



## **Cancer Care for *All* Canadians:**

# **Improving Access and Minimizing Disparities for Underserved Populations**

## **Discussion Paper**

*Prepared by the National Outreach Team of the Canadian  
Partnership Against Cancer*

*CANCER CARE FOR ALL CANADIANS: IMPROVING ACCESS AND MINIMIZING DISPARITIES FOR UNDERSERVED POPULATIONS- DISCUSSION PAPER*

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*Cancer Care for All Canadians: Improving Access and Minimizing Disparities for Underserved Populations- Discussion Paper*

Part 1 – Background  
    Health Disparities in Canada  
    The Promise of Universal and Equal Access to Care  
Part 2 – The Principles  
Part 3 – Recommendations

<http://www.bccancer.bc.ca>

The views expressed in this document are those of the authors and contributors to the National Forum on Cancer Care for All Canadians and the National Outreach Team and do not necessarily reflect those of participating organizations and sponsors.

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## REPORT HIGHLIGHTS

- ❖ Canadians are aware of health disparities as evidenced by the various task forces, commissions and reports that have been produced during the last decades with recommendations and, more importantly, calls for action to reduce health disparities. Despite this work, the reality is that the Canadian Health System does not serve all Canadians equally, as there are significant disparities in health status among Canadians, especially for specific populations, including those living in rural and remote locations, Aboriginal people, immigrants and the poor. Unless we take action now, the enormous cost to the health system and society will only increase.
- ❖ The Canadian Partnership Against Cancer is responsible for mandating the objectives of the Canadian Strategy for Cancer Control, which include: (1) to reduce the expected number of new cases of cancer among Canadians; (2) to enhance the quality of life of those living with cancer, and (3) to lessen the likelihood of Canadians dying from cancer.<sup>1</sup> For an effective pan-Canadian strategy it is essential that **All** Canadians have access to equitable, person-centred, safe and quality cancer care.
- ❖ The Canadian Partnership Against Cancer must be challenged to integrate issues of Diversity and equity across all Action Groups. In doing so the Canadian cancer care system will develop and implement sustainable, culturally competent strategies and frameworks to improve cancer care for **All** Canadians. These strategies and frameworks will aim for the adoption of diversity and equity practices and standards throughout the system and within all levels of organizations from policy to practice.
- ❖ One of the key challenges to addressing inequities in access to the Cancer Care System is the lack of data available to document and analyze health disparities across subpopulations. As an example, currently in Canada, ethnicity or cultural data is not being routinely collected in the cancer registries; consequently, only a limited amount of information exists on the cancer experience among Aboriginal populations and immigrants.
- ❖ It has long been established that disparities are not randomly distributed, but rather differentially distributed mainly among the poor, Aboriginal populations, those with language barriers and those living in rural and remote areas. These subpopulations need attention now.
- ❖ Barriers to access can be sorted into four categories: (1) availability of services, (2) financial barriers, (3) non-financial barriers to presentation of health care needs and (4) barriers to equitable treatment.

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- ❖ Supportive care interventions should be implemented closer to the patient. There is a need for innovative outreach interventions to provide integrated care to patients at the place where they are living and where the system meets the community
- ❖ Evidence-informed approaches to cultural competency have the potential to improve access for a number of underserved groups. Cultural competence embodies diversity, the need for professional skills development and system changes, and requires an integrated and sustainable approach. Provision of medical interpreters, a component of cultural competency, is critical to ensure effective and safe patient-care provider exchange of information and to minimize risk and liability concerns such as uninformed consent, misdiagnosis and mistreatment due to miscommunication.
- ❖ Several organizations in Canada have published guidelines for cultural competency in care, as well as cultural competency assessment tools. In addition USA, Australia and several European countries have identified comprehensive strategies to improve access to care and reduce health disparities. These materials can inform the Canadian cancer control strategy.
- ❖ Partnerships with public, private and volunteer organizations, and early consultation with and participation of community members are essential to success. Networks with other national agencies or programs such as chronic disease; healthy living, or disease specific interventions (diabetes, etc) are critical to create coordinated actions, avoid duplication, create synergies and collaborate for improved outreach to underserved populations.
- ❖ Constant and appropriate (formative, summative, participatory) evaluation of programs and initiatives will need to be conducted to ensure that programs are accountable, effective and of greatest benefit to diverse and underserved populations.
- ❖ Facilitating knowledge creation and development of strategies for sharing information is urgently needed to fill the gaps in documenting and addressing unequal access to care and cancer disparities across Canada. The creation of a national repository of interventions and resources for cross-cultural cancer care is a priority action; e.g. *The Canadian Cross-cultural Cancer Council* will provide a centralized, comprehensive and reliable site for information/education material for patients and care providers. Similarly, development of operational guidelines and indicators for assessing programs' effectiveness need to be part of institutional quality improvement programs.

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<sup>1</sup> Canadian Strategy for Cancer Control: A Cancer Plan for Canada, Discussion Paper (July 2006).  
([http://www.cancer.ca/vgn/images/portal/cit\\_86751114/10/2/1404842209cw\\_CSCC\\_Discussion\\_Paper\\_July\\_2006\\_v2.pdf](http://www.cancer.ca/vgn/images/portal/cit_86751114/10/2/1404842209cw_CSCC_Discussion_Paper_July_2006_v2.pdf)).

## EXECUTIVE SUMMARY

In accordance with the goals of the Partnership and with the endorsement of the Rebalance Focus Action Group, the Outreach team organized the “*National Forum on Cancer Care for all Canadians: improving access and minimizing disparities for vulnerable populations in Canada*”. The Forum was held in Vancouver, BC, on November 1-3, 2007 with the purpose of identifying the actions required for improving access to quality cancer care for underserved Canadians. The specific objectives of the forum were: 1) to share which programs and resources are in place and working across the country, 2) to discuss and identify actions taken by Canadian policymakers to improve access to and use of cancer care services for All, and 3) to form national communities of practice for equitable cancer control initiatives.

