



WELLESLEY INSTITUTE  
a decade of advancing urban health



# Operationalizing Health Equity

## How Ontario's Health Services Can Contribute To Reducing Health Disparities

Michael Rachlis

March 2008

# Commissioned Grants

Commissioned research at the Wellesley Institute targets important new and emerging health issues within the Institute's priority research areas. The projects commissioned may speak to current policy issues, or they may seek to inform and help shape deliberation on policy issues just over the horizon. Wellesley's commissioned research reflects community voices, interests, and understandings, and includes the community fully in the research wherever possible.

## Wellesley Institute Community Roundtables on Health Equity

Health equity is high on the agenda of the Province and LHINs. Wellesley initiated a series of forums with community-based health and social service providers, researchers, advocates and others to flesh out what a community-based framework for addressing health disparities would look like. We also commissioned research and backgrounders to facilitate these discussions and move a community-based health equity agenda forward.

## About the Author

Dr. Michael Rachlis practices as a private consultant in health policy analysis. He has consulted to the federal government, all ten provincial governments, and two royal commissions. He also holds associate professor appointments (part-time) with the University of Toronto Department of Public Health Sciences, and the Department of Health Policy, Management, and Evaluation.

[www.michaelrachlis.com](http://www.michaelrachlis.com)

## Executive Summary

Canada's Medicare system was based on Tommy Douglas' and many others' desire for equity in health care. Medicare did make a tremendous difference in improving access to physicians and hospital services regardless of ability to pay. However, we still have disparities in health and health care. For example, poorer Canadian men are twice as likely to die within the first five years of their retirement as are richer men. Higher income Ontario heart attack patients are more likely to receive specialized investigations, rehabilitation, and specialist follow up.

Disparities in health occur only partly because certain groups face access barriers to the health care system. Disparities in health are mostly due to factors beyond the health system. Members of disadvantaged groups are more likely to suffer illness or injury because of their social and economic circumstances.

This means that the many of the most important forces producing health disparities are far beyond the health care system, and that much of the solution to health disparities lies in macro social and economic policy and in policy collaboration and coordination across governments.

Nonetheless, it is in poor health – and ending up sicker in the health system needing care -- that the effects of this wider inequality are felt. And a great deal can be done within the health system to address the harsh impact of overall disparities and enhance the well being of even the most disadvantaged.

This paper suggests the adoption of the Ontario Health Quality Council's equity framework for operationalizing its policy work on health equity:

1. Improve the accessibility of the health system through outreach, location, physical design, opening hours, and other policies.
2. Improve the patient-centredness of the system by providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.
3. Cooperate with other sectors to improve population health.

This paper outlines current innovations and opportunities for operationalizing each of these aspects of health equity.

## Introduction

Canada's Medicare system was based on Tommy Douglas' and many others' desire for equity in health care. Medicare did make a tremendous difference in improving access to physicians and hospital services regardless of ability to pay. Canadian health status and the health care access for vulnerable groups have both improved relative to the US since we implemented Medicare<sup>1</sup>. However, we still have disparities in health and access to health care. This paper briefly outlines how the Ontario health sector could operationalize a health equity agenda.

## Disparities in Health

Consistent with observations in other countries with publicly funded health care systems, there are persistent disparities in health status. Poorer Canadian men are twice as likely to die within the first five years of their retirement as are richer men<sup>2</sup>. Poorer women are 25% more likely to die of heart attacks every year and poorer men are 35% more likely to die of heart attacks each year<sup>3</sup>. Aboriginal health is improving in Canada<sup>4</sup>. Aboriginal men and women still have life expectancies six and one-half years less than non-aboriginal Canadians. Northern Ontario residents have more illnesses and live shorter lives than residents of other parts of the province<sup>5</sup>.

## Disparities in Health Care

Disparities in mortality from diseases amenable to treatment by health services have decreased substantially since Medicare was implemented in 1971<sup>6</sup>. However, despite over thirty years of universal coverage for physicians and hospital services in Ontario there remain inequalities of access to these services. For example, in Ontario heart attack victims who are wealthier and better educated are more likely to receive specialized investigations, rehabilitation, and specialist follow up<sup>7</sup>. On average higher income Ontarians have more hip and knee replacements, cancer surgery, MRI scans<sup>8</sup>, shorter delays to hospital when they have chest pain<sup>9</sup>, more preventive care such as screening tests for colorectal cancer<sup>10</sup>, and better access to stroke rehabilitation<sup>11</sup>.

