events such as these can be important in decreasing the stigma around socio-economic status (Ribar and Haldeman, 2011). This is one way to ensure that no one is excluded from these social activities, and that no one is treated differently.

Table 6.2: Uptake and Cost of Adult Recreational Discounts at the Family Leisure Centre and Crestwood Recreation Centre, 2008 - 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Overall Cost</th>
<th>No. of Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$1,692.40</td>
<td>34</td>
</tr>
<tr>
<td>2009</td>
<td>$2,837.00</td>
<td>41</td>
</tr>
<tr>
<td>2010</td>
<td>$4,425.50</td>
<td>59</td>
</tr>
<tr>
<td>2011</td>
<td>$5,901.08</td>
<td>102</td>
</tr>
<tr>
<td>2012</td>
<td>$3,572.83</td>
<td>71 (as of July 4)</td>
</tr>
</tbody>
</table>

City of Medicine Hat, 2012

The Elm Street School and North Flats Neighbourhood Association provide examples of neighbourhood-based initiatives, offering free recreational opportunities within a geographically limited area referred to commonly as “The Flats”. This area was described in resident interviews as including a higher concentration of families with low incomes, as well as encompassing a diversity of socio-economic backgrounds. It was also noted for having a great “sense of community” and social capital among residents. The Elm Street School provides ongoing recreational opportunities throughout the year, such as bowling, while the North Flats Neighbourhood Association provides free afterschool care for kids as well as free summer camps which include transportation. Both organizations seemed to be highly regarded by residents.

“In 2011, Kidsport funded 207 children across 17 different sports for a total of $44,000”

- Medicine Hat Resident
What Residents Said:

Generally, residents felt that Medicine Hat has a wonderful system of parks, walkways, trails and outdoor recreational amenities. There was also general consensus that indoor recreation could be very expensive, including the rates for using recreational programs and/or the cost of transit to get there as a family. Subsidized recreational programs such as JumpStart and KidSport were very much appreciated by those who knew about them, which suggests that there may be a benefit to increasing advertising for programs that already exist. Residents also very much appreciated the free bus to Echo Dale, which was organized during the summer by the Lions’ Club and the Rotary Club.

“There’s lots of open space, but it’s pricey if you want to be inside.”
- Medicine Hat Resident

KEY QUESTIONS MOVING FORWARD

1. If accessibility to recreation is defined by cost of recreation, cost of transit, and geographical access to transportation, how can recreational activities be more accessible for people on low-income?

2. What key marketing strategies can be used to promote free or subsidized recreational opportunities for all Medicine Hatters, and particularly for those living on low-income?

3. How can universal recreation opportunities continue to be encouraged in Medicine Hat?

4. How can we eliminate barriers so that all children can access recreational programs?

Parents whose children had access to recreation had a 10% greater chance of moving away from a dependence on social assistance.
Affordable transportation can make an important contribution to social inclusion (the ability to participate fully in the community) by facilitating access to employment, education, and social activities (Litman, 2003).

When we talk about affordable transportation, we often engage in conversations about public transportation. It is a public service where there is opportunity to regulate and as such is often the default solution to providing communities with affordable ways of getting around.

Public Transportation in Medicine Hat

The city of Medicine Hat transit department has 26 regular transit buses and 10 special transit buses. There are 12 peak (daytime) and 8 non-peak (evenings, weekends, and holidays) routes. The city transit provides 64,480 annual hours of regular service and 19,968 hours of special transit service.

From 2009 to 2010, there was an 18% increase in overall ridership. Holiday Services also increased 24% in this time period. As well, in this time period, sales of adult passes increased 22% and College passes increased 48% (Vital Signs, 2010). Our interviews with Medicine Hat residents raised a few key areas for improvement: affordability for families in particular, routes that only run one way, limited access to locations where there is employment, hours of service that are not long enough, and limited flexibility for those with special needs.

Medicine Hat Fares

Regular fares in Medicine Hat are $2.75 for a one-way fare or by books of 20: Adults $37.75; Youth and Senior $34.50. Medicine Hat also has a discount structure in place.
Discount fares are offered to:
- Seniors (38% discount)
- Youth, aged 6 - 17 (45% discount)
- Post-secondary students (13%)
- Children under 5 (free)
- Persons who are blind with a CNIB card (free)

Special Transit is also available for people with disabilities who cannot use regular transit. It is available by application, and to date, operated from Monday – Saturday, 6:45 am to 7:00 pm, with limited service on Sunday. These hours have been extended on a trial basis as of December 2012. Users are asked to schedule social and medical appointments outside of peak hours.

**Subsidized transit programs in other municipalities**

Several municipalities offer a discounted bus pass based on income: Calgary, Waterloo, Windsor, Hamilton, and Kingston (Ellery and Peters, 2010). A study conducted on the benefits of the Calgary low-income transit pass showed an overwhelming response from people who access the pass about improvements to their quality of life, including personal finances (55%) and increasing mobility (35%) (HarGroup Management Consultants, 2007).

![Table 7.2: Cost of Subsidized Transit Programs (per year)](image)

Table 7.2: Cost of Subsidized Transit Programs (per year)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calgary</td>
<td>$2 Million</td>
</tr>
<tr>
<td>Waterloo</td>
<td>$438,000</td>
</tr>
<tr>
<td>Windsor</td>
<td>unknown</td>
</tr>
<tr>
<td>Hamilton</td>
<td>$500,000</td>
</tr>
<tr>
<td>Kingston</td>
<td>$90,000</td>
</tr>
</tbody>
</table>

Ellery & Peters, 2010

“For a refugee making $700/month, a $50 transit pass can be a lot of money.”
- Medicine Hat Resident

Calgary’s fare structure and application process recently underwent an expansion of this ground-breaking program. The eligibility criteria for the Low Income Transit Pass (LITP) will be increased over a period of two years, to include all adults earning 100% of LICO or below. Calgary Transit will also be initiating a pilot project whereby all low-income youth will also be eligible for the LITP.

“The bus ends at 10:30PM – how do you get home from a night-shift?”
- Medicine Hat Resident
The strategy of all Calgary Transit subsidies is to move away from an age-based fee schedule, to one that is income-based.

While most strategies have been aimed at reducing the price of monthly passes, it is also important to consider the price of daily passes, the length of time allowed on transfers, the reliability of bus schedules, and the suitability of the geographic coverage of routes. In a study on lone-parent households (Gavigan and Chunn, 2007), the concept of “trip-chaining” was documented, which is described as: “when commuting for work involves more than one intended destination, such as factoring in additional stops to take care of household needs such as… groceries or in relation to children’s education, care and medical needs (Ellery and Peters, 2010, p.5).” Reliable bus service, affordable fares, strategic stops at common destinations, and longer times allowed on transfers all help improve the process of trip-chaining.

With other cities and the province working towards poverty reduction, there is likely great opportunity here to investigate best practices in transportation collaboratively, and share the costs of expertise in this area.

**Other Transportation Options**

It may be worth exploring how other transportation modes might bolster a robust public transit system. Car shares, car co-operatives, and other innovative ways to share transportation are all options worth considering. Additionally, looking at the built environment including, but not limited to, bike and walking lanes, neighbourhood planning, zoning bylaws, business development policy, etc. can play key roles in creating more accessible communities. Utilizing participatory processes (e.g. Jane Walks), such as the one recently conducted in August of 2012, can be very effective in assessing the barriers and opportunities to promote improved transportation and access to vital services.

**What Residents Said:**

Having transit in Medicine Hat, including a relatively new fleet of buses, was seen as a very positive thing. However, transit was generally viewed as expensive for low-income earners, particularly in the event of family trips.

