

**THE COMPLEXITY OF CHANGE:
AN INTERDISCIPLINARY ANALYSIS OF HEALTH CARE
ORGANIZATIONS' RESPONSES TO ETHNIC DIVERSITY IN VANCOUVER AND
MONTREAL**

by

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Abstract

Research demonstrates that immigrants and racialized populations continue to face notable barriers in accessing health care in Canada. The legislation and public discourse includes multiculturalism, human rights and universal health care, which should be a favourable climate for access; yet research demonstrates it can be challenging for immigrants and ethnically diverse communities to fully exercise those rights.

This dissertation explores access barriers through bringing together an analysis of discursive practices in health care and an institutionalist account of responses to facilitating health care access for immigrants and ethnically diverse communities. Both direct attention to local and historical contexts, with health care discourses additionally focusing on the relationships and engagement between health care providers and diverse communities. The aims of this study are to understand the convergence and divergence of framing health care access between health service providers and representatives of immigrant associations, and to explore initiatives to foster access.

This research provides a review of Canadian federal and provincial policy on health care, human rights and multiculturalism. I also held interviews with immigrant associations and health service providers in Vancouver and Montreal, who were asked to identify access barriers, and to discuss and assess strategies they are engaged in to address these barriers. The examination of engagement processes provides an exploration of potential sites for change. The dissertation examines processes of engagement between health care service providers and immigrant associations aimed at improving access, and shares participants' perspectives on the changes attributed to these engagement processes.

The data demonstrate that despite a favourable policy climate for ensuring service access, all respondents felt that immigrants face barriers when accessing health care services. Engagement can bring together respective and complementary knowledge of the social contexts, institutional norms and experiences to inform strategies for improving access, although there are additional factors that frame if and how these recommendations are realized at the point of care. The results demonstrate that strategies to address immigrants' access barriers to health care should take on the structural constraints that shape access, and changes in practices on the ground that address interpersonal relationships between patients and care providers.

Preface

This research was part of an international research project titled: “Giving New Subjects a Voice” funded by the Volkswagen Foundation, which included research partners in Canada, Germany and Italy with Patrizia Nanz, Carlo Ruzza, Oliver Schmidtke and Elmar Brähler as the principle investigators. I was funded to carry out the research on the Canadian cases for my doctoral work.

The Behavioural Research Ethics Board of the University of British Columbia (BREB #: H07-00352) and the Human Research Ethics Board of the University of Victoria (HREB #: 05-363) both provided approval for this study. Dr. Saime Ozcurumez and I carried out the interviews for the Canadian case together, and co-authored 2 chapters (‘Barriers in Access to Care’ and ‘Strategies for Change among Institutional and Civil Society Actors’) in the forthcoming book: “*Cultural Diversity in the Health Care System*” edited by O. Schmidtke *et al.* published through Ashgate.

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List of Abbreviations

ACCESSS – Alliance des Communautés Culturelles pour l'Égalité dans la Santé et les Services Sociaux

AMSSA - Affiliation of Multicultural Societies and Service Agencies

BC – British Columbia

CAS – Complex Adaptive Systems

CHA – *Canada Health Act*

CHST – Canada Health and Social Transfer

CHT – Canada Health Transfer

CLSC –Centres Locaux de Services Communautaires

CSSS – Centres de Santé et de Services Sociaux

HCO – Health Care Organization

MSSS – Ministère de la Santé et des Services Sociaux

NPM – New Public Management

PHSA – Provincial Health Services Authority

RHA – Regional Health Authorities

RHB – Regional Health Boards

RHSSB – Regional Health and Social Service Boards

SAWC – South Asian Women's Centre

SOI – Spheres of Influence

VCH – Vancouver Coastal Health Authority

ZOI – Zone of Interaction

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I first met Sam Sheps when I applied for the Western Regional Training Centre in Health Services Research (WRTC-HSR). The WRTC experience provided me with an appreciation of the need to have academic research meet the needs of people working in the health care system, a lesson I have carried forward in all of my research work, and I thank Sam for his leadership in this program and in his guidance of my work. Judith Lynam has offered me with tremendous expertise in developing a methodology to bridge political science and health services research, and to be particularly attentive to demonstrating how theory has guided my research process and analysis. I thank Oliver Schmidtke for bringing me into the international research team, and providing expertise in policy and political participation in the processes of decision making. Throughout this process they have all been instrumental in guiding me through the trials of bridging disciplinary traditions, which is not always easy, but as an avid interdisciplinarian, I would not want to approach research any other way. I also want to thank them for their timely feedback on earlier drafts and their technical expertise in using MS word – I couldn't imagine preparing a dissertation in an era before the track-changes function!

My gratitude goes out to all the respondents in the study, who shared with us their expertise as well as their dreams for a better health care system that meets the needs of the diversity in Canada. Thank you for all your work in this area and for sharing your experiences with me in this research. I hope that results of this research can support their work.

I extend a word of thanks to the international research team that I was part of in this research project – it was a valuable experience to see the similarities and differences across the cases, and to explore ways for us to develop common approaches in such distinct contexts. I offer a special note of thanks to my dear friend and colleague Dr. Saime Ozcurumez – the other half of the Canadian research team. Her expertise and encouragement always helped keep me motivated. I also want to note my gratitude for the support staff of UBC - at the Interdisciplinary Studies Graduate Program, the Faculty of Graduate Studies, and the Library. The university has been quite supportive in ensuring I have the resources I need as a distance student, and in reminding me to keep on track.

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Dedication

To everyone who is working towards creating social equality in our public institutions.

Chapter 1: Introduction

Canada has long been recognized as a country of immigration and multiculturalism, supportive of diversity of the cultural mosaic. Immigration policies change over time based on shifting priorities, values or labour market needs, but in general Canada has supported immigration, and from increasingly diverse populations. Growing numbers of people are applying for Canadian citizenship, and many of these from diverse language backgrounds. Canadian census data released in October 2012 demonstrates a continued growth in the number of people speaking languages other than Canada's official languages of French and English. Over 12% in Montreal (Census Metropolitan Area) and a quarter of people in Vancouver (Census Metropolitan Area) speak a language other than French or English at home the majority of the time (Statistics Canada, 2011).

Despite what is seen as a supportive legislative and social climate for the rights of ethnically diverse communities and immigrants in Canada, there is a significant body of research in Canada that demonstrates how racialized populations continue to face difficulties in Canadian society, with notable barriers in accessing health care. The public discourse in Canada has been shaped by multiculturalism and human rights, yet Canadian research highlights that it can often be challenging for immigrants and ethnically diverse communities to fully exercise those rights, for a variety of reasons.

The Canadian government in recent years has taken a variety of approaches to address the difficulties that immigrants with limited French or English language skills may face. Although there are language skills requirements for immigrants to Canada, this was based on an assessment by an immigration official; new legislation enacted in November

2012 requires applicants to pass the Canadian Benchmark Level 4 (Citizenship and Immigration Canada, 2012). Although this may result in fewer immigrants with language barriers, this is only aspect of the problem that immigrants face in accessing health care services.

In a review of immigrant and refugee access to health services in Canada, Gagnon (2002) noted a wide variation of service access and eligibility for different categories of immigrants and refugees across the provinces. Similarly, a number of other authors note that there are barriers to accessing health services for a range of ethnic groups in Canada (see for example Asanin and Wilson, 2008; Bowen, 2001, 2004; Gagnon, 2002; Lai and Chau, 2007; Smith, Matheson *et al.*, 2007; Whitley, Kirmayer *et al.*, 2006).

Understanding the state of access to health care in Canada is not simple, despite the guarantee of near-universal access to insured health services through the *Canada Health Act* (Government of Canada, 1985). The principles outlined in the *Canada Health Act*, the *Multiculturalism Act* (Government of Canada, 1988), and the *Canadian Charter of Rights and Freedoms* (Government of Canada, 1982) are commitments to social inclusion for Canada's ethnically diverse communities. These legislative documents are the legal foundation for addressing access barriers to public institutions (such as healthcare) and for ending discrimination for all of Canada's ethnically diverse communities. They also provide a moral and legal basis from which to argue for ensuring the provision of necessary health care services for ethnically diverse communities, and as such can be valuable for people working to advance these goals. Therefore, there is often an expectation that efforts to enhance inclusion and address access barriers will be well established in the norms and

practices of Canadian public institutions, such as health care, education, legal and political institutions.

The *Canada Health Act* (CHA) does not define “reasonable access” to health services, leaving considerable room for interpretation by each of the provinces and territories that are responsible for health service provision. The CHA does not provide specifics on the delivery of services, but the scope of insured services is restricted to hospital and physician care. Services that would enhance access, such as translation and interpretation, are not guaranteed. There is also variation to service entitlements in relation to immigration status, yet as noted in a policy paper by Canada’s parliamentary research services “that relationship is not straightforward, static, or consistent” (Elgersma 2008: 1).

In addition to barriers in accessing health care services, many immigrants in Canada face a deteriorating health status and a worsening in the determinants of health. Although immigrants who come to Canada are reported to have a better health status than the Canadian population on their arrival (in what has been described as the healthy immigrant effect), alarmingly their health deteriorates to a level comparable or below that of the average Canadian over a period of five to ten years (Ali, McDermott and Gravel, 2004; Newbold, 2005; McDonald and Kennedy, 2004). One reason for this general deterioration of immigrants’ health over time, according to Morton Beiser is that “remarkable little policy is directed to ensuring that [immigrants] stay healthy” (2005: s30). The literature shows that in Canada ‘racialized’ populations have a poorer status in income, housing and employment that are key social determinants of health (Ali, McDermott, and Gravel, 2004; Beiser, 2005; Beiser and Stewart, 2005; Bowen, 2004; Gagnon, 2002; McDonald and Kennedy, 2004; Newbold 2005; Newbold and Danforth, 2003).

1.1 Conceptualizing Access

In their study of the political economy of health care, the authors in Armstrong et al. (2001) demonstrate that economic, cultural, political and institutional barriers affect health care service delivery at both individual and institutional levels, while at the same time noting that health care structures are embedded in broader political, economic and social contexts. In exploring access barriers, this dissertation will examine core themes of health care access barriers, using an interdisciplinary approach that introduces concepts from health services research, and expands on these through using critical theories in political science and health care discourses that broaden the analysis of individual level equity barriers to include societal level factors.

In a report prepared for Health Canada, Bowen (2001) introduces a health services research framework for understanding individual level access barriers. Her framework emphasizes key categories of barriers to access: 1) financial; 2) non-financial; 3) barriers to equitable quality of care, as well as 4) availability of services. Studies in the UK by Bowl (2007) and McLean et al. (2003) regarding the experiences of ethnic minorities have identified three thematic areas of exclusion within health care, which correspond with the first three categories of barriers identified in Bowen's framework. Their conception of cultural exclusion takes up the same issues as Bowen does in non-financial barriers; their theme of socio-economic exclusion addresses similar concerns as Bowen's financial barriers, and institutional exclusion covers the same concepts as Bowen's discussion of barriers to equitable services (Bowl, 2007; McLean et al., 2003).

Researchers in critical theory paradigms focus attention on similar concepts regarding the types of barriers to equitable access and health care provision for people who are traditionally socially excluded, namely social, economic and political exclusion (see for example political economy approaches by Armstrong et al., 2001; Poland et al., 1998; Raphael, 2006; Anderson et al., 2003; Browne, 2005; Browne et al. 2009; Lynam et al., 2003; Ramsden, 1993). These approaches recognize some of the same individual and institutional access barriers as discussed in health services research on access. In addition they also emphasize that health care institutions and the relationships within them are embedded within broader social, political and economic contexts, which have to be part of our conceptualization of access barriers. An analysis of health care must recognize the “integrated nature of politics, economy and society” (Armstrong et al., 2001: 124), and therefore the analysis of barriers to health care must also incorporate a broader scope that examines how current experiences are historically and contextually situated.

1.2 Paradigms of Inquiry

This study is guided by critical theories, which see reality as being shaped by interactions between people that reflect “privilege and oppression that can be based on race or ethnicity, socioeconomic class, gender”, while acknowledging the value of constructivist theories that emphasize reality as “socially and experientially based, local and specific, dependent for their form and content on the persons who hold them” (Lincoln, Lynham and Guba, 2011: 102). These theoretical paradigms direct us to explore the perspectives of people located differently in the system, noting that their position, both in terms of social hierarchy and physical location, shapes their experiences both in society as a whole and within health

care organizations. Their understandings about the nature of access barriers and what should be done to address them will be based on their own experiences. It is therefore valuable to bring in multiple voices that can represent an array of experiences about the challenges and opportunities for improving immigrants' access to health care in Canada.

The line of inquiry that I take up in this dissertation examines health care access through qualitative methods, guided primarily by critical theory in political science and health care discourses. Qualitative research seeks “answers to questions that stress *how* social experience is created and given meaning” (Guba and Lincoln, 2011: 8). Critical theory draws attention to the way that social, political, cultural, economic, ethnic, and gender values are crystalized over time and shape the nature of reality, therefore, guiding the research to focus attention on how social relations are shaped by political, economic and social norms. Constructivism theory emphasizes relativity: local and specific constructions of truth will vary (Lincoln, Lynham and Guba, 2011: 98). The interpretation of reality is shaped by experiences, which are in turn shaped by position in society. Constructivist theory therefore instructs researchers to explore the multiple interpretations of the nature of health care access barriers, without the expectation that there will be a consensus on what those are.

Guided by critical and constructivist research paradigms, I integrate disciplinary traditions from political science, nursing, and health services research to provide a socially embedded analysis of health care access. This interdisciplinary approach provides a guide to the process of research, directing inquiry to an array of issues to consider in developing a fuller picture of health care access.

Examining why events happen in certain times and places and not others can provide insight into favourable contexts, exemplary practices and the innovative role of actors in

leading change. The study presented here is a qualitative comparative analysis that examines barriers in immigrant access to health care services in Vancouver and Montreal, as well as experiences and strategies of key informants from immigrant associations and the health care system who work to improve health care access for immigrant populations. This dissertation will examine their perspectives on the broad conditions that shape immigrants' access to health care services in Canada, the impact of the strategies to enhance access, and what systemic changes are needed to overcome these issues. Taking guidance from the critical and constructivist theoretical paradigms, this dissertation examines broader social contexts as well as specific processes of formal and informal engagement between health care institutions and ethnically diverse communities. The analysis of the responses of research participants explores interpretations of structural norms, broad contexts, as well as social interactions that shape the specific experiences within health care institutions.

1.3 Research Questions

In this thesis I attempt to answer the question: What are the barriers to health care access faced by immigrants in Canada, and what types of processes are people engaged in to address those barriers? In answering this question, I focus on three levels of access: the short-term changes in understanding access barriers, the mid-term changes in practices to address those barriers; and a framework to understand long-term systemic change. Therefore, I explore these three different dimensions of access in this dissertation:

1. **Understanding access:** How do health service providers, immigrant associations and policy documents frame health care access barriers for immigrants? What are the points of convergence and divergence between these conceptions of access?

Are attitudes changing as a result of engagement processes; are shared understandings of barriers emerging?

2. **Institutional, policy and individual strategies for fostering access:** What is being done to address access barriers, how are ethnically diverse communities engaged in developing strategies for inclusion, and how do our respondents (from immigrant associations and health care organizations) assess these strategies?
3. **Re-conceptualizing access:** Drawing on insights from experiences of key informants in answering questions 1 & 2, I develop an integrated analytical model that incorporates the broad social, political and economic contexts as well as the interpersonal relationships that can inform strategies for institutional, systemic and social change.

Much of the research on understanding access and its critical components has been conceptualized through naming and categorizing access barriers. As the discussion above has outlined, structural barriers (economic, social and political) as well as the interaction (engagement) between communities and the health care system are important areas that shape access. Therefore, in this dissertation I examine these streams in order to look both at the conditions of immigrant access to health services and the processes of working to improve access. In addition, rather than focusing on the static concepts of access barriers, I will be looking into diverse understandings of access barriers, noting differences between the respondents regarding their conceptualization of the specific contexts that provide a favourable climate for successfully overcoming access barriers. The thesis explores the dynamics of social change by examining political processes of engagement aimed at

improving access, while drawing attention to the particular social, economic and political contexts in which these negotiations for change occur.

This chapter identified different theoretical traditions that have shaped the way I conceptualize health care access issues for ethnically diverse communities, and has drawn attention to factors that shape those experiences. The following chapter discusses the ways that the theoretical paradigms conceptualize access. I explore the dimensions of access barriers from different disciplinary approaches highlighting research on immigrant access to health care services in Canada. I then examine community engagement and its role in social and institutional change. Chapter 4 describes the research methods undertaken in the study. Chapter 5 provides a contextual backdrop to immigration and health care in Canada and reviews the policies that should provide the basis for improving access. I then provide an analysis of access barriers based on the interview data. Chapter 7 presents an analysis of the programs and practices aimed at improving immigrant access to health care services and identifies some of the successes and challenges. Chapter 8 examines the structures of community engagement, identifying common themes from the respondents on the purpose and outcomes of engagement processes. Chapter 9 discusses the analysis of the data, and reflects on the findings in relation to the access frameworks discussed in Chapter 2, and on the value of an interdisciplinary theoretical approach for analysing access barriers. Chapter 10 reviews these findings in relation to the main research questions, discusses the contributions and limitations of this study and identifies areas for further research.

Chapter 2: Conceptualizing Immigrants' Health Care Access in Canada

In analysing the barriers in accessing health care there is a conflict in the literature about how best barriers can be overcome. The two different theoretical approaches examined here, critical theory and constructivism, draw our attention to different aspects of those barriers. Critical theoretical perspectives emphasize the structural nature of health access barriers, for example focusing on broad social, economic and political structures that create unequal hierarchies that shape social relations. Constructivist theoretical perspectives instead draw our attention to the agency of people who are working to make change, in spite of those structural barriers. In this way, these approaches are often seen in conflict and as incompatible. My struggle in this dissertation is to come to grips with this debate around structure and agency, acknowledging the tension between these perspectives, but also reflecting on the value that each has brought to the analysis of my empirical data. The data from this study has demonstrated that in spite of the structural constraints that shape health care access across Canada, there are significant differences on the ground that reflect the importance of agency of the people working to improve access for immigrant communities.

Although this research begins with an examination of concepts of access barriers, the emphasis must move to foreground the contexts in which these barriers exist. What conditions in society and which practices at the institutional level create or address those barriers? Conditions are constantly changing, therefore developing static concepts of access barriers is not adequate for understanding how they are recreated or overcome.

2.1 Critical and Constructivist Paradigms of Inquiry

An analysis of immigrant access to health care services in Canada provides more depth when examined at both macro and micro levels. The character of social, economic and political relations in society can help us understand the overarching macro themes that shape access barriers. Explorations of the experiences of people involved in processes to improve service access adds depth to the analysis of contexts, providing specific details on what happens on the ground (micro level) in the design and delivery of health care services as people try to address the needs of an increasingly diverse population.

The research paradigms of critical and constructivist theoretical perspectives guide us in focusing on different aspects of the world in order to understand the nature of reality. Critical theorists see human social relations as based on an unequal distribution of power and the conflicts to change or maintain that balance of power (Lincoln, Lynham and Guba, 2011: 101). Critical theory emphasizes the need to examine the broader social, economic and political contexts that shape those social relations. These power imbalances stem from the social, economic and political contexts, or what I will call the “spheres of influence” (SOI), which shape “interactions of privilege and oppression that can be based on race or ethnicity, socioeconomic class, gender, mental or physical abilities, or sexual preference” (Lincoln, Lynham and Guba, 2011: 102).

The aim of inquiry in both critical and constructivist paradigms is for researchers to “find the power structure”, and to understand concepts through the “reconstruction of meaning of lived experience” (Lincoln, Lynham and Guba, 2011: 106). These paradigms of inquiry provide direction to the methodological approaches for examining immigrants’ access to health care services, directing us to examine social, political, and economic

contexts as well as the interactions within the health care system that are shaped by these contexts. How do social actors create or utilize favourable conditions to open the doors to change? What is it about institutions that create opportunities to address the barriers? What are the strategies for change to reduce these barriers? The integrated approach used here embeds an analysis of the responsiveness of health care institutions within the broader contexts, so that not only do we learn from the uniqueness of each organization and the people interacting within them, but also from how broader contexts shape interaction within health care organizations.

2.2 Methodological Approaches

Historical institutionalism, a methodological approach within political science, is a useful approach for analysing how broad societal factors shape institutional norms and experiences. Methodologically, this approach stresses the importance of historical processes and societal norms that are specific to each context. It instructs us to examine social trends in society over time, and how they are shaped by policy and governance.

Institutionalist approaches note that changes in institutions, such as health care organizations, can be slow and there are often limitations to changes permeating the system. As Maioni and Smith acknowledge in their study of healthcare and Canadian federalism: “The existence of multiple institutional settings and policy actors thus increases the potential for ‘veto points’ in the political system” (Maioni and Smith, 2003: 298). These multiple veto points make it difficult to implement policy and new practice norms. They often lead to a lowest common denominator mode of decision making, such as federal guidelines that remain vague enough to allow for varied interpretations, as is seen in the *Canada Health Act*.

At the same time policies create expectations and opportunities for political advocacy, such as the anticipation of community participation in the adaptation of public institutions in line with the language of the *Multiculturalism Act*.

As Hall and Taylor (1996) remind us, we must not assume that institutions were designed on the basis of some timeless rationality such as efficiency in meeting the health care needs of the population. In order to understand what frames institutional practices, it is necessary to critically examine the specific contexts in which institutions develop and are continually transformed. As Pierson notes, “institutional arrangements are adopted because they are perceived to be appropriate...such arrangements may actually be dysfunctional for the particular local context” (Pierson, 2000: 478).

Social, political and economic ideologies are embedded in the design and operation of institutions (e.g. in health care that the biomedical model is the best approach for health services decision making, or the notion that market dynamics create efficiencies not attained by other means), thereby setting the institutional norms for policy and practice. Research in policy studies has noted: “communicating only within the framework of the “western” medical model becomes a barrier to equity for ethnic, cultural and linguistic minorities” (Williams, 2000: 214). As Pierson argues:

[E]ven mistaken understandings of the political world are often self-reinforcing rather than corrective...[O]ur basic conceptions of the political world, of what works and what does not, tend to be path-dependent. ... [A]ctors operating in contexts of high complexity and opacity are heavily biased in the way they filter information into existing ‘mental maps’. Confirming information tends to be incorporated, while disconfirming information is filtered out...once established, basic outlooks...are generally tenacious. Complexity of context and limits of human cognition mean that mistaken understandings in politics often do not get corrected (Pierson, 2000: 489).

Pierson is specifically referring to the political world, but this analysis can be applied to public institutions, which are created and transformed through political processes. Once a way of doing business is established, changes to those norms can be difficult to make, even when policies are in place to set up new norms. Therefore, not only do we need to look at the current social, political and economic spheres of influence, but also at trends over time, as institutions may still embody the norms of previous eras. As Pierson asserts, “established institutions create powerful inducements which reinforce their own stability and further development” (Pierson, 2000: 492). This is not to say that institutions and institutionalized norms shaped by the spheres of influence fully determine outcomes, rather they strongly shape what is possible through the establishment of rules and processes.

In the health care setting, this can make organizations dysfunctional, less resilient, and thus unable to respond to new and unpredictable situations, by basing decisions on institutional rather than patient needs, or on a misreading of these patient needs. Once decisions are made, regarding practice norms for example, they tend to be reinforced for good or ill, simply because people become accustomed to them, thereby creating path dependency, where future decisions are shaped by previous ones.

Path dependency is a concept that notes once a path is chosen, there are costs associated with leaving that path, and therefore earlier decisions shape later ones. This concept therefore suggests that institutional change will be bound by embedded social norms of those institutions. Historical institutionalism therefore methodologically proposes that outdated norms of practice can lead to inappropriate services. As Pierson suggests, “if institutionalization is path-dependent, then we cannot expect accidents to cancel out; instead, early accidents may be self-reinforcing” (Pierson, 2000: 485).

Even as institutions adapt to new contexts, they therefore still embody the fundamental social values that shaped the context in which they were originally created. Social structures can constrain subjective action through the creation of norms that establish which actions are probable or favoured. Such traditions are taken up in communication and discourses of practice. Moreover, the way that discourse frames the problem can influence the type of solutions sought. The problem often faced is that: “the dead weight of previous institutional choices seriously limit their room to maneuver” (Pierson, 2000: 493).

Despite the tendency toward inertia, institutions can and do adapt to changing social environments. Institutional changes often are a conscious response to changing social or material conditions:

When new material conditions emerge, existing structures can be rendered ineffectual, or at least their ineffectuality can be exposed. This opens up opportunities for new perspectives to influence structural transformation. Effective social agents are the ones who anticipate the breakdown of the structures and develop alternative ideational perspectives prior to this collapse (Wylie, 2002a: 75).

Although institutions are often stable, dramatic changes in broader social contexts can disrupt that stability, as problems within the institutions can be more apparent because of those contextual shifts. Historical institutionalists emphasize that changing contexts in the social, political and economic realms (the spheres of influence - SOI) bring pressure to bear on public institutions to respond to those changes. In addition, specific actors are agents of change. Change can take place through political processes that alter decision-making in health care, both at the institutional planning level through engagement between health care managers and community representatives, and in the social interaction between patients and service providers. Individuals still have independent intentions and actions, but their ability

to act upon them or to see effective consequences of their actions may be constrained by institutional norms or social, political and economic contexts. In this way, historical institutionalism methodologically guides the research to explore the different ways access barriers are created through an interaction of coinciding social, economic and political contexts.

Constructivist theories, while compatible with the critical approach of examining broader contexts, directs us to examine the way that individuals construct their understanding of the social world based on their experiences within it, drawing our attention to interpersonal processes. To get a complete picture of a problem, such as health care access barriers, research needs to examine perspectives of those differently located in the health care system. Different understandings of the problem will emerge, and therefore different solutions for change will be put forward. Health care workers will have an understanding of access barriers and strategies for change based on how they interpret patient experiences, combined with their assessment of what are feasible resolutions within their institutional setting. Community groups on the other hand, will have a greater appreciation of what prevents their community members from accessing the system, problems they have, and solutions that will reflect their needs.

The overarching SOIs create a common climate, with varying experiences based on the social and economic position of the individual, meaning that “social reality is a construction based on the actor’s frame of reference within the setting” (Guba and Lincoln, 1985 in Lincoln, Lynham and Guba, 2011: 103). The constructivist paradigm sees knowledge of the social world as based on individual and collective experiences to provide a range of

“local, specific and co-constructed” representations of the nature of reality (Lincoln, Lynham and Guba, 2011: 100).

