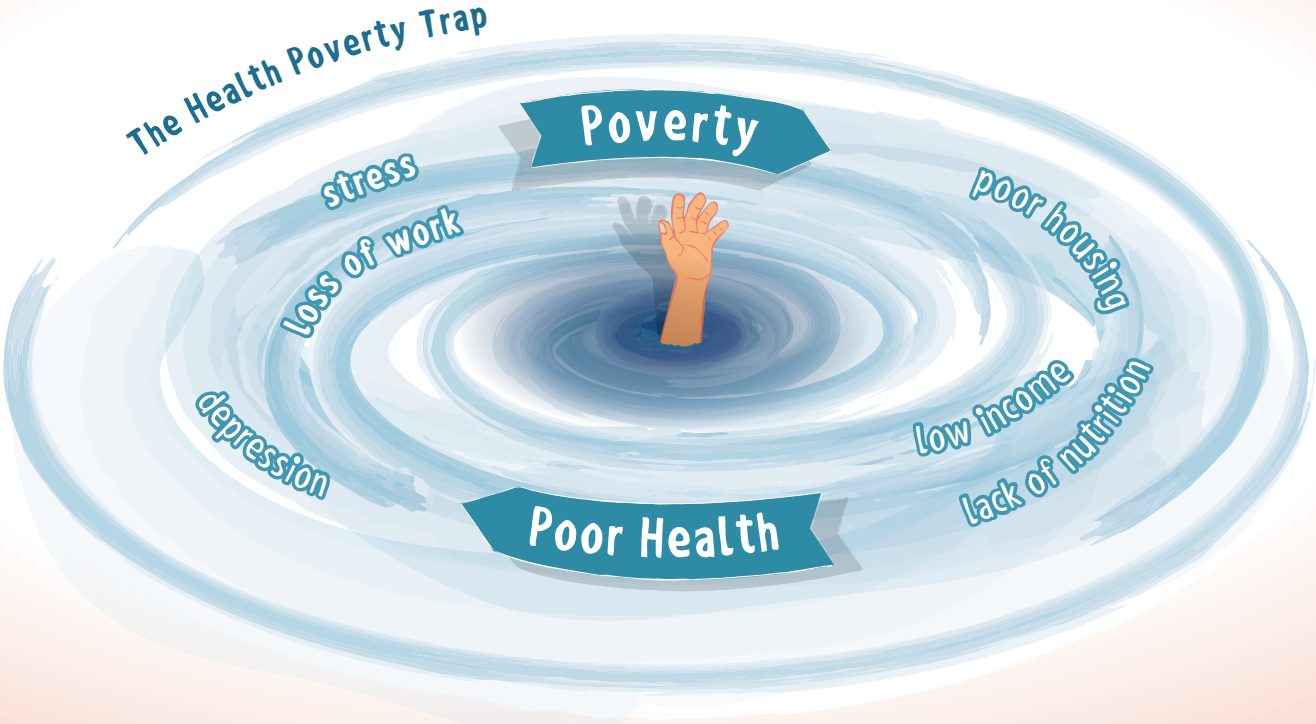
How Poverty Harms Health:
Evidence and Solutions for the Yukon



Yukon Anti-Poverty
COALITION
anti-pauvreté du Yukon

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Funded by: Yukon Strategy for Patient-Oriented Research (YSPOR)

About the Yukon Anti-Poverty Coalition

The Yukon Anti-Poverty Coalition works to facilitate the elimination of poverty in the Yukon through awareness, education, advocacy, action, and community building. The Yukon Anti-Poverty Coalition unites community members and representatives from non-governmental organizations, elected officials, and representatives from the business and faith communities on issues involving food, shelter, income, and access to services.

The vision of the Yukon Anti-Poverty Coalition is that all people in the Yukon live in an inclusive community free from poverty where diversity is respected and human rights are upheld. The official mandate of the organization is to:

- Foster strategies, actions, and partnerships with organizations to reduce and prevent poverty in the Yukon.
- Identify gaps, support collaboration, and facilitate the development of solutions to deal with the effects of poverty.
- Provide specific programming to alleviate the impacts of poverty on individuals and families.
- Provide safe and welcoming spaces for new ideas and solutions to be incubated and supported.
- Increase awareness of the causes of poverty and its impacts on Yukon people.
- Provide factual information on poverty based on research and lived experience.
- Coordinate actions and information, within and outside the Yukon, regarding poverty.
- Advocate and support individuals and families to navigate current systems.
- Advocate for positive systemic change with partner organizations.

For more information: Visit: www.yapc.ca • Email: info@yapc.ca • Call: (867) 334-9317

Design & Layout: Tanya Handley, *www.bearbait.ca*

This project was funded by The Yukon Strategy for Patient-Oriented Research (YSPOR). Dedicated to improving health outcomes in the Yukon through community-driven research, YSPOR honours Indigenous ways of knowing and collaborates with Yukon First Nations. The organisation is housed at Yukon University and funded by the Canadian Institutes of Health Research, with the goal of supporting meaningful and respectful research focused on the unique health context of the Yukon. We are grateful to YSPOR for their support, which made this research possible, and for their commitment to improving health outcomes in the Yukon.

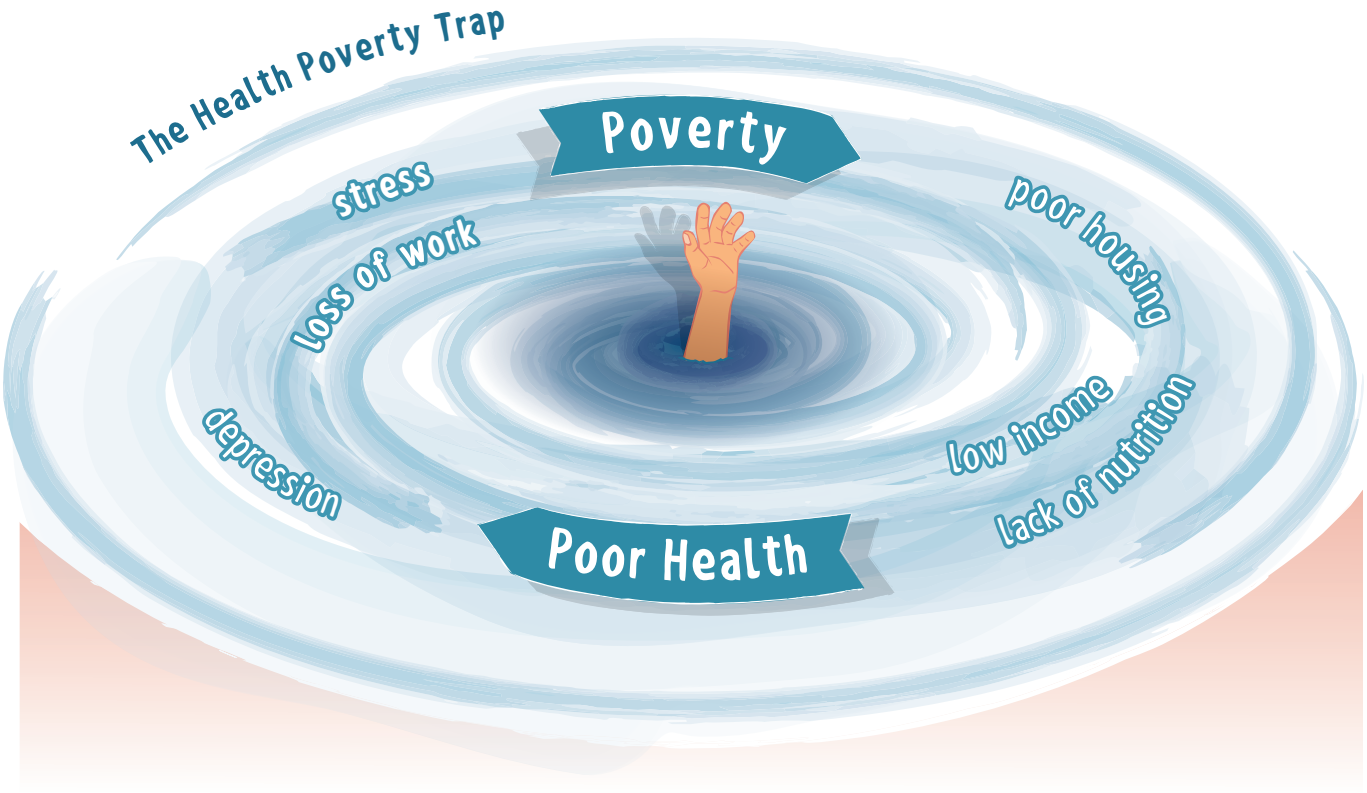
We also want to acknowledge the project's advisory group, which brought together four individuals with lived experience and professionals from the Yukon's health and social sector. The group provided a valuable connection to Indigenous organisations, rural communities, and community-based research. By meeting regularly to discuss the project's direction and review materials, they helped ensure the work remained locally grounded, relevant, and held to a high research standard. We thank the group for their essential role in the success of this project.

Executive Summary:

How Poverty Harms Health: Evidence and Solutions for the Yukon

Health is a human right, yet for many Yukoners, that right remains out of reach. Across the territory, poverty continues to limit access to the conditions that make good health possible—from secure housing and nutritious food to safety and social inclusion. Despite the Yukon's overall prosperity, inequality and hardship strongly persist, often hidden from view.

The link between poverty and poor health is well established in global research, but, in the Yukon, local data on these issues are scarce and outdated. Through a review of over 75 Yukon and external sources, this project set out to provide locally relevant evidence and solutions for the health consequences of poverty.



It's hard to escape

Poverty leads to unmet basic needs, which directly harm health. People living in poverty face disproportionate rates of many health problems, including 3–5× higher risk of mental health conditions, 2–3.5× higher risk of diabetes, and lifespans shortened by 10–15 years. Poor health can also lead to poverty, forming a 'health–poverty trap' with compounding economic and health consequences that are extremely difficult to escape.

Data about poverty and health in the Yukon are low-quality or non-existent. Many indicators are over a decade old, capture only a snapshot in time, overlook rural experiences, or are suppressed due to privacy laws. Data scarcity keeps health disparities hidden and severely constrains evidence-based policy design by decision-makers.

Scarcity of basic needs, such as housing, food, and personal safety, is the main driver of the health-poverty trap.

Boosting access to basic needs is the most powerful policy lever for easing the health-poverty trap.

A Solution for the Yukon

A Basic Needs Guarantee offers a promising, evidence-based strategy for addressing the health-poverty trap. It would combine multiple data-driven policies into a coordinated package that ensures every Yukoner has access to basic needs, such as housing, food, and transportation.

A Basic Needs Guarantee would include a mix of income- and service-based measures. Income supports, such as basic income, promote efficiency and autonomy, while service-based measures, such as improved social housing and public transit, ensure that essential goods and services are available and affordable.