There are similar health care disparities which have been identified for education<sup>12</sup>, lack of English proficiency,<sup>13,14</sup> race,<sup>15,16</sup> gender,<sup>17,18</sup> geography,<sup>19,20</sup>. There is also evidence that gay, lesbian, and transgendered Canadians face barriers to accessing health care services.<sup>21,22</sup>

These access factors tend to add together. For example, wealthier, better educated, urban, non-aboriginal, non-disabled, southern Ontario women are much more likely to get a Pap smear test for cervical cancer than their counterparts<sup>23</sup>.

While Canada's system delivers more equitable care than the mainly privately funded US system, we are at about the middle range for countries with publicly funded systems<sup>24</sup>. Lower income Canadians were found to have more family physician services than upper income Canadians, in accordance with their need for care. However, like most other countries with universal systems, lower income Canadians used less specialty care than their needs for care would predict.

And, there are even greater disparities in access to those services for which there is not universal coverage. For example, dental care is only guaranteed to be publicly funded if care is required in hospital -- a rare event in 2006. Many jurisdictions offer limited dental care for children or other special populations. As a result there are large disparities in access to oral health<sup>25</sup>. Ontario children born outside of Canada have twice as many diseased teeth as those who were Canadian born. And Ontario aboriginal children have up to five times as many diseased teeth as other Ontario children who were Canadian born.

## Access barriers: multiple causes

Of course, disparities in health occur only partly because certain groups face access barriers to the health care system. Disparities are also related to certain groups being less resistant to illness because of their social and economic circumstances.<sup>26, 27, 28</sup> It is very difficult to identify the specific roles played by the health care system and the non-medical determinants of health in causing disparities in health because health care interacts with the determinants of health in complex, unpredictable ways<sup>29</sup>.

The Federal Provincial Territorial Health Disparities Task Group noted<sup>30</sup> that "The health sector has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities." However, what is the specific role for the health care system in remedying health disparities? Unfortunately, Canadian and international reports on health disparities give little guidance to those responsible for funding and managing health services as to what they should do to remedy these disparities.

# How could Ontario's Health Services more effectively reduce health disparities?

The Ontario Health Quality Council identified equity as one of its nine attributes of a high performing health care system in its first report in 2006:

*There should be continuing efforts to reduce disparities in the health of those groups who may be disadvantaged by social or economic status, age, gender, ethnicity, geography, or language.*

This definition, while providing a good starting-point for shaping health care policy and delivery, can be broadened further to include health disparities related to racism and discrimination, culture, citizenship status, sexual orientation, and ability. In their second report in 2007, the OHQC identified a three pronged approach to developing a more equitable system based on maximizing three of the other attributes:

1. Improving the **accessibility** of the health system through outreach, location, physical design, opening hours, and other policies.
2. Improving the **patient-centredness** of the system by providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.
3. Cooperating with other sectors to improve **population health**.

This section identifies examples of front line innovations which address health disparities.

## Improving Accessibility

The OHQC defined accessibility as:

*People should be able to get the right care at the right time in the right time by the right health care provider.*

The OHQC suggested that improving accessibility could enhance equity through outreach, location, physical design, opening hours, and other policies. There are many examples of front-line innovation doing just that.

## CAISI strikes out inappropriate care for the homeless

An example of a practice which has facilitated improvements in access to health care for a disadvantaged population is the Toronto Client Access to Integrated Services and Information (CAISI) Project. The project's goal is to "reduce the plight of chronic homelessness by enhancing the integration of care between agencies at the individual and population levels using an electronic information system"

The clients give permission to a variety of agencies including shelters, drop in centres, outreach teams, hospitals, public health and Toronto ambulance, to link their electronic records. The record is an enhancement of the OSCAR McMaster system, which is an open source Ministry of Health-approved electronic medical record. The system is accessed through the internet so it allows multiple providers to communicate with each other about a very ill group of clients.

The CAISI project recently won the Canadian Information Productivity Silver Award for Not for Profit Efficiency and Operational Improvements<sup>31</sup>.

Another example of innovation is the implementation of Advanced Access by some Community Health Centres and private practices. With Advanced Access, many primary health care practices find they can eliminate weeks long waits for care for routine appointments.

