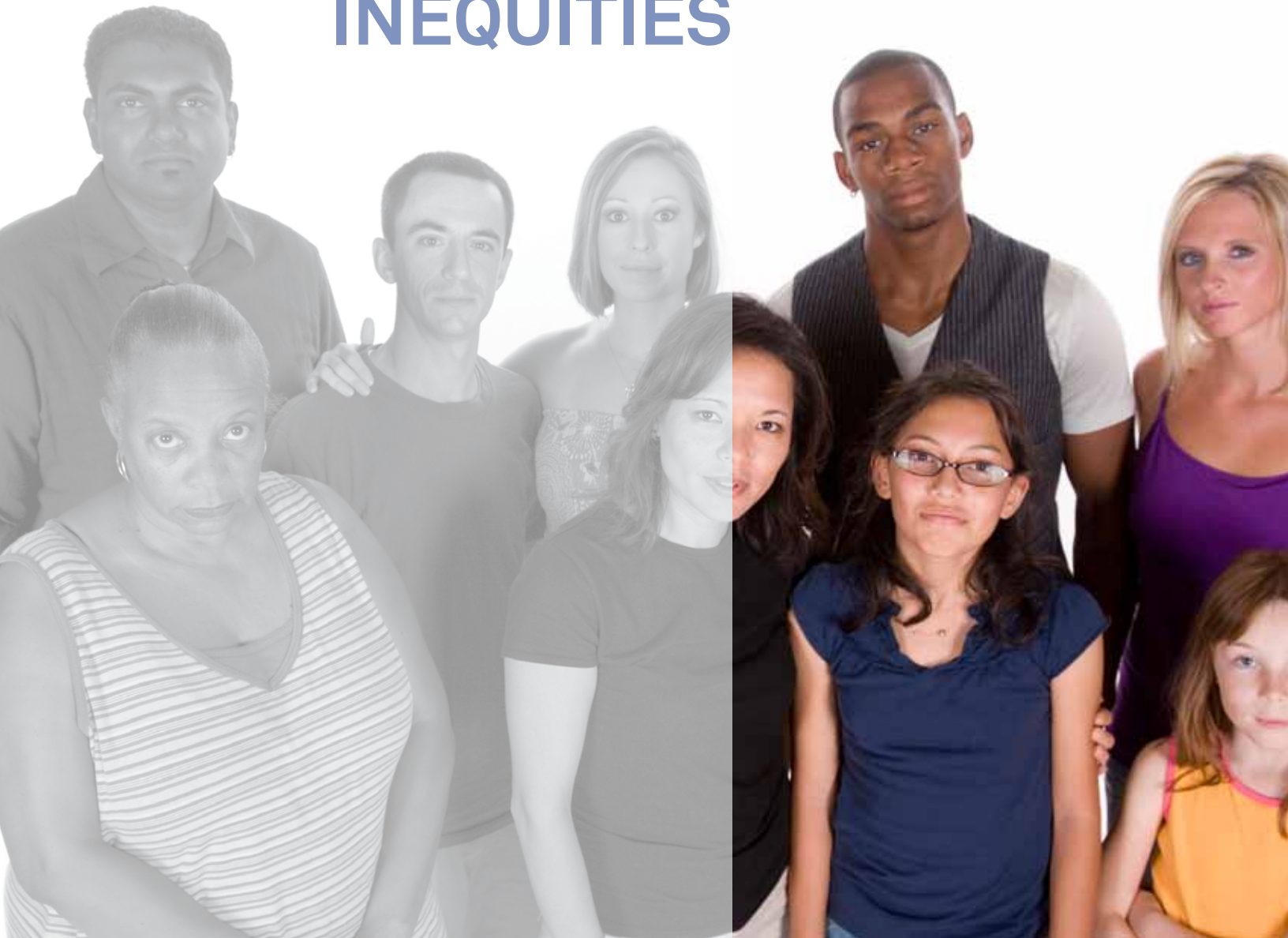


TOWARDS REDUCING HEALTH INEQUITIES



A HEALTH SYSTEM APPROACH TO
CHRONIC DISEASE PREVENTION

A DISCUSSION PAPER

TOWARDS REDUCING HEALTH INEQUITIES

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Executive Summary

Introduction

The increasing prevalence of chronic health conditions among British Columbians has been identified as a key threat to the sustainability of the health care system. Evidence shows “at-risk” or “vulnerable” groups have a higher rate of chronic disease due to their social and economic circumstances; however, the impacts of chronic diseases can be significantly reduced through chronic disease prevention and management efforts (Bromeling, Watson & Black, 2005; Bromeling, Watson, & Prebtani, 2008; Hayward & Colman, 2003). While in the past, many chronic disease prevention strategies have focused on interventions aimed at modifying individual lifestyle and behavioural risk factors associated with increased risk of chronic disease (such as smoking, diet, and physical activity), there is growing evidence that such approaches will have limited success. Research shows that community- and systems-level approaches that target the social, economic, and environmental root causes of poor health can be more effective at preventing chronic disease and can greatly improve the overall health of the population (Bromeling, Watson & Prebtani, 2008; Hayward & Colman, 2003; Health Officers Council of BC, 2008; Pan-Canadian Public Health Network, 2008; Prevention Institute, 2006).

Although British Columbians in general rank among the healthiest in the world, health is not evenly distributed across British Columbia’s population. There are a significant number of British Columbians who have poorer health than others in the province, including:

- Children and families living in poverty,
- People with mental health and substance use issues,
- Aboriginal people,
- Immigrants, and
- Refugees.

Such differences in prevalence rates of chronic disease among various groups in the province are a reflection of the health inequities within our society. Not only do health inequities contribute to poor health within British Columbia, health inequities are associated with significant and wide-reaching health, social, and economic costs. It has been estimated that health inequities cost British Columbia an estimated \$2.6 billion annually (Health Officers Council of BC, 2008).

Health inequities refer to the differences in health status among population groups that are deemed to be unfair, unjust, or preventable, as well as socially produced and systematic in their distribution across the population (Commission on Social Determinants of Health, 2007). Inequities generally exist along two major gradients: socioeconomic status and geographic status (i.e. urban vs. rural location), but inequities also appear along other gradients such as ethnicity, gender, age, and disabilities. Consequently, inequities in health are based on complex social, cultural, and economic processes.

The Chief Public Health Officer of Canada (2008) has stressed the need to address health inequities through such measures as promoting early childhood development, ensuring greater income and food security, and providing affordable housing. However, emerging evidence notes that the health system has an important role to play in achieving more equitable health outcomes for populations through the design, organization,

Executive Summary (cont...)

and management of its programs and services (Health Council of Canada, 2010b). Reducing inequities in health could help reduce the prevalence of chronic diseases and the resulting demand and pressure on health services and also benefit the immediate and long-term health outcomes of individuals, communities, and society as a whole.

The Provincial Health Services Authority (PHSA) initiated the *Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention* project to identify the actions the health system can take towards reducing health inequities. Three underserved populations were identified for the focus of this work: immigrants, refugees, and individuals transitioning into and out of the corrections system. An engagement process was undertaken with a wide range of key stakeholders from across BC representing health authorities, government, and community organizations to collectively put forward recommendations for action to reduce health inequities and improve the quality and accessibility of the health system's policies, programs, and services.

Overview and Findings of the Report

The stakeholder engagement provided new information specific to BC and confirmed information consistent with other emerging evidence. This report adds value in a number of ways by:

- Focusing on what the health system can do in relation to the design and delivery of services, with a particular emphasis on prevention;
- Uncovering and sharing information about several current BC initiatives and recent policy directions that can support the health system's role in reducing health inequities;
- Providing more detailed information about issues and barriers within the health system in BC that may be inadvertently creating or perpetuating health inequities that contribute to chronic diseases in three specific underserved populations. Seven overarching barriers are identified that affect the availability, accessibility, and acceptability of health services in BC (see Section 4);
- Proposing five recommendations for action for addressing the barriers faced by those underserved populations (see Section 5), and highlighting two of those recommendations as priority recommendations (see Section 6);
- Building on the recommendations for action by identifying 27 specific opportunities for appropriate and relevant actions the health system can take (see Section 5);
- Identifying opportunities for further dialogue and action (see Section 6); and
- Providing a list of relevant equity related tools, resources, frameworks, and local activities and initiatives that can be aligned with, utilized, adapted, or built upon to implement the recommendations for action (see Appendix D & E). Tools and resources include health equity/assessment tools, indicators, health literacy toolkits and courses, cultural competency training modules, community engagement frameworks, and cultural broker/patient navigator modules. These tools and resources are conveniently organized by the opportunities for action they are intended to support.

Executive Summary (cont...)

Recommendations for Action

A framework for conceptualizing equity in healthcare was developed in order to guide the development of the project and its recommendations. The framework included three key components: availability, accessibility, and acceptability of policies and services. These components are used to organize the seven overarching barriers and to inform the following five key recommendations for action that address those barriers:

1. Develop health equity targets and plans in consultation with communities and community members and actively monitor and measure their impact on health inequities by:
 - » Building on current initiatives to utilize health equity assessment tools to coordinate the design, implementation and evaluation of ongoing and future policies, programs, and services.
2. Improve health literacy by:
 - » Increasing the capacity of health care providers to communicate effectively with health system users and to respond to their diverse needs.
 - » Supporting opportunities to increase the capacity of underserved or inappropriately served groups to better access, understand, communicate, evaluate, and act on health information and services.
3. Increase equitable access to prevention and curative services for underserved populations by:
 - » Enhancing the availability of community-based primary health care services.
 - » Building on existing specialized, population-focused primary health care services.
4. Develop intersectoral collaborative and knowledge exchange mechanisms to inform existing programs and the development of new health promotion, primary prevention, and self-management support programs that are culturally competent by:
 - » Promoting communication and coordination between the health system and stakeholders, including community members, for dialogue and joint problem solving.
5. Increase the capacity of the health system to better serve the needs of BC's culturally and linguistically diverse population by:
 - » Ensuring that policies, programs, and services are culturally competent.
 - » Providing skill-based cultural competency training opportunities for health system providers to improve communication with users and to respond to their diverse needs.

For each of the five recommendations, specific examples of action the health system can take are described within the body of the report (see Section 5.0).

Recognizing that in practice, not all recommendations can be addressed all at once, project stakeholders propose the first two recommendations be considered priorities. The first recommendation, incorporating “equity thinking” into every level of the health system, should precede the others if they are to be most effective. Health stewards are encouraged to make a clear, strategic commitment to promoting health

Executive Summary (cont...)

equity and setting clear expectations and goals to reduce existing barriers and issues that may be contributing to inequities in access and opportunity. This should involve ongoing monitoring and continuous improvement efforts. The second recommendation on increasing health literacy should be the next priority that health stewards undertake to support the development of existing and new activities in the province.

Moving Towards Reducing Health Inequities: A Call to Action

While acknowledging that many opportunities for improvement still remain, this report identifies ways in which BC's health system is moving in the right direction towards ensuring that the design and delivery of health system policies, programs, and services do not exacerbate health inequities. Although the report focuses on three specific underserved populations, the themes, issues, and opportunities identified are pertinent to many underserved groups in BC.

The information contained in this document is applicable to those working at all levels of the health system. The most significant first step anyone can take towards reducing health inequities is to consider what role they can most effectively play, given their level of engagement within the system.

Senior health executives have an opportunity to endorse the findings in this document, make a strategic commitment for action, and provide their organization and staff with the mandate and support to incorporate the types of strategies identified in this report into health policy, planning, and service delivery. Developing health equity targets and plans and improving health literacy are the recommended priorities.

Health program or service managers have opportunities to incorporate strategies to reduce health inequities into health program and service planning and delivery. They are in a position to:

- Improve existing promotion, prevention, and self-management programs,
- Make the case for new and/or enhanced programs and services as required,
- Utilize intersectoral collaborative and knowledge exchange mechanisms to do so,
- Contribute to the development and measurement of health equity targets,
- Influence and lead health literacy efforts, and
- Encourage cultural competency among their staff.

Front line health care providers have chances to incorporate strategies to reduce health inequities into their day-to-day interaction with health system users. They are in an excellent position to request cultural competency training and to support patients and their families in their efforts to better understand health information and services.

In order to maximize the usability of the information, this document provides general, rather than prescriptive, recommendations for action as well as more detailed opportunities for action. This ensures that each individual, team, and organization can identify what is applicable in their context and chart their own course of action; everyone has a role to play. A process for engaging in this type of reflection and planning to either begin to address or to further address health inequities within any organization is outlined in Section 7.

Executive Summary (cont...)

Conclusion

In summary, the health system has an important role to play in promoting health equity and in ensuring that its policies, programs, and services are available, accessible and acceptable to all British Columbians. This reports builds on previous recommendations to enhance the health system's ability to respond to the health needs of the population and with ongoing efforts within the province to better meet the needs of underserved populations.

Taking action to resolve health system barriers and issues which may be inadvertently creating or perpetuating health inequities would not only improve the effectiveness of the health system in the provision of chronic disease prevention and treatment programs and services for people who are currently underserved, but would also help to reduce the burden and economic costs of chronic disease and health inequities. A health system that incorporates equity into all aspects of the system will better meet the health needs of currently underserved populations in BC, and by reducing inequities will lead to improved quality of life for all British Columbians.

Glossary of Terms

A GP for Me

An initiative of the General Practice Services Committee (joint committee of the BC Medical Association and the Ministry of Health Services). A GP for Me aims to ensure that access to and benefits of primary care are available to all British Columbians, including those who may be hard to serve in traditional practice settings. The aim is that by 2015, all British Columbians who want a family doctor can have one (GPSC, 2009).

Collaborative Services Committee

The Collaborative Services Committee (CSC) is a committee that will initially be composed of representatives of the Division of Family Practice, the Health Authority, and the Ministry of Health Services. The CSC will provide a collaborative venue to co-design clinical programs and new ways of working together. The CSC will ensure that patient, family, and community perspectives are utilized throughout the CSC planning processes (Divisions of Family Practice, 2011b).

Cultural competency

Relates to a set of behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable effective service delivery in cross-cultural situations (National Health and Medical Research Council, 2005). A culturally competent health system extends beyond providing cultural competency training to include culturally competent policies, programs, and services (MSH, 2011).

Determinants of health

The range of personal, social, economic, and environmental factors that determine the health status of individuals or populations (WHO, 1998).

Glossary of Terms (cont...)

Diversity	Refers to the unique characteristics that distinguish individuals from each other and/or identify individuals as belonging to a group or groups. Diversity transcends concepts of race, ethnicity, socio-economic, gender, religion, sexual orientation, disability, and age (BC Ministry for Children and Families, 2006).
Divisions of Family Practice	Groups of family physicians in the same geographic region of BC who work to address common health care goals. Each Division works in partnership with their health authority, the General Practice Services Committee, and the Ministry of Health Services to identify gaps that exist in patient care in a Division's community and to develop solutions to meet their community's needs (Divisions of Family Practice, 2011).
Health	A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1948).
Health disparities	Differences in health status among groups. This term is used interchangeably with health inequalities (PAHO, 1999).
Health equity	Refers to the elimination of the social, economic, and environmental factors that produce inequitable health outcomes among groups (Solar & Irvin, 2007).
Health inequities	Differences in health status among groups that are deemed to be unfair, unjust, or preventable, as well as socially produced and systematic in their distribution across the population (Commission on Social Determinants of Health, 2007).

Glossary of Terms (cont...)