It is well established that health disparities exist and they are not randomly distributed, but rather differentially distributed mainly among the poor, Aboriginal populations, those with language barriers and those living in rural and remote areas. These subpopulations need attention *now*. Given the significant number of Canadians accounted for within these populations, the Partnership will only achieve the most effective pan-Canadian cancer control strategy by prioritizing actions to improve access to and use of care services for those at high risk of poorest outcomes.

Based on current evidence and the discussions and recommendations from the Forum participants, eight key principles have been articulated to guide the Partnership in developing and implementing an effective and efficient national cancer control strategy for *ALL* Canadians. The eight key principles are: Quality, Comprehensiveness, Responsibility, Responsiveness, Accessibility, Safety, Partnership, and Innovation.

This report aims at summarizing the key principles and recommendations and the impact of each one on an effective and comprehensive cancer control strategy. The document is divided in three parts. Part 1 provides background and contextual information related to the magnitude of the problem of not addressing systemic barriers to care for underserved populations. Part 2 describes the eight key principles and their main components providing some examples of strategies to ensure that the principles of Diversity and Equity are integrated as core values across all action groups underlying a pan-Canadian Cancer Control strategy. Part 3 provides a summary of recommendations for the Partnership to take a leadership role in minimizing unequal access to and use of care services.

The three main recommendations are: 1) that the Partnership identify and facilitate immediate **A**ctions to ensure equal access to care for recognized underserved populations; 2) that the Partnership **B**uild partnership with other public, private and volunteer sectors; and 3) that the Partnership takes a leadership role in the **C**reation and sharing of knowledge to develop, implement, and evaluate effective practices and policies for addressing Diversity and Equity issues in the cancer care system.

## BACKGROUND

### The Canadian Partnership Against Cancer

The Canadian Partnership Against Cancer is responsible for mandating the objectives of the Canadian Strategy for Cancer Control, which include: (1) to reduce the expected number of new cases of cancer among Canadians; (2) to enhance the quality of life of those living with cancer, and (3) to lessen the likelihood of Canadians dying from cancer.<sup>2</sup>

To implement its objectives, the Partnership created eight Action Groups. One of these groups, the Rebalance Focus Action Group (RF-AG) led by Dr. Margaret Fitch, has the vision to change the Canadian Health System so that it fully meets the physical, social, emotional, informational, psychological, spiritual and practical needs of patients across the cancer care continuum. The aim of this Action Group is for the care services to move from a disease-centred approach to a person-centred approach. Within the RF-AG an Outreach team was created to identify and implement culturally competent initiatives for underserved populations as a priority for ensuring that the care system is equally accessible to ALL Canadians.

### Rationale for the Forum

In accordance with the goals of the Partnership and with the endorsement of the Rebalance Focus Action Group, the Outreach team organized the “*National Forum on Cancer Care for all Canadians: improving access and minimizing disparities for vulnerable populations in Canada.*” The Forum was held in Vancouver, BC, on November 1-3, 2007 with the purpose of identifying the actions required for improving access to quality cancer care for underserved Canadians. It provided a venue to a) share which programs and resources are in place and working across the country, b) discuss and identify actions taken by Canadian policymakers to improve access to and use of cancer care services for All, and c) form national communities of practice for equitable cancer control initiatives.

The Forum was attended by policy makers and advisors, cancer survivors, social workers, community health representatives, directors, administrators, researchers, managers, nurses, educators and physicians, with representation from many different cultures and from most regions in Canada. The event proved successful in identifying key areas for action and nurturing the development of communities of practice committed to work on Diversity and Equity in Access to care.

Participants developed eight key principles to guide the Partnership in the planning and implementation of national strategies to improve access to care services.

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<sup>2</sup> Canadian Strategy for Cancer Control: A Cancer Plan for Canada, Discussion Paper (July 2006).  
([http://www.cancer.ca/vgn/images/portal/cit\\_86751114/10/2/1404842209cw\\_CSCC\\_Discussion\\_Paper\\_July\\_2006\\_v2.pdf](http://www.cancer.ca/vgn/images/portal/cit_86751114/10/2/1404842209cw_CSCC_Discussion_Paper_July_2006_v2.pdf)).

## HEALTH DISPARITIES IN CANADA

### Magnitude of the Problem

#### Aboriginal Health

- Cancer incidence is on the rise in Canadian Aboriginal populations, specifically from preventable cancers such as lung cancer, and survival following a diagnosis of cancer is poorer than in the general population.<sup>3</sup> The 1992 to 2002 age-standardized mortality rates (ASMR) for BC Status Indians from cancer are higher, at 18.6 deaths per 10,000, than other BC residents with 16.6 deaths per 10,000. Cervical screening rates are lower among Aboriginal women compared to the general population of BC. In BC the ASMR for cervical cancer (0.5) was two and a half times the rates for other residents (0.2).<sup>4</sup> In Ontario, while the rate of new cases of all types of cancer is generally lower in Aboriginal populations, incidence rates are similar or higher in First Nations people for lung, colorectal, kidney, and cervical cancers<sup>5</sup>.
- Between 1996 and 2006, the Aboriginal population grew by 45%, compared with 8% for the non-Aboriginal population. Presently, children under the age of 16 make up roughly 40% of the Aboriginal population in Canada<sup>6</sup>, signifying that capacity needs to be built now before this cohort ages. The age distribution of the population is beginning to resemble that of the rest of Canada, thus suggesting that cancer incidence too would be on the increase. Populations living on reserves have higher mortality and morbidity rates than the total Canadian population; their life expectancies are estimated to be ten years less than the national average. In 2006, Aboriginal people in Canada (First Nations, Métis and Inuit) surpassed the one-million mark, reaching 1,172,790.<sup>7</sup>

#### Rural and Remote

- The distribution of hospital services reflects the uneven supply of medical personnel. A major problem for people in rural regions is the distance they have to travel to reach medical facilities. As well as adding to the discomfort of the ill person, traveling requires time and money. Seniors in Canada are over-represented in rural regions. Medical specialists are clearly under-represented in rural areas with only 5% of the total number of Canadian specialists practicing there. About

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3 First Nations Cancer Research and Surveillance Priorities for Canada, Workshop Report (December 2004)

(<http://www.cancercare.on.ca/documents/ACSFIRSTNATIONSWorkshopReport.pdf>)

4 Regional Analysis of Health Statistics for Status Indians in British Columbia. 1992 – 2002. BC Vital Statistics Agency.

