



Health System Approaches to Promoting Health Equity: A Discussion Paper

Submitted to the “Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention” Project Steering Committee, Provincial Health Services Authority

August 2010

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EXECUTIVE SUMMARY

The health system plays a vital role in promoting and maintaining the health and well-being of British Columbians. However, everyone does not benefit equally from the services that are provided by the Regional Health Authorities (RHA) and the Provincial Health Services Authority (PHSA) Agencies. Individuals with low incomes, women from rural and remote areas of the province, and cultural and linguistic minorities experience substantial difficulties in accessing health services that meet their needs. These inequities in service design and delivery have contributed to health disparities.

More than simply removing geographic or financial barriers to accessing health services, public health professionals are highlighting the need to take a health system approach to addressing health inequities. This approach requires that equity be a central concern at every level of the health system. However, there is a dearth of information on system-level strategies or interventions that have been effective at reducing inequities in access to, and utilization of, health services.

The purpose of this report is to contribute to a productive and informed dialogue among members of the “*Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention*” project. Specifically, this discussion paper will provide background information on how equity within the health system is being conceptualized and insight into how other jurisdictions are taking a health system approach to reduce health inequities among underserved populations.

Health Systems and Health Inequities

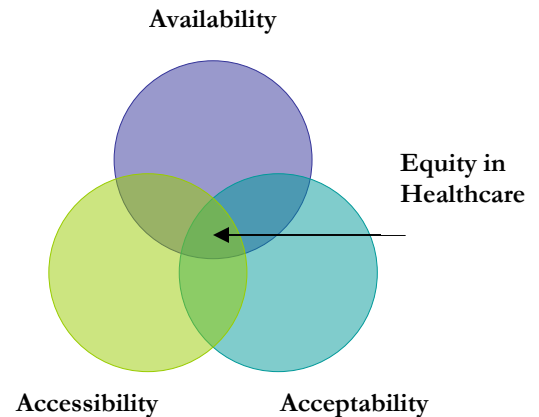
Equity in health care refers to the distribution of health resources such that they are allocated proportionately to need as well as the provision of services that meet the values and cultural beliefs of distinct system users. There are two main ways in which the health system may be inadvertently creating or perpetuating health inequities: through the design and delivery of health services and the focus on acute care over primary health care.

The ways in which the health system is designed and administered have important implications for the extent to which different populations are able to access and navigate health services and, ultimately, health disparities between groups. Three dimensions of equity in health care have been identified in the literature:

- **Availability of Services:** Availability refers to whether services are provided to communities. This dimension of equity is typically discussed in the context of rural British Columbia, as the lack of primary care physicians and other services has been identified as a key contributor to health disparities.
- **Accessibility of Services:** Accessibility refers to the extent to which the health system is designed to meet the needs of health system users as well as the level of openness to the participation of underserved groups in the planning and evaluation of those services. Health literacy, the extent to which individuals are able to access and understand information, is an important component of accessibility. When information or services are not provided in languages other than English, some individuals may be less able to access needed care.

- **Acceptability of Services:** Acceptability, or patient-centered care, refers to whether services are provided in such a way that they meet the needs of distinct cultural, social and ethnic groups. The provision of culturally competent services and creation of culturally safe spaces are key components of the acceptability of services.

When programs or services are not available, accessible, or acceptable to all British Columbians, there is an increased likelihood that certain groups will experience difficulties in obtaining needed care, “receive less care or a lower standard of care, experience different treatment by health care providers, or receive treatment that does not adequately meet their needs” (Bowen, 2001; p. 7). Underserved populations are, therefore, at an increased risk of experiencing poorer health outcomes than the general population, resulting in health inequities.



The health system’s focus on acute care over primary health care may also contribute to health inequities by limiting capacity and interest in the provision of community-based primary health care. In addition to health promotion, disease prevention and curative services, primary health care involves “all related sectors and aspects of national and community development” (WHO, 1978; p. 2). Community-based primary health care programs are an essential component of promoting more equitable health outcomes.

Frameworks for Understanding Equity and Health Systems

Frameworks have important implications for how issues are understood, what type of analysis is conducted and the solutions proposed. This report has identified two frameworks as useful models on which the *Reducing Health Inequities* project members may wish to base their work. These frameworks illustrate the ways in which a health system can promote health equity:

- **The WHO Health System Framework:** This framework identifies the elements of a functioning health system and highlights the importance of strengthening the linkages, relationships, and interactions among sub-systems. This model highlights the need to think beyond service delivery when promoting equity within the health system.
- **The Toronto-Central LHIN Health Equity Framework:** This framework provides a practical approach to addressing inequities from a health systems perspective. In the short-term, this framework argues for targeted interventions and the promotion of equity within the delivery of current services. In the longer-term, this model identifies the importance of system transformation which situates primary health care and primary prevention as central components of the system.

Tools for Promoting Equity within Health Systems

Current efforts to promote equity within the health system have been limited to the creation of tools that assess the impact of a particular program or service on equity. An overview of three tools that have been developed to create a more equitable health system is provided:

- **Health Equity Plans:** The purpose of these plans is to identify promising practices and potential areas of collaboration. The plan template focuses on five distinct thematic areas such as access, priority setting and planning. Importantly, health equity plans build on current successes within the system and raise awareness about health equity and the social determinants of health.
- **Health Equity Impact Assessments:** This tool provides a mechanism for considering the cumulative effect of a program or policy on the health outcomes of underserved groups. Although typically used during program planning, it can also be employed to conduct retrospective analyses. There are six steps which include: screening, scoping, impact identification, assessing the impacts, developing recommendations, and monitoring and evaluation.
- **The Equity Triangle:** This population health promotion tool focuses on three dimensions of inequity in health care: inequality of access, inequality of opportunity and inequality of impacts and outcomes. What is unique about this tool is that it focuses on upstream factors that may affect health equity and provides a myriad of questions that health stewards can use to interrogate the ways in which their program or service may be inadvertently perpetuating inequities.

Health Systems Approaches to Promoting Health Equity

Although the challenges faced by health systems will vary, it is important to learn from the experiences of others. Two international examples of health system approaches to addressing health inequities are presented:

- **Health Inequalities Intervention Toolkit:** This web-based tool provides decision-makers in Primary Care Trusts and Health Authorities in the United Kingdom with local-level data to evaluate the effect of interventions on inequities in infant mortality and all-cause mortality.
- **Establishing Best Practices in the Netherlands:** Led by the Ministry of Health, programs to address socioeconomic and health inequities were implemented and evaluated. Not only did this succeed in collecting local-level data, but evidence-based practices that showed effectiveness in targeting the factors known to produce social and health inequities were established.

In addition to gathering information on international initiatives, conversations were also held with key informants from several programs and projects within RHAs and PHSA Agencies that are working to address health inequities. The purpose of these discussions was to explore how local initiatives are addressing health inequities. Main themes that emerged from these discussions include:

- **Community Development:** Many of these programs employed a community development approach to health, which involves capacity building at an individual and organization level as well as the formation of intersectoral partnerships.
- **Reducing Systems Barriers:** Other programs were directly addressing structural barriers within the health system that inadvertently create inequities in access to, and utilization of, health services.

There were also challenges identified by the key informants to addressing health inequities, including the significant amount of time and energy required to build collaborative relationships combined with difficulty in measuring this process using traditional quantitative evaluation frameworks.

Recommendations for a Health System Response to Health Inequities in BC

Based on the above information, the following recommendations are proposed for how the health system in British Columbia can respond to health inequities:

- Create a provincial vision of health equity, establish targets and develop a provincial strategy for achieving them.
- Encourage health authorities to develop their own health equity targets and plans.
- Develop health equity indicators and build on current initiatives that are collecting local-level data.
- When analyzing data, ensure that it is disaggregated based on categories of social difference.
- Incorporate equity tools into the design, implementation and evaluation of ongoing programs and activities, as well as new initiatives.
- Provide ongoing training opportunities for staff in the area of cultural competency and work to improve health literacy among underserved groups.
- Invest in community-based primary health care. Engage community stakeholders in the development, implementation and evaluation of these programs.

INTRODUCTION

That there are inequities in health status and access to care among British Columbians has been well documented. Adults and children who are homeless or food insecure are more likely to suffer from poor health; individuals from lower income households are more likely to report a chronic disease such as diabetes or cancer; and, ethnic minorities encounter substantial difficulties in accessing culturally competent care (BC Provincial Health Officer, 2009; Bowen, 2001; Health Officer's Council of BC, 2008; Statistics Canada, 2005).

The World Health Organization's Commission on the Social Determinants of Health (2008) has called for a renewed commitment to improving the conditions in which individuals live and has identified the reduction of inequities in power, money, and resources as a key component of achieving greater health equity among populations. Within the Canadian context, the Chief Public Health Officer of Canada (2008) and the Health Officer's Council of BC (2008) have highlighted the need to address social and health inequities by ensuring greater income and food security, providing affordable housing, and promoting early childhood development.

There is increasing evidence which suggests that the health system also has an important role to play in achieving more equitable health outcomes for populations (Barr, 2009b; Bowen, 2001; Gilson et al., 2007). More than simply removing the financial and geographic barriers to accessing and utilizing health care services, researchers and public health professionals are emphasizing the need for health systems to provide culturally competent and inclusive care that is responsive to the needs of diverse groups (Betancourt, 2006; Registered Nurses Association of Ontario, 2007).

Because the health system consists of a myriad of activities and services designed to prevent disease and promote health, it can be daunting to develop effective system-level interventions that will reduce health inequities. Moreover, there is a dearth of information on specific strategies that have been implemented or evaluated (Bambra et al., 2010; Barr, 2009a). Despite these challenges, it is imperative that the health system begin to identify promising practices in the area of health equity and act on what is already known; not only do social and health inequities represent an important social justice issue but they account for a substantial portion of direct and indirect health care costs (Health Disparities Task Group, 2004; LaVeist, Gaskin, & Richard, 2009).

The Centre for Chronic Disease Prevention in the Provincial Health Services Authority (PHSA) has recognized the need to examine and address issues within the health system that may give rise to health inequities. The "*Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention*" Project, which engages stakeholders from across health authorities, government ministries, and other agencies, is working to foster dialogue on health inequities and develop a strategy for use by PHSA Agencies and Regional Health Authorities (RHAs) to reduce the burden of chronic disease borne by the most underserved members of our society.

GOAL AND OBJECTIVES

This goal of this report is to contribute to a productive and informed dialogue among members of the Reducing Health Inequities Project on the ways in which health systems can respond to health inequities. In so doing, it is hoped that this paper will provide meaningful information that will assist in the development of an effective strategy to reduce inequities in the prevalence of chronic diseases within British Columbia.

Specifically, the objectives of this literature review are to:

- Review evidence on the connection between the delivery of health services and health inequities.
- Identify and summarize key conceptual frameworks for understanding how the health system can promote health equity.
- Identify tools that have been developed for use by health systems to promote health equity.
- Review initiatives, interventions and health systems approaches that have been implemented in other jurisdictions that may contribute to the promotion of health equity.

METHOD

Focusing on information from industrialized countries, a search of two academic databases (PubMed and Web of Knowledge) was conducted in March 2010. Additional material was obtained by browsing the websites of relevant organizations (e.g., World Health Organization) for grey literature and through requests for information from members of the Reducing Health Inequities Project Advisory Group. Reference lists were hand searched to further identify key sources.

In addition to searches for formal reports and articles, information on several innovative programs that promote health equity and are funded or operated by a RHA or PHSA Agency was also gathered. Program recommendations were requested from the project's Advisory Group members and, ultimately, nine key informants were contacted (see Appendix A for a list of key informants). One-page program/project summaries were drafted using information garnered from phone conversations and each description was provided to the relevant key informant for approval.