“Transit only goes in one direction – it loops – so it takes a long time to get to work. I have to hire childcare just to get to the bus to get to my minimum wage job. It doesn’t seem worth it.”

- Medicine Hat Resident
There was general consensus that the system could make some strategic improvements with regard to routes, likely by consulting with the public. Residents noted, for example, that buses do not currently service light industrial employment areas. They had heard similar comments from employees in the sector, and suggested that transit be expanded to service these areas. They also expressed difficulty in getting around the city in good time – routes were described as long and circuitous.

Several residents mentioned issues with transit that related to Food Security and Living Wages. For example, one resident pointed out that travelling to evening work was challenging, particularly for parents, and cited paying Living Wages as a way of removing the need to work evening shifts. Another mentioned that parts of the Flats were far from the IGA, which meant making long trips with heavy groceries. This could suggest the need for a more direct bus, more frequent buses, or building a new grocery store in the Flats.

Another resident felt that the bus system didn’t seem to address the needs of residents, and so often, buses were nearly empty. The resident suggested researching different models of public transit, so that the city could implement a more flexible, more accommodating system of transportation. An example the resident had seen abroad involved smaller vehicles covering one street or one zone, more frequent coverage of that zone, and transit vehicles stopping at any point along their route, rather than at designated stops.

“Transit doesn’t take people to where the jobs are and they can’t afford to live by the jobs”.

- Medicine Hat Resident
“Transportation needs to meet most people’s needs and be accessible, and be more flexible. We should look into ways we can adapt our transit model.”

- Medicine Hat Resident

**KEY QUESTIONS MOVING FORWARD**

1. What is the role of monthly fares, individual fares, family passes, and longer transfer periods in making Medicine Hat transit more affordable for individuals and families?

2. How can Medicine Hat be more strategic with its transit system? What alternative models exist for cities of Medicine Hat’s size?

3. How can Transit collaborate with employers to make service more available and affordable for workers?

4. What has been the effect of extending hours of service for Special Transit?
Education is an important tool for poverty reduction. Literacy is a determining factor of future income (Statistics Canada, 2007), and academic qualifications influence employability, to the extent that a person without a high school diploma is two times more likely to be poor than someone with a university education (Nares, 2004). Statistics in Alberta exemplify the correlation between education levels, employment and income. They show that:

- Both male and female graduates with a post-secondary certificate or diploma had a higher employment rate than high school graduates;
- Albertans (both male and female) with bachelor’s degrees experience the highest employment rate; and
- Wage rates for both males and females also increase as education increases (Government of Alberta, 2011).

Just as education is an important tool for poverty reduction, research consistently finds that socio-economic status is a predictor of educational achievement and academic outcomes (TkMC, 2006), creating significant disadvantage for children in poverty to attain outcomes at the same level as their peers.

In public schools, a factor that can contribute to unequal opportunity is school fees, where parents are asked to cover the costs of various school supplies, trips and events. A study in Newfoundland (CSC Newfoundland and Labrador, 2003) shows that school fees can have detrimental impacts to students, parents and teachers. Supplies typically paid for in this way are often necessary to schools’ regular programs, such as textbooks, musical instruments, and lab supplies, which are purchased outright, rented, or secured with deposits.

The study shows that students who cannot afford the fees associated with special events are more likely to avoid going to school on the days when those events are held. Students who cannot afford school fees are more likely to experience low self-esteem, shame and alienation, and are more likely to have difficulty integrating, with implications for their growth and development, and future success. Half of the families in this study stated that it is a financial hardship to pay for school fees. One third said the fees are more than they could afford, and that they experience financial difficulties at the beginning of the
school year. In addition, 92% of teachers surveyed stated that they personally subsidize students who do not have money for field trips, school supplies or other school costs. The study also points to the inequality among schools that can result from depending on fundraising to cover school expenses and amenities, where schools in high-income neighbourhoods would be at a significant advantage.

The study suggested that children’s outcomes in life can be improved by gaining access to and being encouraged to engage in a multitude of school and community activities. It further concluded that education was being underfunded in Newfoundland and Labrador, creating a two-tiered system with negative implications for child outcomes. Their strongest recommendation is to increase funding to schools. In the absence of this change, they recommend measures that contribute to the dignity of all people, and that avoid exclusion. This includes standardizing and advertising payment plans

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Hat Catholic Separate Division (3-year completion)</td>
<td>79.9</td>
<td>84.7</td>
<td>88.5</td>
</tr>
<tr>
<td>Medicine Hat School District (3-year completion)</td>
<td>71.6</td>
<td>68.9</td>
<td>75.4</td>
</tr>
<tr>
<td>Alberta (3-year completion)</td>
<td>71.5</td>
<td>72.6</td>
<td>74.1</td>
</tr>
<tr>
<td>Medicine Hat Catholic Separate Division (4-year completion)</td>
<td>85.1</td>
<td>84.9</td>
<td>86.1</td>
</tr>
<tr>
<td>Medicine Hat School District (4-year completion)</td>
<td>77.2</td>
<td>76.4</td>
<td>75.5</td>
</tr>
<tr>
<td>Alberta (4-year completion)</td>
<td>76.1</td>
<td>76.9</td>
<td>78.1</td>
</tr>
<tr>
<td>Medicine Hat Catholic Separate Division (5-year completion)</td>
<td>84.9</td>
<td>85.7</td>
<td>87.3</td>
</tr>
<tr>
<td>Medicine Hat School District (5-year completion)</td>
<td>82.2</td>
<td>80.2</td>
<td>78.1</td>
</tr>
<tr>
<td>Alberta (5-year completion)</td>
<td>79.0</td>
<td>79.0</td>
<td>79.6</td>
</tr>
</tbody>
</table>


“The college here is good but it needs more options. They have the exact same things every year so everyone takes the same program”.

- Medicine Hat Resident
“I’d like to finish my GED so I can take the courses qualifying me to start my home-based business – that way I can work and spend time with my kids. But because of my previous student loan, I can’t take out a new one.”

- Medicine Hat Resident

to all parents, establishing a school subsidy fund, exercising discretion when subsidizing families in need, creating sensitivity and awareness of social exclusion and inclusion among school staff, limiting graduation and school leaving expenses, and continuing to support extra-curricular activities.

**Education in Medicine Hat**

Medicine Hat School District #76 has 13 elementary schools and 3 secondary schools. The Medicine Hat Catholic School Division includes 6 Catholic elementary schools, 2 middle schools and 1 high school. There are 2 private schools in Medicine Hat, 1 chartered school, and 1 francophone school as part of the Greater Southern Public Francophone Education Region #4 (Alberta Community Profiles, 2012).

High school completion rate refers to “the percentage of students in the Grade 10 cohort who have completed high school within 3, 4 or 5 years, adjusted for attrition”. In Medicine Hat’s public system, high school completion rates are higher than the Alberta average in 3-year completion and slightly lower in both 4 and 5-year completion. Catholic school completion rates are noticeably higher than the school district in all yearly completions (see Table 8.1 on the following page). As seen in Figure 1.10 on page 28, Medicine Hat also has higher academic achievement rates than the provincial average.

With regard to post-secondary education, Medicine Hat has had primarily lower rates of achievement than the province. According to the Medicine Hat Community Profile (2012), which is based on 2006 Census data:

- 12% of Medicine Hatters have a university certificate or degree compared with 22% in Alberta.
- 19% of Medicine Hatters do not hold a high school certificate, diploma or degree, compared to 15% in Alberta;
- 23% of Medicine Hatters hold a college or non-university certificate or diploma compared to 21.5% in Alberta.
Thus, Medicine Hatters do well academically in public school, but are somewhat less likely to finish their 4th and 5th years of high school than the rest of the province. They are also much less likely to have pursued post-secondary education, with nearly half the provincial rate of university degree completion. Resident interviews suggested that this relates to regional opportunities for relatively high paying work in the natural resources sector. They also postulated that Medicine Hatters who leave the city for post-secondary education are less likely to come back to the city. The reasons for the disparity in educational achievement may be worth further investigation.