Critical and constructivist paradigms offer distinct approaches to the examination of access barriers, with critical theoretical perspectives drawing our attention to the overarching social, political and economic structures, and constructivists emphasizing the role of actors involved in working to change those barriers. When examining the specific issues of health care access, it is clear that access barriers are multifaceted, and multiple barriers can simultaneously shape immigrants’ experiences with accessing health care. Due to the complexity of access, I explore the different dimensions of access as a way to frame the discussion. This section below discusses how the disciplinary approaches brought together in this dissertation can help develop a more comprehensive approach to constructing concepts of access. I specifically examine social, economic and political contexts, or the spheres of influences (SOI), which emphasizes the structural aspects of access barriers as guided by critical theoretical perspectives. I then examine relationships at the point of health care services’ provision (what I will call the zone of interaction or ZOI), which is where constructivist theory guide us to focus on in order to understand how barriers can be overcome. In valuing the importance of both structure and agency, it is therefore critical to draw attention to how these interactions are negotiating and reconstructing local experiences. Hence, after the discussion of the SOI and ZOI access concepts, I discuss the engagement processes where this interaction takes place through formal and informal processes of improving health care access.

2.3 The Spheres of Influence

This following section will discuss the spheres of influence (SOI) and how they have been conceptualized in access research across the disciplines of health services research, political science and nursing, with specific emphasis on the constructivist and critical theoretical perspectives within these disciplines. Combining these approaches to develop more comprehensive definitions of access barriers enables us to explore a more complex analysis of how the social, economic and political contexts interact, thereby shaping experiences with health care services.

In terms of individual level access, Bowen identifies financial, non-financial and barriers to equitable services as three of the main categories for conceptualizing health care access concerns faced by immigrants. Studies in Canada and the UK regarding the experiences of ethnic minorities and immigrants with health care services also reflect the value of focusing on socio-economic, cultural and institutional exclusion to understand various health care access barriers (Asanin and Wilson, 2008; Beiser, 2005; Beiser and Stewart, 2005; Bowen, 2004; Bowl, 2007; Dunn and Dyck, 2000; Gagnon, 2002; Lai and Chau, 2007; McLean *et al.*, 2003; Mitra, Jacobsen *et al.*, 2006; Newbold and Danforth, 2003; Smith, Matheson *et al.*, 2007; Whitley, Kirmayer *et al.*, 2006). These health services research approaches draw attention to the wide variety of factors that shape access to care within health care organizations.

Political economy approaches also draw attention to the complexities that shape health inequalities. Political economy of health care offers an integrated analysis of the broad social contexts that shape social exclusion in society, including public institutions such as health care (see for example the work of Leys on neo-liberalism and health care in Britain, as

well as Armstrong's chapter on women's issues in health reform, both in Armstrong *et al.*, 2001). Political economy is seen as a theoretical model that "understands politics and economics as integrally related. For a political economist an adequate study of the whole cannot be developed from a separate study of individual parts" (Armstrong *et al.*, 2001: vii). Inequitable social relations shape health, and political economists argue that to improve health equality, social relations need to be addressed in the realm of politics. Leys has argued that:

social relations are, then, key determinants of the health of populations...depressingly little of the evidence we now have on the social causes of ill-health is reflected in public policy. Government policy in relation to the social determinants of health has been essentially to ignore them (Leys, 2009: 8).

Therefore, political economists draw our attention not only to the social inequities, such as poverty, that shape health, but also to the policy contexts that either perpetuate or reduce those social inequalities. In an international study of the social and political contexts of health, researchers carried out an analysis of the:

causes of the growth of social inequalities in the developed capitalist countries and its consequences for the health of their populations, and to make recommendations on how to improve the health of these populations through public policies (Navarro, 2004: 2).

They concluded in their multi-country study:

it is not only the individual but the way in which individuals interact and organize themselves in society (i.e. their social, economic, political, and cultural networks and liaisons) that determines individual and population health (Navarro, *et al.*, 2004: 221).

As the quote above notes, it is not simply the actions of individuals but the way in which the interactions among people and groups in society are organized that shapes health. This

theoretical stance guides research to not only examine the unequal relations of power between social classes that affect health care access, but also to examine the policies that result in social and economic exclusion, as well as those that can mitigate it.

2.3.1 Economic / Financial Barriers

In health services research, the right to see a health service provider without paying at the point of service is seen as the fundamental determinant of access, and most interpretations of policy consider access “defined simply as the absence of explicit financial barriers” (Bowen, 2001: 13). The provisions of the *Canada Health Act* do not allow charges (extra billing) for insured health services, which carries with it the implication that financial barriers to health care have been overcome. Although it may seem that since there is no charge for these medically necessary services there are no financial barriers to care. However, a number of details dispute this claim. First, in BC, Quebec and Ontario, individuals and families must pay health care insurance premiums (although there are exemptions for those below an income threshold). Second, there are significant indirect personal costs associated with the use of insured services including transportation, child care expenses and lost wages for time taken off for medical appointments (ibid.). Such costs can be particularly burdensome for those with chronic health conditions and for those with limited financial and social resources.

Although under the *Canada Health Act* patients cannot be charged for “medically necessary services,” provincial legislation defines exactly what is covered as medically necessary services. This term frequently undergoes re-definition, usually through a reduction of services covered. The federal legislative contexts of the *Multiculturalism Act* and the

Canada Health Act provide an expectation of, *but not a requirement for*, the provision of programs and services designed specifically to meet the needs of ethno-cultural communities to ensure that as patients they are not excluded from public institutions in Canada. Thus translation / interpretation services at the point of care are an important way of ensuring people are not excluded, and it is silent with regard to guaranteeing funding to cover these services. Many patients do not have free access to interpretation when accessing health care services.

Rather than looking specifically at individual financial barriers to access, political economists emphasize that the economic context shapes access by changing the operating principles of health care institutions. The economic crises of the early 1990s began a period of not just fiscal restraint, but as Evans has claimed the “shock of the early 1990s...triggered unprecedented reductions in public spending” (Evans, 2003: 8). In Canada, the 1995 federal budget incorporated the largest budget cuts to social programs in Canadian history. This significant drop in federal transfers to the provinces, approximately \$20 billion over three years, opened a window of opportunity to force a new agenda in management of public sector institutions, which saw rapid changes to health care where “many provinces either initiated or accelerated the downsizing of the largest and most expensive part of their health systems, the hospitals” (Ostry, 2006: 79). Market oriented approaches to health care management were increasingly adopted as the way to contain costs in health care in Canada.

These changes had a ripple effect throughout the health care system: patients were moved into community care settings; the core of publicly funded services was reduced; and hospital staff faced an intensification of patient acuity and workloads. There has been debate regarding whether these changes in the health care system have “mobilized ingenuity to

provide care more efficiently and effectively, or simply reduced the level and standard of care provided and left real needs unmet” (Evans, 2003: 8). New economic models that privilege efficiency principles in health care service delivery have changed institutional norms. This adaptation of public services to market forces creates a different set of values and operating principles, challenging the ability of public institutions to meet the needs that were once clearly set out for them. More generally, as Leys’ research on public health services in Britain demonstrates, “market-driven politics can lead to a remarkably rapid erosion of democratically-determined collective values and institutions” (Leys, 2001: 4).

It is important to consider the economic contexts that are shaping decisions in health care. Are the barriers that immigrants face related to declines in service that all patients are experiencing, or are there fewer resources available to institutions that provide health care services, thus limiting their ability to provide for the additional needs of immigrants, for example translation services for those with language barriers?

2.3.2 Social and Cultural Barriers

Bowen’s framework places social and cultural barriers within the ‘non-financial’ barriers category. In Bowen’s discussion of specific examples of barriers, this category also includes: linguistic, informational, cultural or educational barriers; ethnocentrism among service providers; and service delivery models that may discourage use. These barriers do not get the same attention in the media and public debates about access as financial barriers do, but as Bowen states, research has shown that “programs working with immigrants and refugees report that all of these factors play a role in impeding access” (Bowen, 2001: 31). Bowen draws attention to language barriers as contributing to poorer health outcomes and an

influence on access to health services. As Bowen has shown:

Poor communication and low trust have been linked to decreased patient satisfaction, lower levels of compliance, subsequent patterns of health service utilization and treatment outcomes. Therefore, discrimination in any form can be expected to result in poorer health outcomes (Bowen, 2001: 20).

Although language is a significant barrier in health care access, it is but one of many in the “cultural” barriers dimension. There remains considerable misunderstanding and contradictory opinion about why these cultural barriers exist. More often than not, the portrayal is one that emphasizes the specific cultural norms of particular ethnic groups as the basis of these barriers:

The concept of ethnicity to describe or explain barriers is problematic as the concept is rarely defined but is often based on the hypothesis that culturally based, traditional health beliefs act as a barrier to access and utilization of services...A primary risk is the tendency to explain the ‘access problem’ in terms of individual cultural incompetence, or even to blame minority communities for what is believed to be the impact of ‘traditional beliefs’ or ‘cultural’ behavioural patterns. As a result, researchers may conclude that minority patients are ‘non-compliant,’ ‘mistrustful or fearful, or ‘reluctant’ (Bowen, 2001: 23).

In addition, categorizing individuals into groups immediately raises the problem of essentialism, of fixing people into immutable cultural categories and not taking into account “the dynamic and shifting nature of people’s identities which intersect with class, ethnicity, gender, religion and many more cultural configurations” (Pfeffer, 1998: 1383 in Reimer-Kirkham *et al.*, 2002: 227). Research and practice that only aim to understand the cultural differences of communities will not overcome the problems that are faced in the system. Instead, it is important for research to “challenge the assumption that ‘cultural beliefs’ or cultural differences are the cause of major barriers to access, pointing instead to

communication barriers, systemic bias, and lack of flexibility in program delivery” (Bowen, 2001: 24). This perspective leads to the erroneous conclusions of some research that claims the link between ethnicity and health is attributed to cultural differences, where the blame of poorer health or socio-economic status is placed on ethnic minority groups’ biological characteristics or social / cultural behaviours. Such an approach conveniently avoids and thus “denies the significance of the political and structural aspects of society and ultimately makes culture itself problematic” (Culley, 1996: 566). It is therefore necessary to be cautious about how cultural barriers are conceived of by respondents in analysing these results.

Although population health research in the UK has demonstrated the influence of socio-economic factors on the link between ethnicity and health status (i.e. Nazroo, 2003), there is still a tendency toward “blaming the victim” for their health status and poor navigation of the health care system. As post-colonial feminist research has identified, many health service providers do just that:

equating social problems with cultural characteristics is not uncommon in health-care discourses...[C]ulture is often given as the primary explanation for why certain people or groups experience various health, social or economic problems (Browne, 2005: 75).

Browne also argues that cultural and social norms must be analysed “as deeply enmeshed in power relations and in economic, political, and historical contexts” (Browne, 2005: 66).

At least one problem with the focus on culture as an explanatory factor of health is that culture itself has multiple definitions and cannot be examined in isolation. As Lynam et al argue, “rather than being static and neutral, [culture] is continuously being negotiated and re-defined within different contexts” (Lynam *et al.*, 2007: 24). In addition, as Culley notes, the emphasis on culture as the problem “plays down or ignores the importance of power,

inequality and racism as embedded in structures or institutions – factors which fundamentally affect the health of minority ethnic groups and their access to good quality health care” (Culley, 1996: 566). This perspective guides us to examine cultural barriers within the contexts that problematize culture, noting that colonial traditions and racial hierarchies shape how we understand culture and its role in society. In addition, our attention is drawn to the fact that these cultural hierarchies also shape peoples’ experiences in the economic and policy realms. Strategies for addressing cultural access barriers will be greatly influenced by how culture is conceptualized by those working for change.

2.3.3 Political / Institutional Barriers

In Bowen’s access framework, the other significant set of barriers includes those related to equitable treatment. The discussion of cultural and linguistic barriers drew attention to some of the ways that health care services can be equal, i.e. everyone gets the same care, while being inequitable, such as in a situation where the patient does not have English language skills to effectively communicate with the health care provider. Barriers to equitable care include: communication difficulties that result in misdiagnosis / mistreatment; confidentiality and consent not ensured; refusal or discouragement of service use or different treatments for some groups linked to provider attitudes; and policies and programs that do not recognize particular needs of some groups (Bowen, 2001: 19).

2.4 The Zone of Interaction

Examining experiences and interpretations of respondents located differently in the system can provide more in-depth insight because of this multi-faceted approach (Smith,

2005; McCoy, 2006; DeVault and McCoy 2006). Engrebretson and Littleton stress the need for health practitioners to be aware of “their own beliefs and cultural heritage to avoid imposing them on others” (2001: 225). Nursing research has emphasized the need for practitioners to be conscious of their own biases.

Cultural safety in nursing education and practice in New Zealand developed out of a long-term effort to transform the nature of transactions between Maori and health service providers. The problem that created access barriers, according to Ramsden, was that “nurses in New Zealand...were confusing the cultures of the indigenous people with the culture of poverty into which the indigenous people have been driven” (Ramsden, 1993: 8). This led to a situation where Maori patients were feeling unsafe in their encounters with the health care system. This is not to say that the attitudes of services providers are intentionally discriminatory, but that the: “The health of people can be placed at risk by an unaware ...[health services] workforce operating from assumptions and stereotypical attitudes” (Ramsden, 1992: 21).

Wood and Schwass have identified a schema for recognizing culturally safe and risky practices, through remembering the three ‘R’s and three ‘D’s. Culturally risky practices are “any actions which diminish, demean or disempower the cultural identity and well being of an individual” while culturally safe practices are “actions which recognise, respect and nurture...unique cultural identity...and safely meet...needs, expectations and rights” (Wood and Schwass, 1993: 6-7). In this way, cultural safety is about recognizing and challenging the inequity of the distribution of power in the health care setting, and rectifying this through “setting up systems which enable the less powerful to genuinely monitor the attitudes and service of the powerful” (Ramsden, 1993: 10). The aim of culture safety as an approach in

training and practice within health care is to improve the quality of care; as Papps and Ramsden assert, “nurses cannot provide quality, patient focused care if they have unconscious negative attitudes towards patients who are different from them” (1996: 496).

The goal of cultural safety is therefore to help practitioners recognise the health consequences of oppression, thereby becoming “expert in understanding the poverty cycle and the various histories and socio-political conditions which establish and maintain it” (Ramsden, 1993: 8). Although cultural safety focuses on the patients’ experience, it draws our attention to the social contexts of patients, particularly focusing on the poverty of indigenous patients that is a direct result of colonialism, noting that this reality of institutionalised poverty needs to be taken into account in ensuring the delivery of quality health care services.

Although cultural safety acknowledges that the patients’ needs must be addressed, which may include the observation of cultural practices in health care delivery, the aim of cultural safety is different from cultural competency. According to the Health Council of Canada:

cultural competency is about creating a health care environment that is free of racism and stereotypes” whereas cultural safety is about the outcome, and is achieved when “people feel they can trust their health care providers as a result of these culturally competent efforts (Health Council of Canada, 2012: 5)

Cultural safety does not intend for practitioners to learn the culture of minority communities. Nor does it propose “to offer a solution that can be used in every situation, but rather to provide tools for health practitioners to form their judgments and determine their actions” (Doane and Varcoe, 2005: 290). This means creating an awareness of the power relations in society, and instituting practices that give the less powerful an opportunity to

have a voice in the way they access and receive services. The focus of safety emphasized that the negative attitudes and lack of consideration for the social contexts of peoples' lives created unsafe situations for indigenous patients.

As Nguyen notes in her discussion of the different approaches to culturally appropriate health care services:

Cultural safety explicitly acknowledges the experience of the recipient of care. Its focus is on the level of clinical care interaction, focusing on the individual patient (based on feelings of being safe in health care interactions) and the practitioner's personal attitude (implying that personal attitudinal changes will of itself positively alter the health care situation) (Nguyen, 2008: 991).

Research in Canada has demonstrated that when health services providers create a welcoming, non-discriminatory environment and make the effort to provide culturally appropriate information about the services available, people from immigrant communities are more likely to make use of them (Ahmad, Cameron *et al.*, 2005; Grewal, Bhagat *et al.*, 2008; Hislop, Teh *et al.*, 2004, 2007; Lai, 2004; Loiselle, Semenic *et al.*, 2005; Nimmon, 2007). Research with immigrants for example, noted that they would more likely use services if they were available in their native language (Ahmad, Shik *et al.*, 2004; Zanchetta and Poureslami, 2006), and if the services took into account religious practices, such as dietary and fasting practices and respecting women's concerns about privacy and modesty by ensuring obstetrical care from women service providers (Reitmanova and Gustafson, 2008). It has also been suggested that providing immigrants with a confidant who could help them navigate the health care system would improve health service use (Lai and Chau, 2007). Having community members involved in the planning, design and delivery of services was also seen as a strategy to improve service use (Hyman, Guruge *et al.*, 2002). These studies clearly

demonstrate that even small changes in the delivery of services can make a significant difference to patient experiences.

Post-colonial feminist researchers provide a unique approach that brings together an analysis of patient level experiences as they are shaped by societal processes that reinforce social hierarchies. Researchers in this tradition:

are now relying on intersectional analyses that begin with the assumption that one cannot understand the experiences of ‘women’ or ‘Blacks’, or ‘migrants’ or the ‘poor’ in isolation from all of the multiple social classifications or identities each individual carries, the privilege or disadvantage associated with these identities (Reimer-Kirkham *et al.* 2009: 155).

Authors writing from a post-colonial feminist perspective (Browne, 2007; Browne *et al.*, 2009; Browne and Smye, 2002; Ramsden, 1993; Anderson *et al.*, 2003; Lynam *et al.*, 2007; Reimer-Kirkham *et al.* 2009), emphasize the need for health practitioners to understand how the structures of capitalism, patriarchy and colonialism shape the health experiences of patients. Nurses need to therefore engage in discussions of institutional change that can mitigate these society-driven barriers. As Reimer-Kirkham and colleagues have asserted:

If our scholarship is to generate knowledge that addresses long-standing patterns of inclusion and exclusion along lines such as race, ethnicity, class, and gender, interpretive frames are needed that account for culture as embedded in fields of power relations, as mediated by social forces such as economics and politics and by historical patterns of oppression and colonization, and as being constantly renegotiated in the in between spaces (Reimer-Kirkham *et al.*, 2002: 225).

Post-colonial feminist perspectives have encouraged the examination of these complex social contexts, specifically focusing on how they shape patient experiences with health care services. Thus, in an examination of patient experiences using a cultural safety lens, a Canadian study noted that patients from a variety of ethnic backgrounds, including

from the dominant groups “experienced difficulty in getting access to the resources that would alleviate their suffering, but for different reasons. The social contexts of their lives are different. It is this context that must be examined, explored, and responded to” (Anderson *et al.*, 2003: 211). This approach highlights that socially marginalized people have access barriers that are embedded in social and historical contexts that need to be considered in the analysis of access. In this way post-colonial feminist research in health care discourses bridges the perspectives of both health services and political science research, bringing together the analysis of broader social factors and the ways they shape interaction between patients and care providers.

Although it is important for individual care providers to question their assumptions based on racialized stereotypes, “a focus on attitudes or assumptions of individual health-care providers overlooks the fact that attitudes and assumptions are deeply entrenched in dominant culture” (Browne, 2005: 81) and its institutions. If inequities in access and responsiveness of health care systems arise out of structural practices, then this suggests that in order to overcome entrenched discriminatory practices, institutional change needs to redress the denial of social and political rights.

In this study I will explore if and how respondents see that these changes in the spheres of influence shape experiences in health service access for immigrants. Lynam’s work demonstrated this relationship between the SOI and the ZOI, noting that the impact of health care reform has shown that “strategies for enhancing efficiencies have contributed to the creation of a situation in which practitioners’ abilities to respond to changing patient constraints of the practice setting are compromised” (Lynam *et al.*, 2003: 114-15). The streamlining of the health care workforce limits the ability of practitioners to be responsive to

particular patient needs:

room for negotiating “alternative models of care” is minimized within an institutional context of staff shortages and heavy workload. For patients from a non-Western, non-English speaking background, the way that their “culture” or perceived cultural needs are managed is inseparable from the interests of a health care system geared toward efficiency (Anderson *et al.*, 2007: 304).

The environment of economic efficiency may make it difficult for ‘cultural’/ social barriers to be addressed. Health care providers are faced with having to make difficult choices because the resources to address the needs of diverse populations are not there:

enacting the mandate of restraint has resulted in compromises that are problematic. The effect is that some groups – those who are most vulnerable, those least able to communicate their needs, those with fewest material resources to mobilize support on discharge, those who are historically without power – are at the greatest risk for not receiving the care necessary to keep them safe. Such conditions also lead to inequities in care (Lynam *et al.*, 2003: 137).

The increasing uncertainty of “economic crises” exacerbates these tensions, bringing to the fore new debates on the rights of newcomers and the responsibilities of the system to accommodate the needs of culturally diverse groups. “There is continued concern that as the restructuring associated with health reform initiatives in the era of fiscal restraint have been implemented, the capacity to ensure equitable access to care for all patients has been eroded” (Lynam *et al.*, 2003: 114). These quotes demonstrate the schism in Canada between the prominent rhetoric of the multicultural approach and the reality of service provision. Therefore, it will be important to focus on the points of disjuncture between the claims made in legal documents and the perception of respondents on what is happening within health care organizations that support or challenge the goals of inclusion for immigrants and ethnically diverse communities in Canada.

The methodological approaches within critical paradigms aim at social understanding and transformation, developing a participatory process to change policy and practices. Constructivist methodology is hermeneutic, whereby researchers elicit constructions to generate consensual language, aimed at creating understandings to inform improved practice (Lincoln, Lynham, and Guba, 2011: 105-6).

Such insights can help us understand some of the factors that lead to institutional change, by identifying the conditions that are present where there is change, and comparing these same conditions in institutions where the change we are examining does not occur. Understanding the broad conditions that shape our health care institutions is not sufficient for analysing barriers in access to care, nor how those barriers are overcome. Even in the context of similar societal conditions, some institutions are better able to respond to the needs of ethnically diverse communities than others.

The actions of individuals working to improve health care access can also have a decisive effect on the provision of health care for immigrants. Institutionally specific practices based on individual and/or team efforts can change the modes of interaction between patients and care providers, even in social contexts that continue to perpetuate inequalities. As the discussion of cultural safety emphasized, the efforts of health services providers to treat patients with respect can have a significant impact on service access.

My aim in undertaking this analysis of barriers to accessing health care is to bring together a multidisciplinary framework to guide the analysis of the puzzle that emerged from my empirical work, revealing a wide range of societal, institutional and individual level processes that influence access to health care for immigrants in Canada.

Cultural safety draws our attention to the experiences of individual patients within the health care system, yet as Bowen states, although the literature on access tends to focus on individual access barriers, it “can relate to client access (the degree to which individuals are able to secure needed services), and to organizational access (the extent to which consumers are represented and/or participate in the planning, development, delivery and administration of services)” (Bowen, 2001: 17). The research presented here will examine both elements, but specifically through examining how the engagement processes create a space for organizational access, whereby communities are provided opportunities to participate in decision-making processes in health care planning and delivery to improve individual access.

The examination of formal and informal engagement processes between health care service providers and immigrant associations allows for an exploration of potential sites for change in health service delivery. This engagement can create an environment that brings together their respective and complementary knowledge of the social contexts, institutional norms and experiences to inform strategies for improvements to health service access. Therefore, to guide the analysis of the community engagement processes examined in this research, I now turn to an exploration of the spectrum of community engagement strategies.

Chapter 3: Community Engagement as a Strategy to Improve Access

Critical theoretical perspectives draw attention to power relations that shape privilege and oppression. Constructivists see reality as “constructed intersubjectively through the meanings and understandings developed socially and experientially” (Lincoln, Lynham and Guba, 2011: 103). Both of these paradigms emphasize a focus on social processes; therefore the examination of engagement between health care institutions and communities is a logical methodological direction for inquiry. Examining social processes of engagement can provide valuable insight into the different ways multiple actors understand access barriers and how they negotiate the social contexts to address problems in service delivery.

Community engagement is often a strategy used by public institutions to bring together diverse voices in consultation with the health sector, although the purpose, processes and perceptions of engagement are varied. Current research into public participation has raised some of the complex issues around engagement and the role of community members in processes that shape strategies for change. The rationales for engaging communities and the challenges in creating inclusive decision-making processes affect the way engagement processes unfold. Political science and health services researchers have demonstrated that the design of engagement processes can shape the way that voices are brought into the discussion. Within these structured processes, actors are engaged in a struggle for power to inform and thus shape service delivery.

The disciplinary traditions brought together in this dissertation, namely political science, nursing and health services research, draw our attention to the complexity of conditions that shape community engagement and participation in health care. Engagement

with community members, as a process for increasing the responsiveness and accountability of the health care system, is a core concept of interest to research on public participation in both health services research and political science. Research on community engagement processes in health services emphasizes involving patients in decision making as a way to improve services by making them more responsive to their needs (Bowen, 2004; Church et al., 2002; Kreindler, 2009). Some political scientists emphasize engagement as a method to both improve accountability of public institutions and the decisions they make (Abelson et al., 2002; Contandriopoulos, 2004). In addition, participation of the public in decision making processes is seen as a strategy to develop a sense of ownership and responsibility among citizens thereby enhancing democracy (Abelson and Gauvin, 2006; Putnam et al., 1993; Tomblin, 2002). These authors conceptualize engagement as occurring along a spectrum, and propose various ways of bringing together multiple voices to identify problems and develop resolutions. In addition, each perspective offers different strategies on how these problems and resolutions are communicated to decision makers and service providers to inform service planning and delivery.

Although much of the literature on access in health care refers to individual patient access, Bowen emphasizes that an equally important concept is that of organizational access, which refers to “the extent to which consumers are represented and/or participate in the planning, development, delivery and administration of services” (Bowen, 2001: 17). Organizational access therefore encapsulates the concept of community engagement, although the forms of engagement and community participation cover a wide spectrum. Some examples include formal processes at the institutional level; ongoing community advocacy that addresses broad systemic access concerns; and informal engagement between

a service provider and community associations, individual patients and their families around specific issues of care (Ableson et al., 2002; Callaghan and Wistow, 2006; Kreindler, 2009; Milewa et al., 2002).

Research from the UK (Callaghan *et al.*, 2006) and more recent Canadian research (Abelson and Gauvin, 2006; Kriendler, 2009) demonstrate that the form and content of engagement can vary significantly, and engagement itself is no guarantee that people will have any impact on policy. Engagement between health service providers and planners with community members is seen as an important part of legitimizing the choices made in public institutions, but as these authors argue, sometimes the design of the process itself can limit its impact. Therefore it seems likely that the different formal and informal venues for interaction among ethnically diverse communities and the health care system will lead to different foci and methods of advancing the responsiveness of health care.

In a study on public input in health care decision making in Canada, Abelson *et al.* identified two categories of the goals of participation: firstly, instrumental goals that consider “participation as a means for achieving other ends, such as better-quality decisions; more informed, accountable or legitimate decisions; or perhaps to delay or share the blame for difficult decisions.” Secondly, developmental goals focus on “the production of a more educated, participatory and engaged citizenry and its associated benefits (e.g., creation of social capital, community capacity, social cohesion)” (Abelson *et al.*, 2002: 78). Kreindler expands on the analysis of participation from the purpose of engaging to the conception of the people who are engaged. In her examination of patient involvement in health services planning in Canadian health authorities, Kreindler argues that the way engagement and participation is conceived leads to different outcomes:

The *consumerist* perspective sees patients as customers who deserve to be satisfied...by service that responds to their individual needs and preferences. The *democratic* perspective sees patients as citizens who have a right to participate in shaping the services they receive (2009: 115).