LIMITATIONS OF THE AVAILABLE EVIDENCE

There are several Canadian and international reports that discuss health equity and the social determinants of health as well as a growing body of academic research that has explored the impact of the health system on social and health inequities. Although several governments internationally have developed targets and strategies for promoting equity in health care, few jurisdictions have published documents outlining the policies or programs that have been implemented to address inequities. Those interventions that have been implemented and published have typically focused on individual programmatic responses aimed at specific

diseases or particular populations, while efforts to effect broader health system transformation or to target the social determinants of health have been lacking.

Indeed, it is challenging to implement health systems interventions that target the macroeconomic and structural factors that affect utilization of the health system and health status disparities among underserved populations (Bambra et al., 2010). Such large-scale interventions often require multiple interrelated and complementary initiatives implemented in whole, or in part, through other sectors; yet, limited research has been conducted on how to support effective intersectoral collaboration (Collins & Hayes, 2007; Canadian Institutes of Health Research, 2009). Also problematic is the paucity of evaluation conducted on the impact programs and policies have had on redressing social and health inequities. Consequently, there are substantial gaps in our understanding of the ways in which health systems can effectively promote health equity.

Other factors that affect the quality and availability of evidence:

- There is a lack of data and indicators to track and measure health disparities and inequalities in access to health services.
- Policy and program interventions may not have a measureable impact on health status for many years, limiting political will to continue funding or implementing such initiatives.
- Populations may respond differently to the same intervention, complicating efforts to apply lessons learned and promising practices in new contexts.
- There is limited evidence on the cost-effectiveness of health systems initiatives to reduce health inequities or the costs associated with maintaining the status quo.

Nevertheless, there are several local, national, and international initiatives that are taking a health system approach to reducing health inequities, most notably in Toronto, the Netherlands, and the United Kingdom. The information presented below represents a synthesis of the knowledge on how the health system contributes to health inequities and what it can do to better address the needs of underserved populations.

KEY TERMS USED IN THIS REPORT

It is important to clearly distinguish what is meant by the terms used in this report. Below are definitions of the key terms that will be used:

Equity in health care: Health care resources are allocated to groups proportionately to their need. Groups can access these resources in a manner that reflects their cultural and linguistic backgrounds.

Health equity: Refers to the elimination of the social, economic and environmental factors that produce inequitable health outcomes among groups.

Health disparities:	Differences in health status between groups. This term is used interchangeably with health inequalities.
Health inequities:	Differences in health status between groups which are deemed to be unfair or unjust.
Health system:	Any program under the purview of a RHA or PHSA Agency that is responsible for hospital- and community-based health services, public health surveillance, health promotion or disease prevention. ¹
Underserved populations:	Groups of individuals who, due to financial, cultural, language or other barriers, do not receive enough or appropriate health services.

THE LINK BETWEEN THE HEALTH SYSTEM AND HEALTH INEQUITIES

The health system plays a vital role in promoting and maintaining the health and well-being of British Columbians. Statistics Canada (2006) reported that approximately 80% of the Canadian population visited a family physician in 2005 and, in general, were satisfied with the quality and timeliness of the care that they received. Not only do individuals seek clinical health services through Canada's publically-funded health system, they benefit from a wide range of programs that prevent disease and promote health (Chief Public Health Officer of Canada, 2008).

From smoking cessation and food security initiatives to childhood immunizations and day programs for seniors, the RHAs and PHSA Agencies have developed a cadre of services that are designed to meet the social, physical and mental health needs of the population. While these programs have contributed to improvements in the quality of life and overall health status of a majority of British Columbians, there remain substantial challenges in designing and delivering health services in a way that meets the needs of all segments of the population. Researchers have defined equity within the health system as *equal access* to health care for people with *equal need* as well as equity in the delivery of services, such that they meet the needs, values, and cultural beliefs of all health systems users (Hopkins, 2009; Waters, 2000). Thus, equity in health refers to both the type and amount of services that are provided to diverse users.

Based on the literature, there are two main ways in which the health system may be contributing to health inequities:

¹ Although definitions of the health system are typically much broader and include the full spectrum of government and non-governmental programs and services that address health, this paper will use a more narrow definition of a health system. Due to the scope of the Reducing Health Inequities Project, whose goal is to develop a strategy for implementation within PHSA Agencies and RHAs, this report will focus on the system of health services that are provided by the Health Authorities within British Columbia.

- The design and delivery of programs including the availability, accessibility and acceptability of care for distinct population sub-groups.
- The focus on acute care rather than primary health care.

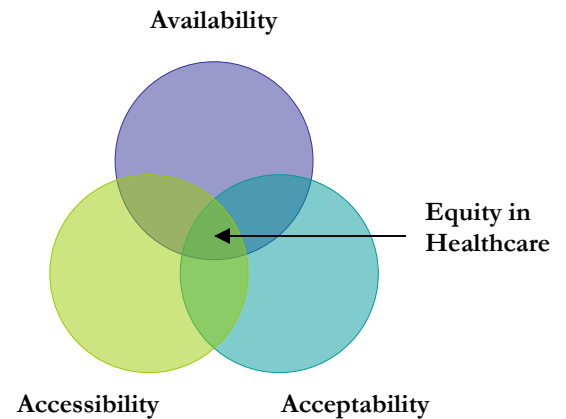
It should be noted that an extensive body of literature exists which examines equity and health systems (see Whitehead, 1992; Williams & Cookson, 2000). Provided below is a broad overview of basic concepts related to equity and health systems as well as evidence linking health service delivery and health inequities within Canada and, whenever possible, British Columbia.

Availability, Accessibility, and Acceptability of Health Services

The design and delivery of the health system has a substantial impact on the extent to which individuals are able to access, navigate and utilize health services and, ultimately, on health disparities between groups.

Availability: Availability refers to whether services are provided. For individuals from rural British Columbia, the availability of health services has been identified as a key barrier to accessing timely and appropriate diagnostic and treatment services. The number of family physicians practicing in rural areas across Canada has been declining steadily since 1991 and more than 30% of rural residents now live over an hour away from the closest family physician (Laurent, 2002). Mental health and addictions programs are often unavailable in rural communities, as are obstetrics, gynecological and maternity services (Ryan-Nicholls & Haggarty, 2007; Society of Obstetrics and Gynecologists of Canada, 2008). Even in urban centers, certain services may not be available due to long waiting lists or because they are not covered under Medicare.

Accessibility: Accessibility refers to the extent to which the health system is designed to meet the needs of health system users as well as the level of openness to the participation of underserved groups in the planning and evaluation of those services (Bowen, 2001). Issues associated with gender, ethnicity, language, literacy, and geography have a substantial impact on the accessibility of health services and the extent to which individuals are able to navigate the health system (Baum et al., 2009). Moreover, the difficulty an individual experiences is often compounded by membership in a number of categories of social difference at multiple levels (Hankivsky et al., 2010). For example, ethnic minority women have reported significant unmet health needs due to language issues and discomfort with male health care providers (Sharif, Dar, & Amaratunga, 2000). Importantly, these barriers can result in limited access not only to treatment, but to diagnostic services as well as health promotion and disease prevention programs.



Health literacy, the extent to which individuals are able to access and understand health information and services, is an important dimension of accessibility (Rootman & Gordon-El-Bihbety, 2008). The failure to provide health information in languages other than English and French, the use of jargon or advanced vocabulary, the provision of information predominantly through web-based media rather than paper format, as well as the complexity of the Canadian health system can present barriers for many individuals (Canadian Public Health Association, 2006). Health literacy has implications for an individual's awareness of service availability, his or her understanding of care regimens and ability to navigate the health system to acquire services along the continuum of care.

Unfortunately, socioeconomic status is an increasingly important component of access to health services within Canada. With the integration of public-private partnerships within the health care system, there is mounting concern that universal coverage may be eroding. Proponents of privatization point to long wait times for surgeries, diagnostic procedures, and specialists, and suggest that, by allowing citizens who can pay to access services through private clinics, wait times will be reduced and the quality and efficiency of care that Canadians as a whole receive will improve (Angell, 2008). However, health care provided through private hospital operators has been shown to be less efficient and to be of a lower quality than that provided by hospitals in a well-funded publically-run system (Woolhandler & Himmelstein, 2007). Moreover, evidence from the United States suggests that privatization does not reduce wait times, it simply changes who is waiting (Angell, 2008). Inevitably, those individuals waiting longer for services will be those people who are unable to purchase private insurance and who have fewer options under this system.

Examples of the ways in which health services may be structured that reduces accessibility include:

- Communication barriers may result in patients being unaware that they can access health promotion or disease prevention programs.
- Services may only be provided during business hours, making them inaccessible to individuals who do not have flexible jobs that allow them to leave for medical appointments.
- Limited funding necessitating user fees for health promotion activities such as day programs and support groups.

Acceptability: Acceptability refers to the extent to which services are provided in a way that meets the needs of distinct social, cultural, and linguistic groups. More than simply an awareness of cultural differences, cultural competency relates to a set of “behaviours, attitudes, and policies that come together in a system, agency, or among professionals” that enables effective service delivery in cross-cultural situations (National Health and Medical Research Council, 2005; pg. 7). When cultural issues are not considered and included within the design and delivery of the health system, health care providers may fail to screen for conditions that have a higher prevalence among certain minority groups, discount knowledge about traditional remedies leading to negative drug interactions, and misdiagnose an individual due to differing interpretations of symptoms and disease (Brach & Fraserirector, 2000).

While acceptability of services is typically discussed in the context of cultural and ethnic groups, it is also relevant to the provision of care to women, older adults, the lesbian, gay, and transgendered community, as well as those individuals who have disabilities or strong religious beliefs. These groups may experience discriminatory practices in the form of overgeneralizations and explanations that evoke notions of culture, gender, or sexuality to explain behaviours or disease outcomes (Koehn, 2009). Experiences of discrimination and ‘othering’ can result in aspects of program delivery being unacceptable to an individual, decreasing the likelihood that he or she will access services in the future.

Examples of how the health system may provide services that are unacceptable to individuals:

- Health care providers may be unfamiliar with a patient’s traditional health practices and beliefs, which may affect the patient’s willingness to access mainstream health services for fear of discrimination or stigma.
- Spaces in which health care is provided may not be designed in such a way as to accommodate additional family members during appointments. The inability to include family members in health appointments may reduce the acceptability of the service.

When programs within a health system are not accessible, acceptable, or available to certain sub-populations, there is an increased likelihood that these groups will experience difficulties in obtaining needed care, “receive less care or a lower standard of care, experience different treatment by health care providers, or receive treatment that does not adequately meet their needs” (Bowen, 2001; p. 7). Underserved populations are, therefore, at an increased risk of experiencing poorer health outcomes than the general population, resulting in health inequities.

Focus on Acute Care over Primary Health Care

The provision of effective primary health care is essential to reducing health inequities. However, the health system’s predominant focus on acute care can limit capacity and interest in providing community-based primary health care services. Primary health care, as defined at Alma-Ata, includes health promotion, disease prevention, curative, and rehabilitative services (WHO, 1978). It involves “all related sectors and aspects of national and community development” (p.2) and the inclusion of local community members in the planning and implementation of health services (WHO, 1978).

In a review of evidence on the effects of primary care on health, Starfield, Shi and Macinko (2005) found that countries whose health systems emphasized primary care over acute care had more equitable health outcomes. The authors also noted that primary care increases access to health services for underserved populations, provides more comprehensive prevention programs, and greater continuity of care (Barr, 2009a; Starfield, Shi, & Macinko, 2005). Although primary care is not identical to primary health care, these findings point to the importance of community-based health services that focus on prevention as a key component of improving health inequities.