## Advanced Access opens doors to ambulatory care

In 2003, at the Rexdale Community Health Centre, which serves 6,000 patients in a disadvantaged community in northwest Toronto, patients faced a four- to six-week wait for appointments. The centre temporarily increased resources to clear its backlog and then went to same-day service. To achieve advanced access, services had to be redesigned as well. The Rexdale CHC enhanced the roles of two nurses, who previously spent a lot of their time telephone-triaging patients who were sent elsewhere for care. Now they spend much of their time dealing with patients with minor illnesses. The Lawrence Heights Community Health Centre in Toronto, the Saskatoon Community Clinic, and Cambridge's Grandview Medical Centre has also implemented advanced access.

Practices which implement Advanced Access can also enrol new patients. Eventually, these facilities achieved new equilibrium, but the new enrolments were significant. Dr. Jeff Harries, a Penticton, B.C., family physician, said he was able to erase his wait lists and add 500 patients.

There are millions of Canadians who cannot find a family doctor to take them on as a patient. Increasingly family doctors screen new patients and are reluctant to add new patients if they have complicated medical problems. These people are disproportionately challenged by other disparities as well. It is a terrible irony that many family doctors are screening out exactly the patients Medicare was designed to assist, poor people with chronic diseases. Dr. Harries comments that, "If every family doctor in the country went to advanced access, there would be no Canadian who didn't have a family physician."

## Improving patient-centred care

The OHQC defined patient-centred care as:

*Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.*

The OHQC suggested that improving patient-centred care could enhance equity through providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.

## Access Alliance CHC Peers reach out to their communities

Toronto's Access Alliance Community Health Centre Peer Outreach Worker Program greatly enhances health care access for new Canadian women and their children.<sup>32</sup> The CHC uses neighbourhood ethno cultural networks and local and ethnic media to recruit and hire peer outreach workers. Many of these outreach workers have university educations and some have been trained as health professionals. They are paid for three months of training and then are offered three year contracts.

The outreach workers and staff from the CHC deliver 20 education programs including six on parenting. The outreach workers also facilitate well child and women clinics conducted by the CHC's nurse practitioner and dietitians in community settings. The outreach workers recruit program participants through local agencies but also directly from community venues such as libraries, Laundromats, places of worship, and shopping malls. As well as their group work, the outreach workers provide information and referral to culturally appropriate services, interpretation, and accompaniment to appointments with health and social service workers.

Access Alliance has trained one hundred peer outreach workers, provided health care to over 10,000 women and their children. Eighty percent of the Peer Outreach Workers go on to employment elsewhere in health or social services after their initial contract with Access Alliance<sup>33</sup>. As a result, the program has also helped to build capacity in these new communities.

## London sweetens care for diabetes

The London InterCommunity Health Centre developed a diabetes program to deal with the special needs of the city's large Latin American population, which has a high rate of diabetes<sup>34</sup>. The program includes screening of high risk populations, primary prevention, and follow up to reduce complications.

The health centre runs self-management diabetes follow up clinics with the Latin American population. The patients meet with a diabetes nurse briefly to identify the issues which require attention. According to the founding program coordinator, nurse practitioner Betty Harvey, some of the time they need to see a professional such as the dietitian. However, she says that 75% of the time, the most pressing issues affecting their diabetes are social rather than strictly medical. And after initial assessments, if the patient needs to see someone else, it's usually one of the community health workers or a social worker, all of whom are Latin American. They help their clients deal with a myriad of problems from illiteracy to landlord tenant problems. As of June 2006, the Centre's Latino diabetes self-management clinic showed an approximately 2% absolute decline in HgbA1C levels after program intervention, from 8.9% to 6.95%<sup>35</sup>. Each 1% drop in HgbA1C co-relates with a roughly 10-20% decline in cardiovascular risk<sup>36</sup>.

## Improving the effectiveness of the health system's work with other sectors to achieve population health goals

Intersectoral action for health has been described by the World Health Organization as<sup>37</sup>:

*A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.*

People have suggested intersectoral approaches to health for many years. There is a growing recognition in the health sector that most complicated social problems require an intersectoral approach, one that works towards "healthy public policy". For example, child development, labour market adjustment, and air pollution all need the cooperation of three levels of government, multiple and diverse ministries and departments, and thousands of non-governmental organizations across many different sectors. Also, sometimes the health sector should take an active leadership role while sometimes it should support other sectors. Unfortunately, intersectoral action has proven much harder to fulfill in practice than to describe in theory.<sup>38</sup>