([http://www.vs.gov.bc.ca/stats/indian/indian2002/pdf/SIreport\\_92\\_02.pdf](http://www.vs.gov.bc.ca/stats/indian/indian2002/pdf/SIreport_92_02.pdf))

5 Cancer Care Ontario: Surveillance & Aboriginal Cancer Care Units, CCO, (2007).

6 Cancer Care for all Canadians: Improving Access and Minimizing Disparities for Vulnerable Populations, Evan Adams p 36.

(<http://www.bccancer.bc.ca/NR/rdonlyres/E6F649B9-761C-4C51-89E0-C2F0834B8DCC/28245/NationalForumProceedingsPart1versionFeb23.pdf>)

7 Statistics Canada (<http://www12.statcan.ca/english/census06/release/aboriginal.cfm>)

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two-thirds of people in remote communities live more than 100 km from a physician.<sup>8</sup> Radiation therapy for palliative purposes is less used in the rural areas of British Columbia. Roughly six million Canadians were living in small towns and rural areas in 2006.<sup>9</sup>

- While the average life expectancy of Canadians is 79 years, Canadians in some rural communities have life expectancies less than 75 years.<sup>10</sup>
- In Canada, most health information is disseminated by televised public service announcements or by printed materials, neither of which may be appropriate for remote communities or communities with high rates of illiteracy.

### Immigrant Population

- Although the general health of new immigrants is better on arrival than that of the average Canadian, it has been known to decrease with time to be similar to the host population. There is evidence of underutilization of screening services among immigrants. Distinct patterns of cancer incidence, mortality and survival appear to prevail among ethnic populations living in BC when compared to the general population.<sup>11</sup> The 2006 Census enumerated 6,186,950 individuals who were born outside of Canada. They represented one in five (19.8%) of the total population.<sup>12</sup>

### Language/Literacy Barriers

- Over 200 languages are spoken in Canada. More than 1.1 million immigrants arrived in Canada in the five years preceding the 2006 Census, and 81% of them had a mother tongue other than English or French. According to the 2006 Census one out of five Canadians has a mother tongue that is neither English nor French.<sup>13</sup>
- Nearly 60% of adult Canadians were found to be unable to obtain, understand, and act upon health information and services and to make timely and accurate decisions on their own.<sup>14</sup>

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8 CIHR Rural and Remote Health ([http://www.cih-irsc.gc.ca/e/documents/rural\\_remote\\_health\\_2005\\_e.pdf](http://www.cih-irsc.gc.ca/e/documents/rural_remote_health_2005_e.pdf))

9 Public Health Agency of Canada ([http://www.phac-aspc.gc.ca/publicat/rural06/pdf/rural\\_canadians\\_2006\\_report\\_e.pdf](http://www.phac-aspc.gc.ca/publicat/rural06/pdf/rural_canadians_2006_report_e.pdf))

10 Canada's Rural Health Strategy: A One-Year Review, Health Canada (2001). ([http://www.hc-sc.gc.ca/ahc-asc/alt\\_formats/cmcd-dcmc/pdf/media/releases-communiques/2001/2001\\_76ebk1.pdf](http://www.hc-sc.gc.ca/ahc-asc/alt_formats/cmcd-dcmc/pdf/media/releases-communiques/2001/2001_76ebk1.pdf))

11 Barroetavena et al. National Forum on Cancer Care for All Canadians, Nov2007

12 Statistics Canada, 2006 Census

(<http://www12.statcan.ca/english/census06/data/highlights/Immigration/Table403.cfm?Lang=E&T=403&GH=4&SC=1&S=99&O=A>)

13 Statistics Canada, 2006 Census

(<http://www12.statcan.ca/english/census06/data/highlights/language/Table401.cfm?Lang=E&T=401&GH=4&SC=1&S=99&O=A>)

14 [www.ccl-cca.ca/CCL/Reports/Other+Reports/HealthLiteracy.htm](http://www.ccl-cca.ca/CCL/Reports/Other+Reports/HealthLiteracy.htm)

## Comfort Level with the Health Care System

- A recent report from the Registered Nurses' Association of Ontario states: "Minorities, whether they be Canadians of colour, First Nation peoples, physically challenged, homosexual, etc. have made it clear that there are ways and times they have felt unwelcome in nursing, healthcare and workplace settings."<sup>15</sup>

## Socio-economic Status

- It is well known that individuals with the highest incomes have longer life expectancy than individuals with middle incomes, and the individual with middle incomes in turn have higher life expectancies than individuals with lower incomes. *Lower income populations* include single parents with at least one child under the age of 18, people with long term disabilities, Aboriginal peoples, recent immigrants and single people between the ages of 45 -59.<sup>16</sup> The Canadian Council Social Development reported that there were an estimated 4,886,000 persons living in poverty in 1999.<sup>17</sup>

## Costs to the Health Care System

- It has been reported that the most important consequences of health disparities are avoidable death, disease, disability distress and discomfort. Furthermore disparities are also extremely costly for the health system and the society as a whole.<sup>18</sup> On the basis of an estimation of health care resources used by Canadian households, approximately 20% of total health care spending may be attributable to income disparities. Despite this higher overall use of health services, health disparities persist among lower SES groups.

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15 Registered Nurses' Association of Ontario (2007). Embracing Cultural Diversity in Health Care: Developing Cultural Competence. Toronto, Canada: Registered Nurses' Association of Ontario

16 Improving the Health of Canadians. Canadian Institute for Health Information (Sept 2004). ([www.cihi.ca](http://www.cihi.ca)).