More local data is needed to design it effectively. Current evidence is too limited to identify which specific set of policies would best guarantee access to basic needs within the territory's unique context. Targeted, solutions-oriented data collection is required to define which needs should be guaranteed, how they should be met, and what level of access is sufficient. Data collection should use mixed methods suited to Yukon's small population and follow principles including OCAP®, participatory methods, and life-course analysis.

First Nations governments should have full freedom to decide how to engage with a Basic Needs Guarantee — whether by developing their own approaches, collaborating in a territory-wide strategy, or pursuing different wellness priorities — with equitable resources to support any path.

Interim measures can provide relief now. Research highlights five priority areas for immediate action—food, housing, social assistance, low-income employment, and First Nations self-determination — while data is gathered to design a Basic Needs Guarantee. For a full list of recommendations, please see the full report.

Health is a human right — yet poverty continues to deny that right to many Yukoners.

A Basic Needs Guarantee, grounded in strong data and First Nations self-determination, offers a direct path to easing the health-poverty trap and building a more compassionate Yukon.

Introduction

Ill health and wellbeing are a core impact of living in poverty in the Yukon, yet data scarcity makes this issue nearly invisible on paper. This project explores where local data is missing on the intersection between poverty and health in the territory and how new data could help transform the health and wellbeing of our population.

Health is a fundamental human right, affirmed for decades by organizations like the World Health Organization.[1] Poverty violates this right by limiting people's access to essential health-determining resources such as food, housing, and education. In the Yukon, scarcity of local data obscures our understanding of this issue and limits our ability to create policies that uphold Yukoners' human right to health.

According to Statistics Canada, one in ten Yukoners lived in poverty and over one in five experienced food insecurity in 2023.[2] Despite having Canada's third highest median household income ($84,500 in 2023), inequality and cost of living challenges strongly persist.[3] Government responses are siloed across various programs, with minimal coordination or unified vision. Additionally, many economic and health data are outdated or unavailable because of small sample sizes, remote geographies, and privacy rules, leaving a sparse evidence base for decision-making. Together, this combination of financial hardship, scattered policies, and limited evidence points to the need for coordinated action and data collection.

This project also highlights First Nations self-determination as a foundational principle for all policies that affect Indigenous communities. Strengthening self-determination is linked to improved health and economic outcomes and is essential for effective and equitable poverty- and health-related approaches in the Yukon.

This project has found that poverty is linked to adverse health outcomes across a wide range of indicators, from self-rated health to asthma rates. Poverty harms health by limiting access to basic needs like education, housing and food. To improve health outcomes for Yukoners living in poverty, basic needs scarcity needs to be tackled directly. A 'basic needs guarantee' offers a promising strategy to boost access to basic needs through a coordinated package of evidence-based policies. To pursue this strategy in an effective and meaningful way, First Nations self-determination and solutions-oriented data collection are essential next steps.

> **"Poverty is associated with a wide range of health issues. These relationships are so strong as to suggest that poverty is the primary determinant of health."**
>
> *- Dennis Raphael, Poverty in Canada.*[4]

Project goals and methodology

This project contributes to broader efforts to improve the health and wellbeing of Yukoners living in poverty.

Problem statement: Adverse health is a core impact of living in poverty in the Yukon, but data scarcity keeps this issue nearly invisible on paper and limits evidence-based action.

Problem components	Project goals
Poverty-health link is nearly invisible across Yukon materials.	Synthesize external research to build an evidence base for the poverty-health link.
Local data scarcity limits evidence-based action.	Identify priority areas for local data collection.
Adverse health is a core impact of living in poverty in the Yukon.	Provide research-backed recommendations for disrupting the poverty-health link.

This six-month project (January–July 2025) is based on a literature and data review of 50 Yukon-focused reports, papers, and data sets, plus 28 external reports, papers and data sets spanning Canadian, Indigenous, circumpolar, rural and global contexts. Local sources were reviewed for insights related to the intersection of poverty and health outcomes in the Yukon. For external literature, iterative thematic analysis was used to explore the evidence for and mechanisms behind the poverty-ill health link, policy and data collection insights, and other connected topics. Findings were then triangulated to identify gaps and areas of continuity between Yukon and external insights.

This project was conducted by a single researcher on a relatively short timeline, which narrowed the scope for stakeholder engagement and the inclusion of unpublished local data. While this means some local nuances may be missing, this limitation ultimately supports the report's findings. It highlights the need for better data collection, transparency, and mobilization in the Yukon, as recommended in the following pages.

Putting People First

Putting People First is the Government of Yukon's ongoing strategy to transform the health and social system in the Yukon. The original *Putting People First* report was released in 2020 after a comprehensive review of health and social programs and contains 76 recommendations that the Government of Yukon has committed to implementing.

This project has generated insights that can help inform the implementation of recommendations that are in progress or yet to begin, while recommendations that have already been implemented can support the next steps identified through this research. Relevant *Putting People First* recommendations are flagged throughout the report.

> **Putting People First recommendation 1.1:** Reorient Yukon's health care system from a traditional and fragmented medical model to a focus on population health accompanied by integrated, person-centred care across the health and social system.[5]

> **Putting People First recommendation 1.5:** Implement a population health approach that considers the social determinants of health to reduce inequities and improve the health of the entire population.[6]

Yukon poverty, policy and data landscapes

Poverty landscape

Prevalence: Statistics Canada estimates that one in ten Yukoners (9.9%) lived in poverty and about one in five (21.8%) experienced food insecurity in 2023, with poverty measured using the Northern Market Basket Measure (MBM-N).[7]

Spotlight: Measures of Poverty

Statistics Canada produces several measures of poverty and low income. The **Northern Market Basket Measure (MBM-N)** is the Canadian government's official poverty line for northern regions, including the Yukon. It estimates the income needed for a family to afford a specific 'basket' of essential goods and services, including food, clothing, shelter, transportation, and other necessities, adjusted for regional costs of living. MBM-N thresholds are calculated annually for Whitehorse, Yukon rural north, and Yukon rural south, excluding Old Crow.

However, the MBM-N has limitations. Its thresholds are often considered insufficient to meet a basic standard of living. Additionally, the rates it produces do not accurately reflect costs of living across Yukon communities, where expenses can vary dramatically. Old Crow is excluded entirely, leaving a high-cost community unrepresented.

Another Statistics Canada measure is the **Low-Income Measure, After-Tax (LIM-AT)**, which defines low income as having an after-tax income below 50% of the national median. Because it applies a single national threshold, it does not reflect the high and uneven costs of living in northern or remote regions.

Overall, estimates of poverty rates in the Yukon should be interpreted with caution. Small sample sizes, limited price data, and uneven geographic coverage make it difficult to produce precise figures. This report draws on available MBM-N and LIM-AT data because they are the only consistent sources of poverty statistics for the Yukon. However, their use does not imply endorsement of these measures as fully accurate representations of poverty in the territory.

In addition to these official measures, this report occasionally refers to income quintiles – a method of dividing a population into five equal-sized groups based on income, from the lowest 20% to the highest 20%. The first quintile represents the 20% of people with the lowest incomes, while the fifth quintile represents the 20% with the highest incomes. Although quintile-based analysis is uncommon in Yukon materials, this concept will occasionally be used in this report when referencing research from other regions.

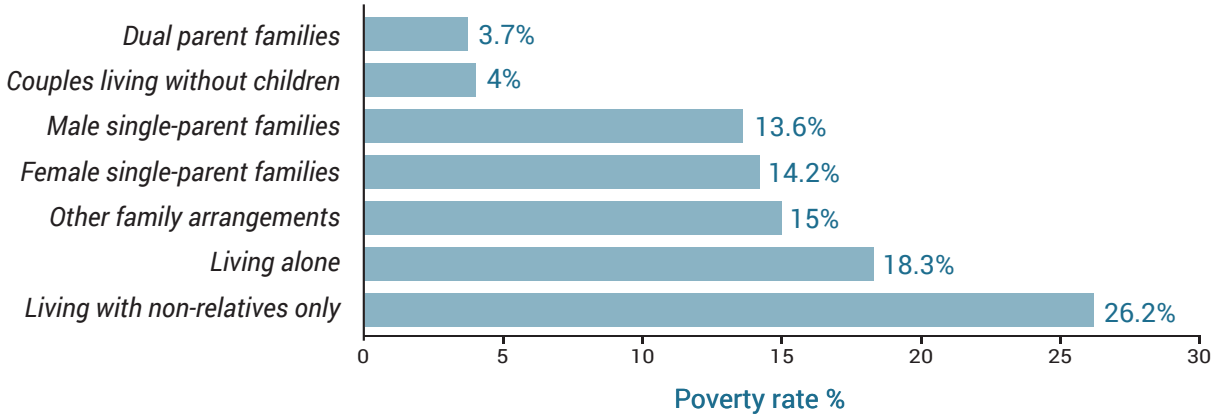
Affordability issues: Despite having Canada's third highest median after-tax income ($84,500), affordability is a persistent barrier.

- **Living wage vs. minimum wage:** The 2025 living wage in Whitehorse ranges from $25.91-$33.95/hour (depending on family type),[8] far above the $17.94 minimum wage.[9]
- **Housing:** The vacancy rate in Whitehorse was 1.3% in October 2024,[10] and 13.1% of Yukon households were in core housing need in 2021.[11]

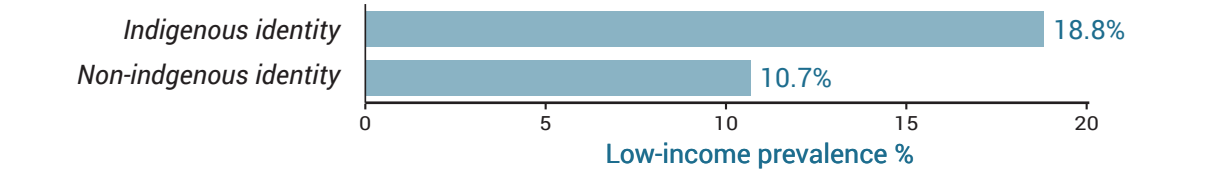
Population distribution: Groups facing disproportionate rates of poverty in the Yukon include members of non-couple family arrangements, Indigenous peoples, and residents of rural communities. While some groups are more affected than others, poverty affects people from a range of demographic backgrounds in the Yukon.

Health and income disparities among First Nations and other Indigenous communities reflect the ongoing impacts of colonization, systemic racism, and violence. At the same time, these communities are diverse, with distinct economic and health contexts—making community-led approaches and self-determination essential. This project's literature review included a strong representation of sources from Indigenous organizations in an effort to represent these realities with sensitivity.

