Better Health for All

Health Status Reporting Series 3

Advancing Health Equity in Health Care

A Message from Dr. Cory Neudorf

Chief Medical Health Officer

Saskatoon Health Region

The ***Better Health for All Series*** highlights key findings about the health status of Saskatoon Health Region residents[1]. Our vision is for a community in which everyone has a chance to live a healthy life and has the same opportunities to reach their full health potential. Our series highlights actions being taken to make this vision a reality and what more we can do to create better opportunities for everyone to achieve better health.

> *The measure of a country's greatness should be based on how well it cares for its most vulnerable populations.*
>
> *-Gandhi*

The conditions in which we live, work, learn and play have a huge impact on our health. The stark reality is that many people who live in our Health Region do not have the same opportunities to be as healthy as others and as a result, live shorter lives. In fact, those who live in areas of highest deprivation[2] are expected to live about 9 years fewer than those who live in areas of lowest deprivation. This is not fair and does not need to be this way. Although achieving health equity is much broader than the health care system, the health care system does make a difference and does have a role in addressing inequities.

Better Health for All - Series 3: Advancing Health Equity in Health Care

Over the years, the Public Health Observatory has identified significant differences in people's health based on where they live and their socioeconomic circumstances. Closing this gap in health equity is a strategic direction for the Health Region. While I am encouraged by the progress toward closing these gaps, we must continue to create greater positive change as there is clearly much more to be done.

> **Saskatoon Health Region's Promise**
>
> *Every moment is an opportunity to create a positive experience in the way we treat and care for people, in how we work and interact with each other, and in how we deliver quality service. We promise to seize every opportunity.*

Series 3 of our information release examines gaps in health status dating back to 1995 and looks at trends to assess whether gaps are widening, staying the same or narrowing across a number of health conditions. In this analysis, a Deprivation Index was used to compare health conditions across five areas of Saskatoon, each containing about 20 percent of the city's population. These five areas were ranked from lowest to highest deprivation. Based on the research findings, an assessment of Region plans and strategies, and a wide consultation process with health care providers and selected non-government health organizations, we report on how available, accessible and acceptable our health care

[1] Data analyzed for the purpose of this report examines city of Saskatoon residents only. Rural data for our Health Region will be examined through an upcoming provincial report to be produced by the University of Saskatchewan.

[2] Deprivation in Saskatoon was identified using an index of six socioeconomic variables (income, education, employment, marital status, single-parent families, and living alone). The index divides the City of Saskatoon into five categories ranging from highest to lowest deprivation and each area contains approximately one fifth of the population

services are; all important elements of a high quality health care system. This information informs recommended next steps.

Promoting Health Care Equity - What Did We Find?[3]

Our latest findings show that we are generally making gains in improving the health of people who live in Saskatoon Health Region:

- Average life expectancy at birth has been increasing for the population. People who live in Saskatoon's areas of lowest deprivation have seen the most gains in life expectancy and generally have better health.
- On average, hospitalization rates for cancer, chronic obstructive pulmonary disease (COPD), stroke, heart disease, mental illness, injury, and intentional self-harm have all decreased since 1995, which is a common trend across Canada.

But we have work to do:

- On average, people living in areas of highest deprivation are not expected to live as long as the general population. Since 1997, average life expectancy is increasing across the Region while in areas of highest deprivation life expectancy has remained the same.
- Those living in areas of highest deprivation have higher rates of hospitalization and physician visits than those living in areas of lower deprivation for the majority of the health conditions examined.
- For most conditions, the differences in health exist not only between the areas of highest and lowest deprivation, but follow a clear gradient pattern. This means that health improves as deprivation decreases.
- The gap in health between those in areas of highest and lowest deprivation remains persistent and in some cases is getting wider. More work is needed to better understand whether health care use appropriately matches health care need.
- Diabetes is the only condition for which hospitalizations are showing signs of increasing for everyone, and most notably for those living in areas of highest deprivation.

What Did We Hear From Health Care Workers?

In order to address the gaps in health equity, we consulted numerous health system managers, physicians, staff and non-government organizations to begin to identify some of the barriers within our own organization and what might be perpetuating them. Here's what they told us:

Health Information Has Gaps: We heard that information to advance health equity and improve patient, client and family-centred care is often not collected, used or shared. We heard that follow up care is more difficult for populations with complex needs and health care providers often don't have enough information about their patients' circumstances limiting their ability to better support them (e.g. patients may have transportation challenges, live in poor housing circumstances or lack social supports). Having this information could lead to better care for patients while potentially reducing the need for more health care services down the road.

Capacity To Meet Needs Effectively Is An Issue: We heard that despite keen interest and understanding that health inequities are unfair and preventable, health care providers told us that they often feel powerless to respond to complex

Hearing from the Front Lines

Public Health Observatory staff, together with Medical Health Officers, held close to 40 focused meetings with programs and services across the Health Region and with relevant health care organizations including the Saskatchewan Registered Nurses Association, College of Physicians and Surgeons, Pharmacists' Association of SK, SK Heart and Stroke Foundation, SK Lung Association, Canadian Diabetes Association, SK Cancer Agency, and SK Prevention Institute. This provided a deeper understanding of some of the barriers to achieving health equity that exist in our Region as well as opportunities to be more health equity focused in our daily service delivery activities, planning and policy development. The key themes generated from the feedback contributed to the development of recommendations to advance health care equity within the Region.

[3] See CommunityView Collaboration for detailed definitions of these indicators.

needs of patients within our complex system. In other words, barriers mean missed opportunities for preventive care. Health care providers are stretched to the limit making it more challenging to find time to "level up" services to better meet patient/client needs. Staff would like to use some of the time and resources freed up by system improvements to better serve those who need it most.

Cultural Considerations Are Extremely Important: We heard that building trusting and strong connections among health care providers and clients, especially those from vulnerable populations, is important and takes time. Racism and discrimination create tremendous challenges to establishing this trust. We heard stories of overt racism in our system. For example, First Nations patients having left the health care system due to negative experiences with staff, not having received the care they needed.

For the newcomer populations, we heard that they face barriers within the system making it challenging for them to navigate.

Health Care System Itself Creates Barriers: We heard that the structure and policies of the health care system are complex and often inadvertently perpetuate inequity. For instance, we heard many examples of where the relationship between the federal and local efforts to meet the needs of First Nation people created access barriers and placed undue burden on patients, health care providers and the system itself.

What Is Saskatoon Health Region Already Doing To Improve Health Equity?

Targeted actions are showing promise. A review of health region plans and strategies revealed that some aspects of equity are reflected in the Region. In addition, the Health Region has made some of the following advances in:

Improving Accessibility: Mental Health and Addictions programs and services have long recognized that community partnerships are key to ensure mental health and addictions needs are met where individuals will benefit most. This has resulted in the Region supporting such initiatives as the Lighthouse stabilization shelter, the Police and Crisis Team (PACT), and staffing of mental health workers directly in the community [e.g. mental health coordinator at Central Urban Métis Federation Inc. (CUMFI)].

Improving Availability: Within its universal provision of immunization coverage services, and informed by an equity lens, Population and Public Health has developed targeted approaches to increasing immunization services in under-immunized neighbourhoods including moving services closer to where the needs are greatest, increasing hours of operation at some locations and partnering with schools to offer services closer to people.

Improving Acceptability: The Aboriginal Health Strategy (2010-2015) was developed by the Strengthening the Circle partnership of Central Urban Métis Federation, Inc., Kinistin Saulteaux Nation and Saskatoon Health Region. *Strengthening the Circle: Partnering for Improved Health for Aboriginal People* led to the creation of the Aboriginal Health Council. The Saskatoon Health Region also established an Aboriginal Patient and Client Advisory Committee to seek the voices of First Nations and Métis patients in improving health care services. The First Nations and Métis Health Services team facilitates navigation services, offers cultural support and provides an interpreter when needed to First Nations and Métis people accessing Saskatoon Health Region services. The Representative Workforce team has been striving to increase the number of First Nations and Métis people who work for the Health Region, and some programs and services across the Region are working to become more culturally competent and have been providing cultural competency workshops for staff. In addition, the Health Region is increasing its capacity to provide translation services in a multitude of languages.

Achieving Better Health for All – A Call to Action for the Health Care Sector

Everyone has the right to achieve their full health potential. Improving health equity means that *everyone's* health improves, that the health care system meets the needs of the population it serves, and our communities become better places in which to live.

To help make health care services more accessible, available and acceptable for everyone, there are several actions for Saskatoon Health Region to consider:

1. **Create A Culture Of Equity In Saskatoon Health Region That Can Be Advanced Through:**

    a. Clear leadership commitment to health equity at the highest levels and throughout the health care system;
    b. Clear commitment to the Region's vision of Healthiest People, Healthiest Communities, Exceptional Service and strategic direction for Better Health, with its explicit focus on reducing health inequities;
    c. Emphasizing that the goal to promote health equity aligns with and supports the Region's goals to improve quality of care, patient satisfaction, staff engagement, and value;
    d. Adoption of a regionally developed position statement on health equity that clearly articulates what it means in practice, with an accompanying plan that provides details for operationalizing health equity;
    e. Commitment to ongoing monitoring and reporting on health equity that looks not only at trends in health outcomes but continues to measure the Health Region's incorporation of equity in its plans and strategies.