Thus, participation “means different things to different groups or individuals...Approaches often reflect differing perspectives of health providers and community advocates on the meaning of citizen involvement in decision-making and control of resources” (Church *et al.*, 2002: 13).

Research from the UK demonstrates community engagement is portrayed as a positive part of the National Health Service, and also notes a variety of formats for participation (Milewa *et al.*, 2002: 583). There is a wide range of values placed on the participatory process, and as Callaghan argues: “To understand the potential for, and limits to, participation it is necessary to understand how it is defined by those in a position to enlist it” (Callaghan *et al.*, 2006: 588). Those who hold controlling power over central institutions are better placed to define the transformations of those institutions within their predetermined parameters. Therefore in analysing the impact of community engagement processes, it is important:

to recognize the significance of how participation is conceptualized because such definitions ‘are real in their consequences’... Both method and content of involvement are relevant because each has a separate impact on the scope and meaning of participation... the methods of consultation used give rise to different kinds of knowledge... These structures necessarily have an impact on the form of knowledge gained and, therefore, the role participation can play in the decisions made by health boards (Callaghan *et al.*, 2006: 597-98).

International research carried out by the World Health Organization examined the role of the state and civil society in addressing inequities in the social determinants of health,

concluding that engagement is an important approach to the design, implementation and evaluation of health care services:

People who are the intended beneficiaries of government policies and actions have a right to participate in their design, delivery, and assessment. Evidence shows that successful engagement of target communities in decisions about how to address social determinants of health will increase the likelihood of policies and actions being appropriate, acceptable, and effective and can have a direct effect on individual health by raising people's sense of control over their lives (Blas *et al.*, 2008: 1686).

In Canada, there is additional legislative imperative to enhance the participation of diverse communities into the design of public institutions. With the explicit recognition of group rights within Canada, "Multiculturalism instructs us to engage in a systematic exploration of the common institutions into which immigrants are pressured to integrate, to ensure that their rules and symbols do not disadvantage immigrant groups" (Kymlicka, 1998: 41). It is important to be clear that the *Multiculturalism Act* was not put in place in Canada until 1985. As legal historian Backhouse discusses in her analysis of the historical construction of racial categories in Canadian legal traditions:

Whites benefited from the hierarchical racial classifications that were delineated by Canadian legislators and judges, while people of colour were systematically denied access to full civic participation, social justice, economic opportunities and public services. Whiteness has always been an affirmative racial identity, from which extraordinary privilege, power and entitlement flow...the legal record unearths precious little trace of the utilization of Canadian law as a tool to enhance civic participation and social justice within the multiplicity of racialized communities (Backhouse, 2001: 21).

The construction of racial privilege and disadvantage shaped economic, social and political contexts in Canada. These racialized norms of white privilege also had an effect on the

development of Canadian health care systems, which still embody some of the legacies of colonialism.

In order to successfully ensure inclusion, critical theoretical perspectives in health care discourses argues that “generating knowledge rooted in the experiences and perspectives of what are often subjugated voices...is paramount for achieving accessible and equitable health care services” (Reimer-Kirkham *et al.*, 2002: 229). The tradition of post-colonialist feminism draws attention to the need to disrupt “the history of race-based thinking and racializing processes, and the concern with the structural inequities perpetuated by historical and current political, economic and social conditions” in the process of examining social justice in health care (Reimer-Kirkham *et al.*, 2009: 155). The post-colonial concept of cultural safety emphasizes that to ensure equitable services, there is a need to recognize and challenge the inequity of the historical distribution of power in the health care setting, and to rectify this through “setting up systems which enable the less powerful to genuinely monitor the attitudes and service of the powerful” (Ramsden, 1993: 10). Engagement with the communities that experience exclusion in the health care system is a logical way to facilitate this feedback on how to overcome those colonial legacies within public institutions. Banting and Kymlicka assert that multiculturalism policies encourage and enable communities:

to participate more quickly and more effectively in mainstream Canadian institutions, by facilitating the self-organisation of the community, by creating new cadres of community leaders who are familiar with Canadian institutions and practices, by creating new mechanisms of consultation and participation, and more generally by creating a more welcoming environment (2010: 62).

This dissertation will examine whether these multicultural policies have supported moving past these colonial legacies of racialization in Canada to ensure the full and equal

participation of ethnically diverse communities in the planning, design and delivery of health care services.

In Canada the increased participation of the population in health care has been seen as an important goal for decades. As Mhatre and Deber noted in their review of provincial health policy commissions in the late 1980s and early 1990s:

Involving individuals in the planning and management of the health system is one of the major principles advocated by all the reviews. The devolution of power through regional authorities is one of the principal avenues recommended to translate the participation principle into practice. Other routes include ensuring the membership of community members on planning committees and the education of consumers on how to use the system more effectively (1992: 658).

As this study demonstrated, community engagement has been cast in policy/legislation as a strategy to achieve the goal of instituting practices to give the less powerful a voice in the way they access and receive services.

Some health researchers in Canada have suggested that the purpose of engaging community members is to respond to criticisms about the lack of accountability. Church *et al.* have emphasized that the “interest in increased citizen participation reflects an attempt by government to respond to the increasing and widespread view that the major institutions of society are unresponsive and unaccountable to citizens” (Church *et al.*, 2002: 12).

Community participation is generally seen in a positive light, and enhances the credibility of public institutions. The adaptation of public institutions is an important part of “negotiating the terms of integration” in a multicultural society (Kymlicka, 1998: 39).

Abelson and Gauvin argue that assessments of engaging public participation in Canada are only beginning to emerge. They note that there should be a development of

common assessment tools to measure increasing responsiveness and accountability of public institutions through public participation:

More work is needed, however, to reach agreement about a common set of evaluation criteria, the defining features of public participation mechanisms and how to categorize and evaluate the crucial role of contextual variables in shaping and influencing public participation (Abelson and Gauvin, 2006: 39).

Kreindler has made a similar argument, stressing that analysis of public participation in health care:

ha[s] tended to concentrate on the *inputs* to the process (e.g., the number and diversity of patients likely to be involved, the resources required) rather than on the *outputs* (e.g., what actually happens when patients are involved in one way instead of another) (Kreindler, 2009: 114).

The particular role of engagement in the process of designing and delivering health care services is not easy to discern. As Abelson and Gauvin warn, “The ability to measure the institutional and societal impacts of the [public participation] process, which can take many years, and are difficult to disentangle from other influences on the policy process, may be limited” (Abelson and Gauvin, 2006: ii). The literature on engagement in health care, discussed below, emphasizes a continuum of distinct models of engagement (from individual patient participation in determining their own care path, to community involvement in decision-making around health care service delivery programs). The different models for engagement focus on different strategies for improving access. Some processes engage communities in more meaningful dialogue about how to improve access to care.

This research on engagement discussed above draws our attention to the fact that there are a variety of purposes for engagement. Below I discuss some of the literature around both models of engagement and power dynamics in those engagement processes in order to

illustrate that the forms adopted not only reflect these various purposes, but can also determine the focus of discussion and the type of input that the community brings. In examining engagement processes it is therefore essential to analyse the relationship between the structures and focus of participation, and how the results are brought back into the decision making process.

3.1 Models of Engagement

The structures of engagement shape the way that the “voice” of ethnically diverse communities is brought to the health care planning table, and can influence whether that process is inclusive and leads to increased responsiveness and accountability to the communities served. In this way, the examination of engagement processes is an appropriate focus for critical theory, as it is the process built into the health care system that structures the struggle for power over the shape of health services between ethnically diverse communities and health system decision-makers. Different structures and agendas of the engagement process can determine which issues are open for discussion. The processes of engagement are not without challenges:

An optimistic view of well-functioning democratic societies assumes that citizens desire and expect to interact with governing authorities in decision making about public policy and that decision-makers support this role as a necessary and important part of these processes. A more realistic view, however, understands that citizens often need to be convinced of the relevance and utility of getting involved, and decision-makers must be willing to give up some control over the process (Abelson *et al.*, 2002: 71).

Since engagement brings differing perspectives together, these processes provide an opportunity to understand diverse perspectives and reach new shared understandings.

Therefore, examining engagement processes is also a valuable methodology in constructivist

theory, as it allows for the examination of a constructed meaning of access emerging from an interactive process.

The literature identifies a range of engagement strategies used by health care organizations to gain information that can help diminish the barriers to health services for immigrant communities. These cover a wide spectrum of formal engagement through institutionalized processes to address broad community concerns to processes of informal engagement around specific issues of patient care. Kriendler notes that engagement strategies on the consumerist side of the continuum often involve patient satisfaction surveys administered individually, while democratic approaches emphasize community (collective) participation in decision-making. Additionally there are many intermediate strategies such as interviews, focus groups and patient participation in committees (Kriendler, 2009: 116). At the same time, informal engagement between care providers and patients has been recognized as a crucial element of health care provision. Engagement with individual patients and their families is an important aspect of the nursing process, and nursing research has demonstrated that “health promotion, disease prevention, and management of chronic conditions rely on engagement and active participation in the therapeutic process” (Engebretson and Littleton, 2001: 223).

These perspectives clearly demonstrate that not all processes of community engagement enhance the role of communities in the decision-making processes. Therefore in examining engagement, it is necessary to look at the structures and explicit purposes of the process from a variety of perspectives. This discussion reminds us that people involved in the same process may have very different perspectives on the purpose of engagement and the expected outcomes, and as such, it is necessary to examine these various perspectives in the

analysis of current processes of engagement with ethnically diverse communities in health care.

Just as not all processes are equal, not all participants in the dialogue have equal power. Some groups may face even more challenges when engaging with the health care system than others. Below I present some of the debate around power in public participation and the challenges in creating inclusive processes of participation that allow for various purposes to be explored.

3.2 Power in the Engagement Process

Critical theoretical perspectives instruct researchers to examine social structures and power and control within those. Engagement processes provide insight into the ways that power is articulated and exercised between communities and institutions that engage them. Engagement processes that are open-ended and not rule bound can have significantly different outcomes than ones that design in advance the “consultation” that takes place in a narrowly defined agenda of collecting opinions. According to political philosopher James Tully, participatory processes need to allow for “the freedom of speaking and acting differently in the course of the game and so modifying the rules or even transforming the game itself” (Tully, 1999: 164). Although engagement could be an opportunity for genuine input into the decision making process, Canadian and UK research has demonstrated that many community engagement processes are not designed to provide decision-making power to community groups. Callaghan’s study of community engagement in the UK showed that participation processes:

place emphasis on minimizing external interference rather than embracing the contribution the public can make. It involves an implicit view that participation should be sought only on those issues considered appropriate by the boards. It would suggest, at best, a minimal shift in the behaviour of the boards, based on an increasing confidence in the limited impact such involvement will have (Callaghan *et al.*, 2006: 590).

Political science research on community engagement in health care decision making has shown: “Participants cite generally positive experiences with their involvement in some consulting roles although they are becoming increasingly impatient when they perceive themselves to be a rubber stamp for decisions that are already taken” (Abelson and Eyles, 2002: 14). When the agenda and the possible choices are already set by the decision makers in the system, involvement does not necessarily enhance the role of community members in setting priorities and goals in the system. Also, the hegemonic position of those with decision-making authority is not likely to be up for negotiation. Therefore it is important to examine how the opportunities for participation are framed, and the ways that community voices are brought from the engagement forum into the decision making processes that shape health service delivery.

Agenda setting by those who are designing the engagement process can limit the type of knowledge and issues that are seen as valid for the discussion. Therefore it is important to keep in mind that “public participation takes place in a specific organisational and social context from which it cannot be extracted” (Contandriopoulos, 2004: 322). Genuine participation requires a context in which people feel free to say what they have to say without fear of reprisal or ridicule. As Tully explains in his exploration of Hannah Arendt’s theories of political freedom:

freedom is associated with new players and new ways of playing coming into being, so political activity is never closed by a frontier. It is never

‘rule-governed’ in the normative or causal sense required by theory or explanation. Indeed, if it were so rule-governed, then, by definition, it would be unfree, an ‘automatic process’ in the realm of labour or work, not action (Tully, 1999: 164).

There is also a concern that participation in the decision making processes is a method to assist with and provide legitimacy for significant funding cuts:

In a fiscal environment where the federal government continues to curtail its financial contributions to the provinces for cost-shared health insurance programs...the provinces, in turn, are responding by moving to decentralize difficult resource allocation decisions to the local level, while concentrating their energies on formulating global system objectives and management principles and facilitating and mobilizing local planning and management initiatives (Charles and DeMaio, 1993: 884).

Often resource constraints can provide a basis for not implementing a solution to the concerns brought up by communities. As political scientist Contandriopolis has noted in his study on community participation in health care decision making in Quebec, political motivation guides debates in which the scarcity of resources and suffering are used to shape discussion: “They are objective contextual factors that can be brought into the political arena by political agents and used as resources in political struggles” (Contandriopoulos, 2004: 328). This has led to a degree of scepticism regarding processes of community input. As Stephen Tomblin has argued:

ideological disagreements between the equity-centred health promotion perspective and the more market-centred new public management model have contributed to public confusion over the real objectives of a more community-based approach (Tomblin, 2002:12).

Although the stated aims for community participation have emerged from laudable goals of empowering community members in the decision making process, some suggest that there has been a shift to more instrumental approaches of gaining ‘buy in’ from the

community for decisions. As Abelson and colleagues conclude on the shifting nature of consultation in health care:

Portrayed strategically as a method to garner support for community decisions, public consultation has recently become a process of “selling ideas” and achieving consensus around a final decision using a variety of methods for achieving this objective. District health council and RHSSB [Regional Health and Social Services Boards] consultations have been heavily influenced by the language of “customers,” “marketing” and “value for money” (associated with “new public management” and its emphasis on the application of private-sector management principles to public-sector activities) and little by that of “community” and “capacity-building” except insofar as these pertain to achieving a desired outcome (Abelson *et al.*, 2002: 91-92).

Social science approaches emphasize that ideas and interests are not operating in a vacuum, and that “Taking the social context more fully into consideration allows us to go beyond the pluralist interest group perspective...by helping us understand why some interest groups ‘get their way’ more than do others” (Poland *et al.*, 1998: 793). As demonstrated in a study on public participation in health decision making in Quebec, “the most efficient actors were those able to strategically use existing power relations to their advantage” (Contandriopoulos, 2004: 324). Technocrats, for example, are structurally privileged as they hold controlling power over knowledge and technical expertise, which are portrayed as necessarily non-political, despite the political consequences of their advice.

Advocacy of community groups has raised the profile of the barriers to services that need to be addressed and, therefore, they have also played a role in setting the agenda for change. Health care decision makers have become increasingly aware of the role of community associations, both as advocates for community members and interests, and for their ability to mobilize community members. Community associations and advocates act as mediators between the health care system and ethno-cultural communities, through both

formal and informal engagement processes. Community associations have played a key role in knowledge translation, i.e. in bringing community perspectives to the health care system, and increasing knowledge about health care services in the community, including brokering the mechanisms of social inclusion on behalf of health care organizations. Engagement can therefore result in proposals based on new knowledge created through that process of interaction.

Participants in engagement processes may have varied perspectives on the meaning and purpose of these engagement processes. For example, people working in the health care system may believe that giving the community an opportunity to provide feedback on existing policy and programs and to review recommendations for new programs is a valuable way to bring the community voice to the table and to increase the democratic character of public institutions. This study aims to offer insight on how engagement processes between communities and the health care system are shaping changes to improve accessibility of services for immigrant and ethnically diverse communities in Canada.

The discussion of engagement instructs us to look at the multiple ways that communities and the health care system interact in the process of improving the responsiveness of the health care system in meeting community needs. These have all drawn attention to the fact that there are multiple purposes at play in engaging communities in health care decision-making, and that when examining participation it is necessary for us to keep in mind issues such as the purpose for engagement, structures that shape the focus of engagement, agenda-setting that lays out the topics for discussion, and the outcomes of what happens with the community input.

Chapter 4: Methods

The study presented here was part of a larger international project examining immigrant access to health care services, using a qualitative comparative analysis based on comparing two urban centres, and comparing perspectives among people placed inside and outside of the health care system who were regularly involved in efforts to improve immigrant access to health services. The specific methods for collecting the data followed common procedures to allow for comparative analysis.

4.1 Case Selection

As the previous chapter has identified, there are many different types of access barriers to health services for immigrants. The comparative method used here considers the possibility of “complex patterns of causation” (Mahoney, 2007: 136), emphasizing that since “several different combinations of factors may each be causally sufficient, the method further allows for multiple paths to the same outcome” (Mahoney, 2007: 135). Comparative analysis highlights these dynamic contextual differences that historical institutionalists note as important variables for understanding change, such as health care governance, policy contexts and institutional forms, as well as the actions of individuals in these particular contexts.

The case study is not a “methodological choice, but a choice of object to be studied...Ultimately, the researcher is interested in a process, or a population of cases” (Denzin and Lincoln, 2011: 247). Each country study within the international research focused on two urban centres, chosen because they present key differences within the

national setting. Vancouver and Montreal were the cases selected in Canada. These cities have common federal policy guidelines and a shared experience of recent regionalization. Some significant differences include the models for community engagement and the governance of health care (in Quebec, health and social services are in the same ministry). Historical institutionalism is a methodological strategy for addressing the similarities and differences in structural factors that can be relevant factors in shaping institutional norms and practices. Emphasizing “clear-cut differences between or among cases” (Skocpol and Somers, 1980: 179), for example highlighting the differences in structures between the cases, makes these structural differences relevant explanatory factors in the outcome of interest. This study thereby recognizes that each “case is a complex entity operating within a number of contexts” (Stake, 1994: 239). It was envisioned that emphasizing common experiences across structurally different cases, for example regionalization (France *et al.*, 2005; Tomblin, 2002; Abelson and Gauvin, 2006), could also provide insight into how that common experience shapes immigrant access and community engagement in health care.

4.2 Sampling and Recruitment of Respondents

In the examination of how access barriers are addressed in the health care system, the research carried out for this thesis was designed to include interviews with people who were positioned in different ways in relation to the health care system, about their everyday experiences of working to improve health care access for immigrants. As we were interested in understanding strategies for engagement between the formal health services sector and community groups working to improve access for immigrant populations, we targeted organizations rather than patients themselves. Key informants in this study, therefore, are

people who are regularly engaged in efforts to improve access for immigrants and ethnically diverse communities. The interviewees included the directors of multicultural and trans-cultural health and translation services at health authorities and hospitals, managers and staff of community engagement departments, members of immigrant associations that deal with health issues for their clients, and service providers working with immigrant communities.

Purposive sampling, where informants are selected based on predefined criteria, is appropriate to ensure that a variety of perspectives are included in the analysis. This purposive sampling approach is common in constructivist and critical theoretical perspectives, as:

they seek out groups, settings, and individuals where (and for whom) the processes being studied are most likely to occur. At the same time, a process of constant comparison between groups, concepts and observations is necessary (Denzin and Lincoln, 2011: 245).

Purposive sampling recognizes that the stratified social relations within the particular context shape how people make sense of that context, and that not only are differing perspectives valid, but they are also essential if one is to develop an adequate understanding of what is taking place within the institutions examined. Institutional ethnography takes the view that “where one stands determines what one experiences, shaping to an important extent what can be known” (Campbell, 2006: 94). It is expected that these differently positioned individuals should have different perspectives on what the problems are, how they are being addressed, and what needs to happen to improve immigrant experiences with health care. In the interviews, respondents were asked to reflect upon where they see problems, and what types of solutions they implement or recommend. These individual experiences, when analysed in

relation to policy documents, provide insight into how policy norms may or may not be taken up in practice.

The people interviewed in Montreal and Vancouver included program managers who worked at either the local or regional levels and were responsible for developing and implementing programs aimed at addressing the specific health needs of immigrant, refugee and ethnic minority communities. I also spoke with service providers within the health care system and supportive community associations (immigrant settlement services) who are working in programs / health centres that provide services specifically for immigrants and refugees in both institutional and community care settings. I also interviewed representatives from pro-immigrant associations with an interest in health services provision. While the organizational structures were not equivalent (some mandates were at the local health authority or hospital level, while others were at the level of the ministries of health), I interviewed people who had the same or a very similar role in terms of service planning / management of services for and engagement with ethnically diverse communities, to ensure we had a comparative sample across the two locations.

After identifying who to interview, I developed a single page letter outlining the purpose of the research, what information we were interested in, and some information about the research project and team (see Appendix A). I also outlined the expected interview length, and a timeframe within which we would carry out the research. If people were interested in participating, they were provided with more material about the study, as well as a copy of the interview questions (Appendix B) in advance of our meeting.

In total, 29 people were interviewed; thirteen people in Montreal, and sixteen people in Vancouver; eleven were program managers; ten were representatives of immigrant

associations, and eight were service providers. Many of the program managers were also service providers, but their responses drew upon their role as program managers, so were classified as such.

Table 4.1 Research Informants

Type of Respondent	Total Numbers
Representatives of Immigrant Associations	10
Service Providers	8
Program Managers	11

Smith guides the qualitative researcher to seek multiple perspectives in order to gain a more complete understanding of the complex processes going on within institutions, not for the purpose of finding agreement among different informants but for the intersections and complementarities of their different accounts in the relations that coordinate their work (Smith, 2005: 63). The people interviewed were not intended to be a representative sample of all people involved in improving access to health care for immigrants in Canada. The aim of recruitment was to have a sample of people involved in efforts to improve health care access for immigrants, who would likely have different perspectives, based on their relationship to health services for ethnically diverse communities.

In assessing the adequacy of one's sample in qualitative research the emphasis is placed on the depth and detail of data gathered and the richness of the analysis that it yields. As Kearney has asserted: "qualitative findings teach the reader something about how context, history, and individuality constitute meaning and explicate human action in a closely observed, highly specific unique situation" (Kearney, 2001: 146). Instead, people's experiences and knowledge are brought together to provide insight into "the ways the

institutional order creates the conditions of individual experience” (McCoy, 2006 109). The data from the interviews is explored as to how it provides insight into a variety of institutional processes that shape the work of people trying to improve immigrant access to health services.

4.3 Data Gathering Strategies

Data gathering included three key aspects: 1) the review of population statistics; 2) the review of legislation and advocacy relevant to health care and the rights of diverse populations; and 3) interviews with key informants. Qualitative research guides suggest “that the logic behind purposeful selection of informants is that the sample should be *information rich*” (Morse, 1994: 229). Due to the richness of their experience, my informant selection strategy focused on exploring the perspectives and strategies of people who are regularly involved in processes aimed at changing policy and practice norms to respond to the needs of ethnically diverse communities.

4.3.1 Document Review

Given that the legislative context of multiculturalism leads to the expectation that health care in Canada is responsive to the needs of ethnically diverse communities, this research began with the review of legislative documents at the federal and provincial levels to identify the language that makes a commitment to inclusion, equality and responsiveness to diversity (presented in Chapter 2). This review identified a variety of supportive policies for accommodating ethnically diverse populations in the health care system.

As Dorothy Smith reminds us that: “Higher-order texts regulate and standardize texts that enter directly into the organization of work in multiple local settings” (D. Smith, 2006: 79). What is important about common guiding texts “is that they are read, seen, heard, watched, and so on in particular local and observable settings...[linking] an individual’s consciousness into relations that are translocal” (D. Smith, 2006: 66). These texts are meant to organize people’s work at the institutional level around a set of commonly recognized principles. Informants were asked if there were legal frameworks that informed their work to improve access, to see if the common policies were indeed “integral to the action and coordination of diverse work across settings and in time” (Turner, 2006: 159).

In both Montreal and Vancouver many community associations and service providers are members of umbrella organizations that bring together a wide variety of newcomer and ethnically diverse communities and service associations. These organizations are called ACCESSS (Alliance des Communautés Culturelles pour l’Égalité dans la Santé et les Services Sociaux) in Quebec and AMSSA (Affiliation of Multicultural Societies and Service Agencies) in British Columbia, and both provide extensive documentation on their website about their advocacy activities and engagement with the health care system in working to improve immigrants’ access to health care services. Their prominence as large associations comprised of a number of community groups, and the high profile they have in raising the debate around the needs of ethno-cultural communities (in health care and many other sectors) made them a logical choice to examine their documentation more closely, as a conglomeration of the perspectives of multicultural advocacy groups in each city.

4.3.2 Interviews

Dr. Saime Ozcurumez (the co-researcher in the Canadian team and a post-doctoral fellow at McGill) and I carried out 23 of the interviews between January and June 2006, and two of the Vancouver interviews were held in February 2008 (one an in-depth follow up at a site of care and another with an influential service provider / program manager who was recommended to us later in the process). The majority of the interviews were in English, and 5 were undertaken in French. Although Ozcurumez has strong French language skills our research assistant Ms Fournier-Tombs (a fully bilingual native Quebec French speaker) also participated in the 5 French interviews. The respondents were asked to choose the meeting location of their preference. Most of our respondents chose to meet with us in their own offices or a departmental meeting room, and one interview was held in a coffee shop close by as office space was not available. Despite busy schedules, people were very interested in meeting to talk about their work in promoting immigrant access to health services. After informed consent was obtained (see Appendix C), each interview session began by asking respondents if there were any other questions that they wanted to ask before we started. We also asked each respondent for permission to tape record the discussion, to ensure we had a full record for our analysis. All the interviews were electronically recorded and then transcribed, and for ease of comparison those in French were translated into English by Ms Fournier-Tombs, and reviewed by Dr. Ozcurumez.

The research team used a common interview tool to cover a variety of information that covered the access barriers, legislation, and strategies for change, including exploring types of programs and community engagement processes (discussed below). The in-depth interviews were carried out as free-flowing, open-ended discussions, where the dialogue is

not scripted, allowing for accounts that are not “wholly constrained” (Smith, 2004: 165) by our framing. Taking this flexible approach to the interview guide allowed respondents to elaborate on any aspect that they felt important to tell us, to explicate their own meanings on the issues, and to be put more at ease through having a discussion rather than a formal question and answer period. This approach allowed the research to follow the train of thought of the respondents, appropriate for qualitative research, where “A key element is the receptiveness of the researcher to contextual cues and the ability to interpret and respond to these cues to guide the study forward” (Appleton, 1997: 8). Following the interviews, the interviewers spent time debriefing, specifically for the purpose of cataloguing the common themes that were emerging, and noting the similarities and differences in how respondents addressed the issues.

The interviews aimed at exploring health care system organizational practices in response to the needs of an ethnically diverse clientele, and our informants’ opinions about the current situation for immigrant and ethnic minorities, and the aspects of their organization and work environment that either facilitated or challenged the improvement of health care services for immigrants and/or ethnically diverse communities. The questions asked in the interviews were directed towards our three common research questions: what are the barriers to access, what are the innovative strategies that people (within and outside of health care) undertake to overcome these barriers; and what type of engagement takes place between communities and health care organizations. We developed a common set of interview questions to use in the three countries, focused on the following lines of inquiry:

- The perception of immigrants’ health care access, and the current programs to facilitate access;

- Concepts for the accommodation of immigrants' health care needs (i.e. multiculturalism vs universalism / equity vs equality);
- Legal Regulations to enhance access;
- The role of immigrant associations in articulating health care needs;
- Immigrant involvement in decision-making processes, and relationships between civil society and health care institutions;
- Specific strategies for enhancing access and culturally appropriate services;
- Successes and failures in immigrants' health care provision (see Appendix B).