MBM-N poverty rate by economic family type, Yukon, 2021 [13]



Low-income (LIM-AT) prevalence by Indigenous identity, Yukon, 2021 [14]



Prevalence of low income (%) by age group and community, Yukon, 2020 [15]

	0 to 17 years (%)	*18 to 64 years (%)*	*65 & over years (%)*
Whitehorse region	6.6	5	11.1
Watson Lake region	12.7	11	20.4
Dawson	6	8.4	18.5
Teslin region	0	3.2	27.3
Ross River	26	22	20
Carmacks	16	11.6	24
Faro	16	11	24
Tagish	16	20	14
Carcross region	0	9.1	20
Pelly Crossing	14	16	16
Haines Junction	8	6.4	9
Alaska Highway North region*	8.8	7.4	10.7

** Beaver Creek, Burwash Landing, Destruction Bay and Haines Junction combined*

Policy landscape

The governments of Yukon and Canada have acknowledged that income is a primary social determinant of health, and both governments fund various initiatives to address poverty and health inequities.[16]

Poverty and health inequity related initiatives available in the Yukon *(not exhaustive)*:

- Social Assistance
- Canada-Yukon Housing Benefit
- Whitehorse Emergency Shelter
- Yukon Housing Corporation social housing
- Canada Child Benefit
- Kids Recreation Fund
- Yukon Child Benefit
- Canada Workers Benefit
- Housing First
- Jordan's Principle
- Medical Travel Program
- Dawson City Women's Shelter
- Child Care Subsidy
- Old Age Security
- Guaranteed Income Supplement
- Paid Sick Leave Rebate program
- Yukon Women's Transition Home
- Pioneer Utility Grant
- Yukon Seniors Income Supplement
- Legal aid

Despite the long list of available supports, the policy landscape is fragmented and often fails to support pathways out of poverty. Initiatives operate in silos with separate application processes, eligibility requirements and infrastructure, leaving recipients to independently navigate multiple complex systems. Social assistance is a primary source of financial support for many individuals facing poverty, yet rates are insufficient to meet basic needs and levels of support are inconsistent across administrators.[17] The current policy landscape leaves poverty and health inequities largely intact, offering limited relief from their root causes. A lack of public program data makes it difficult to evaluate the impact of programs, pointing to broader data scarcity issues in the health and social sector.

Data landscape

Reliable, up-to-date data on poverty and health inequities in the Yukon is scarce. The territory's small, sparse population means that Statistics Canada often suppresses survey results, so many national indicators and tables are not published for the Yukon. Where figures are available, they typically come from small samples, focus on Whitehorse, and capture only a single point in time, offering little-to-no insight into population sub-groups,[18] trends over time, or rural areas. Many national data frameworks—for example those used in *Canada's National Action Plan to End Gender-Based Violence*—are incompatible with the territory's context due to small samples, suppression, and inconsistent territorial coverage.[19]

Beyond data availability and quality, data mobilization is also an issue. Government departments and non-governmental organizations hold various poverty- and health-related data that are not publicly released due to privacy rules, capacity, infrastructure, or other limitations. As with programs and services, poverty- and health-related data in the Yukon is fragmented and siloed across departments and organizations.

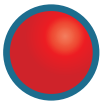
Many of the local data sources used in this report date from 2010 or earlier— the most recent information available for many key indicators. The reliance on these older sources highlights the depth of the territory's data gaps. When the newest available data are more than a decade old, understanding our population and designing effective programs becomes a significant challenge.

Data availability and mobilization issues mean that Yukoners' experiences of poverty and health inequities often remain invisible. With minimal data capturing lived experiences, evidence-based decision-making is highly constrained.

This report identifies specific gaps in data availability and quality. Throughout the report, Yukon data is flagged with a traffic-light icon to quickly illustrate its quality. Ratings are based on key dimensions from the *Open North Data Quality Checklist:* timeliness, completeness, reliability, reusability, and documentation.[20] Please note that these ratings are meant to illustrate broad data quality issues, not to act as definitive judgements on any one data source.

High Quality
- Timely: recent data, regularly updated
- Complete: comprehensive population coverage

Medium Quality
- Some limitations in timeliness or coverage
- Reliable but incomplete or somewhat dated



Low Quality
- Limited sample size or reliability concerns
- Outdated or significant coverage gaps

No Direct Indicators
- No published data linking poverty to outcome
- Proxy indicators or indirect evidence only

The data gaps identified in this report are illustrative of the territory's information scarcity rather than a list of specific data we aim to collect. The goal is not to fill each gap with more data, but to advocate for a policy-oriented, mixed-methods evidence approach that is better suited to the Yukon context.

Evidence summary: Poverty-health link

Living in poverty clearly harms health. Data scarcity in the Yukon makes this issue harder to see, but robust external evidence combined with limited local insights proves that the link holds true in the territory. This section summarizes external and local evidence for the poverty-health link, highlighting that Yukoners living in poverty experience these challenges although the data is missing.

In this section, *direct indicators* refer to measures of income, while *indirect indicators* capture employment and education—key components of socioeconomic status that are closely linked to income. Because Yukon income data are limited, this section also draws on indirect indicators to help illustrate health disparities.

This project acknowledges that wealth can take many forms, such as traditional values, cultural practices, and community connection, all of which influence health. While these broader forms of wealth are important to a holistic understanding of health and poverty in the Yukon, the scope of this project focuses on financial resources as a determinant of health. The following table summarizes external and local evidence on the relationship between poverty and specific health outcomes, as well as the quality of local evidence. In-depth explanations of these findings follow on pages 14-20.

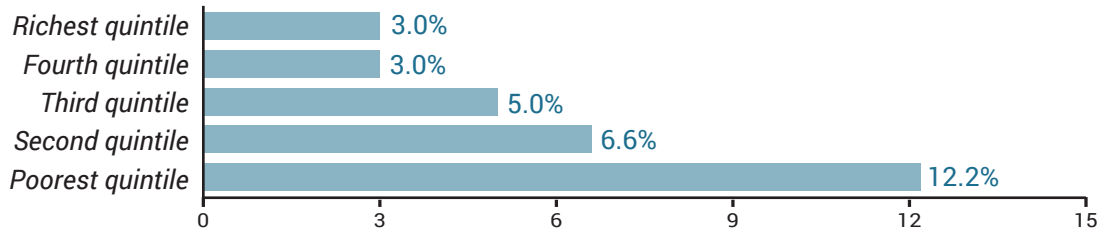
Health outcome	External evidence: *Link between poverty and health outcome*	Yukon evidence	Yukon data quality
Low self-rated health	3 - 4x greater risk	Limited data aligns with external trends.	
Mental health conditions	3 - 5x greater risk	Limited data aligns with external trends.	
Diabetes	2 - 3.5x greater risk	No direct indicators; proxy indicators show mixed alignment with external trends.	
Heart conditions	1.3 - 3.2x greater risk	No direct indicators; proxy indicators show mixed alignment with external trends.	
Respiratory conditions	1.3 - 3.3x greater risk	No direct indicators; proxy indicators align with external trends.	
Reduced life expectancy	1.5 - 1.7x higher annual mortality rate; 10 - 15 year lower lifespan	No data available.	
Activity limitations	1.2 - 2x greater risk	Limited data aligns with external trends.	
Obesity	1.5x greater risk for women	No direct indicators; proxy indicators align with external trends.	
Cancer	Mixed outcomes depending on cancer type	Limited data shows mixed alignment with external trends.	
Substance-related harms	3.8x greater risk of opioid-related mortality	No direct indicators; indirect evidence shows possible alignment with external trends.	
Other conditions	1.45 - 4x greater risk of various other conditions	No data available.	

Self-rated health

External evidence:

- Across 136 Canadian regions, low-income individuals were over three times as likely to rate their overall health as fair or poor; a three- to four-fold disparity was also documented in multiple Ontario studies[21]
- The 2017 *Aboriginal Peoples Survey* found that income was the single strongest predictor of lower self-rated mental health.[22]

Prevalence of self-reported fair or poor mental health by income quintile * [23]

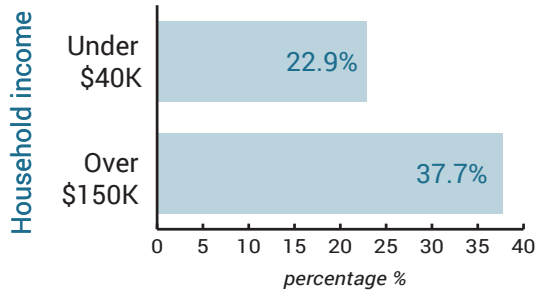


** 2018 Canadian Community Health Survey*

Yukon evidence:

- *Community Wellbeing Survey* (2021): higher-income households were 1.6x more likely to rate their physical health and 1.1x more likely to rate their mental health as high, but pandemic may have skewed disparities (high physical health fell from 54% to 31% and high mental health fell from 63% to 33% overall).[24]
- *Yukon Regional Health Survey:* "clear relationship" of better self-rated health with rising income; exact figures not published.[25]
- Statistics Canada indirect indicators: higher self-rated health linked to employment and higher education attainment (components of socioeconomic status alongside income).[26]

Prevalence of very good or excellent self-rated physical health, Yukon, 2020 [27]



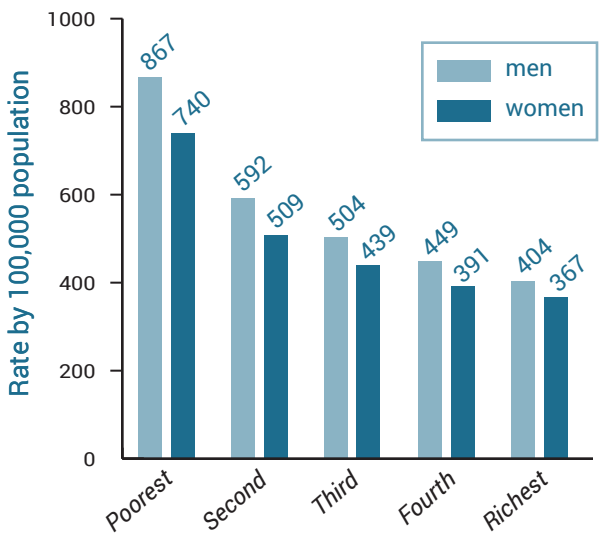
> "Lower income is robustly associated with worse physical health."
>
> *- Matthew Ridley et. al., Poverty, Depression, and Anxiety.*[28]

