

# Health Equity: A Call to Action for the Central East LHIN

# FOREWORD

On behalf of the Culture, Diversity and Equity Project, we are very pleased to present this report to the Central East LHIN office and to everyone across the Central East LHIN and Ontario.

This report is dedicated to all the community members in the Central East LHIN who had the courage and confidence to take part in focus groups, and to share their many and sometimes shocking stories with us. We also dedicate this report to all those community members who, because of negative encounters with the health system in the past, declined our invitation to participate.

We are also grateful to the hundreds of community members and health and community service providers who provided so much invaluable feedback and input. Without their efforts, we could not have developed our recommendations and their promise of greater health equity in the Central East LHIN.

Despite important progress in recent years among numerous organizations, there is much work to be done in addressing health inequities in the Central East LHIN. We believe that one important first step is to recognize health inequity as a pressing issue in all Central East LHIN regions, including Scarborough, Durham, and the Northeast (Haliburton Highlands, Kawartha Lakes, Peterborough and Northumberland-Havelock). Health inequities affect all of us!

This report is just the beginning of an important, much-needed process, one that must be action oriented towards clearly defined goals. It begins with the approval of the proposed recommendations and their implementation under the clear leadership of the Central East LHIN board and staff.

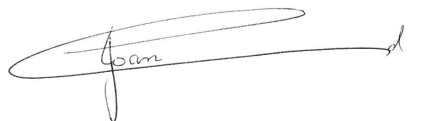
The work undertaken by the Culture, Diversity and Equity project has sparked interest among community members and organizations throughout the Central East LHIN. There is an undeniable sense of urgency and hope among community members and health service providers that the recommendations in this report will be implemented.

Over the coming months and years, the members of the Project Charter Committee look forward to working with the Central East LHIN board and the people of the Central East LHIN and other LHINs. Together we can lay the foundation for an integrated health system that creates true health equity.



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The opinions in this report are those of the authors and the Project Charter Committee and do not necessarily reflect the views of the funder or the supporters.

## **REPORT:**

This report and the appendices can be downloaded from <http://www.centraleastlhin.on.ca>

This report is also available in a larger size font from <http://www.centraleastlhin.on.ca>

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# EXECUTIVE SUMMARY

*“Equity is a key component of an effective health care system, and without understanding how these factors influence health status in our society, the chances of improving the overall health of the population is near impossible.”*

- The Central East LHIN *Integrated Health Services Plan: Technical Report* (2006)

*“When do we stop talking and start doing?”*

- Community Member

NOW IS THE TIME to implement a comprehensive strategy to tackle health inequity in the Central East LHIN. Despite the region’s great diversity of population density, culture, ethnicity, language, age and socio-economic status, the Central East LHIN and its health care organizations continue to lack adequate health equity policies. No clear systems of accountability, compliance or quality assurance have been developed.

Meanwhile, those needing health care experience many forms of health inequity and marginalization, leading to worse conditions of illness that could otherwise be prevented.

BARRIERS TO HEALTH EQUITY ARE EVERYONE’S CONCERN. The marginalized ethno-cultural communities of Scarborough are not the only people affected by health inequities. All of us will experience some form of health inequity during our lifetime—as youth, women, seniors, immigrants, or through a disability.

The widespread experiences of health inequity in the Central East LHIN are in direct conflict with Canadian principles of social justice, human rights and fairness, and with Health Canada’s stated goal of universal health care and nationwide health equity. Health inequities are also costly to a health care system that is increasingly burdened by limited funding.

THE CULTURE, DIVERSITY AND EQUITY PROJECT REPRESENTS THE FIRST STEP in laying the foundations for an integrated health system that creates true health equity in the Central East LHIN. This document outlines the origins, activities and findings of the project, and sets out ten recommendations for action.

## Project Origin

The purpose of the Culture, Diversity and Equity Project (CDE Project) was defined during the 2007 Central East LHIN discussion group on health equities: to investigate current health equity shortfalls and develop recommendations for the Central East LHIN board, in keeping with the guiding Central East LHIN vision statement of “Engaged Communities. Healthy Communities” (i.e., communities that take into account the social determinants of health, provide timely access to culturally competent services, and engage its members in the management of their own health and wellness).

The project’s overall goals, under the direction of the Project Charter Committee, were to:

- Define health equity/inequity;
- Review emerging health equity strategies in other jurisdictions;
- Describe experiences of health inequities and marginalization in the Central East LHIN;
- Outline the principles of successful implementation of health equity policies; and
- Develop recommendations for the Central East LHIN.

## Project Activities

The project assumed a number of underlying values: health, caring, compassion, support for community structures, community engagement and participation, social justice, respect for diversity and accountability to socially and culturally marginalized groups. On the basis of these values, a number of principles were set down, such as proactive inclusion of marginalized communities, support of existing community structures and accommodation for project participants. These guided the project's main activities:

- A comprehensive review of relevant literature;
- An “environmental scan” to identify services for uninsured individuals and culturally appropriate/competent services in the Central East LHIN;
- 23 focus groups (with 134 marginalized community members and 40 health service providers);
- A community consultation that included three community forums (with 63 community members and health and community service providers) and a two-week online consultation (with 175 participants);
- The development of two practical reference guides, one for newcomer clients and the other for health service providers;
- Analysis of emerging health equity strategies in other jurisdictions, and the principles of successful implementation of health equity policies; and
- Ten recommendations for achieving health equity in the Central East LHIN.

## Project Findings

CANADIANS WHO ARE SOCIALLY OR CULTURALLY MARGINALIZED EXPERIENCE WORSE HEALTH OUTCOMES THAN OTHER CITIZENS, according to a growing body of Canadian research. Such health inequities, however, are not limited to Canada. International and national research demonstrates a direct link between the experience of health inequities and social and cultural marginalization, including (but not limited to): ethno-racial or ethno-cultural groups, immigrants, refugees, people living in poverty, sexual and gender minorities, people with disabilities, youth, seniors, people living in rural areas, Aboriginal peoples, women, and people with mental health problems and addictions.

EXPERIENCES OF HEALTH INEQUITIES AND MARGINALIZATION ARE COMMON in the Central East LHIN. Community members identified numerous barriers to health equity, including:

- Lack of access to adequate, sensitive, and culturally appropriate services;
- Experiences of discrimination, stereotyping, and stigma;
- Lack of accommodation (e.g., transportation, interpreters);
- Negative treatment experiences or misdiagnosis due to cultural difference; and
- Experiences of diversity-incompetent health service providers.

Health and community service providers identified barriers such as:

- Unequal funding between regions and organizations;
- Insufficient staff training and leadership in linguistic and cultural diversity;
- Organizational failure to reach out to diverse populations and assure inter-organizational flow of information; and
- Inconsistent or careless internal monitoring.

HEALTH EQUITY WILL PLAY AN IMPORTANT ROLE in achieving two strategic aims of the Central East LHIN's 2010-2013 IHSP (in support of the Ministry of Health and Long-Term Care vision and strategic direction), i.e., to reduce:

- The time spent by patients in the Central East LHIN Emergency Departments by one million hours before 2013; and

- The impact of vascular disease on individuals in the health care system of the Central East LHIN by 10% before 2013.

## **Project Recommendations**

WE PROPOSE AN AMBITIOUS HEALTH EQUITY STRATEGY for the Central East LHIN, one that calls for clear vision and commitment at the highest level of governance, and real change at all organizational levels: policy development, the introduction of accountability systems, ongoing evaluation and research, creation of a client navigation system, education and knowledge exchange for health service providers and a substantial investment of resources by the Central East LHIN.

IMPLEMENTING THESE RECOMMENDATIONS will make the LHIN one of the leaders in health equity in Ontario while assuring significant progress towards achieving health equity for all its residents. Those involved in the planning, funding, overseeing and management of health care delivery must be particularly implicated in this process, as successful interventions have been shown to be simultaneously top-down (e.g., policies) and bottom-up (e.g., community driven). Without strong leadership, other complementary components of positive change will fail to have their full effect, i.e., clearly defined goals, targets and timelines, accountability mechanisms and monitoring, transparency, and community participation (see Principles of Successful Implementation in Part Six of report).

SUCCESSFUL HEALTH EQUITY POLICIES are always collaborative, requiring the input of community members, their families, health service providers, researchers, other LHINs, and the Ministry of Health and Long-Term Care, and most especially, marginalized communities. They are also evidence based and justified by social justice and population health.

Many organizations in the Central East LHIN, though engaged in valuable and exemplary work, find themselves amidst competing organizational needs, and generally without the necessary resources and infrastructure required to develop and support health equity activities. For this reason, real change in the health care system is only possible with strong, committed support from policy leaders.

## **RECOMMENDATIONS:**

1. **The Central East LHIN will define a clear strategic vision for health equity, and will engage community members in the process.**
2. **The Central East LHIN will develop health equity tools to investigate the viability of a Health Equity Office; or, alternatively, hire designated Health Equity staff to monitor and evaluate Health Equity initiatives in the Central East LHIN.**
3. **All Central East LHIN-funded organizations will make health equity a clear strategic vision and commitment.**
4. **The Central East LHIN will monitor health equity data through performance management systems.**
5. **All Central East LHIN-funded organizations will educate their staff in health equity, diversity, and anti-discrimination.**
6. **The Central East LHIN will invest in system and service enhancements to increase access to health care for marginalized populations.**
7. **The Central East LHIN will commit its senior management to a vision of health that includes the broader determinants of health.**
8. **The Central East LHIN will create a navigation system for clients.**
9. **The Central East LHIN will develop an online health equity information and knowledge transfer system for service providers.**
10. **The Central East LHIN will coordinate systematic research on health inequities throughout the Central East LHIN and evaluate pilot projects.**



PART 1:

# THE CULTURE, DIVERSITY AND EQUITY PROJECT

## The Role of the Central East Local Health Integration Network (LHIN)

In 2006, the Ontario Ministry of Health and Long-Term Care (MOHLTC), in its attempt to improve the delivery of health care, organized the province into 14 non-profit Local Health Integration Networks (LHINs). These LHINs took on the planning, co-ordination, integration, and funding of health services at the local level, including hospitals, long-term care homes, community care access centres, community support services, community mental health and addictions services, and community health centres.

Early on, the Central East LHIN adopted as one of its guiding vision statements, “Engaged Communities. Healthy Communities.” In other words, healthy communities exist within supportive and sustainable environments; they are communities that are able to take into account the social determinants of health and thus provide timely access to culturally competent services.

Most importantly, the Central East LHIN aims to actively engage its community members in the management of their own health and wellness, and encourages them to provide leadership within their health care system while maintaining the core values of:

- Accountability;
- Responsiveness;
- Respect;
- Integrity;
- Innovation; and
- Equity.<sup>1</sup>

The Central East LHIN funds more than 130 health care organizations and is divided into three main clusters: Scarborough, Durham, and the Northeast (Haliburton Highlands, Kawartha Lakes, Peterborough and Northumberland - HKPR).

