Report on The *Embedding Health Equity into Policy and Practice* Symposium

Health Equity acknowledges that not all persons and groups are equal and that some experience greater disparities in accessing care and improving health than others.
Health Equity calls for consistent policies, practices and tools to ensure that all persons have equal access to meet their needs, taking into account their differences
Where are these elements evidenced in our institutions? How does health care provide culturally safe spaces to meet the needs of vulnerable patients and their families?

Introduction

To acknowledge the Thirtieth Anniversary of SCIS, MCH, a day and a half of Equity and Social Inclusion presentations took place at The MC Gill University Health Centre in Montreal on topics ranging from Indigenous Health, LGBT Families, Gender Variance, those experiencing homelessness through to refugees, asylum seekers and the participation of vulnerable groups in healthcare. Intersections of *Diversity* were explored under the umbrella of *HPH International Health Equity Standards* and their implementation. Antonio Chiarenza from *HPH MED Italy* and Ragnhild Storstein Spilker *HPH MED Norway* were key speakers. After the presentations, participants in working groups, looked at ways of integrating equity standards and procedures into existing standards such as the accreditation process and organizational policies. The Health Equity Symposium was organized by *Sociocultural Consultation and Interpretation Services at The Montreal Children's Hospital, MUHC and ACCÉSSS - Alliance des communautés culturelles dans la santé et les services sociaux*.

Links to MED and Equity Evaluation Exercises

Past health equity initiatives have involved Canadian health centres in validating the HPH International MED Health Equity Standards for their applicability to Canadian organizations, and in particular Montreal, The MUHC, ACCESSS, CSSS de la Montagne and St Mary's Hospital. In 2014, the revised equity standards (1) were used to assess the same organizations plus others in terms of their compliance with the standards. Overall, and Internationally, Fifty five health centres in Australia, Canada and Europe did moderately well with Standards 2: *Equitable Access and Utilization* and 3: *Equitable Quality of Care* but more efforts were needed in Standard 1, *Policy*, Standard 4, *Promotion* and Standard 5 *Participation*.(2) Globally, health organizations too, have had some difficulty applying the Standards due to language barriers, translation costs and limited resources.

To highlight the work of The Migration, Equity and Diversity Task Force (MED) on creating and implementing the standards and to acknowledge the Thirtieth Anniversary of Sociocultural Consultation and Interpretation Services – SCIS at The MCH–MUHC, SCIS partnered with ACÉSSS to highlight joint health equity initiatives and to identify gaps in services to vulnerable populations. Notably, Indigenous communities, Persons experiencing Homelessness, LGBT groups, Immigrants and Refugees, Equity in in Academic Admissions, and the participation in health systems of the above vulnerable groups were discussed by demonstrating some equity policy and practice examples. (2)

Speakers and presentations from different specializations were selected for their reflection on patient or client diversity and vulnerability in accessing care and their identification of progress made as well as remaining gaps in equity policy and inclusion in practice.

Support for the creation and follow-up for this initiative came from *MCH, Northern and Native Health Program, MCH Family Advisory Forum, Ministry of Health and Social Services*, *La ministre déléguéé à la*

Réadaptation à la Protection de la jeunesse, à la Santé Publique et aux Saines habitudes de vie, la Direction de la planification, de l'evaluation et de la qualité de MSSS, Sociocultural consultation and Interpretation Services – SCIS – MCH and *ACCÉSSS*

Symposium Content:

A brief outline of topics covered is attached in the Symposium program in Appendix 1
The presentations can be seen at:
Information on The Migration, Equity and Diversity Task Force can be seen at:

Through the Presentations

Through the different presentations on health which ~~were~~ opened with International content, we saw that the Migration, Equity and Diversity Task Force looked at the intersections of diversity between migrants and refugees including socioeconomic, destination, and intra group diversity which all need attention for health. Plans are to develop a Rapid Assessment tool available on line for organizations to measure their equity inclusion. The work of NAKMI in Norway explored building an evidence base on migration and health at national and global levels with the creation of related research.