Mental health conditions

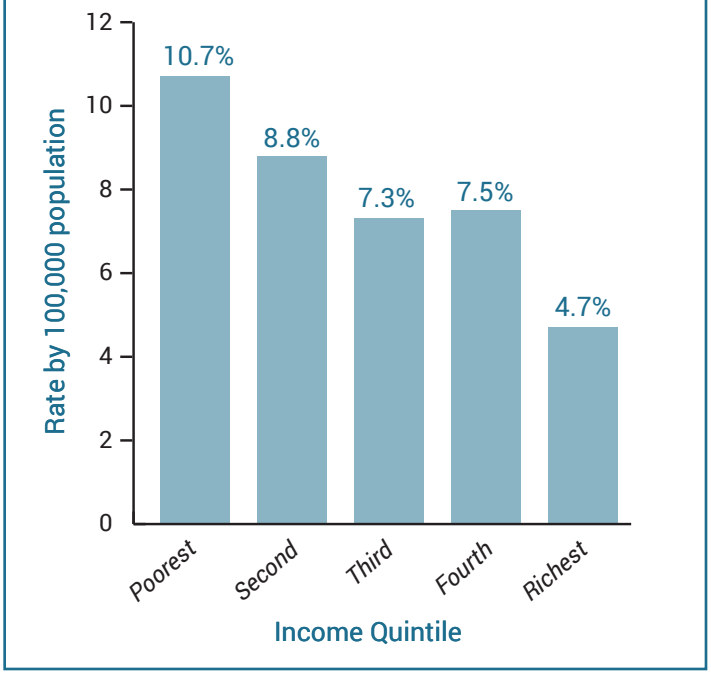
External evidence:

- Low-income Americans: 4x more likely to report chronic nervousness and 5x more likely to report chronic sadness.[29]
- Norwegian children in low-income families: 3 - 4x more likely to have a diagnosed mental health condition vs. higher-income peers.[30]
- 2.3x higher prevalence of major depression among low-income Canadians.[31]
- 1.79x higher suicide death rate among lowest income quintile vs. highest income quintile Canadian men.[32]
- 2.9x higher rate of postnatal depression in lowest quintile vs. highest quintile mothers in England.[33]

Mental health hospitalization rates by income quintile [34]



Having an emotional, psychological or mental health condition, adults (18+ years) [35]



Yukon evidence:

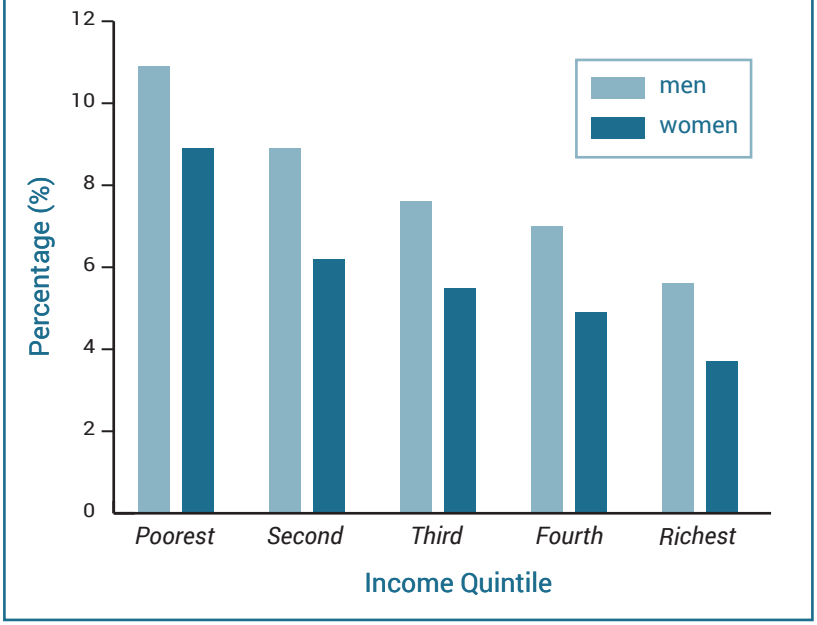
- *Yukon Social Inclusion Survey* (2010): lowest-income group 8x more likely to be dissatisfied with life compared to the highest-income group.[36]
- *Whitehorse Point-in-Time Count* (2024): 44% of unhoused participants reported having a mental health issue.[37]

Diabetes

External evidence:

- 3.5x higher rate of diabetes in low-income vs high-income Canadian women; 2x higher rate among low-income men.[38]
- 2.8x higher rate of diabetes among low-income vs high-income individuals in rural Saskatchewan.[39]

Diabetes prevalence by income quintile, Canada 2010-2013 [40]



Yukon evidence:

- No public data is available on possible links between poverty and diabetes.
- Statistics Canada indirect indicators: education and employment data are missing key values and do not reveal any clear relationship between socioeconomic status and diabetes.[41]

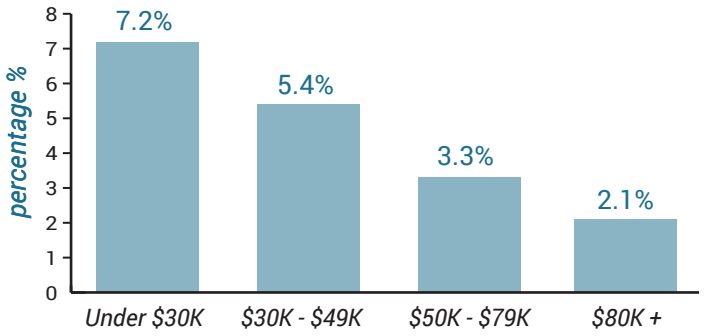
> **"The relationship between income and health-related outcomes is well-established: the poorer one is, the more likely they are to experience health risks in daily life."**
>
> *- Lydia Hicks et al., A national-level examination of First Nations peoples' mental health data, 3.* [42]

Heart conditions

External evidence:

- 3.2x higher prevalence of heart disease among low-income vs. high-income Canadians; disparity widened to 3.8x higher prevalence after 11-year follow-up.[43]
- Hospitalized heart attacks 1.3x more common among lowest quintile vs. highest quintile Canadian men; 1.4x disparity among women.[44]

Heart attack history among *Saskatchewan Rural Health Study* respondents [45]



Yukon evidence:

- No public data is available on possible links between poverty and heart conditions.
- Statistics Canada indirect indicators:
  - Heart disease is more common among unemployed individuals and shows no clear relationship with educational attainment.
  - High blood pressure is less common among university graduates compared to lower levels of educational attainment and shows no clear relationship with employment status.
  - Substantial missing data limits the reliability of these indirect indicators.[46]

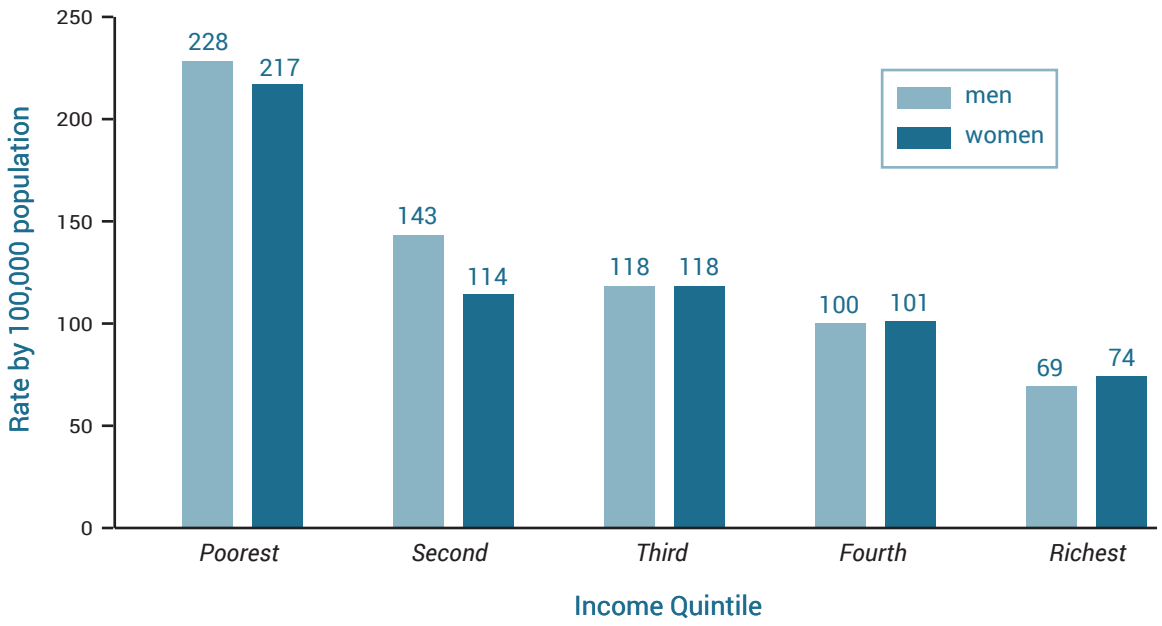
> **"Poverty increases an individual's, a family's, and a community's risk of developing chronic diseases, developing complications, and dying."**
>
> *- Jeffrey Lawrence Reading, The Crisis of Chronic Disease Among Aboriginal Peoples, 13.*[47]

Respiratory conditions

External evidence:

- Chronic Obstructive Pulmonary Disease (COPD) hospitalization rate 3x higher among low-income Canadians.[48]
- 1.36x higher risk of asthma in lowest-quintile men and 1.33x higher risk in lowest-quintile women in Canada.[49]

COPD prevalence by income quintile, Canada 2012 [50]



Yukon evidence:

- No public data is available on possible links between poverty and respiratory conditions.
- Statistics Canada indirect indicators (2015 - 2018):
    - Higher rates of asthma linked to unemployment and lower educational attainment.
    - Higher rates of COPD linked to unemployment.
    - Missing values limit reliability.[51]

Life expectancy

External evidence:

- American men with top 1% incomes live 15 years longer than men in the bottom 1%; women in the top 1% live 10 years longer than those in the bottom 1%.[52]
- 1.7x higher annual mortality rate among lowest quintile vs highest quintile Canadian men; 1.5x disparity among women.[53]
- 1.5x higher infant mortality rate in low-income neighbourhoods in Toronto.[54]

Yukon evidence:

- No public data is available on possible links between socioeconomic status and life expectancy.