In addition to addressing the needs of individuals and their families, primary health care responds to the structural factors that differentially expose certain groups to unhealthy conditions. Gilson et al. (2007) note that when the health system neglects to “address the circumstances of social disadvantaged and marginalized populations, including women, the poor and other groups excluded through stigma and discrimination” (p. viii), health systems fail to realize their full potential in promoting health equity. While the health system cannot solve poverty or homelessness on its own, it can advocate for action on the social determinants of health (Gardner, 2008). Community-based primary health care, which collaborates with organizations that address the social determinants of health, is an essential component of promoting more equitable health outcomes and creating a health system that responds to upstream factors (Baum et al., 2009). In addition, community action which succeeds in effecting changes in policies can have an enormous and sustained impact on social and health equity for underserved populations, yet providing support to advocacy initiatives and the building of intersectoral partnerships to combat social inequities are often lacking within health systems.

FRAMEWORKS FOR UNDERSTANDING EQUITY AND HEALTH SYSTEMS

In order to address the challenges associated with promoting greater equity in health care, it is necessary to identify theoretical frameworks that illustrate the key components of equity within the context of the health system (WHO Task Force on Research Priorities for Equity in Health & the WHO Equity Team, 2005). Theoretical frameworks have important implications for the types of questions that are asked, the analysis conducted, the conclusions drawn and solutions that are proposed (Krieger et al., 2010). Unfortunately, very few conceptual frameworks have been developed which illustrate the ways in which the health system can think about equity and create more equitable systems and health outcomes for underserved populations.

This report will propose two frameworks as useful models on which the Reducing Health Inequities Project may wish to base their work in this area. These are:

- The WHO Health System Framework, published by the Alliance for Health Policy and Systems Research in the World Health Organization (2009).
- Toronto-Central Local Health Integration Network (LHIN) Health Equity Framework (Gardner, 2008).

The WHO Health System Framework

The WHO Health System Framework highlights the need for health systems to take a systems-oriented approach to promote optimal health outcomes, especially in regard to equity, effectiveness and the social determinants of health. Noting that the health system is a complex and dynamic entity with components that are intimately connected and highly sensitive to change, the WHO argues that it is imperative that initiatives designed to promote health equity be cognoscente of the linkages, relationships, and interactions among the elements of the system. Although the WHO (2007) defines the health system broadly as “all organizations, people and actions whose primary intent is to promote, restore or

maintain health” (p. 2), and has developed this framework for use in developing countries, it is still relevant for conceptualizing the complexity of the health system within developed countries as well.

The Health System Framework describes six sub-systems that interact and are mutually reinforcing. These include service delivery, the health workforce, health information, medical technologies, health financing, and leadership and governance.

- **Service Delivery:** Refers to the ways in which services are designed, delivered and managed in order to ensure access, quality, safety and continuity of care.
- **Health Workforce:** Refers to the people engaged in the health system whose primary purpose is to promote the health and well-being of system users.
- **Health Information:** Encompasses the production, analysis, dissemination and use of information on the social and biological determinants of health, health status disparities, and health systems performance.
- **Medical Products, Vaccines, and Technologies:** Refers to the equitable access to medical technologies that are safe and effective.
- **Health Financing:** Refers to the provision of adequate funding such that all individuals have access to appropriate and acceptable health services without fear of financial ruin.
- **Leadership and Governance:** Refers to the need for effective oversight, partnership building and accountability.

Noting that the relationships, interdependencies, and interactions among these sub-systems are what constitutes a functioning health system (not simply the sub-systems in isolation), interventions designed to promote equity must strengthen and evaluate each of these domains as well as the interrelationships between them. At the centre of this model are people, both as beneficiaries of the health system as well as actors within it. This model highlights the need to include members of the public, non-profit organizations and other stakeholders as participants in influencing the direction of each of the health system building blocks.



The WHO Health System Framework is valuable because it encourages health stewards, researchers and decision-makers that are seeking to promote equity to expand the focus beyond the design and delivery of health services to include other aspects of the health system as well. Moreover, this framework directs attention to the need for partnership building across sub-systems as well as with agencies and organizations in other systems, such

as community and social services, education, and government, who may have responsibilities for the social determinants of health.

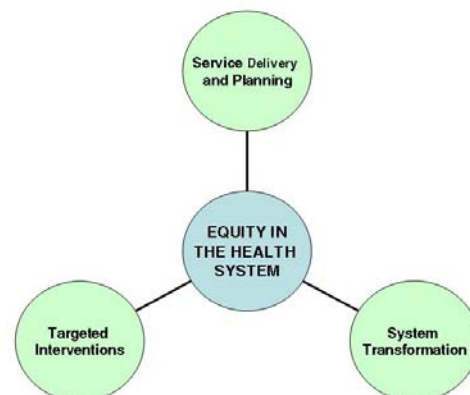
The Toronto-Central LHIN Health Equity Framework

The LHIN Health Equity Framework is based on the belief that the health system has a responsibility to contribute to the reduction of social and health inequities. It highlights the need for health systems to identify health equity as an explicit strategic priority and to embed equity into all service delivery and planning initiatives. While building on current successes within the health system, the framework calls for an incremental and iterative process in which programs and projects are piloted, evaluated, and adapted or ‘scaled up.’ This framework places an emphasis on clear targets to drive action as well as indicators to measure whether services have been effective at reducing health inequities.

The Health Equity Framework identifies three key areas for action:

- **Service Delivery and Planning:** Ensure that equity is built into the planning process and delivery of all health services.
 - Ensure that populations participate in the design and evaluation of health services.
 - Develop clear expectations surrounding equity-related goals for programs and health service providers.
 - Develop clear indicators that can provide feedback on progress towards more equitable service delivery and health outcomes goals.
- **Targeted Interventions:** Concentrate resources and programs on groups that face substantial social and health inequities.
 - Increase the amount and type of multi-disciplinary services among populations that face disadvantage and discrimination.
- **System Transformation:** Build equity into health system reforms such that equity, in addition to the efficiency, sustainability, and quality of care, becomes a fundamental concern of decision-makers.
 - Situate primary health care reform as a priority and enhance primary prevention activities.
 - Address the wider social determinants of health through intersectoral partnerships.
 - Develop mechanisms for the collection and reporting of equity-related data and conduct equity-relevant research.

This framework is useful because it provides a pragmatic and practical approach to incorporating equity into health systems. It advocates for the inclusion of equity concerns at every level of the health system, from an



individual programmatic-level through to the broader system design. It recognizes that system-change is a complex and challenging process, one that requires significant coordinated action and support. Moreover, this framework acknowledges that although the health system does not have direct control over many of the social determinants of health, it can and should build partnerships with community and non-profit agencies to support advocacy initiatives.

Taken together, the WHO Health System Framework and the LHIN Health Equity Framework provide complementary perspectives on health systems approach to increasing health equity. A health systems approach involves addressing all aspects of the health system from human resources and information technology through to programs and services. While the WHO defines the individual elements of the health system and draws our attention to the importance of building the interrelationships between these sub-systems, the Health Equity Framework focuses on action, strategically identifying the three areas in which health systems can promote health equity in the immediate and long-term.

TOOLS FOR PROMOTING EQUITY WITHIN HEALTH SYSTEMS

Taking a health systems approach to improving health equity requires that ‘equity thinking’ be incorporated into every level of the health system. However, current efforts at developing concrete strategies to address health equity have generally been limited to the creation of tools that assess the impact of programs or services on the health of underserved groups. While these initiatives are valuable, research is also needed which explicates the ways in which health systems can build effective intersectoral partnerships, support advocacy efforts on the social determinants of health, and initiate and sustain constructive dialogue on how the system as a whole can be transformed to promote more equitable access to care and health outcomes.

Below is an overview of three tools that have been developed to create a more equitable health system:

- Health Equity Plan, developed by the Toronto-Central LHIN (2008)
- Equity Focused Health Impact Assessment, published by the Australasian Collaboration for Health Equity Impact Assessment (Mahoney et al., 2004)
- The Equity Triangle, published by the Victorian Health Promotion Foundation (2008)

As noted above, these tools are meant to be used as part of an overall approach to the promotion of health equity and not as a standalone strategy. Although time and resource intensive, these tools have been found to be useful in a variety of international contexts (for example, New Zealand: Signal, Martin, Cram, & Robson, 2008). Importantly, each tool may not be appropriate for promoting equity in every context and analyses may be most effective when tools are used in conjunction with each other.

Health Equity Plans

Health Equity Plans are an initiative of the Toronto-Central Local Health Integration Network (LHIN). Based on a vision to “create and sustain a health care system where all residents have equitable access to a full range of high quality health care and support, and systematic and avoidable health disparities are steadily reduced” (Gardner, 2008; p. 3), Toronto-area hospitals have been asked to develop plans that explicitly focus on the reduction of health inequities. The purpose of these plans is to identify promising practices and potential areas for collaboration within and between LHINs; provide a guide for the development of equity plans within community-based health services; and to identify LHIN-wide data support and analysis needs and opportunities.

Health equity plans have significant potential to raise awareness about health equity and the social determinants of health. They also highlight the importance of taking a health systems approach to reducing health inequities. The plan template focuses on five distinct thematic areas including access, priority setting and planning, promising practices, policies, procedures and standards, governance, and communications (see Appendix B for a complete health equity plan template). Some questions that hospitals are asked to address, include:

- How do your hospital utilization patterns compare to the profile of who lives in your catchment?
- What major inequities exist in regards to the social determinants of health among your patient/client populations?
- Are there any specific health equity gaps and challenges that require greater attention at your hospital?

Importantly, health equity plans also build on current successes within the health system as the plans ask health stewards to consider how and in which ways programs provide culturally competent care and highlight current initiatives that are working to reduce barriers to access. In addition, the plans outline specific data collection needs that would allow the health service to better identify and monitor health inequities within their catchment area.

While the development of health equity plans has currently been limited to hospitals, they have a wide applicability and could be implemented in a number of different settings. Health equity plans are an important tool because they explicitly state the goals for achieving greater equity and outline strategies to reduce inequities in the design and delivery of health services. Importantly, health equity plans can contribute to a shared vision of a more equitable health system and identify opportunities for partnerships.

Health Equity Impact Assessments

While health equity plans are valuable tools for mapping out equity-related goals and the strategies for achieving them, the Health Equity Impact Assessment (HEIA) can be a valuable mechanism for considering the cumulative effect (positive and negative) of a specific policy, program or project on underserved groups. Although HEIA are most useful in the planning stage of program development, they can also be helpful in conducting retrospective analyses of existing policies or programs so that changes in investment and

services can be implemented if necessary (Health Development Agency, 2005; Mahoney et al., 2004).

A number of different groups have developed tools for conducting HEIAs. For example, the Toronto Central LHIN, Wellesley Institute, and Ministry of Health and Long-Term Care in Ontario (2009) have collaboratively developed a workbook for identifying the impacts of inequities in health service delivery and planning. Similarly, the Health Development Agency (2005) in the United Kingdom has published a Health Equity Audit tool for use by primary care trusts, as has the Ministry of Health in New Zealand (Signal, Martin, Cram, & Robson, 2008).

The Australasian Collaboration for Health Equity Impact Assessment has published a comprehensive Equity Focused Health Impact Assessment (EFHIA) framework (Mahoney et al., 2004). The detail in this tool will be particularly useful for individuals who may be unfamiliar with methods for conducting the more general health impact assessment (see a diagram outlining the main steps in conducting an EFHIA in Appendix C). They have identified six main steps in the completion of an EFHIA:

- **Screening:** Determine the suitability of conducting an EFHIA on the policy or program, as well as the feasibility (human resources, time, and money) to complete it.
- **Scoping:** Define the scope of the EFHIA, including the dimensions of equity, definitions of terms, and terms of reference.
- **Impact Identification:** Conduct a detailed analysis of the context in which the policy or program is implemented. Identify the target population(s) and collect data on the relationship between the variable of interest, as well as the potential or actual impacts on different groups.
- **Assess the Impacts:** Synthesize the evidence that has been collected and evaluate the equity of impacts as well as the likelihood of the impacts occurring.
- **Develop Recommendations:** Recommend changes to increase the likelihood of greater health equity.
- **Monitor and Evaluate:** Develop and implement strategies for monitoring the EFHIA recommendations and evaluate the outcomes.