## Diversity in the Central East LHIN

The characteristics of the LHIN’s approximately 1.5 million residents (11% of the total Ontario population) resemble those of Ontario generally. However, there are noteworthy differences. For example:

- The population growth rate is twice that of Ontario;
- The number of seniors (65 years old and over) is expected to almost double by 2016;
- More people live in poverty as compared to Ontario; and
- A greater proportion of its residents are recent immigrants and visible minorities.<sup>2,3</sup>

## Building the Culture, Diversity and Equity Project

Following its annual symposium in 2007, the Central East LHIN office invited representatives from several local planning partners and health care organizations to meet and discuss health inequities in the Central East LHIN.

The consensus among discussion group participants was that, while a few health care organizations do have health equity and diversity policies, most of them are inadequate. Furthermore, there are no clear systems of accountability, compliance or quality assurance to monitor their implementation.

At the meeting, it was decided that such policy inadequacies could no longer be ignored. The participants submitted a Culture, Diversity and Equity Project charter to the Central East LHIN that would investigate current health equity shortfalls and develop recommendations for the Central East LHIN board.

Although the Central East LHIN has not statistically demonstrated health inequities within its borders, it recognizes the link between health inequities and social and cultural marginalization, as reflected in the following Central East LHIN statement:

*“Some groups may have a greater biological predisposition to certain health conditions than others. Racial, ethnic, linguistic and gender differences in health status can also result from membership in specific social and occupational classes, as well as the systematic experience of discrimination and prejudice. Health status differences of visible minorities can also result from inequitable access to care, and there is increasing evidence that their social and economic environment may be threatening their health. Equity is a key component of an effective health care system, and without understanding how these factors influence health status in our society, the chances of improving the overall health of the population is near impossible.”<sup>4</sup>*

Diversity in the Central East LHIN is discussed further in Part Three of this report.

## Project Principles and Values

From the outset, the CDE Project assumed a number of underlying values: health, caring, compassion, support for community structures, community engagement and participation, social justice, respect for diversity, and accountability to socially and culturally marginalized groups.<sup>5</sup> On the basis of these values, the project set down guiding principles:

- Conceptualize health as physical, social and psychological;
- Proactively include marginalized individuals and communities;
- Consider the strengths, contexts and lived experiences of marginalized individuals and communities;
- Support existing community structures;
- Consider the broader social determinants of health;
- Frame health inequity and project goals as issues of social justice;
- Respect the diverse experiences of marginalization;
- Make the system and its organizations accountable for the health inequities of marginalized communities; and
- Ensure accommodation for project participants.

## Project Goals

The ultimate goals of the project were to:

- Define health equity/inequity;
- Review health inequity work in other jurisdictions;

- Describe the experiences of marginalized community members in the Central East LHIN;
- Outline the principles of successful implementation of health equity policies; and
- Develop, with the input of community members and health and community services providers, a set of recommendations relevant to the Central East LHIN.

## Project Activities

The CDE Project, comprising both the project charter committee and project staff:

- Conducted a literature review, an environmental scan, focus groups, and a community consultation;
- Developed two practical reference guides, one for newcomer clients and the other for health service providers; and
- Put forward ten actionable recommendations that take into account the unique needs of the Central East LHIN service environment.

The **literature review** (For the full report see Appendix 1) focused on:

- Definitions of health equity;
- Health equity frameworks;
- Policies;
- Compliance, quality assurance, accountability agreements, and other auditing tools; and
- Frameworks for standards of cultural competence education and training.

The **environmental scan** identified services for uninsured individuals and culturally appropriate/competent services in the Central East LHIN (See Appendix 2).

A total of 23 **focus groups** were conducted across the three regions of the Central East LHIN between April and July, 2009. Participants included 134 marginalized community members and 40 health service providers (both front-line and management/leadership). The focus groups (See Appendix 3) examined:

- Health inequity;
- Experiences in the health care system;
- Policies, quality assurance, and accountability;
- Service enhancements; and
- Training needs.

The **community consultation** included three community forums and an online consultation, allowing community members and health and community service providers to provide input on draft recommendations.

The forums were held with a wide range of stakeholders in September 2009, one in each of the Central East LHIN regions. Sixty-three people (29 in Scarborough, 23 in Durham, and 11 in the Northeast) took part; thirty were community members, and 33 health and community service providers.

The forums were followed up by an **online consultation**, held over a two-week period in October 2009. This was an opportunity for additional community members and health and community service providers to participate. A total of 175 (47 community members and 128 health service providers) took part (See Appendix 4).

The two **reference guides** were developed using information from the environmental scan and ongoing input from Central East LHIN community members and health and community service providers. The “Reference Guide for Newcomer Clients” provides:

- Comprehensive lists of health care services for uninsured clients, interpretation services, settlement agencies, and legal clinics;
- Instructions on advocacy and seeking health insurance;
- Databases and websites for culturally and linguistically appropriate services;
- A glossary of terms; and
- Useful questions when engaging with health care services.

The “Reference Guide for Service Providers” provides similar lists, though questions and the glossary of terms are adapted to the needs of health service providers (See Appendix 5).

The **ten recommendations** were developed using input from the literature review, the focus groups, and the environmental scan. They were then adjusted to integrate feedback from the community consultations (community forums and online consultation).

The recommendations fall into three general categories, relating to:

- The Central East LHIN (Leadership, Health Equity Office/Staff, Social Determinants of Health);
- Central East LHIN-funded organizations (Policy, Monitoring, Training); or
- The Central East LHIN Service System (Service Enhancements, Client Navigation System, Information and Knowledge Transfer).

The tenth recommendation, which underscores all three categories, refers to health equity evaluation/research. (See Appendix 6).

## **Project Limitations**

The project confronted a number of limitations, both expected and unexpected. Generally, limitations were to be expected given the ambitious goals of the project as well as the size, geographic composition, and population diversity of the Central East LHIN.

The barriers and limitations of the project are related to statistical relevance, geography, hard-to-reach populations, diversity, accommodation, accessing current information, health equity in health care, and intersectionality.

**Statistical Relevance:** The results of the project carry limited statistical significance since focus groups were designed to collect narratives of personal experience, explore issues and themes, and identify solutions. Findings cannot be used for the purpose of statistical generalizations.

**Geography:** Focus groups and community forums were primarily held in urban settings and this limited access for rural participants. However, steps were taken to facilitate their participation, with some success, by covering transportation and childcare costs.

**Hard to Reach Populations:** People of different sexual orientation, street youth, refugees and certain other populations are hard to locate due to issues of trust, privacy, and disclosure; this often limits their involvement in research of this kind. The project did manage to reach these populations (with varying degrees of success) by conducting participant recruitment in collaboration with organizations that work directly with the communities in question.

**Diversity:** Only a certain number of categories of diversity could be represented in the focus group process. For example, despite the vast variety of disabilities, for practical considerations, only two communities with disabilities had separate focus groups (hearing and visually impaired); however, individuals with other disabilities were present in every focus group.

**Accommodation:** The project was successful in securing the majority of necessary accommodations for focus group participants (Afghan, ASL, Chinese, French, Sudanese, and Tamil interpreters, aid for the visually impaired, etc.). However, timing and availability of resources meant limited language accommodation for the community forums and online consultation. Consequently, fewer voices were heard from certain communities.

**Accessing Current Information:** The environmental scan relied primarily upon accuracy of participants' information. In a few instances, the unavailability of current information limited the project's ability to cross-reference data. The results of the environmental scan reflect the best available data at the time of the scan, and will likely require updating.

**Health Equity in Health Care:** One major limitation of this project is that health inequity is shaped by broader factors than just access to health care and the quality of the health care system. *See box below.*

**Intersectionality:** Intersectionality exists when several dimensions of diversity overlap. People often experience several forms of marginalization at the same time (e.g., a woman of colour who is also a single parent). While the project recognized intersectionalities, the structure of the focus group consultation generally focused on one dimension of diversity per focus group. We did, however, inquire within each focus group about the experiences of other dimensions of diversity, for example, being a female immigrant, senior, youth, and so on.

## Health Equity Frameworks

Three different health equity frameworks were identified in the literature reviewed for this project:

### Framework 1: Structural, Political, and Socio-Economic Context

Health equity is clearly influenced by the broader determinants of health, including social, political, and economic contexts. For example, policies or governmental decisions on matters such as housing, food and income directly influence the health of the population; if policies fail to provide adequate housing and food security for children, children of poor families will experience lower health as compared to children of middle and upper class families.

**Health equity frameworks** that address these kinds of issues recognize the ways in which health related problems are the result of contextual influences. These indirect influences account for approximately 80% of health inequities.<sup>6</sup>

### Framework 2: Access to and Quality of Health Care

Health equity is further influenced by the accessibility and quality of health care services. New Ontario immigrants, for example, have limited access to health care services due to a three-month waiting period before being granted coverage under the Ontario Health Insurance Plan (OHIP). In addition, evidence shows that marginalized individuals experience discrimination and lower quality health care services (as discussed in Part Three of this report).

**Health care equity frameworks** that address these kinds of issues recognize that not all individuals have equal access to quality health care services. It is estimated that the direct influences of the health care system on people's health account for approximately 15% of health inequities.<sup>7</sup>

### Framework 3: Health Equity in Health Care

The third health equity framework—health equity in health care—addresses a combination of the first two frameworks, focusing on achievable policy and accountability interventions within the health care system. The Culture, Diversity and Equity Project's recommendations are aimed at this last framework. Recommendations:

- Combine evidence-based models with practice;
- Identify strategic levers within the health care system;
- Seek collaborations across sectors to better address the macro-level issues;
- Focus on client-centred approaches; and
- Show an awareness and sensitivity to issues of power.<sup>8</sup>

## PART 2:

# HEALTH INEQUITY

## Definitions of Health Equity and Health Inequity

**Health Equity** is best defined as “equal opportunity for good health for all.”<sup>9</sup>

**Health Inequity** is defined in two different ways, either as “normal” health inequity or “unjust/avoidable” health inequity. “Normal” health inequities would include, for example, biological differences or health (dis)advantages as a result of physical activity and diet. “Unjust/avoidable” health inequities, on the other hand, refer to health-damaging situations such as lack of access to health care services or unhealthy living and working conditions (e.g., inadequate housing or exposure to dangerous substances). The fact that illness tends to lead to lower social and economic status, thereby increasing the likelihood of further health problems, can also be considered an “unjust/avoidable” health inequity.<sup>10</sup>

This report mainly focuses on the “unjust/avoidable” health inequities. In order to refer to all of these forms of health inequity at once, we speak of “health inequities.”

## Marginalization

**Marginalization** refers to the process of establishing and maintaining a social hierarchy of people in which the dominant group is considered the norm or the “centre” (e.g., white, heterosexual Canadians), while non-dominant individuals or groups (often referred to as *diversity*) who exist outside that normative centre are necessarily anomalous or “marginal.”