Health literacy	Refers to the extent to which individuals are able to access and understand information and services and to which the health system provides equitable, easy, and shame-free access to and delivery of health programs, services, and information (The Centre for Literacy, 2009; Rootman & Gordon-El-Bihbety, 2008).
Health promotion	The process of enabling people to increase control over, and to improve their health (WHO, 1986).
Health system	All components of the health system whose primary intent is to promote, restore, or maintain health, including leadership, policy, service planning and delivery, health workforce, and health information (WHO, 2007).
Health system users	Any individual that comes into contact with the health system, including those seeking prevention or attention of a health condition as well as any person interacting with the health system (such as an ill person's caregivers or family) (WHO, 2001).
Integrated Health Networks	A mechanism that will support and formalize links between community organizations and resources with primary health care, and re-align health authority and specialist services to integrate with primary health care (Divisions of Family Practice, 2011b).
Self-management	Educating patients about their conditions and helping them to develop the confidence and motivation to use their own skills and knowledge to monitor and manage their chronic illness, in collaboration with their health care providers (Expert Patients Programme Community Interest Company, 2010).
Underserved populations	Groups of individuals who do not have access to health services or do not receive appropriate health services (Bowen, 2001).

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- Members of the *Reducing Health Inequities* project Advisory Group¹
- Members of the Immigrant Population Working Group
- Members of the Refugee Population Working Group
- Members of the Corrections Population Working Group
- Participants of the September 7, 2010 Immigrant Population Working Group's Community Engagement Meeting
- Participants and panellists of the October 4, 2010 Strategy and Partnership Building Forum
- Tannis Cheadle
- Jeanne Legare and Irv Rootman
- Phoebe Long
- Rebecca Mador

¹ Membership lists for each of these groups are provided in Appendix A.

1.0 Introduction

Within British Columbia (BC), as within Canada and around the world, differences in health status can be observed across the population. When health differences can be reduced but not eliminated, such as those stemming from genetic variations, the natural ageing process, or from other unavoidable circumstances between individuals, these health differences are considered to be health inequalities or health disparities. However, when differences in health outcomes are deemed to be unfair, avoidable, or preventable, such differences become health inequities (Commission on Social Determinants of Health, 2007; Health Officers Council of BC, 2008). While health inequalities cannot necessarily be fixed, action can be taken to prevent health inequities through policy, program, and systemic interventions (Health Council of Canada, 2010b).²

The World Health Organization Commission on the Social Determinants of Health has called for a renewed commitment to reducing health inequities and improving the health of all populations (World Health Organization, 2008). Many of the factors affecting and perpetuating inequities in health status lie beyond the health system, in the broader social and economic system. Actions to address this complex issue will require macro-level policy changes and intersectoral collaborative and coordinated efforts.

However, the health system also has an important role to play in achieving more equitable health outcomes for populations (Barr, 2009a; Bowen, 2001; Gilson et al., 2007). The *Canada Health Act* states that the primary objective of Canadian health care policy is to “protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (*Canada Health Act*, 1985, c. C-6). The Canadian health system is founded on principles of universality, equity, and accessibility and as such, has a responsibility to ensure that its policies, services, and programs promote health equity and address inequities in access and health status within the population.

A recent report entitled *Health Inequities in British Columbia: A Discussion Paper* (Health Officers Council of BC, 2008) documented the existence of health inequities in BC. This report highlights the need to take a health systems approach to addressing health inequities. Until now, there has not been a thorough examination of issues or barriers within the health system in BC that may be contributing to inequities in health. The Centre for Chronic Disease Prevention of the Provincial Health Services Authority (PHSA) has recognized this gap and the need to examine and address these issues or barriers, specifically as they pertain to inequities contributing to the development of chronic diseases among certain populations in BC. The PHSA has led the *Reducing Health Inequities* project in collaboration with stakeholders from across PHSA, regional health authorities, government ministries, academia, and community organizations to foster dialogue and to identify opportunities to address issues within the organization and delivery of the health system that may be contributing to health inequities.

² While the terms *health inequalities* and *health inequities* are sometimes used interchangeably, it is important to distinguish between the two terms. While inequality implies differences between individuals or groups, inequity refers to differences that are unnecessary, avoidable, and considered unfair and unjust. Not all inequalities are unjust, but all inequities are the product of unjust, unfair, or avoidable inequalities (PAHO, 1999). See Whitehead (1991) for a more detailed discussion of the differences between inequities and inequalities.

1.0 Introduction (cont...)

The purpose of this discussion paper is to share the outcomes and recommendations for action that have emerged from the *Reducing Health Inequities* project (RHI project). This paper adds to the existing literature on the role the health system can play to reduce health inequities and is intended to foster dialogue and action on health inequities in BC. It supports this type of action by providing a comprehensive list of relevant tools, resources, frameworks, and local activities and initiatives that can be aligned with, utilized, adapted, or built upon. The information within this paper can be used by all components of the health system to help strengthen and enhance the system's capacity to promote health equity and to deliver high quality programs and services that are acceptable, available, and accessible to all British Columbians.

1.1 Content and Organization of the Discussion Paper

After the introduction, the paper is organized into six main sections.

Section 2.0 Overview of the *Reducing Health Inequities* Project: This section describes the scope, limitations, objectives, and activities of the RHI project and how the project aligns with current provincial objectives for the prevention of chronic disease.

Section 3.0 Background: This section describes the prevalence of chronic disease in British Columbia, the existence of inequities in health status and access to care among British Columbians, and the direct and indirect costs of chronic disease and health inequities. It also provides an overview of the main ways in which the health system impacts health equity, and highlights recent national and provincial reports and policy directions that emphasize the health system's role in reducing health inequities.

Section 4.0 Health System Barriers: This section describes overarching system-level barriers that were identified as contributing to health inequities by three Working Groups and supported by the findings of a literature review and the feedback and expertise of participants of a Strategy and Partnership Building Forum.

Section 5.0 Recommendations for Action: This section puts forward the recommendations and opportunities for action that have emerged as a result of the project for how the health system can reduce health inequities and better meet the needs of British Columbians.

Section 6.0 Moving Towards Reducing Health Inequities: Priorities and Additional Opportunities: In this section, two of the recommendations for action are identified as priorities by project stakeholders, and additional opportunities requiring further exploration, dialogue, and action are highlighted.

Section 7.0 Moving Towards Reducing Health Inequities – A Call to Action: This section outlines a simple process for readers of this paper to develop a plan for taking action to address health inequities and improve health equity within their organizations. This could be done at an individual, team, or organizational level and could include aligning with, complementing, supporting, or building on existing work as well as potentially creating new initiatives.

2.0 Overview of the *Reducing Health Inequities* Project

This section provides more detail about:

- The background and rationale of the project,
 - The focus on three underserved populations,
 - The project's governing structure, and
 - Activities, including literature review, discussion paper, workshops and Working Groups.
-

2.1 Background to the Project

The Centre for Chronic Disease Prevention of 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. To address this need, in November 2009, the PHSA implemented a year-and-a-half long primary prevention project entitled *Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention* (*Reducing Health Inequities* or RHI project). The purpose of the project was to engage and collaborate with stakeholders from across health authorities, government ministries, academia, and various community organizations to identify issues and barriers within the health system that may contribute to inequities in the prevalence of chronic disease among certain population groups. The goal of the project was to add to the current knowledge base on health inequities by collectively putting forward recommendations for action for how the health system in BC can reduce health inequities and improve the quality and accessibility of its policies, programs, and services to better meet the needs of underserved populations.

The *Reducing Health Inequities* project aligns with specific objectives outlined in the 2010 *Model Core Program Paper for Prevention of Chronic Diseases* (BC Ministry of Healthy Living and Sport, 2010), both in terms of the project's main objectives and its use of an equity lens. The model core program paper indicates that the use of equity lenses to identify systemic barriers and the differential impacts of health determinants on different segments of the population is foundational to the success of chronic disease prevention strategies (BC Ministry of Healthy Living and Sport, 2010). Specifically, the project aligns with one of the key objectives of the model core program paper for the prevention of chronic disease by aiming to “reduce health disparities among different segments of the population with regard to chronic diseases” (BC Ministry of Healthy Living and Sport, 2010, p. 20).

2.0 Overview of the *Reducing Health Inequities* Project (cont...)

2.2 Scope and Limitations of the Project

Three Underserved Populations of Focus

The original proposal for the *Reducing Health Inequities* project was developed in response to requests from a regional health authority and the BC Centre for Disease Control to address issues related to several underserved populations. To identify health system barriers and issues that may be contributing to health inequities, the project therefore focused on these three populations:

- Immigrants,
- Refugees, and
- Individuals transitioning into and out of the corrections system.

A detailed examination of all groups in the province that may face a greater likelihood of being underserved by the health system or who may be excluded from existing chronic disease prevention and management strategies was beyond the scope of the RHI project. While the project focused on these three populations, the themes, issues, and opportunities that emerged from the project's activities are likely to be pertinent to many underserved groups in BC.

The Population of British Columbia

The *Reducing Health Inequities* project was guided by the principle that while identifying and addressing the needs of priority populations is important for reducing health inequities, there is no “general” population from which these three groups are separate. Identifying people experiencing health inequities as “they” is somewhat misleading as individuals populating this group are actually a component of the greater “us” (Patychuk & Seskar-Hencic, 2008). As individuals are identified whose social and economic circumstances place them at higher risk for experiencing health inequities, increased efforts to support them should become the norm. Focusing public health interventions on priority populations and acknowledging the diverse and intersecting identities of BC's “population” is important not only to minimize risks, but also to meaningfully impact and achieve population health goals (NHS Health Scotland, 2009; Patychuk & Seskar-Hencic, 2008).

The Health System

In the early stages of the RHI project, the “health system” was defined quite narrowly to include any program or service under the purview of a regional health authority or a PHSA agency that is responsible for hospital- and community-based health services, public health surveillance, health promotion, or disease prevention. However, over the course of the project, it became clear that a health systems approach to reducing health inequities involved addressing all aspects of the health system. Therefore a broader definition was required to take into account the complex relationships, interdependencies, and interactions among many components of the health system.

2.0 Overview of the *Reducing Health Inequities* Project (cont...)

The scope of the RHI project moved beyond a focus on the design and delivery of health services and programs under the control of the health authorities to take into account other aspects of the broader health system, including:

- Ministry-led initiatives,
- Members of the public, non-profit and community organizations, and
- Other stakeholders that can engage with and influence the health system.

Although this definition is broader in scope than originally conceptualized, the project's timeline and capacity did not permit collaboration with other key health system stakeholders. For the purposes of this project, the health system is comprised of all components whose primary intent is to promote, restore or maintain health, including leadership, policy, service planning and delivery, health workforce, and health information (WHO, 2007).

Chronic Disease

While the term “chronic disease” most generally refers to non-infectious diseases, the term now commonly includes infectious chronic conditions that are persistent and that require long-term care (Nasmith et al., 2010). Following this definition, within the context of the RHI project, the term “chronic disease” includes:

- Non-infectious diseases such as cancer, hypertension, diabetes, cardiovascular disease, stroke, renal failure, blindness, and mental health and substance use issues,
- Long-term disability resulting from injury or non-life threatening conditions, and
- Certain communicable diseases such as hepatitis and HIV/AIDS.

2.3 Project Activities

The information in this discussion paper emerged as a result of a variety of activities that took place over the course of the project; the following section overviews the timeline and activities that contributed to the main outcomes and findings described in later sections of this paper.

Project Organization and Leadership

The *Reducing Health Inequities* project was funded by PHSA's Centres for Population and Public Health from November 2009 to March 2011. To oversee the project throughout its implementation, a Steering Committee was formed in November 2009 consisting of members from PHSA agencies and programs: Population & Public Health, BC Mental Health & Addiction Services and the BC Women's Hospital & Health Centre, as well as a member from the Vancouver Coastal Health Authority (see Appendix A for a list of Steering Committee members). A project manager was hired for the duration of the project to manage and coordinate the project's activities. A Masters of Public Health student provided support to the project from May to August 2010 and wrote a project discussion paper that examined how equity within the health care system is conceptualized and provided insight into how other jurisdictions are taking a health system approach to reduce health inequities among underserved populations (Mador, 2010).

2.0 Overview of the *Reducing Health Inequities* Project (cont...)

Steering Committee Workshop

A key objective of the *Reducing Health Inequities* project was to work in collaboration with a variety of stakeholders from the regional health authorities, the Ministries of Health Services and Healthy Living and Sport, various PHSA agencies, and external agencies and organizations to foster dialogue and action on health inequities in BC and the role that the health system can play to reduce health inequities. To engage with key stakeholders and obtain feedback on the scope and purpose of project, the Steering Committee held an interactive workshop at the Public Health Association of BC's (PHABC) *Action towards Reducing Health Inequities* conference in November 2009. Forty-five professionals (mainly from across the health authorities and the provincial government) took part in the workshop to learn about the RHI project and to discuss the role the health system can play in reducing health inequities.

Trends in Chronic Disease Prevention

A discussion paper was written by a Masters of Health Administration student during the development of the *Reducing Health Inequities* project proposal. This paper provided some preliminary information on provincial trends in chronic disease prevention as it relates to underserved populations in BC (Morris, 2009). In an effort to further understand the landscape of chronic disease prevention and management in BC, as it relates to inequities in health among underserved populations, several key informants within BC's health authorities were contacted in an initial environmental scan prior to the PHABC workshop³. The key informants shared information about ongoing chronic disease prevention and management services and programs in BC. While several chronic disease prevention projects and programs were noted to exist throughout the province, key informants remarked that many of the available programs and services often failed to reach populations at higher risk for poor health, including people with mental health and substance use issues, refugees, immigrants, Aboriginal people, and women with low socio-economic status. Reasons why many of the programs failed to reach higher risk populations included language and cultural barriers, no or low capacity of services to meet the needs of patients with complex health conditions, geographic isolation, and lack of awareness of the social determinants of health and of the equity lens within the health system.

Project Advisory Group

In January 2010, a project Advisory Group was created with representatives from PHSA agencies, each of the regional health authorities, and the Ministry of Health Services to provide advice and expertise on the project throughout its implementation (see Appendix A for a list of Advisory Group members). The Advisory Group met with the Steering Committee every two months throughout the duration of the project.

³ Due to a time restrictions, only key informants from Vancouver Island Health Authority, Vancouver Coastal Health, and Fraser Health were contacted to participate.

2.0 Overview of the *Reducing Health Inequities* Project (cont...)

Literature Review

From January to March 2010, a literature review was conducted, which provided an overview of current research and available information describing the health status and health care utilization of the three populations identified by the project as currently underserved by the health system in BC: immigrants, refugees, and individuals transitioning into and out of the corrections system*. The literature review highlighted opportunities where the health system could improve its health care delivery for the three populations of interest, specifically through improved information support, enhanced chronic disease prevention efforts, enhanced collaboration with community agencies, and the expansion of health services at the community level (Long, 2010).

Underserved Population Working Groups

Following the development of this literature review, the project established three multi-sector, multi-stakeholder Working Groups, each of which focused on one of the aforementioned underserved populations in BC. All Working Group members had experience working with one of the populations of interest within the health system or a community organization, or within academia conducting research on the health of one of the groups. Each of the Working Groups consisted of between 12 and 16 members, and each group met five or six times between May and October 2010 (see Appendix A for a list of Working Group members). All three of the Working Groups were chaired by a member of the Advisory Group, who helped serve as a communication link between the Working Groups and the larger Advisory Group. The project manager attended all Working Group meetings and when possible, a member of the Steering Committee attended the Working Group meetings as well.

The purpose of the Working Groups was to build on the information put forward in the literature review and to further identify – based on expertise and additional literature circulated amongst the Working Group members – health system issues and barriers that may contribute to reduced access and reduced health service utilization by the three populations. In response to the identified issues and barriers, each Working Group developed recommendations on how the health system could address the identified barriers and how the system could better meet the health needs of their population of focus.

When possible, the Working Groups identified and highlighted existing successes in the delivery of health care or health promotion services, and opportunities to strengthen programs and/or services.

Strategy and Partnership Building Forum

In October 2010, the three Working Groups presented their recommendations at a Strategy and Partnership Building Forum in Vancouver, BC. The Forum brought together 123 stakeholders, representing government, health authorities, academic institutions, and various community organizations to discuss the recommendations put forward by the Working Groups. The Forum provided the opportunity for stakeholders to establish and build partnerships that will contribute to ongoing dialogue and action towards implementing the Working Groups' recommendations and the *Reducing Health Inequities* project's recommendations for action.