Health Equity Impact Assessments are increasingly being integrated into mainstream planning and service delivery within health systems internationally. However, common challenges associated with the successful initiation and completion of these assessments is the lack of high quality local-level data, limited human resources capacity to carry out such assessments and a lack of organizational support for implementing the recommendations produced (Health Development Agency, 2005). Strong leadership is required for equity-focused health impact assessments to be completed successfully.

The Equity Triangle

The Equity Triangle, developed by the Victorian Health Promotion Foundation in Australia (2008), provides a slightly different angle to assessing the impact of a program on health equity. The equity triangle outlines three key dimensions to service delivery that may affect

health inequities, including inequality of access, inequality of opportunity, and inequality of impacts and outcomes. Although specifically designed for health promotion programs, the equity triangle could be useful for evaluating health programs more generally. The tool outlines a number of prompting questions that health stewards can use to facilitate discussion on these three dimensions (see a copy of the full questionnaire in Appendix D).

- **Inequality of Access:** Refers to the extent to which services are accessible and acceptable to the individuals accessing them.
 - Is there a fee for accessing this service or participating in the program?
 - Is there access to childcare or respite care?
 - In what ways were individuals from the populations served involved in the planning, delivery, participation, and evaluation of the program or service?
 - Have staff members received cultural competency training?
- **Inequality of Opportunity:** Refers to the extent to which individuals have the social, economic, geographic and cultural resources necessary to maintain good health and access the health service.
 - Can individuals access the program or service through public transportation, if necessary?
 - Do individuals have the educational resources necessary to navigate the health system and access needed programs or services?
- **Inequality of Impacts and Outcomes:** Refers to the collection of data so that the impact on health equity can be evaluated. Key indicators suggested in this tool include gender, ethnicity, indigenous status, and disability.
 - Are results compared against data from the local community to determine if there are differential outcomes for distinct subpopulations?

HEALTH SYSTEMS APPROACHES TO PROMOTING HEALTH EQUITY

Health systems vary in their recognition of social and health inequities and the extent to which steps are taken to promote more equitable health outcomes and access to services. Internationally, a number of different strategy documents have been published, highlighting the importance of addressing health inequities through a coordinated health system response. For example, in New Zealand, the Ministry of Health (2002) developed and implemented a national health strategy to reduce inequalities among New Zealanders, with a particular focus on the Maori and low income earners in the population. This framework for action identified the need for all levels of government to work collaboratively on the social, economic, and cultural factors that affect health, in addition to the provision of more established health and disability services. European governments that have developed similar national strategy documents include the United Kingdom, the Netherlands and Norway, to name a few.

In order to successfully implement equity-related initiatives through health systems, Sarah Payne (2009) has outlined the following conditions as being essential:

- The availability of good, high quality data which has been disaggregated based on a number of different categories of social difference such as gender, socioeconomic status, ethnicity, and age.
- Political commitment and ownership of the strategy.
- A strong evaluation framework in place to assess the impact of the strategies and interventions implemented.
- The commitment of sufficient financial and human resources for the long-term.
- High quality and on-going training for individuals involved in developing, implementing and evaluating the strategy.
- Involvement and commitment of key stakeholders at every level of the strategy development, implementation and evaluation.
- Effective stewardship by the ministry or health authority responsible for the strategy

Although the challenges faced by health systems in addressing health inequities will be context specific, there is value in learning from the experiences of others. Below are two examples of international approaches to addressing equity within the health system. These examples have been selected because they represent coordinated system-level approaches to promoting health equity.

- The Health Inequalities Intervention Toolkit from the United Kingdom provides local-level data to assist in identifying where targeted health programs and services may best address prominent health inequities.
- A coordinated plan to establish best practices to tackle health inequalities in the Netherlands exemplifies the importance of a health system approach, one that is based on strong leadership and evidence accumulated, in part, through program evaluation.

Transforming the health system so that primary health care is a central component is crucial to addressing health inequities; however, published initiatives in this area which have also been evaluated were not readily available. This is an important gap in the literature, which should be addressed through investments in research, evaluation as well as knowledge translation and exchange.

In addition to the international examples, several local initiatives that are working to reduce health inequities among underserved populations within RHAs and PHSA Agencies will be highlighted.

Health Inequalities Intervention Toolkit: United Kingdom

In order to support local primary care trusts in reducing health inequities, the Ministry of Health in the United Kingdom, in partnership with the Association of Public Health Observatories, has introduced a Health Inequalities Intervention Toolkit (www.lho.org.uk). The goal of the toolkit is to inform “evidence-based local service planning and commissioning” (Ministry of Health, 2010; pg. 1) so that the objectives of the National

Health Inequalities Public Service Agreement can be achieved. The public service agreement target is to reduce inequalities in infant mortality and life expectancy at birth by 10%.

The toolkit consists of a web-based application to access information on two distinct health equity indicators: life expectancy gaps and infant mortality. The life expectancy tool provides access to tables and charts that outline the causes of death as well as the age groups in which disparities are most pronounced. The infant mortality tool provides an overview of the trends in infant mortality rates as well as the factors that contribute to higher rates among certain populations. Both these tools provide a gap analysis between England as a whole and the Spearhead areas, the local health authorities and primary care trusts that have been identified as falling in the lowest quintile on several key health equity indicators.

In addition, the toolkit includes a mechanism to assist program planners to assess the potential impact of a targeted intervention on the life expectancy of groups that are experiencing substantial health inequities. For example, the tool can calculate the impact of interventions that promote smoking cessation and control high blood sugar, visually illustrating the extent to which such interventions will narrow the gap in life expectancy and all-cause mortality.

As previously noted, the availability of local level data in supporting evidenced-based planning is essential in ensuring that services are delivered in an equitable fashion; yet, many policy analysts, program planners, and decision makers within the health system lack the time or knowledge to collect and analyze epidemiological data. This health systems initiative is particularly innovative because it seeks to ‘mainstream’ equality by actively measuring and tracking trends in health status among underserved groups and providing evidence of the impact of interventions on health status over time (Aspinall & Jacobson, 2006). This can help increase the political will to continue investing in programs and services specifically for underserved populations.

Tackling Health Inequities in the Netherlands

Having recognized the need for a national approach to reduce health inequities, the Netherlands Ministry of Health commissioned the implementation and evaluation of programs targeted at the reduction of socioeconomic disparities that produce inequities in health status and access to health services (Mackenbach, 1994). Although surveillance and monitoring had provided substantial evidence on the nature and extent of social and health inequities in Dutch society, there was limited understanding of the types of responses that would most effectively address them. Thus, the goal was to develop a strong evidence base of programs and policies that targeted the factors known to produce health inequities (Machenbach & Stronks, 2002).

The interventions targeted four distinct areas:

- Socioeconomic disadvantage:
 - Additional benefits were provided to families living in poverty, as identified at their child’s health screening appointment.
- Reducing the effects of health on socioeconomic disadvantage:
 - A counseling program was developed for teenage students who were missing a lot of school classes due to illness.

- Reducing the effects of socioeconomic disadvantage on health:
 - Mass media campaigns were implemented, which promoted folic acid during pregnancy.
 - A program to promote tooth brushing was implemented at schools. This program reduced socioeconomic disparities in tooth brushing among school-aged children.
- Addressing accessibility and quality of health care services
 - Local care networks were established which included a diverse range of social and health service providers, such as family physicians, housing staff and the police. These networks were explicitly targeted at individuals with mental health issues and resulted in a decrease in the number of housing evictions and admissions to psychiatric hospitals among this population.
 - Peer education programs were implemented among individuals in the Turkish community who had diabetes. This program improved glycaemic control and increased healthy living behaviours among women.

Once an initial round of interventions had been evaluated, a committee, reporting to the Minister of Health, considered the evidence and developed a national strategy for the Netherlands. The strategy included concrete targets and recommendations for the implementation of a range of policies and programs targeting upstream and downstream factors. Not only were these programs successful in collecting local-level data, but they also established a cadre of evidence-based practices that showed effectiveness in targeting the factors known to produce social and health inequalities. Moreover, these initiatives fostered a shared understanding of equity and created confidence among decision makers that coordinated action could impact health inequalities in concrete and measurable ways (Machenbach & Stronks, 2002).

Local Examples of Equity Promoting Health Services and Programs

It should be noted that the RHAs and PHSA Agencies have begun to develop programs and services that address inequities in health status and access to care among underserved communities in British Columbia. In an effort to capture some of the innovative programs that are being implemented across the province, key informants from RHAs were contacted to gather information on the successes and challenges associated with designing and implementing programs for underserved populations within the British Columbia context. Below is a summary of key themes that emerged in these conversations. Complete descriptions of the programs, including the challenges and successes in providing appropriate services along the continuum of care to underserved populations, are included in Appendix E.

In discussions with key informants, it quickly became apparent that many of the programs were based on a community development approach to health and involved a substantial investment in building relationships with the communities they were serving. A community development approach to health involves capacity building at an individual and organizational level as well as the formation of intersectoral partnerships (Winnipeg Regional Health Authority, 2007). More than simply consulting community representatives, community development activities empower community members to identify shared health needs and appropriate ways to address them (World Health Organization, 2002). For

example, the SMART Fund, a community health fund administered by the Vancouver Coastal Health Authority, actively builds capacity among grantees through training in designing logic models and developing survey tools to conduct evaluation. In addition, many of the projects they fund are peer-led and peer-supported initiatives. Similarly, the Health Promotion Team in the Interior Health Authority supports advocacy initiatives at the community level by working with social planning bodies and anti-poverty community coalitions to provide a health-related perspective on the impacts of poverty.

Other programs address barriers that inadvertently create inequitable access to, and utilization of, health services. The New Canadian Clinic (NCC) within the Fraser Health Authority provides primary health care services to newly arrived refugees and supplies interpreters for individuals who cannot speak English and arranges for interpretation at specialist appointments. The NCC also takes culture into consideration when providing care by celebrating all major non-Canadian holidays and educating patients about the Canadian culture. Prior to funding cuts, the clinic was also able to provide bus tickets to patients, many of whom were unable to afford to pay for transportation to their appointments. These activities have a positive impact on the ability of refugees to manage chronic diseases, navigate the health system, and respond to mental and physical health crises.

Yet, there were also challenges identified by key informants to providing services in a way that truly meets the needs of underserved communities. The significant amount of time and energy required to build collaborative relationships combined with difficulty in measuring this process using traditional quantitative evaluation frameworks was noted as a key challenge.

Another challenge relates to the limited and sometimes uncertain funding available to community-based projects. Term-limited funding affects the long-term sustainability of programs on which community members come to rely. Uncertain funding can contribute to an experience of fragmentation, and may result in communities being less likely to invest their own energy and resources into new initiatives.

Despite these challenges, the key informants all identified the benefits to individuals, communities, and health systems when programs are designed and implemented in such a way that they respond to the unique needs of diverse groups. Benefits included increased social cohesion and feelings of ownership over health services, better understanding of how to prevent and manage chronic diseases among community members, and the provision of programs that addressed the needs of the communities at which they were targeted.

RECOMMENDATIONS FOR A HEALTH SYSTEM RESPONSE TO HEALTH INEQUITIES IN BC

Based on the above information, the following are recommendations for how the health system in British Columbia could respond to health inequities.

1. Create a vision of health equity for the province, establish targets and develop a provincial strategy for achieving them.

