Public Support for Poverty-related Policies

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ABSTRACT

Objective: This research examined how public perceptions of the relationship between poverty and health predict support for poverty-related policies.

Methods: A random sample of 1,203 Albertans were interviewed by telephone to determine their perceptions of the relationship between poverty and health (myth, drift, behavioural, structural), and their support for government spending in six poverty-related policy areas: nutrition programs, housing, child care, increased welfare allowance, wage subsidies, and recreation programs.

Results: The greatest support was for child care programs, with the least support for increased welfare allowance. The degree of support for all policies except wage subsidies and recreation programs differed by the explanation chosen of the relationship between poverty and health. Those who chose a structural explanation were more likely to support government spending than those who chose a behavioural explanation.

Interpretation: Beliefs about the relationship between poverty and health influence support for policies. Public health professionals have a role in increasing public awareness of the structural factors that influence health.

La traduction du résumé se trouve à la fin de l'article.

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Poverty is the most influential determinant of health¹⁻⁵ and affects virtually all other determinants. In 1998, 16% of all Canadians were living in poverty as measured by Statistics Canada Low Income Cutoffs, in spite of seven consecutive years of economic growth in Canada.⁶ Canadians who live in poverty have poorer health status, whether measured by self-rated health, morbidity, activity limitations, or life expectancy.⁷⁻¹¹

Recent literature highlights the importance of public policy as the most effective way to address poverty and its health consequences.¹²⁻¹⁴ There is substantial evidence that public perspectives influence governments in the development of public policy across many policy fields,¹⁵⁻²¹ but particularly in the area of social welfare.^{15,16,18} Yet, there is virtually no Canadian research, other than limited public opinion polling, on public support for poverty-related policies and factors that influence this support.

One factor that may influence public support for poverty-related policies is the belief held about the relationship between poverty and health. Four different explanations of the poverty-health relationship have been postulated in the literature: *Artifact* or measurement bias; natural or social selection – the *drift* hypothesis; *behavioural* explanation; and *structural* perspective.²² The *artifact* explanation, often referred to as the *myth* explanation, maintains that the observed relationship between socioeconomic status (SES) and health results from biases in measuring SES and health. The *social selection* or *drift* explanation suggests that people suffer from ill health first and, due to resultant disability and reduced employment, drift down in social position or become poor. According to the *behavioural* explanation, poor people are unhealthy because they engage in health-inhibiting behaviours, such as smoking, substance abuse, and inadequate nutritional practices. The *structural* explanation emphasizes that poor health results from decreased access to the material conditions and resources that facilitate health. Increasingly, this latter explanation emphasizes both material and psychosocial factors.²³ Those with less purchasing power are more likely to be exposed to the ill effects of inadequate housing, inadequate nutrition, unsafe neighbourhoods, occupational hazards,

TABLE 1

Degree of Support for Government Funding per Policy by Total Sample and by Subgroups by Explanation Chosen

Sample	“To what extent do you agree that the government should fund [_____] for the poor?”					
	Child Care Programs M(SD)	Wage Subsidies M(SD)	Housing M(SD)	Nutrition Programs M(SD)	Recreation Programs M(SD)	Increased Welfare Allowance M(SD)
Total	5.6 (1.4)	5.2 (1.6)	5.2 (1.4)	5.1 (1.5)	4.2 (1.7)	3.9 (1.7)
Subgroups by Explanation Chosen						
Myth	5.6 (1.6)	5.1 (1.9)	5.2 (1.5)	4.9 (1.7)	4.2 (1.8)	3.8 (1.8)
Drift	5.8 (1.4)	5.2 (1.7)	5.6 (1.5)	5.3 (1.5)	4.5 (1.6)	4.0 (1.8)
Structural	5.7 (1.3)	5.2 (1.6)	5.3 (1.3)	5.2 (1.4)	4.3 (1.6)	4.1 (1.6)
Behavioural	5.3 (1.6)	5.2 (1.7)	4.8 (1.5)	4.6 (1.8)	4.1 (1.8)	3.4 (1.8)

Note: The number of respondents for each item varies from 1126 to 1152. Respondents were asked their degree of support using a 7-point scale, where 1=strongly disagree and 7=strongly agree.

and the stresses produced by uncertainty, powerlessness, and lack of control. Lack of income also precludes people making the kinds of behavioural choices that support health.²⁴ This explanation is also congruent with the growing body of evidence on the health effects of income inequality.^{25,26}

Previous research²⁷ that investigated how a representative sample of 1,216 Albertans viewed the relationship between poverty and health found that the most frequently chosen explanation was structural (41%), followed by myth (27%), behavioural (20%), and drift (5%). However, respondents were not asked to indicate their support for various policies. Therefore, it was not possible to determine if there is differential support for policies according to the belief held about the relationship between poverty and health.