2. **Apply A Health Equity Lens To Existing Policy Barriers That:**

    a. Reorients the health care system to promote health equity at all levels, departments, programs and services;
    b. Enables a courageous, transparent and honest acknowledgement of where the health care system plays a role in creating or perpetuating health inequities; and,
    c. Ensures care provided is proportionate to need and available, accessible, and acceptable.

3. **Prioritize Efforts To Continue To Increase Cultural Competency, End Systemic And Institutionalized Racism And Promote Cultural Safety In Saskatoon Health Region.**

    Saskatoon Health Region's boundaries are contained within Treaty 6 Territory. First Nations and Métis people are dynamic and energized populations that have fundamentally contributed to the formation of our society and yet, whose health potential is not fully realized.[4] This is due to a combination of economic, political and social disparities stemming from the complex relationship between Aboriginal peoples and Canada.

    Moving forward, it is important that we consider the emotional and psychological injury that has occurred over the lifespan and across generations of Aboriginal peoples when observing the inequities still present in many aspects of Aboriginal health and well-being.

    Saskatoon Health Region should increase its resources to bolster its current efforts in this area by:

    a. Improving the understanding among all people of the historical and social contexts of First Nations and Métis people;
    b. Adopting the Cultural Competency Framework that emphasizes seven key domains highlighting successful practice. These include: data, community engagement, diversity and training as organizational commitments, service delivery and support, communication, integration into management systems and leadership;
    c. Providing more training to increase cultural competency and cultural safety for professionals across sectors and how it applies to them in their daily lives, recognizing that racism can be intentional and unintentional;

> We envision a world in which all First Nation, Inuit and Métis people have achieved full and equitable access to the conditions of health including: pride in ancestry, cultural reclamation, peace, shelter, education, food, income, a stable environment, resources, and social justice, [a]nd where the gifts and wisdom of First Nation, Inuit and Métis cultures are recognized as valuable, distinctive and beautiful.
>
> Wabano Centre for Aboriginal Health as referenced in the Strengthening the Circle's Aboriginal Health Strategy 2010-2015

[4] Refer to the Saskatoon Health Region's Public Health Observatory for information on health disparity in our Region.

d. Employing more advocates and cultural translators to bridge understanding between the health care system and First Nation and Métis families and provide system navigation support;
e. Setting and meeting targets for a more representative workforce and tying those to accountabilities;
f. Conducting further intervention research aimed at improving the lives of First Nation and Métis people through collaborative, respectful and equitable partnerships; and
g. Increasing delivery of services by First Nation and Métis agencies and providers.

4. Anticipate The Needs Of Newcomers.

The Health Region has expanded services to support this growing proportion of the population through mental health, primary health care, and translation services, but challenges in meeting needs persist.

It is well documented that newcomer health is typically quite good upon arrival in Canada, but tends to decline over time. New local research shows that the health of newcomer children is also at risk as obesity rates are high, food insecurity is high and over 90% of children are not meeting daily healthy food recommendations. We have opportunities to prevent this decline in health by working together to ensure that newcomers have equal opportunities to participate in Saskatoon's economic, social, intellectual and cultural life.

Saskatoon Health Region should increase supports for newcomers by:

a. Providing translation and other services to ensure access and culturally appropriate service delivery;
b. Expanding intersectoral partnerships with NGOs to deliver more efficient and effective service coordination;
c. Collaborating with local researchers to better tailor prevention opportunities to newcomers.

5. Implement Tools To Enhance Patient-Centred Care:

a. Invest in the development and implementation of tools to measure, monitor and improve health equity (e.g., improved sociodemographic data collection);
b. Embed the principles of health care equity within Saskatoon Health Region's Lean Management System; and,
c. Increase capacity within departments, programs and services to conduct Health Care Equity Audits (HCEA).

6. Increase Investment And Supports For Intersectoral Collaboration To Promote Health Equity:

a. Provide leadership and contribute to provincial and regional intersectoral partnerships that address poverty, homelessness, crime, and other deep-rooted social challenges, recognizing that equity in health is broader than the health care system and prevention preferable to treatment;
b. Working with other sectors, promote an 'all of government approach' to improving the social determinants of health, where the health impacts of all policies are considered before they are implemented and evaluated over time to ensure they are helping to reduce inequities.
c. Encourage existing and potential private sector partners interested in promoting health to act "upstream" by investing in social determinants of health other than health care services; and,
d. Promote the societal value of quality universal public services, including health care, which is an ethical imperative and crucial to advancing health equity.

7. Prioritize Action To Advance Health Equity:

We need to prioritize the health conditions showing the greatest inequalities by better understanding the populations that are experiencing them. Through a combination of different equity measures[5] and discussions with health care providers, the population groups most vulnerable to conditions such as mental illness, diabetes, chronic obstructive pulmonary disease (COPD), heart disease, tuberculosis (TB), and

[5] See Technical document for overview of measures. These include rate ratios, rate differences, Lorenz curves and Gini coefficients.

sexually transmitted infections (STI) should be prioritized for interventions aimed at improving health equity. The health care system does have a role to play in identifying those patients/clients that may be experiencing unmet needs and are at increased risk of additional health conditions. Further examination within the identified priority areas using tools such as the Health Care Equity Audit can help us to better understand our patients/clients and provide more equitable services that are available, accessible, and acceptable.

Final Words

While it's clear that this call to action will not be achieved overnight, building the momentum for a fundamental shift in our thoughts, actions and approaches is key to achieving greater equity in health care. There is much already that should be celebrated and replicated; let's use our collective talents, creativity and commitment to spread the successes and ultimately advance **better health for all**.

Over the coming months my team will be bringing this information to you across the health region. We're planning a health equity forum next spring and look forward to working with you to develop our vision and action plan for health equity in Saskatoon Health Region.

Acknowledgments

This report was made possible through Saskatoon Health Region's Public Health Observatory (a department of Population and Public Health) and the many contributions of staff, management, and physicians in Population and Public Health and across Saskatoon Health Region as well as external agencies and individuals.

We wish to thank individuals working in the following SHR departments and partner agencies for their contributions to this series. Contributions include provision of information, data analysis, and interpretation of the data through participation in consultation sessions. Comments shared throughout the consultation sessions are included throughout the series.

Saskatoon Health Region	Outside Saskatoon Health Region
Adult Medicine and Complex Care	Canadian Diabetes Association
Communications	College of Physicians & Surgeons
Ethics	Global Gathering Place
First Nations and Metis Health Services	Heart and Stroke Foundation
Homecare	Individual Physicians
Kaizan Promotion Office (KPO)	Pharmacists' Association of Saskatchewan
Maternal and Children's Services	Physician Advisory Committee
Mental Health and Addiction Services	Saskatchewan Cancer Agency
Office of the Chief Medical Health Officer	Saskatchewan Ministry of Health
Operations Management Committee	Saskatchewan Mental Health Commission
Organizational Learning and Leadership	Saskatchewan Prevention Institute
Population and Public Health	Saskatchewan Registered Nurses Association
Primary Health Care and Chronic Disease Management	Saskatoon Community Clinic
Surgery Services	Student Wellness Initiative Toward Community Health (SWITCH)
	The Lung Association

Suggested Citation:

Neudorf, C., Kryzanowski, J., Turner, H., Cushon, J., Fuller, D., Ugolini, C., Murphy, L., Marko, J. (2014). Better Health for All Series 3: Advancing Health Equity in Health Care. Saskatoon: Saskatoon Health Region. Available from: https://www.saskatoonhealthregion.ca/locations_services/Services/Health-Observatory/Pages/ReportsPublicatlions.aspx

Learn More about the Better Health for All Series

We invite you to consider the information that we have presented in this message and through CommunityView. It is our hope that you will use the *Better Health for All* series to inform the decisions you make towards advancing the vision of a community in which everyone has the opportunity to live healthy lives. Available reports include:

- ✓ **Series 1, March 26 2014**
  Our Population- A high level look at who lives in our Region. Differences in health outcomes by socioeconomic conditions will be released in upcoming series.
- ✓ **Series 2, May 21 2014**
  Immunization- Examines a selected set of immunization indicators to report on progress and gaps in coverage rates. Proposes further action to ensure equal opportunities for access to immunization.
- ✓ **Series 3, June 23 2014**
  Advancing Health Equity in Health Care- Examines a range of health inequalities and proposes health care system action to create equal opportunities for all to achieve better health.

Upcoming Planned Releases Include:

Summer 2014: Communicable Disease

Fall 2014: Health Behaviours, Maternal and Child Health, and HIV

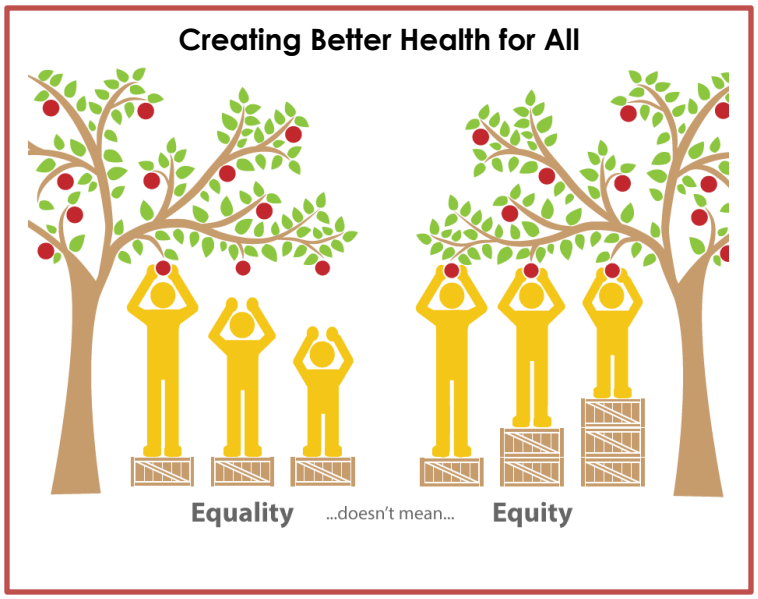
Release date to be determined: A report on Community Wellbeing- Developed in partnership with the Saskatoon Regional Intersectoral Committee discusses, in greater detail, the social determinants of health and wellbeing.