2. Encourage health authorities to develop their own health equity targets and plans.
3. Develop health equity indicators and build on current initiatives that are collecting local-level data. This could be in the form of a provincial-level coordinated data collection and analysis system, or some other mechanism that links decision-makers with the evidence needed for informed policy making.
4. When analyzing data, ensure that it is disaggregated based on gender, ethnicity, socioeconomic status and other relevant categories of social difference.
5. Incorporate equity tools into the design, implementation and evaluation of ongoing programs and activities as well as new initiatives.
6. Provide ongoing training opportunities to staff in the area of cultural competency and work to improve health literacy among underserved groups.
7. Invest in community-based primary health care services. Engage community stakeholders in the development, implementation and evaluation of these programs.

CONCLUSION

A growing body of evidence is explicating the ways in which the health system may inadvertently contribute to the creation and perpetuation of health inequities. Whether by addressing challenges in accessing services or their acceptability to groups with unique cultural and linguistic needs, the health system has an important role to play in promoting health equity. The WHO Health System Framework and the Toronto-Central LHIN Health Equity Framework provide a complementary approach to understanding how health systems can promote health equity. While the WHO Framework draws our attention to the need to consider health system elements beyond service delivery, the LHIN-Health Equity Framework provides a pragmatic and practical approach to incorporating equity into health systems.

Internationally, a number of tools have been developed to evaluate equity within the health system. The three identified in this paper included Equity Plans, Health Equity Impact Assessment, and the Equity Triangle Questionnaire. Although these tools provide an important mechanism for evaluating the impact of services on inequities in health status and equity in health care, there continues to be a need for research that outlines concrete strategies for achieving and sustaining broader system transformation.

Finally, two innovative examples of the ways in which international health systems are responding to health inequities highlighted the need for local-level data collection and the development of a coordinated approach to promoting health equity. Local examples from British Columbia identified community-based participatory approaches to health service provision as being particularly useful in addressing barriers to access and disparities in health status.

REFERENCES

- Angell, M. (2008). Privatization of health care is not the answer: Lessons from the United States. *Canadian Medical Association Journal*, 179(9): 916-919.
- Aspinall, P.J. & Jacobson, B. (2006). *How to Analyse Ethnic Differences in Health, Health Care, and the Workforce: A Toolkit for the NHS*. London, UK: London Health Observatory. Retrieved August 11, 2010 from <http://www.lho.org.uk/Download/Public/10625/1/DH%20TOOLKITSep06.pdf>.
- Bambra, C., Gibson, M., Sowden, A., Knight, K., Whitehead, M., Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: Evidence from systematic reviews. *Journal of Epidemiology and Community Health*, 64:284-291.
- Barr, V. (2009a). *How can the way that Primary Care Services are Structured or Delivered Help to Reduce Health Inequities? A Review of the International Evidence*. Submitted to the BC Ministry of Healthy Living and Sport. Victoria, BC.
- Barr, V. (2009b). *Reducing the Gap: How Primary Care in BC Can Help to Reduce Inequities in Health*. Submitted to the BC Ministry of Healthy Living and Sport. Victoria, BC.
- Baum, F.E., Begin, M., Houweling, T.A.J., & Taylor, S. (2009). Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *Framing Health Matters*, 99(11): 1967-1970.
- BC Provincial Health Officer. (2009). *Pathways to Health and Healing: 2nd Report on the Health and Wellbeing of Aboriginal People in British Columbia*. Provincial Health Officer's Annual Report 2007. Victoria, BC: Ministry of Health Living and Sport.
- Betancourt, J.R. (2006). *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*. New York: The Commonwealth Fund. Retrieved July 13, 2010 from http://www.commonwealthfund.org/usr_doc/Betancourt_improvingqualityachievingequity_961.pdf.
- Bowen, S. (2001). Access to health services for underserved populations in Canada. In "Certain Circumstances": *Issues in Equity and Responsiveness in Access to Health Care in Canada. A Collection of Papers and Reports prepared for Health Canada*. Ottawa, ON: Health Canada.
- Brach, C. & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(Supplement 1):181-217.
- Canadian Institutes for Health Research. (2009). *CIHR Institute of Population and Public Health – Strategic Plan 2009-2014*. Ottawa, ON: Author.

- Canadian Public Health Association. (2006). *Experiences of Adults with Literacy Barriers in the Health System*. Ottawa, ON: Author. Retrieved July 13, 2010 from http://www.cpha.ca/uploads/portals/h-l/barriers_e.pdf.
- Chief Public Health Officer of Canada. (2008). *Report on the State of Public Health in Canada: Addressing Health Inequalities*. Ottawa, ON: Public Health Agency of Canada.
- Collins, P.A. & Hayes, M.V. (2007). Twenty years since Ottawa and Epp: Researchers' reflections on challenges, gains and future prospects for reducing health inequities in Canada. *Health Promotion International*, 22(4): 337-345.
- Gardner, B. (2008). *Health Equity Discussion Paper*. Toronto Central Local Health Integration Network.
- Gilson, L., Doherty, J., Loewenson, R., & Francis, V. (2007). *Challenging Inequity through Health Systems: Final Report Knowledge Network on Health Systems*. WHO Commission on the Social Determinants of Health
- Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). Exploring the promises of Intersectionality for advancing women's health research. *International Journal for Equity in Health*, 9(5):
- Health Development Agency. (2005). *Making the Case: Health Equity Audit*. London, UK: National Health Service. Retrieved July 2, 2010 from <http://www.nice.org.uk/niceMedia/docs/Making%20the%20case-13-03.pdf>.
- Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. (2004). *Reducing Health Disparities – Roles of the Health Sector: Discussion paper*. Ottawa, ON: Minister of Health. Retrieved July 12, 2010 from http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf.
- Health Officer's Council of BC. (2008). *Health Inequities in British Columbia*. Victoria, BC: Public Health Agency of British Columbia. Retrieved June 4, 2010 from
- Hopkins, J. (2009). *Towards a More Equitable Local Health System*. Presentation at "Who are we serving? A workshop on hospital-based strategies to identify health service inequities. April 6, 2009." Toronto, ON.
- Koehn, S. (2009). Negotiating candidacy: Ethnic minority seniors' access to care. *Aging & Society*, 29:585-608.
- Krieger, N., Alegria, M., Almeida-Filho, N., Barbosa de Silva, J., Barretto, M.L., Beckfield, J. et al., (2010). Who, and what, causes health inequities? Reflections on emerging debates from an exploratory Latin American/North American workshop. *Journal of Epidemiology and Community Health*.

- Laurent, S. (2002). *Rural Canada: Access to health care*. (Catalogue No. PRB 02-45E). Ottawa, ON: Library of Parliament.
- LaVeist, T.A., Gaskin, D.J., & Richard, P. (2009). *The Economic Burden of Health Inequalities in the United States*. Washington, DC: The Joint Centre for Political and Economic Studies. Retrieved July 12, 2010 from http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf.
- Machenbach, J.P. (1994). Socioeconomic inequalities in health in the Netherlands: Impact of a five year research programme. *British Medical Journal*, 309:1487-1491.
- Machenbach, J.P. & Stronks, K. (2002). A strategy for tackling health inequalities in the Netherlands. *British Medical Journal*, 325:1029-1032.
- Mahoney, M., Simpson, S., Harris, E., Aldrich, R., & Stewart Williams, J. (2004). *Equity Focused Health Impact Assessment Framework*, the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA). Retrieved June 30, 2010 from http://www.hiaconnect.edu.au/files/EFHIA_Framework.pdf.
- Ministry of Health. (2010). *Health Inequalities Intervention Toolkit*. London, UK: Author. Retrieved July 6, 2010 from http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx.
- Ministry of Health. (2002). *Reducing Inequalities in Health*. Wellington, New Zealand: Author. Retrieved July 5, 2010 from [http://www.moh.govt.nz/moh.nsf/0/523077dddeed012dcc256c550003938b/\\$FILE/ReducIneqal.pdf](http://www.moh.govt.nz/moh.nsf/0/523077dddeed012dcc256c550003938b/$FILE/ReducIneqal.pdf).
- National Medical Research Council. (2005). *Cultural Competency in Health: A Guide for Policy, Partnerships, and Participation*. Canberra, Australia: Australian Government. Retrieved July 14, 2010 from http://www.nhmrc.gov.au/files_nhmrc/file/publications/synopses/hp19.pdf.
- Payne, S. (2009). *How can Gender Equity be Addressed through Health Systems?* Copenhagen, Denmark: World Health Organization on behalf of the European Observatory on Health Systems and Policies. Retrieved July 2, 2010 from http://www.euro.who.int/data/assets/pdf_file/0006/64941/E92846.pdf.
- Pedersen, S., Barr, V., Wortman, J., Rootman, I., & Public Health Association of BC. (2007). *Evidence review: Equity lens. Core Public Health Functions for BC*. Victoria, BC: Population Health and Wellness BC Ministry of Health.
- Rachlis, M. (2008). *Operationalizing Health Equity. How Ontario's Health Services can Contribute to Reducing Health Disparities*. Toronto, ON: Wellesley Institute.

- Registered Nurses' Association of Ontario. (2007). *Embracing Cultural Diversity in Health Care: Developing Cultural Competence*. Toronto, ON: Author. Retrieved July 13, 2010 from http://www.rnao.org/Storage/29/2336_BPG_Embracing_Cultural_Diversity.pdf.
- Rootman, I. & Gordon-El-Bihbety, D. (2008). *Executive Summary. A Vision for a Health Literate Canada: Report of the Expert Panel on Health Literacy*. Ottawa, ON: Canadian Public Health Association. Retrieved July 13, 2010 from http://www.cpha.ca/uploads/portals/h-1/execsum_e.pdf.
- Ryan-Nicholls, K. & Haggarty, J.M. (2007). Collaborative mental health care in rural and isolated Canada. Stakeholder feedback. *Journal of Psychosocial Nursing*, 45(12):37-45.
- Sharif, N.R., Dar, A.A., & Amaratunga, C. (2000). *Ethnicity, Income, and Access to Health Care in the Atlantic*. Halifax, NS: Maritime Centre of Excellence for Women's Health.
- Signal, L., Martin, J., Cram, F., & Robson, B. (2008). *The Health Equity Assessment Tool: A User's Guide*. Wellington, New Zealand: Ministry of Health.
- Society of Obstetrics and Gynecologists of Canada. (2008). *A National Birthing Initiative for Canada*. Ottawa, ON: Author.
- Statistics Canada. (2005). *Canadian Community Health Survey, Cycle 3.1*. Ottawa: Statistics Canada.
- Starfield, B., Shi, Leiyu, & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly*, 83(3):457-502.
- Statistics Canada. (2006). *Access to Health Care Services in Canada*. January to December 2005.
- Toronto Central LHIN, Wellesley Institute, & Ministry of Long-Term Care. (2009). *Workbook: Using the Health Equity Impact Assessment Tool*. Toronto, ON: Authors. Retrieved July 13, 2010 from http://www.torontocentrallhin.on.ca/uploadedFiles/Public_Community/Aging_at_Home/HEIA%20Workbook%20-%20Final%20Version%20-%202009-06-26.doc.
- Victorian Health Promotion Foundation. (2008). *People, Places, Processes: Reducing Health Inequalities through Balanced Health Approaches*. Melbourne, Australia: Author.
- Waters, H.R. (2000). Measuring equity in access to health care. *Social Science & Medicine*, 51:599-612.
- Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services*, 22, 429-445.
- Williams, A., Cookson, R. (2000). Equity in health. In A.J. Culyer, Newhouse, J. (Eds.), *Handbook of health economics*. Amsterdam: Elsevier.