In addition to explanation of the relationship between poverty and health, other factors, such as political beliefs and gender, may influence policy support. Studies conducted within the American political context suggest that those holding conservative ideologies are less likely to support government spending on poverty-related programs than those who are more liberal in their orientation.^{16,28-31} Some demographic variables, such as gender, have been incorporated as control variables to better assess more direct measures or as proxies of self-interest.^{16,32} Women may be more supportive of poverty-related policies as they are more socially and economically vulnerable, and may experience the effects of policies, such as child care, to a greater extent than men.

The purpose of this research was to determine how the degree of support for poverty-related policies varied by the belief held about the relationship between poverty and health. We also examined how sup-

Figure 1. Respondents' choice of the best explanation of the relationship between poverty and health (n=1203)

port varied when the belief held about the relationship between poverty and health was considered in conjunction with gender or political beliefs.

METHOD

This study was part of the annual Alberta Survey administered by the Population Research Laboratory, Department of Sociology, University of Alberta. A random-digit dialling approach was used. Within the household, one eligible person was selected on the basis of gender to ensure an equal selection of male and female respondents. The data were collected through telephone interviews administered between January 5 and February 8, 2000 (See Dennis³³ for a complete technical report). The overall response rate was 54%. The final sample consisted of 1,203 individuals, ranging in age from 18-96 years. The sample is considered representative of the large-

er population from which it was selected, based on postcensal data. Survey results for the province-wide sample are accurate within plus or minus 2.9 percentage points, 19 times out of 20. Demographic data, including voting preference, are collected routinely on the annual Alberta Survey. All questions were tested in a pilot study and were submitted to a University Research Ethics Committee to ensure suitability for administration to the general public.

Respondents were asked, “Which of the following do you think provides the best explanation of the relationship between poverty and health?” They chose from a list of four options representing the four explanations: “There is no real link between poverty and health” (artifact/myth); “People drift into poverty because of poor health” (drift); “Poor people are unhealthy because of the circumstances in which they live” (structural); “Poor people are unhealthy because

TABLE II

Analysis of Variance of Support for Government Funding for Selected Policies by Explanation Chosen and Gender

Policy	Source	Sum of Squares	DF	Mean Square	F-Value	Sig of F
Nutrition Programs	Explanation	63.66	3	21.22	9.49	p≤0.001
	Gender	3.33	1	3.33	1.49	ns
	Explanation x Gender	22.57	3	7.53	3.37	p=0.018
Housing	Explanation	56.31	3	18.77	9.74	p≤0.001
	Gender	19.68	1	19.68	10.21	p=0.001
	Explanation x Gender	3.31	3	1.10	0.57	ns
Increased Welfare Allowance	Explanation	80.64	3	26.88	9.60	p≤0.001
	Gender	0.57	1	0.57	0.20	ns
	Explanation x Gender	15.05	3	5.02	1.79	ns
Child Care Programs	Explanation	26.68	3	8.89	4.53	p=0.004
	Gender	4.97	1	4.97	2.53	ns
	Explanation x Gender	7.070E-02	3	2.357E-02	0.01	ns

Figure 2. Males' and females' support for government funding of nutrition programs by explanation chosen

Note: Respondents were asked their degree of support using a 7-point scale, where 1=strongly disagree and 7=strongly agree

their behaviour makes them unhealthy" (behavioural). Respondents were then asked to indicate their support (on a 7-point likert scale) for each of six policies listed in Table I by responding to the question, "To what extent do you agree that the government should fund ___ for the poor?" The policies reflected both in-kind (e.g., housing, nutrition) and direct financial (e.g., increased welfare allowance, wage subsidies) support, as there is some evidence that the public generally is less supportive of income assistance than in-kind programs to combat poverty.³⁴ In-kind support included the traditional concept of necessities (e.g., food, shelter) and an expanded view of necessities that would enable people living in poverty to participate more meaningfully in society (e.g., recreation).