**What Residents Said:**

Residents felt that kindergarten–Grade 12 schooling was on par with the rest of the province. There were mixed feelings with regard to the impact of school fees within the public system. On the one hand, school fees could be waived, and on the other, waiving them required an investment of time from low-income parents and their advocates. Donations of school supplies through school drives were generally very much appreciated.

There was a suggestion that elementary schools could be put to greater use within the community as community hubs. Key to these hubs would be their inviting, non-judgemental ethos. Several residents commented on the success thus far of the Elm Street School in addressing the needs of the community.

With regard to post-secondary education, there were mixed comments. Some residents felt that the programs offered at the local college were limited, and as a result, there was a lot of overlap in skills in Medicine Hat. Others thought that Medicine Hat was moving in the right direction with the local college, and that it was a draw for people from outside of Medicine Hat, as well as for businesses considering establishing themselves in the city.

There were also very mixed comments with regard to accessing post-secondary education. Some pointed to the variety of bursaries and scholarships available, as well as to the organizations providing vocational training (such as those listed on the Palliser Economic Partnership website under Career and Employment services). Others noted that student loans were very difficult to
obtain – that they required nearly perfect credit, and that previous student loans, even if relatively small, prevented them from getting further loans.

**KEY QUESTIONS MOVING FORWARD**

1. What would it take to eliminate school fees in Medicine Hat? What would it take to enhance and improve low-income subsidies? If using subsidies, can Medicine Hat incorporate recommendations from Newfoundland aimed at fostering inclusion and dignity within the school system?

2. What would it take to develop public schools into supportive Community Hubs? How could these be leveraged within a made-in-Medicine Hat poverty reduction strategy?

3. How can local post-secondary institutions engage the public in dialogue with regard to diversifying course offerings? Could an educational “Jane’s Walk” play a role?

4. How can more Medicine Hatters be encouraged to pursue more post-secondary education? How can residents with post-secondary education be encouraged to stay in the city?
While there are several available definitions of food security, we use a standard definition from an internationally recognized organization:

A condition in which all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life.” (Food and Agriculture Organization of the United Nations, 2003)

The definition above clearly identifies both physical and economic access as key parts of food security. In Canadian cities, economic access to food can be compounded, for example, by hard-to-reach grocery stores, or limited/costly public transportation.

Research on food security differentiates between charitable responses to food provision and food security. Charitable services that provide temporary relief from food insecurity are important emergency measures, but do not increase food security because they do not address long-term access to food (Kirkpatrick and Tarasuk, 2009; McIntyre, 2011). A recent City of Calgary report echoed this sentiment by indicating that in some ways “Calgary food programs mitigate the impacts of household food insecurity but do not address, rather can mask the underlying issue (Calgary Food Committee and Serecon Management Consulting, 2012, p. 18).” These sentiments do not undermine the lifesaving, tireless work of individuals and organizations providing emergency food. Rather, they address the frustration that many Albertans feel: that while emergency food services fill a community need, most of us wish we didn’t need them at all. Investigating the issue of food security means asking the question: why are Albertans hungry? The answer may seem simple. In Canada, the evidence is clear that lack of income is the main cause of food insecurity (McIntyre, 2011).

Food Security and Poverty in Alberta

The Cost of Eating Report in Alberta (Dietitians of Canada, 2008) demonstrates that low-income households are not able to meet their basic needs, which makes them vulnerable to food insecurity. We know that 55% of food insecure households rely on employment for their income (Tarasuk and Vogt, 2009), which reveals a possible synergy between food security and Living Wages.
Some of the realities around food security in Alberta include the following:

- In June 2011 in Medicine Hat, the average monthly cost of the nutritious food basket for a family of 4 was $968 (Alberta Agriculture and Rural Development, 2011);

- In 2009-2010, just over 7% of households were food insecure, up almost a full percentage point from the 2007-2008 report (Health Canada, 2010);

- The Hunger Count 2011 reported that nearly 60,000 Albertans accessed a food bank in March of that year; nearly half were under the age of 18, and more than 25% had employment income.

While less than 2% of Alberta’s population accessed a food bank in the 2007-2008 time period, this means that an additional 5% of food insecure Albertans are unaccounted for by food bank statistics. This tells us that this set of statistics can provide important context, but likely should not be relied upon as indicators of food insecurity. We know, for example, that many people in Alberta experiencing food insecurity do not qualify for assistance from food banks, that there are limits to the number of times people can access food bank services, and that many people in need of food may never go to a food bank (Kirkpatrick and Tarasuk, 2009). Collaborating with other cities to develop good measures of local food insecurity may be worthwhile.

**Medicine Hat and Food Security**

It is difficult to adequately measure food insecurity in Medicine Hat. Given that there is a need for emergency services, and that several emergency services exist in Medicine Hat, we can say with certainty that there are individuals and families experiencing food insecurity. As in the rest of Alberta, barriers exist to using these services. Residents of Medicine Hat indicated that gaining access to emergency measures for food is not always predictable and could be a very demeaning experience, depending on where and with whom they are dealing. This makes them less likely to use these services. Thus, while data on emergency service use indicates that there is food insecurity in Medicine Hat, it doesn’t indicate the scope of the issue. Again, Medicine Hat may want to consider how they could
In Alberta, in 2009 - 2010, just over:

7% of households were food insecure.

Up from 6% in 2007 - 2008.

“How do you feed kids if their parents are being denied at charitable food centres?”

- Medicine Hat Resident

co-ordinate with other cities and experts in the field to choose standard measures of food insecurity.

Medicine Hat has numerous agencies and community groups engaged in food-related activities¹, with multiple objectives: recreation, sustainability, education & skill-building, nutrition, emergency response and charitable giving, community development and food security.

Programs and services in Medicine Hat that are exclusively for individuals in financial distress include the various food banks, of which there are now three in Medicine Hat; food distribution drop-offs; several hot meal programs, and several meal programs for residents of shelters. Again, these are not considered to contribute positively to food security in a community, but provide important emergency help for residents experiencing food insecurity. There are also several school lunch and snack programs established for children in need, run by a number of dedicated volunteers, that are frequently supported through the MH & District Food Bank and other school and community partners. At the time of writing this report, the Medicine Hat Food Bank announced that they would be enhancing their current support of school lunch programs in January 2013, in partnership with several schools and local agencies.

School lunch programs can make an important difference to the quality-of-life of children, and to their academic outcomes. Essentially, they can mimic the positive outcomes of increasing household incomes by reducing household food expenditures. In resident interviews, it was noted that school lunch programs in Medicine Hat are not universal (open to all students), but rather are eligibility-based. In other words, the programs tend to limit participation to children who are identified as living in households that are food insecure.