17 Canadian Council on Social Development ([http://www.ccsd.ca/factsheets/fs\\_pov9099.htm](http://www.ccsd.ca/factsheets/fs_pov9099.htm))

18 Reducing Health Disparities - Roles of the Health Sector: Discussion Paper (Dec 2004). Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security ([http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities\\_discussion\\_paper\\_e.pdf](http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf))

## THE PROMISE OF UNIVERSAL AND EQUAL ACCESS TO CARE

The Canada Health Act from 1984 states that “the primary objective of Canadian Health Policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” The five key principles of the Act include public administration, comprehensiveness, universality, portability and accessibility, and hold the promise of equal access to health care for all Canadians.

Similarly, other documents, including the Epp and the Romanow reports, have also identified health disparities and unequal access to care as action priorities pointing out that public policy needs to address the various determinants of health inequalities. These papers reaffirm the national responsibility for a continuing publicly funded system of care to ensure the health of All Canadians.

More recently, the First Ministers’ Accord on Health Care Renewal represents another commitment by the Government to ensure that:

- all Canadians have timely access to health services on the basis of need, not ability to pay, regardless of where they live or move in Canada;
- the health care services available to Canadians are of high quality, effective, patient-centred and safe; and
- our health care system is sustainable and affordable and will be here for Canadians and their children in the future.

Specifically in relation to unequal access to care services, the Accord highlights the importance of this public health issue by stating that “ *First Ministers direct Health Ministers to continue their work on healthy living strategies and other initiatives to reduce disparities in health status.*”

In summary, Canadians are aware of health disparities as evidenced by the various task forces, commissions and reports that have been produced with recommendations, and more importantly, calls for action to reduce health disparities. Despite all of this work, the reality is that the Canadian Health System does not serve all Canadians equally as there are significant disparities in health status among Canadians, especially for specific populations including those living in rural and remote locations, Aboriginal people, immigrants and the poor. Unless we take action now, the enormous cost to the health system and society will only increase.

## THE PRINCIPLES

### 1- Quality

**ALL cancer patients will have access to quality, safe, and person-centred care**

*“If navigating the cancer system is a challenge for educated, upper-class populations, and we all know this to be the case, imagine the hurdles faced by vulnerable populations.” Jeff Lozon*

The very nature of cancer is complex, and it is made even more difficult by the fact that the cancer experience can be very distressing. The cancer patient often experiences distress and disorientation when confronted with the cancer care services, including innumerable tests, appointments, consultations and treatments, with waiting times in between. Each of the different steps along the continuum of cancer care services requires a transition on the part of the patient to adjust to the new circumstances and to effectively cope with the physical and emotional changes throughout the cancer care continuum.

An ideal cancer system is one in which the system is optimized in order to provide supportive care services that respond to the patients’ physical, social, emotional, informational, psychological, spiritual, and practical needs.

The cancer system aims to serve all Canadians equally; however the cancer system looks very different for individuals from different cultures, and as a result, is not equally accessible to all individuals.

### 2- Comprehensiveness

**The Partnership will integrate diversity and equity issues across all action groups**

*“If we envision and build programs with vulnerable persons in mind, we will create the kinds of systems that will serve everyone.” Jeff Lozon*

The Partnership will take a leadership role in reducing cancer disparities by integrating diversity and equity issues as core values across all working groups underlying a comprehensive national cancer control strategy.

Many of the barriers to the health care system have been described and can include geographical barriers, linguistic barriers, cultural barriers or barriers which results from prejudice or from discrimination against various group or their exclusion in the research and planning process.<sup>19</sup>

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19 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

Barriers to access can be sorted into four categories: (1) availability of services, (2) financial barriers, (3) non-financial barriers to presentation of health care needs and (4) barriers to equitable treatment. These barriers have been identified and well described elsewhere, but can be summarized as follows:<sup>20</sup>

1. Availability of services: affect people in rural or remote areas where services may be unavailable.
2. Financial barriers: include, but are not limited to, issues of poverty.
3. Non-financial barriers to presentation of health care needs: includes language barriers, literacy and health literacy barriers, information barriers, cultural or education barriers and discouraging delivery practices.
4. Barriers to equitable treatment or treatment utilization: can include communication or cultural barriers, the way services are structured and the knowledge base on which assessment and treatment is based.

Many patients face barriers from membership in more than one underserved population.<sup>21</sup> We need to identify where the barriers are of similar nature, and where they have historically not been taken into account, in order to acknowledge the complexities as well as the areas where we can start to move forward. Addressing these barriers has the potential for gains for all Canadians, not just for patients who are vulnerable.<sup>22</sup>

### 3- Responsibility

#### Establish a quality cancer surveillance system

***“Canada must support and expand its efforts to create a knowledge base that informs relevant policies and practices. Research is required to document inequities, to elucidate the mechanisms that produce health inequities, to design and test interventions that reduce inequities and to evaluate programs already in effect”<sup>23</sup>.” Beiser & Stewart***

One of the key challenges to addressing inequities in access to the cancer care system is the lack of data available to document and analyze health disparities across subpopulations. Research generally has not been inclusive of specific ethnic minorities, instead focusing primarily on the Caucasian, English speaking population. As an example, currently in Canada, ethnicity or cultural data is not being routinely collected in the cancer registries, so as a result; only limited amount of information exists on cancer in Canadian Aboriginal populations and in immigrants to Canada. Having these data would enable the creation of an evidence-informed system for health services organization and delivery<sup>24</sup>. This would also allow

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20 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

21 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

22 Reducing Health Disparities - Roles of the Health Sector: Discussion Paper (Dec 2004). Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security ([http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities\\_discussion\\_paper\\_e.pdf](http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf))

23 Health Disparities in Canada, CIHR Volume 96, Supplement #2 March/April 2005 (<http://www.cihr-irsc.gc.ca/e/30371.html>).

24 A proposed diversity Framework for promoting cultural proficiency within the WRHA. (Sept 2007) Sarah Bowen.

identification of groups that have disproportionately poor cancer outcomes or low use of services, and would provide the basis for planning and implementing appropriate services to these groups.