The data were analyzed using the SPSS 10 Windows statistical package. Four

groups were created based on the respondent's choice of the best explanation of the relationship between poverty and health. Descriptive statistics were used to determine the distribution of responses to all questions. Differences between groups in the degree of support for each of the six policies were examined with one-way ANOVA (post-hoc comparisons using the Tamhane test) and non-parametric statistics (Kruskal-Wallis test). As these analyses gave similar results, the ANOVA findings are reported here. To determine main effects and interaction effects when additional variables (gender and political conservatism) are considered along with explanation, we conducted two-way ANOVAs. First, a two-way ANOVA was done using explanation and gender, and then using explanation and political conservatism. The variable "political conservatism" was created from the voting preference variable

and coded as follows: Progressive Conservative or Reform (2), Don't know (1), and Liberal or New Democrat (0). There were insufficient numbers in each cell to conduct a 3-way ANOVA (explanation, gender, political conservatism).

RESULTS

Figure 1 reveals that by far the most common explanation chosen of the relationship between poverty and health was the structural explanation, with over two thirds (67.4%) of respondents choosing this option. Substantially fewer (16.8%) chose a behavioural explanation. Very few chose the drift and myth explanations (6.4% and 5.4% respectively), and only 3.9% either provided no response or indicated they did not know.

Table I reports the degree of support for government funding for each of the six policies for the total sample and for subgroup by explanation chosen. For the overall sample, the highest degree of support was for child care (M=5.6). There was also strong support for wage subsidies for the working poor (M=5.2), housing (M=5.2), and nutrition programs (M=5.1). Recreation programs for the poor (M=4.2) and increased welfare allowance (M=3.9) received considerably less support. When the sample was grouped as to the proportion agreeing or disagreeing (agree=5, 6, 7; disagree=1, 2, 3; neutral=4), a similar pattern prevailed. A high percentage of respondents agreed to supporting child care (81.7%), housing (70.9%), wage subsidies (72.8%), and nutrition programs (68.6%), while less than half supported recreation programs (45%) and just over one third supported increased welfare

TABLE III

Analysis of Variance of Support for Government Funding for Selected Policies by Explanation Chosen and Political Conservatism

Policy	Source	Sum of Squares	DF	Mean Square	F-Value	Sig of F
Nutrition Programs	Explanation	43.21	3	14.40	6.45	p≤0.001
	Conservatism	44.78	2	22.39	10.03	p≤0.001
	Explanation x Conservatism	8.30	6	1.38	0.62	ns
Housing	Explanation	43.52	3	14.51	7.84	p≤0.001
	Conservatism	48.77	2	24.39	13.17	p≤0.001
	Explanation x Conservatism	17.77	6	2.96	1.60	ns
Increased Welfare Allowance	Explanation	69.40	3	23.13	8.56	p≤0.001
	Conservatism	20.30	2	10.15	3.76	p=0.024
	Explanation x Conservatism	10.83	6	1.81	0.67	ns
Child Care Programs	Explanation	23.21	3	7.74	4.04	p=0.007
	Conservatism	19.44	2	9.72	5.08	p=0.006
	Explanation x Conservatism	9.03	6	1.51	0.79	ns

allowance (38.3%). The percentage of respondents who were neutral was highest for these latter two policies (21.1% and 22.2% respectively) (percentages not shown).

There were significant group differences by explanation chosen for four policies: nutrition programs: $F(3,1144)=9.6$ ($p<0.001$); housing: $F(3,1147)=10.7$ ($p<0.001$); increased welfare allowance: $F(3,1122)=9.3$ ($p<0.001$); and child care: $F(3,1148)=5.2$ ($p=0.001$). Post hoc analyses (Tamhane) revealed that those who chose a behavioural explanation were less supportive of nutrition programs than those who chose a structural ($p<0.001$) or a drift ($p=0.01$) explanation. The same pattern was evident regarding policies related to housing and increased welfare allowance: those who chose a behavioural explanation were less likely to be supportive of housing for the poor than those who chose a structural explanation ($p<0.001$) or a drift explanation ($p<0.001$); and those who chose a behavioural explanation were less likely to support increased welfare allowance than those who chose a structural explanation ($p<0.001$). Support for child care was lower only for those who held a behavioural explanation in comparison to those who held a structural explanation ($p=0.002$). In short, it appears that the influence of explanation on policy support is most likely due to significant differences between those who chose a structural as compared to a behavioural explanation.