1 These include 5 community kitchens, the Good Food Box Club, 3 community gardens, farmers’ markets, the Canada Prenatal Nutrition Program (Best Babies), Meals on Wheels, Wheels to Meals, various nutrition and foods classes, Alberta Health Services, City of Medicine Hat, Veiner Centre, FCSS, the Miywasin Centre; REDI Enterprises; CORE Association, Salvation Army, Champions Centre, McMann Family Services, Medicine Hat and District Food Bank, Lynk Food Bank, School Districts and parent councils, BRIDGES Family Programs Association/Best Babies (Canada Prenatal Nutrition Program), SAAMIS Immigration, Medicine Hat Youth Action Society, Medicine Hat College Student Association, Alberta Works/Income Support, FCSS, many churches such as the Dream Centre, Hill Crest Church, 5th Avenue United, 7th Day Adventist, service clubs such as the Knights of Columbus, and numerous citizens who have a personal interest in promoting food security for all.
Interviewees suggested that this was due to constraints associated with funding and volunteer time. Research shows, however, that universality can be very important to child socialization, and to perceptions and usage of these programs. A North Carolina study shows that universal school lunch programs can increase participation by those who are food insecure, by decreasing the stigma surrounding these programs. Only 38% of eligible students took advantage of eligibility-based programs in North Carolina, compared with more than 50% of low-income children in universal programs (Ribar and Haldeman, 2011). In addition, universal programs can improve student integration across socio-economic backgrounds.

Recommendations made in Newfoundland around eliminating barriers to participation and inclusion (in regards to school fees, discussed on p.67) may also be useful around school lunch programs. They describe a range of options that make programs more inclusive, thereby levelling the social playing field among students. School lunch programs are also an area that could benefit from further conversation with the provincial government. While the Government of Alberta is one of the only provinces that does not currently fund school lunch programs, the 5-year plan to End Child Poverty may provide a new platform for discussion.

Community food initiatives – such as community gardens, community kitchens, bulk-purchasing programs, farmers’ markets, cooking and nutrition classes and Community Supported Agriculture (CSAs) – were described as gaining momentum in Medicine Hat. The majority of these programs are open to the community at large, though there are some community kitchens that are for clientele-use only within social service agencies. In addition, the Community Food Connections Association of South Eastern Alberta was pointed to as a key driver and convener of food-related issues and initiatives. It works to increase awareness and promote local action on community and household food insecurity, as well as on sustainable food systems in the area, and it has established a Community Food Charter initiative. From resident interviews, we heard that the benefits reaped from all of these initiatives range from skills-building/education around food and nutrition, to accessing cheaper nutritious food, to building inclusive communities that could enhance informal social safety nets within the community, to passing on cultural cooking traditions to developing awareness of food security and sustainable food systems.

“The Good Food Box Club:

averaging 10 new members per month

“Food security is crucial – you can’t function without food. Not eating healthy food means we pay higher taxes down the road [as a result of] more pressure on the Health Care system.”

- Medicine Hat Resident
Community food initiatives such as these have shown significant benefits for communities at large. Their benefits to people on low-income vary. Initiatives that reduce the cost of healthy food, for example, may have particular relevance to persons experiencing low-income, such as bulk-purchasing programs and Community Supported Agriculture. Research shows that significantly decreasing the price of healthy food has a measurable effect on health outcomes among those on low-income (Neff et. al., 2009). The Good Food Box Club is an example of a program that decreases the costs of fresh food, and it was spoken of very highly by residents. Through bulk-buying, this program offers well-priced boxes of quality food, typically fruits and vegetables, with an average savings of $10.53/box for a large $20 box. The Good Food Club is not geared specifically towards low-income people, so is not associated with a high degree of stigma. Being volunteer-based, it is noted for developing a strong sense of community.

Community kitchens, community gardens and cooking/nutrition classes can also be beneficial to communities in terms of building skills, knowledge and personal connections within the community. However, research in Canada on these types of initiatives does not link them directly to food security thus far, for several reasons (Kirkpatrick and Tarasuk, 2009; Awija, 2012). Firstly, the research typically separates food security from nutritional skill-building/education. It acknowledges that both make important contributions to good nutrition and health outcomes, but in different ways. Adequate income provides consistent economic access to food. Educational and knowledge-sharing programs, on the other hand, can influence the nutritional choices that individuals and families make at all income levels, thereby potentially influencing their health outcomes.

Secondly, studies have found that in Canadian cities, such initiatives as community kitchens and community gardens have had low participation rates among people experiencing food insecurity (Ibid.). Because they have not attracted food insecure individuals so far, it has not been possible to measurably determine their impacts on food security. The studies do not suggest that community kitchens or community gardens are not worthwhile for food insecure households, but suggest that these programs should assess their relevance to food insecure households. How can programs be more responsive to the needs and desires of food insecure households? How can barriers

“Being able to afford to buy food only comes with more income. You have to make more money to afford food. That’s it. Charity isn’t the answer, more wages is the answer”.  
- Medicine Hat Resident
to participation be removed? They emphasize that such programs should be viewed as complementing, rather than replacing, policy reforms that would ensure all citizens have sufficient income to access food on a consistent basis.

In Medicine Hat, community kitchens were spoken of with enthusiasm in resident interviews, with varying perspectives on their successes thus far. Some were excited about the impacts of community kitchens in developing informal social safety networks for persons on low-income, and for passing on cultural food preparation traditions. Others also had wonderful experiences within these initiatives, but also expressed concern around their ability to reach food insecure households and address food security.

Better co-ordination among charitable services, and enhanced, sustainable resources and support for varied programs, could certainly improve circumstances and food accessibility for many people. However, there is only so much that co-ordination and cooperation among food-related agencies can accomplish when it comes to increasing food security. Better service delivery may improve the experiences for people seeking assistance, certainly; but we also need long-term approaches that prevent hunger and the need for people to seek assistance in getting food. The best research brings this back to adequate income. Again, this suggests a possible synergy with the idea of the Living Wage and provincial efforts around poverty policy. Given the energy and knowledge this community has developed around poverty and food security, Medicine Hat is well-situated to engage in dialogue and collaborate on long-term, root-cause solutions to these complex issues.

**What Residents Said:**

One resident felt that food security was one of many areas in which the business sector could become more involved by looking at the infrastructure of the city – discovering where more grocery stores are needed, for example, or starting a “grocery store on wheels” business, a mobile vendor which could sell reasonably priced fruits and vegetables, among other things.

Another reminded us that not everyone has the same dietary needs, and that dietary restrictions are very expensive. Growing one’s own vegetables was noted as helpful, but only reasonable if one has land and time to do
so. Yet another resident asserted that food security is a function of one’s paycheck.

With regard to emergency food services, residents had mixed responses. There were concerns that those accessing the charity-based programs were being granted or denied service based upon personal judgements of what was viewed as their “lifestyle choices”. Residents spoke very positively, however, about the opportunity to bulk-buy quality fruits and vegetables through the Good Food Box Club, while the Dream Centre was cited as a good place to get a hot meal, but not very accessible by transit. Community gardens were appreciated for their social aspects, and for being able to grow small amounts of healthy food.

**KEY QUESTIONS MOVING FORWARD**

1. Given that food security is highly tied to income, what can Medicine Hat do to increase incomes for Medicine Hatters?

2. Can universal lunch programs be implemented in Medicine Hat schools? What would this require?

3. How can community food programs optimize their benefits to low-income households?

4. What sources of data are reliable with regard to food security in Medicine Hat? What data could Medicine Hat collect that is not currently being collected?
MOVING FORWARD WITH REDUCING POVERTY

Medicine Hat has shown tremendous leadership in the province in decreasing shelter use, addressing homelessness and implementing the Housing First initiative. It continues to develop its transit system, most recently with the extension of the Special Transit hours. It is acquiring significant momentum with a number of initiatives aimed at increasing food literacy, decreasing food costs and increasing food security; and it has seen great success with its subsidized child recreation programs, just to name a few.

Potential areas of development that came up in this report ranged from minor to more intensive:

- Engaging business leaders to help strengthen HR practices throughout the business community, and beginning dialogue around a Living Wage of $13/hour;
- Developing more responsiveness and flexibility within the transit system;
- Increasing the affordable housing stock, including supportive housing options;
- Increasing advertising for subsidized child recreation programs;
- Building community/school capacity for universal school lunch programs; and
- Gathering more feedback on local post-secondary course offerings.