Activity limitations

External evidence:

- *2008-2010 First Nations Regional Health Survey:* respondents with incomes under $20k were 2x more likely to report everyday activity limitations than respondents earning $60k+.[55]
- Canadian children living in low-income neighbourhoods were 1.2x more likely to be vulnerable in physical/motor skills vs. those in wealthier neighbourhoods.[56]

Yukon evidence:

- *Census 2021:* lowest income quintile adults 1.4x more likely to have "difficulties doing activities of daily living" vs. highest income quintile adults.[57]
- Statistics Canada indirect indicators: higher prevalence of activity limitations is linked to unemployment and lower education attainment.[58]

> **"Poverty and ill-health are inextricably linked; the lower an individual's socioeconomic status, the worse their health"**
>
> *- National Collaborating Centre on Indigenous Health, 1.*[59]

Obesity

External evidence:

- Canadian women in low-income households have a 1.5x higher prevalence of obesity vs. women in higher-income households. This disparity was not identified among men.[60]

Yukon evidence:

- No public data is available on possible links between poverty and obesity.
- Statistics Canada indirect indicators: unemployment and low education linked to higher obesity rates among women, with mixed evidence among men.[61]

Cancer

External evidence:

- Higher risk for some cancers: Low income is linked to elevated rates of lung, stomach, liver, cervical, hepatocellular, oral/oropharyngeal, and prostate cancers.[62]
- Lower risk for other cancers: Low income is linked to lower rates of breast and colorectal cancers.[63]
- Worse cancer survival: Low income is linked to higher overall cancer mortality.[64]

Yukon evidence:

- Statistics Canada:
    - The rate of breast, lung, and colorectal cancer is similar across income quintiles.
    - Higher income is associated with higher rates of breast and prostate cancer.
    - Large confidence intervals limit reliability.[65]

Substance-related harms

External evidence:

- The United Nations Office on Drugs and Labor cites poverty as the top risk factor for substance use disorders.[66]
- Between 2000 and 2017, lowest income quintile Canadians had a 4.3x higher rate of opioid-related hospitalization and 3.8x higher rate of opioid-related mortality compared to the highest income quintile.[67]
- Smoking is 2x more common among low-income Canadians; this disparity is widening over time.[68]

Yukon evidence:

- *Yukon Social Inclusion Survey* (2010): low-income respondents were 2.4x more likely to identify drugs and public drunkenness as a problem in their neighbourhood vs. high-income respondents.[69]
- *Whitehorse Point-in-Time Count* (2024): 75% of unhoused participants indicated having substance use disorder.[70]
- No direct indicators are available on possible links between poverty and substance use disorders or substance-related mortality.

Other conditions

External evidence:

- Various other health conditions have been linked to poverty, such as HIV/AIDS,[71] back problems,[72] stroke,[73] influenza, tuberculosis,[74] and injuries.[75]

Yukon evidence:

- No public data is available on potential links between poverty and HIV/AIDS, back problems, stroke, influenza, tuberculosis, or injuries in the Yukon.

Causality & the health-poverty trap

> **"Ill health causes poverty."**
>
> *- Owen O'Donnell, Health and health system effects on poverty, 1.*[76]

Most studies linking poverty and health focus on poverty leading to ill health, but some researchers argue that the reverse pathway (ill health causing poverty) deserves equal attention. Because so many overlapping and mediating economic and health factors act at once, isolating definitive causes and effects is difficult.

Where researchers do focus on ill health causing poverty, they often cite contexts with high out-of-pocket healthcare costs, where medical bills alone push households into poverty. Canada's universal healthcare system softens these expenses, but the pathway from poor health to poverty is still important. Illness can limit work, education, and other economic opportunities, contributing to poverty even when healthcare is publicly funded.[77]

In practice, separating the two directions may be beside the point, since the relationship functions more as a cycle than as two isolated pathways. The compounding hardships of poverty and ill health form a "health-poverty trap" – a cycle that is extremely difficult to break without outside support.[78] For example, living with a low income can lead to chronic illness, which can then reduce employment options, further limiting earnings and entrenching poor health.[79] Yukon qualitative research echoes this framing: participants articulated a "cycle of poverty" intensified by chronic illness and disability.[80]

From a policy standpoint, the cyclical nature of the poverty-health relationship presents an opportunity. A well-designed and sufficiently resourced intervention targeted to one component of the cycle can disrupt it, simultaneously boosting economic and health outcomes.[81] To design such interventions, we need to better understand the mechanisms underlying the health-poverty trap.

Basic needs scarcity:
The key mechanism underlying the health-poverty trap

> **"Socioeconomic status operates as a flexible resource, helping individuals acquire and produce good health."**
>
> *- James Iveniuk, Income, social support, and well-being in the GTA, 1.*[82]

Across the research literature, scarcity of basic needs emerges as the key mechanism linking poverty and poor health. Basic needs scarcity refers to insufficient access to the essential conditions that sustain health and wellbeing — such as nutritious food, secure housing, safety, education, social inclusion, and healthcare.

Whether poverty precedes health issues or health issues precede poverty, scarcity of needs triggers and continually deepens the health-poverty trap. Once basic needs are unmet, the body and mind are exposed to compounding hazards and stress, leading to illnesses, constrained wellbeing, and shortened lifespans. Illness then limits opportunities for employment, education, and social participation, deepening poverty and further restricting access to basic needs.

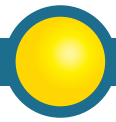
Understanding this mechanism shifts the policy focus from treating downstream illness to securing upstream conditions for health. By improving access to basic needs, interventions can weaken both directions of the poverty-health link at once — protecting those experiencing poverty from illness and preventing illness from leading to poverty.

The following pages summarize evidence on how scarcity of specific basic needs links poverty and poor health in the Yukon and beyond.

DIRECT PATHWAYS between poverty, ill health, and unmet basic needs

Rather than presenting a complete list of basic needs, this report draws on the needs that surfaced most consistently in the literature linking poverty and poor health. The list that follows is therefore illustrative, not prescriptive. For future policy development, a local list of basic needs should be defined.

HOUSING

Yukon data quality: 

What scarcity looks like:

Living with home hazards such as mould, pests, overcrowding, and lack of heating.[83]

Experiencing homelessness, from rough sleeping and couch surfing to emergency shelter use.

Health impacts of scarcity:

Poverty-driven home hazards are linked to increased risks of infection, chronic disease, injury, mental illness, and premature death.[84]

Homelessness can lead to premature death, injury, mental health concerns, infectious diseases, sleep deprivation, and more.[85]

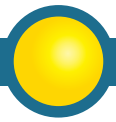
Yukon evidence:

Whitehorse Housing Adequacy Study (2010): participants reported widespread concerns about mould, pests, and inadequate heat, with overcrowding and homelessness concentrated in the lowest-income brackets.[86]

Community engagement initiatives have linked substandard housing to cycles of poor health.[87]

Whitehorse Point-in-Time count (2024): 44% of unhoused respondents reported a mental health concern.[88]

FOOD

Yukon data quality: 

What scarcity looks like:

Inability to afford a sufficient, nutritious diet.[89]

Health impacts of scarcity:

Food insecurity is linked to a wide range of consequences for mental and physical health,[90] including 2.5x greater risk of depression and anxiety.[91]

Yukon evidence:

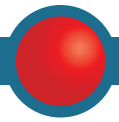
Social Inclusion Survey (2010): 61.2 % of the lowest-income households faced at least one indicator of food insecurity, vs. 4.1 % of the highest-income group.[92]

Community Wellbeing Survey (2020): 26.5% of low-income respondents reduced food intake for financial reasons compared to 1.3% of high-income peers.[93]

Qualitative research shows residents describing food insecurity's toll on mental health and its link to poverty, low wages, and unemployment.[94] Yukoners also raised concerns that lack of availability of healthy food is leading to higher rates of diabetes and heart disease.[95]

Community engagement participants shared that poverty can limit access to traditional foods, as hunting can be prohibitively expensive.[96]

SAFETY

Yukon data quality: 

What scarcity looks like:

Heightened risk of suffering and witnessing violence and crime.[97] Heightened risk among women, particularly Indigenous women, of experiencing violence, traumatic sexual experiences, and exploitation.[98]

Health impacts of scarcity:

Poverty-driven safety concerns linked to stress-induced genetic and hormonal issues like heightened cortisol and adrenaline, which contribute to chronic illness.[99]

Unstable and insufficient access to basic needs makes women vulnerable to exploitation and abuse,[100] and gender-based violence makes women highly vulnerable to poverty.[101] Women and children fleeing violence face immediate material deprivation, and a lack of secure housing and income acts as a primary barrier to leaving unsafe environments.

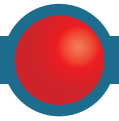
Yukon evidence:

Social Inclusion Survey (2010): 71.8% of low-income respondents reported feeling safe walking in their neighbourhood at night, vs. 87.5% of high-income respondents.[102]

Qualitative findings reveal a lack of services for those facing interpersonal violence, especially in smaller communities,[103] and Indigenous women report higher rates of abuse.[104] Low-income Yukon women report facing layered abuse that traps them in unstable and unhealthy living situations, including involvement in the sex trade.[105]

The Yukon Bureau of Statistics reported that in 2022, the territory had the third highest rate of police-reported family and intimate partner violence in Canada.[106] Heath system data shows that nearly all emergency visits for sexual assault involve women[107] and adolescent girls report high levels of abuse in romantic relationships.[108]

EDUCATION AND EMPLOYMENT

Yukon data quality: 

What scarcity looks like:

Limited access to education and employment options, entrenching low earnings.

Low-paying jobs are often tied to job insecurity and a lack of workplace benefits.[109]

Health impacts of scarcity:

Limited education and employment attainment are linked to type 2 diabetes and overall chronic disease risk.[110] The precarity and physical demands of low-paying jobs expose workers to health risks such as injury and mental health concerns.[111]

Yukon evidence:

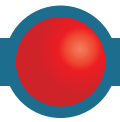
Community engagement cites "low education" and "lack of life skills" as drivers in the cycle of poverty.[112]

Social Inclusion Survey (2010): 52.1 % of the lowest-income group faced barriers to returning to school, versus 29.0 % in the highest group; financial barriers were most often cited.[113]

Community Wellbeing Survey (2020): low-income respondents reported poorer work-life balance and fewer flexible schedules, though high earners more frequently report working long hours.[114]

HEALTHCARE

Yukon data quality:



What scarcity looks like:

Lower likelihood of having extended health benefits.[115] Inability to afford medications and non-insured services like vision care and therapy.[116] Difficulty going to medical appointments due to transportation barriers and struggling to take time off work.[117]

Health impacts of scarcity:

Forgoing necessary healthcare directly worsens overall health outcomes.[118]

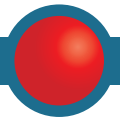
Yukon evidence:

In 2020, the Yukon Bureau of Statistics reported that around 38% of Yukon residents lacked extended health benefits; a breakdown by income was not available.[119]

Community engagement found that the costs of medical travel, prescriptions, and counselling are healthcare barriers for low-income Yukoners.[120] Some participants reported needing to choose between healthcare and other basic needs, worsening their wellbeing and long-term health.[121]

INFRASTRUCTURE AND ENVIRONMENT

Yukon data quality:



What scarcity looks like:

Lower-income areas face substandard public infrastructure (public transit, parks, emergency services, etc.) and disproportionate exposure to environmental harms (pollution, extreme temperatures, etc).[122]

Health impacts of scarcity:

Substandard infrastructure and environment are linked to community-level health harms.[123]

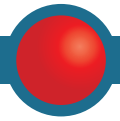
Yukon evidence:

2010 community engagement identified transportation issues, such inadequate public transit and unaffordable taxis, as barriers to wellbeing.[124]