Advancing Health Equity in Health Care

What is Health Equity? A Primer for the Health Care System

Saskatoon Health Region's vision of *Healthiest People, Healthiest Communities, Exceptional Services* establishes the strategic directions of Better Health, Better Care, Better Teams and Better Value. Health equity is a principle that underpins this vision and directions.

This primer provides a better understanding of the complex concepts of health equity and identifies the role the health care system in advancing health equity.



Health Equity: is the principle of and commitment to incorporating fairness into health by reducing health inequalities.[1] It implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.[2] Health inequity occurs in the absence of health equity.

Health Inequities: are defined as "differences which are **unnecessary** and **avoidable** and which are also considered **unfair** and **unjust**".[3] Health inequities represent *differences in opportunity* for different populations which result in unfair and unequal life chances, access to services etc. Health inequities arise from gaps related to the **social determinants of health**, which are the socially determined circumstances in which people are born, grow, live, work and age, including the health care system.

Health inequalities: represent *differences in health experiences and health outcomes* between different populations. Health inequalities may be health inequities if they are due to socially determined circumstances.

Advancing health equity is the right thing to do, the fair thing to do, and ultimately, something that we need to do to achieve ***better health for all***.

What Does Health Equity Mean For The Health Care System?

Although the conditions that enable equity in health are much broader than the health-care system, the *system does make a difference* and *does have an important role in addressing inequities*.

Equity is an underlying principle of quality in a health care system (OECD, 2012). It is important that health-care equity is considered in system planning (strategic and operational) in order to provide and organize health services in ways that contribute to reducing overall health inequities. Health care is a social determinant of health and, therefore, the health care system is accountable for incorporating health equity as an underlying principle of care.

> "**Equitable care does not mean treating every patient exactly the same**. Instead, equitable care ensures optimal outcomes for all patients regardless of their background or circumstances."
>
> Source: The Roadmap to Reduce Disparities, Robert Wood Johnson Foundation (2014)

Health care equity principles: Health care services should be *available*,

---

[1] Braveman P. What are health disparities and health equity? we need to be clear. Public Health Rep 2014; 129 Suppl 2: 5-8.

[2] Adapted from Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: levelling up part 1. Copenhagen: World health Organization Regional Office for Europe; 2006.

[3] The World Health Organization

pho@saskatoonhealthregion.ca | 306.655.4679

accessible, and *acceptable* to everyone in the population, while also maintaining a high degree of *quality*.

Accessibility of services refers to the extent to which the health care system is designed to meet the needs of its users. It means having health facilities, goods and services accessible to everyone in four overlapping dimensions – non-discrimination; physical accessibility; economical accessibility; and, information accessibility. The ultimate goal is not simply equitable access to health services, but equitable access to health.

Availability of services refers to whether services are provided within a community. It includes having a sufficient quantity of functioning health care facilities, goods and services, as well as programs for health promotion, protection and disease prevention.

Acceptability of services refers to whether 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. All health facilities, goods and services must be respectful of medical ethics and cultural appropriateness as well as sensitive to gender and age. It also includes the level of openness to the participation of underserved groups in the planning and evaluation of those services (Bowen, 2001).

Quality and equity are key dimensions of one another. Quality care is defined as "doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results," (The Agency for Healthcare Research and Quality, 2014). Quality health care means providing services and programs that are safe, effective, timely, efficient, and patient/family-centred.

Quality improvement initiatives that target the overall population and overlook the needs of specific population groups can result in health inequities (i.e. unequal quality) (Robert Wood Johnson Foundation, 2014). Equitable health care means providing services and programs that do not vary in quality because of race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where people live, socioeconomic status or other socially determined circumstances.

What Can I Do?

The Health Care Equity Audit (HCEA) Tool can and should be integrated within already existing processes. Ongoing quality improvement initiatives, such as LEAN management and strategic planning, provide opportune use of the HCEA Tool at both a regional and a department-specific level. The Health Care Equity Audit Guide leads decision-makers and health care providers through the steps of the tool. Additional Health Equity Considerations from leading best and promising practices can also be found in the guide.

The Bottom Line:

Health outcome data is just a starting point for conversations on health equity. Wide gaps between those living in the most and least deprived areas of Saskatoon, as well as those in between, are persistent and, in some cases, growing. While it is important to identify trends and priority areas, the message is clear: we have work to do. Although many of the factors that influence health lie outside the health care system, we must do what we can to decrease health inequities.

Questions to Consider

- Are there any barriers to access or uptake of services and facilities amongst any particular population group or area that you frequently encounter?
- Is more targeted action with specific groups and areas required?
- Are the supports and resources available in the system to adequately address health inequities in your area? What other resources would be helpful?
- Are there any already existing priorities for action that contribute to improve health equity?
- What programs, services, approaches/practices already exist in your areas which might help in reducing gaps in equity?
- What further action is required from existing services or structures to address gaps in equity?
- How can health equity principles be embedded into existing work?

Advancing Health Equity in Health Care

Cultural Considerations: Aboriginal Peoples[1] in Canada

A History of Colonization Has Sustained Impact on Health.

Despite efforts to improve Aboriginal health, in general, there remain substantial inequities in the health of Aboriginal peoples in Canada compared to the rest of the population.[2,3,4] These inequities are due to a combination of economic, political and social disparities that have resulted from the complex history of relations between Aboriginal peoples and Canada.[5]

Local Geography: Of particular concern within our local geography are the existing health inequities between Aboriginal and non-Aboriginal peoples.[6] Saskatoon has the second highest percentage of Aboriginal residents of all major cities in Canada at just over 9% of the population, and this population is expected to increase.[6,7] Unfortunately, over 45% of the Aboriginal peoples living in Saskatoon are living in poverty (below the Low Income Cut-Off) and likely in areas of highest deprivation (Q5) where health inequities are most persistent [The Deprivation Index].

A History of Colonization: The colonial legacy is engrained in the identity of Aboriginal Peoples and continues to act as a social determinant of health today. At the core of the colonization experience is the loss of culture, which includes the loss of language, land, resources, spiritual practices, political and personal autonomy.[8] Aboriginal peoples were subjected to a system of forced assimilation that sought to destroy cultural identity through such things as residential schooling.[9,10] Over 150,000 First Nation, Métis and Inuit children attended these schools between 1857 and 1996. The stress, isolation and abuse that stemmed from residential schools has affected generations of Aboriginal peoples and resulted in problems such as family dysfunction, addictions, homelessness, and violence, all of which contribute to poor health status.[11]

> "Canada's relationship with the indigenous peoples within its borders is governed by a well-developed legal framework a number of policy initiatives that in many respects are protective of indigenous peoples' rights. **But despite positive steps, daunting challenges remain.** The numerous initiatives that have been taken at the federal and provincial/territorial levels to address the problems faced by indigenous peoples have been insufficient. The well-being gap between aboriginal and non-aboriginal people in Canada has not narrowed over the last several years, treaty and aboriginal claims remain persistently unresolved, indigenous women and girls remain vulnerable to abuse, and overall there appear to be high levels of distrust among indigenous peoples toward government at both the federal and provincial levels. "
>
> - United Nations Report of the Special Rapporteur on the Rights of Indigenous Peoples (Anaya, May 2014)

Beyond Poverty: While there is a clear link to poverty and health, studies suggest that the severe health inequities between Aboriginal and non-Aboriginal peoples cannot be solely attributed to socio-economic status (SES) due to the complex history of relations.[11] Individual choices and lifestyles that contribute to health risk behaviours are also unable to account for such inequity.[11] Research suggests that the historical stressors from colonization have led to intergenerational trauma and post-traumatic stress response (PTSR), collectively referred to as historical trauma, throughout the Aboriginal population. Such negative emotional states can have detrimental effects on the immune system and can change behavioural patterns affecting disease risk, leading to a greater burden of physical and mental disease and shortened life expectancy.[11,12,13,14]

Microagressions: A common form of racism faced by many Aboriginal peoples are microagressions, "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color."[15] Microagressions are commonly found in our society and many people are often unaware that they use them. Over time, being the target of frequent microagressions can make people more vulnerable to mental health concerns, substance abuse, and alienation.[16]

---

[1] Within the local context, the term Aboriginal is used to refer primarily to First Nations and Métis peoples, given the geography and demographic composition of Saskatoon Health Region. Nationally, however, the term Aboriginal includes all of Canada's first peoples including First Nations, Métis, and Inuit peoples.