Other opportunities did not fit directly under the 6 priority areas included:

- Having charity-based organizations collaborate with policy experts and funders to develop measures of success and accountability, such that these measures reflect the best available research.
- Looking at overlaps among the 6 priority areas – for example, how businesses can collaborate with public transit to best support their employees.
- Engaging in dialogue with the province around income supports policies that have been described as insufficient, ineffective, or rigid.
Key to a poverty reduction strategy will be to track progress, and this report has provided potential measures of progress as the community moves forward with poverty reduction. In many cases, tracking success over time will be straightforward. In other cases, it will be important to look at several indicators in tandem. For example, increases in the use of recreational subsidies will typically be considered positive; however, if the use of these subsidies decreases along with a decrease in poverty numbers, we can also interpret this decrease as positive – potentially as a sign that more people can afford recreation on their own.

The very next step in addressing poverty in Medicine Hat, however, will be to engage the Medicine Hat community across sectors, to identify strategic collaborations, and to begin setting targets. The Roundtable is looking to broadly engage the community as it moves forward, including participants from earlier roundtables, newly engaged individuals resulting from key informant interviews, and you, the readers of this report. Valuable participants will include a broad group, including but not limited to: interested community members, representation from various population groups, persons with lived experience from identified at risk groups, business people, representatives from community organizations (particularly housing, food security, mental health, recreation, churches, prenatal/child health organizations, social services, and service clubs), funders, councillors and administrators with the City of Medicine Hat, provincial government (particularly from Service Canada, Income Support, AISH, and AB Community Development), public health nutrition and health promotion, police, education (LEARN, College, Schools), and wellness organizations such as the Be Fit for Life Centre and the YMCA.

The Community Roundtable on Reducing the Cost of Poverty in Medicine Hat is inclusive and open to community members wanting to join this work. Please phone (403) 529-8316 if you are interested in becoming part of this work and/or receiving notification of Roundtable meetings.

We’d love to hear from you!
REFERENCES


Alberta Education. (2012b, August 9). Grade 9 Provincial Achievement Test Results for Schools in Medicine Hat. System Assurance Branch,


Alberta Health Services. (2012). Individuals receiving Mental Health Services in Medicine Hat. Edmonton, AB: Knowledge and Strategy, Community Treatment and Support, Addiction and Mental Health, Primary and Community Care.


McIntyre, L. (2010, March 29). Dr. Lynn McIntyre on food insecurity and guaranteed annual income Part I (Video file). Retrieved from: http://www.youtube.com/watch?v=RbJcLxaEr1A


Medicine Hat Community Housing Society (2013) Snapshot on Housing and Homelessness February 2013


APPENDIX 1: Framework for Change - Medicine Hat Poverty Roundtable

OUR ASPIRATION:
To Move from Charity to Investment: Reduce the Cost of Poverty in Medicine Hat

OUR FIVE ACTION FOCUS POINTS:

• Increase access to Recreation for Children and Youth
• Invest in Affordable Housing
• Ensure employees working full time receive a Living Wage
• Increase the availability of Affordable and Accessible Transportation
• Ensure individual and community food security for all

THE MEDICINE HAT POVERTY ROUNDTABLE WILL WORK IN THE FOLLOWING WAYS:

• Focus on a universal approach where everyone in the community benefits
• Use research and evidence to share our knowledge about poverty and its costs to Medicine Hat
• Advance the social and economic inclusion of all residents
• Influence policy and systems change
• Work with our community to leverage change and investments
• Leverage the Medicine Hat Advantage for everyone

IMMEDIATE NEXT STEPS:

1) Communications and Community Engagement
   • Identify opportunities to share progress to date on an ongoing basis

2) Research Priorities:
   • Complete a Poverty Matrix – a demographic profile of poverty in Medicine Hat
   • Research the Medicine Hat Advantage
   • Research a Living Wage

3) Strategic Alliance Building:
   • Map community resources which align with poverty efforts
   • Identify key community partners to assist with advancing the framework
### APPENDIX 2: Impacts of Inequality as determined by Wilkinson and Pickett, South Zone and Alberta data

<table>
<thead>
<tr>
<th>Indicators of Inequality</th>
<th>South Zone</th>
<th>Alberta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leisure time physical activity; moderate or active</td>
<td>69.2%</td>
<td>63.8%</td>
</tr>
<tr>
<td>Sense of community belonging</td>
<td>50.6%</td>
<td>56.2%</td>
</tr>
<tr>
<td>Child intervention caseloads</td>
<td>304 (2009/10) 266 (2010/11) 260 (2011/12)</td>
<td></td>
</tr>
<tr>
<td>Perceived mental health; very good or excellent</td>
<td>74.5%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Patients with repeat hospitalizations</td>
<td>13.5%</td>
<td>9.6%</td>
</tr>
<tr>
<td>30-day readmission rate for mental illness</td>
<td>10.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Perceived life stress</td>
<td>17.8%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Patients accessing physician services for mental health and/or substance-related problems (2009/10)</td>
<td>14,282</td>
<td></td>
</tr>
<tr>
<td>Accessed General Practitioner</td>
<td>10,510</td>
<td></td>
</tr>
<tr>
<td>Accessed Psychiatrist</td>
<td>4,264</td>
<td></td>
</tr>
<tr>
<td>Accessed another form of physician</td>
<td>2,405</td>
<td></td>
</tr>
<tr>
<td>In 2011/12, for mental health and/or substance-related issues, Medicine Hat Regional Hospital saw:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>660</td>
<td></td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>5,952</td>
<td></td>
</tr>
<tr>
<td>Emergency department visits</td>
<td>1,429</td>
<td></td>
</tr>
<tr>
<td>Life expectancy (years)</td>
<td>80.2</td>
<td>80.7</td>
</tr>
<tr>
<td>Mortality rate (per 100,000 population)</td>
<td>561.44</td>
<td>496</td>
</tr>
<tr>
<td>Diabetes incidence rate</td>
<td>7.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Heart disease incidence rate (per 100,000 population)</td>
<td>425.8</td>
<td>417.1</td>
</tr>
<tr>
<td>Osteoporosis incidence rate (per 100,000 population)</td>
<td>295.0</td>
<td>329.2</td>
</tr>
<tr>
<td>Low birth weight (% of live births)</td>
<td>5.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>5.67</td>
<td>5.12</td>
</tr>
<tr>
<td>Cancer incidence rate (per 100,000 population)</td>
<td>377.5</td>
<td>394.8</td>
</tr>
<tr>
<td>Obesity rate</td>
<td>20.5%</td>
<td>18.8%</td>
</tr>
<tr>
<td>High school graduates aged 25 - 29</td>
<td>77.2%</td>
<td>82.6%</td>
</tr>
<tr>
<td>Post-secondary graduates aged 25 - 29</td>
<td>52.6%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Drop-out rates (Medicine Hat School District vs Alberta)</td>
<td>3.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Grade 9 achievement tests (2010/11): Mathematics / Language Arts</td>
<td>67.0 / 88.0%</td>
<td>66.0 / 79.0%</td>
</tr>
<tr>
<td>Fertility rates among teen girls 15 - 19</td>
<td>20.3%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Suicide rate</td>
<td>2.7%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

* All data, unless otherwise noted, has been drawn from the Canadian Community Health Survey Data, 2011

1 Government of Alberta, 2012d
2 Alberta Health Services, 2012
3 Alberta Health Interactive Data Application - Mortality
4 Alberta Health Interactive Data Application - Chronic Disease
5 Alberta Health Interactive Data Application - Children's Health
6 System Assurance Branch, Alberta Education
7 Alberta Health Interactive Data Application - Demographics
8 Medicine Hat Police Service 2011 Annual Report
## APPENDIX 3: Median incomes, with surplus/shortfalls per household and per person - Statistics Canada, 2010, CANSIM tables 111-0020 & 111-0015