* See Section 2.2 Scope and Limitations of the Project for further information on why the project focused on these populations.

2.0 Overview of the *Reducing Health Inequities Project (cont...)*

Final Discussion Paper

Following the Forum, the Steering Committee synthesized the outcomes of the project's activities into this discussion paper. During this process, the Steering Committee continued to engage with key stakeholders to elicit feedback on the paper and to foster dialogue on the role the health system can play to reduce health inequities. Key stakeholders engaged during this process included:

- The Advisory Group,
- The three Working Groups,
- PHSA's Provincial Language Service,
- The BC Population Health Network,
- The Ministry of Regional Economic and Skills Development's WelcomeBC Vulnerable Population Reference Group,
- Vancouver Coastal Health's Employee & Workplace Health & Safety,
- The Ministry of Safety and Solicitor General,
- Providence Health Care's Diversity Services, and
- The Interpreter Services in Primary Care Working Group.

Please note: As a compilation of the activities and findings of the Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention project, this discussion paper incorporates sections of the literature review, the discussion paper, and the Working Group recommendations.

3.0 Background

This section describes:

- The prevalence of chronic disease in British Columbia,
 - Inequities in health status and access to care among British Columbians,
 - The direct and indirect costs of chronic disease and health inequities,
 - Two main ways in which the health system impacts health equity,
 - Four key components of the health system that can lead to health inequities between groups,
 - How health inequities can be reduced if these key components are effectively addressed, and
 - Recent national and provincial reports and policy directions that emphasize the health system's role in reducing health inequities.
-

3.1 Chronic Disease in British Columbia

The increasing prevalence of chronic health conditions among British Columbians has been identified as a key challenge for the province. There is growing awareness not only of the impact of these conditions on health status, but also of the resulting economic costs, including direct costs to the health care system, as well as indirect costs, such as productivity losses. Chronic health conditions afflict approximately 34% of British Columbians and account for nearly 67% of provincial health care costs (Bromeling, Watson, & Black, 2005). In addition, multiple chronic conditions can have a considerably negative impact on quality of life, both in terms of people's day-to-day lives and their mental well-being (Walker, 2007).

There is mounting evidence that the impacts and consequences of chronic disease can be significantly reduced through chronic disease prevention and management efforts (Bromeling, Watson & Black, 2005; Bromeling, Watson, & Prebtani, 2008; Hayward & Colman, 2003). While in the past, many chronic disease prevention strategies have focused on interventions aimed at modifying individual lifestyle and behavioural risk factors associated with increased risk of chronic disease (such as smoking, diet, and physical activity), there is growing evidence that such approaches will have limited success. When such strategies are designed for the population at large, they may in fact be inaccessible to more at-risk or vulnerable groups due to their social and economic circumstances. Consequently, these approaches often only lead to improved health among more advantaged groups (Health Officers Council of BC, 2008). Research shows that community- and systems-level approaches that target the social, economic, and environmental root causes of poor health can be more effective at preventing chronic disease and can greatly improve the overall health of the population (Bromeling, Watson & Prebtani, 2008; Hayward & Colman, 2003; Health Officers Council of BC, 2008; Pan-Canadian Public Health Network, 2008; Prevention Institute, 2006).

3.0 Background (cont...)

3.2 Health Inequities in British Columbia

Although British Columbians in general rank among the healthiest in the world, health is not evenly distributed across British Columbia's population. There are a significant number of British Columbians who are at greater risk for poor health than others in the province, including:

- Children and families living in poverty,
- Homeless people,
- People with low incomes or that are under/unemployed,
- People with mental health and substance use issues,
- People suffering from social exclusion,
- Aboriginal people,
- Immigrants, and
- Refugees (Barr, 2009a; BC Healthy Living Alliance, 2009; BC Provincial Health Officer, 2009; Health Officers Council of BC, 2008).

Ample evidence confirms that there is an increased concentration of risk factors for chronic disease within these populations and that there are also intersections and linkages between specific groups and certain social conditions that can influence health status (BC Healthy Living Alliance, 2009). Such differences in prevalence rates of chronic disease among various groups in the province are a reflection of the health inequities within our society, according to the Health Officers Council of BC (2008).

Health inequities refer to differences in health status among population groups that are deemed to be unfair, unjust, or preventable, as well as socially produced and systematic in their distribution across the population (Commission on Social Determinants of Health, 2007; Health Officers Council of BC, 2008). The World Health Organization defines health equity as “the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically” (Solar & Irvin, 2007, p. 7). Given this definition, achieving health equity entails eliminating the social, economic, and environmental factors that produce inequitable health outcomes among groups.

The existence of inequities in health status and access to care among British Columbians has been well documented:

- Individuals from lower income households are more likely to report a chronic disease such as diabetes and heart disease or to suffer from depression and anxiety than their higher income counterparts.
- Individuals living in rural areas are more likely to suffer from poor health than their urban counterparts.
- Women are more likely to have poorer health status than men for many health indicators (Barr, 2009a; BC Provincial Health Officer, 2009; Bowen, 2001; Chasey, Pederson & Duff, 2009; Health Officers Council of BC, 2008; Statistics Canada, 2005).

3.0 Background (cont...)

The Health Officers Council of BC (2008) has noted that inequities generally exist along two major gradients: socioeconomic status and geographic status (i.e. urban vs. rural location). Individuals in more socio-economically advantaged groups are generally more likely to experience better health and increased life expectancy than those in less advantaged groups. Residents of rural communities often experience significant barriers, such as geographic distance, poor transportation systems, and a limited range of available services, which can impact their health (BC Provincial Health Officer, 2009).

Chasey, Pederson and Duff (2009) note that in addition to health inequities existing along a socio-economic gradient, health inequities also appear along other gradients including ethnicity, gender, age, and disabilities. For example, within Canada, women are more likely than men to be impoverished, which can limit their access to food, housing, and the health and social services that are necessary to achieve and maintain good health.

Along with many public health professionals and researchers, the Public Health Agency of Canada (2010) has noted that health is influenced by a broad range of interrelated “determinants of health”, including social, economic, demographic, and environmental variables, as well as individual characteristics and behaviour. The structural, or “upstream”, variables have a powerful influence over an individual’s health behaviours, exposure, and vulnerability to unhealthy conditions, and health outcomes (Barr, 2009a; BC Healthy Living Alliance, 2009; Chief Public Health Officer of Canada, 2008; Public Health Agency of Canada, 2010). Consequently, inequities in health are based on complex social, cultural, and economic processes. As the Health Officers Council of BC notes, “[h]ealth inequities stem largely from an unequal distribution of (or exposure to) significant determinants of health” (2008, p. 20).

Not only do health inequities contribute to poor health within British Columbia, health inequities are associated with significant and wide-reaching social and economic costs. It has been estimated that health inequities cost British Columbia an estimated \$2.6 billion annually (Health Officers Council of BC, 2008). Inequities in health can result in high costs to the health care system, can reduce quality of life, and can have indirect costs on the economy through reduced productivity of those who are ill as well as their caregivers and family (Hollander et al., 2009). The BC Healthy Living Alliance has stated that the increasing prevalence of chronic diseases arising from persistent inequities in British Columbia “is a costly economic drain in terms of lost productivity, foregone tax revenue, reduced consumer spending, and higher public expenditures” (2009, p. 8).

Reducing inequities in health would benefit the immediate and long-term health outcomes of individuals, and also communities and society as a whole. Better health positively affects prosperity and economic growth by enabling individuals to be more productive and able to participate in the economy. Furthermore, reductions in inequities in health could help reduce the prevalence of chronic diseases and the resulting demand and pressure on health services (Health Officers Council of BC, 2008). If not addressed, it is reasonable to presume that the direct and indirect costs of health inequities will continue to increase.

3.0 Background (cont...)

3.3 Promoting Health Equity within the Health System

Recent reports from the Chief Public Health Officer of Canada (2008) and the Health Officer's Council of BC (2008) have stressed the need to address health inequities through such measures as promoting early childhood development, ensuring greater income and food security, and providing affordable housing. Over the past several years, there has also been an increasing amount of literature highlighting the need to look at the role the health system can play in addressing health inequities. Recent literature has noted that the health system has the potential to promote health equity through the design, organization, and management of its programs and services, and public health professionals have emphasized the need for the health system to provide inclusive and responsive care to the populations it serves (Barr, 2009a; Betancourt, 2006; Bowen, 2001; Health Council of Canada, 2010b; Registered Nurses' Association of Ontario, 2007).

Although the health system is commonly classified as a “downstream” determinant of health, the WHO Commission on the Social Determinants of Health has shown that health systems also have “upstream” influences and are able to have a powerful impact on the broader socio-political environment (Gilson et al., 2007). Additionally, over the past decade, there has been increasing evidence that suggests health inequities stem in part from how the health system understands and responds to the needs of the population, and that the health system has an important role to play in achieving more equitable health outcomes for populations (Barr, 2009a; Bowen, 2001; Chief Public Health Officer of Canada, 2008; Gilson et al., 2007; Health Council of Canada, 2010b; Health Officers Council of BC, 2008).

3.3.1 How the Health System Impacts Health Equity

Equity in health care refers to the distribution of health resources; 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 (Hopkins, 2009; Waters, 2000). To date, two main ways in which the health system may impact health equity have been identified: through the focus on acute care over primary health care and through the design and delivery of health services.

Focus on Acute Care over Primary Health Care

The health system's focus on acute care over primary health care may 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” (World Health Organization, 1978; p. 2). 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. Primary care increases access to health services for underserved populations, provides more comprehensive prevention programs, allows for greater continuity of care, and can act as a navigation point within the complex health system (Barr, 2009b; Health Council of Canada, 2010; Starfield, Shi, & Macinko, 2005). Although primary care is not identical to primary health care, these findings point

3.0 Background (cont...)

to the importance of community-based health services that focus on prevention as a key component of improving health inequities. As noted by Nasmith et al. (2010), a community-focused approach (in which “community” may refer to a geographic area or to socio-economic, cultural, or demographic groups), is consistent with the conclusions of researchers who have examined the health system’s role in reducing health inequities and have recommended integrating population health practices within primary care. Community action that succeeds in effecting changes in policies can have an enormous and sustained impact on social and health equity for underserved populations.

Design and Delivery of Health Services

The ways in which the health system is designed and administered may have important implications for the extent to which different populations are able to access, navigate, and utilize health services and, ultimately, on health disparities between groups. Three dimensions of equity in health care have been identified in the literature: availability of services, accessibility of services, and acceptability of services. In addition, health literacy and cultural competency have emerged as key components underlying the availability, accessibility, and acceptability of the health system.

1. Availability of Services

Most generally, availability refers to whether services are provided within a community. This dimension of equity is typically discussed in the context of rural British Columbia. Lack of available services has been identified as a key barrier to accessing appropriate and timely diagnostic and treatment services, thereby contributing to health disparities within the province. More specifically, the lack of primary care physicians practicing in rural areas and the limited availability of specialty services, such as mental health and substance use programs, and obstetrics, maternity, and gynecological services, have been noted (Laurent, 2002; Ryan-Nicholls & Haggarty, 2007; Society of Obstetrics and Gynecologists of Canada, 2008). However, even within urban centres, certain services may be unavailable due to limited hours of operation, long waiting lists, or because they are not covered under Medicare. Recent literature shows that ensuring the availability of community-based primary health care services – including specialized, population-focused clinics and programs – can increase continuity of care and potentially reduce the likelihood of individuals relying on emergency care (Baum, 2009; Starfield et al., 2005).

2. 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 (Bowen, 2001). Issues associated with literacy, language, gender, ethnicity, and geography can all have substantial impact on the accessibility of the health care system. This includes health promotion and disease prevention programs as well as diagnostic and treatment services (Baum et al., 2009). Health literacy (the extent to which individuals have the capacity to access and understand health information and services needed to make appropriate health decisions) is an important dimension of accessibility (Rootman & Gordon-El-Bihbety, 2008). Some of the barriers to health literacy include:

3.0 Background (cont...)

- Failure to provide health information in languages other than English and French,
- The use of jargon or advanced vocabulary within both spoken and written communication,
- The provision of information predominantly through web-based media rather than paper format, and
- The complexity of the Canadian health system (Canadian Public Health Association, 2006; Zanchetta & Poureslami, 2006).

Equitable access can be defined as “the provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health” (Bowen, 2001, p. 19). The ultimate goal is not simply equitable access to health services, but equitable access to health.

3. Acceptability of Services

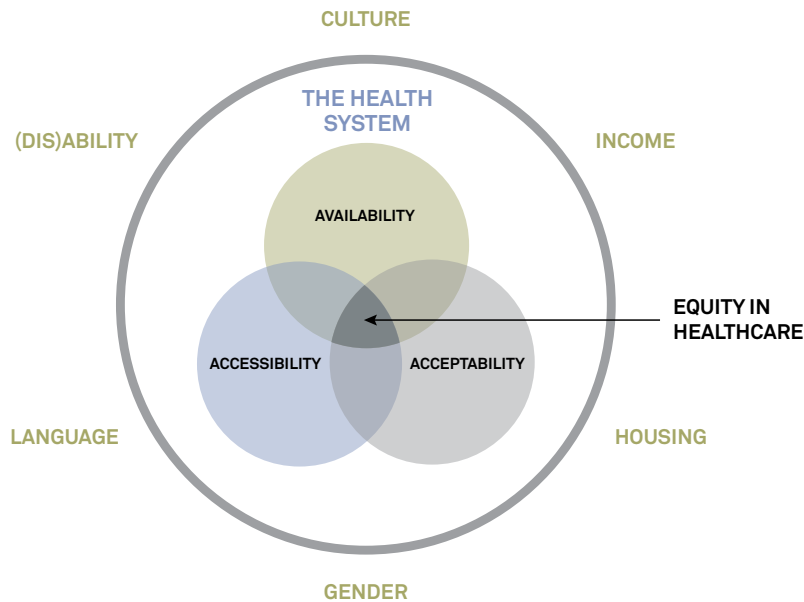
Acceptability refers to the extent that services are provided in a way that meets the needs of distinct cultural, linguistic, ethnic, and social groups. The provision of culturally competent services and creation of culturally safe spaces are key components of the acceptability of services. More than 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). Health care services can help bring about more positive health outcomes when they are respectful and responsive to the diverse health beliefs, practices, and cultural and linguistic needs of their patients (Office of Minority Health, 2005).

While cultural competency 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 communities, and 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 or service delivery being unacceptable to an individual, decreasing the likelihood that he or she will access services in the future.

In *Health System Approaches to Promoting Health Equity: A Discussion Paper*, Mador (2010) puts forward a visual framework for conceptualizing equity in health care (see Figure 1). Within this framework, equity within the health system refers to equal access to health care for people with equal needs (i.e., if there is a greater need for services, there are more services available).

3.0 Background (cont...)

Figure 1: A Framework for Conceptualizing Equity in Health Care⁴



Availability, accessibility, and acceptability are represented by the three overlapping circles in the diagram, with equity in health care existing within the centre of the three circles. The health system itself operates within a much larger context. The items outside of the large circle (i.e. outside of the health system) represent several social categories, all of which compound and intersect at multiple levels to affect an individual's ability to identify and access services, as well as navigate the system. For example, individuals with limited knowledge of the English language and low incomes may experience substantial difficulties in accessing and utilizing health services. They may be unable to afford to pay for public transit to attend their appointments, or they may be unable to understand and enact the health advice they receive. When programs or services are not available, accessible, or acceptable to all British Columbians, 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).