Those who exist at the social, political, and economic edges of society do not have the same access to life opportunities that members of the dominant group have.<sup>11</sup> Put another way, marginalization refers to “the experience of certain groups, which do not have full and equal access to and cannot participate in the social, economic, cultural and political institutions of society.”<sup>12</sup>

## Evidence of Marginalization and Health Inequities

According to a growing body of Canadian research, Canadians who are socially or culturally marginalized experience worse health outcomes than other citizens.<sup>13</sup> This is inconsistent with Health Canada’s stated goal of nationwide health equity and the principles of universal health care.<sup>14</sup> Such health inequities, however, are not limited to Canada. International and national research demonstrates a direct link between social and cultural marginalization and the experience of health inequities: **those living at the margins of society tend to have poorer health.**

**Ethno-Racial or Ethno-Cultural Groups:** The health gap in Canada between ethno-cultural minority communities and non-minority communities has long persisted and is well documented.<sup>15,16</sup> Canada’s racialized communities—Black Canadians<sup>17</sup> and South-Asian Canadians<sup>18</sup> for example—experience significantly poorer health outcomes than their white counterparts.<sup>19</sup>

MARGINALIZED GROUPS include, but are not limited to, ethno-racial or ethno-cultural groups, immigrants and refugees, people of low socio-economic status, women, sexual and gender minorities, people with disabilities, youth, seniors, people living in certain geographic areas, Aboriginal peoples, and those experiencing addictions and mental health issues.

**Immigrants:** Typically, immigrants arrive in Canada with better health than the Canadian average, an occurrence often referred to as the *healthy immigrant effect*. However, research shows that these health advantages decrease over time until chronic conditions and disabilities become prevalent among immigrant groups.<sup>20, 21, 22</sup> Multiple studies also identify higher rates of morbidity and mortality among immigrant groups.<sup>23</sup>

Similar patterns have been found among immigrant groups in Europe,<sup>24, 25, 26, 27</sup> Australia,<sup>28</sup> and the United States.<sup>29</sup>

**Refugees:** Refugees, on the other hand, tend to experience poorer health than the Canadian average upon arrival, due to the typically difficult circumstances they suffer prior to migration such as civil unrest, war, living in refugee camps, or simple lack of access to health care.<sup>32, 33, 34</sup> These groups are at greater risk than other Canadians of developing depression, anxiety, post-traumatic stress disorders and a number of developmental disorders.<sup>35</sup>

### Three Barriers to Health Care for Immigrants and Refugees

1. Limited access to health information due to language or cultural differences. Navigating a foreign health care system and communicating with health care professionals in a foreign language can become exceedingly difficult. In the domain of mental health care this is especially problematic, as miscommunication between the patient and the health care provider can lead to "misdiagnosis and inappropriate treatment."<sup>30</sup>
2. Denial of comprehensive health care services to new immigrants in the first three months after arrival (unless able to afford private health insurance). Uninsured/undocumented immigrants are denied health insurance altogether, further exacerbating the problem.
3. The tendency on the part of health care professionals to provide lower standards of treatment to immigrants and refugees whose health insurance level cannot be determined prior to treatment.<sup>31</sup>

**People of Low Socio-Economic Status:** There are clear links between poverty and shorter life expectancy,<sup>36</sup> increased risk of developing chronic diseases (e.g., cancers, heart disease, diabetes, and respiratory diseases among others) and poorer mental health.<sup>37, 38, 39</sup> By the accumulation of such health disadvantages throughout a lifetime, an individual living in poverty is consistently shown to have poorer material, social and economic circumstances.<sup>40</sup>

**Sexual and Gender Minorities:** Lesbian, gay and bisexual communities are at higher risk for suicide attempts, depression, anxiety disorder,<sup>41</sup> and alcohol and other substance dependence.<sup>42</sup> Research in the United States<sup>43</sup> and the Netherlands<sup>44</sup> has demonstrated poorer access to and utilization of health care services among these populations. The higher likelihood of health problems is believed to be rooted in experiences of prejudice, rejection, internalized homophobia and poor coping processes.<sup>45</sup>

**People with Disabilities:** Increasingly, the health needs of people with disabilities are not being met.<sup>46</sup> For example, there is a lack of appropriate services for individuals with disabilities such as deafness (including cultural deafness).<sup>47</sup> Lack of access to services has been shown to lead to increased rates of depression and other adverse health conditions.<sup>48, 49</sup> Such disabilities are generally not viewed as a primary health care issue by health service providers, and individuals can fall through the cracks as a result.<sup>50</sup>

*"Language is a barrier. An elderly person often must take a family member with them to interpret – what if the senior does not want to share the problem with the family member? Immigrant seniors are the most likely not to have good English skills."*

- Health Service Provider

**Youth:** Children and youth from families in lower income brackets are at the greatest risk of behavioural and emotional problems, food insecurity and developmental issues.<sup>51</sup> In Canada, children and youth are the fastest growing segment of the homeless population. The generally poor health outcomes among children and youth are made worse by factors such as different sexual orientation, minority status, disability and immigrant status.<sup>52</sup>



**Seniors:** Seniors, particularly female seniors, have lower incomes on average than most other age groups.<sup>53</sup> This lack of financial resources places seniors at greater risk of health issues caused by inadequate nursing and medical attention (and other health services not covered by OHIP), which can lead to further physical and mental health problems that can be avoided by those with greater educational and economic resources.

Ethnicity also affects the health status of seniors. For example, South Asian seniors in Canada generally experience high rates of depression.<sup>54</sup> Difficulties accessing mainstream health services, language barriers, different health habits and unfulfilled expectations or preferences are the source of the unique stresses and challenges faced by ethnic seniors.<sup>55</sup>

**People Living in Rural Areas:** Rural Canadians have less access to health services and tend to have poorer health than urban Canadians.<sup>56</sup> Rural-urban health disparities have also been shown in Australia.<sup>57</sup> Research also suggests that the apparent health advantage enjoyed by people living in urban settings compared to those living in rural settings can serve to mask the disparities that exist between the urban poor and urban non-poor, particularly amongst children.<sup>58</sup>

**Gender:** Gender-based discrimination contributes to poor health among women.<sup>59</sup> Certain groups of women are made more vulnerable by other circumstances: those suffering from addictions and mental health issues, women raising families by themselves, Aboriginal women, and women with disabilities. Poverty, which has been established as one of the strongest indicators of poor health,<sup>60</sup> is especially relevant for women, as they account for 70% of all those living in poverty in Canada.<sup>61</sup>

**Mental Health and Addiction:** Low socio-economic status is considered both a cause and a consequence of poor mental health.<sup>64</sup> Examples of poor mental health outcomes include schizophrenia, mood disorders, suicide, personality disorders, and substance abuse and addiction.<sup>65</sup> Research from the United States,<sup>66</sup> the United Kingdom<sup>67</sup> and Canada<sup>68</sup> have also demonstrated these linkages.

The health consequences of substance abuse are particularly well documented and include higher rates of physical injury, disability, certain diseases (e.g., hypertension, respiratory disease, HIV and Hepatitis C), as well as higher mortality rates and years of potential life lost.<sup>69</sup> In addition to the experience of discrimination in housing, health care, the work place, and other social contexts, substance abuse is also linked with patterns of long-term homelessness or unstable housing.<sup>70</sup>

**Aboriginal Peoples:** There is a clear and uneven burden of illness and social disadvantage among Canada's Aboriginal communities.<sup>62,63</sup> In fact, the Aboriginal community deserves significant attention with regard to health inequity that is beyond the scope of this project. Fortunately, this community is the focus of investigation within other projects, particularly in regions where there is a larger Aboriginal community.

**Intersectionality:** Gender, age, race, sexual orientation, socio-economic status and disability often intersect and people who fall into any of these categories should not be considered a homogenous group.<sup>71</sup> Only focusing on poor economic status, for example, may distort our understanding of how inequity works, who suffers from it, and how it can be addressed. For this reason, any effective solution to health inequities must be informed by an understanding of intersectionality.

Chronic disease, mortality and morbidity, for example, are particularly high across ethnic groups living in lower income, urban Canadian neighbourhoods.<sup>72</sup> There is also growing evidence of a relationship between the clustering of minority groups and concentrations of poverty in the urban neighbourhoods of many Canadian cities.<sup>73, 74</sup>

The prevalence of mental health and addictions is also consistently higher among the socially and economically disadvantaged, a group that includes women, youth, ethnic minorities and other marginalized identities.<sup>75</sup>



## PART 3:

## DIVERSITY AND MARGINALIZATION IN THE CENTRAL EAST LHIN

Data that is specific to each LHIN is very limited. Using figures gathered from the 2006 census, the following section highlights the key features of diversity within the Central East LHIN.

Dimensions of *diversity* include, but are not limited to, ethnicity, immigration status, language, age, sexual orientation, ability, mental health, education, family status, geographic location and life experience. The experience of *marginalization* applies to many of these identities and was established in the previous section.

The great diversity within the Central East LHIN poses unique challenges, and it has important implications for health care services in the region.

### The Central East LHIN Compared to Ontario

Based on available data, the following characteristics describe the Central East LHIN as a whole as compared to the Ontario average.

Similarities	Differences
Similar population growth	Higher population of visible minorities
Similar population with a high school diploma	Lower population of aboriginal identity
Similar average age	Lower median and average household income
Similar age distribution	Higher population with no knowledge of English or French
Similar prevalence rate of substance abuse	Higher number are recent immigrants
	Lower prevalence rate of mental illness

### General Diversity in the Central East LHIN

By any measure, the Central East LHIN has great diversity in terms of population density, culture, ethnicity, language, age, and socio-economic status. Scarborough accounts for almost 40% of its population and has the highest numbers of visible minorities, recent immigrants, individuals who speak neither English nor French, and people of low socio-economic status. In contrast, Haliburton Highlands, the most rural region, has relatively low immigration and high rates of home ownership and seniors.

**Visible Minorities:** The population of the Central East LHIN is one of the most culturally diverse in Ontario. From 2001 to 2006, the percentage of population of visible minorities increased from 30.4% to 34.5%. The provincial average for visible minorities is just under 23%. The most prevalent visible minorities are Chinese (25%), South Asian (31%), Black (19%), Filipino (9%) and West Asian (2%); three per cent identify as belonging to more than one minority group. Scarborough has a particularly large visible minority population, at 79% compared to the 34.5% for the rest of the LHIN.<sup>76</sup>

**Aboriginal Peoples:** The percentage of individuals of Aboriginal identity in Central East LHIN is much lower than the provincial average (1.2% compared to 13.0% for the province). Within the Central East LHIN, the Peterborough region has the highest Aboriginal population, at 3%.<sup>77</sup>

**Immigration:** Between 2001 and 2006, the percentage of recent immigrants (those who have arrived within the previous five years) stood at 4.8% provincially. In that same period, the percentage of recent immigrants in the Central East LHIN stood at approximately 5.6%, just over 1% higher than the Ontario average. Within the Central East LHIN, there is significant variation in the distribution of recent immigrants: as high as 12.5% in Scarborough and as low as 0.3% in the Northeast.<sup>78</sup>

**Language:** Seventy-two per cent of the Central East LHIN population speaks English. In the Northeast, this percentage is as high as 94%, and in Scarborough, as low as 41%.<sup>79</sup>

Approximately 2.2 % of those living in Central East LHIN are Francophone (i.e., they declare French as their mother tongue),<sup>80</sup> which is highest in the Durham Region at 2.3%. Nearly 3% of the Central East LHIN population speaks neither English nor French; again, this percentage is highest in Scarborough.<sup>81</sup>

**Socio-economic Status:** The Central East LHIN population is slightly more disadvantaged than Ontario as a whole when considering the number of low-income families (16.1% vs. 14.7% for the province). This percentage is as high as 27.3% in Scarborough and as low as 6.7% in Durham (which, following the 2009 recession, is likely to increase significantly).<sup>82</sup>

**Seniors:** The percentage of seniors (65 or older) is 13.7% in the Central East LHIN, almost equal to the provincial average of 13.6%. However, within the Central East LHIN, some regions have a significantly older population than others. The distribution of seniors is highest in the Northeast (24.6% in the Haliburton Highlands) and lowest in Durham (8.7% in Durham West).<sup>83</sup>

## Other Categories of Diversity

Census data remains the best available resource for developing a profile of the Central East LHIN. However, this data provides an incomplete picture of the region's diversity. While gender, age, ethnicity, language and socio-economic status are important categories, diversity also includes characteristics such as disability (physical and mental), sexual orientation and mental health and addictions. Very little Central East LHIN specific data related to these categories is available.