<table>
<thead>
<tr>
<th>Family Composition</th>
<th>Number of Families</th>
<th>Number of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>All families</td>
<td>32,720</td>
<td>71,870</td>
</tr>
<tr>
<td>All low-income families</td>
<td>4,620</td>
<td>8,860</td>
</tr>
<tr>
<td>All lone-parent families</td>
<td>3,070</td>
<td>8,040</td>
</tr>
<tr>
<td>All lone-parent low-income families</td>
<td>1,180</td>
<td>3,360</td>
</tr>
<tr>
<td>Single person</td>
<td>11,640</td>
<td>11,640</td>
</tr>
<tr>
<td>Low-income single person</td>
<td>2,490</td>
<td>2,490</td>
</tr>
<tr>
<td><strong>COUPLE FAMILIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couple families with no children</td>
<td>9,310</td>
<td>18,610</td>
</tr>
<tr>
<td>Couple families with 1 child</td>
<td>5,170</td>
<td>13,790</td>
</tr>
<tr>
<td>Couple families with 2 children</td>
<td>3,620</td>
<td>14,490</td>
</tr>
<tr>
<td>Couple families with 3 or more children</td>
<td>1,640</td>
<td>8,750</td>
</tr>
<tr>
<td>Single-earner male couple families with 1 child</td>
<td>1,410</td>
<td>2,240</td>
</tr>
<tr>
<td>Single-earner female couple families with 1 child</td>
<td>200</td>
<td>600</td>
</tr>
<tr>
<td>Single-earner male couple families with two children</td>
<td>560</td>
<td>2,240</td>
</tr>
<tr>
<td>Single-earner female couple families with two children</td>
<td>150</td>
<td>600</td>
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<tr>
<td>Single-earner male couple families with no children</td>
<td>1,410</td>
<td>2,820</td>
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<tr>
<td>Single-earner female couple families with no children</td>
<td>190</td>
<td>560</td>
</tr>
<tr>
<td>Single-earner male couple families with 3 or more children</td>
<td>190</td>
<td>770</td>
</tr>
<tr>
<td>Single-earner female couple families with 3 or more children</td>
<td>70</td>
<td>373</td>
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<td><strong>LOW INCOME COUPLE FAMILIES</strong></td>
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<td></td>
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<tr>
<td>Low-income families, including single persons, with no children</td>
<td>2,910</td>
<td>3,330</td>
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<tr>
<td>Low-income couple families, no children</td>
<td>420</td>
<td>840</td>
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<tr>
<td>Low-income couple families, 1 child</td>
<td>190</td>
<td>560</td>
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<tr>
<td>Low-income couple families, 2 children</td>
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<td>770</td>
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<td>Low-income couple families, 3 or more children</td>
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<td>850</td>
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<td><strong>LOW INCOME LONE PARENTS</strong></td>
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<tr>
<td>Low-income lone-parent families, 1 child</td>
<td>540</td>
<td>1,080</td>
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<td>1,080</td>
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<td><strong>LONE PARENT FAMILIES</strong></td>
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<td>Lone-parent families, 1 child</td>
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<td>2,800</td>
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<td>Lone-parent families, 3 or more children</td>
<td>410</td>
<td>1,780</td>
</tr>
<tr>
<td>Family Composition</td>
<td>Median Household Income ($)</td>
<td>Surplus or Shortfall (-) per household per year ($)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>All families</td>
<td>49,950</td>
<td>21,552</td>
</tr>
<tr>
<td>All low-income families</td>
<td>13,010</td>
<td>-13,587</td>
</tr>
<tr>
<td>All lone-parent families</td>
<td>34,780</td>
<td>3,772</td>
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<td>All lone-parent low-income families</td>
<td>16,370</td>
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<tr>
<td>Single person</td>
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<td>7,099</td>
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<tr>
<td>Low-income single person</td>
<td>10,780</td>
<td>-8,381</td>
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<td><strong>COUPLE FAMILIES</strong></td>
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<td>Couple families with 2 children</td>
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<td><strong>LOW INCOME COUPLE FAMILIES</strong></td>
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<tr>
<td>Low-income families, including single persons, with no children</td>
<td>13,010</td>
<td>-13,587</td>
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<td>Low-income couple families, no children</td>
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<tr>
<td>Lone-parent families, 3 or more children</td>
<td>34,560</td>
<td>-5,364</td>
</tr>
</tbody>
</table>
APPENDIX 4: Living Wage Calculation: Medicine Hat - July 2012: 35 hrs/wk + 35 hrs/wk

Two Parent, Two Children, Two Income Family

Family has a car and bus pass for one of the parents.
Children ages 4 and 7:
- 1 child in full-time child care, and
- 1 child in before and after school care and summer care.

A household’s income should equal the basic cost of living

\[
[(\text{Living Wage} \times 35 \text{hrs} \times 52 \text{wks}) \times 2 \text{parents} + \text{benefits}] = (\text{expenses} + \text{taxes})
\]

Table I: Family Expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>Monthly ($)</th>
<th>Annually ($)</th>
<th>% of Total Expenses</th>
<th>% of Total Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified MBM</td>
<td>882.26</td>
<td>10,587.15</td>
<td>21.4%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Food</td>
<td>156.74</td>
<td>1,880.83</td>
<td>3.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Clothing and Footwear</td>
<td>786.00</td>
<td>9,432.00</td>
<td>19.1%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Shelter¹</td>
<td>271.84</td>
<td>3,262.08</td>
<td>6.6%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Transportation</td>
<td>769.43</td>
<td>9,233.16</td>
<td>18.7%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Subtotal</td>
<td>2,866.27</td>
<td>34,395.24</td>
<td>69.6%</td>
<td>74.6%</td>
</tr>
<tr>
<td>Child Care</td>
<td>880.82</td>
<td>10,569.83</td>
<td>21.4%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Health Expenses²</td>
<td>133.00</td>
<td>1,596.00</td>
<td>3.2%</td>
<td>3.5%</td>
</tr>
<tr>
<td>2 Weeks Pay</td>
<td>147.82</td>
<td>1,773.80</td>
<td>3.6%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Parent Education</td>
<td>88.15</td>
<td>1,057.78</td>
<td>2.1%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Total</td>
<td>4,116.05</td>
<td>49,392.63</td>
<td>100.0%</td>
<td>107.1%</td>
</tr>
</tbody>
</table>

¹ CMHC estimate for 3-bedroom apartment
² Blue Cross estimate

Table II: Non-Wage Income (Government Transfers)

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Monthly ($)</th>
<th>Annually ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada Child Tax Benefit (CCTB)</td>
<td>222.66</td>
<td>2,734.00</td>
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<tr>
<td>Universal Child Care Benefit (UCCB)</td>
<td>100.00</td>
<td>1,200.00</td>
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<tr>
<td>National Child Benefit Supplement</td>
<td>61.06</td>
<td>732.72</td>
</tr>
<tr>
<td>Goods &amp; Services Tax (GST) Rebate</td>
<td>53.55</td>
<td>642.60</td>
</tr>
<tr>
<td>Child Care Subs.</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Alberta Family Employment Tax Credit (AFETC)</td>
<td>98.35</td>
<td>1,180.20</td>
</tr>
<tr>
<td>Total</td>
<td>437.27</td>
<td>6,489.52</td>
</tr>
</tbody>
</table>
Table III: The Living Wage and Government Deductions and Taxes