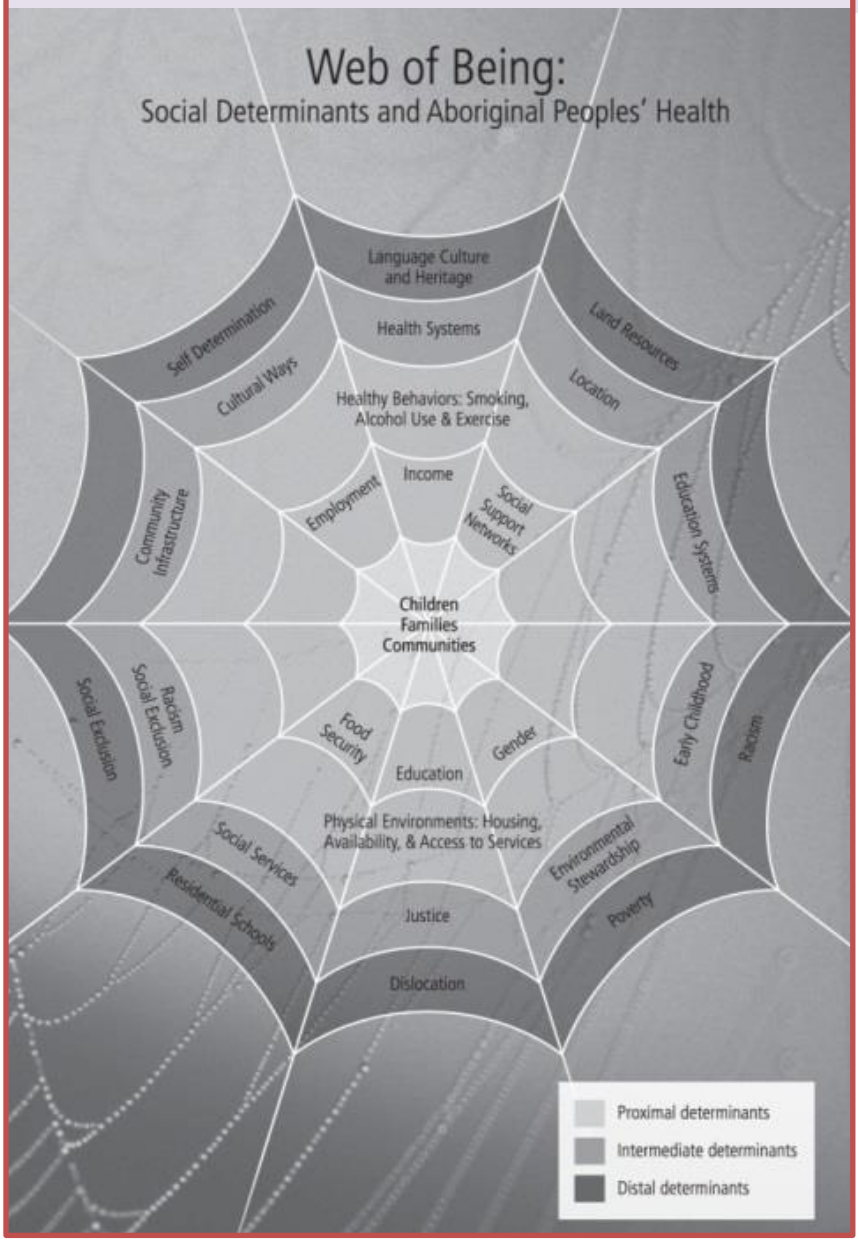
Advancing Health Equity in Health Care

Cultural Considerations: Aboriginal Peoples[1] in Canada

Institutional & Systemic Racism: Institutional racism involves polices, practices and procedures of institutions that have an unfairly negative effect on racial minorities[6] access to and quality of services and opportunities. Systemic racism is the value system that is embedded in a society that supports and allows discrimination. These types of racism distort our social and economic systems, including education, health, employment, community, housing, and criminal justice. As such, institutional and systemic racism are a direct cause of poverty. Poverty greatly influences all of the social determinants of health and thus contributes to creating health inequities. While many different population groups face racism, studies suggest, "there is an invisible hierarchy of racism in Canada with Aboriginal people at the bottom of the order and Aboriginal people receive the most intense and frequent racism".[16] Whether intentional or not, Aboriginal people face racism on a daily basis that has a direct impact on their health and well-being.

Health-Seeking Behaviour: The erosion of culture has created ongoing oppression and disempowerment that has silenced the voice of many Aboriginal peoples and adversely affected the way in which they seek out care.[17] Stemming from contemporary institutionalized racism and discrimination, both overt and unconscious, poor communication experiences between Aboriginal peoples and health care providers are common.[17] These experiences often result in distrust of the health care system leading to avoidance of care, reluctance to disclose personal information and reluctance to return.

Figure 1. A framework for Indigenous Peoples' social determinants of health, NCCAH, Greenwood (2009)[18]



Looking to the Future

To improve the health of ***all*** Canadians we must work to decrease gaps in health, which are particularly concerning among our Aboriginal population. It is clear that the health of Aboriginal peoples is complex. Moving forward, it is important that we consider the collective emotional and psychological injury that has occurred over the lifespan and across generations of Aboriginal peoples when observing the inequities still present in many aspects of Aboriginal health and well-being. Greater understanding of social determinants of health that include the unique experiences of Aboriginal peoples can help facilitate the change that is necessary to overcome persistent health inequities. In addition, we must work in partnership with the full spectrum of First Nations and Métis agencies and organizations to improve health equity and the social determinants of health, as each group has a unique experience that needs to be honoured.

For references, please see: Technical Appendix

Advancing Health Equity in Health Care

Equity Measure Findings

Why is this Important?

Health equity is the principle of and commitment to incorporating fairness into health by reducing health inequalities. [1] It implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.[2]

Examples of Action Being Taken:

For examples of progress that is occurring in Saskatoon Health region, please see Tackling the Barriers to Better Health for All.

To see how health equity is currently being considered in Saskatoon Health Region, please see Measuring Equity Region Plans and Strategies.

What More Can Be Done?

See the Chief Medical Health Officer's Call to Action for further recommendations.

Methods and Tools:

- What Did We Hear? A Summary of Health Care Sector Consultations
- Health Care Equity Audit Guide
- Technical Appendix

Highlights

Health Inequalities Remain Persistent.

- **Life Expectancy is Shorter for Some Residents:** Average life expectancy at birth is unfairly distributed in our city and the gap between those living in areas of highest and lowest deprivation of the city is widening [The Deprivation Index]. While life expectancy has continued to improve in areas of lowest deprivation of the city, it has remained unchanged for those living in areas of highest deprivation [Life Expectancy Results].
- **Gaps are Persistent:** Those living in the areas of highest deprivation in the city are experiencing poorer health compared to those living in areas of lower deprivation. Over time many of these gaps are persistent and unchanging [Trends in Health Equity Summary].
- **Health Improves as Deprivation Decreases:** For most conditions, the differences in health exist not only between areas of highest and lowest deprivation, but follow a gradient pattern. This means that residents living in areas of moderate deprivation experience poorer health than those in areas of lowest deprivation, and those in the highest deprived areas experience the poorest health of all.
- **Hospitalizations are Decreasing Disproportionately:** Cancer, chronic obstructive pulmonary disease (COPD), heart disease, intentional self-harm, mental health disorders, and stroke hospitalizations have consistently decreased since 1995. The general decrease has been disproportionate however, with large, persistent gaps between those living in the most and least deprived areas of the city for injuries, intentional self-harm, diabetes, heart disease and mental health disorders. For stroke and COPD, gaps are large but decreasing over time.
- **Primary Care Visits are Increasing Disproportionately:** Those living in areas of highest deprivation in Saskatoon are visiting a physician much more than those in other areas of the city. High inequalities and persistent wide gaps in primary care visits exist for all of the health outcomes examined. Further examination of these trends will be required to identify if service utilization is appropriate to need.
- **Prioritizing Action:** Areas like chronic disease [i] and mental health[ii] show some of the greatest inequalities. While some conditions, like COPD, have narrowing inequalities, the gaps remain wide and additional work is needed. Other issues, such as teen pregnancy and Hepatitis C, have high inequalities and widening gaps. We need to prioritize the population groups most vulnerable to health conditions showing the greatest inequalities. Links between some of these conditions, such as diabetes, COPD, heart disease, and mental health are particularly common and alarming[3]. For example, those living with mental illness often face challenges with living in poverty, finding stable housing, and having strong social networks. Because of this social disadvantage, people become vulnerable to acquiring additional chronic illnesses. Conversely, those living with chronic conditions also are at greater risk of experiencing mental illness.[4]

The Bottom Line:

The data is a starting point for conversations on health equity. Wide gaps between those living in the highest and lowest deprived areas of Saskatoon are persistent and, in some cases, growing. While it is important to identify trends and priority areas, the message is clear. We have work to do. Many factors that influence health lie largely outside the health care system; however, we must do what we can to decrease health inequities from within.

---

[i] The term chronic disease is used to refer to COPD data and diabetes data.
[ii] The term mental health is used to refer to intentional self-harm data and mental and behavioural disorders data.

Advancing Health Equity in Health Care

Equity Trends over Time: Summary Tables

Equity trends using Disparity Rate Ratio (DRR), Disparity Rate Difference (DRD), and gini coefficients are shown in *Table 1*. Also included are trends in the overall population rates. See the Methods and Technical Document for more information on interpreting equity measures and a complete table of data results.

Table 1: Rates per 1000, Inequality Measures and Trends over Time, Saskatoon, 1995 to 2011.