Fortunately, national and provincial estimates exist for both sexual orientation and disability. Although further research is necessary, given the size and geographic distribution of the Central East LHIN, these estimates can be used to better understand the distribution of such characteristics within each region.

**Disabilities:** The Canadian population with disabilities is estimated to be approximately 12.4% compared to 13.5% in Ontario.<sup>84</sup> In terms of visual disability, the national prevalence rate among adults is 2.5% compared to 4.4%.<sup>85</sup>

**Sexual Orientation:** 1.7% of Canadians identify themselves as homosexual or bisexual.<sup>86</sup> However, there is reason to believe that these figures significantly underestimate the true incidence of homosexuality and bisexuality, given the common unwillingness of gay, lesbian, bisexual or transgendered individuals to accurately disclose their sexuality.

**Mental Health and Addictions:** On average, nearly 30% of people with mental illness also experience a substance use issue in their lifetime.<sup>87</sup> The prevalence rate for mental illness in the Central East LHIN at any given time is 2.5 - 3% compared to approximately 6.6% for the province.<sup>88,89</sup>

In 2007, the overall prevalence rate of substance abuse in the Central East LHIN was not significantly different from the provincial rate (6.6% compared to 6.5% for Ontario). Generally, rates of substance related problems have been found to be higher among men than women.<sup>90</sup>

## PART 4:

# EXPERIENCES OF HEALTH INEQUITIES AND MARGINALIZATION IN THE CENTRAL EAST LHIN

*“When I was in hospital I felt like I was nobody. Everyone including nurses and doctors only talked to my husband and not to me. You can say my English is broken, but can’t I speak for myself?”*

- Chinese Community Member

Not surprisingly, experiences of marginalization and health inequities are common within the Central East LHIN. In focus groups, community members identified numerous barriers to health equity, including:

- Lack of access to adequate, sensitive, and culturally appropriate services;
- Experiences of discrimination, stereotyping, and stigma;
- Lack of accommodation (e.g., interpreters);
- Negative treatment experiences due to cultural difference; and
- Experiences of diversity-incompetent health service providers.

The project conducted a total of 23 focus groups across the three regions of the Central East LHIN between April and July 2009. Six of these were held with health service providers and the other 17 with immigrants, youth, seniors, sexual and gender minorities, people living in poverty, people with disabilities, and uninsured individuals.

## Purpose

The purpose of the focus groups was to examine:

- Conceptualizations of health equity;
- Experiences in the health care system;
- Organizational practices and ability to respond to diverse and marginalized communities;
- Organizational commitment, governance, monitoring; exemplary models and programs;
- Challenges for community members and health service providers; and,
- Ideal visions of health equity policies, monitoring, accountability, and education.

*“I had to get blood work done at the hospital. I told the nurse before she took my blood that I was HIV positive. The nurse left the room but said she would be right back. She never returned to take my blood.”*

- Community Member

## Recruitment, Facilitation, Informed Consent and Questions

**Recruitment:** Community member participant outreach and recruitment was carried out in partnership with community organizations such as CNIB, Hong Fook Mental Health Association, TAIBU Community Health Centre, and the Peterborough AIDS Resource Network.

Health service provider participant recruitment and outreach was carried out by the project team. Invitations to participate were sent to randomly selected Central East LHIN-funded organizations, based on a quota designed to ensure all areas were represented (hospitals, long-term care, community health centres, etc.).

**Facilitation:** Each focus group session took approximately 60-90 minutes. Project staff facilitated all health service provider focus groups and the majority of community member focus groups. Staff from relevant organizations provided facilitation when language, trust and additional accommodation were required.

**Informed Consent:** Prior to focus groups, all participants were given an overview of the project and asked to sign an informed consent form and fill in a demographic form.

**Questions:** Focus group questions reflected each of the areas identified under Purpose above.

## Focus Groups Details

During the 23 focus groups, we spoke to a total of 174 individuals: 134 people were community members and 40 were health service providers. Health service providers were also asked additional questions specific to their work in the health field.

Focus Group Participants (174)	Community Members(134)	HSP (40)	HSP Employment (40)	HSP
<b>Scarborough</b>	55%	37%	<b>Years in the Health Profession</b>	
<b>Durham Region</b>	28%	40%	Less than one year	3%
<b>Northeast</b>	17%	23%	One year to less than 5 years	15%
<b>Female</b>	63%	77%	5 years to less than 20 years	50%
<b>Also Trans</b>	2%	0%	More than 20 years	30%
<b>Age Range</b>			<b>Work in Health Sector</b>	
18-30	18%	10%	Nursing	13%
31-40	17%	25%	Social Work/ Counselor	35%
41-50	25%	38%	Occupational Therapist	3%
51-60	14%	23%	Physician	3%
60 +	13%	3%	Health Promoter	10%
<b>Highest Level of Education</b>			Peer Support	5%
High School	22%	0%	Administrator / Manager	25%
Professional Certificate or College Diploma	35%	38%	Board Member	3%
Bachelors Degree or Higher	24%	60%	Other	5%
<b>Born Outside of Canada</b>	66%	58%	<b>Areas of Health Sector</b>	
<b>Years lived in Canada</b>			Addictions and Mental Health	20%
less than 3 years	13%	35%	Community Health Centre	10%
3 to less than 10 years	20%	17%	Community Support Services	25%
More than 10 years	34%	5%	Hospital	10%
<b>Self Identified Category of Diversity</b>			Long-Term Care Facilities	10%
Ethno-Cultural Group	25%	28%		
Visible Minority	34%	35%		
LGB (& two-spirit, questioning)	12%	3%		
Transgendered or Transsexual	2%	0%		
People with Disability (visible / invisible)	16%	5%		
Immigrant/Refugee	27%	13%		
Senior	10%	0%		
Francophone	8%	4%		
Low socio-economic status	19%	0%		
Youth	2%	0%		

## Overview of Findings

What follows is a limited discussion of the focus group findings. More detailed information can be found in Appendix 3.

### Common Findings

A number of barriers to health equity were named by both community members and health service providers in all focus groups:

- Substandard service delivery due to stereotyping and discrimination;
- Inadequate access to services for financial and geographical reasons;
- Refusal or inability to provide translation or interpretation services; and
- Lack of accommodation (e.g., interpretation, ASL).

*“Some of them [hospital nurses] are actually kind of rude. Just because you are a teenager they like treat you like ... like you ... are a lazy bum - you are not worth their time and they would rather take in some 30 year old guy.”*

- Community Member

### Common Recommendations

For the most part, focus group participants were consistent in their recommendations as well. Community members and health service providers both advocated for:

- Recruitment and retention of diverse (ethno-culturally and other dimensions) staff in health care organizations;
- Greater cultural competence among staff;
- Consistent, rigorous monitoring of organizational policies on culture, diversity and equity; and
- Better outreach and communication to marginalized communities.

## Community Member Findings

Community member experiences can be grouped into the following categories: access barriers; discrimination, stereotyping, and stigma; accommodation issues; treatment experiences; and health service provider incompetence.

### Access Barriers to Services (particularly for marginalized community members)

- Lack of accommodation (e.g., ASL, interpretation);
- Lack of local specialized services (examples are Sherbourne Clinic, Centre francophone, which are both located in the Toronto Central LHIN);
- Financial constraints (e.g., cost of medicine, travel costs in rural areas, certain immunizations, ambulances);
- Health care workforce that does not reflect communities and diversity;
- Geographic distances; and
- Unavailability of free services for newcomers without OHIP.

*“We had a [First Nations] man who had a plan in place and requests for his passing and immediately after for ceremony and things. It was time and we had to wheel him outside into the rain and we didn’t actually get all of them – all we were attempting to do was sticking his head out through the doors so we weren’t actually setting off the alarms – the smoke alarms, fire alarms. While we were struggling with the logistics of sticking a glove over the sensors he passed away with his head sticking out the fire exit.”*

- Front-line Worker

### Experiences of Discrimination, Stereotyping, and Stigma

- Heterosexism;<sup>91</sup>
- Racism;
- Ageism;
- Ableism;<sup>92</sup>
- Intolerance towards cultural explanatory models of illness and treatments;<sup>93</sup>
- Stereotyping according to cultural identity;
- Pathologizing culture (e.g., deafness);

- Denial of access to and informed consent to treatment;
- Lack of interest in marginalized identities (e.g., culturally deaf); and
- Lack of understanding of the intersectionalities of identity.

### Issues Related to Accommodation

- Lack and denial of interpretation services (including American Sign Language);
- Inappropriate use of family members for cultural interpretation;
- Lack of transportation (particularly for the visually impaired and seniors in rural areas);
- Inaccessible facilities (e.g., lack of signage and audible elevators); and
- A lack of diverse ways of communicating (e.g., calling names in waiting rooms despite knowing that culturally deaf patients are present).

#### Service Delivery

Community members suggested family-centred care that embraces cultural specificity and a client bill of rights. This means service delivery that includes accommodation related to:

- Language (e.g., access to translated information, interpreters including ASL);
- Visual impairment (e.g., note takers, non-harassment policy regarding guide dogs, global positioning system, signs);
- Hearing impairment (e.g., alternative means of communication including waiting areas);
- Religion/faith (e.g., diets, prayer times and rooms);
- Culture (e.g., gender matching of health care providers); and
- Poverty (e.g., internal and external financial assistance related to health care and treatment).

### Negative Treatment Experiences

- During intake, administrative forms do not reflect diversities (e.g., same-sex families);
- Improper assessments and poor accommodation (awareness, skills and knowledge of service providers);
- Insufficient time taken by practitioner to understand client issues;
- Lack of understanding of culturally based explanations of illness;
- Refusal of services (e.g., blood work of HIV positive individual and uninsured clients);
- Lack of affordable medicines; and
- Poor communication by health service providers.