Table II reports the support for government funding for nutrition programs, housing, increased welfare allowance, and child care when gender is added to the analysis. Explanation continued to exert a main effect for all four policies. Gender

exerted a main effect only for housing, with women being more supportive of providing housing for the poor. There was a significant interaction between explanation chosen and gender in support for nutrition programs. As depicted in Figure 2, there is considerable variation by female respondents in the degree of support for nutrition programs depending on the explanation chosen, with the lowest scores for those who chose the myth explanation, and the highest scores for those who chose the drift explanation. On the other hand, scores for male respondents are less variable across explanations. Interestingly, there is virtually no difference between males and females who chose the behavioural explanation in their degree of support for nutrition programs.

Table III depicts the support for government funding by explanation chosen and conservatism for the same four policies. Explanation has a main effect for all four policies. Political conservatism exerted main effects for all four policies, with no interaction effects. As expected, each of the four policies were less likely to be supported by those who would vote Progressive Conservative or Reform than by those who would vote Liberal or New Democrat.

DISCUSSION

The study results indicate that the explanation chosen for the relationship between poverty and health explains different levels of support for some policies but not others. Further, the study provides a profile of Albertans' beliefs about the relationship between poverty and health.

A large majority of Albertans believe that poverty influences health, and a substantial

majority favour a structural explanation of that link. These findings differ from previous research,²⁷ conducted in 1996, in which there was greater variation and uncertainty. For example, in this study there was a 26% increase in those favouring a structural explanation, and a 22% decrease in those favouring a myth explanation. However, there was little change in the percentage choosing the behavioural explanation (17% vs 20%) or the drift explanation (6% vs 5%). A slightly lower percentage of respondents in the current study did not respond or volunteered "don't know" (4% vs 8%). These changes over a four-year period may reflect actual changes in public beliefs, perhaps related to more media attention to poverty-related issues. Alternatively, the changes may reflect differences in the survey format. Although the same question was used in both surveys, in the 1996 survey, a series of preceding questions relating to the explanations may have influenced the "best" explanation response.

The explanation chosen about the relationship between poverty and health explained different levels of support for four policy areas: nutrition, housing, increased welfare allowance, and child care. In general, those who chose a structural explanation were more likely to support government spending on both in-kind and income support for the poor than those who chose a behavioural explanation. This finding suggests that the explanations chosen may represent an underlying social or individual approach to the causes and solutions to poverty. For example, those who chose a behavioural explanation may perceive that unmet nutritional needs result from an individual's inadequate knowledge

or skills in food preparation and budget management rather than from inadequate purchasing power. Similarly, from a behavioural perspective, solutions to nutritional inadequacy may be viewed as the responsibility of the individual and family, rather than the state.

The public's explanation of the relationship between poverty and health continued to exert an independent albeit small effect over and above the effects of gender and political conservatism, suggesting that the explanation chosen is not merely a proxy for political beliefs or self-interest. Therefore, in future research it is important to include explanation held of the relationship between poverty and health as a variable when exploring support for poverty-related policies.

Support for government spending on low wage subsidies for the working poor and on recreation programs is more or less evenly held regardless of differing views about how poverty influences health. These policies may represent "valence issues"³⁰ for which the population as a whole has strongly held opinions. The high degree of support for wage subsidies across groups may reflect the view that working low income people are deserving of government assistance because they are striving toward independence and self-sufficiency. A study conducted by the Canadian Policy Research Networks revealed that Canadians strongly value individual effort, self-responsibility, and self-reliance. Those perceived as deserving of support are "those making an honest attempt at becoming financially self-reliant."³⁵ In this regard, Canadian values support American perspectives that personal responsibility must be balanced with social responsibility for those living in poverty.^{16,31,34} The consistently low degree of support for government spending for recreation programs may reflect the perspective that recreation is not an essential or legitimate need.

For the four poverty-related policies where support varied by the belief held about the relationship between poverty and health, the variables of political conservatism and gender exert independent effects on support for government spending. Political conservatism contributes unique effects on policy support for all four policies: those who are more conserva-

tive in their voting preferences are less likely to support government spending for poverty-related social policies. The effect of gender was less consistent, with main effects exerted for only the housing policy, and an interaction effect was evident for nutrition programs. Interestingly, for child care programs, support did not differ between men and women. Overall, these findings are congruent with American studies, which reveal that political ideology is more likely than gender to determine policy support.^{16,29,31,36}

The disposition-attribution model of policy support developed empirically by Cook and Barrett¹⁶ provides a useful context within which to locate our findings and suggests directions for further research. In their model, four factors are held to influence support for social welfare: *self-interest* (the public will support programs that benefit them); *political predispositions* (support is guided by political preferences); *recipient deservingness* (support is based on perceived level of need and perceptions that need is caused by forces beyond the individual's control); and *program effectiveness* (support based on perceptions that the program achieves intended goals with minimal waste or abuse). Moreover, it is proposed that self-interest and political predispositions affect support directly as well as indirectly by shaping views about recipient deservingness and program effectiveness.