Indicator	Data Type	Rate/1000	DRR	DRD	GINI
Cancer	Hospitalizations	↓	**NS**	**NS**	**NS**
		1995: 7.20	1995: 1.13	1995: 0.92	1995: 0.13
		2011: 4.66	2011: 1.18	2011: 0.84	2011: 0.04
	Physician Visits	**NS**	**NS**	**NS**	**NS**
		1996: 5.66	1996: 3.91	1996: 6.13	1996: 0.25
		2009: 7.54	2009: 5.56	2009: 11.09	2009: 0.28
COPD	Hospitalizations	↓	**NS**	**NS**	↓
		1995: 2.82	1995: 2.59	1995: 2.61	1996: 0.33
		2011: 1.71	2011: 3.42	2011: 2.19	2009: 0.28
	Physician Visits	**NS**	↑	**NS**	**NS**
		1996: 26.65	1996: 6.23	1996: 40.38	1996: 0.32
		2009: 29.91	2009: 9.26	2009: 38.05	2009: 0.37
Diabetes	Hospitalizations	**NS**	↑	**NS**	**NS**
		1995: 1.13	1995: 1.74	1995: 0.60	1996: 0.18
		2011: 1.16	2011: 2.75	2011: 1.31	2009: 0.19
	Physician Visits	↑	**NS**	**NS**	**NS**
		1996: 5.21	1996: 8.28	1996: 8.38	1996: 0.40
		2009: 11.20	2009: 9.91	2009: 22.73	2009: 0.39
Heart Disease	Hospitalizations	↓	↑	**NS**	**NS**
		1995: 4.90	1995: 1.41	1995: 1.64	1996: 0.15
		2011: 2.37	2011: 1.75	2011: 1.43	2009: 0.16
	Physician Visits	**NS**	↑	**NS**	**NS**
		1996: 4.70	1996: 5.02	1996: 6.93	1996: 0.36
		2009: 5.96	2009: 7.29	2009: 11.2	2009: 0.37
Injury	Hospitalizations	**NS**	↑	**NS**	**NS**
		1995: 6.91	1995: 1.82	1995: 4.35	1996: 0.17
		2011: 5.79	2011: 2.35	2011: 5.11	2009: 0.20
	Physician Visits	↓	↑	**NS**	**NS**
		1996: 62.41	1996: 5.23	1996: 85.49	1996: 0.30
		2009: 44.52	2009: 7.41	2009: 71.43	2009: 0.33
Intentional Self-Harm	Hospitalizations	↓	**NS**	**NS**	**NS**
		1995: 0.84	1995: 5.58	1995: 1.28	1996: 0.28
		2011: 0.39	2011: 3.58	2011: 0.48	2009: 0.23
Mental Disorders	Hospitalizations	↓	**NS**	**NS**	**NS**
		1995: 6.17	1995: 2.90	1995: 6.35	1996: 0.20
		2011: 3.48	2011: 2.44	2011: 3.28	2009: 0.18
	Physician Visits	↑	↑	**NS**	**NS**
		1996: 31.87	1996: 6.81	1996: 51.86	1996: 0.35
		2009: 41.95	2009: 9.05	2009: 81.44	2009: 0.38
Stroke	Hospitalizations	↓	↑	**NS**	↓
		1995: 2.41	1995: 1.67	1995: 1.24	1996: 0.23

		2011: 1.19	2011: 2.03	2011: 0.76	2009: 0.16
	Physician Visits	↓	**NS**	**NS**	**NS**
		1996: 1.62	1996: 4.85	1996: 2.60	1996: 0.42
		2009: 1.19	2009: 6.16	2009: 2.26	2009: 0.38
Chlamydia	STIs	**NS**	↓	**NS**	**NS**
		2004: 3.31	2004: 4.22	2004: 4.94	2004: 0.29
		2010: 4.85	2010: 2.96	2010: 5.24	2010: 0.25
Gonorrhea	STIs	**NS**	**NS**	**NS**	**NS**
		2004: 0.46	2004: 8.40	2004: 0.93	2004: 0.40
		2010: 0.40	2010: 4.79	2010: 0.73	2010: 0.47
Hepatitis C	CD	↓	**NS**	**NS**	↑
		2004: 0.81	2004: 7.84	2004: 1.94	2004: 0.43
		2010: 0.37	2010: 11.14	2010: 1.54	2010: 0.51
Tuberculosis	CD	**NS**	**N/A**	**NS**	**NS**
		2004: 0.01	2004: N/A	2004: 0	2004: 0.58
		2010: 0.06	2010: N/A	2010: 0.21	2010: 0.56
All-Cause Mortality	Vital Statistics	**NS**	↑	**NS**	**NS**
		1995: 6.09	1995: 2.28	1995: 4.61	1995: 0.28
		2009: 5.88	2009: 2.34	2009: 5.38	2009: 0.23
High Birth Weight	Vital Statistics	**NS**	↑	**NS**	↓
		1995: 106.37	1995: 0.73	1995: -33.71	1995: 0.15
		2009: 134.82	2009: 0.95	2009: -6.54	2009: 0.08
Infant Mortality	Vital Statistics	↓	**NS**	**NS**	**NS**
		1995: 10.73	1995: 2.87	1995: 10.71	1995: 0.18
		2009: 8.36	2009: 1.61	2009: 3.39	2009: 0.17
Low Birth Weight	Vital Statistics	**NS**	**NS**	**NS**	**NS**
		1995: 65.95	1995: 2.27	1995: 54.50	1995: 0.06
		2009: 61.49	2009: 1.53	2009: 27.79	2009: 0.06
Teen Abortion	Vital Statistics	**NS**	↑	**NS**	↓
		1995: 245.45	1995: 0.63	1995: -119.36	1995: 0.31
		2009: 195.61	2009: 0.93	2009: -13.19	2009: 0.21
Teen Pregnancy	Vital Statistics	↓	↑	**NS**	↑
		1995: 87.09	1995: 4.19	1995: 113.31	1995: 0.17
		2009: 56.64	2009: 8.63	2009: 114.25	2009: 0.25
Childhood Immunization (MMR by 2 years)	Immunization	↑	**NS**	**NS**	**NS**
		2002: 624.90	2002: 0.58	2002: -312.10	2002: 0.09
		2011: 745.87	2011: 0.76	2011: -202.86	2011: 0.07

Table 2: Health Inequality Trends over Time by Gini Coefficient for Selected Indicators, Saskatoon, 1995 to 2011.

Degree of Inequality	Widening	Stable (NS Trend)		Narrowing
		Trend to Widening	Trend to Narrowing	
HOSPITALIZATIONS (1995 to 2011)				
HIGH		Injuries	Intentional Self-Harm	COPD
MEDIUM		Diabetes Heart Disease Mental Health Disorders		Stroke
LOW			Cancer	
PHYSICIAN VISITS (1996 to 2009)				
HIGH		Cancer COPD Heart Disease Injuries Mental Health Disorders	Diabetes Stroke	
COMMUNICABLE DISEASE (2004 to 2010)				
HIGH	Hepatitis C	Gonorrhea	Chlamydia Tuberculosis	
VITAL STATISTICS (1995 to 2009)				
HIGH	Teen Pregnancy		All-Cause Mortality	Teen Abortion
MEDIUM		Low Birth Weight (same OT)		High Birth Weight
			Infant Mortality	
IMMUNIZATION (2002 to 2011)				
MEDIUM			Child Immunization	

Note: The change in the Gini coefficient between the most and last recent times was used to determine direction of trend. Non-significant (NS) changes over time (OT) were deemed stable. The inequality trends by Gini coefficient account for total inequality ***within*** the entire population, from Q1 through to Q5.

Table 3: Levels of Inequality in Selected Health Indicators, Saskatoon, 1995 to 2011.

Data Source	High Inequalities	Medium Inequalities	Low Inequalities
Hospitalizations (1995 to 2011)	COPD Injuries Intentional Self-Harm	Diabetes Heart Disease Mental Disorders Stroke	Cancer
Physician Visits (1996 to 2009)	Cancer COPD Diabetes Heart Disease Injuries Mental Disorders Stroke		
Communicable Disease (2004 to 2010)	Chlamydia Gonorrhea Hepatitis C Tuberculosis		
Vital Statistics (1995 to 2009)	All-Cause Mortality Teen Abortion Teen Pregnancy	High Birth Weight Infant Mortality Low Birth Weight	
Immunization (2002 to 2011)		Child Immunization	

Note: The most recent Gini coefficient was used to categorize the indicators. High inequalities are those with Gini coefficients >0.20, medium inequalities are those 0.06 – 0.20, and low inequalities are those <0.06.

Table 4: Health Inequality Trends over Time by Gini Coefficient for Selected Indicators, Saskatoon, 1995 to 2011.

Data Source	Widening	Stable	Narrowing
Hospitalizations (1995 to 2011)		Cancer Diabetes Heart Disease Injuries Intentional Self-Harm Mental Disorders	COPD Stroke
Physician Visits (1996 to 2009)		Cancer COPD Diabetes Heart Disease Injuries Mental Disorders Stroke	
Communicable Disease (2004 to 2010)	Hepatitis C	Chlamydia Gonorrhea Tuberculosis	
Vital Statistics (1995 to 2009)	Teen Pregnancy	All-Cause Mortality Infant Mortality Low Birth Weight	High Birth Weight Teen Abortion
Immunization (2002 to 2011)		Child Immunization	

Note: The Gini coefficient at the most and last recent times was used to determine direction of gap. Non-significant changes over time were deemed stable. The inequality trends by Gini coefficient account for total inequality ***within*** the entire population, from Q1 through to Q5.