Ground work is needed to establish the minimum dataset to create a national cancer surveillance system to effectively document, monitor and compare the extent and nature of cancer disparities as well as to evaluate programs effectiveness across regions.

Research barriers are not limited to the collection of ethnic data alone; some other challenges identified include creating data linkages to other administrative health data bases (e.g. census data and medical health records). Mechanisms for data sharing between organizations need to be developed to ensure that research provides the information needed by policy makers and health administrators to implement evidence based strategies.

Canada is lagging behind other countries in identifying the extent and nature of cancer disparities. Patterns and trends of cancer incidence, mortality and survival among culturally diverse populations allow us to better understand the interplay of environmental and genetic factors on cancer etiology. Integrating diversity, equity and access concepts within the care system organization means that standardized definitions, metrics, procedures and methodologies need to be developed, which can be adopted uniformly across the country.<sup>25</sup>

In addition, the ethical and social sensitivities surrounding the collection of personal identifiers must be addressed.

#### **4- Responsiveness**

### **Taking Action NOW based on evidence identifying underserved populations**

*“An effective health system requires a balance between individual responsibility for personal health and our collective responsibility for the health system. First Ministers direct Health Ministers to continue their work on healthy living strategies and other initiatives to reduce disparities”. 2003 First Ministers Health Accord*

During the last two decades several reports produced by National as well as Provincial governmental organizations have documented the existence of health disparities and recommended that the health system focus NOW on addressing the needs of underserved populations to avoid increasing health disparities.

It has long been established that disparities are not randomly distributed but rather differentially distributed mainly among the poorest, the Aboriginal populations, those with language barriers and those living in rural and remote areas. These subpopulations need attention now.

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25 Access to Quality Cancer Care – CIHR Workshop Report (June 14, 2007) (<http://www.cihr-irsc.gc.ca/e/28794.html>)

Because health disparities have a tremendous impact not only on the cost of the health system but in the social capital of a Nation, The Partnership will achieve the most effective and efficient pan-Canadian cancer control strategy by prioritizing actions directed at improving access to care for those at higher risk of poorest health outcomes.

## **5- Accessibility**

### **Ensure that accessible supportive care is available when and where is needed**

*“Effective person-centred interventions imply that supportive care services are tailored to the patient’s individual needs. Thus it is crucial that the care provider understands that a particular intervention that is effective for one individual may not be equally effective for another individual.”*  
**Marg Fitch**

Approaches for overcoming systemic barriers include: 1) patient-centred care, 2) supportive care and 3) cultural competent care. These three approaches need to be manifested in outreach initiatives.

The three approaches share the same core goals: 1) seeing the patient as a unique person with unique needs; 2) that health care services need to meet patients needs and preferences; 3) that educational materials should be tailored to patients needs, health literacy and preferred language; and 4) all have the potential to improve health care quality by removing barriers to access and meeting the needs of vulnerable populations.<sup>26</sup>

Supportive care interventions should be implemented closer to the patient. There is a need for innovative outreach interventions to provide supportive care to patients at the place where they are living and where the system meets the community. Effective outreach strategies to improve access and enhance patient safety include patient navigation, personal coach, community liaison, use of telehealth, or other web based applications, as well as a 24hr- telephone help line. The experience derived from the delivery of these programs constitutes a valuable resource to inform new initiatives that may need to be adapted to the local needs of the population of interest.

## **6- Safety**

### **A safe system to address cultural barriers**

*“To be competitive provincially, nationally and globally we have to address diversity; cultural competence enables this. To reduce health disparities and inequities we have to reach marginalized people; cultural competence supports this. It is also a practical path to social justice.”*  
**Sharon Davies Murdock**

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26 The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality. The Commonwealth Fund Report (October 2006). Beach, Saha, and Cooper ([http://www.commonwealthfund.org/usr\\_doc/Beach\\_rolerelationshipcultcompatient-cent\\_960.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Beach_rolerelationshipcultcompatient-cent_960.pdf?section=4039))

Cultural competence is a fundamental element of an equitable system of care and is essential as a core value of a pan-Canadian Cancer Control Strategy. Provision of medical interpreters, a component of cultural competency, is critical to ensure effective and safe patient-care provider exchange of information and to minimize risk and liability concerns such as uninformed consent, misdiagnosis and mistreatment due to miscommunication.

Evidence informed approaches to cultural competency have the potential to improve access for a number of underserved groups<sup>27</sup>. Cultural competence embodies diversity, the need for professional skills development and system changes, and requires an integrated and sustainable approach.

In addition, culturally competent services are associated with many positive benefits for patients including empowerment, decreased anxiety and fear, greater access and representation of culturally diverse population members, increased satisfaction of care, improved quality of care, improved health outcomes for minority and underserved populations, increased patient safety and risk management and workplace cohesion.

For organizations, cultural competency initiatives can include interpreter services, recruitment and retention policies, training, coordination with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, and administrative and organizational accommodations.<sup>28</sup>

Several organizations in Canada and abroad have published guidelines for cultural competence in care as well as cultural competence assessment tools. In addition USA, Australia and several European countries have identified comprehensive strategies to improve access to care and reduce health disparities. These materials can inform the Canadian cancer control planning.

## **7- Partnership**

### **Partnerships with public, private, and community organizations**

***“The necessary components of great partnerships are: incorporation and sharing of relevant strategic aspects; be balanced in membership; not duplicating efforts; respectful of each other’s expertise; focused and time limited.” Lori Messer.***

The Partnership needs to identify and develop relevant and key partnerships to help it move towards its goals and vision effectively. Networks with other national agencies or programs such as chronic disease; healthy living, or disease specific interventions (diabetes, etc) are critical to create coordinated actions, avoid duplication, create synergies and collaborate for improved outreach to underserved populations.