We also asked people to provide information about the organization that they worked in, how they were specifically positioned in the organization, and how they worked with others on issues of health care and diversity. We were able to triangulate our results through interviewing participants from different places in the health care system. Each participant provided a unique perspective on, and experiences with, specific programs and/or practices. Through many of our initial interviews we noted a lot of new information and perspectives, but in later interviews this earlier data was being reconfirmed. Qualitative researchers note that this is a way to determine if the research has been thorough:

Adequacy is attained when sufficient data have been collected that saturation occurs and variation is both accounted for and understood... In qualitative research, the investigator samples until repetition from multiple sources is obtained. This provides concurring and confirming data, and ensures saturation (Morse 1994: 230).

After hearing the same themes many times from various respondents, the interviewers (Dr. Ozcurumez and I) decided we had saturation; through our interviews we had reached a point of “intersubjective agreement and reasoning among actors” (Lincoln, Lynham and Guba, 2011: 108). The variety of data sources, the many opportunities for feedback on the results through conference presentations and workshops with our research participants and other experts, and the comparability of our findings with the existing Canadian data on the

experience of immigrants with health care services, provided additional validity of our results.

The relationships between the researchers and participants in this study follow ethical principles and guidelines, whereby participants' privacy and confidentiality is protected, and no one is coerced to participate. Interviewees were provided with letters about the study in advance (see Appendix C). The Behavioural Research Ethics Board of the University of British Columbia and the Human Research Ethics Board of the University of Victoria both provided approval for this study (see preface for ethics approval information).

4.4 Analysis

The research team consisted of anthropologists, sociologists, political scientists, and health services researchers, with myself as the author of this study coming from a political science and health services research background. Thus it was important to focus on a transdisciplinary analytical framework that could work for the different research styles and analytical modes represented by the team. There are advantages to bringing together a variety of disciplines to inform the analysis, as “the social organization of everyday life is complex, so are the methods of analysis that can adequately address its complexity” (Campbell and Gregor, 2002: 113).

The interviewers on the Canadian team (Wylie and Ozcurumez) met regularly to discuss field notes and themes emerging from the interviews. We began an initial analysis by identifying common themes from the experiences of informants about the most influential factors in preventing or facilitating innovative practices for improving access and engagement. It also facilitated the analysis to compare and contrast the similarities and

differences between the two local contexts and to project “beyond the local to discover the social organization that governs the local setting” (Smith, 2005: 41) across a variety of contexts.

4.4.1 Coding

In the summer of 2007 we began developing the coding schema (see Appendix E) for use in all three countries. The purpose of the coding was to sort the data in a way that would be manageable to work with and for drawing comparisons, within and across the cases. I met with the team again in person in Germany in November 2007 to review the analytical framework, the final coding list, and to discuss the details of the coding process, and ensure consistency across our interpretation of the codes. Codes were not mutually exclusive, since some statements could be coded as both a strategy and participation. Transcripts from all three countries were coded with the same schema using ATLAS.ti. A test file with text selections from each country was shared in order to assess the congruence of the coding across the cases. In addition to the codes, respondents were grouped into three types: immigrant associations, programme managers (responsible for program planning and development) and service providers (that deliver health care services). This would allow us to produce outputs that linked the quotes with the respondent’s position in relation to the health care system, i.e. differences between service providers and immigrant associations on access barriers.

We developed descriptive codes to answer our main research questions on access, engagement / participation, and strategies for improving care for ethnically diverse communities, with multiple codes for each of these three themes. There are for example,

multiple codes under participation based on the type of engagement people are involved in (through immigrant associations, advisory committees, informal engagement with care providers), and for the different types of strategies for improving access (such as developing culturally competent practice guidelines or hiring multilingual staff).

I carried out the coding of the Canadian data set together with a research assistant. We discussed meanings and compared results to see quotes coded adequately reflected these meanings. The coding of the transcribed interviews is maintained in an ATLAS.ti file, and data reports for each code by type of respondent and by city are grouped in more accessible sub-files. I produced output documents of all the quotes for each grouping of codes (access, engagement/participation, strategies) by respondent type (immigrant association, service provider, program manager). The location of the quote in the original transcript was noted, so they can be reviewed for accuracy and representativeness, as well as to allow for ease of review for the context of the quote.

I then read through these documents to develop the analysis of the emerging themes from the interview data, to see if they were representative of the social, economic and political spheres of influence that critical and constructivist theoretical perspectives would anticipate. Under ‘access’ quotations I identified common themes emerging, which were then grouped into broad categories. This categorization allowed me to group common issues into sub-themes, while maintaining the link between the quotes and type of respondent and city. “It is the context-specific actions and interrelationships that influence people’s interpretations and which give the data meaning” (Appleton and King, 2002: 644). Therefore, the context in which each participant was working was kept linked to the responses described in the interviews. I then systematically reviewed all of the coded quotes from the transcripts for

each theme (access, engagement, strategies), to identify similarities and differences in perspectives based on the different standpoints of respondent's relationship with the health care system and the city where they are located, with each data file categorized by type of respondent, and each respondent designated with a city-specific code.

4.4.2 Analytical Framing

The theoretical paradigms and disciplinary traditions that informed the conceptualization of access discussed in Chapter 2 have guided this study to focus on the relationship between broad social, political and economic factors that shape access. In this way, “the analytic goal is to make visible the ways the institutional order creates the conditions of individual experience” (McCoy, 2006: 109). The examination of public documents as well as key informant interviews provided the data upon which to begin the analysis, which involves “moving back and forth between collected speech and the context that produced it” (DeVault and McCoy, 2006: 40). The data evoked questions such as why did people feel their actions were constrained? What institutional processes shaped their actions? How did contextual differences alter the strategies of respondents? How are the actions of these respondents connected to each other? Reflecting on the various work and strategies of respondents is not about “individual motivation but about the institutional context in which such strategies make sense” (McCoy, 2006: 115). What are the common challenges and supports that they identify? How do these diverse experiences shed light on the institutional interface in which these experiences take place? Do these themes align with the categories of social, economic and political barriers? Are there access barriers that are outside of these categories? Examining institutional contexts, such as political and economic

restructuring, “may bring into view the specific aspects of institutional changes that are being planned and are taking place and their consequences for people’s work and institutional outcomes” (Turner, 2006: 159-60).

The analysis provides insight into:

a ‘section’ of the social world from the standpoint of the organization of the work of those who in various ways are involved in its production. This kind of ethnography takes as its problematic the complex of relations in which this local world is embedded. In this sense, the ethnographic enterprise is not confined to what can be directly observed, or to what informants have directly observed. Rather, it seeks to reveal the extended bureaucratic, professional, legislative, and economic, as well as other social relations involved in the production of local events and activities” (G. Smith *et al.*, 2006: 172).

The analytical approach used here, which brings together critical theoretical perspectives in political economy and health care discourses, has guided a process of gaining unique insight into a number of concomitant interacting factors that shape access barriers and the processes of engagement to address those barriers. To develop the analysis of engagement further, this dissertation will present a comparison of different forms of engagement as well as perspectives from people in different positions in that process (i.e. community advocates and health care staff responsible for community liaison).

The combined qualitative approaches from health services, political economy and nursing contribute to a comprehensive framework through which to examine the relationship between structure and agency as it has played out in the experiences of individuals engaged in the processes of change in health care specifically to meet the needs of ethnically diverse communities. The theoretical and methodological perspectives presented in this dissertation draw attention to a variety of factors that shape access and engagement processes.

4.5 Credibility and Limitations

To discuss the initial interpretation and analysis of the research results with our key informants and to share experiences, we held two workshops in which we presented our early findings (these were summarized in a poster, drawing attention to the key strategies and challenges for improving immigrant access to health services – see Appendix D). The first, in July 2006, was held in Vancouver, bringing together study participants from Vancouver and Montreal, as well as people we had not interviewed, but who could offer additional insight into the issues raised. In June 2007, the second workshop was held in Montreal, in French and English with simultaneous translation. The workshops were used as an opportunity to get feedback and assessment of our analysis, as well as for participants to present other aspects of their work. This format allowed people to learn from each other’s experiences, discuss common strategies, and maintain ongoing engagement with the research.

Discussion of our tentative interpretation of results during the workshops demonstrated that our analysis was relevant to understanding the situations that workshop participants collectively faced in their own work. As suggested by ethnographic methods, “validity depends on the ‘interpretive communities,’ or the audiences—who may be other than researchers and academics—and the goals of the research” (Altheide and Johnson, 1994: 488). In constructivist theory validity is a “construct of the development of consensus” (Lincoln, Lynham, and Guba, 2011: 114); therefore it seemed that our analysis had validity. Sharing preliminary results is a way to validate the analysis, as seen in qualitative approaches: “If the results matched other groups’ experiences then the study findings become meaningful” (Appleton, 1997: 10). The similarity of the results between the two cities in Canada confirmed that our results had implications relevant for a variety of contexts, and

therefore potential transferability across contexts. The measure of validity from critical paradigms is based when the research can create action for positive social change (Lincoln, Lynham and Guba 2011: 114). This will be explored in the recommendations discussed in the concluding section of the dissertation.

This study drew on the experiences of a small, comparative sample of respondents, including health service providers, health program managers and community advocates who function as a bridge between individual patients and the health care system. Although this study is based on a relatively small sample, I am confident that the information collected provided new insights into the question of what conditions create challenges or opportunities for addressing the barriers in access to health care that immigrants face. The data from these interviews was used to provide the basis for extending the access frameworks introduced in Chapter 2 to include an additional level of analysis of policy and governance. The results presented here are therefore not a comprehensive picture of immigrants and ethnically diverse groups' experiences in health care.

The research also does not fully explore the differences between various immigrant categories and characteristics that lead to a variety of experiences. Rather, this dissertation presented a combined critical and constructivist paradigm that guided the exploration of how to conceptualize access barriers in a socially-embedded model of analysis. There are certainly a much wider variety of issues that can populate the model to further extend its analysis of barriers in access to care for immigrants.

The following chapters present the data and explicate the differences between participants and the contexts within which they operate, as well as the variety of perspectives

on the nature of barriers and what needs to be done to improve immigrant and ethnically diverse communities' access to health care services.

Chapter 5: Background and Legislative Context

This chapter presents the background context of immigration and legislation that supports equal rights and inclusion, presenting a more detailed backdrop to what creates these expectations. I first provide a brief overview of Canadian immigration trends through examining census data, looking at changes over time. I then review of a selection of federal and provincial legislation as it relates to health and individual and collective rights in Canada, specifically looking at those aimed at Canada's ethnically diverse populations (i.e. the multiculturalism acts, human rights acts). I also examine how these documents portray the government's responsibilities for ensuring those rights are respected in the delivery of public services. I then discuss some of the tensions in the debates on multiculturalism and immigrant rights in Canada. Following this I provide a brief overview of health care governance in Quebec and BC, noting specific guidelines for meeting the needs of ethnically diverse communities. Generally, the legislation provides a strong moral case for the basic right of inclusion, which research has demonstrated is linked to better health (Wilkinson, 2005, 2006; Nazroo, 2003).

5.1 Immigration Trends

Immigration in Canada has historically been fraught with tension. In the early periods of the settlement of Canada the aim of immigration policy was one of "agricultural colonization;" and after the Second World War the emphasis was on the needs of fulfilling labour demand in manufacturing and construction (Hiebert, 2000: 26). Immigration policy debates were characterized by the ongoing tension between the "conflicting interests of

preserving the ‘whiteness’ of the nation while simultaneously ensuring an adequate supply of labour” (Thobani, 2000: 35). The policy of “controlled migration was intended to enlarge the population and stimulate production and demand without sacrificing cultural homogeneity or the status of the domestic working class” (Walsh, 2008: 794); this was, of course, impossible. However, restrictive immigration practices did have a significant influence on the early post-war ethnic makeup of Canada, as seen in Table 5.1 on the origins of the Canadian population, from Canadian census data in 1961.

Table 5.1 Nationality of Origin of Immigrants to Canada 1961

Nationality of Origin	Population Numbers
British	7,996,669
English	4,195,175
Irish	1,753,351
Scottish	1,902,302
Other	145,841
Other European Countries	9,657,195
French	5,540,346
German	1,049,599
Ukrainian	473,337
Italian	450,351
Dutch	429,679
Scandinavian	386,534
Polish	323,517
Asiatic	121,753
Chinese	58,197
Japanese	29,157
Other	34,399

(Source: Census of Canada, 1961)

The immigration policy changes in the 1960s and the reorientation to business class immigrants in the 1980s led to a significant change in Canadian immigration. The majority of immigrants coming to Canada after 1985 are from what was once considered “non-

traditional” sources, with Asia (Hong Kong and China in particular) as the most predominant. Table 5.2, based on Statistics Canada data from the 2006 census, shows the changing origin of immigrants in Canada. This significant change in the ethnic make-up of Canada has led to new issues in addressing the needs of these communities. Given that health care institutions were established in a period of greater cultural homogeneity, addressing issues of diversity were not seen as explicitly required with regard to their original objectives or design.

Table 5.2 Top Countries of Origin of Immigrants to Canada, by Total Numbers and Percentage of All Immigrants, Grouped by Year of Immigration

Country of Origin	Total	before 1991	1991 - 1995	1996 - 2000	2001 - 2006
United Kingdom	579,620	515,135	20,630	18,200	25,655
	9.40%	15.10%	2.50%	2.20%	2.30%
China	466,940	133,910	69,635	108,285	155,105
	7.50%	3.90%	8.50%	12.80%	14.00%
India	443,690	156,830	67,825	89,890	129,140
	7.20%	4.60%	8.20%	10.60%	11.60%
Philippines	303,195	107,765	65,485	52,060	77,880
	4.90%	3.20%	7.90%	6.20%	7.00%
Italy	296,850	289,820	2,540	2,225	2,270
	4.80%	8.50%	0.30%	0.30%	0.20%
USA	250,535	168,840	18,770	24,155	38,770
	4.00%	5.00%	2.30%	2.90%	3.50%
Hong Kong	215,430	107,925	66,570	33,505	7,430
	3.50%	3.20%	8.10%	4.00%	0.70%

(Source: Statistics Canada, 2007b)

The most frequent destinations for settlement have traditionally been the cities of Toronto, Montreal and Vancouver, although there are growing numbers of immigrants moving into other areas. In 2000, over 70 per cent of Canadian immigrants lived in greater Toronto, Montreal, or Vancouver, and as a result “the ethnocultural composition of these

centres is changing rapidly” (Hiebert, 2000: 26). Table 5.3 shows the 2006 census figures for these gateway cities.

Table 5.3 Immigrants as Proportion of Total Population in Canada’s Top Three Cities

Place	Total Population	Immigrant Population	Immigrants as % of Total
Canada	31,241,030	6,186,950	19.8%
Vancouver	2,097,965	831,265	39.6%
Montreal	3,588,520	740,355	20.6%
Toronto	5,072,075	2,320,160	45.7%

(Source: Statistics Canada, 2007b). (Note that these figures are for Census Metropolitan Areas – concentration of immigrants in the urban centres is higher).

This trend of immigrating to the largest cities in Canada is changing, with more immigrants moving to smaller centres. At the same time, the extended history of immigration in Vancouver and Montreal make these centres ‘ideal’ cases for examining processes of fostering access to health care services for immigrants, and identifying issues that are going to be of increasing relevance to other areas of Canada that are newly experiencing growing diversity of their populations. Focusing on urban centres also acknowledges the reality of established immigrant communities and their role in advocacy and support. In addition, each of these cities also has its own unique composition of immigrants, with Vancouver attracting more business immigrants and the highest numbers of immigrants from Asia (China and India specifically), and Montreal attracting the most francophones (Hiebert, 2000: 27). These high concentrations of ethnic groupings also tend to reinforce a continuity of these immigration patterns, as “immigrant location choices are path-dependent and heavily influenced by pioneering co-ethnics” as “migration relies on a social network that often is linked within ethnic or nationality groups” (Haan, 2008: 754). The result has been two-fold: ethnic communities tend to be concentrated in particular areas (Kobayashi and Peake, 1997), and these concentrated communities maintain stronger ties to their traditional languages and

cultural practices. As an example of this cultural continuity, Table 5.4 shows the number of people living in Montreal and Vancouver who speak a language other than English or French at home, and demonstrates the differences in ethnno-cultural make-up between the two cities.

Table 5.4 Languages Other than French or English Spoken at Home

Top Languages	Vancouver:		Montreal			
		2006	2011		2006	2011
1	Chinese languages:	257,610	252,350	Spanish:	44,670	74,755
2	Punjabi:	87,150	103,895	Italian:	42,610	38,855
3	Korean:	35,925	34,850	Chinese languages:	40,430	48,550
4	Tagalog (Philipino):	22,365	26,830	Arabic:	40,165	66,910
5	Persian (Farsi):	19,260	23,895	Vietnamese:	15,545	19,555
6	Vietnamese:	15,880	14,925	Romanian:	13,630	21,380
7	Spanish:	14,255	17,105	Greek:	13,615	19,750
8	Hindi:	11,185	11,690	Creoles:	13,490	19,000
Total of All Non-Official Languages:		547,660 (70,630 of these are of the non-immigrant population)	579,840		346,065 (62,500 of these are of the non-immigrant population)	469,410

(Source: Statistics Canada, 2007c; Statistics Canada, 2012)

These differences in ethnicity and language groups of immigrants between the cases allowed for an exploration of whether these variations were connected with differences in health care access or strategies to foster access. There are significant numbers of immigrants as well as non-immigrants speaking languages other than French or English in the home. With hundreds of thousands of people speaking languages other than French or English in both Vancouver and Montreal, it is clear that there is a high need for translation services in these urban areas.

5.2 Legislative Guarantees of Rights and Responsibilities

Rights of immigrants and ethnocultural groups are protected under legislation at both federal and provincial levels. The Canadian Charter of Rights and Freedoms of 1982 includes provisions against discrimination and promotes programs of affirmative action.

(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability (Government of Canada, 1982: Part 1, Section 15, subsection 1 and 2).

These policy changes were a result of a shift in discourse towards the formal recognition of human and civil rights generally, as well as a response to the growing ethnic diversity of Canada following the new immigration agenda of the 1960s. In his introduction of the multicultural experiment, Canadian Prime Minister Trudeau had four explicit aims:

to support the cultural development of ethnocultural groups; to help members of ethnocultural groups overcome barriers to full participation in Canadian society; to promote creative encounters and interchange among all ethnocultural groups; and to assist new Canadians in acquiring at least one of Canada's official languages (Kymlicka, 1998: 15).

The multicultural approach with protection for ethnic minorities is now enshrined in legislation, starting in 1971 with the *Multiculturalism Policy* later consolidated in the *Multiculturalism Act* of 1988. Section 3 of the *Canadian Multiculturalism Act* states that it is Canadian policy to:

(a) recognize and promote the understanding that multiculturalism reflects the cultural and racial diversity of Canadian society and acknowledges the

freedom of all members of Canadian society to preserve, enhance and share their cultural heritage;

(b) recognize and promote the understanding that multiculturalism is a fundamental characteristic of the Canadian heritage and identity and that it provides an invaluable resource in the shaping of Canada's future;

(c) promote the full and equitable participation of individuals and communities of all origins in the continuing evolution and shaping of all aspects of Canadian society and assist them in the elimination of any barrier to that participation;

(d) recognize the existence of communities whose members share a common origin and their historic contribution to Canadian society, and enhance their development;

(e) ensure that all individuals receive equal treatment and equal protection under the law, while respecting and valuing their diversity;

(f) encourage and assist the social, cultural, economic and political institutions of Canada to be both respectful and inclusive of Canada's multicultural character;

(g) promote the understanding and creativity that arise from the interaction between individuals and communities of different origins;

(h) foster the recognition and appreciation of the diverse cultures of Canadian society and promote the reflection and the evolving expressions of those cultures;

(i) preserve and enhance the use of languages other than English and French, while strengthening the status and use of the official languages of Canada; and

(j) advance multiculturalism throughout Canada in harmony with the national commitment to the official languages of Canada (Government of Canada, 1988: Section 3, Subsection 1).

The *Multiculturalism Act* also charges federal institutions to provide equal opportunities for hiring, develop multicultural programs, collect statistical data, and be responsive to the multicultural reality of the country, in order to "affirm the value and dignity

of all Canadian citizens regardless of their racial or ethnic origins, their language, or their religious affiliation” (Government of Canada, 1988: Section 3, Subsection 2).

In British Columbia there are comparable examples of how the goals of federal multicultural legislation are taken up at the provincial level. The *BC Human Rights Code* includes a provision that states no one can deny or discriminate against a person in accessing public services “because of the race, colour, ancestry, place of origin, religion” of that person. The *BC Multiculturalism Act* of 1996 promotes concepts of social inclusion, including building a society free of racism and discrimination. The *BC Multiculturalism Act* of 1996 states that it is the policy of the government of BC to:

- (a) recognize and promote the understanding that multiculturalism reflects the racial and cultural diversity of British Columbians,
- (b) promote cross cultural understanding and respect and attitudes and perceptions that lead to harmony among British Columbians of every race, cultural heritage, religion, ethnicity, ancestry and place of origin,
- (c) promote the full and free participation of all individuals in the society of British Columbia,
- (d) foster the ability of each British Columbian, regardless of race, cultural heritage, religion, ethnicity, ancestry or place of origin, to share in the economic, social, cultural and political life of British Columbia in a manner that is consistent with the rights and responsibilities of that individual as a member of the society of British Columbia,
- (e) reaffirm that violence, hatred and discrimination on the basis of race, cultural heritage, religion, ethnicity, ancestry or place of origin have no place in the society of British Columbia,
- (f) work towards building a society in British Columbia free from all forms of racism and from conflict and discrimination based on race, cultural heritage, religion, ethnicity, ancestry and place of origin,
- (g) recognize the inherent right of each British Columbian, regardless of race, cultural heritage, religion, ethnicity, ancestry or place of origin, to be treated with dignity, and

(h) generally, carry on government services and programs in a manner that is sensitive and responsive to the multicultural reality of British Columbia (British Columbia, 1996a: Section 3).

The *BC Human Rights Code* of 1996 is also a tool that can be used to protect the rights of ethnic minority communities. Specifically with reference to service provision, the *BC Human Rights Code* states that:

A person must not, without a bona fide and reasonable justification, a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or b) discriminate against a person or class of persons with respect to any accommodation, service or facility customarily available to the public, because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex or sexual orientation of that person or class of persons (British Columbia, 1996b: Section 8, Subsection 1).

Multiculturalism has never been a popular way of framing the rights of ethnically diverse groups in Quebec, as it has been seen as a tool of the federal government “as a means to weaken Quebec and reduce it to the position of a cultural group” rather than as a nation (Juteau, 1992: 331). In addition, Quebec nationalists saw the use of languages other than French as threatening to their linguistic heritage (although there are guaranteed services for English speaking Quebecers). Despite these tensions, the *Quebec Charter of Human Rights and Freedoms* supports the rights of ethnic minority people. The *Quebec Charter* states that:

Every person has a right to full and equal recognition and exercise of his human rights and freedoms, without distinction, exclusion or preference based on race, colour, sex, pregnancy, sexual orientation, civil status, age except as provided by law, religion, political convictions, language, ethnic or national origin, social condition, a handicap or the use of any means to palliate a handicap. Discrimination exists where such a distinction, exclusion or preference has the effect of nullifying or impairing such right (Quebec, 1975: Section 10).

Increasing ethnic diversity in Canada has highlighted the challenges in delivering health care services to all people that reflect these legislative contexts. These policies demonstrate legal support for removing all barriers to full participation and ending discrimination, but they have not guaranteed funding to support such efforts. Examples of how the health care system has taken up this legislation through identifying and responding to issues that impede equal access will be discussed below. First I will provide an overview of the structure and governance of health care in Canada, noting the specific differences between Quebec and British Columbia.

5.3 Tensions Between Human Rights and Multiculturalism

The *Canadian Charter of Rights and Freedoms* (Government of Canada, 1982), enshrined the protection of individual rights against discrimination, and the *Multiculturalism Act* (Government of Canada, 1988) provide a supportive legislative context for the recognition of individual and collective rights of ethnic and other minorities in Canada. There has been a long-standing debate, however, on multiculturalism and how it frames the status and role of immigrant communities in Canada. The debate in Canada regarding the impact of multiculturalism remains divided, in line with the debates of equality versus equity. On the one hand, some argue that the recognition of group rights undermines individual equality based on universal rights. There are those who argue that the “special rights” granted to ethno-cultural groups are divisive, in that they undermine equality and incentives to integrate into Canadian society. In addition, those who argue against multiculturalism advance the perspective that “multiculturalism is divisive because it politicizes ethnicity by getting the federal government involved in what should be a private matter; that is, the preservation of

minority cultures and personal ethnic identities” (Patten, 1999: 36). This perspective is still reflected in the current debates in Canada, where multiculturalism is blamed for blinding us to ethnic divides (Gregg, 2006), or as in the ‘reasonable accommodation’ debate in Quebec, it is seen as an excessive accommodation to immigrants (Quebec, 2008).

Although the Charter strengthens individual rights, Canadian constitutionalist expert and political philosopher James Tully notes that it “is shaped by western, individualist and male cultural biases respectively” (1994: 94). He further recognizes that “one prominent feature of modern constitutionalism is a uniform and centralized legal and political system which recognizes each citizen as equal (in the sense of being treated identically rather than equitably)” (Tully, 1994: 81). In contrast, his argument supports multiculturalism, which protects minority rights and advances goals of equity (i.e. procedural fairness), as the way to ensure equality in diverse societies. Kymlicka explicitly argues that: “immigrant groups integrate more quickly and more effectively today than they did before the adoption of the multiculturalism policy, and they do so more successfully in Canada than in any country that does not have such a policy” (Kymlicka, 1998: 8). Recent debates on multiculturalism have demonstrated that despite this continued controversy and the concerns about growing ethnic tensions in Canada:

the Canadian record on integration is relatively strong. The economic integration of recent immigrants is taking longer; some racial minority immigrants and their children feel less confident that they fully belong; and there important gaps in the representative face of Canadian democracy. In comparison with other western nations, however, the integrative power of Canadian society for newcomers should not be under-estimated...In comparison with the citizens of many other countries, Canadians are relatively supportive of immigration and comfortable with the place of immigrants within society. (Banting and Kymlicka, 2010: 56-57).

The different perspectives on multiculturalism and what it should mean in practice can have a significant impact on the experiences that immigrants have in the health care system. The divide between equal rights for all individuals and equity for members of specific groups is not simply a philosophical debate. For those who believe in the principles of equality, the measurement of access to health care services would be based on whether all groups, regardless of language or ethnicity, have the same access to the same services. Others who take the principles of equity to guide their service provision note that sometimes there are additional needs to be addressed in order to ensure reasonable equality of services (and hopefully health outcomes). For example, providing equal care to a patient who does not speak one of Canada's official languages requires that interpretation or translation services are available. Therefore, the principles of equity recognize that some patients have greater needs that must be taken into account to ensure that the health care services provided are appropriate and effectively equal.