On a National level, we saw Innovative initiatives at Federal Government level with the Public Health Infobase and the Health Inequalities Data Tool that measures indicators of health status based on a range of social and economic variables. These variables can be used to identify populations at risk. (3) One presentation featured a multicultural clinic for newcomers, identifying disparities in refugee health.

In terms of mental health, newcomer family security and the question of identity arises for youth. Possible anger at their families' social exclusion (lack of employment, discrimination) can be an issue. Tools have been created to raise awareness of culture in interventions to address these factors. The mental health of those without homes was also discussed and the support services offered.

Others discussed disparities in Indigenous health, , same-sex parenting outcomes, and services acknowledging gender variance, inclusive community programming, emergency services, accreditation initiatives, innovation in equitable academic teaching and recruitment processes, as well as community and user participation and involvement in decision making.

While inclusive practices provided safe spaces for patients/clients/familes they also laid bare the discordance between services and systems that lacked concrete equity policy, education, evaluations and support to guide equity planning and practice. These missing elements often prohibited full enagagement with patients. Linear, polarized communication styles limited the patients' ability to fully access, let alone participate in care. Healthcare generalists were often quick to refer diverse patients to specialized services even though the patients' health concerns were routine. It emerged that this points to a need for Cultural Safety Training, not only at the academic level but ongoing in every health centre as part of equity policy and practice. In other cases, structural barriers prohibited full access to care.

Structural Barriers

Transportation costs for low-income families, lack of health insurance coverage for children of undocumented parents, unaccompanied minors who are flown alone from the North because of travel restrictions, certain medication costs and others represent significant barriers. Users of the Interim Federal Health Plan who are refused care at various medical clinics because the clinics do not have the mechanisms in place to process the claims for re-imbursements present risk factors. Other language speakers having limited participation in their care dependent on the recognition of the language

difference by attending staff and/or the availability of Interpretation services. Gaps in the availability of basic and specialized other language health information limit the patient's progess. In academic medical health faculties there are gaps in representation of both ethnocultural and indigenous groups which if filled will assist in addressing the cultural health needs of related communities. While creating intracultural impact for patients/clients, diverse representation among health graduates will open up dialogue with medical and health trainees from mainstream backgrounds broadening the knowledge base for all. At this time, Indigenous representation is low. (4)

Recomendations from the Working Groups:

The working groups took place before the close of the symposium and the results circulated for additional comments

Working Group #1: Putting equity into policies & procedures

One working group focused on the mandating of equity into policies and procedures. *The Act Respecting Health Services and Social Services* could act as an enforcer. *Art. 10* states that *Every user is entitled to participate in any decision affecting his state of health or welfare. He is entitled in particular, to participate in the development of his intervention or individualized service plan where such plans are required….. The same applies to any modification made to such plans.* Patient or Client participation requires mutual understanding of lifestyle, culture, health, treatment, and a common language as starting points. Accreditation standards on Accessibility were also discussed. *There is a process to identify, report and try to remove barriers to access which include proximity and distribution of services, ….cultural acceptability of services……..language barriers, financial barriers,……* Combining Article 10 with Accreditation Accessibility into policies and practices were proposed. Supported by other Accreditation measures and The Health Equity Standards for vulnerable populations developed by The MED Task Force, HPH International, healthcare equity could be further applied, especially to the Canadian and Québec context (thanks to available data, research results…). Equity Training for health professionals, administrators and support staff was suggested. This would greatly assist in decision-making, especially with the development of online equity tools. Equity Training could be accessible on a local and global level and reach everyone at no cost. Suggested too was the idea of combining the work of health centres and community programs, to generate inspirations and partnerships, whether on a municipal, provincial or international scale. This already happens in some places, with physicians and nurses involved with Médecins du Monde, the involvement of social work interns at Montreal City Mission etc. Incorporating and accommodating language diversity was considered essential since it remains a significant barrier to providing good care. (5)