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27 Access to Health Services for Underserved Populations in Canada, Sarah Bowen p 11-60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

28 Standards of Organizational Cultural Competence for Community Health and Social Service Organizations (March 2005) U of Ottawa ([http://www.sciencesociales.uottawa.ca/crcs/pdf/standards\\_organizational\\_cultural\\_competence\\_19-12-2005.pdf](http://www.sciencesociales.uottawa.ca/crcs/pdf/standards_organizational_cultural_competence_19-12-2005.pdf))

Working in collaboration with other public sectors, such as Education, is fundamental to reach populations with the key messages that will have the greatest impact in the medium and long term. Immigration services need also to be engaged in facilitating broad reaching strategies for underserved communities.

Partnership with the Canadian Cancer Society and other community voluntary organizations will facilitate capacity building at the community level as well as promote sustainability of the initiative.

With regards to the planning and implementation of effective strategies, one of the key points moving forward is that the communities and cultural representatives need to be involved from the beginning in the process of planning. This is necessary to obtain buy-in for the programs and to ensure uptake of the strategy by the community members. Community driven strategies with participatory action approaches are recommended.

## **8- Innovation**

### **Innovation for further knowledge creation and sharing of information**

*“It is my hope that this (Forum) will not be an end in itself but a start in building a nationwide knowledge network of cancer care providers who put patients specifically vulnerable populations front and centre”. Jeff Lozon.*

The creation of a national repository of interventions and resources for cross-cultural cancer care is a priority action; e.g. *The Canadian Cross-cultural Cancer Council* will provide a centralized, reliable site for information/education material for patients and care providers. In addition, other areas for immediate action include: 1) development of national standards for culturally competent care that can be adopted or adapted to regional needs and resources; 2) development of guidelines re: operational procedures e.g. how to conduct a needs assessment among Aboriginal populations; Who are the key partners to involve in outreach strategies; 3) development of indicators to evaluate organizations’ involvement in patient-centred care, equity, culturally competent care.

Profiling of initiatives and models that are working across Canada and that can help others to start implementation of similar strategies is also needed and can be part of *The Canadian Cross-cultural Cancer Council* proposed here.

A database of networks and programs in this area will also add value to a national comprehensive strategy for cancer control.

Already in Canada, many programs and services have been and are being implemented to provide more comprehensive cancer care services including supportive care services, provision of interpreters in medical encounters and interventions to reach vulnerable/underserved populations. While some of these programs have included an evaluation component in their process, there are others lacking resources for implementing an evaluation. Support to evaluate programs that have already been started will be critical to advance evidence on best practices.

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Appropriate (qualitative, mixed-method and participatory) research must be conducted to identify and address gaps in knowledge, define evidence and areas of prioritization for resource allocations and actions. Research is needed which investigates the impact of a broad range of social determinants across a diverse patient population to identify and address inequities in health care and health status. A focused research agenda will be advanced to increase understanding and practice on patient-centred care with specific attention to diversity within and between patients and providers of health care.

Constant and appropriate (formative, summative, participatory) evaluation of programs and initiatives will be conducted to ensure that programs are accountable, effective and of greatest benefit to diverse and underserved populations. Programs need to incorporate evaluation criteria (methods) to measure effectiveness and to determine where improvements can be made. Using indicators related to an organization's diversity and equity climate is critical to measuring success and determining accountability for the implementation of a diversity and equity strategy. (See also<sup>29 30</sup>).

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29 Registered Nurses' Association of Ontario (2007). *Embracing Cultural Diversity in Health Care: Developing Cultural Competence*. Toronto, Canada: Registered Nurses' Association of Ontario

30 The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality. The Commonwealth Fund Report (October 2006). Beach, Saha, and Cooper ([http://www.commonwealthfund.org/usr\\_doc/Beach\\_rolerelationshipcultcompatient-cent\\_960.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Beach_rolerelationshipcultcompatient-cent_960.pdf?section=4039))

## RECOMMENDATIONS

As a result of the Forum, the following recommendations are brought forward to the Partnership to inform future actions to address access, diversity, and equity in the cancer care system for underserved populations. The recommendations can be grouped under 3 critical headings, each encompassing distinctive components as follows:

That the Partnership:

- 1) **Act now** by identifying and facilitating implementation of culturally competent outreach strategies throughout the spectrum of the cancer system to ensure equal access to care for recognized underserved populations.

How:

\*The Partnership will integrate issues of Diversity and equity across all Action Groups. In doing so the Canadian cancer care system will develop and implement sustainable culturally competent strategies and frameworks to improve cancer care for **All** Canadians. These strategies and frameworks will aim for the adoption of diversity and equity practices and standards throughout the system and within all levels of organizations from policy to practice. (See also<sup>31 32 33 34 35</sup>)

\*Ensure systems are in place so that health care organizations evaluate patient-centeredness, diversity and cultural competence as part of their efforts to deliver high-quality cancer care. (See also<sup>36</sup>) In addition ensure that the outcomes of these evaluations are utilized and shared with others to help inform better practices throughout the system.

\*Take a leadership role in identifying and sharing information about systems that enhance accessibility and meet the needs of reducing unequal access to health care services for Aboriginal people, those with cultural and linguistic barriers, those living in rural and remote locations and those who are the poorest. Where systems do not exist, take a leadership role in establishing capacity in order to meet the needs required.

\*Take a leadership role in the creation of a national cancer surveillance system to ensure that data is effectively generated for the underserved population. In addition include the capacity to

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31 Reducing Health Disparities - Roles of the Health Sector: Discussion Paper Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security December 2004 ([http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities\\_discussion\\_paper\\_e.pdf](http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf))

32 The Frontline Health Dialogues, Report from the Ottawa Roundtable by Nathalie Pierre, Helen Seibel [http://www.cprn.org/documents/49117\\_EN.pdf](http://www.cprn.org/documents/49117_EN.pdf) Release Date: 13 Dec 2007

33 Access to Health Services for underserved Populations in Canada, Sarah Bowen p 11 – 60.

34 The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality. The Commonwealth Fund Report (October 2006). Beach, Saha, and Cooper ([http://www.commonwealthfund.org/usr\\_doc/Beach\\_rolerelationshipcultcompatient-cent\\_960.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Beach_rolerelationshipcultcompatient-cent_960.pdf?section=4039))

35 Access to Quality Cancer Care – CIHR Workshop Report (June 14, 2007) (<http://www.cihr-irsc.gc.ca/e/28794.html>) 35 Registered Nurses' Association of Ontario (2007). Embracing Cultural Diversity in Health Care: Developing Cultural Competence. Toronto, Canada: Registered Nurses' Association of Ontario

36 The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality. The Commonwealth Fund Report (October 2006). Beach, Saha, and Cooper ([http://www.commonwealthfund.org/usr\\_doc/Beach\\_rolerelationshipcultcompatient-cent\\_960.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Beach_rolerelationshipcultcompatient-cent_960.pdf?section=4039))

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monitor and evaluate various programs to determine their effectiveness for replication in other regions and producing positive outcomes

- 2) **B**uild partnerships with other public, private, volunteer and community sectors for an effective and efficient national strategy to address equity and accessibility within the system and aid in minimizing disparities.