- Winnipeg Regional Health Authority. (2007). *Community Development Framework*. Retrieved July 9, 2010 from http://www.wrha.mb.ca/community/commdev/files/CommDev_Framework_07.pdf.
- Woolhandler, S. & Himmelstein, D.U. (2007). Competition in a publicly funded healthcare system. *British Medical Journal*, 335(7630):1126-1129.
- World Health Organization. (1978). *Declaration of Alma-Ata*. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Retrieved July 15, 2010 from http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.
- World Health Organization. (2002). *Community Participation in Local Health and Sustainable Development. Approaches and Techniques*. Retrieved July 9, 2010 from http://www.euro.who.int/_data/assets/pdf_file/0013/101065/E78652.pdf.
- World Health Organization. (2007). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva, Switzerland: Alliance for Health Policy and Systems Research.
- World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report*. Geneva, Switzerland: WHO Press.
- World Health Organization Task Force on Research Priorities for Equity in Health & the WHO Equity Team. (2005). Priorities for research to take forward the health equity policy agenda. *Bulletin of the World Health Organization*, 83(112).

APPENDIX A. KEY INFORMANTS

The following people were contacted between June and July 2010 in order to gather information on initiatives within the British Columbia RHA or PHSA Agencies that promote or support health equity:

Maylene Fung

Manager, Healthy Living
Vancouver Coastal Health

Ruth Hellerund-Brown

Healthy Living/Health Community
Specialist
Fraser Health Authority

Theresa Hermary

Population Health Facilitator
Interior Health Authority

Ginny Hind

Family Nurse Practitioner
Kla-How-eya Healing Place

Kym Howay

Tobacco Reduction Coordinator
Interior Health Authority

Connie Lapadat

Family Nurse Practitioner, New Canadian
Clinic
Fraser Health Authority

Tracy Steere

Coordinator, Aboriginal Health
Fraser Health Authority

Natasha Robillard

Project Coordinator, Aboriginal Health
Program
Provincial Health Services Authority

Lezlie Wagman

Manager, the SMART Fund
Vancouver Coastal Health

APPENDIX B. TORONTO-CENTRAL LHIN HEALTH EQUITY PLAN TEMPLATE

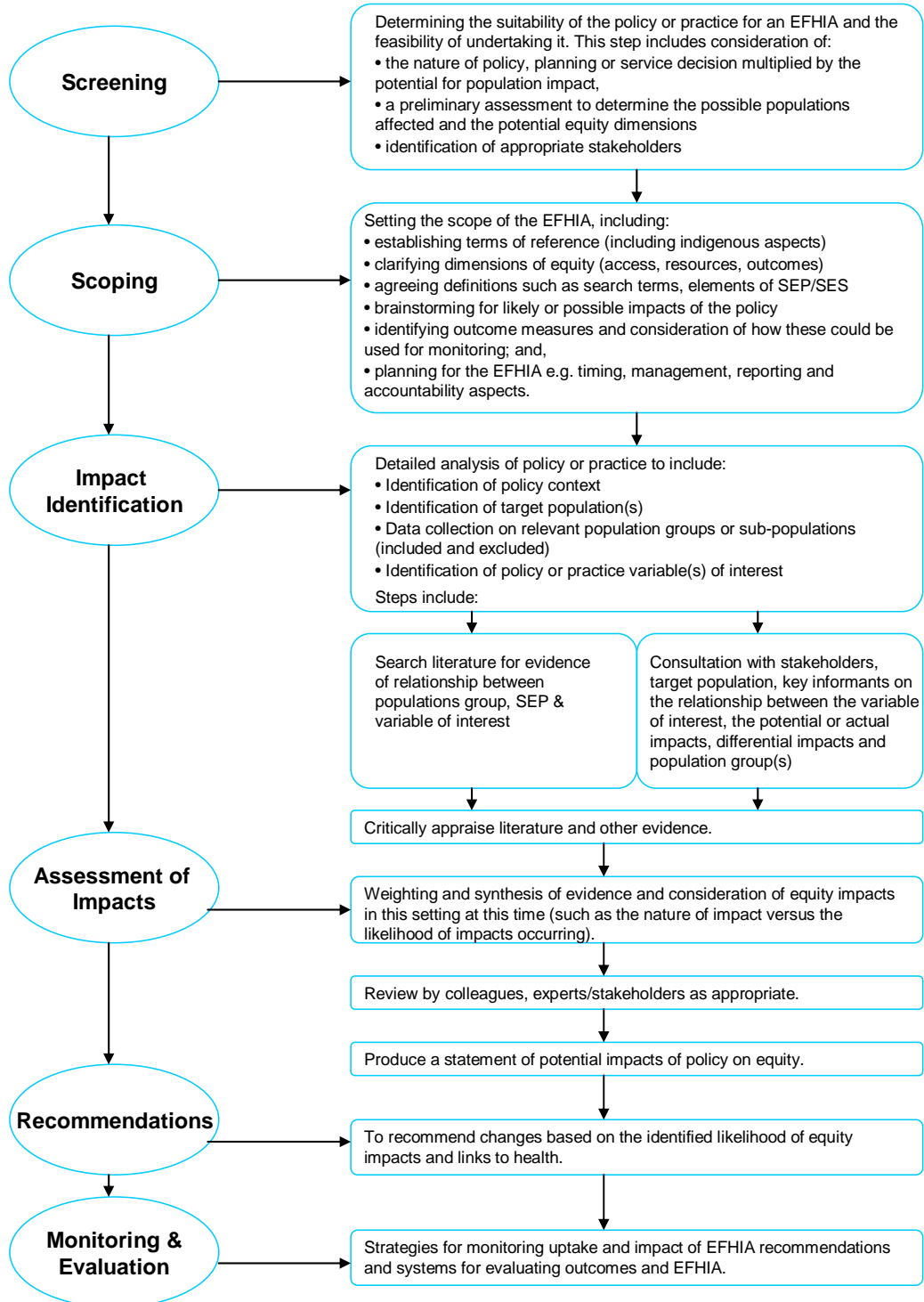
Below is the Health Equity Plan Template in its entirety. The template was developed by Bob Gardner (2008) for the Toronto-Central LHIN.

Section 1: Access, Priority Setting, and Planning
<p>1a) How do your hospital utilization patterns compare to the profile of who lives in your catchment? (If your catchment is undefined, where do the majority of your patients/clients come from?) Please indicate data sources.</p> <p>1b) What major inequities exist in regard to the social determinants of health among your patient/client population? Please indicate data sources.</p> <p>1c) Are there any specific health equity gaps and challenges that require greater attention at your hospital?</p>
Section 2: Promising Practices
<p>2a) Please briefly describe a maximum of 5 current hospital initiatives that help to improve access to health services by underserved or underrepresented populations?</p> <ul style="list-style-type: none"> - Which population do they target and/or which access barriers do they seek to remove? - In what ways is success being measured and what outcomes yielded as a result? Please provide samples of related documents, if any. <p>2b) Are there hospital-based initiatives that address the social determinants of health identified in 1b? Please describe briefly.</p> <p>2c) Describe specific partnerships, projects, or activities that your hospital has undertaken with other organizations to address health equity, including those addressing the broader social determinants of health. Please include the names of organizations and outcomes of the projects.</p>
Section 3: Policies, Procedures, and Standards
<p>3a) What specific policies, procedures and/or standards does your hospital have to ensure equitable access and treatment for all patients/clients? (E.g., a Patient Charter).</p> <ul style="list-style-type: none"> - How do you ensure that these policies are followed? <p>3b) How does your hospital provide for the delivery of culturally-competent care? Please provide specific examples.</p> <ul style="list-style-type: none"> - Do you have any special programs or policies that address the needs of Aboriginal and Francophone communities? Please describe. <p>3c) What non-English language services are provided corporately? How are these services provided? (E.g., volunteers, staff, contractual agreements, family members, telephone, etc.)</p> <ul style="list-style-type: none"> - Please name or attach the list of languages available and the number of requests you receive for each language, if this is recorded. <p>3d) Does your hospital have dedicated FTE or other positions that promote, lead or address your health equity goals? (E.g., Director of Corporate Diversity, Access or Human Rights Officer, Mentorship Coordinator, Equity Trainer, etc.). If yes, please list main role components.</p>

<p>3e) How has your hospital implemented any special initiatives to mentor, recruit and retain staff from diverse communities? (E.g., where jobs are posted, Internationally Educated Professionals projects, staff education, etc.)</p> <p>3f) Please give some examples of how your hospital accommodates patients/clients, visitors and staff with disabilities and/or other special needs in compliance with the Ontarians with Disabilities Act.</p>
<p>Section 4. Governance</p>
<p>4) Do you collect information to evaluate how well your employees and Board of Directors reflect the communities you serve? If yes, please describe how well your employees and Board reflect your communities and indicates your data sources. If not, please explain why.</p>
<p>Section 5: Targets and Measurement</p>
<p>5a) Please outline the goals and action plans to address your health equity and access priorities.</p> <p>5b) Please provide some examples of how you incorporate your access and equity objectives, or use an equity lens, in your initiatives to address the MOHTLC and LHIN priorities? (E.g., Strategic Plan, Wait Times Reduction, Patient Safety, Staff Interactions, Capital Projects including Facility Improvements, etc.)</p> <p>5c) What indicators and tools are used to monitor progress? (E.g., interpreter requests, accessibility plan implementation, balanced scorecards, patients compliments and complaints, etc.)</p> <p>5d) What information and data do you require in order to better identify and monitor health inequities?</p> <p>5e) How are members of diverse communities, staff, and board members involved in planning and setting health equity priorities for action by your hospital? (E.g., Community Engagement Approaches).</p>
<p>Section 6: Communications</p>
<p>6) In what ways are your health equity goals communicated to staff and physicians, board of directors, patients/clients, families and community members, health and social service partners, the Toronto-Central LHIN, and others?</p>
<p>Section 7: Potential Roles for the Toronto-Central LHIN</p>
<p>7) Does your hospital have specific requests, actions or comments that the LHHIN should consider to ensure a system-wide approach to improving health equity?</p>

APPENDIX C. EQUITY-FOCUSED HEALTH IMPACT ASSESSMENT TOOL

Below is an adapted diagram outlining the steps of the EFHIA as discussed in Mahoney et al. (2004):



APPENDIX D. THE HEALTH EQUITY TRIANGLE FULL QUESTIONNAIRE

Below is the complete questionnaire that accompanies the Health Equity Triangle tool (Victoria Health Promotion Foundation, 2008).

Equality of Access: Immediate Barriers

Inequality of access refers to barriers to the services that support health and wellbeing. It includes barriers created by services being physically inaccessible and through services being culturally inappropriate for some people living in the area.