Overall, to apply equity policies in health systems, with procedures to include implementation at all levels using the above enforcers. This means planning processes with mandates to implement equity in all activities with measurable outcomes and facilitated with attached budgets. Under this umbrella, equity elements will appear in evaluation processes that recognize intersections between vulnerability and intra and intercultural diversity and ensure their inclusion. Health materials and patient feedback in other languages, adaptations for lifestyle differences (Indigenous status, housing insecurity, sexual orientation, gender variance, immigration status etc.). Currently these populations are largely invisible in patient feedback except in specialized studies. One key development that has been initiated and borne fruit both in Canada and in the US is Data Collection(6) to address health disparities or inequities. Data could be collected on Race, Ethnicity, Mother Tongue, Religious Beliefs, Sexual orientation, Income, Housing and Literacy Preferences. Carefully collected, this information would help identify individual and

clusters of patients who may need guidance through the health system and/or who would benefit from further health investigation.

Working Group #2: Removing Barriers to Inclusive Participation

The second working group asked this question: what does « sensitivity to equity » mean? Four possible meanings were explored. The first, being able to look through many lenses. From cultural sensitivity and asking questions we move to Cultural Safety: examining one's own cultural lens and biases, then third, engaging the patient by referencing their cultural experiences and practices in provision of care. The fourth aspect would allow for comfort level, trust and beginning empowerment.

Responses touched upon building capacity to "ask questions" since this requires 'time' and 'involvement'. A « sensitivity to equity » would work on improving partnerships between patient, family and health care provider. Communication that is mindful of cultural or different frames of reference requires more exploration. "*We don't know what we don't know"* Mentorship with knowledgeable diverse others is to be mandated for guidance in this area. The expression raises the importance of transversal and lateral integration in practice so that equity and safety are understood and interchangeable across the health network.

Equity based assessments must be reflective so that when we ask about housing: Is the accomodation a home? What is home? How does the patient/family/client live? We then understand that temporary or transitional housing is not conducive to well-being and self care. What is feasible then in terms of self-care planning? The housing needs and health stability must be addressed. Cultural Safety training is essential

Research and Promotion

When planning research and promotion projects, the invitation of other language speakers and different others to participate is essential. The use of gender inclusive language reflecting gender variances and sexual orientation will be a facilitator, meeting patients in their milieus. Using Interpreters and translations of materials that are factored into budgets in order to be easily accessible for wider participation. All patient satisfaction surveys can be available in other languages to ensure participation and feedback. Attention paid to health literacy when communicating, helps to identify language barriers especially when the patient speaks some of the official language but not enough. Using clear and simple language and asking open-ended questions to verify that what was communicated was actually understood, is important to consider.

Overall Recommendations

For system compliance, it would be useful to initiate equity based discussions at ministerial levels. Clear incentives communicated to Health organizations with budgets attached to develop policies and practices with tools and measurements to evaluate their effectiveness could follow.

Cultural Safety Training

Cultural Safety (7) or similar training is usually carried out at the academic level but then often vanishes once the HCP enters the field where support for such practice is often missing. To encourage flexibility and openness to working with different populations, ongoing discussion and awareness is necessary for HCPs. Whole teams must be on board with Cultural Safety concepts in order to provide seamless supportives services. This is especially important to help reduce clinician, physician and other staff biases to allow patients to freely express their health concerns and have them addressed. Cultural Safety

requires healthcare professionals and others to be mindful of power imbalances; to examine personal values and/or commonly held stereotypes and then to put them aside for optimal safe outcomes.

The ability to engage with minority and diverse populations is to recognize that not all their health concerns require specialized care. Not all refugees/asylum seekers require an ethnocultural specialist, nor do transgendered patients who may also be indigenous, refugees or asylum seekers experiencing housing insecurity, need to be referred to identified clinics when its comes to general medicine. Cases of common to routine healthcare can be addressed directly by the presenting clinician with links made to support services where need be. Consultations between the physician and designated specialist follow where questions remain. Broadening the knowledge base intra clinician and across the health network helps foster inclusive, equitable health services for all patients.