How:

- \* Aid in identifying and showcasing community driven interventions that utilize participatory action approaches that build knowledge and human capacity within the communities.
- \* Work in partnership with national programs such as the Healthy Living and/or the Chronic Disease Management in designing a pan-Canadian strategy for cancer control.
- \* Partner with the CCS for sharing resources in the areas of primary and secondary prevention information/education; peer-led supportive care for patients and caregivers, volunteer development, etc.
- \* Partner with key national Aboriginal organizations to aid in creating mutual solutions for identified problems in the system for the Aboriginal population. Potential partners might include: National Aboriginal Health Organization, Aboriginal Nurses Association of Canada and Indigenous Physicians Association of Canada, Métis National Council, National Association of Friendship Centres, Assembly of First Nations and Inuit Tapiriit Kanatami.

- 3) **C**reate knowledge and the mechanisms to share this knowledge across Canada to build the foundation for an equitable pan-Canadian cancer control strategy.

How

\*National standards for quality and safe cancer care will incorporate diversity and equity issues. Practice-based models of care will be developed at the national level to serve **All** Canadians, which are balanced with regional strategies that focus specifically on underserved populations. To streamline costs, attempts should be made to avoid unnecessary duplication, by strategically leveraging research and successful knowledge transfers.

\*Ongoing, systematic and agenda-planned forums for constructive dialogue, discussion, information/resource sharing, support, and capacity building will be promoted. Face to face meetings to bring together all levels of people are essential to implement an integrated diversity

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and equity strategy to the system, and for learning from each other about other systems and programs in use already. (See also <sup>37, 38</sup> )

\*Creating a national repository of interventions and resources for cross-cultural cancer care i.e. Canadian Cross-cultural Cancer Council. Developing national standards for culturally competent care that can be adopted or adapted to regional needs and resources. Developing standards regarding operational procedures (e.g. How to conduct a Needs Assessment among Aboriginal populations, who are the key partners to involve in outreach strategies). Development of indicators to evaluate patient-centred care, equity, culturally competent care.

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37 Reducing Health Disparities - Roles of the Health Sector: Discussion Paper Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security December 2004 ([http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities\\_discussion\\_paper\\_e.pdf](http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf))

38 The Frontline Health Dialogues, Report from the Ottawa Roundtable by Nathalie Pierre, Helen Seibel  
[http://www.cprn.org/documents/49117\\_EN.pdf](http://www.cprn.org/documents/49117_EN.pdf) Release Date: 13 Dec 2007

## APPENDIX 1 – OPERATIONAL DEFINITIONS

**Aboriginal Peoples:** Indigenous peoples including First Nation’s peoples on and off reserve, Métis and Inuit

**Access** is defined as “availability of services” or the “provision of services in a way that is both responsive to the needs of users and open to the participation in planning of services by underserved groups”<sup>39</sup>. The phrase **reasonable access** is used to mean equal access for equal need, and the absence of explicit financial barriers<sup>40</sup>.

**Cancer System:** The cancer system is a system designed to deliver care. It is made up of various oncology specialists, other care providers (paramedical and non medical), and agencies concerned with care of the patient throughout the cancer spectrum, from pre-diagnosis through to diagnosis and treatment, to post-cancer care, survivorship, palliative care and bereavement. The cancer system is described as an “objective identity” in that it offers the same services to all Canadians; however, each Canadian *may* approach the cancer system from a different, individual perspective which could influence their care.

**Community:** a group of people. The term ‘community’ is a notoriously elastic term, meaning many different things to different people in different contexts. Communities can be identified as such by its members, or be ascribed by outsiders. They can be associations that are voluntary or coerced, short or long-term, formal or informal. Communities can be based on geography, identity, activity, specific goals, status, or social, economic, or political ideology or affiliation. Although the idea of community typically conjures up positive images, group affiliations are also typically characterized by varying degrees of internal heterogeneity. This heterogeneity in structure, purpose and identity suggests that the notion of community should be used carefully to avoid making important differences (and potentially, inequalities) invisible<sup>41</sup>.

**Culture:** a variably shared way of life that includes knowledge, attitudes, beliefs, customs and values of a group of people. A cultural group shares an identity that shapes worldview expectations and perceptions and also guides behaviors<sup>42</sup>. The diversity of identifying characteristics includes one's race, culture, language, faith/religion, gender, sexual identity, family status, ability, socio-economic status, immigrant status, age, and other relevant life experiences such as homelessness, mental health issues and addictions<sup>43, 44</sup>.

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39 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

40 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

41 Definition contributed by Ann Vanderbijl

42 <http://www.moffitt.org/moffittapps/ccj/v14n1/pdf/70.pdf> Impacting Health Disparities Through Community Outreach: Utilizing the CLEAN Look (Culture, Literacy, Education, Assessment, and Networking) (date)

43 GTA Diversity & LHINs Working Group

44 Definition contributed by Gurwinder Gill

**Cultural competency:** a set of behaviors, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations<sup>45</sup>. The phrase ‘cultural competency’ refers to the abilities of caregivers and organizations to respond respectfully and effectively to the unique needs of all patients and families. The term is often used interchangeably (but there are inherently different concepts and these should be recognized) with that of cultural safety, cultural awareness, cultural sensitivity, and others. Despite the lack of a consistent definition within the healthcare literature, all these terms generally point to the need for new approaches, skills and knowledge for providers and institutions, in order to eliminate individual and population disparities in the access to, and delivery of healthcare<sup>46</sup>.