The key barriers to effective intersectoral action addressing health disparities are:

- The impact of investing in cross-sectoral action and social determinants of health would only be felt in the long run, but governments are under considerable pressure to reduce costs and show results immediately
- The key people interested in so-called ‘healthy public policy’ come from the health sector. But the decisions about the social determinants of health are made in other sectors: e.g. housing, employment or by central agencies of government, e.g. cabinet office, department of finance. The way government is organized, and the “culture” within government, also affects what policy decisions are made and how – the ‘silo’ structure of modern government can be a significant barrier to cross-sectoral collaboration
- Sometimes there are competing interests, e.g. the tobacco industry. Sometimes there are competing or conflicting public policies, such as reducing taxes or supporting economic growth that has adverse environmental health implications. Sometimes, people and organizations argue for small government and reduced public spending over possible health gains.
- Information on the scientific relationship between a social determinant and health status is a weak factor for making policy. Partly this is because, almost all people, even well-educated ones, are not trained to interpret scientific evidence and those holding competing values or interests may raise obfuscating questions which cause decision-makers to query the confidence of any information. Generally, government has a weak capacity for leading and analyzing research. Sometimes data are not presented in a strategic way that tells a story and suggests workable policy and program solutions that reflect the realities of how public policy is made (including the imperatives and constraints that decision-makers deal with).

It is easier to gain the cooperation of different sectors for effective action at the local or community level than at the national or even provincial level. However, action at higher levels (e.g. federal, provincial) tends to have more impact on population health. Intersectoral action at higher levels often generates more political conflict, especially around different values and competing interests. This is the central problem of intersectoral action. The most effective intersectoral actions are those at higher policy levels and yet it is at these levels where they are most difficult to implement.

However, effective action at higher levels usually requires action at the community level first. The most effective intersectoral action dexterously combines activity at all levels and creates positive feedback loops to sustain itself.

There needs to be a two-pronged approach to promoting more effective intersectoral action for health. First, the health sector needs to engage communities to develop local projects. Second,

governments, especially senior levels of government, need to be more effective at supporting effective local and regional activities.

## Regent Park blazes a pathway to education

An example of effective local health system engagement to promote intersectoral action is Regent Park's award winning Pathways to Education. The residents of Canada's oldest public housing project face many significant challenges to health and accessing health care services. Incomes are less than half the Canadian average. Over 80% of residents are immigrants and English is a second language for nearly 60% of Regent Park adults. Health care access is reduced, for example for pap smears, mammograms, and infant immunizations.<sup>39</sup>

The Regent Park Community Health Centre identified education as the major determinant of the future health of neighbourhood children. In 2001, the health centre launched Pathways to Education with a number of partners. Pathways provides support for Regent Park children entering high school, including transit passes, tutoring, and mentoring. In 2005, the first pathways students graduated from high school.

From September 2001 to present, compared to Regent Park youth before Pathways, the program has<sup>40</sup>:

- Reduced the dropout rate from 56% to 10%
- Enrolled 95% of the eligible high school age youth in the Regent Park community in the Pathways program
- Reduced absenteeism by 50%, and youth with serious attendance problems by 60%
- Increased the college/university enrolment of graduates from 20% to 80% (and over 90% of those were the first in their families to attend post-secondary institutions).

The long-term economic benefit to society for every \$1 invested in Pathways is \$12.

## Provincial initiatives to support local action

Regent Park has successfully implemented Pathways to Education. But, there will be tough barriers to implementing P2E in all the communities in Ontario which need such a program without significant provincial resources. The health sector must push intersectoral action provincial and national levels to be effective. The key factors here are:

1. Cabinet level social policy coordination,
2. Based upon a strong value placed on equity, and
3. Common boundaries for governance and service delivery.

## Saskatchewan

Saskatchewan established the Human Services Integration Forum in 1994. It includes associate and assistant deputy ministers from eleven ministries and secretariats. The development of the forum was spurred by a 1993 investigation of twenty-seven child deaths, which concluded that broad social policy initiatives were required in order to address the issues. The forum focuses on promoting better service integration. It links its work with the ten Regional Intersectoral Committees (RICs).

The Saskatoon Health Region has identified significant disparities in health and health care access within its catchment area<sup>41</sup>. For example, there are sixteen times as many suicide attempts in the poorest neighbourhoods than in the wealthiest, but only twice as many physician visits for mental health problems.