Social Inclusion Survey (2010): 36.0% of Yukon households earning under $30,000 reported missing appointments or social events due to lack of transportation, compared to just 3.4%–3.6% of those earning over $60,000.[125]

SOCIAL INCLUSION

Yukon data quality:



What scarcity looks like:

Poverty is tied to social exclusion and discrimination.[126] Poverty-related difficulties can strain relationships, leading to issues like family conflict, divorce, and barriers to socializing, dating, and forming intimate connections.[127]

Health impacts of scarcity:

Feelings of low status, shame and loneliness raise risk of depression and anxiety.[128] Social exclusion undermines health and wellbeing.[129]

Yukon evidence:

Community engagement participants described children in poverty as socially excluded. Rural participants described that social exclusion was intensified by their community's reluctance to acknowledge local inequalities.[130] Social isolation was also linked to unaffordability of communication tools such as phones and the internet.[131]

Community Wellbeing Survey (2020): 33.9% of low-income households reported weak community belonging, compared to 17.2% of high-income households.[132]

INDIRECT PATHWAYS between poverty, ill health, and unmet basic needs

Early life and intergenerational burdens

> "Child poverty is family poverty, is community poverty, is generational poverty. That is, poverty rarely affects just one individual, at one time, but is an issue that transcends age and time."
>
> *- Jeffrey Lawrence Reading, The Crisis of Chronic Disease Among Aboriginal Peoples.*[133]

How it links poverty and health:

Pregnancy: Maternal poverty during pregnancy raises lifelong risks of depression, respiratory illness and infections in children.[134]

Childhood: Children in low-income families show higher rates of impaired cognition, altered stress responses, chronic disease, premature mortality, injury, obesity, and mental health conditions; these effects often persist into adulthood even if earnings improve.[135]

Life-course accumulation: Long-term poverty compounds health harms, widening health inequities into middle age.[136]

Intergenerational cycle: Children born into low-income families are more likely to remain in poverty and inherit associated health disadvantages.[137] Indigenous worldviews explicitly recognise the transmission of experiences across generations.[138]

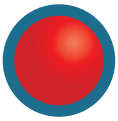
How it connects to basic needs scarcity:

Early-life and long-term deprivation of needs like food, housing, safety and social support deepen the health-poverty trap and make it harder for subsequent generations to meet their own basic needs.[139]

Yukon data:

Community engagement participants identified "growing up poor" as a driver of long-term poverty.[140]

Yukon Regional Health Survey (2007): residential school survivors report extreme deprivation – isolation from family (88%), language and culture loss (87%), verbal abuse (80 %), physical abuse (75 %), insufficient food (50 %), sexual abuse (47 %).[141] Data on local intergenerational impacts is not available.

Yukon data quality: 

Stress

How it links poverty and health:

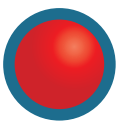
Persistent financial insecurity creates chronic stress that can lead to genetic and hormonal disruptions like raised cortisol and adrenaline, increasing risks of chronic illness.[142] A perceived lack of control over present and future circumstances further heightens stress and erodes overall physical health, mental health, and quality of life.[143]

How it connects to basic needs scarcity:

When access to basic needs is uncertain, limited resources need to be constantly prioritized and rationed, keeping psychological stress high and amplifying the harm caused by each unmet need.

Yukon data:

Qualitative interviews revealed a "constant mental burden" of juggling rising costs on fixed incomes and choosing between basics like food, transportation, and utilities.[144]

Yukon data quality: 

Bureaucratic and colonial barriers

How it links poverty and health:

Administrative rules, complex paperwork, and jargon-heavy information systems disadvantage marginalized people, including those with low income, limited literacy, or no internet access. These create barriers to health care and social services, worsening material hardship and stress. For Indigenous peoples, an added colonial layer means engaging with services coded in different cultural norms; lack of cultural safety and outright discrimination further deters care seeking and undermines trust.[145] The result is a form of "structural violence" that normalises suffering, re-traumatises clients, and compounds health harms.[146]

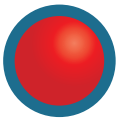
How it connects to basic needs scarcity:

Bureaucratic and colonial barriers exclude people from information, services, and full social participation, cutting off the basic need of social inclusion. Social exclusion can amplify other unmet needs.

Yukon data:

Participants in a Yukon food security study articulated that limited nutrition knowledge contributed to unhealthy food choices.[147]

Community engagement participants reported feelings of humiliation and powerlessness when accessing services like income assistance and public transit, pointing to social exclusion within public services.[148]

Yukon data quality: 

Mind-body connection

How it links poverty and health:

Poverty is tied to both mental and physical health harms.[149] Mental and physical health are tightly intertwined; physical illness increases the risk of depression and anxiety, while mental illness raises the likelihood of chronic conditions.[150] Through exposure to many risk factors, people living in poverty are vulnerable to compounding mental and physical health challenges.

How it connects to basic needs scarcity:

When poverty deprives people of essentials such as safe housing and nutritious food, it can set off a self-perpetuating cycle of mental and physical health issues.[151]

Yukon data:

No Yukon studies map the role of the mind-body connection in poverty and health outcomes.

Yukon data quality: 

Substance use

How it links poverty and health:

Low-income Canadians smoke nearly twice as much as higher-income peers, and smoking-related illnesses such as lung cancer cluster in the same groups.[152] Substance overdoses and substance use disorders also disproportionately affect lower-income groups.[153]

How it connects to basic needs scarcity:

Unmet basic needs can make individuals and communities vulnerable to substance-related harms.[154] Substances may be used as a coping response to poverty and unmet needs.[155]

Yukon data:

No Yukon studies link poverty, substance use and health outcomes.

Yukon data quality:

Exercise

How it links poverty and health:

Poverty can limit opportunities for physical activity, an essential component of health and wellbeing.[156] An American study found that low-income participants exercised less and experienced higher obesity rates than higher-income participants.[157]

How it connects to basic needs scarcity:

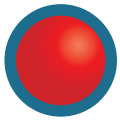
Lacking certain basic needs, such as safe, spacious housing, nourishing food, and reliable transportation, can make it harder to get enough exercise. Boosting basic needs access improves exercise outcomes better than health promotion campaigns alone.[158]

Yukon data:

Engagement participants noted that poverty can lead to difficulty participating in recreation due to financial, transportation, and time barriers.[159]

The 2016 Yukon Healthy Living Study identified cost as a key obstacle to physical activity.[160]

Yukon data quality:



Conclusion: Poverty harms health through scarcity of basic needs

Across the reviewed literature, scarcity of basic needs stands out as the dominant mechanism linking poverty and poor health. Where available, sparse local data generally support these external findings.

To turn this insight into policy design, interventions should target scarcity of basic needs. By improving access to basic needs, policies can disrupt health inequities, reduce suffering, and boost population wellbeing.

Basic Needs Guarantee

Public health research consistently shows that preventative, upstream interventions are more impactful and less costly than downstream approaches that only treat health concerns after they appear.[161] Approaches aimed at improving access to basic needs reflect these insights, offering a promising path to greater health equity. Basic needs-focused interventions prevent adverse health outcomes among low-income individuals and protect those experiencing illness from being pushed into poverty, targeting both pathways within the health-poverty trap.

A Basic Needs Guarantee offers a comprehensive, rights-based approach. It would establish a minimum standard of basic needs below which no Yukoner should fall, guaranteeing that every person has sufficient access to essentials like food and housing. This strategy would convert the right to health into a concrete commitment, target the upstream roots of health disparities, and disrupt the cycle that links poverty and poor health.

Rather than a single program, a Basic Needs Guarantee represents a coordinated framework that brings together multiple policies to ensure everyone can meet essential needs. In practice, a Basic Needs Guarantee would be delivered through a package of initiatives that ensure access to core essentials such as a healthy diet, stable housing, and reliable transportation. The following sections outline the types of policies that could together form a Basic Needs Guarantee — universal, targeted, income-based, and service-based initiatives.

By streamlining supports under a single, coordinated framework, a Basic Needs Guarantee could also help reduce the fragmented, siloed nature of current health and social policies. Rather than requiring individuals to navigate multiple complex systems with different eligibility rules and application processes, it would simplify access for beneficiaries and reduce administrative burdens for service providers, making the system more equitable and efficient.

> **Putting People First recommendation 1.7:** Use clearly identified savings from some current initiatives and invest additional resources to move from a focus on acute medical care to a primary-care based population health model with upstream investments in prevention to improve outcomes and ensure the long-term sustainability of the health and social services system.[162]

A Basic Needs Guarantee would be implemented through a coordinated set of policies tailored to the unique circumstances of Yukon's population. Designing the right mix of policies requires local data, community input, and a strong foundation in First Nations self-determination. The following sections outline how a Basic Needs Guarantee could be built by exploring potential policy tools and identifying essential data and governance approaches.

Possible policy approaches

The following approaches, drawn from external literature, illustrate the kinds of policies that could form part of a Basic Needs Guarantee. An ideal strategy would combine multiple policy tools to balance their strengths and to best meet Yukoners' needs.

Universal approaches are accessible to the whole population. They are simple to administer and provide baseline support for all, preventing major consequences from economic or health shocks.[163] A wide range of demographic groups experience poverty and health inequities in the Yukon, making the inclusive nature of universal programs valuable. These approaches tend to boost health outcomes across the income spectrum, improving absolute population health but not necessarily reducing relative health disparities faced by low-income individuals.[164]

Examples: recreation- and health-focused community design, minimum wage increases, community kitchens, universal healthcare.

Targeted approaches are accessible to population sub-groups that face pronounced disparities – such as certain age groups, income levels, or geographic regions. Targeted approaches are cost-efficient and can be customized to address unique challenges faced by specific groups.[165] When effectively designed, they can also generate benefits for the broader population — the so-called curb cut effect, where interventions for those facing the steepest barriers end up improving accessibility and outcomes for everyone. Targeted support for children and young families is especially efficient, yielding high return on investment for long-term health outcomes.[166] Downsides of targeted approaches include risk of stigmatization, political vulnerability, the administrative burden of eligibility testing, and the difficulty of targeting without high-quality data.[167]

Examples: prenatal/infant nutrition vouchers, rural public transportation, Housing First.

Income-based approaches provide financial support to help people pay for their expenses. This approach encourages autonomy and flexibility as recipients can prioritize where their household most needs the funds, which has itself been linked to better health and wellbeing outcomes. Additionally, income-based programs can be simpler and more cost-efficient to administer than service-based approaches. A limitation of income-based programs is their inability to boost access to basic needs in the context of market failures.

Examples: Basic Income Guarantee initiatives, tax benefits, rebates.

Service-based approaches directly provide basic needs through public services. These approaches ease the impact of market failures, such as supply chain gaps, low quality and low affordability of essential goods and services. However, it can be difficult to maintain long-term funding and to ensure the services provided meet all recipients' cultural or personal preferences.