### Experiences with Health Service Provider Incompetence

- Incompetence related to culture, diversity and health equity, especially in the areas of awareness, skill, knowledge and power imbalance;
- Denial of different cultural explanatory models of illness;
- Poor understanding of broader determinants of health (e.g., immigration and poverty);
- Staff unable to recognize difference and diversity (service providers lack awareness and knowledge);
- Onus placed on clients to raise health issues that are related to their cultural and social location (e.g., that people from the Caribbean have a higher incidence of diabetes or issues of transsexual/transgendered individuals); and
- Lack of sensitivity in processes such as intake and service delivery (lack of service provider awareness).

*"My previous family doctor misdiagnosed my HIV. Initially he gave me a cancer diagnosis until I was hospitalized. When it came out I am gay my doctor simply said: "If I had known that you were gay, I would have tested you for HIV."*

- Community Member

## Health Service Provider Findings

Health service provider perceptions and experiences that were shared with us can be grouped into the following categories: health inequity issues, systemic challenges, clinical contexts, organizational contexts, policy, accountability and monitoring, and education.

### Health Inequity Issues

Health inequities are the consequence of a great number of interrelated issues. First and foremost among them is the fact that health service providers do not acknowledge health equity as a civic duty or an issue of social justice, and are thus unlikely to recognize the different health statuses of marginalized communities. Other issues include:

- Lack of planning to deal with the different realities of rural versus urban settings;
- Lack of planning to deal with regional difference (e.g., high ethno-cultural diversity in Scarborough and Durham or the growing seniors population in the Northeast);
- Lack of planning to address issues related to Aboriginal communities;
- Negative experiences (e.g., discrimination);
- Cultural stereotyping (e.g., cultural profiling) and other stigmas (e.g., mental illness);
- The fact that service delivery is tied to the ability to express, demand and request services; and
- The relationship between technology and service delivery: the inaccessibility for seniors and other individuals of website information, or the dependence on email for health service volunteers.

*"The clinic near us - they always seem quite surprised that we both go in. Like if we are taking our son for whatever – we both go with him. It's like 'is this your sister? No, this is his other mother. Oh, you mean stepmother? No, he has two mothers' ... you always have to give a little background information first before they click in that it is ok that two people of the same sex come into the appointment."*

- Community Member

### General Barriers to Health Equity - Voices from the Focus Groups with Health Service Providers

- Those who require the most service are often the ones who do not or cannot express their needs. From the perspective of seniors in the Northeast, for example, having to travel to services rather than having services travel to them is an important barrier to health equity.
- The declared universality of both the Canadian health care system and the Central East LHIN funding system is a contributing factor to health inequity because they create the misconception that everyone has the same level of access to appropriate services, implying there are no health inequities.
- Health care equity in the Central East LHIN cannot be said to exist. Funding between regions is unequal and most services are geared towards mainstream patients, creating access barriers for others. And is the Central East LHIN commitment to tackling culture, diversity and equity in health care the consequence of guilt, cynical politics, or a passing trend ("the flavour of the month")?
- The limited interpretation services offered within the Central East LHIN force many family members to take on the role of translators and interpreters. This can compromise the quality and confidentiality of care.
- From the perspective of the Northeast, because of the large number of individuals without a family doctor and a general lack of walk-in clinics, clients with multiple health issues (e.g., seniors, people with mental health and addiction problems) have very little hope of finding primary health care (not to mention specialized care), and therefore end up in emergency rooms with advanced health problems. Since emergency rooms tend not to follow-up with clients, health issues can be exacerbated. This, combined with the lack of long-term care beds, leads to hospital bottlenecks particularly for the frail elderly who are put into long-term care beds that are often far away from their homes.



## Systemic Challenges

Community members perceive a number of systemic barriers to health care services, from the individual client level to the societal level.

At the **individual client** level, systemic challenges include poverty and mistrust of mainstream service providers.

At the **service provider** level, systemic challenges include:

- Discrimination and prejudice against marginalized individuals (particularly but not limited to, the elderly, immigrants, First Nations and those with mental health and addictions problems);
- A tendency to excuse or deny racism; and
- Insufficient cultural competence training for health service staff.

*"I have been seeing a psychiatrist regularly for the past 10 years but never had a yearly physical check-up because my psychiatrist said it is not his job and I can't find a family doctor that speaks Chinese who takes new patients?"*

- Chinese Community Member

At the **organizational** level:

- Lack of commitment to reaching out to diverse populations;
- Lack of inter-organizational information flow regarding diversity;
- Lack of linguistic and cultural diversity among staff and leadership; and
- Organizational hiring practices that restrict diversity and perpetuate token hiring (e.g., one person of colour on a board).

At the **Central East LHIN** level:

- Unequal access to financial resources for services and organizations; and
- Lack of human resources and funding related to culture, diversity and equity.

*"When you immigrate to Canada you must live in Ontario for three months before being covered by OHIP. This is a time of high stress and problems escalate."*

- Community Member

At the **societal** level:

- The broader determinants of health (e.g., access to education, housing, living wage);
- The reality of intersectionality (e.g., youth not a homogenous group);
- Lack of culture-specific disease control (e.g., diabetes mellitus prevalence in particular ethnic groups); and
- Liability issues and ministry policies that create barriers to providing responsive and client-centered care (see quote).

## Clinical Issues

Various clinical issues were identified related to language and education. For example, lack of interpretation or translation services leads to an ongoing reliance on community volunteers and family members to act as interpreters. In terms of education, health service providers identify a lack of clinical training and education in the areas of culture, diversity and equity and a related failure to recognize diversity within cultures. Instead of trial and error, which is the current learning method, they suggest transmitting basic core knowledge and approaches so as to avoid clinical errors. Several other points of concern arise, which can be placed along the health care continuum:

- Inappropriate health care service delivery during intake due to lack of knowledge of culturally appropriate practices (e.g., often during drop-ins);
- Poor assessment of patients due to lack of understanding and thus inadequate information gathering (onus should be on the service providers to ask questions), and lack of comprehensive cultural assessments;
- Unmet cultural and religious needs;
- Limited informational flow from assessments to clinical staff regarding culturally specific issues;
- Lack of culture matching (e.g., physician from the same culture);

- Lack of non-traditional and family-centered treatment approaches;
- Failure to revise treatment plans when cultural issues arise during planning and treatment;
- General lack of culturally competent services;
- Lack of time required to find appropriate services during referrals; and
- Power differentials not adequately recognized in clinical encounters.

## Organizational Issues

Issues of concern at the organizational level relate to a general lack of resources for culture, diversity and equity policies (e.g., translation, interpretation and training). There is a highly inconsistent level of cultural competency among staff due to lack of training and rare opportunities for staff to share knowledge and expertise amongst themselves and with other organizations (e.g., First Nations organizations).

When it comes to policies and commitment, the following issues are present:

- The general lack of any commitment to introducing organizational policies relating to culture, diversity and equity;
- The failure of outreach and community partnerships, too often driven by staff initiative and not formalized processes;
- The failure to recruit and retain diverse staff (particularly outside of Scarborough).

*“Language barriers also pose a problem for recent immigrants, as many will use family members as translators when receiving healthcare services – which often times means that health issues of a more private nature can be neglected due to embarrassment.*

- Health Service Provider

## Policy Issues

Policies have been mostly developed by staff in management positions and in locations of privilege, and this is in itself a policy issue. Furthermore, health care providers find that certain policies create a culture of fear, for example when it comes to the few existing policies around cultural competence (e.g., requirements from the Ministry and accreditation bodies). As a result, policies prove difficult to implement.

## Accountability and Monitoring Issues

Culture, diversity and equity policies are not sufficiently monitored and lack rigour, according to health service providers. *Sensitive* issues are often swept under the carpet, and diversity committees fail to focus enough attention on action. This is at once the result of and reason for the following concerns:

- Existing commitments are due more to accreditation and politics than to a desire to ensure social justice;
- Diversity committees fail to focus enough attention on action;
- Internal monitoring is inconsistent and lacks rigour;
- Current accreditation systems are tokenistic; and
- The client’s ability to complain is limited.

## Educational Issues

Inadequate initial education and training in culture, diversity and health equity is an ongoing issue in the Central East LHIN. Health service providers identify three points of concern:

- The great disparity in the amount and type of training currently given (e.g., general lack of diversity training for physicians);
- Lack of training among board members; and
- The better preparedness of recent graduates than senior staff to work with diverse communities.

PART 5:

# ACHIEVING HEALTH EQUITY IN THE CENTRAL EAST LHIN

*“When my husband got sick I didn’t know where to look for help in the night. I’ve never felt so lonely in my own country.”*

- Community Member

There are compelling reasons for the Central East LHIN’s efforts to achieve health equity within its borders. First, health equity is an ethical responsibility, consistent with the fundamental Canadian values of assistance, security and compassion for all. Second, greater health equity will result in significant cost savings to the health care system. Finally, health equity is a vital component of the Central East LHIN’s strategic vision and goals.

## Values

Social inequities and their health consequences are neither natural nor inevitable. Too many people find themselves without the opportunities to achieve good health simply because of their race, ethnicity, age, gender, sexual orientation, disability, or socio-economic status. Untreated illness leads to more illness.

Yet, such conditions are preventable and avoidable. All that is required is good policy. By seeking health equity, we show more than simple charity; we fulfill our responsibility to work towards social justice.

According to the World Health Organization, international law renders countries legally responsible for “the health of every person within their jurisdiction.”<sup>94</sup> Health Canada has proclaimed itself committed to improving and maintaining the health of the entire Canadian population and to reducing inequities in health between population groups.<sup>95</sup>

Health equity is a fundamental issue for all Canadians. Not only does the *Canadian Charter of Rights and Freedoms* guarantee health as a human right, but Canada’s commitment to equal assistance, security and compassion for **all** is, for many Canadians, a special point of pride.

## Cost Effectiveness

Canadians pay dearly for health inequities. Study after study demonstrates the links between marginalization and poor health outcomes in the long-term. Poor health outcomes mean additional costs for the health care system and for society at large. By not addressing the causes of health inequity now we increase the burden on the health care budget of the Central East LHIN in the future.

In Canada, **health inequity creates significant costs**. Income disparities have been estimated to contribute to 20% of total health care costs.<sup>96</sup> While the true costs of inequity to the health care system (e.g., providing care to sicker and more disadvantaged populations), as well as indirect costs (e.g., lost productivity, lost wages, absenteeism, family leave and premature death) are not well documented in Canada, researchers at Johns Hopkins University and the University of Maryland recently estimated that 30.6% of the direct medical costs faced by African Americans, Hispanics, and Asian Americans were due to health inequities.<sup>97</sup>

Researchers also predict that eliminating health inequities could reduce medical care expenditures in the United States by nearly \$230 billion over a three-year period. Implementation of health equity policies between 2003 and 2006 could have saved a combined \$1.24 trillion for the health system.<sup>98</sup> This data provides some indication of the potential cost savings for Canada and the Central East LHIN if health equity is achieved.