<table>
<thead>
<tr>
<th></th>
<th>Parent 1</th>
<th>Parent 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours / Week</td>
<td>35</td>
<td>35</td>
<td>70</td>
</tr>
<tr>
<td>Hourly Wage</td>
<td>12.67</td>
<td>12.67</td>
<td>--</td>
</tr>
<tr>
<td>Employment Income</td>
<td>23,059.40</td>
<td>23,059.40</td>
<td>46,118.80</td>
</tr>
<tr>
<td>Adjustments</td>
<td>-9,369.83</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Net Income</td>
<td>13,689.57</td>
<td>23,059.40</td>
<td>36,748.97</td>
</tr>
<tr>
<td>EI Premiums</td>
<td>410.46</td>
<td>410.46</td>
<td>820.91</td>
</tr>
<tr>
<td>CPP Premiums</td>
<td>968.19</td>
<td>968.19</td>
<td>1,936.38</td>
</tr>
<tr>
<td>Fed. Income Tax</td>
<td>0.00</td>
<td>440.25</td>
<td>440.25</td>
</tr>
<tr>
<td>Fed. Refundable TC</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Prov. Income Tax</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>After Tax Income</td>
<td>21,680.75</td>
<td>21,240.51</td>
<td>42,921.26</td>
</tr>
<tr>
<td>Monthly After Tax Inc.</td>
<td>1,806.73</td>
<td>1,770.04</td>
<td>3,576.77</td>
</tr>
</tbody>
</table>

Table IV: Family Income less Gov’t Deductions and Taxes plus Gov’t Transfers

<table>
<thead>
<tr>
<th>Income or Deduction ($)</th>
<th>Total Annual Income from Employment</th>
<th>- EI, CPP, Fed. and Prov. Taxes</th>
<th>Equals Family Take Home Pay</th>
<th>+ CCTB, UCCB, GST</th>
<th>Equals Total Disposable Family Income</th>
<th>- Family Expenses</th>
<th>Equals Income less expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46,118.80</td>
<td>3,197.54</td>
<td>42,921.26</td>
<td>6,489.52</td>
<td>49,410.78</td>
<td>49,392.63</td>
<td>18.15</td>
</tr>
</tbody>
</table>

Table V: Family Income Less Family Expenses

<table>
<thead>
<tr>
<th></th>
<th>Annually ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Annual Income</td>
<td>49,410.78</td>
</tr>
<tr>
<td>Annual Family Expenses</td>
<td>49,392.63</td>
</tr>
<tr>
<td>Gap</td>
<td>18.15</td>
</tr>
</tbody>
</table>
## APPENDIX 5: Alberta Works Expected to Work and Barriers to Full Employment Caseloads, Medicine Hat and Alberta, 2009 - 2012

<table>
<thead>
<tr>
<th></th>
<th>Medicine Hat</th>
<th></th>
<th></th>
<th>Alberta</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expected to Work (ETW)</td>
<td>Barriers to Full Employment (BFE)</td>
<td>ETW/BFE Total Caseload</td>
<td>ETW/BFE Total Caseload</td>
<td></td>
</tr>
<tr>
<td>2009/Jan</td>
<td>311</td>
<td>341</td>
<td>652</td>
<td>29,444</td>
<td></td>
</tr>
<tr>
<td>2009/Feb</td>
<td>311</td>
<td>350</td>
<td>661</td>
<td>30,302</td>
<td></td>
</tr>
<tr>
<td>2009/Mar</td>
<td>334</td>
<td>364</td>
<td>698</td>
<td>31,610</td>
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</tr>
<tr>
<td>2009/Apr</td>
<td>342</td>
<td>360</td>
<td>702</td>
<td>32,850</td>
<td></td>
</tr>
<tr>
<td>2009/May</td>
<td>328</td>
<td>357</td>
<td>685</td>
<td>34,143</td>
<td></td>
</tr>
<tr>
<td>2009/Jun</td>
<td>332</td>
<td>353</td>
<td>685</td>
<td>34,975</td>
<td></td>
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<tr>
<td>2009/Jul</td>
<td>337</td>
<td>354</td>
<td>691</td>
<td>35,617</td>
<td></td>
</tr>
<tr>
<td>2009/Aug</td>
<td>349</td>
<td>350</td>
<td>699</td>
<td>35,740</td>
<td></td>
</tr>
<tr>
<td>2009/Sep</td>
<td>363</td>
<td>341</td>
<td>704</td>
<td>36,438</td>
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</tr>
<tr>
<td>2009/Oct</td>
<td>349</td>
<td>352</td>
<td>701</td>
<td>36,630</td>
<td></td>
</tr>
<tr>
<td>2009/Nov</td>
<td>347</td>
<td>359</td>
<td>706</td>
<td>36,935</td>
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</tr>
<tr>
<td>2009/Dec</td>
<td>359</td>
<td>361</td>
<td>720</td>
<td>38,230</td>
<td></td>
</tr>
<tr>
<td>2010/Jan</td>
<td>360</td>
<td>373</td>
<td>733</td>
<td>39,315</td>
<td></td>
</tr>
<tr>
<td>2010/Feb</td>
<td>361</td>
<td>386</td>
<td>747</td>
<td>39,517</td>
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<tr>
<td>2010/Mar</td>
<td>354</td>
<td>415</td>
<td>769</td>
<td>40,144</td>
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</tr>
<tr>
<td>2010/Apr</td>
<td>362</td>
<td>410</td>
<td>772</td>
<td>40,177</td>
<td></td>
</tr>
<tr>
<td>2010/May</td>
<td>373</td>
<td>421</td>
<td>794</td>
<td>39,920</td>
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<tr>
<td>2010/Jun</td>
<td>368</td>
<td>424</td>
<td>792</td>
<td>40,130</td>
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</tr>
<tr>
<td>2010/Jul</td>
<td>367</td>
<td>418</td>
<td>785</td>
<td>39,814</td>
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</tr>
<tr>
<td>2010/Aug</td>
<td>367</td>
<td>424</td>
<td>791</td>
<td>39,633</td>
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</tr>
<tr>
<td>2010/Sep</td>
<td>346</td>
<td>421</td>
<td>767</td>
<td>39,517</td>
<td></td>
</tr>
<tr>
<td>2010/Oct</td>
<td>308</td>
<td>422</td>
<td>730</td>
<td>38,885</td>
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<tr>
<td>2010/Nov</td>
<td>272</td>
<td>431</td>
<td>703</td>
<td>38,712</td>
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</tr>
<tr>
<td>2010/Dec</td>
<td>285</td>
<td>434</td>
<td>719</td>
<td>39,006</td>
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<tr>
<td>2011/Jan</td>
<td>303</td>
<td>448</td>
<td>751</td>
<td>39,153</td>
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</tr>
<tr>
<td>2011/Feb</td>
<td>277</td>
<td>460</td>
<td>737</td>
<td>38,760</td>
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<tr>
<td>2011/Mar</td>
<td>262</td>
<td>483</td>
<td>745</td>
<td>38,952</td>
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<tr>
<td>2011/Apr</td>
<td>271</td>
<td>486</td>
<td>757</td>
<td>38,677</td>
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<tr>
<td>2011/May</td>
<td>251</td>
<td>493</td>
<td>744</td>
<td>38,386</td>
<td></td>
</tr>
<tr>
<td>2011/Jun</td>
<td>256</td>
<td>489</td>
<td>745</td>
<td>38,016</td>
<td></td>
</tr>
<tr>
<td>2011/Jul</td>
<td>260</td>
<td>479</td>
<td>739</td>
<td>36,815</td>
<td></td>
</tr>
<tr>
<td>2011/Aug</td>
<td>269</td>
<td>472</td>
<td>741</td>
<td>36,067</td>
<td></td>
</tr>
<tr>
<td>2011/Sep</td>
<td>248</td>
<td>465</td>
<td>713</td>
<td>35,398</td>
<td></td>
</tr>
<tr>
<td>2011/Oct</td>
<td>261</td>
<td>450</td>
<td>711</td>
<td>34,536</td>
<td></td>
</tr>
<tr>
<td>2011/Nov</td>
<td>254</td>
<td>104</td>
<td>358</td>
<td>34,446</td>
<td></td>
</tr>
<tr>
<td>2011/Dec</td>
<td>261</td>
<td>56</td>
<td>317</td>
<td>34,537</td>
<td></td>
</tr>
<tr>
<td>2012/Jan</td>
<td>249</td>
<td>47</td>
<td>296</td>
<td>34,882</td>
<td></td>
</tr>
<tr>
<td>2012/Feb</td>
<td>248</td>
<td>53</td>
<td>301</td>
<td>34,910</td>
<td></td>
</tr>
<tr>
<td>2012/Mar</td>
<td>251</td>
<td>56</td>
<td>307</td>
<td>34,848</td>
<td></td>
</tr>
<tr>
<td>2012/Apr</td>
<td>266</td>
<td>65</td>
<td>331</td>
<td>34,511</td>
<td></td>
</tr>
<tr>
<td>2012/May</td>
<td>247</td>
<td>74</td>
<td>321</td>
<td>34,551</td>
<td></td>
</tr>
<tr>
<td>2012/Jun</td>
<td>242</td>
<td>85</td>
<td>327</td>
<td>34,290</td>
<td></td>
</tr>
</tbody>
</table>
Two different ways of calculating a Living Wage were investigated in writing this report. The method used by community organizations in Calgary bases the Living Wage on the Low-Income Cut Off (LICO) for 1 person, which for Medicine Hat is currently $19,941 per year, before tax – thus taking into account the income required to support one individual. This measure, which is reviewed annually, can be translated into hourly wages if divided by 52 weeks of the year, and again by a 35-hour workweek. If an employer does not provide benefits, this methodology adds an additional $1.50/hour to the Living Wage in lieu of benefits.