Our study was designed to address political predisposition (political conservatism) and self-interest (gender), but perceptions of recipient deservingness and program effectiveness also may have determined respondents' support for policies. For example, the high support for child care may reflect the dependent status of children, who generally are perceived to be deserving of support.^{34,37} Child care programs also may be viewed as effective because they permit parents to more readily succeed in the labour market. Peters³⁵ found that Canadians supported the position of single mothers joining the labour market and becoming self-supporting, and they recommended child care subsidies and housing support to enable single mothers to earn a reasonable income. The low level of support for increasing welfare allowances also may be related to deservingness and program effectiveness. Lack of knowledge of the current welfare

allowances (which in Alberta range from 30-54% of the poverty line³⁸) may lead to perceptions that welfare recipients are not truly in need, and therefore not deserving of more funding.¹⁶ Other Canadian research³⁵ has shown that the public may believe that welfare rates are too high, particularly if they appear to enable recipients to afford luxuries, such as cigarettes, or when the public perceives welfare recipients as lacking motivation. Many Canadians believe that social programs create dependency and complacency, and are subject to widespread abuse.³⁵ Therefore, some Canadians have recommended that welfare assistance rates be coordinated with other (in-kind) programs, such as housing and child care subsidies.³⁵

Future research on support for poverty-related policies should determine how the belief about the relationship between poverty and health is related to other variables, such as perceptions of deservingness or program effectiveness. Use of path analysis or structural equation modelling to more clearly differentiate the contribution of these variables would contribute a more detailed understanding of the dynamic underlying public support for poverty-related policies.

The limitations of this research relate to both methodological and conceptual issues. A forced choice question asking respondents to choose one "best" explanation of the relationship between poverty and health does not provide an understanding of the underlying rationale for their choice, nor the way that explanation influences policy support. This may best be determined through follow-up focus groups. The general nature of the policy questions poses another limitation. For example, nutrition programs could take a variety of forms and may be targeted to different subgroups (e.g., school lunch programs, nutritional supplements for pregnant women, etc.). People may view different subgroups as more deserving of government funding, based on their perceptions of need and of alternate (to government) sources of support. In future studies, it would be beneficial to include more specific questions related to each of the policy areas.

In spite of these limitations, this study has extended previous research²⁷ by providing new information regarding the effect of

people's beliefs about poverty and health on their support for poverty-related policies. Beliefs are generally thought to be more modifiable than values and ideologies.³⁹ Public health professionals have a role in influencing public beliefs about how poverty influences health by providing evidence of the effect of structural factors on health. This approach may ultimately generate greater support for poverty-related policies.

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RÉSUMÉ

Objectif : Étudier les perceptions publiques du lien entre la pauvreté et la santé comme prédicteurs de l'appui aux politiques de lutte contre la pauvreté.

Méthode : Entretiens téléphoniques avec un échantillon aléatoire de 1 203 Albertains pour déterminer leur perception du lien (mythique, dérivé, comportemental ou structurel) entre la pauvreté et la santé et leur appui aux dépenses publiques dans six secteurs liés à la pauvreté : les programmes alimentaires, le logement, l'aide à l'enfance, la hausse des allocations d'aide sociale, les subventions salariales et les programmes de loisirs.

Résultats : Les programmes d'aide à l'enfance ont reçu le plus d'appui, et la hausse des allocations d'aide sociale, le moins d'appui. Sauf pour les subventions salariales et les programmes de loisirs, le niveau d'appui accordé différait selon l'explication choisie du lien entre la pauvreté et la santé. Les personnes ayant privilégié l'explication structurelle avaient plus tendance à appuyer les dépenses publiques que celles ayant choisi l'explication comportementale.

Interprétation : Les convictions au sujet du lien entre la pauvreté et la santé influencent l'appui aux politiques. Les professionnels de la santé publique ont donc un rôle à jouer pour sensibiliser le public aux facteurs structurels qui influencent la santé.