Table 5: Health Inequality Gap Trends over Time by Disparity Rate Ratio in Selected Indicators, Saskatoon, 1995 to 2011.

Data Source	Widening Gap	Stable Gap	Narrowing Gap
Hospitalizations (1995 to 2011)	Diabetes Heart Disease Injuries Stroke	Cancer COPD Intentional Self-Harm Mental Disorders	
Physician Visits (1996 to 2009)	COPD Heart Disease Injuries Mental Disorders	Cancer Diabetes Heart Disease Stroke	
Communicable Disease (2004 to 2010)		Hepatitis C Gonorrhea Tuberculosis*	Chlamydia
Vital Statistics (1995 to 2009)	All-Cause Mortality High Birth Weight Teen Abortion Teen Pregnancy	Infant Mortality Low Birth Weight	
Immunization (2002 to 2011)		Child Immunization	

Note: The disparity rate ratio (DRR) at the most and last recent times was used to determine direction of gap. Non-significant changes over time were deemed stable. The inequality trends by DRR account for inequality ***between*** those living in the highest areas of deprivation (Q5) and those living in the lowest areas of deprivation (Q1).
*Unable to calculate due to 0 cases in Q1 for some time periods.

Table 6: Rate per 1000 Population Trends over Time in Selected Indicators, Saskatoon, 1995 to 2011.

Data Source	Increasing	Stable	Decreasing
Hospitalizations (1995 to 2011)		Diabetes Injuries	Cancer COPD Heart Disease Intentional Self-Harm Mental Disorders Stroke
Physician Visits (1996 to 2009)	Diabetes Mental Disorders	Cancer COPD Heart Disease	Injuries Stroke
Communicable Disease (2004 to 2010)		Chlamydia Gonorrhea Tuberculosis	Hepatitis C
Vital Statistics (1995 to 2009)		All-Cause Mortality High Birth Weight Low Birth Weight Teen Abortion	Infant Mortality Teen Pregnancy
Immunization (2002 to 2011)	Child Immunization		

Note: The rate per 1000 population at the most and last recent times was used to determine direction of trend. Non-significant changes over time were deemed stable.

Advancing Health Equity in Health Care

Life Expectancy

Why Is This Important?

Life expectancy at birth is one of the most widely used public health indicators to assess population health. Increases in life expectancy are often associated with improvements in health. In developed countries, life expectancy is related to socio-economic factors such as poverty and education levels and is not sensitive to the health system changes. Life expectancy is higher for women than for men, and may be related to differences in risk-taking behaviour, use of health care services, and the adoption of healthier lifestyles.

Examples of Action Being Taken:

Saskatoon Poverty Reduction Partnership

The Canadian Public Health Association has listed 12 achievements that have increased life expectancy over the years.

What More Can be Done?

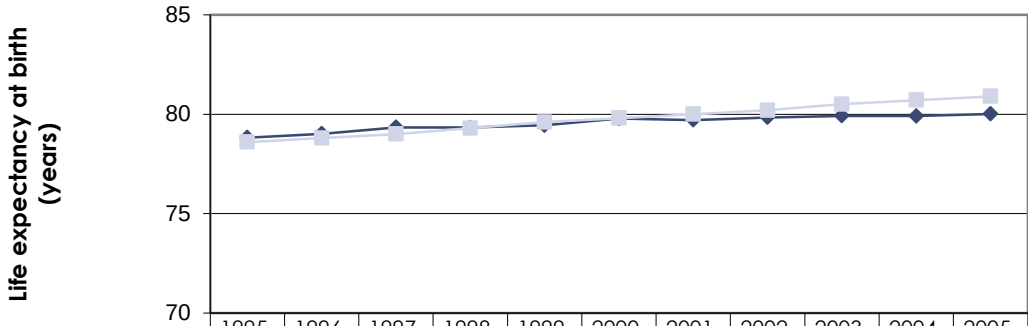
Chief Medical Health Officer's Call to Action

Highlights

Life expectancy is increasing over time in Saskatoon Health Region. Disparities exist.

- Life expectancy at birth for a Regional resident was 80 years in 2007 and has been increasing over time. This is slightly below the Canadian average for this time period (*Figure 1*).
- The gap in life expectancy between those living in the highest socio-economic quintiles and those in the lowest has been increasing (*Figure 2*). The gap between these two groups was 6 years in 1995-1999 and has increased to 8.7 years in 2005-2009.
- Life expectancy for females and males, Registered Indian Status populations and non-Registered Indian Status populations, and Saskatoon and rural areas is shown here.

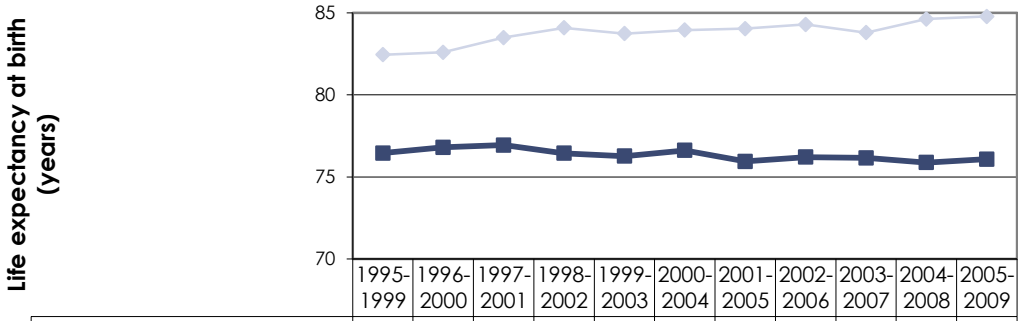
Figure 1: Life Expectancy at Birth, Saskatoon Health Region and Canada, 1995 to 2009



	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007	2004-2008	2005-2009
SHR	78.8	79.0	79.3	79.3	79.4	79.8	79.7	79.8	79.9	79.9	80.0
Canada	78.6	78.8	79.0	79.3	79.6	79.8	80.0	80.2	80.5	80.7	80.9

* Canada values based on three year avg. Source: Vital Statistics and Statistics Canada

Figure 2: Life Expectancy at Birth, Socio-economic Areas in Saskatoon, 1995 to 2009



	1995-1999	1996-2000	1997-2001	1998-2002	1999-2003	2000-2004	2001-2005	2002-2006	2003-2007	2004-2008	2005-2009
Highest socio-economic area	82.4	82.6	83.5	84.1	83.7	83.9	84.0	84.3	83.8	84.6	84.8
Lowest socio-economic area	76.5	76.8	76.9	76.4	76.3	76.6	75.9	76.2	76.2	75.9	76.1

Source: Vital Statistics

pho@saskatoonhealthregion.ca | 306.655.4679

Advancing Health Equity in Health Care

A Summary of Health Care Sector Consultations

Why is this Important?

Health equity is the principle of and commitment to incorporating fairness into health by reducing health inequalities.[1] It implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.[2]

Achieving equity in health care means that services are available, accessible and acceptable for the needs of all people.

Examples of Action Being Taken:

For examples of progress that is occurring in Saskatoon Health region, please see Tackling the Barriers to Better Health for All.

What More Can Be Done?

See the Chief Medical Health Officer's Call to Action for further recommendations.

Methods and Tools:

- Equity Measure Findings
- Health Care Equity Audit Guide
- Technical Appendix

Highlights

Gaps in health outcomes persist over time in Saskatoon between people living in areas of highest and lowest deprivation. Tackling barriers within health care is part of the solution.

- Over the past several months, Saskatoon Health Region's Medical Health Officers and Public Health Observatory staff held close to 40 health sector consultations to identify barriers to achieving equity in health care [Technical Appendix]. We looked at a range of health conditions from 1995 to 2011 and discussed what could be done to close wide and persistent gaps in health outcomes between population groups. Ideas were generated that could contribute to removing the many barriers that were identified through the process. See Call to Action for more details.

What Did We Hear?

Information is limited: We heard that follow up care is more difficult for populations with complex needs and health care providers often don't have enough information about their patients' circumstances limiting their ability to better support them (e.g. patients may have transportation challenges, live in poor housing circumstances, lack social supports or be residential school survivors). Having this information could lead to better care for patients, while potentially reducing the need for more services.

- For example, one physician shared that knowing his patient's housing circumstances led him to support her in acquiring an air conditioner which helped her breathe easier in the summer months and avoid a visit to hospital for COPD.

Capacity is an issue: Health care providers said they are stretched to the limit making it more challenging to find time to "level up" services to better meet patient/client needs. As such, system improvement opportunities such as Lean may lead to efficiencies that would provide more time to those who need it most. Striking a good balance here will be important.

- For example, a public health nurse shared her challenge in simply being able to allot the time to help a client fill out a form so that she could receive the services she needed. Without her help, she knew her client would not be able to receive the services she required.

Cultural considerations are important: Building trusting and strong connections among health care providers and clients, especially those from vulnerable populations, are important and take time. Racism and discrimination create tremendous challenges to establishing this trust [see Cultural Considerations for important reflections on the health of Aboriginal Peoples].