The Living Wage for Families developed by the CCPA takes a different approach, calculating a wage that would allow two income earners to support a family of four. This methodology makes a very detailed calculation that assumes the following scenario:

- 2 parents working full time
- 2 children aged 4 and 7
- Family members are healthy with no special needs, dietary, medical or other
- 1 parent taking evening courses at a local college
- Costs of living including transportation, food, housing, clothing, and other
- Rental housing (not ownership)
- Taxes, tax rebates and government benefits, namely child tax benefits.

Appendix 4 shows the calculation in its full complexity. In simplified terms, the Living Wage calculation can be described like this:

\[
[\text{Living Wage} \times 35 \text{hours} \times 52 \text{ weeks}] \times 2 \text{ parents} + \text{benefits} = (\text{expenses} + \text{taxes})
\]

Living Wage for Families suggests sourcing data on food, clothing and “other” expenses from Statistics Canada’s Market Basket Measure database, and transportation, childcare and educational expenses from local sources. For this report, we sourced housing costs from the Canada Mortgage and Housing Association (CMHC) for a 3-bedroom apartment in Medicine Hat. “Other” expenses include things like household cleaners, hygiene products, recreation, and furniture. The inclusion of electronics as items that contribute to a “basic standard of living” has been a topic of significant debate and discussion, so it is interesting to note that the MBM now includes computer equipment and internet, but not cellular phones – only landlines. For a detailed list of the household expenses included in the MBM data, see Hatfield et al. (2010).

Benefits and Drawbacks of the Methodologies

Both methodologies are rather conservative, based, according to the Living Wage for Families (2011), on “bare bones budget without the extras many of us take for granted.” While the Living Wage for Families (LWF) methodology accounts for a range of costs, taxes and benefits experienced by a family, it is worth mentioning what it does not account for:

- Credit card, loan or other debt/interest payments;
- Savings for retirement;
- Owning a home; Saving for childrens’ future education;
- Anything beyond minimal recreation, entertainment and holidays;
• Costs of caring for a disabled, seriously ill, or elderly family member; or

• Anything other than the smallest cushion for emergencies or hard times. (CCPA, 2009)

The Living Wage for Families methodology can certainly be adapted in terms of the sources it uses and the expenses it includes, and there are advantages and disadvantages to doing so. On the one hand, different communities can tailor their Living Wage to local conditions and local priorities. On the other hand, there may be an advantage to streamlining Living Wage methodology nationally, such that, for example, companies with locations in several provinces can adopt Living Wage policies equitably throughout their organizations. In fact, a significant benefit of using the LWF methodology is that it is being used by several other Canadian cities, and has been tabled as the standard in the development of a national framework for a Living Wage, through a pan-Canadian Living Wage network convened by the Tamarack Community. This is something with which the Medicine Hat community may want to engage.

Compared to the LICO methodology, the LWF is more sensitive to changes in local and provincial costs of living, and it is much more comprehensive with regard to the costs, taxes, and benefits a family would receive. It is also significant that the LWF recognizes that in addition to employers, governments and communities are also responsible for ensuring the well-being of their citizens. It does this by taking into account child tax benefits (provincial and federal initiatives), the cost of a transit pass (municipal) and lastly, the cost of housing and other expenses (CCPA, 2009), adjusting the Living Wage accordingly. The LWF is still biased, however, because of the specific scenario it uses – 2 income-earning parents with two children. This Living Wage does not reflect the realities of single parents or single income-earning families, for example, which fall well short of their needs.

The Living Wage based on LICO takes into account the needs of a single person living in a city of 30,000 – 99,999, regardless of which city this might be. So while it is sensitive to city size, it is not sensitive to the differences in cost of living that might exist between cities across the country – which could be quite significant given different economies, taxation rates, and social safety nets. In addition, while the LICO updates its cost-of-living figures annually, these are based on spending patterns from 1992, which will not be updated.

One upside to the LICO methodology, however, is that it takes little expertise to update the Living Wage figure annually due to the simplicity of the methodology, as described earlier. The LWF, on the other hand, is quite complex given that to supplement the national data, local data needs to be gathered that may not be as readily available. Thus, updating the LWF regularly would require a certain level of expertise and a more substantial yearly time commitment.
APPENDIX 7: Glossary

Core Needs Income Threshold (CNIT)
These numbers are calculated by the Canadian Mortgage and Housing Company on a yearly basis. They represent the income threshold needed to afford a rental unit of varying size and by city. Affordable is defined as spending no more than 30% of total income on housing.

Corporate Social Responsibility (CSR)
Corporate Social Responsibility is defined as the way companies integrate social, environmental, and economic concerns into their values and operations in a transparent and accountable manner. http://www.international.gc.ca/trade-agreements-accords-commerciaux/ds/CSR.aspx?view=d

Gini Co-efficient
The gini coefficient is a measure of income equality across an entire population. A coefficient of “1” denotes a population in which one individual holds all of the resources, and the rest of the population owns nothing. A coefficient of “0” on the other hand, denotes a population in which every individual has an equal share of the total scale. With such a scale, even a change of 0.01 is significant. Coefficients outside of the range of 0.25 – 0.40 are associated with a shrinking economy.

Low Income Cut Off (LICO)
Low Income Cut Off represents an income threshold at which a family is likely to devote 20% more than the average family on basic need

Low Income Measure (LIM)
Low Income Measure represents 50% of the median income in a geographical area, often used internationally

Market Basket Measure (MBM)
Market Basket Measure is disposable income compared to the cost of a basket of goods determined by geographical pricing