## Central East LHIN Alignment

### Integrated Health Services Plan (IHSP) 2006

In its first Integrated Health Services Plan in 2006, the Central East LHIN set out a mandate to respond reasonably and fairly to the diversity of communities. Achieving health equity became part of its vision.

In the 2006 IHSP, the Central East LHIN acknowledged the role of interpreter services, recruitment/retention policies, hiring of minority staff, provider training in cultural competence, culturally competent health promotion, and so on as key factors in reducing culturally-based health disparities in the region.

The Central East LHIN went further, adding that the theme of cultural competency could be found throughout each of its priorities for change in the 2006 IHSP, including, as a first step, its plans for a Mental Health and Addictions Network.<sup>99</sup>

The IHSP also established that both the community and the LHIN need to urge collaboration among all sectors (health, education, housing, transportation, etc.) to improve individual and population health and reduce health inequity.

### IHSP 2010

In support of the Ministry of Health and Long-Term Care vision and strategic direction, the Central East LHIN 2010-2013 IHSP renewed its commitment to equity as part of its vision and values. In fact, health equity will play an important role in achieving two strategic aims defined by the Central East LHIN in its 2010-2013 IHSP.

*“Another critical factor in improving the health of our communities – and a theme that was raised consistently by community residents – is the importance of culturally competent strategies and services that will reach people marginalized as a result of their ethnicity, language, race, gender, sexual orientation, economic status or religious affiliation. Equity is a key component of an effective health care system, and without understanding how these factors influence health status in our society, the chances of improving the overall health of the population is near impossible.”*

- Central East LHIN 2006 IHSP

### **Strategic Aim 1: Save 1,000,000 Hours of Time Patients Spend in Central East LHIN Emergency Departments by 2013.**

While all patients generally spend a lot of time in hospital emergency departments, there are certain patients who can expect to have to wait longer for services or treatment. Factors other than severity of illness come into play. Race and ethnicity, for example, have been shown to influence patient wait times across a range of encounters from the moment they register to the time they physically leave, most consistently during initial clinical assessment.<sup>100,101,102</sup>

Several possible explanations have been offered including discrimination, cultural incompetence, language barriers and other social factors. It is likely that this disparity of wait times can be seen in the Central East LHIN.

Although the specific mechanisms are unclear, such evidence would suggest that addressing some of these underlying factors would not only significantly improve patient experiences, but likely also contribute to the overall reduction in the number of hours spent by patients in LHIN emergency rooms.

**Strategic Aim 2: Reduce the Impact of Vascular Disease in the Central East LHIN by 10% by 2013.**

Cardiovascular disease (CVD) is a leading cause of mortality and disability in Ontario.<sup>103</sup> While progress has been made in the quality of care and outcomes for CVD, inequities in health status continue to be associated with gender and socio-economic status.<sup>104</sup>

Although the Central East LHIN sets out to reduce the impact of CVD in the Central East LHIN, overall quality of care has been shown to be less of a factor in determining health outcomes for CVD than socio-economic status. This once again underscores the need to address health equity and the social determinants of health in order to achieve the LHIN's aim of a 10% reduction by 2013.<sup>105</sup>

## PART 6

# A CALL FOR ACTION

The ten recommendations put forward in this report are the basis of a comprehensive health equity strategy for the Central East LHIN. They call for clear vision and determination at the highest level of governance. At the organizational level, they will require real policy changes, the introduction of accountability systems and serious ongoing evaluation and research. They also stipulate a client navigation system, education and knowledge exchange for health service providers and a substantial investment of resources into the cause of health inequity in the Central East LHIN.

Implementing these recommendations will be the first significant step towards achieving health equity for all residents in the Central East LHIN. Recommendation #1 calls upon the board to develop a comprehensive plan that includes health equity goals, vision and principles.

The Central East LHIN cannot develop the plan alone, nor can it implement its plan without the collaboration and input of community members, their families, health service providers, researchers, other LHINs and the Ministry of Health and Long-Term Care. In doing so, it must ensure the participation of the most marginalized communities.

Those involved in the planning, funding, overseeing and management of health care delivery must be particularly involved in this process, because achieving health equity will require considerable change. Many organizations in the Central East LHIN, though engaged in valuable and exemplary work, find themselves amidst competing organizational needs, and generally without the necessary resources and infrastructure that would be required to develop and support health equity activities.

Finally, while frequently started at the grass-root level, successful changes within the health care system have almost always eventually involved leadership and support from the highest level. Successful change also necessitates a plan that includes various complementary components:

- Community engagement;
- Scope/comprehensiveness;
- Justification and objectives;
- Targets and timelines;
- Accountability and monitoring mechanisms; and
- Transparency (see Principles of Successful Implementation below).

## Other Jurisdictions: Health Equity Activities Elsewhere

Whereas in Canada there have only been a few disjointed attempts to address health equity, internationally significant policy developments have already been adopted. This section outlines the current health equity strategies in the United Kingdom, the United States, Australia, New Zealand, Netherlands, Sweden and Ontario (See Appendix 1 for further details).

**The United Kingdom** is considered a leader in its efforts to tackle health inequities. Broad, coordinated, governmental policies that focus on the broader determinants of health, particularly the need to tackle the causes of health inequities, are producing results. There are currently national service frameworks in place to standardize care, and ongoing investment in attempts to address poverty and social exclusion, comprising issues such as education, employment (particularly for priority groups), living standards, low income and transportation and mobility.

The United Kingdom has also initiated pilot projects to explore organizational barriers that inhibit equitable service, statutory ‘equality’ requirements, and perhaps more importantly, the legal obligation to eliminate discrimination and promote equality.

**The United States** generally focuses on cultural competence in its policies and standards, particularly within the context of a health care equity framework. Central to this approach are awareness-raising policies through the creation of national centres that fund research on health disparities, support health care professional training and commission reports to monitor health disparity trends.

The United States strategy also involves nationwide policy objectives around leading health indicators such as physical activity, substance use, responsible sexual behaviour, mental health and access to health care. Additional policies have been adopted to improve cultural competency:

- The development of National Standards for Culturally and Linguistically Appropriate Services (CLAS);
- State legislation requiring physician cultural competency training as condition of licensure by the state; and
- State wide assessment of workforce trends on cultural competence and minority participation in the health profession.

**Australia, New Zealand, Netherlands and Sweden** have all developed promising government policies and strategies relating to health equity. The Australian government currently provides training on health equity impact assessment. In New Zealand, a focus on health equity has been embedded into all levels of work in the health sector, along with templates to reduce health inequities. Both the Netherlands and Sweden have achieved broad consensus on the need to reduce health inequities and have started a national dialogue on the determinants of health.

## Other LHINs in Ontario

Of the LHINs in Ontario, the Toronto Central LHIN and the Central LHIN have made the most progress in addressing health inequity.

**The Toronto Central LHIN** has developed its health equity plan in collaboration with a number of stakeholders including the LHIN’s Hospital Collaborative. The plan advances a motion requiring hospitals to document challenges, gaps, practices and improvement plans around health equity including priority setting and planning, promising practices, policies, procedures and standards, governance, targets and measurements, community and potential roles for the Toronto Central LHIN. These requirements are also included in the LHIN’s Accountability Agreements. The report that resulted from this process determined to:

- Track hospitals’ progress in responding to health equity;
- Make recommendations to the Toronto Central LHIN to develop a system-wide approach to health equity;
- Measure data and performance and define of management problems;
- Suggest immediate action in the LHIN and hospitals; and
- Identify mid to long-term initiatives.

Among other activities, the LHIN has developed a Health Equity Impact Assessment tool and Health Equity Impact Assessment workbook, and is active on health equity research and knowledge exchange as well as the development of a LHIN-wide model for the delivery of interpretation services.

**The Central LHIN** has identified diversity and inclusion as key enablers in its Integrated Health Services Plan, and has set up an Advisory Group to establish expectations and provide oversight on reducing health inequities. The Central LHIN approach to health equity is to:

- Establish a multi-stakeholder *Community of Practice* to develop and share information about barriers and good practice;
- Fund research on promising diversity and inclusion practices;



- Develop a health equity policy and plan to implement health equity training, develop health equity policies, demonstrate responsiveness to the community and provide leadership;
- Require hospitals to develop their own health equity plans as part of their accountability agreements; and,
- Develop a diversity data profile for the region.

## Principles of Successful Implementation of Health Equity Policies

Health equity policies that are succeeding in other contexts, national and international, share common principles and mechanisms. First, they are evidence based and justified by social justice and population health. Second, they are collaborative, requiring the involvement, not only of experts, but of affected and interested communities. Interventions are simultaneously top-down (e.g., policies) and bottom-up (e.g., community driven).

The following points are essential to a meaningful health equity plan that will engender positive outcomes.

**Leadership:** Those at the governance level should have a clear set of goals and a firm grasp of why they are enacting change. They should also be able to envision how the health system will exist in the future. To ensure compliance across the system, equity policies and strategic goals need to be adopted at the highest levels of the Central East LHIN.

The same level should be present throughout the process of system-level improvement, with direct responsibility for implementing and monitoring health equity initiatives. Moreover, all management must act directly and according to high standards of transparency, by ensuring that interim goals are reached.

**Community Engagement:** The engagement of health service staff, management and community members/clients will always be vital in the process of achieving health equity in the Central East LHIN. Senior project leaders must receive ongoing guidance from the experience and insight of front-line health service providers and community members, as their involvement is the best guarantee that the process of change is moving in the right direction.

In fact, the Local Health System Integration Act requires each of the LHINs to develop an Integrated Health Services Plan with input from the community, and in accordance with the provincial (MOHLTC) Health System Strategic Plan.

**Scope:** When defining objectives for health equity policies, it is important to make clear if their purpose is a relative reduction in health inequalities or an absolute elimination of health inequities. Policy makers should also know whether the goal or objective of health equity is the reduction of inequalities in health status broadly, or more narrowly within the health care system. Ideally, health equity policy includes both broad level and narrow goals.

Furthermore, in defining the scope of communities being addressed, policies should consider the breadth of marginalized groups (e.g., cultural groups, class, gender, etc.) and the breadth of organizational domains: leadership, governance, service and service delivery, research and education, human resources, contracting and procurement, and communications. Ideally, health equity policy includes all disadvantaged populations across all organizational domains.

**Transparency:** The results of monitoring and assessment should be regularly reported, ideally, to the public, and in a manner that allows for comparability of reported information across the health system. The production and publication of diversity/health equity report cards on an annual basis, available to the public, has been shown to be a particularly good incentive for motivating action, compliance and good performance on health equity issues<sup>106</sup> and is a growing phenomenon in numerous jurisdictions.

This kind of transparency works against the tendency to conceal negative data and gloss over unflattering results. Instead, it galvanizes health services to address any shortcomings and, at the same time, helps community members feel respected and valued because they come to understand that their input is accounted for and that it can have direct consequences on the health system.



**Justification and Objectives:** The main terms of policy debate are (1) whether to focus health equity policy interventions and resources ‘upstream’ on inter-sectoral action and broad social determinants of health such as housing and employment, or ‘downstream’ on, for example, health care access issues; and (2) whether to prioritize universal or targeted (selectivist) approaches that focus interventions on the most disadvantaged populations.