However, as Braveman and Gruskin (2003) have suggested, there are no clear measures of equity:

Equality can be assessed with respect to specified measurable outcomes, whereas judging whether a process is equitable or not is more open to interpretation. Furthermore, in practical terms, it is generally those who are in positions of power who are likely to be determining at a societal level what is equitable and what is not, with respect to the allocation of resources necessary for health (255).

They suggest that the concept of health equity is open to wide interpretation, not only in its specific conceptualization, but also in analysing equitable access to both health care services and to the resources necessary for health – i.e. the social determinants of health. Despite this ambiguity, there are likely to be some measures that can help identify inequitable situations.

According to Bowen, “Equity in health refers to the fair and just distribution of resources...the measure of health care equity is not that everyone receives the same service, or the same number of services, but that service [to everyone] is based on need” (Bowen, 2001: 17).

There will be different perspectives on how this need should be determined, and as is suggested in the quote above by Braveman and Gruskin, those in power determine what is fair. This implies that those in greater need must be centrally involved in the discussion of those needs and how they can be addressed in order to balance the power of elites. In this sense, it is important to note that equity is specifically related to issues of social justice: “Equity in health is an ethical value, inherently normative, grounded in the ethical principle of distributive justice and consonant with human rights principles” (Braveman and Gruskin, 2003: 256). Echoing the need for a social justice and human rights approach to health care access, McGibbon explains that:

inequities in access are intimately related to the social determinants of health...Barriers related to inequities in health service access are linked to inequities in health outcomes and the systematic, policy based obstacles that sustain them (McGibbon 2009: 318).

Equity in health services therefore is not about providing equal services to all, but ensuring that health systems planning and design address the specific concerns of populations that face discrimination and socially marginalization (Gilson *et al.*, 2007).

Therefore there are significant differences in the debate on how to deal with cultural diversity, and this has become a growing issue in Canada for the past few decades. Canada is seen as being a welcoming nation that provides extensive social supports to new arrivals. The importance of immigration is generally acknowledged, and researchers have noted for some

time that “we take in our stride a level of immigration that in most countries would provoke xenophobic nationalism” (Kymlicka, 1998: 3). Despite this strong legislative and policy framework, polling data for some time has shown that Canadian support for this policy stance is equivocal. A study from 1992 noted that Canadians: “are supportive of multiculturalism, yet they express serious reservations about new, visible ethnic groups coming into Canada and maintaining a cultural identity” (Frideres, 1992: 65). Moreover, recent Canadian perspectives suggests that although Canadians have a positive view towards immigration, they feel that immigrants’ adaptation to dominant social norms is the best approach:

Canadians are as likely as citizens in other democracies to want immigrants to adapt and blend into society rather than to maintain distinct traditions. But they are much less likely to believe that immigrants increase crime rates, and are much more likely to believe that immigrants are generally good for the economy (Banting and Kymlicka, 2010: 58)

Although the concept of multiculturalism is intended to recognize that Canada has a wealth of cultures and ethnic groups that make up the nation, some argue that rather than instilling respect for cultural diversity, multiculturalism in Canada is framed by the notion of a tolerance of difference. “It implies positions of superiority and inferiority in implicitly assuming that some attributes and behaviours associated with minority groups need to be accepted, condoned, or sanctioned” (Henry and Tator, 2000: 337), rather than acknowledged for the contribution made to enriching Canada’s social and cultural life. Interestingly, this is in spite of the specific provisions of the *Multiculturalism Act* cited above that clearly acknowledges (and indeed promotes) enrichment and diversity.

Kymlicka also argues that: “ethnocultural relations are inevitably accompanied by various strains and tensions...that we can only hope to ‘manage’, not to solve” (1998: 3).

Rather than seeing multiculturalism as divisive or threatening, Tully suggests that it is the inadequacy of the policy response that has caused problems:

Canada's crisis suggests that the recognition and affirmation of the culturally diverse identities of modern citizens does not lead to disunity and disintegration of modern nation states. Quite the opposite. The steady glacial movement towards disunity and separation in Canada is caused by the failure mutually to recognize and accommodate the aspirations of Quebec and the First Nations along with the just demands of the other cultural groups. This is a complex political task but it is neither hopelessly complex nor a threat to liberal democratic constitutionalism. It is possible by forms of political reasoning and norms of equity available in our constitutional traditions and it is required by, rather than a threat to, the liberal and democratic conventions of constitutionalism (Tully, 1994: 95).

This discussion draws our attention to the fact that there are different interpretations of the rights that immigrant groups are entitled to in Canada, as well as how the principles of multiculturalism shape public institutions. In order to understand health care access for immigrant populations in this socio-political context, I will examine how different actors interpret and apply the principles of multiculturalism and equal rights, and how these principles have guided the approaches of health service providers and immigrant associations in pursuing improvements in access to health services. In addition, I will examine if and how institutions and health practitioners have taken up these legislative and moral codes in the delivery of health care services.

5.4 Health Services Governance and Delivery

Health care in Canada is federally legislated, based on principles of universality, accessibility, portability, comprehensiveness and public administration. Health services are publicly funded through federal payments and tax transfers to the provinces and territories, each of which is primarily responsible for its own systems of service delivery. In this sense,

the Canadian health care system is in reality 13 provincial and territorial systems. The health care system in Canada was established through the Hospital Insurance and Diagnostic Services Act in 1957, providing access to hospital and some diagnostic services. This was followed by the Medical Care Insurance Act (better known as Medicare) in 1966, which added free access to “medically necessary” services, which were determined by the provinces. By 1972 all of the provinces and territories participated through enactment of their own legislation, thereby providing publically insured health services to all Canadians.

The delivery of health services is under the jurisdiction of the provinces and the territories, while the Federal government establishes guidelines and monitors the provincial delivery of care to ensure they comply with the funding criteria. The federal government oversees health services such as public health and health protection programs, health research, as well as services for the armed forces, veterans and Aboriginal peoples (although the latter is changing through new self-governance arrangements for some Aboriginal groups).

Concern over extra-billing that started with the reduction in funding during the recessions of the early 1970s and 1980’s led the federal government to establish a new set of guidelines for the provision of care in the *Canada Health Act* (established in 1984). The *Canada Health Act* put forward five principles for the delivery of health care:

- (a) public administration;
- (b) comprehensiveness;
- (c) universality;
- (d) portability; and
- (e) accessibility.

8. (1) In order to satisfy the criterion respecting public administration, (a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;...

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province (a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;...

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons...(Government of Canada, 1985: S. 8-12).

These principles form the basis of claims for equity and are meant to guide provincial health care delivery. These legislative contexts should create a favourable climate for immigrants to access health services as well as to advocate for services designed to meet the specific needs of ethnically diverse communities in Canada. However, research in Canada on immigrants' access to health care services has noted that barriers remain, with gaps in legislation and multiple interpretations of what these policies mean for the delivery of health services. One of the noted gaps is that in the *Canada Health Act* (CHA), the section on accessibility focuses exclusively on financial access barriers: there is no mandate to address other types of access barriers, such as language, culture beliefs and location of services. In

addition, the CHA defines medical services as those delivered by physicians and hospitals, which has narrowed the definition of health services. This definition has shaped health service delivery in Canada since. As Bowen has demonstrated:

It has reinforced the position of acute care and institutional services at the expense of community and preventive services, and defined care by who provides it, and where it takes place, rather than whether care is needed (Bowen 2001: 13).

There have also been strained relationships between the provinces and the federal government regarding the financing of provincially controlled health care services. In the mid to late 1990s transfer payments from the federal government to the provinces were cut, and grouped into the Health and Social Transfer, which covered health care, post-secondary education and social assistance. In his analysis of these changes to health care financing, Ostry argued that it led to decreased accountability and transparency for how health care dollars were spent, and reduced the federal government's authority in dictating terms to the provinces and territories (Ostry, 2006: 71). Provinces had more flexibility to divide up fewer social spending dollars, and would be solely responsible for rising costs. Therefore different models for delivering health services have emerged that emphasized cost-control measures. These policy changes predated my data collection by a decade, although many of the respondents of the study noted that it set into motion a different management framework that still shapes decision making in health care. These new operating principles were seen as creating a difficult context in which to advocate for more resources for initiatives to improve the responsiveness of the system for immigrants and ethnically diverse communities.

I will now turn to a discussion of the different models of health care systems in Quebec and British Columbia.

5.4.1 Health Care Services and Diversity in Quebec

The health-care system in Quebec is unique among Canadian provinces, in that health and social services have been integrated within a single ministry since 1971, the Ministère de la Santé et des Services Sociaux (MSSS / Ministry of Health and Social Services). Recent reforms in Quebec restructured the health and social services network into 18 regional agencies. Each regional authority is responsible for the organization and delivery of services in their area. The mandate of the Ministry of Health and Social Services (MSSS) is legislated in the Act Respecting Health and Social Services. The law explicitly states a number of assurances for ethnocultural communities, as the following selections demonstrate:

1. The health services and social services plan established by this Act aims to maintain and improve the physical, mental and social capacity of persons to act in their community and to carry out the roles they intend to assume in a manner which is acceptable to themselves and to the groups to which they belong...

(7) attaining comparable standards of health and welfare in the various strata of the population and in the various regions...

2. In order to permit these objectives to be achieved, this Act establishes an organizational structure of human, material and financial resources designed

(1) to ensure the participation of individuals and groups of individuals in the selection of orientations and in the setting up, improvement, development and management of services;

(2) to foster the participation, in the various sectors of activity of the community, of all intervening parties whose action may have an influence on health and welfare;

(3) to apportion responsibilities among public bodies, community organizations and other parties working in the field of health and social services;

(4) to ensure that services are accessible on a continuous basis to respond to the physical, mental and social needs of individuals, families and groups;

(5) to take account of the distinctive geographical, linguistic, sociocultural, ethnocultural and socioeconomic characteristics of each region;

(6) to foster, to the extent allowed by the resources, access to health services and social services through adapted means of communication for persons with functional limitations;

(7) to foster, to the extent allowed by the resources, access to health services and social services in their own languages for members of the various cultural communities of Québec;

(8) to foster effective and efficient provision of health services and social services and respect for the rights of the users of such services;

(8.1) to ensure users the safe provision of health services and social services;

(9) to ensure participation of human resources of institutions referred to in Title I of Part II in the selection of orientations and the determination of priorities;

(10) to promote research and education so as to respond more adequately to the needs of the population (Quebec, 2010: Sections 1 and 2).

In addition to the guarantees outlined above, Bill 83 led to the establishment of the Committee for the Dispensation of Health and Social Services to persons of Ethnocultural Communities. As stated in the act “The Minister may establish a committee to advise the Minister on the provision of health services and social services to persons from ethnocultural communities...The Minister shall determine the composition and rules of operation of the committee” (Quebec, 2010: Section 433.1). This committee provides advice and recommendations on policy as well as works to identify priority issues for Quebec’s many ethnocultural communities.

In a report on health status of its population in 2006, the government of Quebec explicitly states that poverty and social exclusion have a significant impact on health, and need to be addressed, noting that health and social services are founded upon principles of

social justice and equity (Quebec, 2006). Similarly, a Quebec Public Health report clearly states that “social solidarity allows us to take into account the specific needs of groups or individuals who have more problems or risk factors,” identifying ethnic minorities as communities that are vulnerable and calling for a balance between universal measures and selective measures targeting vulnerable groups (Quebec, 2003: 20-21).

The Montreal Agence (one of the 18 regional health authorities) is responsible for delivering health services on the Island of Montreal. The population served is approximately 1.9 million people, about 25% of the population of Quebec. The population in this area is ethnically diverse, with a large proportion speaking languages other than French or English. The Montreal Agence also states that the accessibility of health and social services for ethnocultural communities is an integral part of their work, aiming to break down communication barriers and support intercultural training of managers and workers (Sante Montreal, 2004).

5.4.2 Health Care Services and Diversity in British Columbia

The Health Care System in British Columbia was restructured in 2001, following the national trend of regionalization seen throughout Canada. The BC health system was divided into six Health Authorities (one with a provincial and 5 with regional mandates) under the jurisdiction of the provincial Ministry of Health. The provincial government signs accountability contracts with the Regional Health Authorities on the services that they are to provide and the financial resources that they will have to provide them. The service contracts between the Ministry of Health and Vancouver Health Authority states that: “The Health Authority will...provide services that meet the priority health needs of the population of the

health authority within its available budget” (British Columbia, 2005: 2). There is no specific provision in the contracts of health authorities regarding services for ethnocultural communities, such as a guaranteed right to interpreters in health care, although the *BC Multiculturalism Act*, discussed in detail above, clearly makes reference to the need to make public services sensitive and responsive to the multicultural reality of BC.

The Provincial Health Services Authority offers a variety of interpretation, translation, and training services to help health organizations across BC provide better services to ethnic and linguistically diverse populations. Regional Health Authorities (RHAs) are responsible for the delivery of care within regional boundaries, from hospitals to community based health services and public health and health promotion activities. Vancouver Coastal Health (VCH) is responsible for the city of Vancouver and coastal communities across a relatively small geographic area with a high population density. VCH serves just over 1 million people, 25% of the population of British Columbia, including the city of Vancouver, which is one of the most ethnically diverse cities in Canada.

The Vancouver Coastal Health Authority has a variety of multicultural service programs including outreach, health promotion, maternity care, and provides translation services on site at the Vancouver General Hospital. Many patient information materials are available in multiple languages. The Bridge Clinic was established in 1994 and provides services to any newly arrived refugees or refugee claimants. As the Bridge brochure notes, “the name ‘Bridge’ conveys the clinic’s mandate to provide a bridge or temporary transition to medical services in the Vancouver area” (VCH, n. d.: 2). In addition, Vancouver Coastal Health has a department dedicated to community engagement (discussed in chapter 8). Their documentation states that:

VCH recognizes that community engagement is part of good decision-making processes. With such diverse communities in the region, having a formalized approach for gathering feedback from the public is vital to our organization... VCH staff actively consult clients, patients, residents and other community stakeholders to improve decisions and ensure that the system is responsive to their concerns (VCH, 2005: 1).

The documentation from the Vancouver Coastal Health Authority makes it clear that engagement is a key strategy for making their health care services responsive to the needs of the diverse communities in their service area. Their approach to engagement is formalized to ensure patient and community perspectives are brought to the table, although as was discussed before, the nature of engagement covers a spectrum of approaches which do not necessarily provide communities with influence at the health services planning table.

5.5 Summary

The discussion above demonstrates that there is what appears to be a favourable political climate around immigrants' rights such as policies that promote participation in public services, while ensuring the support for cultural diversity. The information presented in this chapter also shows that Canada has a universal health care system that guarantees access to health care services, as well as the infrastructure to support immigrants, including funding for settlement services and community associations. The documentation of health ministries and health authorities state that it is their responsibility to provide services that meet the specific needs of immigrants, refugees and diverse ethno-cultural communities within their service areas. Such documents can organize people's work around common principles, but local contexts and individual interpretations differentiate how those texts are activated in practice (Smith, 2005, 2006; Turner, 2006). These legislative contexts create the climate for supporting integration of immigrants into publically available services, but this

does not necessarily translate into equitable care based on specific needs. For example, the federal legislation does not state that interpreter services are medically necessary, and thus they are not an obligation under the *Canada Health Act* or the *Multiculturalism Act*.

Therefore, even though language and cultural barriers create communication problems that undermine both access and quality of care (Bowen, 2004), these are not part of the package of insured services that need to be covered under the public health insurance plans.

In addition, in some provinces newcomers are formally denied access to the same level of care while they are being ‘processed’ as new immigrants or refugees, according to a study that compared access to health services for newcomers across Canada (Gagnon, 2002). Research in Canada on immigrant health has shown that the lower socioeconomic position and social exclusion that many immigrants face in Canada are linked to lower health status (Ali, McDermott and Gravel, 2004; Asanin and Wilson, 2008; Beiser, 2005; Beiser and Stewart, 2005; Dunn and Dyck, 2000; McDonald and Kennedy, 2004; Newbold, 2005; Newbold and Danforth, 2003; Whitley, Kirmayer *et al.*, 2006). Many immigrants face health care access barriers due to socio-cultural and economic conditions, as well as provider attitudes (Asanin and Wilson, 2008; Whitley, Kirmayer *et al.*, 2006), although these experiences are by no means identical or unchanging. It has been noted, for example, that immigrant women face greater access barriers, as do more recent immigrants, those with limited social supports and immigrants who have a stronger identification with the health beliefs of their own culture (Lai and Chau, 2007; Smith, Matheson *et al.*, 2007). Therefore, it is clear that there is no uniform immigrant experience in accessing health care in Canada.

Chapter 6: Barriers to Access

Despite these goals of inclusion represented in various legislative documents in Canada, the literature on immigrant access to health care still demonstrates that immigrants face a variety of barriers. Chapter 5 outlined highlights from the federal and provincial legislation that should provide a supportive framework for improving immigrants' access to health care services. Despite this myriad of policy and program initiatives, research in Canada (discussed in chapter 2) shows that immigrants still face barriers in accessing health care services. This chapter explores the conceptualization of access barriers by taking up the first research question: How do health service providers, immigrant associations and policy documents frame health care access barriers for immigrants? What competing conceptions shape their understanding of access? Through an iterative process of reflecting on the data from this study and reviewing research on social inequities in health and health care, I grouped together key themes that emerged from the interview data. The analysis presented here is based on the interview transcripts, illustrated by respondents' statements about immigrants' access to health care services. Therefore, it is not necessarily a comprehensive portrayal of access, but instead presents the interpretation of access barriers from people positioned differently in relation to the health care system.

The paradigms of critical and constructivist theories emphasize the focus on social, economic and political contexts, as well as the relationships between actors when examining social processes. The disciplines brought together here examine how these contexts impact health and health care in different ways. From the health services research field, Bowen identified financial, non-financial; and barriers to equitable treatment that occur at both

institutional and individual levels. The discussion in chapter 2 also showed that research in political economy and post-colonial feminist health discourses identifies similar barriers, drawing our attention to both systemic problems in the social, political and economic realms, as well as interpersonal relationships that shape experiences immigrants have in the health care system (Armstrong *et al.*, 2001; Browne, 2005; Browne *et al.*, 2009; Evans, 2003; Labonte, 2003; Leys, 2009; Lynam 2005). Therefore, this chapter presents the interview data regarding health care access across these three broad categories that are recognized across the three disciplinary traditions, political science, nursing and health services research. The following chapter will explore the social relations as experienced through engagement between health care institutions and community associations.

A comparative approach to understanding access barriers is a useful method as the variations between Montreal and Vancouver can help us learn about what conditions influence access across immigrant groups, different sectors of the health care system and different locations. The discussion in Chapter 5 provided an overview of the different structures for health governance in Quebec and British Columbia, as well as population differences between immigrant communities in Montreal and Vancouver. At the same time, there are common trends in health care restructuring in both locations. Historical institutionalism draws our attention to how these systemic differences and similarities may shape experiences. The methodological tools of institutional ethnography inform us that the standpoint of respondents, i.e. their different relationships and levels of power within the health care system, are likely to lead to varying perspectives on the nature of the problem, and therefore a different characterization of access barriers. The purpose of this chapter is to

analyse the data from the interviews about the nature of access barriers to health care faced by immigrants in Canada.

The consensus among respondents in this research study – immigrant associations, program managers and service providers alike – was that, despite favourable legislation and an array of programs to address access barriers, immigrants in Canada experience unequal access to health services, although the situation is nuanced, with many factors shaping the extent of access barriers experienced. When asked if immigrants had equal access to health care services, respondents did not provide a yes or no answer, but instead talked about the various dimensions of access, and emphasized significant differences between people, ethnic groups, types of services, location, etcetera.

In analysing the data on access barriers it was valuable to identify comments that provided specific examples of where the health services provided a similar quality of care for all patients, as well as examples of care that demonstrated inequalities across ethnic and linguistic groups. Interview transcripts were then coded for any statements that expressed unequal or inequitable access to care for immigrants as code 1 (access is not equal), and for comments where the respondents expressed examples of services where immigrants were seen to have equal access to the rest of the population (code 2). Although this coding is based on a dichotomous categorization of equal or unequal care, for consistency of comparison across all cases in the international study, the primary purpose of this was to note how respondents conceptualize access barriers, and how they interpret equality and equity in health services. An analysis of the content in these categories was contextualized by using the specific accounts of participants to explain the nuances in each category.

Through the analysis of these coded interviews, it became clear that although individual level barriers impeded access to health services, most expressed the view that the onus was on the health care system to do more to diminish access barriers through a systems approach of taking into account those individual level barriers. A program manager in Vancouver noted that quality standards could be used as a way to measure equity, suggesting that health services providers should explore the reasons that for: “certain population groups we don’t achieve quality standards” (B10: 1378:1381). Respondents strongly felt that many people faced discrimination when accessing services, which undermined equality. For those who felt that formal access was equal, the outcomes of that access were not equal because the further needs that some immigrant patients require were not ensured.

As noted in Chapter 5, equality and equity have different meanings and can be at odds. Equality of access does not simply mean equal access to the same services, as many focus on the need to be equitable in service delivery, responding to the specific needs of particular groups that face barriers. Therefore, equal services are not necessarily equitable for patients with greater needs. Given the differences in interpreting the concepts of equality and equity, it is valuable to assess how the working definitions people are using shape their understanding of access barriers. The majority of respondents used the notion of equality in a way that encompassed the definitions of both equality and equity. There was an exception of two respondents who stated that technically there is equal access to services, with the Vancouver respondent noting that social determinants tend to mediate whether that access is realized, while the respondent in Montreal emphasized that it was the responsibility of immigrants to learn French so that they could benefit from the services available to them.

Therefore, even with these various interpretations, all respondents believed that immigrants and ethnocultural communities were not achieving either equality or equity in service access. It was also noted that the care provided to certain communities, while they are accessible, may not be appropriate for their needs. For example, a Vancouver program manager responsible for diversity services noted that often programs and services are not designed with the immigrants' particular needs in mind. Equality in a context of diversity is therefore a multi-dimensional issue:

I like to talk about accessible, appropriate and comprehensive care as the three dimensions. Accessibility we have more or less. Everybody can get in, but is the care appropriate? Not necessarily, because of a whole range of cultural issues that come up. And then...is it comprehensive? I'll just give you two examples. One, HIV, AIDS. Clearly that's a condition that affects more people from Africa...Are the HIV services accessible? Probably they are. You could get an interpreter and go to one. Would it be appropriate? Not likely, because it would be the services developed by and for Caucasian, middle-class, men, mostly, and we get a lot of HIV [+] women, right? Black, African women. So it's not necessarily appropriate or comprehensive...Another good example is renal care. Kidney failure. Kidney disease. We know that South Asians and Asians have a much higher instance of diabetes and hypertension...They're more likely to get diabetes, more likely to get hypertension, and if they start having kidney problems that are related to that, they go downhill much quicker than the Caucasians... they get sicker sooner..., and they're more likely to die sooner. So again, if you have a renal program that's based on the Caucasian trajectory of disease,...the service is not suited to meet that need [of the Asian population] (B10: 625:675).

As this quote illustrates, respondents noted that it is important to consider equity based on clinical appropriateness, ensuring that the services provided are responsive to the particular needs of immigrants, rather than pursuing equality through equal treatment. The comment represents an important concept of historical institutionalism, which emphasizes how programs reflect the context for which they were developed, and therefore may be difficult to adapt to other settings. At the same time, this quote also demonstrates that

different patient groups can have a different experience of the quality of care within services that are provided along a standardized approach. In this sense, the services that may have been equal with regard to access were not regarded as equitable in that they did not provide the additional services required to achieve the same level of care, such as the extra time or interpretation that would allow for the patient and service provider to communicate properly.

Although it is clear that unequal access was a concern for all participants, immigrant associations provided a wider range of meanings around the concepts of inequitable / unequal access and how this inequality played out in individual experiences with health services encounters. Specific examples of the barriers discussed by the respondents in Vancouver and Montreal are presented in this chapter.

All respondents emphasized both individual and institutional level barriers to access for immigrants. A program manager in Vancouver explicitly stated these different levels:

[There are] patient driven barriers, provider driven barriers and system driven barriers. With the system the main barrier has been the waiting time to get the MSP [Medical Services Plan] number. So people come into the country and having to wait three months before the health insurance kicks in...In terms of provider driven barriers, it is mostly the way we in the Western world see health and how we approach health from a purely biological point of view...We have to take into consideration these cultural differences. For the providers we haven't really changed much. We have done some things, created diversity components to their program and bringing in workshops once in a while to talk about some cultural differences, but I don't think they have made the real effort to change and be more sensitive...Patients barriers are hard to change...Language is the main barrier, the lack of English language skills or French language skills is important. And the lack of knowledge of the system...Also people's priorities in the resettlement period. When people come to a new country they might not be necessarily thinking that they have to see a doctor or a nurse. They might be feeling unwell, but they might not know how to access. Secondly, they are already used to neglecting this part of their health because they had no access anyways (B9: 9:23 – 16:53).

This demonstrates that access barriers take a variety of forms and therefore that the ways to resolve access barriers will also need to take a multi-dimensional approach. Once again, a respondent's interpretation of access barriers emphasizes both the institutionalized norms of the health care system, an incongruence of perspectives between patients and providers, and the social context of that the patient is trying to navigate that shape specific barriers in access to health care services.

Another program manager in Vancouver emphasized that access barriers were not uniformly experienced, noting individual patients and their support networks also created differential access:

Everybody has equal access to the healthcare system. If you've been here for three months, you get health insurance and therefore, theoretically you can come into the system... You are eligible to have an interpreter... So arguably there isn't a barrier in that very formal sense. What gives people differential access to healthcare?... [That has] a lot to do with their education level, their social status, the social networks that they've developed already, either because of them as individuals or because of the existence of a prior community here... In Canada, it's very difficult to make any of these kind of blanket statements, visible minorities get this, or immigrants get that, because... some people may have a lot of access, and some people may not. And yes it's related to the fact that they're an immigrant and because they're culturally diverse, but it's just, it's not a simple equation (B10: 494:523).

This quote also draws attention to intersecting issues (e.g. poverty or limited education) experienced by many immigrants that compound the access challenges. The access barriers identified by respondents are presented following the interdisciplinary analytical framing of the political, social and economic spheres of influence. The access barriers discussed by respondents were grouped together into the corresponding category, allowing for comparisons between types of barriers, respondents and locations. The themes regarding the nature of access from the interview transcripts are presented below.

6.1 Social / Non-Financial Barriers

This category encompassed by far the widest range of barriers identified by respondents in the study. The different types of non-financial barriers are grouped along three major themes: lack of knowledge about the health care system, language barriers, and barriers based upon ethnicity.

6.1.1 Lack of Knowledge of the Health Care System – Individual Level

Those who are not part of the dominant culture may not share the common understandings of how the health care system works, as the norms of the system may be uncommon to people who are not part of the dominant culture or familiar with public health care systems, and therefore can itself be a barrier to accessing the health care system. The lack of knowledge that immigrants have about the health care system, how it works and what services they have a right to access is a significant barrier that limits the use of services. Some services are more often used than others simply because of awareness of the availability of those services.