The Saskatoon Regional Intersectoral Committee is co-chaired by the Health Region's vice-president for primary health care and the city's director of parks and recreation. The committee includes representatives from various provincial and federal government departments, municipalities, regional health authorities, housing authorities, educational institutions, tribal councils, police, and Métis organizations.

The forum supports a number of initiatives, including Saskatchewan's Action Plan for Children. The Action Plan has established the Children's Advocate Office, coordinated interdepartmental budget planning, supported the development of an early childhood initiative, and funded more than three hundred interdepartmental prevention and support grants to local groups. The forum also provides overall policy co-ordination to several provincial initiatives, including Integrated School-Linked Services, the Aboriginal Policy Framework, the Culture and Recreation Strategy, the Saskatchewan Training Strategy, the Restorative Justice and Aboriginal Justice Strategies, Saskatchewan Assisted Living Services, and Health's Strategy for Intersectoral Collaboration. The most recent focus is Schools Plus, a plan to use the schools as a place to integrate services for children and families.

Saskatchewan has also re-drawn the boundaries for various government activities (health, social services, education, and municipal government) to make them co-terminus.

## Quebec

Quebec has coordinated its social policy around a series of health goals since 1987. Quebec's passed two public health acts in 1998<sup>42</sup>. The Public Health Act prescribes the mandates and responsibilities of the minister, the ministry and the other components of the public health system, including the National Institute of Public Health, the regional health and social services authorities, and local community health centres.

The National Institute of Public Health Act established the Institute and details its specific mandates and responsibilities as the lead agency for public health. The Governor in Council

appoints the board of directors and the director general/president. The minister can issue directives to the Institute with which it must comply.

The legislation outlines a broad program of public health well beyond simply controlling communicable disease. The public health system is charged with "exerting a positive influence on major health determinants, in particular through trans-sectoral coordination."

The National Institute of Public Health is responsible for developing a provincial health plan based upon the province's health goals<sup>43</sup>. The Quebec regional health authorities are responsible for developing their own health plans which are consistent with the provincial plan. The CLSCs (Centres Locaux Services Communautaire), provide both public health and primary health care services. Under Quebec's public health legislation, the CLSCs are responsible for coordinating their local community's input into developing local public health plans, congruent with the provincial and regional plans.

## Conclusion

The implementation of Medicare greatly improved access to health care, particularly for poorer Canadians. But there still are persistent disparities in health status and access to health care. Disparities in health occur partly because certain groups face social and economic access barriers to the health care system and partly because these same access barriers independently increase the risk for most illnesses and disabilities.

Canadian policy makers have known about these disparities for decades. Governments need to develop broad intersectoral plans to remedy social disparities. But we also need to develop an operational plan for the health system's interventions to reduce inequities. This paper recommends that the provincial Ministry of Health and Long Term Care adopt the Ontario Health Quality Council's equity framework to operationalize its policy work on health equity:

1. Improve the accessibility of the health system through outreach, location, physical design, opening hours, and other policies.
2. Improve the patient-centredness of the system by providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.
3. Cooperate with other sectors to improve population health.