In this regard, the comprehensive approaches that have proven most effective combine and incorporate in varying degrees:

- Health equity and health care equity policy objectives;
- Upstream, midstream and downstream (“all stream”) policy interventions; and
- Universalist and selectivist approaches.

Political will and a favourable policy/political environment are critical to the advancement of health equity policies. Health equity policies as such should strategically align themselves, wherever possible, with national and local policy contexts and drivers to gain traction.

**Targets and Timelines:** Policy objectives should be clearly articulated in realistic, measurable, operational terms, based on evidence of what causes health inequity and what remedies or prevents health inequity (i.e., appropriate and successful interventions).

Any action plan should:

- Set dates for when activities such as monitoring, reviewing procedures, training and guidance are to be accomplished;
- Detail how these deadlines will be met and by whom; and
- Clarify the measures of success and how and when they will be evaluated.

**Accountability and Monitoring Mechanisms:** Compliance, quality assurance, and monitoring systems are necessary components for policy and strategy implementation.

The first means of ensuring compliance with health equity policies and strategies is to place the monitoring of health equity outcomes within performance management systems. The Central East LHIN possesses a number of major opportunities for managing health equity performance; these include:

- The Central East LHIN’s funding and allocation powers;
- The Central East LHIN’s local health system planning role (Integrated Health Services Plans); and
- Service accountability agreements.

Compliance cannot be mandated into existence, especially where there is insufficient capacity to comply with espoused equity objectives. However, the LHIN can play a supportive role and build capacity by:

- Providing or supporting training initiatives;
- Developing health equity/cultural competence ‘guidelines,’ if not standards, for care; and
- Establishing or collaborating with existing health equity researchers, teams and/or corporate research and evaluation units to assist in knowledge/data gathering and exchange processes that are critical to ensuring effective implementation and accountability.

## PART 7:

# RECOMMENDATIONS

We propose a comprehensive plan for health equity in the Central East LHIN that includes ten ambitious recommendations. Our recommendations have been developed using multiple approaches:

- A comprehensive literature review on the issue of health equity;
- An environmental scan of culturally competent services and services for uninsured individuals;
- Focus groups with 174 diverse participants, either community members or health and community service providers; and
- A public consultation process to discuss the recommendations, with the input of 63 community forum participants and 175 online participants.

For each of the recommendations, we have identified the priority actions that, if implemented, would result in a direct and significant improvement of health equity in the Central East LHIN.

## Recommendation Overview

The recommendations fall into three general categories, relating to:

- The Central East LHIN (Leadership, Health Equity Office/Staff, Social Determinants of Health);
- Central East LHIN-funded organizations (Policy, Monitoring, Training); or
- The Central East LHIN Service System (Service Enhancements, Client Navigation System, Information Knowledge Transfer)

The tenth recommendation, which underscores all three categories, refers to health equity evaluation/research.

## Recommendation #1: Central East LHIN Office Leadership

**The Central East LHIN will define a clear strategic vision for health equity, and will engage community members in the process.**

**Priority Actions:** The Central East LHIN will:

- Receive **comprehensive training** on power, oppression and health inequity;
- Develop a **Health Equity Health Interest Network (HEHIN)**<sup>107</sup> including 50%+ marginalized community members, Central East LHIN board members, and health service providers;
- Develop and adopt **health equity vision statement and guiding principles**, in collaboration with the Health Equity Interest Network;
- **Set ten-year goals** with clear leadership roles, targets, milestones, and outcomes and develop a **three-year Health Equity and Evaluation Plan**;
- **Commit resources** to organizational development, service enhancements, a client navigation system, an information and knowledge transfer system, health equity research, and the Health Equity Office (*see later recommendations*);
- Develop an **intra-LHIN Health Equity Committee**;
- Develop and adopt **health equity guiding principles** for request for proposals, assessing proposals, research, contracts, etc.; and
- Incorporate health equity into the **performance management** of all Central East LHIN office staff.

Among participants in the Community Consultations 76% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 4th among the ten recommendations.**

- *“Good idea to have clear set of definitions for a common language.”*
- *“The recommendation seems to me to say that we are going to get health equity by saying we are going to get health equity.”*
- *“[It is] important that all health care organizations are represented, i.e., hospital, home care, long term care etc. and each work toward shared goal with respect for what each brings to the table, this will take [both] time and commitment.”*

## Recommendation #2: Central East LHIN Health Equity Office/Staff

**The Central East LHIN will develop health equity tools to investigate the viability of a Health Equity Office; or, alternatively, hire a designated Health Equity staff to monitor and evaluate Health Equity initiatives in the Central East LHIN.**

**Priority Actions:** The Central East LHIN will:

- Develop a **Health Equity Office** or, alternatively, hire a designated **Health Equity staff member**;
- Develop an **accessibility plan** for community members who need to file a complaint; receive, investigate and monitor client and staff complaints regarding discrimination;
- Develop a **Health Equity Planning and Implementation Framework** for Central East LHIN-funded health care organizations;
- Develop a **Health Equity Monitoring and Accountability System**;
- Develop a **Health Equity Education Framework** for the Central East LHIN;
- Develop **Health Equity Indicators and Evaluation Standards**; and

- Develop a **Communication Plan**, with reporting on overall health equity work and monitoring to community and other stakeholders.

Among participants in the Community Consultation 60% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 7th among the ten recommendations.**

- *“Good. Providers need to be assessed more and in a structured format.”*
- *“Is this a replication of what is happening in other LHINs? If so, perhaps there is an opportunity for some synergy.”*
- *“There’s danger of this becoming another ‘smoke and mirrors’ program.”*
- *“It is a large but valuable undertaking and will require a dedicated and committed group to facilitate.”*

### Recommendation #3: Organizational Policies

**All Central East LHIN-funded organizations will make health equity a clear strategic vision and commitment.**

**Priority Actions:** Each organization (or cluster of organizations) will:

- Develop a **Health Equity Committee (HEC)** including 50+% local marginalized community members, board members, and health and social service providers;
- Adopt the **health equity guiding principles** created by the Central East LHIN board;
- Develop and adopt an **organizational health equity vision statement**;
- **Review and enhance all organizational policies** to reflect the organizational vision and the Central East LHIN principles of health equity;
- Develop a **three-year Health Equity Plan** that incorporates the Central East LHIN ten-year goals; and
- **Commit/shift internal resources** to implement their Health Equity Plans.

Among participants in the Community Consultation 69% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 3rd among the ten recommendations.**

- *“I believe that for the most part this recommendation makes sense, is timely, needed and achievable.”*
- *“This is going to be a huge task, to be adopted across all organizations there will need to be guidance.”*
- *“This is great. It creates the beginnings of two-way accountability.”*

### Recommendation #4: Organizational Monitoring

**The Central East LHIN will monitor health equity data through performance management systems.**

**Priority Actions:** The Central East LHIN will:

- Guide a process with stakeholders including epidemiologists and information technology experts to **identify relevant health equity data** (existing and missing) and methods for collection,<sup>108</sup> in coordination with other LHINs (e.g., the Toronto Central LHIN);
- **Require monitoring** of health equity data through different accountability agreements (e.g., HSAA, LSAA and MSAA);

- **Monitor organization compliance** regarding their health equity policies, work plans, client satisfaction, and data; and
- **Allocate funding** to organizations based on organizational health equity plans and achievements.

Among participants in the Community Consultation 73% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 9th among the ten recommendations.**

- *"This is very clear, specific and attainable but very complex, time consuming and expensive. Unsure if the type of funding it will require would be allocated."*
- *"Health providers should be given time to comply with the requirements."*
- *"Health equity plans and achievements should be one of the factors to determine funding allocation, not the only factor."*

## Recommendation #5: Organizational Education

**All Central East LHIN-funded organizations will educate their staff in health equity, diversity, and anti-discrimination.**

**Priority Actions:** Each organization will:

- Assess current levels of health equity, diversity, and anti-discrimination awareness, knowledge, and skills among staff, board and volunteers, using a **toolkit developed by the Health Equity Office**;
- Set **health equity, diversity, and anti-discrimination goals**;
- Develop and implement an **educational plan** for the organization;
- **Evaluate the outcome** against organizational goals;
- **Report their results** to the Central East LHIN office; and
- **Develop plans for ongoing health equity, diversity, and anti-discrimination education.**

Among participants in the Community Consultation 88% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 2nd among the ten recommendations.**

- *"This needs to be accomplished!"*
- *"I see this as a key recommendation - only weakness is lack of resources to ensure consistent use of tool kit and staff and facility training."*
- *"This needs to have the ability to be customized for the needs of the provider organization."*

## Recommendation #6: Service Enhancement

**The Central East LHIN will invest in system and service enhancements to increase access to health care for marginalized populations.**

**Priority Actions:** The Central East LHIN will:

- Invest in developing a **LHIN-wide diversity accommodation system** such as language, visual impairment, and physical mobility;

- **Identify regional health equity priority populations** and respective health care gaps, using community consultation (community members and health service providers);
- Invest in a minimum of three **regional pilot projects** aimed at above identified priority populations (possibility to enhance existing services/projects);
- **Review its regional health equity priority populations** after a three-year period based on community demographics, emerging research and data;
- Review its regional pilot projects through **external evaluations**;
- Reserve the right, based on community consultation and evaluations of funded pilot projects, to discontinue (negative outcomes and/or community needs met), extend (unclear outcomes and/or continued community needs), or transform any of these projects into a program (positive outcomes and/or continued long-term community need); and
- Continue the expansion and **improvement of primary health care**.

Among participants in the Community Consultation 75% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 1st among the ten recommendations.**

- *"This sounds like a good practical recommendation. I hope the pilot projects will have concrete goals like adequate housing, or income stability"*
- *"There aren't enough resources in the LHIN to achieve this goal successfully."*
- *"These types of initiatives begin with a strong commitment to involving community members, but ultimately the decisions come from the top down. Somehow we need to ensure community representation is maintained throughout the process."*

## Recommendation #7: Social Determinants of Health

**The Central East LHIN senior management will commit to a vision of health that includes the broader determinants of health.**

**Priority Actions:** The Central East LHIN will:

- Promote and ensure the **inclusion of the broader determinants of health** into Central East LHIN planning partnerships;
- Develop and participate in **cross-sectoral partnerships and coalitions** (e.g., housing, food security);
- Require organizations to develop cross-sectoral partnerships and coalitions; and
- Advocate **to different levels of government** to address the link between policies and social and economic inequities.

Among participants in the Community Consultation 78% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 5th among the ten recommendations.**

- *"Excellent recommendation and will need "buy in" and long-term commitment from those involved."*
- *"It amazes me how we can build such systems; it's no wonder there is no money for real health care."*
- *"I think this is a critical recommendation. The social determinants of health need to become the most important part of the planning of all the LHIN work. This is mainly why I chose to do this questionnaire, to be able to say how important I think this is."*
- *"The recommendation needs to start with a strong commitment to influence the overall culture of the Central East LHIN. The broader determinants of health need to be fully integrated into the overall culture of the network."*

## Recommendation #8: Client Navigation System

The Central East LHIN will create a navigation system for clients.