- We heard stories of overt racism in our system. For example, First Nations patients have left the health care system due to negative experiences with staff, not having received the care they needed.

Health care system itself creates barriers: The complexity of the way the system and its policies are set up can often perpetuate inequity.

- We heard many examples of the relationship between the federal and local efforts to meet the needs of First Nations peoples created access barriers and placed undue burden on patients. Access to drug coverage was a clear concern for many with some physicians stating that they would recommend patients back to the ED as a necessary step in getting their clients the care they needed in a timely fashion.

Advancing Health Equity in Health Care

Tackling the Barriers to Better Health for All

Highlights

There are many examples of progress towards health care equity in Saskatoon Health Region.

- The Health Region's Better Health For All – Series 3 health status report shows wide and persistent gaps between Saskatoon's lowest and highest areas of deprivation over a 15 year time-span.
- While the factors that influence health (i.e., the social determinants of health) lie largely outside the health care sector, there are many barriers to health care that can be removed within health care to help tackle health inequity.
- Throughout close to 40 consultation sessions, we found many examples of great progress across programs and services toward removing system barriers and better meet patient and client needs.
- While many of these examples show promise, many of those we spoke to also shared that barriers are often harder to tackle than anticipated. Tools are available to assist with incorporating the principles of health equity in everyday planning and care.

Improving Accessibility *Making health care "accessible" means that facilities and services are free of physical, economic and discriminatory barriers and information is also easy to access. It also includes the participation of underserved groups in the planning and evaluation of those services. Examples include:*

- The Region's Mental Health & Addictions programs and services have long recognized that community partnerships are key to ensure people with mental health and addictions needs are met where individuals will benefit most. This has resulted in the Region supporting such initiatives as the Lighthouse stabilization shelter, the Police and Crisis Team (PACT), and situating outreach workers directly in the community (e.g. mental health coordinator at Central Urban Métis Friendship Centre Inc.) In addition, the department has streamlined process so that wait times have been eliminated for adult outpatient addictions services.

- The Provincial Hotspotting initiative announced in the 2014 Speech from the Throne also shows promise as an opportunity to increase accessibility as it recognizes that those who are most frequent users of health care services require new and different care approaches in order to better meet their health care needs.

- Saskatoon Health Region has a number of Patient and Advisory Councils in place across departments. The establishment of an Aboriginal People's Patient and Family Advisory council is a great step in including the participation of underserved groups in planning.

Improving Availability *Improved health care service availability, particularly to vulnerable populations, refers to whether services are provided within a community. It includes having sufficient and functioning public health and health care facilities, programs and services that address the entire disease course (primary, secondary and tertiary prevention and treatment), and life course (from prenatal to end of life care) such as timely diagnostic and treatment services, available primary care providers, and reasonable hours of operation to name a few.*

- Within its universal provision of immunization coverage services, the Region's Population and Public Health department has developed targeted approaches to expanding availability of immunization services in under-immunized neighbourhoods including moving services closer to where the needs are

greatest, increasing hours of operation at some locations and partnering with schools to offer services closer to people.

- The Saskatchewan Cancer Agency has also recognized that accessibility of screening programs can be a challenge in rural and remote areas and they have partnered with First Nations and Métis organizations as well as established a mobile bus that travels to rural communities to ensure more equity in access to breast cancer screening for example.

- The Health Region's Telehealth program also provides services to rural and remote communities for many services including a dementia program which allows for more timely diagnosis and improved follow up care since patients (often elderly) are not required to travel.

Improving Acceptability *Acceptable health care services are those which are provided in a way that meets the needs of distinct cultural, linguistic, ethnic, and social groups. Culturally competent services and culturally safe spaces are key components of the acceptability of services.*

- While evidence from our consultations demonstrates there is much room for improvement, there are many programs and services across the Region that have been striving to become more culturally competent and have been providing cultural competency workshops for Region employees.

- Saskatoon Health Region's First Nations and Métis Health Services team provides supports and services to First Nations and Métis peoples in the Region's to ensure that their health needs are being met in a culturally competent fashion. The team facilitates navigation services, offers cultural support and provides an interpreter when needed to First Nations and Métis clients.

- The Health Region's chronic disease management programs have long recognized that their services are not a "one-size-fits-all" and they have been making modifications to their programs in order to better meet a range of needs. For example, their medicine management models have been tailored so that their approach is directly based on the needs of the patients and clients they serve

- The Heart and Stroke Foundation of Saskatchewan has worked with partners to develop tools to assist women of South Asian descent prevent and manage heart disease. Research has shown that people of South Asian descent are at greater risk of developing diabetes, high blood pressure, heart disease and stroke – and at a much earlier age – compared with other ethnic groups. The Foundation has translated and culturally adapted some key resources to help people understand the risk factors and provide information and support in reducing that risk, including how to recognize heart disease and stroke.

Advancing Health Equity in Health Care

Measuring Equity in Region Plans and Strategies

Why is this important?

Health equity is the principle of and commitment to incorporating fairness into health by reducing health inequalities.[1] It implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.[2]

Although health equity is influenced by much more than the health care system, the health care system does make a difference and does have a role to play in addressing inequities. By doing so, the health system can become more patient/client-centred, more efficient and effective.

Examples of Action Being Taken:

Tackling the Barriers to Better Health For All

What More Can Be Done?

See the Chief Medical Health Officer's Call to Action for further recommendations.

Methods and Tools:

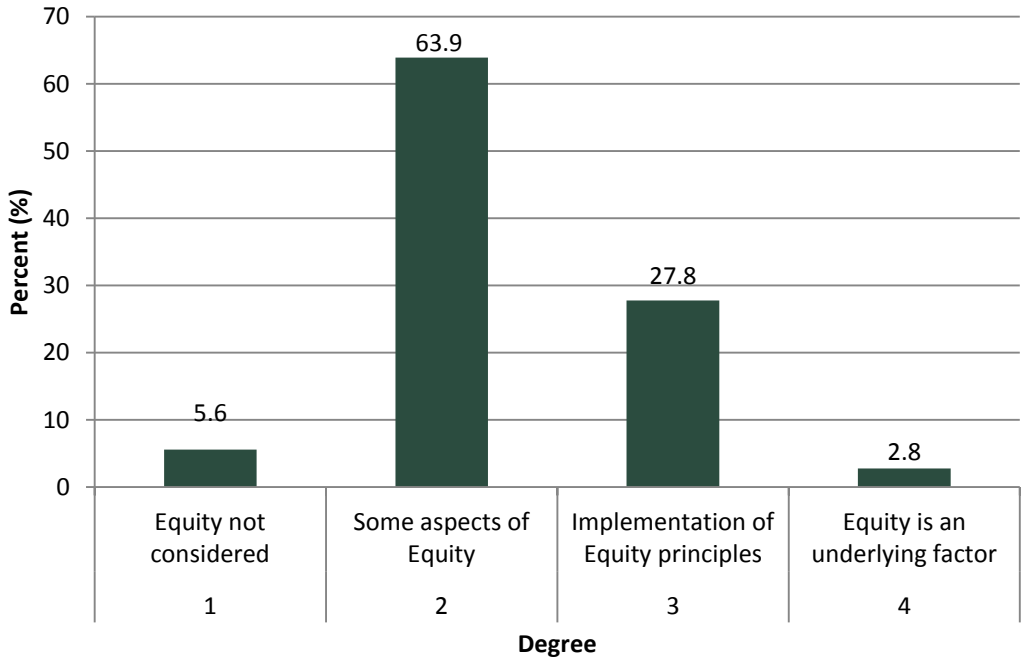
- Health Care Equity Audit Guide
- Technical Appendix

Highlights

Saskatoon Health Region plans and strategies reflect some aspects of health equity and there is room to improve.

- In 2013, the Region piloted a tool to assist in measuring to what degree health equity was present in Regional plans and strategies.
- Of the 36 plans and strategies reviewed, 64% were found to reflect "some aspect" of health equity and health promotion principles.
- Close to a third of the documents reviewed demonstrated implementation of health equity and health promotion principles and 3% incorporated health equity as an underlying principle.
- As the Health Region works to incorporate health equity principles to help achieve "Better Health", monitoring of plans and strategies will continue.
- Findings will assist departments to assess their own progress toward incorporating health equity/health promotion principles in their departmental or programmatic plans/strategies/reports.
- Plans to further test the tool are in place and it is likely that it will be implemented every 2 years to monitor improvements over time.

Figure 1: Percent of Saskatoon Health Region Department/Programs by Four Degrees of Health Equity/Health Promotion Consideration/Implementation



Advancing Health Equity in Health Care

What You Can Do as a Health Care Provider and Decision-Maker

How Can I Improve Health Equity in My Everyday Work?