4. Cultural Competency and Health Literacy

As essential and complementary components underlying the availability, accessibility, and acceptability of the health system, cultural competency and health literacy merit further examination. “Culture” is dynamic and ever-changing. It most simply refers to patterns of human behaviour, including the beliefs, customs, values, communications, language, thoughts, actions, and institutions belonging to a group or groups of individuals (Office of Minority Health, 2005). Cultural competency entails utilizing the appropriate skills necessary for effective communication and interactions. Cultural competency in the health system does

⁴ The framework was adapted from the work of Baum et al. (2009) and Bowen (2001).

3.0 Background (cont...)

not imply that all health providers will have knowledge about *every* cultural tradition or speak *every* language (Ardiles, 2006). Rather, cultural competency is a process that requires health care providers to be aware of the ways their culture and personal characteristics, such as gender, communication style, attitudes, and beliefs impact and influence their provision of care and interactions with health system users (Ardiles, 2006).

While individuals in an organization can begin to gain cultural competence through formal training, consistent individual practice and the support of a culturally competent organization is required to continuously develop and maintain individual cultural competence (MSH, 2011). Cultural competency should extend well beyond the training of health care providers to include:

- The development of administrative and organizational policies and procedures (e.g. decisions related to improving access to care),
- Human resource policies in recruitment and retention of diverse staff (to better represent population diversity),
- Engagement strategies with family and community members to be inclusive of community values (e.g. alternative medicines and practices),
- Interpreting/translation services, and
- Health literacy materials which take into account culture-specific attitudes and values in education or health promotion messages (Ardiles, 2006; Sue et al., 1992).

An organization cannot be clinically or programmatically competent unless it is culturally competent (MDHS, 2011). A culturally competent health organization is a learning organization that continuously strives to improve its relationships with:

- The community,
- The administration and management's relationship with staff,
- Inter-staff relationships at all levels, and
- The user-provider relationship (MSH, 2011).

Health literacy is also an important component underlying the availability, accessibility, and acceptability of the health system. While health literacy is often referred to in relation to health system users, health literacy also applies to the health system. The Centre for Literacy (2009) describes how the health literacy of a society can be improved both by developing the skills of individuals and by lowering the barriers created by health service personnel and systems.

This reciprocal relationship in health literacy has been described as a relationship in which the expectations, preferences, and skills of individuals seeking health information and services meet the expectations, preferences, and skills of those providing information and services (Institute of Medicine, 2004). This understanding of health literacy underscores the shared responsibility between health system users and health care providers/the health system. As previously noted, individuals are health literate when they are able to use the skills needed to find, understand, evaluate, communicate, and use health information

3.0 Background (cont...)

and services. Health care providers are health literate when they are able to present and communicate information in ways that improve the understanding and ability of their patients or clients to act on the information. Health systems can be health literate by ensuring equitable, easy, and shame-free access to and delivery of health programs, services, and information (The Centre for Literacy, 2009).

Improving health literacy can contribute to more informed choices, reduced health risks, increased prevention and health promotion, better navigation of the health system, improved patient safety, better patient care, fewer inequities in health, and improved quality of life. Increasing the capacity of the health system to be health literate and culturally competent can have a positive impact on the availability, accessibility, and acceptability of the system.

3.4 Recent Policy Directions Supporting the Health System's Role in Reducing Health Inequities

There has been increasing support within British Columbia in recent years to ensure that the design and delivery of health system policies, programs, and services do not exacerbate health inequities. In 2007, the *Core Public Health Functions for BC: Evidence Review – Equity Lens* report emphasized the role of health authorities as being “absolutely critical” to reducing health inequities (BC Ministry of Health, 2007, p. 39). The report noted that health authorities should advocate for policies and programs that have the potential to reduce disparities in health and develop meaningful relationships with communities to help ensure that new and existing health system programs and services do not have the unintended consequence of widening disparities in health status.

Equity has also been emphasized as a foundational dimension of quality within the BC Health Quality Matrix, adopted by the Health Quality Network in June 2009 (BC Patient Safety & Quality Council, 2009). The matrix provides a common language, understanding, and approach for health care organizations and individual health care practitioners to use when thinking about health care quality. It is designed to be used as a tool at every level of BC's health system to measure quality. The matrix positions equity as underlying the acceptability, appropriateness, accessibility, safety, and effectiveness of the health system and as key to ensuring fair access to and the sustainability of health programs and services.

There have also been several policy directions and actions put forward for the health sector to reduce health inequities. In 2004, the Health Disparities Task Group of the Federal / Provincial / Territorial Advisory Committee on Population Health and Security stated that it was time for the health sector to show leadership and action on reducing health disparities, given the evidence showing the potential benefits of doing so not only for the health system, but also in terms of health outcomes and the overall quality of life for Canadians (Health Disparities Task Group, 2004). The Task Group identified a need and an opportunity for the health system to play an important role in reducing health disparities in Canada and identified four key policy directions and actions for the health sector:

3.0 Background (cont...)

1. Make health disparities reduction a health sector priority. Coordinate efforts on several fronts, with health sector leadership facilitating the roles of the health sector and encouraging policy action in other sectors.
2. Integrate disparities reduction into health programs and services. Focus on the needs of disadvantaged populations and communities, and on mitigating the causes and effects of other determinants of health through interventions with disadvantaged populations. Clearly articulate objectives, deliverables, and expected outcomes.
3. Engage with other sectors in health disparities reduction. Requires participation from those sectors whose work aligns with key health determinants, including the public, private, and voluntary sectors.
4. Strengthen knowledge development and exchange activities. Documentation of disparities, development of evidenced-based policies, evaluation of interventions, and communication of results.

By playing a leadership role in reducing health disparities, the Task Group stressed that the health sector would be able to take action in areas within its direct control and would be able to support and influence policy action in other sectors to achieve health gains.

In 2008, the Health Officers Council of BC (HOC) once again highlighted the health care system as one of the upstream, structural roots of health inequities – along with the labour and housing markets, urban planning and government regulation, and the education system. The HOC noted that these structural components of the socio-economic system are powerful determinants of health and can only be transformed through political, social, and economic processes (Health Officers Council of BC, 2008). Within HOC's discussion paper on health inequities in BC, five broad policy options for reducing health inequities were put forward for consideration. Health care – more specifically, ensuring that health services apply an equity lens and ensuring equitable access to health services – was one of the five areas identified where action could be taken.

In addition to the four actions put forward by the Health Disparities Task Group in 2004, the HOC added the following two policy options to enhance health outcomes and improve access to health services for all British Columbians:

1. Reduce financial and other barriers to health care. Aim to ensure equitable and timely access to effective preventive and curative health care services.
2. Provide information to patients in a format that they can understand. Provide patients with health information that is accessible, regardless of level of literacy/health literacy.

In addition, the HOC put forward guiding principles for addressing health inequities in BC, including recognizing that health inequities will need to be addressed through an integrated approach on many fronts through multiple, interrelated strategies, and emphasizing the importance of developing interventions based on a combined universal/targeted approach. The importance of incorporating a sex- and gender-based analysis as the health system moves to address health inequities has also been stressed. Within their analysis of health inequities in BC, Chasey, Duff and Pederson (2009) note that incorporating a sex- and gender-based analysis “provides critical insight into the social, cultural, and economic forces that shape population health as well as the ways in which policies can exacerbate, reinforce, or create health inequities. These insights help to tailor more effective, equitable, and cost-efficient policies” (p. 7).

3.0 Background (*cont...*)

Most recently, a 2009 review of international evidence on interventions to reduce health inequities noted that because health inequities arise from deeply rooted factors and long-standing structures within society, to achieve long-term and sustainable reductions in health inequities, the health system needs to “do things differently across a broad range of services” (Barr, 2009b, p. 3). In her review, Barr stresses the importance of the health sector continually re-evaluating its role and its ability to alter and adapt its role when necessary (Barr, 2009b). The author notes that health systems have a significant potential to influence health equity both through designing services and programs that address the needs of more vulnerable, disadvantaged, or marginalized populations, but also through the system’s impact on broader socio-political environments. As previously noted by the Health Disparities Task Group (2004) and again supported by Gilson et al (2007), the health sector is in a position to provide leadership to help develop processes and mechanisms that will support and provide leverage for intersectoral action.

4.0 Health System Barriers

This section describes seven overarching system-level barriers that were identified as contributing to health inequities by three Working Groups. These findings were supported by a literature review and the feedback and expertise of participants of a Strategy and Partnership Building Forum.

The overarching barriers, discussed in more detail below, are:

- Limited attachment to health care providers,
- Unavailability of extended health care services,
- Complexity of the health care system,
- Geographic and operational barriers,
- Discontinuity and limited partnerships between health services and other community services,
- The broader social determinants of health, and
- Lack of culturally-competent health services.

Building on the findings of the literature review *Improving Health Care System Responses to Chronic Disease among British Columbia's Immigrant, Refugee, and Corrections Populations* (Long, 2010), the three Working Groups identified⁵:

- Issues faced by members of their population of interest when using or navigating the health system,
- Gaps in health care service delivery, and
- Issues in the organization and delivery of health services or programs that may contribute to inequities in opportunity, inequities in access, and /or inequities in health.

In addition to several population-specific barriers identified by each Working Group, seven overarching barriers were consistent within all three Working Groups. These barriers were further reinforced as overarching contributors to inequity by participants of the Strategy and Partnership Building Forum. It is anticipated that these overarching system-level barriers are pertinent to many populations or groups in BC, particularly those that are currently underserved by the health care system.

The majority of the barriers identified by the Working Groups were found to be issues affecting the availability, accessibility, and acceptability of services. As noted in the Background section of this document, availability, accessibility, and acceptability are three key dimensions to equity in health care. The seven overarching barriers are organized below within the three dimensions, along with examples provided by the Working Groups to help demonstrate the challenges created by each barrier.

⁵ See Appendix C for a more detailed list of the specific recommendations of the three working groups.

4.0 Health System Barriers (*cont...*)

4.1 Availability

All three Working Groups identified limited availability of certain health care services as a significant barrier for populations obtaining needed health care and/or prevention services. Two overarching barriers that emerged were limited attachment to health care providers, including primary health care and family physicians, and the unavailability of extended health care services, including alternative therapies, mental health, dental, and vision care.

Factors that contributed to these barriers included:

- Lack of specialty clinics to address the unique mental health needs of refugees,
- Lack of services that address complex health needs (such as mental health and substance use issues or trauma),
- Limited services available in certain languages (resulting in language barriers), and
- Services that may not be widely available due to complex barriers to participation (such as strict eligibility criteria) or services that are not available to some clients because the services are not covered by Medicare or the Interim Federal Health Program.

4.0 Health System Barriers (cont...)

Barrier #1

Limited attachment to health care providers, including primary health care, specialty clinics, and family physicians.

Examples:

Immigrant Population Working Group:

- a. Immigrants may experience difficulties finding a primary health care provider, particularly in their own language. This can result in immigrants relying on certain segments of the health care system, such as emergency rooms, for their health care needs.
-

Corrections Population Working Group⁶:

- a. There is a limited number of primary prevention initiatives that address mental health and substance use issues or help reduce the impact of trauma – initiatives which could address vulnerabilities that can lead to criminal activity.
 - b. Members of this population often experience difficulty obtaining a primary health care provider or being eligible for services due to complex health needs (for example, mental health care and substance use treatment are often separate/exclusive from each other).
-

Refugee Population Working Group:

- a. There are many barriers that may prevent primary care providers from taking on refugee clients. Barriers identified include limited options or funding for interpreting services, insufficient reimbursement for the increased length of time required to provide appropriate medical care, and lack of knowledge regarding immigration procedures and overall refugee health. This population must often rely on Bridge Clinic, the New Canadian Clinics, and emergency rooms to address their health care needs.
 - b. There are limited available specialty clinics for refugees who require enhanced medical support, as well as limited available mental health services that have the capacity to understand the unique health needs of many refugees (for example, professionals trained to provide trauma counselling).
-

⁶ The 'Corrections Population' refers to individuals transitioning *into* or *out of* the corrections system.

4.0 Health System Barriers (*cont...*)

Barrier #2

Unavailability of extended health care services, including alternative therapies, mental health, dental, and vision care.

Examples:

Immigrant Population Working Group:

- a. Some immigrant sub-groups (e.g., sponsored seniors) experience difficulties obtaining extended medical care.
 - b. Most existing mental health services focus on persistent, major mental health issues. There is a lack of available mental health services for those individuals with depression, anxiety, or post-traumatic stress disorder.
-

Corrections Population Working Group:

- a. There are limited available extended health care services, particularly surrounding mental health. Furthermore, clients may encounter barriers to participation in services that *are* available due to strict referral and inclusion processes, limited capacity, or strict eligibility criteria.
-

Refugee Population Working Group:

- a. Government Assisted Refugees and refugee claimants frequently encounter significant barriers related to the Interim Federal Health program (IFH). Many primary health care clinics do not have the administrative staff to fill out the IFH forms, which can lead to refusal of care. Consequently, many clients are unable to be cared for within their communities.
 - b. Refugees may experience difficulty obtaining enhanced medical support due to a lack of specialty clinics, and they may be unable to pay for services that are not covered by IFH or Medicare. Refugees may have complex health needs that require additional support beyond what is offered by traditional primary care teams.
-

4.0 Health System Barriers (*cont...*)

4.2 Accessibility

Significant issues and barriers related to health system accessibility emerged throughout the project and were stressed to a great extent both within the Working Groups and among participants at the Strategy and Partnership Building Forum. Four overarching barriers related to accessibility emerged:

1. The complexity of the health care system as well as the provision of information in such a manner that does not enhance or promote health literacy,
2. Geographic and operational barriers that limit the accessibility of health services and programs,
3. Discontinuity and limited partnerships between health services and other services (community/settlement/social), and
4. The broader social determinants of health (including transportation and housing) significantly impact the extent to which individuals are able to utilize and navigate the health system.

The identified barriers highlight significant challenges that inhibit users from being able to fully and easily identify available services, access such services, and navigate the system as a whole. The impact of the broader social determinants of health on an individual's ability to access and utilize the health system was found to be a very important factor for all three populations of interest. In addition, opportunities to enhance the health literacy of all three populations through partnerships and linkages between the health system and community-based organizations were often limited due to poor coordination or lack of capacity.

4.0 Health System Barriers (cont...)

Barrier #3

Complexity of the health care system which leads to navigation and communication challenges and does not promote the user's ability to seek, understand, evaluate, communicate, and use health information and services.

Examples:

Immigrant Population Working Group:

- a. It can be extremely challenging for new immigrants to navigate and understand the complex Canadian health system.
 - b. The health system can hinder health literacy among health system users (for example, through the provision of information only in English or the use of jargon and advanced vocabulary).
-

Corrections Population Working Group:

- a. Many individuals that are transitioning into and out of the corrections system may have difficulty connecting with health services due to the complex manner in which services are offered. For example, some mental health programs do not take referrals; clients have to show up on a first come, first served basis but may not be seen as a result of limited capacity.
-

Refugee Population Working Group:

- a. Many refugees are unsure how to locate and access services or find a service provider that speaks their language. Communication is one of the most notable obstacles for refugees: lack of English proficiency can pose major obstacles and miscommunication with health care providers can lead to misdiagnosis, mistreatment, or lack of follow up.
-

4.0 Health System Barriers (cont...)

Barrier #4

Geographic and operational barriers that limit the accessibility of health services and programs.

Examples:

Immigrant Population Working Group:

- a. Many immigrants must travel long distances to obtain services in their own language or that meet their cultural needs.
 - b. Some immigrants are unable to access health care services or programs as a result of the hours during which services are provided.
-

Corrections Population Working Group:

- a. Services offered within the health system may be fragmented (i.e. mental health and substance use services are often not integrated), which can create challenges for many individuals in being able to have their health needs met.
-

Refugee Population Working Group:

- a. The physical location of health services can make it difficult for refugees to access care (e.g. due to cost of transportation and mothers who need to bring their children with them).
-

4.0 Health System Barriers (cont...)

Barrier #5

Discontinuity and limited partnerships between health services and other community services such as settlement or social programs.