## References

---

- <sup>1</sup> Lasser KE, Himmelstein DU, Woolhandler S. Access to care, health status, and health disparities in the United States and Canada: Results of a cross-national population-based survey. *American Journal of Public Health*. 2006;96:1300-1307.
- <sup>2</sup> Wolfson M, Rowe G, Gentleman JF, Tomiak M. Career earnings and death, a longitudinal analysis of older Canadian men. *J Gerontol* 1993; 48(suppl):167-179.
- <sup>3</sup> Statistics Canada, Catalogue 82-003. Supplement to Health Reports, volume 13, 2002, p. 57.
- <sup>4</sup> Statistics Canada. Canada's Performance Report 2005 - Annex 3 - Indicators and Additional Information. Found at: [http://www.tbs-sct.gc.ca/report/govrev/05/ann304\\_e.asp](http://www.tbs-sct.gc.ca/report/govrev/05/ann304_e.asp). Accessed: March 13, 2008.
- <sup>5</sup> Ward A. An Overview of Health Status in Northern Ontario. North Health Information Partnership. Found at: <http://www.healthinformation.on.ca/Reports/Northern%20HIU/2004/Northern%20Health%20Status.pdf> Accessed 060302
- <sup>6</sup> James PD, Wilkins R, Detsky AS, et al. Avoidable mortality by neighbourhood income in Canada : 25 years after the establishment of universal health insurance. *Journal of Epidemiology and Community Health*. 2007;61:287-296.
- <sup>7</sup> Alter DA, Iron K, Austin PC, et al. Socioeconomic status, service patterns, and perceptions of care among survivors of acute myocardial infarction in Canada. *Journal of the American Medical Association*. 2004;291:1100-1107.
- <sup>8</sup> Tu JV, Pinfold SP, McColgan P, Laupacis A. Access to Health Services in Ontario. Institute of Clinical Evaluative Science. April 2005. Found at: [http://www.ices.on.ca/webpage.cfm?site\\_id=1&org\\_id=67&morg\\_id=0&gsec\\_id=0&item\\_id=2862&type=atlas](http://www.ices.on.ca/webpage.cfm?site_id=1&org_id=67&morg_id=0&gsec_id=0&item_id=2862&type=atlas). Accessed March 2, 2006.
- <sup>9</sup> Govindarajan A, Schull M. Effect of socioeconomic status on pre-hospital transport delays of patients with chest pain. *Annals of Emergency Medicine*. 2003; 41 (4): 481-490.
- <sup>10</sup> Singh S, Paszat L, Li C, et al. Association of socioeconomic status and receipt of colorectal investigations: a population-based retrospective cohort study. *Canadian Medical Association Journal*. 2004; 171 (5): 461-465.
- <sup>11</sup> Kapral M, Wang H, Mamdani M, et al. Effect of socioeconomic status on treatment and mortality after stroke. *Stroke*. 2002; 33: 268-273.
- <sup>12</sup> Rhodes A, Jaakkimainen L, Bondy S, Fung K. Depression and mental health visits to physicians: a prospective, records-based study. *Social Science and Medicine*. 2006; 62 (4): 828-834.

- 
- <sup>13</sup> Croxford R, Friedberg J, Coyte P. Socioeconomic status and surgery in children: myringotomies and tonsillectomies in Ontario, Canada, 1996-2000. *Acta Paediatrica*. 2004; 93 (9): 1245-1250.
- <sup>14</sup> Language barriers in access to health care. Bowen S. Health Canada mimeo. November 2001. Found at: [http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-lang-acces/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-lang-acces/index_e.html). Accessed January 10, 2005.
- <sup>15</sup> Halwani S. Racial Inequality in Access to Health Care Services. A paper for the Ontario Human Rights Commission. 2002. Found at: <http://www.ohrc.on.ca/english/consultations/race-policy-dialogue-paper-sh.pdf> accessed 060226
- <sup>16</sup> Kafele K. Racial Discrimination and Mental Health: Racialized and Aboriginal Communities. A paper for the Ontario Human Rights Commission. 2002. Found at: <http://www.ohrc.on.ca/english/consultations/race-policy-dialogue-paper-kk.shtml> accessed 060226.
- <sup>17</sup> Tu K, Mamdani MM, Hux JE et al. Progressive trends in the prevalence of benzodiazepine prescribing in older people in Ontario, Canada. *Journal of the American Geriatrics Society*. 2001;49:1341-1345.
- <sup>18</sup> Slaughter PM, Bondy SJ. Difference in access to care. In: Canadian Cardiovascular Society 2000 Consensus Conference; women and Ischemic Heart Disease. 2000;17(supplD):63D-67D.
- <sup>19</sup> Woodward G, van Walraven C, Hux JE. Utilization and outcomes of HgbA1c testing: a population-based study. *Canadian Medical Association Journal*. 2006;174:327-329.
- <sup>20</sup> Haider A, Mamdani M, Shaw J, et al. Socioeconomic status influences care of patients with acne in Ontario, Canada. *Journal of the American Academy of Dermatology*. 2006; 54 (2): 331-335.
- <sup>21</sup> Brotman S, Ryan B, Jalbert Y, et al. The impact of coming out on health and health care access: the experiences of gay, lesbian, bisexual, and two spirit people. *Journal of Health and Social Policy*. 2002;15:1-29.
- <sup>22</sup> Bowen DJ, Bradford JB, Powers D, et al. Comparing women of differing sexual orientations using population-based sampling. *Women and Health*. 2004;40:19-34.
- <sup>23</sup> Fehringer g, Howlett R, Cotterchio M, et al. Comparison of Papinicolau (Pap) test rates across Ontario and factors associated with cervical screening. *Canadian Journal of Public Health*. 2005;96:140-144.
- <sup>24</sup> Van Doorslaer E, Masseria C, Koolman X, et al. Inequalities in access to medical care by income in developed countries. *Canadian Medical Association Journal*. 2006;174:177-183.
- <sup>25</sup> Lawrence HP, Leake JL. The US Surgeon Generals Report on Oral Health in America: A Canadian perspective. *Journal of the Canadian Dental Association*. 2001;67:587-595.
- <sup>26</sup> "A population health strategy focuses on factors that enhance the health and well-being of the overall population. It views health as an asset that is a resource for everyday living, not simply the absence of disease. Population health concerns itself with the living and working conditions that enable and support