**Priority Actions:** The Central East LHIN will:

- Develop components for **creating a system for navigation**, in partnership with the HEHIN;
- **Fund the development** of a navigation system for clients (including a web site) to increase awareness and access to the health system that addresses local needs;
- **Assess the applicability** of accessing the information on the navigation system for clients in different languages (including French);
- **Develop a communication plan** for the navigation system; and
- **Train community members** and health service providers in using the navigation system.

Among participants in the Community Consultation 64% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 6th among the ten recommendations.**

- *“Improving navigation is good as long as there are adequate services available, otherwise it will only increase demand.”*
- *“It will cost money to provide resources to provide accessibility for providing information to various community groups as well as the mainstream community.”*
- *“Too much money has already been allocated to 'doors' to services, i.e., Community Access Centres.”*
- *“The information must be perceived as up to date and relevant!”*
- *“If it is not advertised well no one will know about it, so it needs to be well advertised in key places like at local doctor's offices, hospitals, maybe even bus shelters.”*

## Recommendation #9: Information and Knowledge Transfer

The Central East LHIN will develop an online health equity information and knowledge transfer<sup>109</sup> system for service providers.

**Priority Actions:** The Central East LHIN will:

- **Promote health equity knowledge transfer** in the planning partnerships;
- Organize, coordinate, and promote events that **facilitate knowledge transfer** among health service providers;
- Fund the development and maintenance of a **website for health service providers** to share information (e.g., resources, definitions, best practices, literature, links, tools) and facilitate interactive dialogue (e.g., chat room, opportunities to ask questions);
- **Offer training** in using the knowledge transfer system; and
- Develop **communication plan** to promote the knowledge transfer system.

Among participants in the Community Consultation 67% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 8th among the ten recommendations.**

- *“This would be a great resource for organizations; one weakness I can see is if computers and access to the site is not available to all employees in the organization.”*
- *“There is already too many websites that we are all supposed to access... too many portals of information from too many sources.”*
- *“Is the LHIN office best positioned to maintain such a virtual resource that needs to grow and evolve over time?”*

- “[Such a resource] would need to be weaved into what’s already being done.”
- “[It is] essential to keep information up to date, which will require significant commitment and human resource and expertise.”

## Recommendation #10: Health Equity Research/Evaluation

**The Central East LHIN will coordinate systematic research on health inequities throughout the Central East LHIN and evaluate pilot projects.**

**Priority Actions:** The Central East LHIN will:

- Guide a process with stakeholders including an epidemiologist and information technology experts to **identify relevant health equity data** (existing and missing) and methods for collection, in coordination with other LHINs (e.g., Toronto Central LHIN);<sup>110</sup>
- Develop **an ongoing and systematic method and action plan** for the evaluation of health equity within the Central East LHIN (e.g., access, treatment, health outcomes);
- Require Central East LHIN-funded organizations to collect the data identified to measure health equity;
- Provide funding to external organizations to **evaluate the projects** (e.g., universities); and
- **Shares all findings** with relevant stakeholders.

Among participants in the Community Consultation 63% felt that this recommendation was essential to advancing health equity in the region. **The recommendation ranked 10th among the ten recommendations.**

- “Seems like a vast commitment, however, it is needed and some organizations will have difficulty with resources and money.”
- “Much of the data is not being collected. Agreements would need to be reached to share the data that is available. Consent documents may need to be changed.”
- “The projects must lead to future valid processes to provide health care.”



# NOTES

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- <sup>1</sup> Central East LHIN, 2006.
- <sup>2</sup> Ibid.
- <sup>3</sup> Statistics Canada, 2009
- <sup>4</sup> Central East LHIN, 2006.
- <sup>5</sup> Marginalized groups include, but are not limited to, ethno-racial or ethno-cultural groups, immigrants and refugees, people of low socio-economic status, women, sexual and gender minorities, people with disabilities, youth, seniors, people living in certain geographic areas, Aboriginal peoples, and those experiencing addictions and mental health issues.
- <sup>6</sup> Mackenbach et al., 2002.
- <sup>7</sup> Exworth et al., 2006.
- <sup>8</sup> Gardner, 2008a.
- <sup>9</sup> Ibid.
- <sup>10</sup> Whitehead, 1990.
- <sup>11</sup> Bishop, 2002.
- <sup>12</sup> City of Toronto Task Force on Community Access & Equity, 1999.
- <sup>13</sup> Public Health Agency of Canada, 2002.
- <sup>14</sup> Ibid.
- <sup>15</sup> See Beiser & Stewart, 2005.
- <sup>16</sup> See Frankish, Hwang & Quantz, 2005.
- <sup>17</sup> See Rodney & Copeland, 2009..
- <sup>18</sup> See Lia & Surood, 2008.
- <sup>19</sup> Veenstra, 2009.
- <sup>20</sup> See Chen, Ng & Wilkins, 1996.
- <sup>21</sup> See Beiser, 2005.
- <sup>22</sup> See Hyman, Vu & Beiser, 2001.
- <sup>23</sup> See Access Alliance Multicultural Community Health Centre, 2005.
- <sup>24</sup> See Carballo, Divino & Zeric, 1998.
- <sup>25</sup> See Carta, Bernal, Hardoy, Haro-Abad, 2005.
- <sup>26</sup> See Machtleidt, 2005.
- <sup>27</sup> See Yoong, Wagley & Fong et al., 2004.
- <sup>28</sup> See Donovan, d'Espaignet, Merton & van Ommeren, 1992.
- <sup>29</sup> See Stephen, Foote, Hendershot & Schoenborn, 1994.
- <sup>30</sup> WHO, 2003, p. 28.
- <sup>31</sup> Ibid, p. 28.
- <sup>32</sup> Steel, Lemieux-Charles, Clark & Glazier, 2002.
- <sup>33</sup> Gagnon, 2002.
- <sup>34</sup> Gagnon, 2006.
- <sup>35</sup> Waddell et al., 2002.
- <sup>36</sup> Wilkins, Tjepkema, Mustard & Choinière, 2008.
- <sup>37</sup> Raphael, 2002.
- <sup>38</sup> Hayward & Colman, 2003.
- <sup>39</sup> Steele, Glazier & Lin, 2006.
- <sup>40</sup> Shaw, Dorling, Gordon & Davey-Smith, 1999.
- <sup>41</sup> See King, Semlyen, Tai & Killaspy et al., 2008.
- <sup>42</sup> See Hyde, Comfort, McManus, Brown & Howat, 2009.
- <sup>43</sup> See Diamant, Wold, Spritzer, & Gerlberg, 2000.
- <sup>44</sup> See Bakker, Sandfort, Vanwesenbeeck & van Lindert, et al., 2006.

- <sup>45</sup> Meyer, 2003.
- <sup>46</sup> McColl, 2005.
- <sup>47</sup> Hayden, Kim & DePaepe, 2005.
- <sup>48</sup> Woodcock & Pole, 2007.
- <sup>49</sup> Adam & Pickering, 2004.
- <sup>50</sup> Gold & Biljana, 2005.
- <sup>51</sup> Kidder, Stein & Fraser, 2000.
- <sup>52</sup> Ibid.
- <sup>53</sup> Chenier, 2002.
- <sup>54</sup> Lia, & Surood, 2008.
- <sup>55</sup> Chenier, 2002.
- <sup>56</sup> McGibbon, 2007.
- <sup>57</sup> Pong, DesMeules & Legace, 2009.
- <sup>58</sup> Fotso, 2006.
- <sup>59</sup> Sen & Ostlin, 2007.
- <sup>60</sup> Cohen, 1994.
- <sup>61</sup> Commings & Phillips, 1998.
- <sup>62</sup> Loppie & Wien, 2009.
- <sup>63</sup> Adelson, 2005.
- <sup>64</sup> Langer & Langer 1963.
- <sup>65</sup> Murali & Oyeboode, 2004.
- <sup>66</sup> See Langer & Michael, 1963.
- <sup>67</sup> See Townsend, 1979.
- <sup>68</sup> See Stephens, Dulberg & Joubert, 2000.
- <sup>69</sup> Kirby, 2006.
- <sup>70</sup> McCarty, Argeriou, Huebner et al., 1991.
- <sup>71</sup> Davis, 2008.
- <sup>72</sup> O'Loughin, Maximova, Tan & Gray-Donald, 2007.
- <sup>73</sup> Galabuzi, 2005.
- <sup>74</sup> Walks & Bourne, 2006.
- <sup>75</sup> Steele, Glazier & Lin, 2006.
- <sup>76</sup> Statistics Canada, 2009
- <sup>77</sup> Ibid.
- <sup>78</sup> Ibid.
- <sup>79</sup> Ibid.
- <sup>80</sup> With the Inclusive Definition of Francophone (IDF) this figure stands at approximately 2.2% using numbers put together by the Health Analytics Branch (32,379). The IDF is mother-tongue and first official language, so includes many immigrants otherwise not counted when only the mother tongue definition is used.
- <sup>81</sup> Statistics Canada, 2009.
- <sup>82</sup> Ibid.
- <sup>83</sup> Ibid.
- <sup>84</sup> Statistics Canada, 2001.
- <sup>85</sup> Ibid.
- <sup>86</sup> Statistics Canada, 2003.
- <sup>87</sup> CE LHIN, 2006.
- <sup>88</sup> Ibid.
- <sup>89</sup> CAMH, 2009.
- <sup>90</sup> Sarnocinksa & Stike, 2008.
- <sup>91</sup> Heterosexism is a form of discrimination in which preference is shown for people who are heterosexual.
- <sup>92</sup> Ableism is a form of discrimination in which preference is shown for people who appear able-bodied.
- <sup>93</sup> E.g., Chinese yin/yang imbalance of forces.
- <sup>94</sup> Whitehead, 1990.
- <sup>95</sup> Health Canada, 1998.

- <sup>96</sup> Health Disparities Task Group, 2005.  
<sup>97</sup> LaVeist, Gaskin & Richard, 2009.  
<sup>98</sup> Ibid.  
<sup>99</sup> Central East LHIN, 2006.  
<sup>100</sup> See James, Bourgeois & Shannon, 2005.  
<sup>101</sup> Banks & Conwell, 2009.  
<sup>102</sup> Pines, Localio & Hollander, 2009.  
<sup>103</sup> Shiller & Bierman, 2009.  
<sup>104</sup> Ibid.  
<sup>105</sup> Central East LHIN, 2009.  
<sup>106</sup> GTA Diversity and LHINs Working Group, 2008a.  
<sup>107</sup> The role of the Health Equity Health Interest Network (HEHIN) is the same as other health interest networks (e.g., Seamless Care for Seniors) which are expert tables which advise the Central East LHIN directly on its priority initiatives and activities.  
<sup>108</sup> See also Toronto Central LHIN recommendations: Gardner.  
<sup>109</sup> Not linked to client health records.  
<sup>110</sup> See also Toronto Central LHIN: Gardner

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