Examples:

Immigrant Population Working Group:

- b. Settlement workers and immigrant serving agencies often have limited knowledge about the services health authorities provide, and vice versa, which limits how easily this information can be transferred to the community.
-

Corrections Population Working Group:

- a. The fragmentation of services (health promotion, primary prevention, care, and treatment) provided by community-based organizations, health authorities, correctional facilities, and government ministries can result in a failure to link individuals with available programs and services.
-

Refugee Population Working Group:

- a. The limited partnerships and linkages between health, settlement, and community-based programs can hinder a refugee's ability to navigate the complex health care system.
-

4.0 Health System Barriers (cont...)

Barrier #6

The broader social determinants of health (including transportation, housing and child care), which significantly impact the extent to which individuals are able to utilize and navigate the health system.

Examples:

Immigrant Population Working Group:

- a. The social determinants, including poverty, transportation, and housing, that impact the ability of immigrants to access health services.
-

Corrections Population Working Group:

- a. There is a significant lack of services that meet the basic needs of this population, particularly surrounding housing. It was noted by the Working Group that “the social determinants of health are the same as the social determinants of crime.”
-

Refugee Population Working Group:

- a. Housing, income assistance, loan repayment, employment, language, child care, and transportation were all highlighted as having a significant impact on a refugee’s ability to access and utilize the health system.
-

4.0 Health System Barriers (cont...)

4.3 Acceptability

The lack of available culturally competent health services and programs emerged consistently as an overarching barrier throughout the *Reducing Health Inequities* project's activities. The Working Groups noted that there is often limited cultural competence among health care providers, including a limited awareness of the health needs of newcomers to Canada or of the often complex health challenges experienced by many individuals involved with the corrections system. Furthermore, it was noted that the health system may not recognize the health knowledge and expertise of these populations and may neglect the possible extensive social stigma or additional determinants of health that play an important role in the lives of many of these individuals.

4.0 Health System Barriers (cont...)

Barrier #7

Lack of culturally competent health services, including limited cultural competency among health care providers.

Examples:

Immigrant Population Working Group:

- a. The health system does not always recognize the knowledge and expertise of new immigrants and immigrant communities.
- b. A lack of cultural competency can lead health care providers to neglect to consider potential interactions between Western medicine and traditional therapies that some immigrants might also employ.

Corrections Population Working Group:

- a. As a distinct cultural group, the corrections population has often experienced both stigma and social/community exclusion and often have complex health needs. Members of this population – particularly those transitioning into and out of the corrections system – require meaningful attachment to culturally competent health care providers who consider the basic needs and realities of this population.

Refugee Population Working Group:

- a. There is often limited understanding by health care providers of the complex health needs of refugees, which may significantly differ from the health care needs of the majority of patients.

In addition to the barriers that affect the availability, accessibility, and acceptability of the health system, another overarching barrier that emerged from the RHI project's activities was the lack of communication or knowledge exchange among different sectors. While the fragmentation between the health system and community-based organizations was noted to affect the accessibility of the health system, the Working Groups and forum participants further stressed that the health system may be neglecting to draw from a significant amount of expertise and knowledge within the community.

5.0 Recommendations for Action

This section sets out the recommendations for action that have emerged as a result of the project for how the health system can reduce health inequities and better meet the diverse needs of British Columbians.

Those five recommendations, discussed in more detail below, cover five areas:

- Developing, monitoring and measuring health equity targets,
 - Increasing health literacy,
 - Increasing equitable access to prevention and curative services for underserved populations,
 - Developing intersectoral collaboration and knowledge exchange mechanisms, and
 - Increasing the capacity of the health system to better serve the needs of BC’s culturally and linguistically diverse population.
-

5.1 Framing the Recommendations

Drawing on the literature review, the discussion paper, the recommendations of the three Working Groups, and the feedback received at the Strategy and Partnership Building Forum, recommendations for action have been identified for how the health system in BC can respond to health inequities and better meet the needs of currently underserved populations. The proposed recommendations build on the policy directions put forward by the Health Disparities Task Group (2004) and the Health Officers Council of BC (2008), and contribute to the increasing amount of recent literature that has emphasized the role the health system can play in reducing health inequities. Many of the recommendations that have emerged from this process are consistent either with past recommendations to enhance the health system’s ability to respond to the health needs of the population or with ongoing efforts within the province to better serve populations identified as “disadvantaged” or “vulnerable”. This consistency reflects the complex and challenging process of incorporating equity into the health system – a process that will require long-term, coordinated support and action at all levels of the system.

To address the challenges associated with promoting greater equity in health care, theoretical frameworks are helpful to 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). Mador (2010) describes the following two frameworks to guide and support the recommendations for action outlined in this section:

5.0 Recommendations for Action (cont...)

- The WHO Health System Framework, published by the Alliance for Health Policy and Systems Research in the World Health Organization (2007).
- Toronto-Central Local Health Integration Network (LHIN) Health Equity Framework (Gardner, 2008).

Many of the concepts put forward in these two frameworks outlined in Appendix B have been used to guide and support the proposed recommendations for action. Specifically, the concepts highlighting the need for the health system to identify health equity as an explicit strategic priority, the need to build equity into health system reforms, and the need for partnership building with external agencies, organizations, and members of the public. Collectively, the recommendations for action address four areas of the health system the WHO and LHIN frameworks identify as key areas to focus efforts to reduce health inequities:

- Leadership and governance,
- Service delivery and planning,
- Health workforce, and
- Health information/knowledge base.

5.2 Recommendations for Action

Within this section, five overarching recommendations for action are put forward to address systemic issues that may be contributing to health inequities and which respond to the main, overarching barriers identified by the three Working Groups⁷. A brief discussion of each recommendation is included, followed by a list of specific opportunities for action. Some of the opportunities for action are quite broad, while others address more specific barriers highlighted by the Working Groups. Several existing resources and initiatives have been identified that could be adapted, used, or built upon when implementing the proposed opportunities for action. These resources and initiatives are listed in Appendix E.

All of the recommendations and opportunities for action are intended to be undertaken by the health system in partnership with the communities being served and/or to be informed through meaningful involvement with local communities, stakeholders, and community members in their development, implementation, and evaluation. The proposed suggestions are intended to stimulate and inform further dialogue and action on how the health system can work to promote health equity and ensure more accessible, available, and acceptable health services to enhance the health of currently underserved groups in British Columbia.

⁷ Summaries of the specific recommendations put forward by each Working Group can be found in Appendix C.

5.0 Recommendations for Action (cont...)

1. Develop health equity targets and plans in consultation with communities and community members and actively monitor and measure their impact on health inequities by:

- » Building on current initiatives to utilize health equity assessment tools to coordinate the design, implementation and evaluation of ongoing and future policies, programs, and services.

Taking a health systems approach to improving health equity requires that “equity thinking” be incorporated into every level of the health system. Health stewards are encouraged to make use of all possible channels and resources available for enabling, encouraging, and ensuring health equity. Making a clear, strategic commitment to promoting health equity and setting clear expectations and goals to reduce existing barriers and issues that may be contributing to inequities in access and opportunity are important for the health system to be successful at reducing health inequities in the long-term. Continuously learning from and building on improvements that have worked well, monitoring policies, programs, services, and interventions for their impact on health equity, and adapting policies, programs, and services based on what has been learned will create an ongoing cycle of “equity-driven innovation” (Gardner, 2008, p.8).

Opportunities for Action:

- 1.1 Utilize equity assessment tools to ensure equity is incorporated in the design, implementation, and evaluation of ongoing and future policies, programs, services, activities, and initiatives.
- 1.2 Create a Health Equity Protocol or Audit process to ensure that equity targets are incorporated in the development of all system-wide policies and programs.
- 1.3 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. When analysing data, ensure that it is disaggregated based on gender, ethnicity, socio-economic status, and other relevant social categories.

2. Improve health literacy by:

- » Increasing the capacity of health care providers to communicate effectively with health system users and to respond to their diverse needs.
- » Supporting opportunities to increase the capacity of underserved or inappropriately served groups to better access, understand, communicate, evaluate, and act on health information and services.

Access to health information and resources has been shown to have a positive impact on health and health equity (Gilson et al, 2007). 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. Limited health literacy has been shown to be an important risk factor for poor health outcomes and health disparities (Volandes & Paasche-Orlow, 2007). The health system has a significant role to play in removing literacy-related barriers, utilizing clear communication practices, and ensuring that the proper mechanisms are in place to promote better understanding among all health system users (Agency for Healthcare Research and Quality, 2010).

5.0 Recommendations for Action (cont...)

Opportunities for Action:

- 2.1 Support the development, implementation, measurement, and evaluation of a Health Literacy Strategy for BC.
- 2.2 Implement multi-pronged educational strategies that will enhance the capacity of health care professionals to clearly communicate with their clients and to support improved access to information and services for health system users.
- 2.3 Develop partnerships with universities and colleges to ensure health literacy is embedded within the education of future health care professionals.
- 2.4 Build on and increase the capacity of language and interpreting services within the health system to provide interpreting services for a wide range of health services, including primary health care and counselling services.
- 2.5 Develop linkages with local community stakeholders, including community programs, organizations, agencies, faith communities, early settlement services, and educational or school programs to share information with currently underserved groups about navigating and accessing health system programs and services.
 - 2.5.1 Support the introduction of health literacy coordinators who could work in collaboration with community-serving organizations/programs and health authorities to provide improved health literacy support to health system users. For example, a health literacy coordinator could help improve health literacy among recent newcomers to BC by working in collaboration with settlement agencies, immigrant serving agencies, and health authorities.
- 2.6 Provide improved information support to health system users by utilizing community-based media sources as well as other information sharing methods and tailored information tools such as webinars, interactive plays, art, and interactive educational focus group or learning sessions as avenues to communicate health promotion and chronic disease prevention and self-management information. Involve local communities and stakeholders in the development of appropriate messaging.
- 2.7 Develop linkages with English as a Second Language (ESL) classes to support the introduction of health literacy curricula.
 - 2.7.1 Provide training to ESL teachers on educating their students about the Canadian health system.
 - 2.7.2 Introduce health promotion and education materials in a variety of formats, such as pictorial flashcards and role playing, tailored to a different learning abilities and strengths.

3. Increase equitable access to prevention and curative services for underserved populations by:

- » Enhancing the availability of community-based primary health care services.
- » Building on existing specialized, population-focused primary health care services.

The provision of effective primary health care is essential to reducing health inequities. Community-based primary health care that 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). As noted by all three Working Groups when discussing

5.0 Recommendations for Action (cont...)

health system barriers, there are a substantial number of barriers that can limit a population's ability to access and navigate the system. Implementing specialized health services that strategically target populations that are at greatest risk of being underserved by the health system or that face substantial social and health inequities is an effective strategy for reducing health system barriers and inequitable access to care (Gardner, 2008). In terms of prevention-oriented or self-management support programs and services, targeted programs that are designed to specifically address the health needs and issues of a particular geographic or underserved population, combined with universal programs, are necessary in order to have the greatest impact on reducing critical barriers to health services and programs. In the long-term, efforts to make the health system more equitable will benefit the entire population – not just those populations that require more targeted programs or services – as a result of the improved availability, accessibility, and acceptability of the health system all-around.

Opportunities for Action:

- 3.1 Increase the accessibility of primary health care services, health promotion, and primary prevention programs, and self-management services by offering and delivering services in locations where populations congregate (such as community centres, outreach organizations, and community and social organizations).
- 3.2 Support the implementation of collaborative health networks whose focus is to improve care for specific populations with complex chronic health conditions such as refugees or individuals transitioning into or out of the correctional system.
- 3.3 Support and expand specialty clinics that offer multi-disciplinary services, including mental health programs, trauma counselling, and social support services, to better meet the complex health needs of currently underserved or inappropriately served groups.

4. Develop intersectoral collaborative and knowledge exchange mechanisms to inform existing programs and the development of new health promotion, primary prevention, and self-management support programs that are culturally competent by:

- » Promoting communication and coordination between the health system and stakeholders, including community members, for dialogue and joint problem solving.

Engaging with other sectors whose work aligns with addressing the social determinants of health as well as community stakeholders in the development of health system policies, programs, and services is key to reducing health inequities and allowing the health system to be more responsive to the populations it serves (Gilson et al., 2007; UK Department of Health, 2002). Recognizing and effectively leveraging the breadth of knowledge and expertise that exists among community stakeholders will increase the health system's capacity to improve the accessibility and acceptability of the services it offers, such as health promotion and primary prevention programs. Unfortunately, there are often limited coordinated mechanisms and forums to share experiences and information about what is and is not working well. Providing opportunities for external stakeholders to provide input on health system programs and policies, while simultaneously partnering with community stakeholders to improve communication and raise awareness of the range of programs and services that are available, can help to decrease fragmentation between the health system and other sectors that are also working to reduce health inequities. Enhanced collaboration and coordinated mechanisms for knowledge exchange would provide opportunities to share available research, evaluations, and existing promising practices.

5.0 Recommendations for Action (cont...)

Opportunities for Action:

- 4.1 Develop a centralized coordinating mechanism within the health authorities to bring together stakeholders, including community members, for dialogue and joint problem solving.
- 4.2 Improve the health system's accessibility and responsiveness by developing, implementing, and evaluating health programs and services in partnership with the communities and community members being served by supporting and building on existing community support programs and advisory committees.
- 4.3 Promote communication and coordination between the health system and external stakeholders by examining where opportunities exist to set up processes for information sharing to communicate best practices and research findings more effectively.
- 4.4 Improve continuity of care by developing mechanisms for secure patient care information sharing between health authorities and other health care providers such as primary care physicians or the correctional system's health facilities.
- 4.5 Strengthen linkages with community-serving organizations and other local stakeholders to share information about the range of services and programs available within the health system and the community.
 - 4.5.1 Link to existing health and community information and referral services that could be communicated widely.

5. Increase the capacity of the health system to better serve the needs of BC's culturally and linguistically diverse population by:

- » Ensuring that policies, programs, and services are culturally competent.
- » Providing skill-based cultural competency training opportunities for health system providers to improve communication with users and to respond to their diverse needs.

Rather than simply fixing health system barriers, a culturally competent health system responds to the particular needs of its population by developing a variety of approaches to meet the health needs of currently underserved populations (Gardner, 2008). A health system that is responsive to the diverse health beliefs, practices, and linguistic and cultural needs of its users enhances the acceptability of the health system.

Opportunities for Action:

- 5.1 Develop a centralized infrastructure to oversee cultural competence within the health system, including the development and implementation of provincial standards for culturally competent policies, programs, and services, and the measurement of the impact and outcomes of such standards.
- 5.2 Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population.
- 5.3 Learn from and build on existing cultural competency training models to create a multicultural competency training program available to all health system staff to enhance the delivery of high quality programs and services.
 - 5.3.1 Utilize the knowledge and expertise of community members and organizations to help develop the cultural competency training modules and tools for health system employees.

5.0 Recommendations for Action (cont...)

- 5.4 Implement multi-pronged educational strategies to ensure that all health system staff receive ongoing education and training in cultural competency and about the importance and appropriate use of interpreting services.
- 5.5 Monitor and evaluate the implementation of cultural competency training and overall organizational cultural competence to continually modify and improve the training based on identified barriers and successes. Measures could be included within staff/department performance improvement plans and patient-satisfaction assessments.
- 5.6 Partner with universities and colleges to ensure cultural competence is embedded in medical education and training.
- 5.7 Engage with community members and community organizations to help assess and enhance the system's capacity to deliver health services and programs, including prevention efforts and interventions to enhance coping skills, in a culturally competent manner.
- 5.8 Utilize existing websites created for primary care teams and health care providers to provide information on best practices in providing care for diverse populations. Include tools, resources, and a directory of relevant community organizations.
- 5.9 Explore the introduction of cultural health broker⁸ and patient navigator programs, building on existing models. Patient navigators and cultural health brokers can help individuals navigate the health system, help improve health literacy, enhance the capacity of health care providers and organizations to deliver more culturally competent care, and work in liaison with the health system and other sectors.

