or below the poverty level. Families who expend more than 70 per cent of their total income on basic necessities (food, clothing, shelter) were considered to fall into the "poverty class". However, poverty does not only mean lack of money. It is a total state made up of many factors; economic, social, political, judicial, educational, informational, intellectual, moral, emotional and perceptual deprivation.

Many areas of poverty in Canada are of the collective type, affecting a group of people in a specific geographical area, e.g., the urban ghetto. The cause of these delineated areas is not uniform; ethnic and language barriers, changes in the economy of the areas, the downward trend found in the heart of many cities, slow economic development because of demographic and geographic factors can be contributing factors.

The environment of poverty is pictured as lack of good sanitation, poor housing, overpopulation, poor nutrition, poor education standards; these factors lead to the flourishing and spread of diseases.

In 1968 the infant mortality rate for all Canadians was 21 per 1,000 live births, 49 per 1,000 for Indians and 89 per 1,000 for Eskimos. In 1968 35 per cent of all Indian deaths and 56 per cent of all Eskimo deaths occurred in children 5 years old and under.

Tuberculosis is a disease found frequently among the poor and although there has been a spectacular drop in mortality from the disease, the morbidity rates have tended to flatten out with the highest incidence of the disease being in the lower socio-economic segments of the population.

Various studies have shown that the highest incidence of social mal-adjustment is found among the poor and that their emotional disturbance is often of a more serious nature than in the non-poor.

Ill health and poverty are inter-twined in dental care and a large segment of the Canadian poor receives either no dental care or care only at the time of a dental emergency. Orthodontics is almost unknown to the poor and in some instances could aggravate the individuals status, e.g., psychological factors, unemployability because of appearance, etc.

Lack of education among the poor can also predispose towards accidents and it has been shown for example, from Indian health statistics, that the accident mortality rate for Indians is 4 times the national rate.

The association between ill health and poverty is pointed up in figures indicating dependency. In March 1969 in Ontario, 30 per cent of all General Welfare recipients were granted aid because of major health problems as compared with 43 per cent granted assistance because of unemployment.

The cycle of poverty-ill health is often perpetuated by the loss of wage earning capability because of ill health by the main wage earner of the family. This loss leads to a change in a downward progression of the family's socio-economic environment and so the cycle is maintained. Where an individual or family unit is already marginal economically, ill health is often sufficient to depress them even further and interfere with education processes which is one of the main avenues of escape from poverty.

Problems

Perceptual deprivation contributes very largely to the inability of the poor to actively seek out methods of improvement in their status, and perpetuates the inertia and apathy.

In some of the poor, there is an absence of the innate drive, possessed by many of the "non-poor", to "break into the system" and the so-called "instinct of self-preservation" is either absent or so depressed that the impoverished remain paralysed in their physical, mental and ill health environments.

For some of the poor, attempts to break out are rebuffed, often unintentionally and because of the lack of tenacity and perseverance the will to make further attempts is destroyed. This is when helpless despair takes over and ill heath allowed to increase to one of two outcomes. Either the health picture reaches "emergency status" and medical aid is sought at that point or the individual sinks into apathy where there is nothing to lose except life itself and death may come as a welcome relief.

In addition to the lack of drive on the part of the individual there are other barriers which lie between the poor and health care. These can be summarized into two groups:

(i) The Education/Information Barrier

(ii) Mechanical Barriers

The Education/Information Barrier

No matter how large the array of services, they cannot be said to be truly available if those who should use them the most do not know of their availability. It is going to be difficult to persuade the poor, who do not use health care facilities because of this barrier, to take advantage of the facilities offered;