This lack of awareness about the health care system was seen as related to the fact that many immigrants do not have experience with welfare state models of health care services. One service provider explained that people may be unaware of the role of family doctors as an access point into the health care system in Canada. An immigrant association in Montreal expressed that immigrants or refugees “come here and they don’t know the ropes, they don’t know the rules of the game” (A2: 350:353). A service provider in Vancouver also identified the lack of experience with a public health care system as a barrier, particularly noting the different conceptions and expectations about health services and institutions:

We have people coming from refugee camps or displaced areas where they have not necessarily experienced the type of health system that we have...In many cultures people see the hospital as the place to die so when I have a clinic in the hospital some patients are reluctant to come, because they have that fear that you go to the hospital to die (B9:124:138).

Service providers emphasized that immigrants underutilize prevention or early intervention programs, and are rarely involved in self-help groups. Some noted that preventive care may not be part of an immigrant's concept of health care, although others noted that often prevention programs are not necessarily oriented to immigrants, and outreach to communities is inconsistent. This can result in people accessing services when they are in worse health. A program manager in Vancouver noted that "generally it seems that there are delays in presenting for care, people present more often in emergency wards" (B12: 764:766). The likelihood that immigrants arrive at a medical facility in advanced stages of illness is therefore higher.

6.1.2 Lack of Information about the Health Care System – Institutional Level

Many people working in the health care system in both Vancouver and Montreal are aware that immigrant and ethnic minority communities are not accessing the health care system in the same manner as ethnic majority communities. In Vancouver, an immigrant association identified access across the continuum of care as a concern: "People are using the services, but with problems, and the system is fragmented" (B2: 287:288).

Part of the problem is the fact that information about services is not adequately provided to ethnic communities in their own languages and in non-technical formats that are easy to comprehend. Many materials are program or disease specific and do not provide an overview of the system as a whole. In addition, printed materials are available once people

access the system, and are based on the assumption that patients have the necessary literacy skills, which may not always be the case, even in their native language.

As for all communities, systematic bottlenecks at the points of entry into the health care system are also linked with access barriers, i.e. people face crowded emergency rooms or cannot access a family doctor. This predominant use of the emergency departments is seen as linked to the fact that many immigrants do not have a family doctor for a number of reasons. Respondents noted that immigrants had even greater problems in finding a physician, specifically ones with a similar ethnic background or experience working in cross-cultural environments, or who simply would be willing to take on a patient that may have greater needs. As an immigrant settlement worker in Vancouver noted:

The issue of finding family physicians is compounded for non-English speakers, particularly trying for refugees, given the fact that many of them have been medically compromised. There is reluctance to take on the whole individual who needs more than 15 minute visits (B5: 58:62).

Also the availability of family doctors was also seen as a problem, as an immigrant association in Montreal explained:

There are families that don't have family medicine because the doctors available in their area they say: "We are full. We cannot take any more patients." ...If they have some emergency, if they have some problem, they're just running to the hospitals (A3: 545:553).

This concern is not unique to immigrants, but highlights the systematic limitations of family doctors as the gateway into the health care system. The difference for immigrants is that they can have a harder time finding a doctor that can speak their language, and they may not be as familiar with the role of physicians as the first point of contact for care.

6.1.3 Language Barriers – Individual Level

There are significant numbers of people in both Vancouver and Montreal who speak a language other than English or French at home (547,660 in Vancouver and 346,065 in Montreal according to 2006 statistics - see table 5.4). Therefore, health facilities in these cities are likely to see high numbers of people with limited fluency in either official language. Indeed, language barriers are seen as the most significant problem with accessing health services in both Vancouver and Montreal. Program managers in a hospital in Montreal also noted that language barriers are often exacerbated by the gendered nature of social exclusion, expressing the isolation of immigrant women as contributing to the language barrier. Immigrant associations in Montreal noted that a risk factor and access barrier for a lot of immigrant women was their isolation: “women who are here for a long time... because they don’t feel comfortable to participate in the civil life, they stay home if they are depressed, or they are isolated” (A1: 399:406). In addition, a health service provider in a Montreal hospital also highlighted the gendered nature of access for many immigrant women:

In Quebec the important thing is that people have to speak French when they come here and for the immigrants it’s hard for them to learn. Most of them speak a little bit of English but here in Quebec everything is French so for them it is an obstacle when they have to access health care services. For paediatric care the thing that seems the most problematic is that the mother, the immigrant woman, stays home with the kids. When they have to come to the hospital she’s the one who goes to see the doctor with the kids. Because there are [few opportunities for] immersion, she doesn’t learn to speak French. So it’s very hard to communicate with the parents, especially the mother, when they come to the hospital. So communication is a big issue (A11: 1:13 2:09).

These comments reflect processes of social exclusion as a result of language or cultural barriers that take place in both the private and public realms. Firstly, the lack of

opportunities for integration, particularly for women who are not in the workforce, exacerbates isolation and barriers to gaining an understanding of the language and culture of the new host country. At the same time, the social exclusion that people feel as a result of these limited language skills can make them too intimidated to ask for the help they need, because of their apprehension of hostility, contempt or miscommunication. An immigrant association in Vancouver suggested that immigrants themselves need to be made aware of their rights to interpretation services and of the problems with inappropriate interpretation, through “social marketing to the population saying your 13-year-old kid doesn’t have to do the interpretation for you when you’re talking to a doctor about sensitive matters; you have the right to an interpreter” (B2: 422:425).

6.1.4 Language Barriers – Institutional Level

Despite the existence of interpretation programs in both Montreal and Vancouver, there are many barriers that remain regarding the use of interpreters. Access to interpretation services varies across location, service, and language group in both Quebec and BC. For example, interpreter services remain underutilized by health service providers, due to the lack of acknowledgement of its importance to patient care, because of limited availability of interpreters, and the cost of the services.

The lack of interpretation services across the continuum of care were seen as a significant concern for health service providers in Vancouver: “if they need to go to a specialist, the specialists don’t provide interpreters” (B7: 259:265), and a program manager in Vancouver stated that: “interpretation services are kind of piecemeal. Some services have some languages and some others don’t” (B9: 9:23 7:30). It was also noted that in Vancouver,

interpretation services were only regularly available at the hospital, and not at all in most community health centres. In contrast to this, community health centres in Montreal use more interpreter services than the hospitals, as originally the program provided funding for all services in the health and social services network. In addition, it was widely noted in both cities that interpretation services are concentrated in the urban centres, and that outlying areas often do not have the resources to be able to provide interpretation services, even if the right to one is in place.

The importance of language barriers often goes unrecognized: “English-speaking people largely don’t realize how easy the world is when you’re communicating in your own language, versus how very, very difficult it is when you’re not” (B13: 42:48). In Montreal it was noted by an immigrant association that many immigrants may have more English language skills, so the use of French by service providers and written documentation creates further communication barriers. Even in the urban centres where there is good access to interpretation services, these services were often not used.

Although there is an interpreter bank in Quebec, not every health service provider throughout Quebec uses the Interregional of Interpreters Bank (IIB)¹. The main problem that program managers in hospitals have identified is that they do not have enough money to afford the growing need for interpretation services. Interpreters from the IIB cost \$45 an hour, for a minimum of two hours. Originally the MSSS covered the costs of the IIB, but recently cut the funding, so the institutions need to find this money in their operating

¹ The Interregional Interpreters Bank is operated by the Ministry of Health and Social Services of Quebec. Interpretation requests are made via the CSSS, which covers the cost of the service. The bank operates regular office hours, and schedules the interpreter services for approved appointments with the CSSS.

budgets. It was noted by community liaison personnel in Montreal that often the choice not to use interpreter services is the cost:

It costs institutions money, and so some institutions are not too willing to use the [Interregional Interpreter] Bank. They'll use staff members, which don't necessarily guarantee their confidentiality and the quality of the interpretation. Family members are also used by the person. And again, it's not always appropriate that a family member accompany a patient, again for confidentiality (A9: 167:171).

In both cities the choice to have an interpreter is made by the health professional. In addition, for many situations the need for an interpreter is not planned in advance and therefore harder to manage. This is particularly common in the emergency room. The IIB is closed during the evenings and weekends, and therefore service providers have to scramble to find a way to communicate with the patient. In Montreal it was noted that the hospital interpretation coordinator will do a triage to assess the needs of the patient and the service being provided. This allows them to decide to either delay treatment or to determine that a volunteer interpreter will be adequate if the problem is not complex. Often staff will try to have a member of the family or someone else among the hospital staff who can interpret. An immigrant association in Montreal noted that inappropriate interpretation practices are common, expressing that often when people arrive: "at emergency and they go to find a janitor for the translation, because he's the only one that speaks the language" (A2: 770:773). Even in non-emergency situations, interpretation coordinators have to make decisions regarding how to prioritize the use of these services because they need to keep to established budgets for these services. In this case, triage of need is also done, not because of the lack of availability of an interpreter, but rather due to financial limitations.

A community liaison worker in Vancouver stated that despite the official access to interpreter services often assessments on the need for interpretation were not adequately made:

To be honest, they weren't even calling the interpreters. Because if you have a few words, you say 'hi, my name is' and 'how are you?'... The nurse would hear a few words in English, and would think "oh she's fine" and wouldn't call the interpreter. But in fact, this woman only had a few words, and certainly didn't understand medical terminology (B13: 624:634).

A program manager in Vancouver also noted problems with interpretation practices:

Some are still using their staff to do interpretations very inappropriately, or using family members to do interpretation which again is inappropriate because some sensitive information might be missed (B9: 9:23 7:30).

Vancouver community engagement staff aimed to raise awareness among health service providers about the need for interpreters:

so the staff have made the change, where they automatically call the interpreters, and they involve the interpreters now in case management. So the interpreter is part of case conference now. That wasn't happening before. So, those are the little changes that can happen quickly (B13: 636:654).

Similar to Montreal, in Vancouver there is often the problem of the unplanned need for interpreter services, so reliance on family and other staff in the hospital to interpret is common. In addition, many community associations offer their own interpreters, so some patients will pay to have their own interpreter with them. A lack of signage also creates access barriers in the institutional setting. A program manager in Montreal explained that often patients leave the hospital without accessing all of the services that they are there for:

because they're afraid to ask where is the x-ray so they go round and round in the hospital and finally they get tired and they go home. Because they are

afraid to be looked at as an ignorant person so they don't ask. They simply leave ... 'I didn't know where to go, I was shy, I was afraid' ... So they're not asking (A11: 13:04 1:14).

This demonstrates that limited language skills also make patients apprehensive about asking for the services they need, therefore drawing attention to the need for institutions to be more welcoming.

6.1.5 Ethno-Cultural Differences in Access to Care – Individual Level

Although most of the comments about ethnic differences in access stemmed from attitudes and practices within health care institutions (discussed below), there were some comments from respondents about access barriers that were based upon characteristics of the patients themselves. It was noted, for example, that variation in the health beliefs between immigrants of different ethnic backgrounds as well as differences within immigrant groups (broadly defined) depending on their length of residence in Canada shaped access. For example, it was noted that in the Chinese community there is reluctance to access mental health services, as that is seen as a family matter and acknowledgement of a problem would be seen as a failure of the family.

Some immigrant communities have only a short experience with the Canadian health care system, while others with larger numbers and longer histories in Canada have better access than people from newer waves of immigration. A program manager in Vancouver noted that:

Numbers create better access. So, some of the larger groups - it's Cantonese, Mandarin and Punjabi in Vancouver and surrounding areas. So I think that those groups probably tend to have more voice. And because of the numbers, we also have more resources... There are what we call languages of lesser diffusion... where they're having to rely on resources

that are not as well trained, maybe not as accessible...So it does change, from group to group (B11: 218:228).

Another informant noted that groups that had been in Vancouver for a shorter period of time had worse access, such as refugees, or people coming from war-torn regions, as both of these groups were usually people speaking “languages of lesser diffusion,” and arriving with greater needs:

New communities like...the Acehnese [from Indonesia], the Sudanese, that are emerging communities...would in an ideal world require early intervention prevention programs that encompass the broader determinants of health (B5: 441:446).

6.1.6 Ethno-Cultural Differences in Access to Care – Institutional Level

In both Montreal and Vancouver there is wide variation in health services access across (and within) ethnicities, denoting racial and social hierarchies that have an impact regarding who is able to realize their putative rights of equal access to health care. Some language groups have greater barriers to access than others, as some are more established in the community. The framing of this unequal access was quite different in the two locations. In Vancouver the main difference in access to care emphasized repeatedly by a number of respondents, was seen as linked to critical mass (numbers) and length of time a particular ethnocultural community had been present in the system. Program managers and community liaison personnel in Vancouver discussed the importance of these factors in access to care:

If we have more people in the population from a particular group, we are more likely also to have staff that are working in our system from those communities. So, in terms of representation, and people in our system at the front line who have cultural knowledge, can speak the language, all of those things are much more likely (B12: 99:116).

In Montreal the discussion about ethnic differences in access to care did not emphasize the size of the communities or their length of time in Quebec. Instead, the difficulties that immigrants and ethnic minority communities have in accessing care are seen as closely related to a history of discrimination against particular ethnic groups. In general it was noted that communities with cultural and ethnic similarities to the English or French Canadian ethnicity fare much better in terms of access to care. As an immigrant association in Montreal noted:

The further away you get from European culture...towards, like say, Africa or Asia, groups that are very recent, that do not share the same value[s] as the European traditional Canadian majority, then the resources will not be there. So health care will not be as good. So again, it has a lot to do with the time factor, and it has to do with cultural prejudices that are built into the way that Quebec and Canada perceive the population (A2: 62:67).

This observation was also made by three program managers working in different hospitals in Montreal:

We tend to see a lot of people from Asia, or Latin America, Asia largely, so that would be China, Hong Kong...South Asia, so India, Pakistan, Bangladesh, Sri Lanka. So number one they're visible, or I'm not sure which is number one, number two they don't speak English or French...so they're at a greater disadvantage right away...If you have immigrants coming from Europe, from France, you speak French, you're quite welcome here...right away you have something in common...[and] if you're coming from the States...These people understand how these systems work and can adapt more easily, and maybe are coming at it with a better status or access to employment, they're going to fit in easily. But obviously, for the people I've mentioned, the barriers are greater (A7: 115:131).

And in another hospital:

R1: "it is easier for some communities than others. I would say for Latin origin communities, it's very easy"

R2: “yes, Italians”,

R1: “South Americans, Brazil,”

R2: “Spanish community”

R1: “It is easy for European people, too...It’s not so easy for Asian people...they won’t ask very much, they won’t ask enough”...“It’s not so easy for North African people, like Arabian”

R2: “Tunisian”

R1: “Egyptian, Lebanese, and Moroccan. For me that just shows that it’s not only and it’s not mainly a question of language” (A11: 18:51 1:36).

Although there are attempts to address cultural stereotypes and cross cultural misunderstandings among health service providers, respondents noted that the major impediment to intercultural training is that staff do not have enough time and availability to participate. Most health service delivery institutions are already short staffed, due to budgetary constraints, and cannot dedicate staff time for these training programs. In order to facilitate this training, managers need to be committed to provide dedicated staff time, including having a budget for hiring staff to replace people while they are involved in training programs. For many of the intercultural training programs, staff try to fit it into a narrow time frame in a meeting, or even during lunch and coffee breaks:

we do provide a variety of in-services. We’re usually called upon to do them within agencies that already use our service, but we frequently try to thrust ourselves upon others that don’t always want us. It’s hard, you might get 20 minutes or 10 minutes at a meeting or something like that, so it’s hard to get the time that you need (B11: 126:130).

Intercultural training sessions are generally voluntary, so usually those people who are already committed to the accommodation of diversity tend to be the ones who attend. The

main challenge is not only to sensitize the health care workers at the front lines, but it is also critical to ensure that middle and higher management are aware of the importance of these issues. One reason for this is that often management is not committed to intercultural training. In Vancouver diversity programs have targeted these decision makers:

We've worked hard this year to try to build more awareness at the higher levels, so we've had a number of information sessions with the executives and with the senior teams and senior management and staff so that, at least in terms of interpretation and language, that they understand why that's significant (B10: 177:181).

6.2 Economic / Financial Barriers

6.2.1 Institutional Level Economic / Financial Barriers

One of the main problems that program managers in hospitals have identified is that they do not have enough money to afford the growing need for interpretation services. Due to the budgetary restraints there are often pressures to cut back, and to use staff and volunteers, which health care providers see as a regression:

We have to really defend our budget and each year, the number of interpretations increases, and each year we have to justify keeping the service... There's no additional money on the part of the government. So the hospital is obliged to see where they can trim back. So one of the ways they can trim back is to say: "Okay well how come we're using all these interpreters? Other hospitals manage without!"... People will say that money could be used on new equipment... or a staff person... So I say the nurse or the physician cannot do their job without the interpreter. They're faced with a family that doesn't speak English or French. They run the risk of error... Another thing I'm adding is after a number of years, if we're always told that it's not essential, it starts to look like neglect. And neglect becomes discrimination (A7: 598:605).

Services for ethnic minority communities are generally reliant upon short-term project funding, and therefore financial uncertainty and fluctuations in resources are

common. Key informants from Immigrant associations noted that funding resources have been decreasing, and organizations have been forced to compete with each other for shrinking resources for project funding. An immigration services provider in Vancouver explained: “there is a reluctance still to really move towards multi-year funding. It’s coming, we’ll get there, but we still have to apply every year for the same things that we’ve been doing forever” (B5: 767:770).

Immigrant associations and program managers in Montreal noted that the changes in the health care system have created more access barriers:

Well I think it’s becoming more difficult, because of again the fact that people are working so fast with limited resources... Those that have obstacles and barriers to services, those barriers are becoming bigger, higher... So it’s quite hard. You have to be very persistent and persevering (A7: 99:109).

An immigrant women’s association in Montreal noted that women “will say that before, when my first child was born, I had more help from the CLSC... I was able to access more easily than when my third child was born... Because more health workers were available” (A3: 439:443). A service provider in Montreal noted that in the few years preceding 2006 there has been a decline in the services available for refugees and immigrants: “there are periods when it’s a little better, and periods when it’s worse. Now they’re not offering very much” (A7: 371:373). In Vancouver some of the same problems of limited resources for health practitioners and service provision specifically for immigrants and refugees were identified. A service provider in a program for immigrants and refugees emphasized that the demands were not being met due to the limited resources:

We have limited resources, very limited resources. For example, I could be working full-time, but there is no money for us. Because we are crowded,

we have lots of people here... We are only open from 1:00-4:00 Monday to Friday (B7: 404:413).

6.2.2 Financial Barriers and Economic Determinants of Health for Immigrants

Financial barriers affect immigrants both through reducing the availability of services (discussed above), and through limiting their access to adequate employment that will allow them to improve their socio-economic status. For example, a service provider in Montreal noted that language courses have been cut, creating further exclusion of immigrants. It was also noted that the increase in poverty levels in Canada overall has a significant impact on new immigrants; as one program manager in Montreal noted: “Being an immigrant in Canada ten years ago was easier than being an immigrant in Canada today” and that “the conditions that we used to associate with recent immigration have a tendency to stretch out in time” (A12: 366:396).

A consistent theme in both Vancouver and Montreal was the lack of employment options for immigrants when they come to Canada. These limited employment options have been aggravated by a downturn in the economy, but are also due to the fact that many immigrants do not get recognition for their credentials or work experience from another country. Therefore, many immigrants are forced to choose different careers, often in lower paying unskilled jobs in a subordinate position in the labour market. This discrimination is seen as a significant factor in their declining socio-economic status post emigration to Canada.

Many respondents noted, for example, that foreign doctors come to Canada and are unable to practice, and neither the government nor medical and other professional associations do much to facilitate the recognition of immigrant doctors. Many foreign

educated doctors work as auxiliaries in CLSCs, and in Vancouver, many health liaison workers are immigrants themselves who are unable to practice their health profession in Canada. The cost of the exams for doctors to recertify is extremely high. Respondents noted that if the health system wanted to increase its integration of immigrant doctors, there should be facilitating conditions for the exams and for training.

6.3 Political / Institutional Barriers to Equity

The barriers to equitable treatment were all seen as system and institutional level barriers.

6.3.1 Governance and System Design Barriers

Not only are there significant differences between individual immigrant's experiences with access, variations across the health system also make it difficult to make a definitive statement about access. A program manager in Vancouver, who works specifically to bring community perspectives into health care planning, summed up the sentiment of everyone we spoke with: "It's all over the map...there is still a lot of work to do" in terms of realizing equality in access to health care (B12: 76:96). A representative of an immigrant association in Montreal who works closely on health care issues noted that:

The major stumbling block is that the whole thing is so haphazard... You've got some very good situations, some middle of the road and some real horror stories. So, you got a whole spectrum of possible answers, and it's all left to local people to somehow organize themselves to get the service that they need (A2: 373:381).

As the discussion above noted, access to immigrant specific clinics and programs as well as interpretation services varied significantly across regions. For Vancouver, the clinic

specifically oriented to immigrants was located in the centre of the city, while many newer immigrants are moving into communities in the suburban areas where housing is more affordable. Some areas like Surrey and Richmond have developed immigrant service organizations and improved responsiveness in health care. In some of the outlying areas, the services and infrastructure, such as immigrant settlement agencies, interpreter services, or culturally competent staff, may not be in place.

The presence of clinics and services for immigrant communities in urban centres may be an improvement locally, yet respondents in both Vancouver and Montreal noted that in some respects this made service planners neglect the need to adapt services in locations with smaller ethnic communities. This has also led to significant variation in experience with the health care system depending on where people were living, with “complete barriers to anything to do with cultural access” (B2: 87:89) in areas outside of the urban centres.

The lack of planning to address the specific health service needs of an increasingly diverse population is seen as contributing to the lack of equality of health care services. For example, in Montreal a strategy for mental health was developed without input from or discussion about ethnic minorities and their particular issues in mental health. A Vancouver program manager also echoed the same problems, where the specific health needs of the ethnically diverse communities are not taken into account in the planning of service provision:

We don't collect ethnocultural data...it's very...idiosyncratic. Like we'll talk to staff and they'll say “wow, we're seeing huge numbers of people from Eastern Europe” ... We can track...by looking at census data but we're always a year behind with that. So, we see that there are newer groups that we're starting to serve in different communities within our region, but we don't have a systematic way of capturing the data and then planning a response that's appropriate (B12: 99:116).

In general, respondents felt that the diversity in the population is not adequately taken into account in health care planning.

6.3.2 Immigrants' Legal Status

Legislation regarding access to services shapes entitlement to care, with illegal status or those in uncertain status facing the most barriers. The three-month waiting period for access to public medical insurance in Ontario, British Columbia and Quebec is repeatedly mentioned as a significant barrier for immigrants. It was seen by respondents in both Montreal and Vancouver simply as a denial of service access that need to be addressed. Research carried out by Anita Gagnon on health service access for newcomers shows that access is very unequal across the country and by immigrant status:

Landed immigrants have access to the same services as Canadians. Those with employment authorizations have the same access depending on the valid duration of the authorization...The time at which coverage begins for all immigration classes except refugees and asylum seekers is up to 3 months for all provinces, except Nova Scotia where those with an employment authorization have access after 6 months and students after 12 months. Time to access health plans for provinces and territories that offer refugees coverage varies, with the shortest being the Northwest Territories where access is upon arrival. There is a 2-3 week delay in Quebec, a 3-month delay in British Columbia and Ontario, while in Manitoba the timing depends on the employment authorization... IFHP [Interim Federal Health Plan] benefits are limited to essential health services for the treatment and prevention of serious medical/dental conditions, essential prescription medications, contraception, prenatal and obstetrical care, and the Immigrant Medical Examination (Gagnon, 2002: 11-12).

As this description of access emphasizes, the coverage of medical services for immigrants and refugees is varied across locations, service areas and the status of the patient. There are also long delays for those whose immigration status is uncertain. For example, the Interim Federal Health Program: "gives them access to basic health resources...In order to

get more complex procedures, the doctors have to write a letter, even for a small surgery, and then it takes time for it to be approved” (B7: 6:12 - 6:37).

In addition, health care providers are often uncertain of what is covered and how to complete the paperwork for the Interim Federal Health Program (IFHP):

Many doctors don't know about it - don't know how to bill the federal government for that, and they refuse to see the patients...I have received calls from hospitals, 'how do I bill this person? Where do I go?' So I have to fax them the form - they are supposed to get it from the federal government, not from us. But this is what we do - we do the liaison here for all the hospitals and institutions (B7: 39:44).

While the IFHP provides access to “emergency services,” this is seen as a very narrow provision, often leaving out potentially vital services that have to be paid for by the patient. In Montreal program managers noted that a key issue for refugees was that they often needed services that they could not pay for. They also noted that this denial of services creates an ethical problem for care providers:

This whole business of payment – what are essential services, where is family responsibility for a refugee claimant. What if they need more than they're allowed, or someone that doesn't have a status or whose status is ambivalent...and they have to pay and they can't pay. [For example] someone with mental health issues. There are a lot of issues around that. Because physicians and healthcare professionals feel frustrated because they're obliged to give service, ethically, but the systems in place don't always coincide (A7: 351:361).

Although there have been some noted improvements to access for government assisted refugees, the three month waiting period aggravates unequal access, according to a Vancouver program manager:

There was an agreement in the late '90s with the federal and provincial government [of BC] whereby government assisted refugees will have their health insurance available the day they arrive. So that system barrier has

been already removed for this particular group. That is not the case other groups, for instance the family sponsored landed immigrants, someone who brings a partner, or their dependents, they still have to wait three months. The difference is that refugees are coming under what now is seen more as compassionate grounds and therefore the government is more willing to step in and provide that service. While family sponsored immigrants, the family assumes the responsibility (B9: 9:23 7:30).

Another concern among refugee claimants and illegal immigrants in Canada is that many people in precarious immigration situations often do not use health services because of their concerns about being deported.

In Tables 6.1 – 6.3 below I present the issues that emerged from the data from Montreal and Vancouver that characterize main conceptual categories of access, namely social, economic and political (including governance and institutions).

Table 6.1 Economic Barriers

SOI	Montreal		Vancouver	
	<i>(white columns are responses from people within the health care system/shaded are from immigrant associations)</i>			
Economic	Fewer health care resources—less staff in the system	Fewer health care resources—less staff in the system	Fewer health care resources—less staff in the system	Fewer health care resources—less staff in the system
	departments compete for resources			
	Cuts to language programs	Cuts to language programs	Limited resources for immigrant specific services	Decreased funding for immigrant services Short term project funding
	More financial difficulties for new immigrants	Need for Employment equity for diverse populations in health care	Socio-economic status affects access	

Table 6.2 Social Barriers

SOI	Montreal		Vancouver	
	<i>(white columns are responses from people within the health care system/shaded are from immigrant associations)</i>			
Social	Isolation of women Few opportunities for social immersion Some communities are better served than others	Immigrant Women are isolated	Some communities (larger) better served – social networks	
		Lack of understanding of how the system works	Lack of knowledge about the system Education level	
	Need to enhance cross-cultural skills of staff Racism and ethnocentrism	Racism /ethnocentrism	Cultural bias in the system—western notions of health Multi-lingual staff enhance access	Lack of cross-culturally trained staff

The interview data provide insight into some of the health care access barriers for immigrants in Canada. Despite the general acceptance of Canada as a multicultural society and the legislative context of multiculturalism and human rights, many barriers to equal access remain. There is significant correlation with other Canadian and UK access frameworks discussed in chapter 2, although some barriers are either not represented in these access categories, or cannot be defined under one heading. The data presented here demonstrate that most of the barriers to equitable treatment, such as communication problems or discriminatory attitudes of providers, can also be categorized as “non-financial” access barriers – influenced by social norms. The organizational barriers, though, are distinct from the social barriers to equity which tend to be driven by patient/provider interaction and ethnocentrism in program design.