⁸ Cultural health brokers are multilingual, bilingual and bi-cultural, meaning they have a deep cultural understanding of both the culture of the health system and the health system user's cultural community.

6.0 Moving Towards Reducing Health Inequities: Priorities & Additional Opportunities

This section outlines:

- The two recommendations for action that have been identified as priorities by project stakeholders, and
 - Additional opportunities requiring further exploration, dialogue, and action.
-

6.1 Priority Recommendations

This discussion paper brings together the knowledge and expertise of many stakeholders that have an interest in reducing health inequities. As a determinant of health, the health system has an important role to play in reducing health inequities and ensuring that its policies, programs, and services are organized and delivered in a manner that meets the health needs of all British Columbians. The themes and recommendations for action that have emerged from the *Reducing Health Inequities* project can be used to inform all components of the health system, including ongoing and future activities of the health authorities in BC, as well as initiatives and policies put forward by the Ministry of Health Services⁹. The recommendations and opportunities for action in this report can be adapted by the health system to examine, modify, and build on existing and future policies, programs, and services, but in practice, not all can be addressed at once. The following two recommendations for action have been identified by project stakeholders as priorities:

1. Develop health equity targets and plans in consultation with communities and actively monitor and measure their impact on health inequities by:
 - » Building on current initiatives to utilize health equity assessment tools to coordinate the design, implementation, and evaluation of ongoing and future policies, programs, and services.
2. Improve health literacy by:
 - » Increasing the capacity of health care providers to communicate effectively with health system users and to respond to their diverse needs.
 - » Supporting opportunities to increase the capacity of underserved or inappropriately served groups to better access, understand, communicate, evaluate, and act on health information and services.

⁹ See Appendix D for a list of ongoing activities and initiatives.

6.0 Moving Towards Reducing Health Inequities: Priorities & Additional Opportunities (cont...)

6.2 Additional Opportunities for Further Dialogue and Action

One of the main objectives of the *Reducing Health Inequities* project was to foster dialogue and action on health inequities in BC and to add to the existing literature and evidence on the role the health system can play in reducing those inequities. Due to the short timeframe of the project, there are certain areas and potential opportunities that were put forward by RHI project stakeholders that will require further exploration, dialogue, and action. The areas include:

- Exploring the unique role medical health officers have in maintaining and improving the health and well-being of BC's communities, and utilizing their knowledge and skills to identify and report on health inequities*.
- Reviewing the current Ministry of Health Services Business Case Template for Clinical Services or Programs. Currently the template includes “population equity” and “geographic equity” under the section titled “Analysis of Other Impacts”. The template could be reviewed and expanded to include an equity focused health impact assessment that all submitting authors are required to complete to determine the potential impact of proposed projects and initiatives on reducing variations in health and to identify any potential unanticipated inequities.
- Creating a practical, pragmatic strategy that highlights the benefits to community and patient safety as well as the cost-effectiveness of reducing health inequities. Perhaps this could be in the form of a Provincial Health Officer's report.
- Exploring opportunities to enhance the capacity of internal (health system) and external (non-health system) champions to voice their concerns related to health inequities to decision makers.
- Creating a business case to present to decision makers with evidence for reducing health inequities (including the size and significance of the issue) along with a cost-analysis that demonstrates the cost-effectiveness of reducing health inequities.
- Exploring opportunities for health authorities and medical health officers to utilize their ongoing relationships with municipal planners to become more involved in the planning of healthy communities.
- Creating targeted health improvement plans for currently underserved groups, such as a “Refugee Health Improvement Plan,” to present to the provincial government.
- Supporting the creation of a Provincial Health Officer's report on immigrant and refugee health in BC that highlights patient safety and cost-effectiveness in a practical and pragmatic way.

* A description of the roles and responsibilities of medical health officers can be found at: http://www.health.gov.bc.ca/pho/public_health.html

7.0 Moving Towards Reducing Health Inequities: A Call to Action

This section explains:

- The need for ongoing attention to health inequities in BC,
 - How senior health executives can contribute,
 - How health program or service managers can incorporate strategies to reduce health inequities,
 - How front-line health care providers can play a role,
 - A simple process individuals or teams can use to address health inequities, and
 - How addressing health inequities can have broad benefits for British Columbians.
-

The outcomes of the *Reducing Health Inequities* project support the ongoing commitment and work within British Columbia to ensure that the design and delivery of health system policies, programs, and services do not exacerbate health inequities. This report identifies ways in which BC's health system is moving in the right direction, but opportunities for improvement still remain. And, even though not everyone in the health system works with the three specific underserved populations focused on in this report, the themes, issues, and opportunities identified are likely to be pertinent to many underserved groups in BC.

The information contained in this document is valuable and applicable to those working at all levels of the health system. The most significant first step anyone can take towards reducing health inequities is to consider what role they can most effectively play, given their level of engagement within the system.

Senior health executives have an opportunity to endorse the findings in this document, make a strategic commitment for action, and provide their organization and staff with the mandate and support to incorporate the types of strategies identified in this report into health policy, planning, and service delivery. Developing health equity targets and plans and improving health literacy are the recommended priorities.

Health program or service managers have opportunities to incorporate strategies to reduce health inequities into health program and service planning and delivery. They are in a position to be able to:

- Improve existing promotion, prevention and self-management programs,
- Make the case for new and/or enhanced programs and services as required and to utilize intersectoral collaborative and knowledge exchange mechanisms to do so,
- Contribute to the development and measurement of health equity targets,
- Influence and lead health literacy efforts, and
- Encourage cultural competency among their staff.

7.0 Moving Towards Reducing Health Inequities: A Call to Action (cont...)

Front line health care providers have chances to incorporate strategies to reduce health inequities into their day-to-day interaction with health system users. They are in an excellent position to provide cultural competency training and to support patients and their families in their efforts to better understand health information and services.

In order to maximize the usability of the information, rather than being prescriptive, this document provides general recommendations as well as more detailed opportunities for action so that each individual, team, and organization can identify what's applicable in their context and chart their own course of action.

An important contribution any individual or group can make towards reducing health inequities is to ask themselves how they and/or their team, agency, or organization can examine, modify, and build upon existing and future policies, programs, and services in order to help strengthen the system's capacity to promote health equity and to deliver high quality programs and services that are available, accessible, and acceptable to all British Columbians. A process for engaging in this type of reflection and planning could take place at an individual, team, or agency/organizational level. Individuals working in the health system can take steps to modify or improve the way they do their work in order to help decrease inequities and improve health equity for populations – many of the opportunities for action are relevant at the individual as well as the group level. The following steps outline a simple process to initiate work to either begin to address or to further address health inequities within any organization:

1. Identify the level from which to approach this task (e.g., individual, team, or organizational) and proceed accordingly. Form a team if/as appropriate (reviewing questions #2 and #3 below should stimulate some ideas regarding who to involve).
2. Review the five broad recommendations for action and 27 specific opportunities for action in this report with the following questions in mind:
 - » Where are individuals, where are certain teams, or where is the organization as a whole already playing a role? That is, where is work to address inequities or promote health equity already being done within the organization? For those areas where a role is currently being played, ask whether there are any opportunities for improvement or enhancement. Add to or revise team membership as necessary in order to most effectively address these questions.
 - » Where is there a gap? That is, where does an individual, team, or the organization as a whole have an appropriate role to play but is not currently playing one? Identify how to become involved. For example, review the list of current BC activities and initiatives (Appendix D), and ask if it is possible to align with, complement, and/or support any of these nine initiatives. Identify other initiatives not listed, and ask if it is possible to align with, complement, and/or support them. Ask whether there is a need and opportunity for an individual, team, or the organization as a whole to lead or co-lead a new initiative. Review the opportunities for further dialogue and action highlighted in Section 6 and identify ways to contribute. Add to or revise team membership as necessary in order to most effectively address these questions.

7.0 Moving Towards Reducing Health Inequities: A Call to Action (cont...)

3. Based on the answers to these first two questions, the final step is to develop a plan for taking action which identifies activities, expected outcomes, deliverables, timelines, and lead(s). The plan can be as simple or as complex as desired. For example, for an individual, a plan could be to complete the PHSA Aboriginal cultural competency training; for a team of health system managers, the plan could involve a much more detailed list of actions required to implement a comprehensive strategy to improve health literacy around the programs and services their health authority offers. Consider the following as the plan is being developed:
 - » Is it possible to work on the development of health equity targets and improvement of health literacy as priority actions? If so, this is the recommended course of action.
 - » Are there existing tools, frameworks, and/or other resources that could be used to help develop and implement the action plan? See Appendix E for a list of those resources.
 - » How can the health system partner with the communities being served? The action plan should include mechanisms to establish meaningful engagement with local community stakeholders in the development, implementation, and evaluation of actions.

Conclusion

In summary, the health system has an important role to play in promoting health equity and in ensuring that its policies, programs, and services are available, accessible and acceptable to all British Columbians. This report builds on previous recommendations to enhance the health system's ability to respond to the health needs of the population and with ongoing efforts within the province to better meet the needs of underserved populations.

Taking action to resolve health system barriers and issues which may be inadvertently creating or perpetuating health inequities would not only improve the effectiveness of the health system in the provision of chronic disease prevention and treatment programs and services for people who are currently underserved, but would also help to reduce the burden and economic costs of chronic disease and health inequities. A health system that incorporates equity into all aspects of the system will better meet the health needs of currently underserved populations in BC, and by reducing inequities will lead to improved quality of life for all British Columbians.

Appendix A: Participants in the *Reducing Health Inequities* Project

Steering Committee

Name	Organization / Agency
Paola Ardiles (Chair)	BC Mental Health & Addiction Services
Lydia Drasic	Population & Public Health (PHSA)
Carole Gillam	Vancouver Coastal Health
Andrew Kmetic	Population & Public Health (PHSA)
John Millar	Population & Public Health (PHSA)
Ann Pederson	BC Women's Hospital & Health Centre and the BC Centre of Excellence for Women's Health
Meredith Woermke	Population & Public Health (PHSA)

Advisory Group

Name	Organization / Agency
Paola Ardiles (Co-Chair)	BC Mental Health & Addiction Services
Sherry Bar	Ministry of Health Services
Lex Bass	Interior Health
Paul Beckett	Ministry of Public Safety and Solicitor General
Ted Bruce	Vancouver Coastal Health
Gail Butt	BC Centre for Disease Control
Veronic Clair	Fraser Health
Lydia Drasic	Population & Public Health (PHSA)

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*

Advisory Group (cont...)

Name	Organization / Agency
Dominic Fung	Ministry of Regional Economic and Skills Development
Joan Geber	Women's Healthy Living Secretariat, Ministry of Health Services
Carole Gillam	Vancouver Coastal Health
Trevor Hancock	Ministry of Health Services
Caryl Harper	Vancouver Island Health Authority
Julie Kerr	Northern Health
Andrew Kmetic (Co-Chair)	Population & Public Health (PHSA)
Eric Kowalski	Interior Health
Mel Krajden	BC Centre for Disease Control
Victoria Lee	Fraser Health
Kelly McQuillen	Ministry of Health Services
John Millar	Population & Public Health (PHSA)
Joanne Mills	Interior Health
Donna Murphy-Burke	BC Renal Agency
Judi Mussenden	Fraser Health
Ann Pederson	BC Women's Hospital & Health Centre and the BC Centre of Excellence for Women's Health
Sylvia Robinson	Ministry of Health Services
Helena Swinkels	Fraser Health
Leslie Varley	Centre for Aboriginal Health (PHSA)

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*

Advisory Group (cont...)

Name	Organization / Agency
Fiona Walks	BC Cancer Agency
Meredith Woermke	Population & Public Health (PHSA)
Laurie Woodland	Ministry of Health Services

Immigrant Population Working Group

Name	Organization / Agency
Ted Bruce (Chair)	Population Health, Vancouver Coastal Health
Annie Carnot	Provincial Language Service (PHSA)
Patricia Dabiri	BC Multicultural Health Services Society / REACH
Arminee Kazanjian	University of British Columbia
Sharon Koehn	Centre for Healthy Aging, Providence Health
Karla Maranhao	Cross Cultural Mental Health Program, Vancouver Coastal Health
Lucie McNeill	Community Engagement, Vancouver Coastal Health
Helen Novak Lauscher	University of British Columbia
Iraj Poureslami	University of British Columbia
Dora Replanski	Affiliation of Multicultural Societies and Services (AMSSA)
Norma Sanchez	Cross Cultural Mental Health Program, Vancouver Coastal Health

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*Corrections Population Working Group¹⁰

Name	Organization / Agency
Paul Beckett	Ministry of Public Safety and Solicitor General
Gail Butt (co-chair)	BC Centre for Disease Control
Jane Buxton	BC Centre for Disease Control
Adriaan de Vries	BC Persons with AIDS Society
Toni Edenshaw	Aboriginal Health, Vancouver Island Health Authority
Ruth Elwood Martin	University of British Columbia
Caryl Harper	Public Health, Vancouver Island Health Authority
Drew Hart	Complex Mental Health and Addictions, Vancouver Coastal Health
Heather Hay	Complex Mental Health and Addictions, Vancouver Coastal Health
Mel Krajden (co-chair)	BC Centre for Disease Control
Jamie Livingston	BC Mental Health and Addictions Services
Larry Loranger	AIDS Society of Kamloops
Dale Lutes	John Howard Society of the Lower Mainland
Maureen Olley	Ministry of Public Safety and Solicitor General
Kelly Reid	Mental Health and Addiction, Vancouver Island Health Authority
Nadar Sharifi	BC Mental Health and Addictions Services
Karen Sloat	Correctional Service Canada
Stephen Smith	Former Ministry of Healthy Living and Sport

¹⁰ The 'Corrections Population' refers to individuals transitioning into or out of the corrections system.

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*

Refugee Population Working Group

Name	Organization / Agency
Cheryl Anderson	University of British Columbia
Cindy Arbeau	New Canadian Clinics, Fraser Health
Daljit Badesha	DiverseCity
Denise Bradshaw	Bridge Clinic, Vancouver Coastal Health
Byron Cruz	BC Centre for Disease Control
Dominic Fung	Ministry of Regional Economic and Skills Development
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Kiran Malli	Provincial Language Service (PHSA)
Maureen Mayhew	Bridge Clinic, Vancouver Coastal Health
Judi Mussenden (Chair)	Health Promotion and Prevention, Fraser Health
Chaya Ransen	BC Multicultural Health Services Society
Jane Sauer	Langley Community Services

Participants at the October 4, 2010 Strategy and Partnership Building Forum

In addition to members of the Steering Committee, Advisory Group, and Working Groups

Name	Organization / Agency
Carol Anderson	South Fraser Community Services Society
Dieter Ayers	PHSA – Population & Public Health
Linda Bachmann	Fraser Health

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*

Participants at the October 4, 2010 Strategy and Partnership Building Forum (cont...)

Name	Organization / Agency
Suzanne Barclay	PHSA – Provincial Language Service
Marci Bearance	Ministry of Advanced Education and Labour Market Development
Blaine Bray	Providence Health Care
Johann Brink	PHSA – BC Mental Health and Addictions Services
Jami Brown	Fraser Health
Lynn Buhler	Vancouver Coastal Health
John Carsley	Vancouver Coastal Health Authority
Wendy Chang	Circles of Care and Connection
Ronald Chapman	Northern Health Authority
Kathleen Cherrington	BC Persons with AIDS Society
Karen Clarke	Vancouver Coastal Health
Leslie Clough	BC Children's Hospital, Sunny Hill Health Centre for Children, BC Women's Hospital & Health Centre
Trevor Corneil	Vancouver Coastal Health Authority
Susan Craigie	BC Persons with AIDS Society
Jasmine Dadachanji	Adult Custody Division of the Corrections Branch, Ministry of Public Safety & Solicitor General
Meenakshi Dawar	Vancouver Coastal Health
Brian Evoy	General Practice Services Committee
Jeanne Fike	Burnaby Family Life

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*

Participants at the October 4, 2010 Strategy and Partnership Building Forum (cont...)