**Diversity:** a broad term referring to any number of distinct qualities, traits or characteristics – including, but not limited to skin colour, gender, age, race and ethnic identification, citizenship, sexual orientation, and physical and cognitive abilities<sup>47</sup>.

**Equity** in health: it refers to the fair and just distribution of resources based on need, and implies that persons in poorer health or at greater risk to poor health outcomes should receive more appropriate services<sup>48</sup>. This is in contrast to equality, in which every person receives the same service, or the same number of services, but may not lead to equal health outcomes.

**Equitable access** is defined as “*provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health*”<sup>49</sup>.

**Language access:** in health care, language access includes interpreting (oral or sign language rendering) and translation (written language rendering). Health care interpreting involves converting and conveying of a message between the patient and provider while being faithful to the intent and meaning. To ensure accuracy, the health care interpreter may clarify the meaning of a message from the sender or clarify that the message has been understood by the receiver within the parameters set through a formal code of standards. Translation involves rendering written communication from one language (source) to a second language (target) while maintaining the same meaning as the written communication is the first language. A quality translated document is faithful to the source text, reads easily and in a manner so natural to the reader that it gives the impression of an original text.

The impact of not providing appropriate language access has been felt by participants across the continuum of cancer care. The health sector has long acknowledged communication as an indispensable component of health care and that linguistically appropriate services are essential in the face of the current demographic reality. Numerous studies quantify the adverse effects of, not only, patients being unaware of services available to them, but also not being able to understand the services they receive.

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45 Cross et al, 1989; Isaacs & Benjamin, 1991

46 Definition contributed by Ann Vanderbijl

47 Registered Nurses' Association of Ontario (2007). Embracing Cultural Diversity in Health Care: Developing Cultural Competence. Toronto, Canada: Registered Nurses' Association of Ontario

48 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

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These adverse outcomes impact all involved: non-English speaking patients, their families and the institutional systems that inadequately respond to a changing patient demographic.

Essentially access to appropriate language resources is a necessary function to ensuring health care providers are equipped to implement the required care<sup>50</sup>. Language Access is a key component of Cultural Competency.

**Patient-centred care:** a way of characterizing how physicians should interact and communicate with patients on a more personal level, with the goal to provide individualized care and restore and emphasis on personal relationships in order to elevate quality for all patients<sup>51</sup>. Patient-centred care includes dimensions of coordination and integration, the provision of information and education to patients, attention to physical comfort, emotional support and involvement of family and friends

**Patient Navigation:** a process that provides support and information to cancer patients, their families, survivors and health professionals through the cancer continuum. Literature demonstrates that patients experiencing barriers associated with language, cultural beliefs, literacy, and ethnicity experience difficulties accessing cancer screening and the cancer system. An innovation such as Patient Navigation is a strategy to improve access and minimize disparities among diverse populations. Patient Navigator / Navigation programs have been used since the early 1990's to target diverse populations as they navigate the maze of the cancer system<sup>52</sup>.

**Supportive Care:** includes the necessary services as defined by those living with or affected by cancer, to meet their physical, social, emotional, nutritional, informational, psychological, spiritual and practical needs throughout the spectrum of the cancer experience<sup>53</sup>. It can include self-help and peer support, the provision of information and education, psychological support and therapy, pain and symptom control, social support, rehabilitation, complementary therapies, spiritual support, palliative care end of life and bereavement care<sup>54</sup>. Supportive care helps the patient maximize the benefits of treatment and to live as well as possible with the effects of the disease and in some cases the treatment.

**Underservice** is defined as *“an increased likelihood that individuals who belong to a certain population (and people can belong to more than one) may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by health care providers, receive treatment that does not adequately meet their needs, or that they will be less satisfied with health care*

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49 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

50 Definition contributed by Kiran Malli

51 The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality. The Commonwealth Fund Report (October 2006). Beach, Saha, and Cooper ([http://www.commonwealthfund.org/usr\\_doc/Beach\\_rolerelationshipcultcompatient-cent\\_960.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Beach_rolerelationshipcultcompatient-cent_960.pdf?section=4039))

52 Definition contributed by Donna Smith

53 Canadian Strategy for Cancer Control: Supportive Care/Cancer Rehabilitation Workgroup, Final Report. January 2002, p. 7.

<http://209.217.127.72/csc/pdf/finalsupportiveJan2002.PDF>

54 Contributed by Richard Doll.

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*services than the general population*<sup>55</sup>. Underservice relates to the barriers to access including problems with service availability, series access or quality of treatment

**Underserved or Vulnerable populations** are those who are at risk of poor health outcomes as a consequence of systemic barriers for equity in access to care services. Our definition is centered on the failure of a system to meet the needs of various populations, and does not refer to characteristics or weaknesses of the populations. There are many different examples of persons who are at risk of poorer health outcomes, and the different factors (poverty, rural/remote location, immigrant, language and cultural barriers, transportation barriers) may intersect and further influence the quality of care. Underserved/vulnerable populations may include, but are not limited to: First Nations, immigrants, refugees, injection drug users, street youth, homeless people, ethnically diverse populations, those with disabilities, people who do not speak or read either of Canada’s official languages, sex trade workers, people with alternate sexual orientations, as well as people with socioeconomic challenges and those with mental illness. Vulnerable/ underserved also includes those who are in rural and remote locations, sometimes called “underserved” populations: *“geographic regions that experience difficulty in recruiting and retaining sufficient numbers of health personnel to meet the needs of the population or are undersupplied”*<sup>56</sup>. The emphasis on our initiatives is to address underserved cultures and not just ethnic populations.

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55 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))

56 Access to Health Services for underserved Populations in Canada, Certain Circumstances, Sarah Bowen p 11 – 60. ([http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces_e.pdf))