Prompting Questions	Areas to follow these up
1. Cost	
<ul style="list-style-type: none"> a. Is there a cost involved in participating/accessing the program/project/service, including travel? Are there any costs involved in participating such as uniforms, books, tools? b. If there is a cost, is there a pricing policy/concession rate (or capacity to waive the fee) to ensure that those facing the greatest inequality are not further disenfranchised? What parking is available and is it free? c. Is there access to childcare? (Either provided or by ensuring partnerships and easy referral pathways?) d. Is there access to respite care? (Either provided or by ensuring partnerships and easy referral pathways?) 	
2. Culturally appropriate service delivery	
<ul style="list-style-type: none"> a. In what ways will the focus population be involved in planning, delivery, participation and evaluation of the work? b. Has the data been reviewed on the number of people in the project/service catchment area: with low socioeconomic status? Of Indigenous background? With a disability? Of non-English speaking, and particularly refugee, backgrounds (and from which countries in particular?) c. Have staff been trained in cultural security/diversity/respect and anti-racism? d. Are there regular opportunities to maintain and enhance training in cultural security/diversity/respect and anti-racism? e. What training is available for people involved in the program from reception intake/service access and what policies/procedures support inclusion in services? f. Are there policies and procedures to recognize the traditional owners at public events? g. How are Aboriginal and Torres Strait Islander peoples made to feel welcome? h. How are Aboriginal concepts of health incorporated into the program? i. Are resources available in languages other than English? Do these reflect findings from the data review (question 2.2)? j. Are staff aware of how to access interpreter services? Are there policies and procedures to enable use of interpreter services, including tracking use? How do limitations to the use of interpreters inform advocacy for better service provision? k. How are new arrival communities engaged and what level of awareness do program managers/team leaders/coordinators have of these populations? l. How are people from culturally diverse backgrounds made to feel welcome? m. Have needs of both women and men been considered? Has a gender equity tool 	

<p>been used?</p> <p>m. Have program workers thought creatively about how to break down gender stereotypes?</p> <p>n. Does the service/program have TTY access and electronic support such as enlarged documents on the internet/</p> <p>o. How does the program/activity support the needs of the children of participants? If a service, are children’s needs assessed separately to their presenting parent(s)?</p> <p>p. How does the program/activity support the needs of carers of participants? If a service, are carer’s needs assessed separately to service users?</p>	
3. Physical barriers	
<p>a. Are resources available in large print?</p> <p>b. Is language clear and in plain English?</p> <p>c. Are venue layout and scheduled times of activities accessible for people with vision impairment and/or limited mobility?</p> <p>d. Are project staff aware of how to access:</p> <ul style="list-style-type: none"> - taxi subsidy support services? - Aids and equipment financial support? <p>Are there policies and procedures to train staff in use of supports?</p> <p>e. Have transport routes been mapped to ensure access is possible? Does the program venue encourage diverse socially excluded groups to gather and mix with others through the provision of such things as disability parking, seating, walking and bicycle tracks, bicycle parking capacity, and parking facilities that are free or low-cost?</p> <p>f. Can alternative transport be provided?</p>	

Equality of opportunity: Building opportunities for life

Inequality of opportunity refers to the social, geographic and economic resources necessary to achieve and maintain good health, such as education, employment, income and a safe place to live.

Prompting questions	Areas to follow these up
4. Place (built/natural environment) influences	
<p>a. Is consideration given to the perceptions of the venues’ safety by participants through such things as efficient lighting, enhanced use by diverse groups, safe walking paths, and lack of vandalism, graffiti and litter?</p> <p>b. What are the levels of housing affordability in the program/project/service catchment area? (Households paying more than 30% of their income on housing are considered to be in housing stress).</p> <p>c. Is there data on the number of private renters and public tenants in the program/project/service catchment area? How are these residents engaged?</p> <p>d. How accessible are the local transport and walking routes for residents in the program/project/service catchment area?</p> <p>e. Is there a high outlet density of places that sell tobacco, alcohol and fast food? Is there local access to fresh fruit and vegetables?</p> <p>f. Are there local community centres and other areas for people to come together collectively?</p> <p>g. How can stresses on transport, housing, and the business/community mix be addressed through the program/project/service?</p>	
5. Education and employment influences	
<p>a. Does the program/project/service offer opportunities for participants to improve their own reading, numeracy and other skills through program activities?</p>	

<ul style="list-style-type: none"> b. Are program/project/service staff aware of referrals for: Social security payments advice, housing support, community banking and financial counseling? c. Does the program/project/service develop skills that increase the opportunities for participants to access education and employment opportunities, including referral pathways and by developing partnerships and alliances? d. Does the program/project/service make explicit links between the activities provided and job readiness and potential education and employment opportunities? e. Does the program/project/service address barriers that participants may have to education and employment opportunities? f. Are there ways the program/project/service can generate new income for participants or reduce the current income participants would spend? g. Does the organization practice healthy workplace policies such as: control over conditions experienced by workers, diversity within the workforce, offering appropriate reward for effort, reducing workplace stress, and reducing the size of income differentials between staff? h. Are there longer-term opportunities to hire program/project/service participants and other low-income people? 	
6. Social influences	
<ul style="list-style-type: none"> a. How are people made to feel welcome? b. Does the program increase participants' access and participation in broader social networks? c. How are new program/service users inducted? d. Do program activities provide opportunities for participants to mix and work in partnership with people of all ages, people with disabilities, migrants, Indigenous people and people with varying socioeconomic position and work status, including those with secure incomes and employment? 	

Equality of impacts and outcomes: Measuring and sharing success

Inequality of impacts and outcomes refers to the differences in health status between groups (for example, in rates of death, illness or self-reported health). It is important to measure health outcomes so that it is possible to notice who is and who is not achieving good health and wellbeing in the community.

Prompting questions	Areas to follow these up
7. Evaluation and dissemination	
<ul style="list-style-type: none"> a. Are statistics collected and used in planning which can be measured by: <ul style="list-style-type: none"> - Gender - Ethnicity - Indigenous status - Disability - A measure of socioeconomic position b. Do evaluation activities ensure results are analyzed by the following population demographics: <ul style="list-style-type: none"> - Gender - Ethnicity - Indigenous status - Disability - A measure of socioeconomic position c. Are results compared against total figures or a local average in order to determine if outcomes are different for sub-populations facing the greatest inequality? d. How will the program show ongoing benefits for participants and maintain community and partner commitment? e. How do you plan to disseminate the successful strategies? 	

APPENDIX E. SAMPLE PROGRAMS WITHIN THE BC HEALTH CARE DELIVERY SYSTEM THAT PROMOTE HEALTH EQUITY

Project Title: Tobacco Reduction

Agency: Interior Health

Project Contact Person: Kym Howay, Tobacco Reduction Coordinator

Email: Kym.howay@interiorhealth.ca

Phone: 250.549.6349

Project Description:

As a component of Interior Health's tobacco reduction initiatives, a Tobacco Reduction Coordinator works exclusively with Aboriginal communities to prevent smoking initiation and provide tobacco reduction and smoking cessation programs. Because this is a new position, the coordinator has been working on building relationships with Aboriginal Bands and Friendship Centres and putting together resources that are Aboriginal-centered.

Relationship building and social networking is a large component of this position. Given the large geographic area covered by this position, identifying key community leaders and establishing strong relationships can be a challenge. Teleconference and emails are not the best way to build relationships: face-to-face meetings are essential, particularly in the initial phases of establishing connections with communities.

When providing workshops, the Tobacco Reduction Coordinator ensures that an Elder from the area is included, that the workshop contains Aboriginal-centered content, and other traditions are incorporated.

Challenges:

The program is currently in the process of setting-up an outcomes and evaluation process. However, relationship building can take a substantial amount of time and the outcomes of relationship-building activities are difficult to measure.

Successes:

By working closely with Aboriginal Communities, Interior Health has been able to provide valued programs and resources to these communities. Building trust between the Health Authority and Aboriginal Communities can have important long-term implications for other programs and services.

Project Title: The New Canadian Clinic

Agency: Fraser Health

Project Contact Person: Connie Lapadat, Family Nurse Practitioner

Email: connie-marie.lapadat@fraserhealth.ca

Phone: 604.412.6580

Project Description:

The New Canadian Clinic (NCC), which was established in 2006 at Burnaby Hospital, provides primary health care services to Government Assisted Refugees (GAR). The NCC won a health innovation award from the province and was receiving so many referrals, that the clinic had to move to a larger space.

When the NCC first began, the clinic received GAR and Refugee Claimants; however, due to funding cuts, the clinic now only provides care to GARs who receive a referral from Bridge Clinic. There is also increasing pressure on the NCC to discharge patients once they are stabilized and can access care through walk-in clinics.

Health Care Providers include:

- Physician (1.5 days/week)
- Primary Health Care Nurse (2 days/week)
- Medical Office Assistant
- Interpreters (mainly Farsi and Arabic speakers, but some Spanish and African languages as well)

Accessibility:

- **Is transportation or bus tickets provided?** The NCC used to be able to provide bus tickets to patients before the funding cuts. The clinic is currently located near the Sky Train and is on a major bus route. Many of the Arabic patients live within a few blocks of the clinic, so are able to walk to their appointments.
- **Is there a fee for service?** No fee for services. The NCC is funded by the Fraser Health Authority
- **Is Language or Translation Provided?** Interpreters are provided. The NCC also arranges for interpreters to attend their patients' appointments with specialists.
- **What is the Literacy and Reading Level of Intake Forms?** Because many of the patients are illiterate in their own languages, they are unable to complete the intake forms. Consequently, the NCC completes the intake forms verbally, necessitating two appointments to complete an intake session. The first appointment usually consists of a medical history and ordering blood work, while the second appointment involves a physical or well-woman exam.
- **Is there a restriction on how long the service can be used?** Yes, Fraser Health has implemented a policy that requires the NCC to discharge patients when they have become medically stable and able to access walk-in clinics.
- **Is this program ongoing or is it a pilot program?** This program receives operating funds from Fraser Health Authority. However, there have recently been cutbacks to the program's funding (which included the loss of a mental health counselor and a community liaison worker).

- **Does the program take into account culture, as well as language?** Yes, the program takes into account culture both by educating patients about the Canadian culture, and providing culturally competent care. For example, the clinic celebrates all major holidays (Canadian, Arabic holidays, etc.) and tailors their approach in the clinic room (e.g., by having lots of chairs in the room to accommodate other family members, learning through their interpreters by asking questions about patients' cultures).
- **What are the hours of operation of service?** Monday-Friday, 8:30-4:30pm.

Challenges:

- Appointments with this population often take longer than 15 minutes, which reduces the clinic's performance on standard indicators (such as the number of new patients seen each week, number of patients seen per day). Indicators must be interpreted within the context of the population that the clinic is serving.
- The NCC experiences substantial difficulty getting specialists to accept and see their patients. The clinic has to arrange for interpreters to attend appointments with their patients, rather than the specialist taking on this responsibility. If an interpreter is not able to attend the appointment at the last minute, the patient will not be seen due to this language barrier. There is a need to educate specialists so that they understand their responsibilities to this underserved group.
- Understanding and navigating the system can be difficult for refugees. The NCC staff spends a lot of time educating refugees about the Canadian Health Care System.
- Almost all patients who attend the NCC have depression, anxiety or post-traumatic stress disorder. Mental Health issues can compromise physical wellness; yet, a counselor position was eliminated with funding cutbacks.

Successes:

The NCC has an important impact, not just on the individual that attends the clinic but on their family and larger ethnic community. The knowledge that the patient receives (for example, how to navigate or access the health system) is often passed onto others within their communities

Project Title: Population Health: Responding to Health Inequities

Agency: Interior Health

Project Contact Person: Theresa Hermary, Population Health Facilitator

Email: theresa.hermary@interiorhealth.ca

Phone: 250.420.4124

Project Description:

As part of a small unit tasked with responding to health inequities, population health facilitators work to build awareness, capacity and partnerships surrounding the Social Determinants of Health.

For example, one project that the population health team took on was looking at the impact of income insecurity on access to recreation services. In order to raise awareness about this issue, the population health facilitator attended a brown bag lunch meeting, hosted by the mayor of Cranbrook, during which community members were invited to ask questions and provide comments. The population health facilitator was able to raise awareness about physical recreation and the barriers that income may present to individuals who wish to participate in recreation programs. The population health facilitator became a member of a municipal steering committee that looked at this issue and, ultimately, implemented an access pass program for low income members of the community.

A key component of this role is the provision of information to decision-makers about what's happening in other communities and partnering with organizations and groups that are engaged with issues surrounding the social determinants of health. Recognizing that municipalities are an important context in which change happens and people experience their health, the population health facilitator supports advocacy at the community level. For example, the population health facilitator works with social planning bodies and anti-poverty community coalitions throughout the Interior region to provide a health-related perspective on the impacts of poverty.