Thirteen broad policy and program recommendations for improving health equity have been developed based on leading best and promising practices across Canada (See Technical Appendix for references). Consider these following key principles:

1. **Consider literacy and language diversity in the development of public messaging and materials.**
   - Incorporate visuals into learning resources for patients.
2. **Integrate social supports.**
   - Create safe ways for patients, clients and families to get help without feeling embarrassed or put on the spot.
3. **Include provider care systems to support equitable service provision.**
   - Use reminders, regular communications, flow sheets, and metrics to ensure that equitable care is 'top of mind' for everyone.
4. **Orientate services to be provided within the home, school, workplace and/or community.**
   - Provide services at times and in places that meet patient and client needs.
5. **Deliver programs and/or services specifically for priority populations.**
   - Provide programs or services to meet needs not addressed by other plans/strategies.
6. **Ensure culturally-safe service provision.**
   - Develop knowledge or skills of workforce to provide culturally-safe services.
7. **Develop innovative approaches for the inclusion of skill-building and interactive components for interventions.**
   - Assess people's readiness for change, build on their strengths, and tailor activities appropriately.
8. **Include clients and/or families in health programming.**
   - Engage clients and families in planning and decision-making at individual (client) and program level.
9. **Facilitate the formation of multidisciplinary teams, integrated services and case management for high risk and marginalized populations.**
   - Support advocacy for individual patients, clients and families' needs within the health care system and with intersectoral partners.
10. **Integrate community health and lay workers within health program planning and delivery.**
    - Provide community members with innovative opportunities to learn new skills and play a role in the health care system (e.g. community program builders, Elders, and patient/client/family advisors).
11. **Work towards supporting long-term sustainable change.**
    - Build upon and/or scale up previously successful programming.
12. **Identify the role of sectors other than health (e.g. education, housing, social services etc.) as active partners in order to address the social determinants of health and increase equity.**
    - Collaborate with other service providers to address social determinants of health.
13. **Be regularly informed by evidence.**
    - Identify the exact result to be achieved, follow best practices, and include how to know whether or not you are succeeding (target-setting).

Find more examples of how you can build health equity into your own practice in The Health Care Equity Audit Guide.

Additional Resources:

- What is Health Equity?
- Cultural Considerations: Aboriginal Peoples Health
- The Health Care Equity Guide
- The Health Care Equity Tool
- Tackling the Barriers to Better Health For All

Advancing Health Equity in Health Care

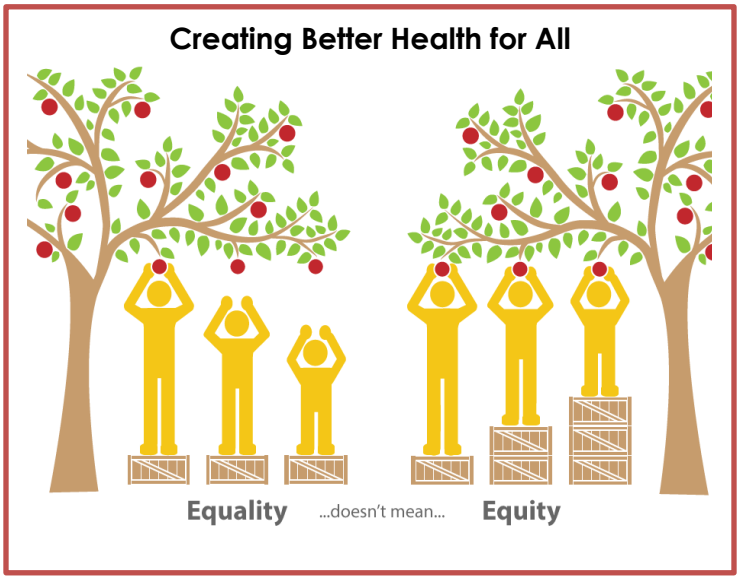
An Introduction to the Health Care Equity Audit Guide

What is Health Care Equity?

Health equity is the principle of and commitment to incorporating fairness into health by reducing health inequalities.[1] Health equity implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.[2]

The goal of an equitable health care system is to support improved health outcomes for ***all*** while decreasing gaps between different population groups. Health equity should be a priority for all areas of the health care system.

Although equity in health is influenced by factors that are much broader than the health care system (i.e. the social determinants of health), the system does make a difference and does have a role in addressing inequities.



What is the Health Care Equity Audit Guide?

The Health Care Equity Audit Guide was developed as a tool to assist health care providers and decision makers in examining how fairly health care system resources are distributed relative to the needs of different groups. The Guide describes the 4 stages of the audit cycle and provides worksheets and templates that can inform evidence-based practice and actions.

Through using the Guide, end-users are able to systematically identify health inequalities in the health care system (stage 1), develop actions to address health inequities (stage 2), implement evidence-based interventions and/or strategies (stage 3) and evaluate the impact of actions on reducing inequities (stage 4).

> "**Equitable care does not mean treating every patient exactly the same**. Instead, equitable care ensures optimal outcomes for all patients regardless of their background or circumstances."
>
> Source: The Roadmap to Reduce Disparities, Robert Wood Johnson Foundation (2014)

What will it help me do?

The Health Care Equity Audit Guide can be used at various stages of program and policy development and planning to:

- → guide the development of new programs or actions;
- → explore an equity issue that has been raised by clients, staff, or senior leadership;
- → review existing policies, programs, services or plans;
- → complement existing planning and quality improvement efforts;
- → identify gaps and barriers in services and care;
- → improve understanding of health care equity;
- → to identify potential concerns; and
- → measure the equity within an existing program or service.

How do I get started?

For more information refer to the Advancing Health Equity in Health Care series. More detailed description of the HCEA can also be found in the Health Care Equity Audit Guide. Select specific stages to explore, based on your available capacity, priorities and commitments. The Public Health Observatory is available for consultation, data analysis, and can answer any questions you may have during this process.

Advancing Health Equity in Health Care

The Health Care Equity Audit (HCEA) Tool

What is the HCEA Tool?

The HCEA Tool is a 4 stage process (see diagram) that assists health care providers and/or decision makers in systematically exploring and identifying potential health inequities that produce unfair health differences in their community. Beyond identifying potential health inequities, evidence-based practices are implemented, evaluated and reflected on until gaps in health are addressed. Further action is often undertaken to address the inequities and incorporated into policy, plans and practice (NHS, 2004).

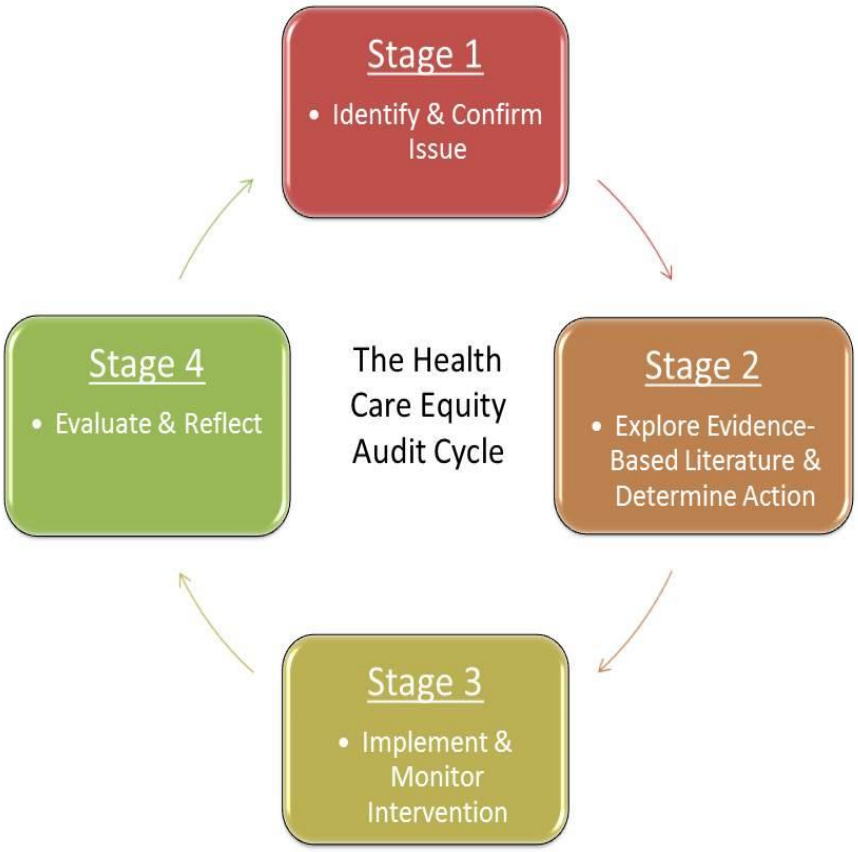
It is not always necessary to go through the entire cycle or complete each stage in order. Any stage can be explored.

Health equity is the principle of and commitment to fairness in health by reducing health inequalities. It implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.

- Adapted from Whitehead & Dahlgren (2006)

Stage 1: Identify & Confirm Issue

Identify the problem (i.e. the perceived inequity and the associated factors) and confirm the presence of a health inequity (i.e. using suggested data sources coupled with qualitative feedback). Data sources differ based on area of care but, if possible, consider examining the data by demographic variables such as age, sex, ethnicity, socio-economic status or other socially determined circumstances. Health care inequities can occur when population groups in equal need are not provided equal service.



Stage 2: Explore Evidence-Based Literature & Determine Action

Build an action plan by choosing interventions through literature searches and identifying actionable steps (e.g., resource allocation, social and language supports, safety considerations, skill building opportunities for staff, etc.). Review Health Equity Considerations.

Stage 3: Implement & Monitor Intervention

Track whether an action plan is working (e.g., examine sustainability of service, whether patients' needs are being met, are patients and families feedback being considered, etc.).

Stage 4: Evaluate and Reflect

Consider, has the gap in health equity narrowed between different population groups? Are patients and families satisfied with service? What mistakes can be rectified? Are root causes of the problems experienced by patients in need being addressed? Continue the cycle. Re-enter any stage as appropriate.

For more information, please see The Health Care Equity Audit Guide.