Examples: supportive employment programs, Food is Medicine, social housing.

This report presents a broad proposed framework for improving health and wellbeing outcomes for people living in poverty through a Basic Needs Guarantee. It is not yet clear what specific policies will most effectively deliver this strategy. Determining these details requires solutions-oriented data collection and First Nations self-determination.

A central design question is finding the right balance between universal versus targeted, and service-based versus income-based support. The best approach would combine these four types of policies to maximize their complementary advantages.[168] Universal programs provide broad access and reduce stigma, while targeted measures shrink wide disparities. Income-based supports promote autonomy and efficiency, while service-based supports ease the impact of market failures.

The task ahead is to design the right mix of policy tools to guarantee access to basic needs. To make these decisions well, we need better data and First Nations self-determination. Currently, only highly limited Yukon data is available to inform evidence-based policy design for this strategy. We need a more detailed understanding about the support needed across the territory. At the same time, any policy that affects Indigenous peoples must be grounded in self-determination. This is not only a matter of justice, but of effectiveness—First Nations-led approaches lead to greater well-being improvements among their citizens.

The next section explores data and self-determination as the foundation for designing a locally effective Basic Needs Guarantee.

Spotlight: Basic Income Guarantee (BIG)

> **Putting People First recommendation 5.7:** Design and implement a guaranteed annual income pilot, in collaboration with the Yukon Anti-Poverty Coalition, and potential funding partners such as the federal government, health and social research programs and others.[169]

Building on YAPC's previous *Basic Income Background Report*, this section situates a Basic Income Guarantee (BIG) within the broader Basic Needs Guarantee framework proposed in this report. Together, the two reports outline complementary pieces of a shared vision:

- The *Basic Income Background Report* examines how a BIG could function in the Yukon;
- This report introduces the broader Basic Needs Guarantee framework, and suggests that a BIG could operate as one pillar within a coordinated system that also includes universal, targeted, and service-based supports.

A basic income guarantee offers perhaps the most straightforward route to improving access to basic needs. Evidence from basic income studies shows that recipients typically spend the income on food, housing, and other health-promoting essentials, with measurable gains in physical and mental well-being.[170]

How it works

A BIG functions as a negative income tax. Low-income households receive a monthly financial benefit tailored to household size and earnings. The benefit tapers gradually with increased income.[171] This model is one specific tool that could form part of a broader Basic Needs Guarantee.

Key advantages

- **Autonomy and dignity.** Recipients decide how to spend their benefit, without intrusive oversight, and automatic payment minimizes stigma.
- **Smooth employment incentives.** The rate structure ensures paid work is always financially rewarding, avoiding the 'welfare wall'.
- **Administrative efficiency and fiscal returns.** Delivered through the tax system, BIG is simple to administer. Studies suggest long-term government savings through reduced health care and criminal-justice costs and higher tax revenues.[172]

continues...

Spotlight: Basic Income Guarantee (BIG) continues...

Key limitations

- **Local market failures.** The Yukon has notable supply gaps such as scarce affordable housing and limited delivery of fresh, healthy food to rural communities. In these cases, cash alone cannot fully improve access. A BIG-only approach could raise incomes yet still leave basic needs unmet.[172] To address supply gaps, service-based approaches may be needed.
- **First Nations considerations.** Whether and how BIG aligns with First Nations governance, culture, and priorities requires additional research and collaborative design.
- **Substance use crisis.** Further exploration is needed on how a Basic Income Guarantee can support ongoing responses to the substance use health emergency, including ensuring strong access to mental health and harm-reduction supports.

A Basic Income Guarantee could form a key part of a broader Basic Needs Guarantee. The latter sets the commitment of ensuring everyone has access to essentials, while a BIG program would help achieve that goal by providing an income floor that lets households meet their needs with autonomy and flexibility.

However, the territory's market constraints mean that an income-based program alone will not ensure every Yukoner's basic needs are met. A combination of policy approaches is needed to meet those needs effectively.

The task ahead is to design the right mix of policy tools to guarantee access to basic needs. To make these decisions well, we need better data and First Nations self-determination. Currently, Yukon-specific data is not strong enough to inform evidence-based policy design in this area. We need a more detailed understanding about the support needed across the territory. At the same time, any policy that affects Indigenous peoples must be grounded in self-determination. This is not only a matter of justice, but of effectiveness—First Nations-led approaches lead to greater well-being improvements among their citizens.

The next section explores data and self-determination as the foundation for designing a locally effective Basic Needs Guarantee.

Next steps: self-determination and data improvements

Self-determination: The most important determinant of health for Indigenous Peoples

Putting People First recommendation 3.1: Involve communities in assessing their local health and social needs and planning local health and social programs and services that meet their needs and are culturally safe.[173]

Putting People First recommendation 4.3: Collaborate with Yukon First Nations governments to develop understanding of Indigenous determinants of health in Yukon and their role in health disparities, and implement effective interventions to address them, in order to eliminate the disparities in health outcomes experienced by First Nations Yukoners.[174]

With eleven self-governing First Nations, the Yukon is far ahead in self-determination both nationally and internationally. Supporting Yukon First Nations in further strengthening this self-determination is essential to poverty and health equity interventions in the territory.

Indigenous and public health research show that self-determination is an essential governance principle for any policy that touches First Nations communities. For poverty- and wellness-related interventions such as a Basic Needs Guarantee, self-determination is especially urgent and decisive.

First Nations communities with greater self-determination have demonstrated both higher wellbeing and higher financial outcomes.[175] Self-determination is often called "the most important determinant of health for Indigenous Peoples" and is cited as an essential foundation for wellness-promotion and poverty-reduction strategies.[176] The diversity of health and economic outcomes across First Nations communities – which is often overlooked – makes self-determination all the more important to ensure approaches are relevant to individual community contexts.[177] Evidence consistently shows the positive impacts of self-determination, and Indigenous organizations have repeatedly emphasized its importance. As such, any evidence-based decision-making in the health and social sectors should actively support it. Self-determination must be a foundational element of any future work on a Basic Needs Guarantee strategy in the Yukon.

> **"First Nations communities, supported by access to reliable and valid research, are in the best position to determine their needs and develop effective and relevant approaches for meeting those needs."**
>
> *- Melisa Brittain & Cindy Blackstock,*
> *First Nations Child Poverty: A Literature Review and Analysis.*[178]

Self-determination includes First Nations-led priority setting, policy design and delivery.[179] Leadership from First Nations governments from the ground up protects against harmful "assimilative" approaches tied into many Canadian policies,[180] and maximizes the positive impact of interventions because they are based on Indigenous knowledge.[181] Effective and sustainable self-determination also involves strong, supportive and sustainable partnerships with researchers and government,[182] as well as sufficient, flexible funding to carry out chosen initiatives.[183]

> **"Self determination has been recognized as the path forward toward improved health."**
>
> *- Jeffrey Lawrence Reading, The Crisis of Chronic Disease Among Aboriginal Peoples [184]*

Self-determination in the context of a Basic Needs Guarantee means that Yukon First Nations governments have freedom to determine their relationship to the strategy – whether that involves developing a unique basic needs approach for their community, collaborating or sharing information with territorial or First Nations governments or organizations, participating as full partners in a territory-wide strategy, or pursuing entirely different wellness priorities. These are examples, not prescriptions, with flexibility for First Nations communities having different needs, capacities, and approaches. Whatever approaches First Nations governments choose, they must be supported with adequate and equitable resources, including upfront resources for planning and decision-making.

Defining basic needs

Before a Basic Needs Guarantee strategy can be developed, a clear local definition of basic needs must be established. This definition will serve as the foundation for data collection and policy development, determining which needs will be included in the guarantee and what level of access will be provided for each need.

As discussed above, First Nations self-determination must be foundational to the development of a Basic Needs Guarantee. In defining basic needs, First Nations governments should have complete freedom to engage however they choose, including developing their own definitions or pursuing alternative priorities.

We recommend using the Northern Market Basket Measure (MBM-N) as a starting point. This would build on existing work to identify basic needs in Northern Canada, saving time and effort compared to starting from scratch. The MBM-N can serve as a model that is then tailored to the Yukon's context, by adding, removing, or adjusting existing categories and allotments. While the MBM-N is based on a sound methodology, we do not recommend adopting it without adaptation. It has limitations, including concerns about adequacy, localization, and lack of alignment with First Nations ways of life. It was also not designed to support a Basic Needs Guarantee strategy, and careful local adaptation is needed to make it fit for this purpose.

The MBM-N list focuses solely on material needs: food, clothing, transportation, shelter, and 'other necessities.' [185] In contrast, this report has also discussed non-material needs such as safety and social inclusion. The local definition process should consider whether and how to include such non-material needs, particularly in terms of setting clear, measurable thresholds. In some cases, it may be more practical to focus on material needs only, since meeting them may indirectly improve access to non-material ones. However, care must be taken to ensure that the health impacts of unmet non-material needs are not overlooked.

The definition process should result in a clear list of basic needs and a measurable threshold of access for each need. This will provide the basis for data collection and policy design by clearly establishing the guaranteed level of access that basic needs policies should deliver.

Improving data

Extensive research shows that poverty harms health; we do not need to re-prove this in the Yukon. What the territory needs is high-quality local health and socioeconomic data to make evidence-based decisions. **To design a locally sensitive Basic Needs Guarantee, we need to gather solutions-oriented data.**

This means gathering sufficient evidence to answer four key policy design questions:

1. Which basic needs should be supported through income-based programs, service-based programs, or a combination?
2. Which supports should be universal and which should be targeted (e.g., by income, age group, region, or other demographic characteristics)?
3. How should existing anti-poverty and health equity interventions be integrated or folded into a Basic Needs Guarantee?
4. What level of resources is required to guarantee each basic need?

Data mobilization

Developing an approach for how exactly to collect the needed evidence requires further planning and additional information about data availability and mobilization. Stakeholders have articulated that large amounts of data currently sit unpublished in silos across government departments and non-governmental organizations in the Yukon. Because of these silos, it is difficult to say what types of evidence need to be newly collected vs. mobilized from existing sources.

> **Putting People First recommendation 5.4:** Create a framework and provide support for data management and analysis for social support programs. This work should be completed with associated reporting timelines attached, to ensure relevant data is reviewed and reported upon regularly.[186]

Transparency, accountability, and collaboration across data holders is needed to mobilize existing data. A community-of-practice approach, where departments and organizations actively work together to build a shared evidence base and make decisions from it, could be transformative, especially if supported by adequate infrastructure.