Table 6.3 Political/Governance Barriers:

SOI	Montreal		Vancouver	
	<i>(white columns are responses from people within the health care system/shaded are from immigrant associations)</i>			
Political/Governance	Disjuncture between ethical commitment to provide care and coverage	Inadequate planning for diversity	Diversity not part of planning Limited commitment to diversity among managers Limited understanding of staff of the need for interpreters—not normalized in the system Little time for intercultural training	
	IIB closed eve and weekends Waiting time for coverage	family doctor bottleneck Waiting period for coverage Credential recognition	System bottlenecks Waiting time Confusion about the IFHP Credential recognition	physician as bottleneck of the system waiting time for coverage
			Deportation concerns	

The constructivist paradigm that informed this research emphasized the value of a qualitative approach to collecting a variety of perspectives from different types of respondents and from different locations. Despite their location in different parts of the health care system, different cities and different positions in relation to the system, most of the respondents identified similar access barriers, and there was an overwhelming sense that the health care system needs to make a better effort to address these barriers. The results demonstrate that the unique experiences across the system are therefore framed by the broader social, political and economic contexts, but at the same time the specific

characteristics of the institution, care provider and/or patient also shape the outcome of social interaction that takes place in the provision of health care services. Rather than strictly focusing on the interaction within the health care setting, the critical and constructivist theoretical paradigms guided us to also examine exogenous systemic societal issues within which people navigate access to health care.

Historical institutionalism emphasizes the value of understanding the history of institutions: who created them; for what purpose; with which operating principles; influenced by what type of values; and how have these changed over time. It is important to be aware of these historical facts, as the “practical performance of institutions...is shaped by the social context within which they operate” (Putnam et al., 1993: 8). If institutional design is based upon the perceptions of those who established them (governments, health authorities, institutional boards – i.e. the representatives of higher power structures) then they embody the ideologies and culture of the particular context in which they were formed and of the people who created them. This can result in institutions being unable or unsuitable to address new challenges, as societies, technologies and contexts change, so too the assumptions that underpin them may be called into question. Acknowledging the historical contexts of access barriers, and the power structures that operate within them focuses our analysis on whether and how these structural bases for inequality can be addressed through processes of engagement that bring in the voices of those typically excluded from the power structures.

Respondents noted the multifaceted nature of access barriers, clearly demonstrating that there is a need for a variety of strategies to make the health care system more responsive to the needs of immigrants and ethnically diverse communities. The following chapter explores some of the strategies that have been taken up.

Chapter 7: Initiatives to Address Access Barriers

The analysis presented in chapter 6 demonstrates that all of our respondents, immigrant associations and service providers alike, agree that although there are a number of initiatives that aim to facilitate improved access, there are still a wide range of barriers that some immigrants face in accessing the health care system. This chapter explores the interview data where respondents reflect on what is being done to address access barriers. First I examine responses regarding how people interpret the legislative context to guide their own work in improving access. The analysis then groups initiatives into different types of strategies to address specific access barriers, illustrated by quotes from the interview respondents.

7.1 Policy Context

To recap, there is legislation in Canada, BC and Quebec to support immigrants' rights, many of which imply an onus on public institutions to ensure these rights. At the federal level, the Canadian Charter of Rights and Freedoms (Government of Canada, 1982) includes provisions against discrimination and promotes programs to address systemic disadvantages. The *Canadian Multiculturalism Act* states that it is Canadian policy to “promote the full and equitable participation of individuals and communities of all origins in the continuing evolution and shaping of all aspects of Canadian society and assist them in the elimination of any barrier to that participation.” It also aims to “ensure that all individuals receive equal treatment and equal protection, while respecting and valuing their diversity” and “encourage and assist the social, cultural, economic and political institutions of Canada

to be both respectful and inclusive of Canada's multicultural character" (Government of Canada, 1988).

BC and Quebec have similar human rights' legislation that protects against discrimination. The *BC Human Rights Code* of 1996 makes specific reference to service provision: "No person...shall...deny...or discriminate against a person or class of persons with respect to any accommodation, service or facility customarily available to the public, because of the race, colour, ancestry, place of origin, religion" (British Columbia, 1996b). The Quebec Charter states that: "Every person has a right to full and equal recognition and exercise of his human rights and freedoms, without distinction, exclusion or preference based on race, colour, sex,...religion, political convictions, language, ethnic or national origin, social condition" (Quebec, 1975). In BC there is also the *Multicultural Act* that aims to "foster the ability of each British Columbian, regardless of race, cultural heritage, religion, ethnicity, ancestry or place of origin, to share in the economic, social, cultural and political life" and to "carry on government services and programs in a manner that is sensitive and responsive to the multicultural reality of BC." It also states that "violence, hatred and discrimination on the basis of race, cultural heritage, religion, ethnicity, ancestry or place of origin have no place in the society" and it is the "inherent right of each British Columbian, regardless of race, cultural heritage, religion, ethnicity, ancestry or place of origin, to be treated with dignity" (British Columbia, 1996a).

Health legislation also supports access for new immigrants and the incorporation of diversity. The *Canada Health Act* explicitly states that "health care insurance plan of a province (a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled

to insured health services” and that “the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions” (Government of Canada, 1985). The Health and Social Services Act of Quebec makes extensive provisions for incorporating diverse communities. It includes such aims as: “to take account of the distinctive geographical, linguistic, sociocultural, ethnocultural and socioeconomic characteristics of each region;” and “to foster, to the extent allowed by the resources, access to health services and social services in their own languages for members of the various cultural communities of Québec” (Quebec, 2010: Sections 1 and 2).

Although not a legal document, Vancouver Coastal Health states that: “community engagement is part of good decision-making processes... VCH staff actively consult clients, patients, residents and other community stakeholders to improve decisions and ensure that the system is responsive to their concerns” (VCH, 2005: 1). In addition, there are provisions to foster participation of, or consultation with, communities to facilitate the responsiveness of health care services, specifically through the formalized channels of community engagement. Given these fairly explicit commitments, one might be led to expect that there will be a variety of services and supports in place to promote health care access for immigrants in Quebec and British Columbia. How has the health care system responded to the increasing diversity of its population? How are the principles of the legislation interpreted and upheld in service delivery? Below I analyse how study participants interpret these legislative guidelines, and what they have identified as the key issues and concepts inherent to fulfilling these responsibilities. I then introduce some of the program and service initiatives that have been implemented to meet these commitments.

The analysis presented below comes from interview transcripts carried out with key informants, namely program managers, service providers and community associations involved in ongoing efforts to increase access to health services for immigrants in Canada (see Appendix B interview guide). Respondents were asked if they felt there were any legal bases that facilitate or improve immigrants' access to health care services. The data presented below first reflects on how people felt the legislative norms guided their work, and how they interpreted these legal guidelines to inform their practice.

Many respondents drew upon the guarantees of equality provided by the *Charter of Rights and Freedoms*, and also upon the equity principles of the *Multiculturalism Act* to shape their notions of rights to health care services and the responsibility to ensure those rights. An immigrant association in Montreal notes that they also use the *Quebec Charter* to argue for the rights of immigrants in health care:

the *Quebec Charter*, if you look at the articles dealing with the residents, they don't talk about citizens or residents, they say: la personne. Toute personne...regardless of race, origin...must be treated equally, if not it's discriminatory. So our push is to say...look at the *Charter of Rights and Freedoms*, apply that to the way you provide health care (A2: 422:432).

In Quebec a program manager noted that although there is stronger language in the health and social services bill that talks about the rights of service users, "it's always 'given the resources.' So evidently, given the resources, when we say zero deficit, it's not always easy" (A8: 313:327). Therefore, in Montreal, it was noted that despite the legislative support for ensuring equal access, economic constraints often outweighed the moral case for providing additional services to ensure equitable care.

In BC a program manager noted that despite the existence of the *Canadian Charter of Rights and Freedoms*, the *BC Human Rights Code* as well as multicultural legislation both

federally and provincially, “there’s no requirement to respond to culture or language. It can be inferred, and argued for, but there’s nothing explicit” (B10: 1273:1287). At the same time, respondents were acutely aware of the fact that legislation does not necessarily translate into action. As a program manager in Vancouver noted:

Does legislation and legality help? It can, if you have people on the ground who are willing to push for that, push for the concrete use of those pieces. And does it actually make a difference for a mom at a hospital who needs translation? I sure hope so, but it’s dependent on staff who are aware of their responsibilities and willing to make the effort to ensure that a translator is brought in...So I suppose that the legislation and legalities are one piece, and the education and training is another piece, so the staff have the awareness of the services, and the willingness to use them, and then getting the information out to people at the ground level saying these services are available, and you have the right to ask for them (B13: 763:772).

In this example, the barriers to equitable care fall within the social sphere of influence, where awareness about the potential needs of linguistic minorities were not well understood by care providers, nor normalized in institutional practices.

7.2 Initiatives to Foster Health Care Access

Below I present the different types of responses within health care to improve service access for immigrants, based on information collected through the interviews with key informants, as well as a review of public documents and websites. The analysis is categorized into a number of key themes that represent the main strategies pursued to improve access. Each section presents the data from both Montreal and Vancouver, noting the similarities and differences of the approaches.

In each city a number of different initiatives have been adopted to improve the services provided to ethnically diverse communities. Some are offered through the health

authorities, while others are coordinated at the point of service delivery. Many programs are provided in cooperation with community associations, e.g. between immigrant service organizations and health workers. Clinics or programs that provide services specifically for immigrants and refugees were identified as a successful practice for enhancing access to health care services. These spaces provide a safe environment, where people are able to get health care services and advice on accessing other services. Respondents felt that the existence of these immigrant oriented clinics provided a safe place for the delivery of culturally competent health care, yet at the same time led to complacency on dealing with access barriers in other health service areas.

7.2.1 Interpretation and Translation Services to Address Language Barriers

Respondents noted that the primary efforts health care systems have made in responding to access needs were through the development of interpretation and translation services. Given the legal and ethical implications in ensuring informed consent for medical procedures, the need for interpretation is taken seriously. In Montreal and Vancouver there are formalized interpretation and translation services available in parts of the health care system, with both locations providing hospital interpreter services, and in Montreal as noted above community health centres have access to interpreter services as well. The section below discusses these services and some of the strategies used by health care providers to ensure interpretation is available when needed.

7.2.1.1 Services to Address Language Barriers in Montreal

In 1989 there was a mandate from the Ministry of Health and Social Services (MSSS) to create an interpretation service, which was launched in April 1993. To develop the model consultations were carried out in Quebec as well as communicating with France, Switzerland and Belgium as to how they organized their interpretation programs. Consultations were also undertaken regarding the development for the training of interpreters. Immigrants, community organizations, health practitioners and training program designers were consulted. Starting in 2000 a continuing education training program for health interpreters has been offered at the University of Montreal. The training of other (non-health) interpreters is provided by the University of Montreal and at the University of Quebec at Montreal (UQAM) in inter-cultural communication and interpretation, connected with the Languages Department at University de Montreal.

The interpreter service aims to have a sufficient number of interpreters covering approximately 60 languages, and try to have a man and a woman available for each language group. The aim is to have career interpreters, and they try to ensure that people have enough work to stay in the program and maintain their competencies. The service provides additional training to interpreters specifically for health services and to address the pressures of working in this field, as interpreters not only have to be able to interpret in the language, but they have to know enough about health care so that they will not incorrectly translate a diagnosis. The interpreters also work as cultural facilitators, assisting health professionals in cross-cultural communication. Almost 90 percent of the interpreters in the program are themselves immigrants.

The interpreter program receives more than one hundred calls per day, and provides more than 20,000 hours of interpretation per year, with about 90 percent of this for services in Montreal. The program provides its services to health establishments (e.g. hospitals and community health centres), schools, and other public institutions interacting with the health and social services network. They also provide guidelines for service providers on working with interpreters:

Interpretation in the health sector is different than interpretation of a conference. You are not hiding in a little booth. You don't have a colleague to whisper words to you. You are sometimes very close to the client. If you are in a small community, then, everyone knows each other. So how do you manage this stress, this pressure? So that's part of the training that we provide (A8: 490:533).

There is a sense among health professionals that interpreter training should be based on a standardized national accreditation process, with professional recognition and equitable salaries, which does not exist anywhere in Canada.

Chapter 5 identified some of the barriers of the interpretation services, specifically that the service was no longer paid for centrally, but out of the institution or program's own budget. In addition, the availability of the interpreter service was limited to Monday to Friday, 8:30 am to 4:30 pm. Therefore, some respondents from hospitals in Quebec noted that they have their own connections with interpreters who they call upon for unplanned interpretation. For example, a hospital program manager explained to us that they have had an interpretation service in place before the larger program was developed, and have maintained their own program that is an integral part of their service delivery:

We have an interpretation service and we do about 6000 interpretations a year. We also do screening and selecting of interpreters and training for interpreters. We do four sessions a year... And the interpreters act as

cultural mediators, helping bridge the gap between family and physician or professional, helping them understand the cultural context and the practices and the customs, and to incorporate those into healthcare delivery [and] to ensure...compliance,...[and] the families are more likely to follow through on the medical plan, if their needs are understood, their beliefs are respected. At the same time, if their practices are acknowledged, they can then sometimes incorporate those practices...So it just makes for a better outcome all around. People feel more comfortable, they feel that they're connecting (A7: 39:50).

This institution values having their own interpreters because they will use them whenever there is any uncertainty about language comprehension:

in cases of doubt...it's recommended that an interpreter be present. And sometimes the family might get offended, because they say, you know, I understand English, or French or whatever. And [we] say to them [that we want] to make sure that we don't make any mistakes. We want to be absolutely sure that on both sides we fully understand (A7: 70:74).

As these quotes suggest, people working in hospitals in Montreal have become creative in addressing the need for interpreters. They will sometimes hire community organizations that charge a lower fee. They also recruit international medical students through volunteer internships, many who speak more than one language, who are often asked to do interpretation.

7.2.1.2 Services to Address Language Barriers in Vancouver

Interpretation services were originally spearheaded in the early 1990s at Mount St. Joseph's Hospital run by Providence Health Care, a Catholic care organization that runs a number of hospitals in Vancouver. Interpretation services policy emphasized the following standards: "confidentiality, respect for the individual, accuracy, proficiency, objectivity / impartiality, clear role boundaries, cultural sensitivity, and standardized interpreting format" (Providence Health, 2001: 2). This model was adopted in 1996 at the Vancouver General

Hospital, run by Vancouver Coastal Health. These interpretation services are limited to the hospital setting (with the exception of Bridge Clinic, discussed below).

In a Vancouver hospital there is a dedicated centralized budget for the translation and interpreter services, so neither patients nor departments have to cover the costs, demonstrating a commitment to ensure the availability of this service. Interpreter services can be provided within 24 hours, although for the more dominant language groups it can be available more quickly. The program uses a variety of interpretation forms, depending on availability and needs, including telephone translation services, the language bank volunteers of bi/multilingual hospital staff, or professional healthcare interpreters. There are over 5000 annual requests for interpretation services through this program. Although these services are in place, the discussion of barriers presented in chapter 5 demonstrates that they are either not used or inadequate to meet the demand. Some community groups also offer interpretation services for patients who need language support. They will accompany patients to appointments if requested for a fee to the patient, while other community groups do this on a volunteer basis. There is a training programme for health care interpreters available through Vancouver Community College.

The Provincial Health Services Authority also operates an interpreter services program that offers these services in its areas of jurisdiction, such as the BC Women's Hospital and the Children's Hospital. Over 100 languages are available through a telephone interpretation service available across the entire province of BC, so most languages can be covered. Therefore, as noted by a respondent, "in theory, you should never be without, if you need it" (B10: 601:604). They also provide staff training on working with interpreters.

Program providers have developed innovative ways to ensure that their patients get access to services in their own language, if they are unable to converse in English. A program manager in a hospital clinic in Vancouver noted that they try to ensure that interpretation is available for anyone needing it. They have a protocol whereby the receptionist determines if an interpreter is needed when the appointment is made. This allows them to make sure that an interpreter is available at the appointment, rather than having to call one after the patient has arrived. In addition, when designing the clinic, he made sure that each examination room had a speaker phone in it to ensure that they could access the telephone interpretation services if needed (B9: 23:20 1:06). Although this demonstrates a commitment within a particular clinic, the discussion in chapter 5 notes that for most cases, there is no opportunity to schedule an interpreter in advance for hospital visits, as many are unplanned. Therefore, patients are often not provided translation services from trained medical interpreters when there are language barriers; instead family members, other hospital staff or telephone translation services may be used.

The BC Health Guide (British Columbia, 2011) is published in Chinese, Punjabi and Farsi, and over 300 patient education materials are translated. A key informant in the study noted that the translation for patient materials comes from program budgets, limiting the ability to update materials or translate into other languages, as the money for this would need to be taken out of service delivery funding (B10: 73:83). The Nurseline and the BC Dial-a-Dietician telephone service, a telephone health service, has over 130 languages available. Some hospitals in Vancouver have signage in Chinese and Punjabi in addition to English. In Vancouver there are also language designated public health nurse positions that match

language groups with the translation needs of the local population, with designated positions for Chinese, Punjabi and Spanish speaking nurses.

A maternity program in Vancouver with a multidisciplinary team of physicians, midwives, nurses and doulas representing a diversity of ethnic groups developed a strategy for addressing language barriers. In establishing their program, staff realized it was important to have interpreter services, but the cost of interpreters was too expensive for the program. To address this concern the staff provided Doula training for women with multilingual skills in order to provide care in the mother tongue of many of their clients:

One of the things that we really wanted to do was to provide translation, language services but, as you probably know, it's prohibitively expensive to get translators. So we trained our own Doulas...Right now we have 14 different language groups, so all of our Doulas are bilingual...So then we match them - say if their language is Punjabi, then we match them with a Punjabi-speaking woman, so then they also can translate for us, of course not as an official translator, but certainly as a communicator for the woman. Even if the woman speaks English, sometimes it's more comfortable for her in labour to communicate in Punjabi, so we can get the information from the Doula (B6: 75:88).

The Doulas attend the birth, so that the mother will have someone there for her with whom she can communicate.

This section demonstrates that many of the services provided specifically aim to tackle the linguistic barriers in accessing health care. Respondents noted that despite the limitations of the interpretation and translation programs, this was by far the area where the most progress has been made in taking up access barriers. When reflecting on the types of barriers that were referred to in chapter 5, it is clear that linguistic barriers are only a part of the problem in accessing care.

7.2.2 Bridging Programs and Service Adaptation to Support Diversity

Many respondents noted that adapting health services and creating bridges that specifically link immigrant communities to health care services available, do in fact help improve immigrants' access to health services. An important strategy for building bridges is through liaison workers, who aim to assist in connecting immigrants with the variety of services that they need and use. Liaison workers are in a good position to enhance access through providing support for immigrant patients' navigation of the health system, and to facilitate bringing the perspectives of community groups into health program design. Examples are provided below of both bridging and program adaptations that respondents identified as improving immigrants access to health care services.

7.2.2.1 Programs and Services for Supporting Diversity in Montreal

In Montreal many key informants expressed that since health and social services are within the same ministry, it is easier for people to access the variety of services available to them. When people first arrive in Quebec, they are informed about the health and social services network, and once they are in the system they are easily connected to a variety of services. As an immigrant association staff member noted: "Quebec does a good job in terms of informing the new arrivals about the health care structure. If you have a problem...you have a variety of channels" (A2: 354:361). The system functions in a way to promote liaison and referrals between service providers.

In Montreal, immigrant associations play a significant role acting as liaison workers between ethnic communities and the health and social services network, particularly with the CLSCs (Centre local de services communautaires - local community service centres), now

grouped into the CSSSs (Centre de santé et de services sociaux - health and social services centre). For example, one of the associations we spoke with provides regular information sessions to make new immigrants aware of the services available and how to access them:

We inform people of the services here. Not necessarily health services, there are social services, and also education, employability, even consumption... Every Saturday there is an information session... So it helps a lot, people come in great numbers, and the room is full every Saturday. So those who have just arrived [to Montreal], they follow a series of information sessions. They have a lot of information, [so] when situations present themselves [they] know where to go (A1: 30:37).

Immigrant associations in Montreal also noted that often staff in the health care system would call on their expertise when dealing with patients of different ethnic backgrounds:

Many times, like [the] CLSCs... they call [us] to give... information with reference [to] the culture. How to deal with patients when they are from this community, how to approach them, how to get information, things like that (A1: 380:383).

Alternatively, many of the associations get requests from patients to provide assistance in navigating the health care system:

Our clients tell us that they don't know how to do something, and we send a volunteer... Very often, the person asks for us to go with them. Either they do not speak sufficiently, or they say that they aren't really familiar with [how the service works] and can we come [with them] (A1: 244:250).

Health centres that encourage staff to consider the social contexts of immigrants' lives and to provide culturally appropriate material about the services available are seen as an important enabling factor for community health access. In Montreal respondents noted a few CLSCs that stand out as particularly welcoming of diversity. CLSC that are in areas with multi-ethnic neighbourhoods have a significant integration of diversity, because of the nature

of the population within their service areas. In one CLSC region, approximately 80 languages are spoken, and this health centre has been addressing diversity and health care access issues for over a decade. At one CSSS (which encompasses multiple CLSCs), they have a number of documents that address issues of immigrant health to help professionals know about the challenges linked to immigration. They also address issues that many recent immigrants face, such as poverty, and economic and social exclusion. The CSSS has a three theme research program that addresses: immigration and ethnicity towards a practice of inclusive citizenship; health and practices to adapt to diversity; and coordinated actions and actors which will examine organizational issues.

One CLSC has a birthing house that provides services to their diverse community. A staff member from this program explained that because of the diverse community in the area: “you have to adjust. You can’t really say: ‘Okay, we [follow]...the Quebec perception of giving birth’. So you have to adapt...It’s less difficult for us, because [cultural adaptation is part of] our philosophy” (A6: 41:44). There is another maternal health clinic situated near China Town, which receives requests for high risk pregnancy clinics in Mandarin, Cantonese and more recently by people from the Middle East. There are many high risk pregnancy clinic follow-ups that draw upon interpreter services, since there are very thorough follow-ups with the patients and babies (A10: 122:154).

7.2.2.2 Programs and Services for Supporting Diversity in Vancouver

In Vancouver there is a more formalized approach to liaison workers than in Montreal. Immigrant Settlement Services of BC offers support for new immigrants and refugees for their first year in Canada, many of whom are directed to ISS offices when they

first arrive. New immigrants are provided information on programs and services available to them, and are offered language and job seeking support (ISS of BC, 2009). In addition, they are linked up with the Bridge Clinic, which, as noted above, is designated to provide health care services for new immigrants and refugees.

The Bridge Clinic in Vancouver was established in 1994 with the aim of providing access to primary and preventative health care services for immigrants and refugees. This clinic is funded by VCH and serves new immigrants and refugees for their first year in Vancouver. According to the Bridge Clinic brochure, it aims to bridge people into the rest of health care services, helping them acquire their health care cards and locating a family doctor. A variety of languages are spoken by a diverse staff: physicians, nurses, interpreters, settlement workers, nutritionists, a physiotherapist, a speech language pathologist, a psychologist and a psychiatrist. Specialty services include: prenatal care, the Newcomer's Pediatric Health Clinic, chronic disease management, immigration medical examinations, mental health services, nutritional counselling, physiotherapy, respiratory therapy and speech language pathology (VCH, Bridge Clinic Brochure, n.d.).

In addition to the health settlement workers in the immigrant settlement services offices who help orient newcomers to the health care system, a pilot project was funded to provide liaison workers to accompany the patient throughout the health care system, who:

do more than just interpreting. These are people who are bilingual, and largely bi-cultural. They largely come from medical backgrounds in their home countries. And they will accompany a patient through the health care system. So [while] an interpreter just comes in for that one hour appointment with the doctor, the [liaison worker] will follow the patient through various health care settings. And help them not [just] understand what the doctor is physically saying, but the meaning of what is being said as well, so they'll help with advice, advocacy, some support. And they'll also help the doctors, so it'll become really a three-way conversation. Now,

they're not there to give medical advice, but they're there to support the patients, so the patient is actually empowered, to make their own decisions (B13: 91:102).

The pilot project started as a partnership between a hospital and community health centres in the 1990s, with the initial goal of providing peri-natal support services, partly to assist in the hospital's aim to reduce the length of stay after giving birth. These liaison workers accompany patients through the health care system and the various services they use in the system for a fee. Patients are referred by settlement workers and health service providers in both hospital and community settings. The overall aim was for this program is to increase the appropriate use of health care services, and ensure that patients get appropriate care:

These clients have so many different problems - they come with more complications: they will be misdiagnosed, have delayed diagnosis, unnecessary hospitalization, unnecessary, inappropriate referral to specialists or...diagnostic tests. [The liaison workers] will reduce the pressure and the burden financially on the health care system. The health care provider will have more time...because the communication will be facilitated...and their patients have better health outcomes and support, and increased access to services (B8 460:472).

The project has evolved over time from its initial focus on increasing the appropriate use of services to a broader approach of partnering with the immigrant settlement services organizations. Some of their work includes training immigrant associations about the types of health services available, how to access them, as well as how to identify mental health issues that their clients may be experiencing. In addition, facilitators are provided with training about the services beyond health care, such as information about housing, daycare, schooling, counselling and other services to facilitate the successful settlement of new immigrants by addressing the social determinants of health. As one of the project coordinators explained:

For example, if your client has a problem with housing,...if there is a problem with daycare, [the] medical service plan, health insurance, or schooling, counselling, all those things. We try to cover a lot of different things, like non-medical determinants of health and resources available... We had a session for them about Canadian health care, the people in the health care system, the [Canada] Health Act and the rights of the patients... We had the training about palliative care and hospice, because it was a new term and new idea for them (B8: 200:211).

The settlement workers cooperate by sharing information about the services available for immigrants in all areas of the city and surrounding communities.

This demonstrates a structural difference between the organization of service delivery between Quebec and BC. With the integration of health and social services within the same ministry, Quebec has ensured that referral processes link necessary health and social services. Therefore, the institutionalist approach is validated, with the data demonstrating that governance of health care shapes the specific provision of care in distinct ways between Quebec and BC.

7.2.3 Intercultural Training to Enhance Responsiveness of Staff

Intercultural training of health care personnel was seen by many respondents as one of the key ways of ensuring that the health care system was providing a welcoming environment for ethnically diverse populations. In both Vancouver and Montreal workshops on intercultural training are available for staff in the health care system, and there are a variety of different approaches taken for the training.