---

people in making healthy choices, and the services that promote and maintain health.” From Federal Provincial Territorial Advisory Committee on Population Health. *Strategies for Population Health: Investing in the Health of Canadians*. 1994.

<sup>27</sup> Lalonde M. *A New Perspective on the Health of Canadians*. Ministry of Supply and Services 1974. Found at: <http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/perspective.pdf>. Accessed November 4, 2005.

<sup>28</sup> Epp J. *Achieving Health for All: A framework for Health Promotion*. Released at First International conference on Health Promotion. Ottawa. 1986. Found at: [http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-frame-plan-promotion/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-frame-plan-promotion/index_e.html). Accessed September 7, 2006.

<sup>29</sup> Zimmerman B, Globerman S. (2004) *Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like?*, In: Forest P-G, McIntosh T, and Marchildon G. (eds) *Health Care Services and the Process of Change*, Toronto: University of Toronto Press. pp. 21-53.

<sup>30</sup> Health Disparities Task Group of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security. *Health Disparities: Roles of the Health Sector*. 2004. Found at: [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). Accessed September 23, 2006.

<sup>31</sup> See: <http://www.cipa.ca/>. Accessed November 20, 2007.

<sup>32</sup> See: <http://www.accessalliance.ca/>

<sup>33</sup> Personal communication with Sonja Nerad. Toronto. June 7, 2006.

<sup>34</sup> See the website for the London InterCommunity Health Centre: <http://www.lihc.on.ca/> , or the Latin American Diabetes Program: <http://www.pldiabetes.com/>.

<sup>35</sup> Harvey B. *The diabetes epidemic from a CHC perspective*. Presentation to the annual meeting of the Association of Ontario Health Centres. June 5, 2006. Kingston.

<sup>36</sup> UK Prospective Diabetes Study (UKPDS). VII. Study design, progress and performance. *Diabetologia* 1991;34(12):877-890.

<sup>37</sup> WHO International Conference on Intersectoral Action for Health 1997. Halifax.

<sup>38</sup> Fortin J-P, Groleau G, Lemieux V, O'Neill M, Lamarche P. *Intersectoral Action for Health*. Laval University. mimeo. 1994.

<sup>39</sup> City of Toronto Community Health Profile at: <http://www.torontohealthprofiles.ca/dataTablesLevel1.php> accessed 060226.

<sup>40</sup> See: <http://pathwaystoeducation.ca/results.html>.

<sup>41</sup> M. Lemura, C. Neudorf, and J. Opondo, “Health disparities by neighbourhood income,” *Canadian Journal of Public Health* 97 (2006): 435–9.

---

<sup>42</sup> Quebec Public Health Act. (Updated September 1, 2003)

[http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S\\_2\\_2/S2\\_2\\_A.html](http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html)  
accessed 030926. National Institute of Public Health Act

[http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/I\\_13\\_1\\_1/I13\\_1\\_1\\_A.html](http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/I_13_1_1/I13_1_1_A.html)  
accessed 030926.

<sup>43</sup> Quebec Public Health Act (updated 1 September 2003) [http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S\\_2\\_2/S2\\_2\\_A.html](http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html) (accessed 26 September 2003); National Institute of Public Health Act [http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/I\\_13\\_1\\_1/I13\\_1\\_1\\_A.html](http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/I_13_1_1/I13_1_1_A.html) (accessed 26 September 2003).



45 Charles St. E. Suite 101  
Toronto, ON, M4Y 1S2  
416-972-1010  
[contact@wellesleyinstitute.com](mailto:contact@wellesleyinstitute.com)  
[www.wellesleyinstitute.com](http://www.wellesleyinstitute.com)