Gender friendly language and open questions

The first and one of the most common identification steps that preludes an inclusive or exclusive health encounter is the Admission or Registration Process at a health centre or clinic. This step can lead to a person's diminished sense of self worth at a time when they are not well and most vulnerable. To ensure openness and recognition of variance, health systems can create forms that address Gender in multiple forms: Male, Female, M to F , F to M, other etc., In terms of including same sex and single parents , the use of Parent 1 and Parent 2 is preferred over Mother, Father. There may be at some points, the need for genetic based information that reflects on the biological parentage but this can be asked in an appropriate context when trust has developed, not at registration.

Enlarging the data collection at registration will not only be inclusive but will help develop a knowledge base useful for research and focused care for patients and can include race, ethnicity, sexual orientation, housing (temporary or permanent), socioeconomic status and literacy preferences. This has been done elsewhwere in Canada and the US. (8)

Mandated language interpretation

Currently cultural and language interpretation is conducted according to a health centre's commitment to such services or can be offered in an ad hoc manner. While La Banque Interrégionale d'interprètes serves many institutions but increased additional services are required to meet the demand. Some centres such as The Montreal Children's Hospital have their own bank but overall, institutions, are not mandated to provide interpreter services although they are encouraged to meet the patient/client's language needs. Policy is required around interpreter job descriptions and training which is largely absent without a provincially recognized framework, salary scale, and mandated implementation.

Other language health literacy materials

In addition to Interpreters, other language materials are required with key health information on flu prevention, hand washing, the use of emergency services etc., and education around different health specialities. Some materials are accessible on line but there are huge gaps. Patients, families generally like to receive materials directly from their health care professional in whom they trust. Currently, in terms of material in other languages, this happens rarely (Lambert et al)

Indigenous friendly environments

Given the Recommendations of The Truth and Reconciliation Commission, (6) health centres are encouraged to deconstruct not only the way they dispense healthcare to indigenous peoples but also to create friendly and safe healing spaces for Indigenous users. These could include circular meeting spaces

to be used for team and family consultations as well as healing rituals. The use of gardens to grow herbs and root vegetables with the produce shared and managed by the communities opens up a myriad of possibilities for intersectorial partnerships from developing trust and dialogue for improved health outcomes to promoting food security

The above initiatives, accompanied by fluid networks in which healthcare professionals have easy links to material support services: shelters, food banks, housing etc., for patients/clients would facilitate wellness. Interconnected services, easily accessible to staff for patients would facilitate full assessments, with the knowledge of being able to equitably meet patients' material needs as related to health.

Building Capacity

Recruiting and involving participants from minority communities in health settings, both academic and in the field, to foster understanding and build capacity is a slow process initially. Backed with Cultural Safety principles and Equity guidelines and in partnerships between academia, field and community, peer support initiatives can be created in health settings. Staff and volunteers recruited from under served groups and trained to reach out to others in similar settings as members of advisory committees, patient navigators, volunteers, interpreters etc., will attract others. Diversity recruitment is successful in bringing in and working with different others. Once in the system and over time, participants and their communities have improved access to healthcare and to the healthcare professions. Outreach is mandated to ensure diversity inclusion in the professions and in some cases, affirmative action processes.

The setting up of health equity offices with adequate staffing to advise and act on equity inclusion would be a starting point to launch such initiatives using the HPH International Migration, Equity and Diversity (MED) updated health equity standards (soon to be released) as guidelines (9)

Summary

Without consistent policies and multiple equity interventions, health initiatives in one place will be less effective if not linked to other equity based services and practices. The health system can install equity guidelines, and offer ~~to~~ support to health centres, academia and community based partnerships. In their execution, the partnerships would involve the creation of pilot initiatives to install equity policies. These policies followed through to implementation would measure gaps in services for the above identified clients/patients, communities . They could begin to address the gaps with data collection, all operating from equity principles. These models can then be measured for effectiveness and the knowledge translated into other settings with other populations.

References:

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