Due to the territory's small, isolated population, data privacy legislation is often the bottleneck to mobilizing existing data. Yukon's *Access to Information and Protection of Privacy Act and Health Information Privacy and Management Act* limit data holders' ability to contribute data to decision-making processes, especially when that data captures vulnerable minority groups such as individuals facing poverty.[187] Recognition is needed that privacy legislation can lead to valuable data sitting in silos. Innovative approaches or legislative changes could help mobilize this data for decision making while maintaining respect for privacy.

Another data mobilization barrier is the Government of Yukon's inconsistent and opaque relationship with evidence itself. Since high-quality, publicly available data is scarce, it is often unclear what evidence, the territorial government has consulted to make its decisions.[188] This challenge is compounded by the absence of a consistent definition of what counts as 'evidence' for policy and spending decisions, leading to inconsistent and unclear decision-making standards. Additionally, stakeholders have articulated that qualitative data, which is especially crucial in the northern context, is often undervalued in governmental decision-making.

To effectively mobilize data and convert it to policy design, the Government of Yukon needs to establish a clear definition of evidence that explicitly values qualitative and organizational data, which are often better suited to the Yukon context than traditional quantitative data.[189]

> **Putting People First recommendation 1.6:** Implement an evidence-based approach to system planning and decision-making.[190]

Ideally, effective data mobilization efforts across government departments and NGOs would reveal where the evidence to design a Basic Needs Guarantee already exists and where it needs to be newly collected. By broadening what counts as valid data—including qualitative and community-based insights—the territory could make fuller use of existing knowledge while maintaining respect for privacy.

Data collection

Appropriate data collection approaches depend on what evidence gaps remain after data mobilization efforts are undertaken. Depending on identified gaps, longitudinal and proxy data approaches could be valuable methodologies for data collection.

Longitudinal data: A longitudinal study would follow a panel of Yukon residents at regular intervals, such as every two years, using a mix of quantitative and qualitative methods. This approach is the gold standard for health and socioeconomic data. It is especially useful for revealing the life-course effects that are crucial to the health-poverty trap. The first wave of data could already serve as evidence for designing a Basic Needs Guarantee, and subsequent waves would deepen the findings and help track the impacts of interventions. It is important to note that the territory's small population and data privacy legislation would limit disaggregation of the study results, making careful prioritization of cross-tabulations important.

Proxy data: Proxy data shifts the focus from individuals to whole communities, using administrative and infrastructure insights to determine a community's exposure to risks rather than residents' direct experiences of harm. Because the measurements are at the community level, privacy laws do not restrict publication, and the findings can be fully transparent and public. These indicators are quicker to mobilize and less resource-intensive than running a longitudinal study, but they rely on underlying assumptions that must be carefully unpacked before the findings are used for policy decisions. [191]

Key principles

Regardless of what data collection and mobilization methods are pursued, several key principles should be followed:

Data collection principle	Details
OCAP	Ensure data initiatives align with OCAP and Yukon First Nations data governance strategies.[192]
Data-to-policy pipeline	Design data mobilization and collection to explicitly answer the four policy design questions outlined on page 37. Commit upfront to developing and implementing policies once sufficient evidence becomes available. This promotes accountability, efficiency, and action.
Participatory methods	Include individuals with lived experience of poverty and health inequities at every stage of the data mobilization and collection process.[193]
Life-course lens	Prioritize approaches that capture how poverty and health interact and accumulate across a person's lifespan. A longitudinal study is ideal for this, but other approaches can incorporate this lens, for example with retrospective questions or linkage of historical records.
Disaggregation	Disaggregated data is important for revealing the varying experiences of population subgroups, but Yukon's small population and privacy laws limit how data can be analyzed and shared. Carefully prioritizing cross-tabulations and using mixed methods and proxy data are possible workarounds.
Rural representation	Where permissible under OCAP, adequately capture lived experiences in rural communities, which are consistently overlooked in Yukon data. Oversampling and qualitative approaches can support this.
Sensitivity to local contexts	Keep unique local contexts in mind, such as the impacts of residential schools and colonial displacement, the crisis of missing and murdered Indigenous women, girls and Two-Spirit+ people, and the substance use health emergency, so data collection is compassionate and trauma-informed.
Gender-based analysis	Embed gender-based analysis to ensure policies are effective for all, as experiences of poverty and health inequities can vary greatly across genders.[194]

To create a Basic Needs Guarantee, we already have the key policy design questions but not the evidence to answer them. Closing this gap requires collaboration between data holders to mobilize unpublished data, strategic collection of remaining data, and a commitment to translate generated findings into policy. Broadening what counts as evidence will support this process, as will grounding data approaches in the research-backed principles outlined above. Together, these steps can build the evidence base needed to design a locally informed, effective Basic Needs Guarantee.

Interim approaches

A Basic Needs Guarantee is a comprehensive, long-term strategy that will take time to develop. However, people are suffering the impacts of poverty today, and they need more urgent support. We recommend urgently implementing interventions in five areas – self-determination, food, housing, social assistance, and low-income employment – to provide more short-term relief. Once data has been collected to inform a Basic Needs Guarantee, these policies should be refined or collapsed into new interventions.

Below, we outline our rationale for selecting each intervention area and present a recommended policy in each area. The policies are selected to be quick to implement, fitting into existing systems with minimal bureaucracy, so that people living in poverty can be supported as quickly as possible.

These interim measures offer quick, impactful support for people, but they are not a full solution. A comprehensive, long-term Basic Needs Guarantee is needed to disrupt the health-poverty trap.

First Nations self-determination	**Recommendation:** Provide flexible funding to First Nations governments and organizations for self-determined priorities. **Rationale:** Self-determination is key to any intervention that touches First Nations communities and has been linked to improved health and economic outcomes. First Nations governments and organizations are best suited to determine how to address their citizens' needs and require sufficient, flexible funding to do so.
Food	**Recommendation:** Increase funding to universal school food programs, ensuring that every child in the Yukon has daily access to nutritious meals, including during summer breaks and holidays. **Rationale:** In 2023, over one in five Yukon households experienced food insecurity.[195] Food insecurity is a core impact of poverty and a core cause of poor health, making it an essential intervention area for the health-poverty trap. School food programs operationalize evidence that early-life interventions maximize health and economic returns.[196]

Housing	**Recommendations:** Expand the Canada-Yukon Housing Benefit to provide upfront financial support for individuals signing a new lease. Allow individuals receiving social assistance to access the Canada-Yukon Housing Benefit. Provide proactive services at every housing shelter in the Yukon to help clients exit into safe, appropriate long-term housing. **Rationale:** The housing crisis in the Yukon is a key driver of the health-poverty trap. While increasing overall housing supply is crucial, that will take years; the two recommended interim measures can help ease more immediate housing barriers. Currently, the Canada-Yukon Housing Benefit only helps after a lease is signed, which is too late to support many individuals who can afford ongoing rent but cannot afford the upfront lump sum required to sign a lease. Expanding the benefit to provide upfront financial support can help more people access stable housing. Providing proactive housing services at the Whitehorse Emergency Shelter would reflect lessons from the growing housing-focused shelter model, where shelter stays are brief, emergency interventions rather than long-term arrangements.[197] Supporting people to exit the shelter system into stable housing can help improve health and economic outcomes. With the Yukon's high rate of gender-based violence, support for housing is particularly critical for women and children leaving violent situations, for whom housing insecurity is often the final barrier to long-term safety and wellness.
Low-income employment	**Recommendations:** Introduce a Yukon top-up to the Canada Worker's Benefit. Low wages undermine labour rights, job security, health and wellbeing. Low-income workers often face deeply precarious circumstances, with incomes too high to receive social assistance but too low to meet basic needs. **Rationale:** The Canada Workers Benefit aims to ease the challenges of low-income employment, but rates can still leave full-time workers in poverty. A Yukon Workers Benefit could be delivered through the tax system as a top-up to the federal benefit. This mirrors the approach of the existing Yukon Child Benefit, which tops up the Canada Child Benefit.

Social assistance	**Recommendation:** Increase social assistance rates to Northern Market Basket Measure (MBM-N) thresholds. Ensure all social assistance administrators have the resources to deliver compassionate wraparound support, including for housing and mental health. **Rationale:** Social assistance rates leave many recipients in deep poverty. The MBM-N provides a clear set of thresholds, tailored to Yukon regions, that are easily convertible between household sizes. Indexing social assistance rates to the MBM-N is a straightforward and efficient intervention to boost access to basic needs and improve wellbeing. One issue with the MBM-N is that it does not provide thresholds for Old Crow. This requires developing a workaround for social assistance recipients in Old Crow, which could involve a local MBM-N-inspired threshold set by Vuntut Gwitchin First Nation. Social assistance is provided by CIRNAC, the Government of Yukon, and self-governing First Nations. Although they are governed by the same Social Assistance Act, levels of wraparound support vary across providers. Some recipients report experiences of stigma, discrimination, and an unsupportive system. Wraparound support should be consistent across providers, reflecting compassionate, person-focused principles. This should include identifying barriers in people's lives, advocating for clients, and mental health and housing support.

Conclusion

Health is everything – our biggest asset.[198] When we systemically deny the human right to health through widespread poverty, we fall short of caring for our population. It is within reach to build a more compassionate Yukon, where we refuse to let Yukoners live with preventable suffering on the basis of socioeconomic status.

A Basic Needs Guarantee presents a tangible path to operationalizing the right to health and narrowing health disparities. With greater transparency, collaboration, accountability, compassion and evidence-based action, we can disrupt the health-poverty trap.

The next steps are clear. Develop and launch a solutions-oriented data collection and mobilization effort; commit to a Basic Needs Guarantee framework; locally define 'basic needs'; roll out interim supports to urgently relieve hardship; and embed First Nations self-determination in every stage.

Recommendations

Interim:

- Provide flexible funding to First Nations governments and organizations for self-determined priorities.
- Increase funding to universal school food programs, ensuring that every child in the Yukon has daily access to nutritious meals, including during summer breaks and holidays.
- Expand the Canada-Yukon Housing Benefit to provide upfront financial support for individuals signing a new lease.
- Provide proactive services at the Whitehorse Emergency Shelter to help clients exit into safe, appropriate long-term housing.
- Allow individuals receiving social assistance to access the Canada-Yukon Housing Benefit.
- Increase social assistance rates to Northern Market Basket Measure thresholds.
- Ensure all social assistance administrators have the resources to deliver compassionate wraparound support, including for housing and mental health.
- Introduce a Yukon top-up to the Canada Worker's Benefit.

Long-term:

- Commit to developing a coordinated, comprehensive Basic Needs Guarantee strategy grounded in First Nations self-determination and based on the locally developed basic needs definition and the results of data collection.
- Define a list with thresholds of basic needs for Yukoners. Use the Northern Market Basket Measure as a base design, modifying it as needed to more accurately reflect our population's needs.
- Develop and implement a data collection and mobilization strategy to directly inform the design of a Basic Needs Guarantee, based on the eight data principles outlined on page 39.

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December 2025