Challenges:

Supporting advocacy initiatives at the community level is a strategic component of this position and it would be helpful to have a region-specific advocacy framework which guides employees on how to support advocacy initiatives. In addition, there has been limited discussion on how and in what ways the health system should respond to the social determinants of health that lie outside of the health care delivery system and perform in advocacy roles.

Successes:

This position has provided an opportunity for the health authority to work collaboratively with community groups. These relationships, as they continue to strengthen, can be valuable in addressing health inequities within the community

Project Title: The Many Walks of Life Program

Agency: Fraser Health

Project Contact Person: Tracy Steere, Coordinator, Aboriginal Healthy Living Program

Email: tracy.steere@fraserhealth.ca

Phone: 604.614.1268

Project Description:

In 2009, Fraser Health partnered with Mission Friendship Centre to implement a pilot program related to healthy living. The partnership emerged from a networking opportunity whereby Fraser Health staff were at a meeting with representatives from the Mission Friendship Centre.

The Many Walks of Life program was a component of the overall healthy living pilot project and involved the group setting goals related to physical activity and working together to achieve them. For example, the group decided to “walk” to the city of Hilo on the island of Hawaii. The group members wore pedometers and tracked their steps over the upcoming days and weeks. A variety of workshops were presented and a feast was held once the fictional goal was achieved.

Participants from the community volunteered to take on leadership roles within the project. For example, some individuals were responsible for tracking the steps on the group chart while others cooked healthy meals for the group. Enthusiasm from participants encouraged others in the community to join the program.

The Mission Leisure Centre helped reduce barriers to participation in the program by providing complementary passes to the facility and play passes for children.

Project Title: The Sharon Martin (SMART) Community Health Fund

Agency: Vancouver Coastal Health

Project Contact Person: Lezlie Wagman, Manager, SMART Fund

Email: lezlie.wagman@vch.ca

Ph: 604.714.3799

Project Description:

The Sharon Martin Community Health Fund (SMART Fund) provides resources and funding for a number of different programs at not-for-profit agencies that provide health promotion and disease prevention strategies to vulnerable populations and marginalized individuals throughout the region served by VCH.

For example, the SMART Fund is currently supporting a group of Aboriginal-focused chronic disease self-management programs in four First Nations Communities. In order to build on existing infrastructure and programs, communities were asked to identify the types of programs that would be most effective for preventing chronic diseases in their geographic areas. While all of the programs incorporate Aboriginal traditions and ways of knowing, each community's needs were different, and the resulting programs are also unique. Some types of projects that were initiated include community gardening as well as, wild harvesting of traditional plants, education surrounding chronic disease prevention, and diabetes self-care programs. Many of these projects are peer-led and peer-supported, which also encourages community cohesion and social wellbeing.

The SMART Fund actively fosters community capacity building and brings these grantees together on a regular basis to conduct a joint evaluation. Using a program called Splash and Ripple Outcome Measurement, the Fund provides training to all grantees. Participants learn how to design a logic model and develop simple survey tools, such as focus groups and questionnaires, to evaluate the project's activities. All funded programs are evaluated on an annual basis.

Relationship building is a key component of providing funding and support to communities.

Challenges:

Limited Funding: The funding available to the non-profit sector is limited, which puts the long-term sustainability of these important projects in jeopardy. Even when additional funding can be found for a project, the lack of money for infrastructure can limit the effectiveness of the project. Without infrastructure support (for example, administrative staff, office space, telephones and computers), many projects face substantial challenges in achieving their full potential.

Knowledge Transfer and Succession Planning: Capacity building is a key component of the SMART Fund goals. Grantees, program coordinators, and volunteers possess a great deal of knowledge and experience, which can be lost when individuals move onto new opportunities. There is a need for knowledge transfer mechanisms to be implemented within community settings, so that the "lessons learned" get passed on.

Future Directions:

The SMART Fund, in collaboration with the project grantees and other funders, is working to secure ongoing funding to sustain these important projects.

Non-profits can provide incredible benefits to community health and well-being, yet they are not supported adequately. By linking with community organizations, public health can be more responsive to the needs of underserved populations. There is a need for public health to get more creative in how we support communities in identifying their own needs and developing programs and projects to address them.

Project Title: Kla-How-eya Healing Place

Agency: Fraser Health

Project Contact Person: Ginny Hind, Family Nurse Practitioner

Email: Ginny.hind@fraserhealth.ca

Ph: 604.585.5910

Project Description:

The primary health care program began as a partnership between Fraser Health Authority and Kla-How-Eya Aboriginal Centre. Kla-How-Eya Aboriginal Centre had been operating for many years as a grassroots, community friendship centre for urban Aboriginal people and identified a need for primary health care services for the Aboriginal community at the centre. The primary health clinic would work in partnership with other Kla-how-eya services such as school, family and pre/post natal support programs, infant development and drop-in daycare for young mothers, employment services and the culinary arts training program for clients using their services.

The primary health care program's mandate is to provide primary care services to urban Aboriginal people who are without a regular doctor or are feeling disconnected from regular health services. The program started with approximately 20 charts and now has almost 500 patients, from newborns to elders.

The program's staff have created a space that is a comfortable and a welcoming place in which to provide health services. Having an office assistant who is from the Aboriginal community is helpful in making cultural connections and building relationships with clients. This program works to actively build a bridge between western health services and traditional Aboriginal healing approaches and to help reconnect Aboriginal clients to regular health services by establishing trusting relationships.

Accessibility:

- **What are the hours of operation of the service?** Daily clinic hours with scheduled appointments and drop-in appointments. Program staff have added an additional drop-in morning, recognizing that the program needs to accommodate people when they can get to the service more easily when attending other programs.
- **Partnerships:** The program partners with Fraser Health programs, including public health, home healthcare, and mental health and addictions services. The program also provides referrals to Kla-How-Eya programs and receives referrals from these also.
- **Does the program take into account culture?** Aboriginal culture highlights the importance of providing holistic care and incorporating the spiritual, community, mental, spiritual and physical components of healing and health. Health services are client-centered and take into consideration these different dimensions.

Challenges:

Outcome Measurement and Relationship-Building: Outcome evaluation is a key component of evaluating the impact of the program. However, relationship building and cultural sensitivity takes a lot of time to develop and is important in providing care, yet may not be easily measureable.

Meeting the Basics: When patients are in “survival mode” and are not able to meet their daily living needs, it is difficult to focus on other personal health challenges. There is a need to address Maslow’s Hierarchy of Needs, which focuses on meeting the basic survival needs first – housing, food, and income security – while also providing care for physical needs and to support changes to health.

Mental Health and Addictions: Many Aboriginal people have experienced a great deal of trauma from interactions with western culture, which has resulted in differing experiences of abuse and disconnection with their aboriginal culture and home communities which have led to mental health and addictions issues. There is a need to address these issues before individuals can begin to focus on other health issues and better manage chronic diseases, such as diabetes.

Successes:

This program is a great example of a grassroots community development project. Having been initiated by the community and supported by the health authority, the program was structured in a way that makes sense for the community members who access the service. The primary health clinic continually modifies health services to better meet their client’s needs.

Project Title: Modeling Healthy Foods in Temples for the South Asian Population

Agency: Fraser Health

Project Contact Person: Ruth Hellerud-Brown, Healthy Living/Healthy Community Specialist

Email: ruth.hellerud-brown@fraserhealth.ca

Ph: 604.918.7637

Project Description:

The Temple Project emerged from a partnership between Fraser Health, DiverseCity and the Canadian Diabetes Association and was made possible through funding from the Public Health Agency of Canada via the Canadian Diabetes Strategy. Before the project was formally initiated, a staff member from DiverseCity who was connected to the South Asian community visited different temples to talk about the project, gauge the level of interest and facilitate community buy-in.

The project itself involved the development and implementation of a food policy in order to encourage healthier eating both at the temple and in the home. Sikh temples often provide free meals to the community several times a week and many permit bookings for families to host special functions during which food is served.

Contracted dietitians worked with the temple to analyze the nutritional content of the traditional foods that were being provided and revised the recipes to make them healthier. The goal was to model healthier eating and develop lower fat and lower sodium ways to enjoy traditional South Asian foods. The most significant change the dietitians recommended centered on the amount of oil and salt used in their food preparation. As well, the dietitians made recommendations on the use of butter and lower fat dairy products. They also suggested using more nutritious lettuce for salads and offering fruit more often as a dessert item

Challenges:

Translation of resource materials proved to be somewhat of a challenge to the project team. This was mainly because the time required for the translation process was underestimated. The team was further challenged in this area because not all team members were able to read the Punjabi language. Some examples of material that were translated into Punjabi include a brochure on healthy eating for the congregation, signage and posters in the temple and the food policy.

Future:

Other temples are now interested in developing their own food policy, etc. This program could be modified and implemented in other communities.

Successes:

This project raised awareness about the importance of eating healthy and the possibility of enjoying traditional foods that taste great but are much lower in fat and salt

Program Title: Vancouver Community Healthy Living Program

Agency: Vancouver Coastal Health

Project Contact Person: Maylene Fung, Manager, Healthy Living Program

Email: maylene.fong@vch.ca

Ph: 604.708.5285

Program Description:

Using a community development approach to chronic disease prevention and health promotion, the Vancouver Healthy Living Program connects with communities that are at high-risk of developing a chronic disease. Together, community members and the program team develop health promotion and chronic disease prevention activities that are reflective of the needs of different groups around the lower mainland. The program focuses on three main pillars of population health: healthy eating (and healthy weights), physical activity, and smoking cessation.

The program consists of a multidisciplinary team with nurses, dietitians and physiotherapists with two key roles being a healthy eating coordinator and a physical activity coordinator. Imbedded in each of the team member's roles is the function of community development.

Some activities and programs that the Vancouver Community Health Living Program have initiated include:

- Pre-diabetes programming
- Support to community events by providing information and resources on healthy living
- Health screening
- Partnering with recreation centres to deliver a "Healthiest Winner" program
- Providing Grants to support community initiative in healthy living
- Education to staff on health promotion and chronic disease prevention
- Prediabetes Research

The Program Team has worked closely with the Canadian Diabetes Association and community partners within Vancouver Coastal Health to identify key community leaders and link with community groups. For example, in 2006, the program partnered with Britannia Health Recreation Centre, which provides services to populations that are at high risk of developing a chronic disease, such as Aboriginal people, individuals who have low incomes, and single mothers. Because the project team worked closely with this community partner, team members were able to build effective relationships within the community. This enabled them to identify and respond to the chronic disease prevention needs of community members with programs that were culturally appropriate.

The Healthy Living Program also provides small grants to communities who want to address one of the project's three pillars. While the community submits a proposal, they must be willing to work closely with the Program Team. Evaluation is built into each project and there is also a focus on the project's long-term sustainability.

Under the umbrella of the Healthy Living Program are two chronic disease programs which provide information on management and prevention. They are the Vancouver Chinese Diabetes Education Center and the Community Pulmonary Rehabilitation Program. Both these programs

charge a cost recovery fee but if participants are unable to afford the cost, these fees are often waived.

Accessibility:

- **Is there a fee for the service?** Program activities initiated by the Healthy Living Team do not charge a fee for participation. Some community centres with whom the project collaborates may have fees; however, fees are generally waived if individuals cannot afford to pay them.

Challenges:

1. Relationship Development and Partnership Building:

In order for these programs to be successful, it is essential to develop strong relationships and connect with key community leaders. This process, however, is slow.

2. Evaluation and Indicators:

Governments require indicators and evaluation to identify the progress that has been achieved. Yet, in a community-development approach to health promotion and chronic disease prevention, relationships and capacity building can take a substantial amount of time – outcomes may not be measureable within a 1-year time frame. In addition, many of the current indicators are acute-care based and it can be difficult to develop indicators that can be captured by the diverse program activities implemented by the Healthy Living Team.