Name	Organization / Agency
Tim Foggin	Community Medicine Resident
Maylene Fong	Vancouver Coastal Health
Debra Gaskell	Correctional Service Canada
Shannon Griffin	PHSA – BC Mental Health and Addictions Services
Reka Gustafson	Vancouver Coastal Health Authority – Vancouver Health Service Delivery Area
Jan Hajek	PHSA – BCCDC
Scott Harrison	BC Centre for Excellence in HIV/AIDS
Lorie Hrycuik	Ministry of Healthy Living and Sport – Women's Healthy Living Secretariat
Deepthi Jayatilaka	PHSA – Population & Public Health
Bashir Jiwani	Fraser Health
Teresa Kazieva	SHARE Family and Community Services
Tom Keenan	Ministry of Housing & Social Development – Fraser Region
Mandip Kharod-Clark	Canadian Cancer Society
Jennifer Kim	Ministry of Advanced Education and Labour Market Development
Martine Lagasse	La Boussole
Jeanne Legare	Consultant
Ranjit Lehal	Fraser Health Authority
Pauline Lentinu	Correctional Services of Canada

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*

Participants at the October 4, 2010 Strategy and Partnership Building Forum (cont...)

Name	Organization / Agency
James Lu	Vancouver Coastal Health
Gabor Maté	Portland Hotel Society
Anne McNabb	Vancouver Coastal Health
Lori Medeiros	Ministry of Healthy Living & Sport – Aboriginal Healthy Living Branch
Lynn Moran	AMSSA
Val Munroe	Vancouver Coastal Health
Marina Niks	Centre for Health and Community Partnerships Douglas College
Brian O'Connor	Vancouver Coastal Health
Carol Park	Vancouver Coastal Health Authority
Coreen Paul	PHSA – Aboriginal Health
Kayla Pompu	Simon Fraser University
Ajay Puri	UBC
Alana Rauscher	PHSA – BC Mental Health and Addiction Services
Michael Rekart	PHSA – BC Center for Disease Control
Nadya Repin	Health Canada – British Columbia Region
Joyce Resin	Impact BC
Irv Rootman	University of Victoria
Madhvi Russell	Citizenship and Immigration Canada
Beth Snow	Fraser Health

Appendix A: Participants in the *Reducing Health Inequities Project (cont...)*

Participants at the October 4, 2010 Strategy and Partnership Building Forum (cont...)

Name	Organization / Agency
Andrea Sola	Family Services of Greater Vancouver
Kusum Soni	Mission Community Services
Holly Stamm	PHSA – BC Mental Health and Addiction Services
Elizabeth Stanger	Vancouver Coastal Health
Adrienne Taplin-White	Public Health Agency of Canada
Jim Thorsteinson	BC College of Family Physicians
Samantha Tong	Fraser Health
Ann Vanderbijl	Providence Health Care
Dr. Wameed	Physician
George Watson	General Practice Services Committee
Michelle Webb	Lower Mainland Purpose Society
Lesley Woodman	DiverseCity
Brian Worth	Calibre Health Services

Appendix B: Frameworks for Understanding Equity and Health Systems

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. 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). 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 it is imperative that initiatives designed to promote health equity be cognizant of the linkages, relationships, and interactions among the elements of the system. Although the WHO has developed the Health System 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:

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

Noting that the relationships, interdependencies, and interactions among these sub-systems are what constitutes a functioning health system, interventions designed to promote equity must strengthen and evaluate each of these domains as well as the interrelationships among 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 to expand the focus beyond the design and delivery of health services to include other aspects of the health system. 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.

Appendix B: Frameworks for Understanding Equity and Health Systems (cont...)

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 (Gardner, 2008). 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:

1. **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.
2. **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.
3. **System Transformation:** Build equity into health system reforms so 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.

The Health Equity Framework 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 the 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.

Appendix B: Frameworks for Understanding Equity and Health Systems (*cont...*)

The WHO Health System Framework and the LHIN Health Equity Framework provide complementary perspectives on a health systems approach to increasing health equity. A health systems approach involves addressing all aspects of the health system, including leadership, financing, program and service delivery, the health workforce, health information, and medical technologies. 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.

Appendix C: Specific Recommendations of the Three Working Groups

Towards Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention

Corrections Population Working Group Recommendations

The Corrections Population Working Group included representatives from a diverse range of organizations including:

- AIDS Society of Kamloops (ASK)
- BC Persons with AIDS Society
- Correctional Service Canada
- John Howard Society of the Lower Mainland
- Ministry of Healthy Living and Sport
- Ministry of Public Safety and Solicitor General, Corrections Branch
- PHSA – BC Centre for Disease Control
- PHSA – BC Mental Health and Addictions Services
- University of British Columbia
- Vancouver Coastal Health- Complex Mental Health and Addictions
- Vancouver Island Health Authority

Care provided during incarceration is generally good. However, there are major challenges to maintaining continuity of care, particularly when individuals transition into and out of the corrections system. Continuity of care must be addressed to avoid gaps during transition points:

- in the community,
- entering custody,
- during custody,
- release from custody, and
- re-integration within the community.

Based on five meetings, the Corrections Working Group identified five recommendation areas aimed at reducing fragmentation across the continuum of care.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

Corrections Population Recommendations

Barrier

Opportunities for Action

Vulnerabilities can lead to criminal activity.

Implement primary prevention initiatives to address vulnerabilities that can lead to criminal activity. A population-based prevention focus integrated with a Primary Care Health Services model would enable people to access health and social services early and thereby reduce the risk of requiring correctional services as a result of unaddressed addictions/mental illness issues. This prevention initiative would have two aspects:

- High level partnerships between sectors and jurisdictions, including the Ministry of Housing and Social Development.
- Educational programming for service providers and decision makers involved with under-served populations about successful prevention initiatives and alternatives to entering corrections.

Need for a culturally-responsive and person-centred approach.

Health services should integrate a culturally-responsive and person-centred approach.

- A culturally-responsive approach could help communities understand the basic needs of corrections populations.
- A person-centred approach could help communities recognize the need for integrated services to prevent care fragmentation e.g. integration of mental health and addictions services due to the frequency of these co-morbidities.

Inadequate access to health and social support services increases the risk of recidivism.

- Government ministries, health authorities, and provincial and federal corrections should work in partnership to improve continuity of care. Improved partnerships can ensure better access to health and social support services and reduce the risk of recidivism.
- Participation in health services accreditation processes by correctional facilities would help identify the organizational practices that could strengthen service delivery and transition planning to improve continuity of care.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

Corrections Population Recommendations (cont...)

Barrier

Health information gaps present enormous obstacles to providing continuity of care and can lead to morbidity or death.

Opportunities for Action

Information exchange processes should be developed to enable corrections and the health authorities to share relevant information. This includes:

- Clarifying and consistently applying information sharing policies and procedures.
- Implementing standardized information sharing procedures and processes wherever possible.

Insufficient transition planning for corrections populations.

Improve transition planning to enable corrections populations to bridge the gaps when individuals move within and/or between systems. This includes:

- Formalizing agreements between corrections and the relevant provider(s).
- Implementing a quality monitoring process implemented.
- Implementing a participatory approach to transition planning that engages individuals who are in, or have been through the corrections system.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

Towards Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention

Immigrant Population Working Group Recommendations

The Immigrant Population Working Group includes representatives from a diverse range of organizations including:

- Affiliation of Multicultural Societies and Service Agencies
- Centre for Healthy Aging, Providence
- Provincial Health Services Authority
 - » Provincial Language Services
- REACH Community Health Centre
- University of British Columbia
 - » Faculty of Medicine
 - » School of Population Health and Public Health
- Vancouver Coastal Health
 - » Community Engagement
 - » Cross Cultural Mental Health Program
 - » Population Health

The Working Group used “A Framework for Conceptualizing Equity in Health Care” to organize recommendations. This framework is based on three dimensions for understanding equity in the delivery of health services:

- Availability,
- Accessibility, and
- Acceptability.

Based on five meetings of the Immigrant Population Working Group and a Community Engagement meeting with various settlement and immigrant serving agencies, a number of Barriers and Opportunities for Action were identified. The following is a summary of the Working Group’s findings.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

1. Availability of Services

Barrier

Opportunities for Action

Immigrants can experience difficulties finding a family physician and accessing health care in their own language.

- Increase capacity within the interpreting community to provide services to GPs.
- Provide the opportunity for foreign trained health care professionals to act cultural health brokers.

It can be challenging for some immigrant sub-groups (e.g. sponsored seniors) to obtain extended medical care.

- Improve the availability of extended health care services.

2. Accessibility of Services

Barrier

Opportunities for Action

Immigrants have challenges in navigating the complexity of the Canadian health care system.

- Increase support for cultural health brokers.
- Hire foreign trained health care professionals as cultural health brokers.

A lack of culturally responsive and physically accessible health services means:

- Immigrants may travel long distances.
- Services may not be provided at suitable times for immigrants.
- Health care providers may not recognize mental health issues of immigrants.

Partner with localized immigrant community organizations to provide:

- Health promotion.
- Medical outreach services.
- Mental health services.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

2. Accessibility of Services (cont...)

Barrier	Opportunities for Action
<p>Discontinuity between settlement services and health services means that settlement workers often have limited knowledge about available health services.</p>	<ul style="list-style-type: none"> • Build capacity among settlement workers & immigrant serving agencies. • Improve information support between health literacy coordinators and settlement agencies. • Improve collaboration between community agencies and settlement workers.
<p>Information is provided in a way that does not enhance health literacy, such as using only English and using jargon or advanced vocabulary.</p>	<ul style="list-style-type: none"> • Improve health literacy by utilizing: <ul style="list-style-type: none"> » cultural health brokers and existing community programs, » media, such as radio and TV, and » ESL classes. • Promote awareness of interpreting services for health care providers. • Develop partnerships between immigrant serving agencies and the BC Health Literacy Strategy.
<p>Waiting periods can delay access for new immigrants to access the publicly funded health care system.</p>	<p>Examine waiting period policies in BC, as they appear to contradict the Accessibility Principle of the Canada Health Act.</p>
<p>The Social Determinants of Health including poverty, transportation and housing affect health status of immigrants.</p>	<p>Support within the health sector to address the social determinants of health.</p>

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

3. Acceptability of Services/Patient Centered Care

Barrier	Opportunities for Action
<p>Limited cultural competency means that health care is not always culturally responsive.</p>	<p>Improve culturally competency and cultural safety by:</p> <ul style="list-style-type: none"> • providing education to health care providers, including how to work with cultural brokers and interpreters, as well as on the use of alternate therapies, and
<p>Limited cultural safety means that immigrants don't always feel their cultural identity has been respected.</p>	<ul style="list-style-type: none"> • utilizing the knowledge and expertise of immigrant serving agencies to help train health care providers and/or improve health programs and services.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

Towards Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention

Refugee Population Working Group Recommendations

The Refugee Population Working Group included representation from:

- BC Multicultural Health Services Society
- DiverseCity
- Fraser Health
- Langley Community Services (Early Years Refugee Project)
- Ministry of Advanced Education and Labour Market Development
- Provincial Health Services Authority
- University of British Columbia
- Vancouver Coastal Health

The Working Group defined “refugee” to include government-assisted refugees (GAR), refugee claimants and migrant workers.

Over the course of five meetings, the Refugee Population Working Group identified **three main strategies** for how the health care system can better meet the needs of refugee populations in British Columbia. The following is a summary of Barriers and Opportunities for Action for each strategy.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

1. Build capacity and quality in the health care system

Barrier	Opportunities for Action
<p>Limited capacity of primary care providers to take on refugee clients, as:</p> <ul style="list-style-type: none"> • interpretation services are limited. • practitioners are insufficiently reimbursed for working with refugees. • there is a lack of knowledge about health issues that refugees face. 	<ul style="list-style-type: none"> • Add refugees to chronic disease group so GPs will receive extra remuneration. • Create MSP fee code for interpreting services. • Create a website that provides information to primary care teams. • Ensure the availability of specialty clinics for refugees who require enhanced medical support.
<p>Limited resources available to address Pre/post migration stressors can cause high rates of mental illness.</p>	<ul style="list-style-type: none"> • Increase availability of trauma counselling. • Train teachers and counsellors to identify mental health concerns in refugee children. • The Interim Federal Health (IFH) program should fund counselling and interpretation for counselling for refugees. • Create a website to help caregivers locate resources.
<p>Inadequate medical insurance coverage for refugees.</p>	<ul style="list-style-type: none"> • Extend medical coverage to migrant workers. • Simplify the IFH processes and improve timeliness of the payment system.
<p>Inadequate number of culturally competent health care providers.</p>	<ul style="list-style-type: none"> • Provide cultural competency training to front line staff, health care providers and students. • Implement a cultural health broker program.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

2. Improve partnerships between health care system and settlement/community-based organizations

Barrier

Opportunities for Action

Limited partnerships and linkages with organizations that work with refugees to raise the awareness about the range of services that are available to refugees.

- Create new government position that could serve as a liaison between organizations.
- Create a list of community groups arranged geographically and by language.
- Promote communication and coordination between health services and settlement agencies.

Inadequate legal representation for refugees.

- Provide free legal representation for refugees.
- Ensure that laws and regulations under Employment Standards and WorkSafe BC are complied to by employers of migrant workers.

Refugees face difficulties navigating the complexity of the Canadian Health Care System.

- Implement a cultural health broker program, building on existing models.

Appendix C: Specific Recommendations of the Three Working Groups (cont...)

3. Health care system utilization linked to the social determinants of health

Barrier	Opportunities for Action
Lack of safe, affordable and adequate housing, and difficulties in securing housing.	<ul style="list-style-type: none"> • Increase the number of housing search workers. • Eliminate wait period for BC Rental Assistance. • Increase the transition time period out of Welcome House.
Financial constraints affect access to health care.	<ul style="list-style-type: none"> • Enhance level of income assistance. • Extend income assistance period for refugees, after they find employment. • Abolish travel loan repayment. • Provide childcare for two years post-arrival.
Insufficient job training and employment opportunities for refugees.	<ul style="list-style-type: none"> • Develop job coaching, counselling and specialty training services for refugees.
Miscommunication between health care providers and refugees.	<ul style="list-style-type: none"> • Increase diversity of types of English as a second language classes, including programs for illiterate people, different learning abilities, locations, rates of learning, etc.
Difficulties with mobility and transportation to access health care.	<ul style="list-style-type: none"> • Provide bus pass. • Revise policy around the number of stroller permitted on the bus. • Develop and fund mobile health clinic. • Provide accompaniment (e.g. cultural health broker).

Appendix D: Aligning with Ongoing Activities and Initiatives

Project stakeholders have identified the following ongoing activities and initiatives that the outcomes of the *Reducing Health Inequities* project can align with, complement, and support:

- ***Divisions of Family Practice.*** Divisions are groups of family physicians in the same geographic region of BC who work to address common health care goals. Each Division works in partnership with their health authority, the General Practice Services Committee, and the Ministry of Health Services to they identify gaps that exist in patient care in a Division's community and to develop solutions to meet their community's needs. The initiative uses a population health approach with the intention of improving health outcomes in the community. Benefits of Divisions include increased ability to address the needs of patients and the provision of primary care as a collective responsibility (Divisions of Family Practice, 2011).
- ***Health Authority Employee Wellness and Safety.*** The outcomes and recommendations for action that have emerged from the *Reducing Health Inequities* project can potentially be used to support the work of health authorities around employee health and safety.
- ***Integrated Health Networks (IHNs).*** An IHN is a set of community-based health care resources centered on the partnership between a patient, their family doctor, and a team of providers. These partners develop a customized health care plan based on each patient's unique health care needs. The IHNs require involvement and fund participation by non-profit organizations and local government. IHNs are examples of innovation both in engaging civil society and in population needs-based planning, given the requirement to target the implementation to areas with populations who have complex needs (Barr, 2009a; Vancouver Coastal Health, 2010). The outcomes and recommendations for action that emerged from the *Reducing Health Inequities* project could be used to support the selection of the IHNs' Year 3-5 priority populations.
- ***Patients as Partners.*** This initiative engages patients in their own health care and in shaping and improving the primary health care system. Through direct engagement and partnerships among primary health care, communities, patients, and their families, new information and opportunities emerge on existing barriers to accessing primary care and opportunities to address such barriers. Involving the public in ongoing dialogue and planning for primary health care allows for an increased sense of ownership, involvement, and interest in the health of their communities (ImpactBC, 2009).
- ***Patient Voices Network.*** This network is an initiative led by ImpactBC in collaboration with Patients as Partners, BC Ministry of Health Services. The network creates mechanisms for patients, their families, and community stakeholders to participate in primary health care changes that will positively affect their lives. Patients from around the province are brought together through this network to connect, share their experiences, and learn from each other (ImpactBC, 2011).
- ***The Provincial Breast Health Strategy.*** This strategy aims to provide more timely, equitable access to breast cancer screening, diagnostic, and prevention services for all women in BC. The Strategy is in response to recent evaluation reports that had shown that BC currently falls short in many of the national targets, including low participation rates, and there are inequities in access and utilization of screening services across the province. The Strategy is led by the Ministry of Health Services and PHSA, in partnerships with frontline care providers and policy makers throughout BC's health care

Appendix D: Aligning with Ongoing Activities and Initiatives (cont...)

system and various community groups. A component of the strategy will include better understanding the barriers that exist for women and to develop innovative strategies that address inequities in access and utilization of screening services in order to improve screening rates within “hard to reach” communities.

- *The PHSA’s Provincial Language Service’s “Community Engagement for Well-Being: Addressing the Health of French Speaking Newcomer Families with Children and Youth in BC” project.* This two-year initiative aims to improve the health and well-being of French-speaking newcomer families to BC through the development of strategies and resources that better align health utilization patterns of the target population with practices of the health system. The project is being developed in partnership with health care organizations, Francophone community associations, and immigrant serving agencies, and will engage community members.
- *Ministry of Health Services’ Key Result Areas (KRAs).* The implementation of the Key Result Areas by all health authorities in BC presents an opportunity for the concepts that have emerged from the *Reducing Health Inequities* project to be drawn upon as health authorities work to align with these areas. Specifically, the outcomes of the *Reducing Health Inequities* project could support the key result areas that centre on targeting health promotion and prevention initiatives to reduce chronic disease and improve the health and wellbeing of the population, and implementing integrated and targeted community care.
- *Ministry of Advanced Education – Integration and Multiculturalism Branch.* The outcomes and recommendations for action that have emerged from the *Reducing Health Inequities* project could support the direction of policy and services for vulnerable immigrant populations.

Appendix E: Existing Resources and Initiatives

Many existing tools, frameworks, resources, and initiatives were identified that could be adapted or built on in order to implement the proposed opportunities for action. Identified resources are listed below many of the opportunities for action.

1. Develop health equity targets and plans in consultation with communities and community members and actively monitor and measure their impact on health inequities by:

- » Building on current initiatives to utilize health equity assessment tools to coordinate the design, implementation and evaluation of ongoing and future policies, programs, and services.

Opportunities for Action:

- 1.1 Incorporate equity tools into the design, implementation, and evaluation of ongoing and future policies, programs, services, activities, and initiatives.

Existing opportunities that could be adapted or built on:

- Adapt and build on health equity assessment tools that have already been developed or which are currently being used within health authorities in the province, including the evaluation of such tools.
- Utilize the BC Health Quality Matrix to measure and ensure quality of care, and to support the strategic direction of quality improvement activities. Website: <http://www.bcpsqc.ca/reports/bc-health-matrix.html>

Examples of equity tools that could be adapted¹¹:

- Workbook: Using the Health Equity Impact Assessment Tool (Toronto-Central LHIN, 2009).
 - Health Equity Plan, developed by the Toronto-Central LHIN (Gardner, 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).
 - Sex- and Gender-Based Analysis Informed Policy Analysis Framework (Chasey, Duff & Pederson. 2009)
- 1.2 Create a Health Equity Protocol or Audit process to ensure that equity is incorporated in the development of all system-wide policies and programs.
 - 1.3 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. When analysing data, ensure that it is disaggregated based on gender, ethnicity, socio-economic status, and other relevant social categories.

¹¹ A detailed overview of the Health Equity Plan, the Equity Focused Health Impact Assessment, and the Equity Triangle can be found in the discussion paper by Mador, 2010.

Appendix E: Existing Resources and Initiatives (cont...)

Example of indicators related to equity that could be adapted:

- Measuring Equity of Care in Hospital Settings: From Concepts to Indicators (Centre for Research on Inner City Health, St. Michael's Hospital, 2009): http://www.stmichaelshospital.com/pdf/crich/measuring_equity.pdf

2. Improve health literacy by:

- » Increasing the capacity of health care providers to communicate effectively with health system users and to respond to their diverse needs.
- » Supporting opportunities to increase the capacity of underserved or inappropriately served groups to better access, understand, communicate, evaluate, and act on health information and services.

Opportunities for Action:

- 2.1 Support the development, implementation, measurement, and evaluation of a Health Literacy Strategy for BC.
- 2.2 Implement multi-pronged educational strategies that will enhance the capacity of health care professionals to clearly communicate with their clients and to support improved access to information and services for health system users.

Example of a health literacy toolkit and courses that could be adapted:

- Online course for health care professionals: "Health Literacy, you talk to your patients, but do they understand? The Importance of Health Literacy to your Practice" (developed by the Canadian Medical Association). Online course available at: http://mdcme.ca/course_info.asp?id=90
 - Health Literacy Universal Precautions Toolkit (Agency for Healthcare Research and Quality, 2010). Toolkit available at: <http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf>
- 2.3 Develop partnerships with universities and colleges to ensure health literacy is embedded in the education of future health care professionals.
 - 2.4 Build on and increase the capacity of language and interpreting services within the health system to provide interpreting services for a wide-range of health services, including primary health care and counselling services.
 - 2.5 Develop linkages with local community stakeholders, including community programs, organizations, agencies, faith communities, early settlement services, and educational or school programs to share information with currently underserved groups about navigating and accessing health system programs and services.
 - 2.5.1 Support the introduction of health literacy coordinators who could work in collaboration with community-serving organizations/programs and health authorities to provide improved health literacy support to health system users. For example, a health literacy coordinator could help improve health literacy among recent newcomers to BC by working in collaboration with settlement agencies, immigrant serving agencies, and health authorities.

Appendix E: Existing Resources and Initiatives (cont...)

- 2.6 Provide improved information support to health system users by utilizing community-based media sources as well as other information sharing methods and tailored information tools such as webinars, interactive plays, art, and interactive educational focus group or learning sessions as avenues to communicate health promotion and chronic disease prevention and self management information. Involve local communities and stakeholders in the development of appropriate messaging.
- 2.7 Develop linkages with English as a Second Language (ESL) classes to support the introduction of health literacy curricula.
 - 2.7.1 Provide training to ESL teachers about educating their students about the Canadian health system.
 - 2.7.2 Introduce health promotion and education materials in a variety of formats such as pictorial flashcards and role playing, tailored to a different learning abilities and strengths.

3. Increase equitable access to prevention and curative services for underserved populations by:

- » **Enhancing the availability of community-based primary health care services.**
- » **Building on existing specialized, population-focused primary health care services.**

Opportunities for Action:

- 3.1 Increase the accessibility of primary health care services, health promotion, primary prevention programs, and self-management services by offering and delivering such services in locations where populations congregate (such as community centres, outreach organizations, and community and social organizations).

Existing opportunities that could be adapted or built on:

- Utilize existing primary care networks, such as the Divisions of Family Practice, to help improve accessibility by delivering health services to unattached populations in locations that they congregate.
- 3.2 Support the implementation of collaborative health networks whose focus is to improve care for specific populations with complex chronic health conditions, such as refugees or individuals transitioning into or out of the correctional system.

Existing opportunities that could be adapted or built on:

- The Integrated Health Networks, which are community-based health care resources centered on the partnership between a patient, their family doctor, and a team of providers.
 - A GP for Me, an initiative that aims to ensure that access to primary health care services is available to all British Columbians.
 - The Divisions of Family Practice, which could consider implementing population-specific information sharing mechanisms that cross geographic and Division boundaries.
- 3.3 Support and expand specialty clinics that offer multi-disciplinary services, including mental health programs, trauma counselling, and social support services, to better meet the complex health needs of currently underserved or inappropriately served groups.

Appendix E: Existing Resources and Initiatives (cont...)

Existing opportunities that could be adapted or built on:

- The Refugee Trauma Project (funded by Immigration and Welcome BC), which trains mental health clinicians to provide trauma counselling to refugees and works to strengthen linkages with refugee serving agencies to maximize the health and development of refugees.
- Specialty clinics, such as the Bridge Clinic and the New Canadian Clinics, as well as specialized health and social support services, such as Sheway.

4. Develop intersectoral collaborative and knowledge exchange mechanisms to inform existing programs and the development of new health promotion, primary prevention, and self-management support programs that are culturally competent by:

- » Promoting communication and coordination between the health system and stakeholders, including community members, for dialogue and joint problem solving.

Opportunities for Action:

- 4.1 Develop a centralized coordinating mechanism within the health authorities to bring together stakeholders, including community members, for dialogue and joint problem solving.

Existing opportunities that could be adapted or built on:

- The Collaborative Services Committees provides a collaborative venue for representatives of the Division of Family Practice, the health authority, and the Ministry of Health Services to co-design clinical programs and new ways of working together.
- Patients as Partners, an initiative which engages patients in their own health care and in shaping and improving the primary health care system.
- Patient Voices Network, an initiative led by ImpactBC, which creates mechanisms for patients, their families, and other community stakeholders to participate in primary health care changes.

- 4.2 Improve the health system's accessibility and responsiveness by developing, implementing, and evaluating health programs and services in partnership with the communities and community members being served by supporting and building on existing community support programs and advisory committees.

Existing opportunity that could be adapted or built on:

- Patients as Partners, an initiative which engages patients in their own health care and in shaping and improving the primary health care system.

- 4.3 Promote communication and coordination between the health system and external stakeholders by examining where opportunities exist to set up processes for information sharing to communicate best practices and research findings more effectively.

- 4.4 Improve continuity of care by developing mechanisms for secure patient care information sharing between health authorities and other health care providers, such as primary care physicians or the correctional system's health facilities.

Appendix E: Existing Resources and Initiatives (cont...)

- 4.5 Strengthen linkages with community-serving organizations and other local stakeholders to share information about the range of services and programs available both within the health system and within the community.
- 4.5.1 Link to existing health and community information and referral services that could be communicated widely.

Existing opportunities that could be adapted or built on:

- The Affiliation of Multicultural Societies and Service Agencies of BC's (AMSSA) online multicultural health resources inventory: <http://www.amssa.org/multiculturalhealthyliving/onlineresources.html>
- Health Link BC. Individuals can access to non-emergency health information and services at any time online or over the phone. Information is available in over 130 languages.
Website: <http://www.healthlinkbc.ca/> or call 8-1-1
- United Way 211. Individuals can connect to a full range of non-emergency social, health, and government services in their community at any time online or over the phone.
Website: <http://www.211.ca/> or call 2-1-1

5. Increase the capacity of the health system to better serve the needs of BC's culturally and linguistically diverse population by:

- » Ensuring that policies, programs, and services are culturally competent.
- » Providing skill-based cultural competency training opportunities for health system providers to improve communication with users and to respond to their diverse needs.

Opportunities for Action:

- 5.1 Develop a centralized infrastructure to oversee cultural competence within the health system, including the development and implementation of provincial standards for culturally competent policies, programs, and services, and the measurement of the impact and outcomes of such standards.
- 5.2 Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population.
- 5.3 Learn from and build on existing cultural competency training models to create a multicultural competency training program available to all health system staff in order to enhance the delivery of high quality programs and services.
- 5.3.1 Utilize the knowledge and expertise of community members and organizations to help develop the cultural competency training modules and tools for health system employees.

Examples of existing cultural competency training models:

- The Cultural Competency Assessment Tool. Prepared by the Vancouver Ethnocultural Advisory Committee of the (former) Ministry for Children and Families: http://www.llbc.leg.bc.ca/public/pubdocs/bcdocs/339295/assessment_tool.pdf

Appendix E: Existing Resources and Initiatives (cont...)

- The Provincial Health Services Authority's Indigenous Cultural Competency Training Program: <http://www.culturalcompetency.ca>
 - A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia: http://www.healthteamnovascotia.ca/cultural_competence/Cultural_Competence_guide_for_Primary_Health_Care_Professionals.pdf
 - Building Cultural Competency in Practice, Guidelines, Models, Interventions and Best Practices. Prepared by Hamilton Health Sciences: <http://www.hamiltonhealthsciences.ca/body.cfm?id=1969>
 - Cultural Competence Health Practitioner Assessment. National Center for Cultural Competence, Georgetown University: <http://nccc.georgetown.edu/features/CCHPA.html>
 - The Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>
- 5.4 Implement multi-pronged educational strategies to ensure that staff at all levels of the health system receive ongoing education and training in cultural competency and cultural safety, and about the importance and appropriate use of interpreting services.
- 5.5 Monitor and evaluate the implementation of cultural competency training and overall organizational cultural competence in order to continually modify and improve the training based on identified barriers and successes. Measures could be included within staff/department performance improvement plans and patient-satisfaction assessments.
- 5.6 Partner with universities and colleges to ensure cultural competence is embedded in medical education and training.
- 5.7 Engage with community members and community organizations to help assess and enhance the system's capacity to deliver health services and programs, including prevention efforts and interventions to enhance coping skills, in a culturally competent manner.

Existing opportunities that could be adapted or built on:

- The Vancouver Coastal Health Community Engagement Framework: <http://www.vch.ca/media/CE%20Booklet%202009.pdf>
- 5.8 Utilize existing websites created for primary care teams and health care providers to provide information on best practices in providing care for diverse populations. Include tools, resources, and a directory of relevant community organizations.
- 5.9 Explore the introduction of a cultural health broker¹² and patient navigator programs, building on existing models. Patient navigators and cultural health brokers can help individuals navigate the health system, help improve health literacy, enhance the capacity of health care providers and organizations to deliver more culturally competent care, and work in liaison between the health system and other sectors.

¹² Cultural health brokers are bilingual and bi-cultural, meaning they have a deep cultural understanding of both the culture of the health system and the health system user's cultural community.

Appendix E: Existing Resources and Initiatives (cont...)

Examples of existing cultural broker/ patient navigator models:

- In 2005, an evaluation was conducted of the Cross-Cultural Health Brokerage Project implemented by the BC Multicultural Health Services Society and funded by the Vancouver Coastal Health / SMART Fund and VanCity Community Foundation (Sunell, 2005).
- Aboriginal Patient Navigator Program, Vancouver Coastal Health: http://www.vch.ca/your_stay/cultural_&_translation_services/aboriginal_patient_navigators
- The Cultural Consultation Service, McGill University: <http://www.mcgill.ca/ccs>
- Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs. Developed by the National Center for Cultural Competence, Georgetown University: http://www11.georgetown.edu/research/gucchd/nccc/documents/Cultural_Broker_Guide_English.pdf

Existing opportunity that could be explored:

- The introduction of a cultural health broker program would provide an opportunity to leverage capacity and engage communities to address a need. For example, hiring foreign trained health care professionals as cultural health brokers while they transition through their medical licensing process would allow them to gain work experience, while also helping the health system better meet the cultural and linguistic needs of the diverse population it serves.

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