7.2.3.1 Intercultural Training in Montreal

The Ministry of Health and Social Services (MSSS) of Quebec provides support for the increasing the cultural competency of institutions, through intercultural training for the

network of practitioners, offering approximately 20 intercultural training courses each year. Since 1997 the MSSS has provided consultants who carry out the training for institution managers, who are then responsible for training their staff and adapting services according to the needs of their diverse clientele. The focus of these programs includes ensuring that institutions are aware of their responsibilities to obtain informed consent and protect health care users, as well as to make institutions aware of the value of interpreters. The emphasis is on the need to ensure communication between care providers and patients, to develop sensitivity about intercultural relations, and to increase competency in intercultural interventions. The training draws attention to the need to adapt approaches to service delivery that takes into account cultural and linguistic diversity, including reviewing standardized evaluation tools to ensure diversity is also considered in program reviews. The health service delivery institutions are responsible for initiating intercultural training, either on their own or via requests to the MSSS.

Many respondents emphasized that the Montreal Children's Hospital is a stellar example of service excellence for ethnically diverse communities. The multicultural health program has been in existence at MCH for over twenty years, and the MCH is seen as one of the most welcoming places for immigrants and refugees. Because of this reputation, many people specifically go to this hospital, and staff are trained in cross-cultural care.

Multicultural health care workers facilitate education programs throughout hospitals, and maintain a multicultural library. A service provider in Montreal noted that the multicultural clinics provide more comprehensive care for newcomers:

people who are new to the country are coming in and maybe don't have very clear medical histories, that they're not documented. In the multicultural clinic they take very detailed medical histories. And get to

know the families, and provide services where other CLSCs cannot or don't know how to really get into it because it's too overwhelming for them. That's what they say. Whereas [at the clinic] every effort is made to ensure that the person's health is checked, the child's health is checked. And that families have what they need within the context of a hospital service (A7: 337:344).

A hospital multicultural program aims to help care providers understand and recognize the importance of cultural practices for ensuring respectful patient care, and how those can inform service delivery. Hospital staff note that through their multicultural training programs, emphasis was placed on the need for service providers to see adaptation as a two-way process, not just the responsibility of patients, but health providers also need to be prepared to shift their approaches to care delivery when working with immigrant families. They maintain a resource library and provide intercultural training on a regular basis, giving workshops on anti-racism and working across cultures, tailored to the needs of particular departments (like emergency) or service providers (like nurses, doctors, occupational therapists, etc.). In addition, many facilities provide intercultural training manuals to their staff, addressing such issues as religious perspectives, such as practices regarding death. One hospital relies on volunteer students to carry out projects to produce intercultural material, because they do not have the budget to dedicate staff to research and prepare these documents.

Another important tool to enhance cultural understanding among staff is the formation of intercultural / multicultural health committees among the health care staff. These committees meet regularly to discuss issues that have arisen in practice or from research. These committees include a cross-section of health professionals and often students who are working as interns. This provides an opportunity to enhance the skills and facilitate collaboration among the staff regarding the needs of their clientele from diverse ethnocultural

backgrounds, through discussing particular cases that people have faced in their own work, including providing trans-cultural psychiatric care or addressing communication issues between the hospital and immigrant communities. This mix between intervention and research allows staff to apply the latest knowledge to their own daily activities.

Another hospital in Montreal has adopted a unique program to raise awareness and provide staff with the tools needed for working in cross-cultural contexts. The program is led by a medical anthropologist, who works with a multi-disciplinary intervention group, including paediatricians, anthropologists, and psychiatrists. The aim of this intervention group is to meet with staff that have experienced a difficult situation in cross-cultural patient care. Through reviewing the case, the group helps providers:

understand why the situation evolved in a negative way...But it's never by giving an answer. It's by giving clues and they make their path...When an exchange is made, like for example in a service unit where I made observations...I was told after a year that there were changes. That is, they think about things about which they are not used to thinking, and it has a snow-ball effect, which provokes, what we call the reflective effect of research. And it works (A12: 230:250).

In Montreal intercultural training has been going on for over ten years, and it is slowly moving out into other regions of Quebec, as immigrants are locating elsewhere.

7.2.3.2 Intercultural Training in Vancouver

In Vancouver, a diversity program provides intercultural training through staff orientation sessions. They also provide handbooks on working across cultures. One of the key themes for a cross-cultural education program in Vancouver is to provide tools to assist the health care providers understand patients from another culture beyond stereotypes:

Around the cross-cultural care piece, a lot of times what people want is...cultural profiles. The trouble with the cultural profiles is that they have a very limited [value]... So what I try to do is...talk about the intersections of ethnicity, migration history and some of the social issues like education, class, marriage status, all that kind of stuff...And then, because people are so keen on cultural profiles...we do an exercise with cultural profiles, and help them see what is useful in a cultural profile and what's not useful, because there are some that are actually good...So we do an exercise with them on that...I give them a cultural profile, give them a case study, and...say how is this person like their culture, and how are they different? (B10: 844:907).

A service provider who has expertise in cross-cultural health does occasional presentations in a health care course at the University of British Columbia, but was unaware of any standardized approach to teaching cross-cultural care to health professionals in training, nor of any ongoing collaborative efforts between the teaching institutions and those delivering professional development programs to health care personnel.

An important part of increasing awareness of cross-cultural issues is through cooperation with immigrant service organizations. For example, immigrant settlement services in Vancouver regularly present to the health authorities:

providing background contextual information for new communities to give people a heads up on what they're dealing with - what they're going to see. And it helps then for their own internal program planning and in-service training (B5: 258:261).

The expectation of intercultural training and raising awareness about cross-cultural issues is that it increases staff knowledge about the types of communication barriers that may exist between patients and care providers. This type of intervention generally puts the onus on particular care providers to learn about other cultures and thus adapt their specific interactions with patients. As the barriers presented in Chapter 6 identify, the language and cultural barriers are only part of the problem in ensuring equity of access to health care

services. Despite the value in ensuring care providers are aware of different cultural values and approaches to health, the standardized norms of service delivery and the fee structures for the provision of care often limit the ability and the incentives for health care professionals to alter their service practices.

7.2.4 Community Health Partnerships to Support Increased Access

Many respondents in both Montreal and Vancouver identified the practice of transferring program delivery to communities as an effective way to increase access to services for groups with access barriers, although it was also seen as a strategy for shifting costs outside of the health care system. Many of the initiatives to enhance immigrant access to services have been developed through collaboration between community associations and health services organizations. In addition, there are a variety of advocacy strategies adopted by community groups to raise awareness about the issues of diversity, and to inform community groups about the availability of services.

7.2.4.1 Community Health Partnerships in Montreal

In Montreal, community groups representing immigrants and ethnically diverse populations focused a lot of their work on raising awareness within health services institutions: “to promote the understanding of diversity as being a primary concern, and that the health care institutions have to adapt to that” (A2: 52:55). This includes preparing statements to governments about the issues communities face, particularly where there are service gaps, such as in mental health. In addition, community groups provide information sessions for their members on the services available and how to access them, through weekly

open houses and ongoing presentations involving health service providers. Many community groups will accompany clients if they need support when accessing health services. A community group worked with the local CLSCs to initiate a project aimed at addressing the mental health of immigrant women, to help address the isolation and lack of participation in civil life that is common for many immigrant women.

Many community organizations have become more involved with training and services. For example, one association works with various groups of women on cancer prevention. In addition, they focus on nutrition, diet, and sensitizing women about other health issues, such as weight, baby weight, nutrition, and sexuality. They also focus on improving understanding of the mental health issues that face immigrants and refugees, particularly those from war torn areas.

One initiative to provide support was to develop collaborative partnerships on mental health initiatives between women's organizations and the community health centres. The partnership worked to share knowledge between women in the community and the health centres. The staff at a women's association noted that progress can be made "if everybody gets involved, comes to know...what is available here and what these people are going through" (A1: 416:420). For two years a community group organized pre-natal courses, in collaboration with local health authorities. The CLSCs were providing prenatal courses, but not in a variety of languages, so there was need among immigrant women for multi-lingual pre-natal courses.

7.2.4.2 Community Health Partnerships in Vancouver

In Vancouver community associations and health service providers also share information about health care in community contexts. For example the health authority will send staff to participate in English as a Second Language courses to provide information to newcomers about the services available. One ongoing public partnership project is the Multicultural Health Fair, hosted by the community associations in collaboration with the health authorities, community health centres, other health services providers and other community associations. This fair takes places every year, and all groups participating need to offer multilingual interactive activities. The fair takes place in a community neighbourhood house, and provides an opportunity for community members to find out about health programs and services that tailor to the needs of immigrants.

In Vancouver there is also collaboration between the health authority and community associations in providing multicultural health promotion programs. For example there are diabetes education programs offered in Cantonese, Mandarin and Farsi, and a multicultural healthy eating campaign aimed at seniors. Other programs address food security issues through community kitchens and nutritional counselling for ethnic communities. An immigrant settlement worker explained that they offer:

a number of programs for immigrant youth - children and youth, that involve training modules in...mental health... We have an 80-hour leadership facilitation-training program for immigrant youth which has a big section on mental health, where we have guest speakers coming in. So [we are] increasing the capacity of youth to deal with not only their own mental health concerns or issues, but also to be better support for incoming youth in their schools or neighbourhoods (B5: 174:184).

Programs such as health promotion initiatives to raise awareness, can be more effectively delivered through community groups, so there are cases where the process has led

to a transfer of resources and responsibilities to community associations to operate these programs.

The results from this research demonstrate that the response of the health care system as a whole to the needs of linguistic and ethnically diverse communities remains piecemeal and initiatives are often unsupported in the institutional setting. This chapter has demonstrated that there are a variety of strategies to address access barriers that immigrants face in the health care system, but that these strategies are applied inconsistently and many respondents felt that their own personal strategies are not necessarily supported by the health care system. Of these strategies, those addressing language barriers are the most systematically applied, even though there remain gaps in translation and interpretation services as noted in the previous chapter. One reason for this is that there has been a more concerted effort to provide evidence and a business case for their value. As Bowen *et al.*

note:

Addressing language barriers is the one strategy for improving organisational cultural competence that has both theoretical and empirical evidence linking it to improved health outcomes...However, in spite of this evidence, response to addressing language barriers has been slow and uneven, and in many areas important gains made over the years risk being lost (2010: Section 2).

The findings presented in this dissertation reflect that although language barriers are taken the most seriously, it is still not standardized in practice. As the data presented here note, although it is acknowledged that trained health care interpreters ensure quality care and patient safety for people with language barriers, the practice of using untrained interpreters is often the norm in many health care settings. This is a serious problem, as Bowen *et al.* have

asserted: “there is compelling international evidence of the risks of language barriers and use of services of untrained interpreters (to both the health of individuals, and to the health system itself)” (2011: 11).

The impacts of the other strategies are much more difficult to measure. For example, intercultural training does not have a research base to demonstrate its effectiveness in improving health services. Rather, research has shown that these approaches can be problematic: “there is emerging evidence on the limitations of many approaches to cultural training...[and] many educational programs rely on messages that are known to contribute to stereotyping” (Bowen *et al.*, 2011: 11). Respondents in this study emphasized the need to challenge stereotypes through their intercultural training. The problem raised by many health providers was that there were few opportunities to provide intercultural training opportunities. Another significant barrier noted by our respondents was that there were no mandates for service providers to change practice to accommodate diversity. In this sense, the cultural competency training approach has demonstrated limited effectiveness if not accompanied by the development of new institutional norms.

Misunderstandings about the relationship between ethnicity and health can continue to shape how services are delivered to ethnic minorities, through the development of institutional traditions or conventions. Research on the NHS in the UK argues that “the inertia from the history of previous decisions and existing institutions dominated by structural forces mean that policy movements are typically incremental, and strong conjunctural forces are required to move from an existing path onto a new trajectory” (Bevan and Robinson, 2005: 53-54). Real change requires a significant impetus.

Increasing knowledge exchange between communities and the health care system demonstrates a promising strategy for improving access to health services. The results above demonstrate that partnership programs between the health care system and communities associations often come from communities themselves based on their awareness of their needs. In addition to the partnership approaches discussed above, respondents noted a number of strategies to engage ethnically diverse communities in health system design, evaluation and delivery. These engagement strategies are discussed in the following chapter.

Chapter 8: Community Engagement: Structures, Processes and Practices

As noted in the previous chapter, many of the initiatives to improve access are based on partnerships between the health care system and community associations. This chapter explores how communities are engaged with the health care system in developing strategies for inclusion, and how these strategies are assessed by respondents. The information presented in the chapter is based on public documents as well as on the interviews with respondents.

8.1 Community Engagement Structures, Quebec

Community participation has been a longstanding commitment of health care reform in Quebec (Abelson *et al.*, 2002: 73). Health care researchers see engagement as potentially a way to develop more effective means of delivering health care services (Bowen, 2004; Church *et al.*, 2002; Kreindler, 2009), while political science researchers emphasize it as a strategy to improve accountability, including for tough decisions around priority setting (Abelson *et al.*, 2002; Contandriopoulos, 2004). In addition, participation was seen to increase citizens' sense of ownership and responsibility for health care institutions (Abelson and Gauvin, 2006; Putnam *et al.*, 1993; Tomblin, 2002).

The involvement of the public in health care boards did not necessarily lead to community decision-making around health services. For example, participation was a major theme of the Commission of Enquiry on Health and Social Welfare (1967-1971) in Quebec, which resulted in "extensive government-legislated public participation on a variety of Quebec health care boards" (Charles and DeMaio, 1993: 887). Despite the government

mandated participation in the regional health and social service boards (RHSSB), some scholars have argued that the process “ended up consolidating the power of professionals and bureaucrats rather than empowering citizens” (Charles and DeMaio, 1993: 887).

During the reforms that followed funding cuts in the 1990s, bodies were also used for “preparing their communities to digest and accept the changes imposed on them by their provincial governments’ health-care restructuring processes” (Abelson *et al.*, 2002: 81). The legislated reorganization of the health and social services networks in Quebec in 2001 “dissolved previously elected boards in favour of smaller government-appointed boards and changed the accountability of the boards’ chief executives” to the government rather than the elected representatives (Abelson *et al.*, 2002: 74). The end of the elected boards has created a situation where community groups no longer have a consistent place at the table in local planning. Instead, boards are now mandated to hold a people’s forum before submitting their three-year strategic plan to the Ministry of Health and Social Services (Abelson *et al.*, 2002: 75). This change has been viewed as a significant reduction in the opportunities for democratic participation in health care decision making, despite the limited power that the community representatives had on the boards.

8.1.1 Montreal: The Provincial Committee

A new engagement strategy for the formal participation of ethnocultural communities in Quebec is the Provincial Committee on the Dispensation of Services to Persons from Ethnic & Cultural Communities (from here on referred to as the Committee). The Committee was established in 2004 with the purpose of providing advice to the Minister of Health and Social Services on the planning, delivery and evaluation of services for persons from

Quebec's ethnic and cultural communities. The Committee is modeled on one that was formed in the mid-1990s for representing the needs of the English speaking community in Quebec. The aim of the Committee is to provide representatives from community associations with formal access to the policy process. The Committee has a legal mandate in the Health and Social Services Act (Quebec, 2009). It, therefore, enjoys a more permanent place in the system, although the Minister has discretion to constitute such a committee, so it is possible for a minister to decide to disband it at any point.

The Committee consists of eleven people named by the Minister who are nominated by various cultural communities and come from different regions in the province. The Committee acts as an expert group composed of people who have experience in their individual fields, strong ties to various ethnic communities, as well as knowledge of the health care system. They provide advice on matters concerning the health and social services network ranging from youth protection to care for the seniors to mental health particularly focusing on the needs of the cultural communities.

When commenting on the committee a respondent stated that: "The role of the committee is to see problems that others don't see" (A4: 328:328). The identified priorities of this committee include:

- Equal job opportunity in the selection of new staff members from ethnic and cultural communities;
- Increased participation of persons from ethnic and cultural communities on the boards of directors of health and social service institutions, users' committees...On the job training in intercultural relations for care givers, managers and administrators (A9: 12:31).

The members of the Committee are in contact with various community agencies across Quebec, and many issues are brought to the attention of the Committee through

ACCESSS, an umbrella association with affiliates on this committee. The Committee emphasizes institutional rather than patient level concerns. It prioritizes the employment of personnel of diverse backgrounds in the health care system, and have called for equal access programs that aim to recruit health care professionals such as nurses from different cultural communities (A4: 457:464). Committee members also visit different establishments in the health system providing services to ethnocultural communities. One of the demands raised by the Committee is to ensure that decision-makers are informed on matters concerning cultural diversity and receive intercultural training (A4: 471:477). The Committee emphasizes the need for adequate resources to be supplied to community organizations.

The Committee's main function is to advise the Minister on specific needs of ethnocultural communities in health and social services. When there is a Bill produced by the Ministry of Health and Social Services, it is sent to the Committee, to assess the details concerning its impact on cultural communities, or to evaluate whether any additions could be made to include needs of the cultural communities. They send their advice directly to the Minister. The Committee may decide to make its opinions public; however it can only do so after a 30-day period, to allow the Minister to respond or to take action before the advice is made public. This structure is meant to provide the Committee members with a direct link to the key decision-maker, although as will be discussed later, this link has not been so direct in practice.

8.2 Community Engagement Structures, British Columbia

The rationale for community participation in health care decision making in BC emerged in the 1970s from the Foulkes report. It recommended regionalized governance of

health care, which would give local authorities control and counter the overwhelming strength of the vested interests of the professions, institutions, and the bureaucracy (Charles and DeMaio, 1993: 886). This approach would see that “services be provided in line with local needs, and that community representatives be elected to newly created community human resources and health centres” (Charles and DeMaio, 1993: 886-87).

In 1993 the New Democratic Party (NDP) government in BC produced the report *New Directions for a Healthy British Columbia*. This regionalization plan for health care reform had the intent “to devolve substantial power over health services to citizens at the community level, not only to counter the power of the health professional elites, but also to foster a community orientation to wellness” (Davidson, 1999: S35). The stated aim of the policy was to improve democratic accountability of the service providers to the community, although after the re-election of the NDP in 1996 the focus changed, with a “retreat from political accountability to the community and an advance toward managerial accountability to the ministry” (Davidson, 1999: S36). The idea of elections for the Regional Health Boards was abandoned in 1996, although there were efforts to engage communities, particularly in the Vancouver-Richmond Health Board. They introduced a number of Population Health Advisory Committees, including a multicultural committee, and in 2000 developed a Framework for Diversity.

After the election of the Liberal Party in 2001, the Regional Health Boards were reorganized into 5 Regional Health Authorities and an overarching Provincial Health Services Authority for managing province wide services (Emergency Medical Services, BC Cancer Agency, Renal and Transplant programs and Women’s and Children’s Hospital). The restructuring was seen as a way to create efficiencies and further embed managerial

accountability, and included reductions in services and increased privatization of aspects of the system (Fuller, 2003: 3). The Vancouver Richmond Health Board was brought into the fold of the new and larger Vancouver Coastal Health Authority. The boards of the new Regional Health Authorities are appointed by the Provincial government.

8.2.1 Community Engagement in Vancouver

In the Vancouver-Richmond Health Board, long-time community involvement in health care decision making had become a norm, and the newly formed Vancouver Coastal Health Authority (VCH) maintained the community engagement department to continue participatory processes (though reducing its budget in the restructuring in 2001). The community engagement department had been around for a long time, as part of the previous Vancouver / Richmond Health Board, and it maintains a very active role in ensuring community participation. Since 2002 VCH has proceeded with consulting communities via the use of Community Health Advisory Committees, three that are regionally based and one for Aboriginal Communities (Vancouver Coastal Health, 2005). The aim is that members will reflect the diversity of their health service delivery areas, but they are not specifically oriented to immigrant communities. Members are appointed to the committees via a nomination process, and are expected to have an understanding of the health care system and be connected to communities. In addition to these committees, Vancouver Coastal Health carries out broad based community engagement through focus groups, surveys and interviews, often involving hundreds of participants (Vancouver Coastal Health, 2006). These consultation processes are the primary mechanism for engagement with Vancouver's ethnocultural communities. The stated aim of VCH's community engagement is to have: "A

two-way interaction process between VCH and its communities, so that communities have a role in decision-making about health services and policies that affect their lives” (Vancouver Coastal Health, 2006: 14). An example of the recent community engagement processes include:

- Palliative Care Strategy: Summer 2005 (139 participants, 5 languages)
- Diabetes: Fall 2005 (414 Participants, 7 languages)
- Multicultural Mental Health: March 2006 (266 participants, 8 languages)
- Pain Strategy: January 2007 (610 Participants, 7 languages)

At the time of the fieldwork, the advisory committees were regionally based, so there was no longer a multicultural advisory committee, but rather program based engagement that involved a variety of ethnic communities. Vancouver Coastal Health emphasizes the value of community engagement in building capacity both in the community and in their organization. Improving the health of communities and individuals in the service area are the main goals of the engagement processes. It is also designed to support the accountability of the health authority through building trust and credibility with communities served. The priority areas for engagement are often focused on specific health care practices, and on program development and evaluation.

A program manager noted that the “job in community engagement is to try and act as a bridge between community and [the health care system], so that community members have a voice, and feel that they have a mutual sort of communication relationship with [the health care system] about services, and policies that affect their health” (B13: 16:19). In addition, an important priority is to find out from communities how the services could be more culturally

appropriate and more in line with the needs of the community.

VCH Community Engagement protocols are available online to the public, as well as to their staff to provide information to both about why engagement is important. These documents emphasize the need to ensure that participants are aware of the purpose of their participation and what will be done with the information collected (VCH, 2003). The terms of reference for engagement emphasized the importance of informing participants of the potential for improvement of community services as a result of their input, and clearly define what is negotiable in the consultation. Engagement staff informs participants of the timelines for decision making and when they will receive reports about changes made. Participants are also offered more opportunities for engagement if they are interested.

As was noted by a service provider in Vancouver, community engagement processes: “usually have different activities like involving the community in the process of changing policies, and you know, kind of like re-designing the system and all those things” (B8: 120:125). The sessions are the primary vehicle for bringing the concerns of diverse ethnic communities to the decision-making and planning process. These engagement processes are provided in a variety of languages, and engagement personnel employ innovative approaches to reach communities that are known to have barriers to their access and use of health services.

Vancouver Coastal Health’s framework for community engagement identifies some of the following benefits:

- Bringing diverse voices into the planning process and allowing for consideration of perspectives that would not otherwise be understood

- Providing the health system with detailed information concerning community members' priorities and an opportunity to evaluate the responsiveness and accessibility of programs
- Enabling greater accountability
- Stimulating innovation as the system responds to emerging needs
- Increasing health literacy and health system literacy on the part of the public
- Developing bridges between the health system, non-profit organizations working in areas of health and social services and other relevant partners
- Empowering and activating individuals, families, and local communities to take increased responsibility for self-care and self-management
- Helping inform VCH on priority areas where it can fulfill an advocacy and health promotion function (Vancouver Coastal Health, Community Engagement Framework, 2006).

Despite the value that the health care organizations have placed on engagement, not all respondents felt that community participation actually serves to uncover the real concerns of the diverse communities. As the examples above have suggested, many of the substantial decisions about service delivery priorities are not brought to the community engagement table. For example, the agenda for engagement is set by the health authority, and some issues are not up for discussion (such as budgetary concerns), as was expressed by respondents in Vancouver. In Montreal respondents felt that the engagement process allowed the health care institutions or governance structures to selectively decide what information from community would be solicited, thereby filtering the input from communities to just the acceptable recommendations from participants. The different formal processes of community engagement of the health care systems in Montreal and Vancouver demonstrate the institutionalist emphasis on how the structure shapes the content of the discussion, and the types of strategies pursued. For example, the focus on programs as seen in Vancouver leaves some of the larger more long-term policy issues (such as the recognition of foreign

credentials) unaddressed. While in Montreal, respondents felt that the community engagement process of the Committee focused on higher level policy change that was difficult to achieve. In both cases, it was noted by representatives from immigrant advocacy associations that the decision makers in the health care system often knew the changes that they wanted, and community input would be selectively inserted into an already defined approach to health care policy and or practice.

8.3 Informal Processes of Engagement

In addition to the formal processes discussed above, many people we spoke with have been involved in more ad-hoc engagement also shaping health care service delivery. Often health service delivery institutions rely on ad-hoc consultation with local community associations.

The two associations focus on participation throughout their respective provinces, identifying disparities across different regions, as well as within cities in terms of provision of services, access and participation. Both associations engage in needs assessment for ethno-cultural communities and report and disseminate this to the general public. The fact that these organizations were frequently referred to by other respondents in the study clearly demonstrates that they are important players in setting the agenda and raising awareness of the issues that ethno-cultural communities face in Canada. The numerous resources available through their websites also emphasize their valuable contribution to raising awareness among ethno-cultural communities about the rights and services that they are entitled to.

8.4 Perspectives of Participants on Engagement Processes

People differently placed in their relation to the decision making process (for example community representatives and program managers) present different views regarding the nature of access barriers, as was seen in Chapter 6. Including various perspectives in the analysis provides an opportunity to compare participation in formalized processes versus informal processes of working for change, and the purpose that people feel is served by engagement between health care providers and communities. The data provided here are quotes from the interview transcripts, that were coded as methods of participation in advocacy aimed to improve health care for immigrants and ethnically diverse communities. Specifically our participation codes (codes 6-9) are grouped by participation through: 6) general civil society organizations; 7) immigrant associations; 8) individual efforts; and 9) health care sector and state actors.

A liaison worker in Vancouver observed that there is a lot of openness among service providers to address the problems of unequal access:

They want programs improved for immigrant communities. They want the programs running at the optimum not only for English-speakers, but for non-English speakers...There's not this "oh those people don't need" or "oh we're doing fine" "it's too expensive to do consultation"... We're finding a lot of openness from people (B13: 118:126).

Although there is this openness, there may be different perspectives on what it means to make improvements in service access. Service providers observed that immigrants lacked knowledge about how the health care system works, emphasizing the individual deficit model, so their efforts for change included providing community associations with more multilingual information about how to access the health care system and about particular programs. Immigrant associations placed more emphasis on the health care service

provider's lack of knowledge in providing culturally competent care, therefore focusing on the need service providers to be trained in providing culturally competent health care to make health services more welcoming.

Below I provide the most significant themes that reflect the data, using comments from people active both within and outside the health care system, to illustrate the different engagement processes, their value, effectiveness, and sustainability.

8.4.1 Engagement and Knowledge Brokerage

In general the main benefit of community engagement was the opportunity created for sharing knowledge between health care providers and the communities that use their services. As noted by staff in Vancouver:

Hopefully it's always mutual learning - that's our goal...It's that we're giving information out to the community, so that they're informed enough to then give information back to [the health system], so that [it] grows as well (B13: 392:395).

A key focus in Vancouver was the importance of establishing ongoing partnerships with community agencies. The voice of the communities plays an important role in bringing the issues to the agenda, and at the same time, community organizations can play a significant role in bringing to the table people who would be otherwise difficult for the health system to reach. Often health care workers will come to already established community associations to ask them to participate in engagement and information sharing, rather than trying to set up their own community meetings:

No-one would have come to a focus group if I had called it for the Korean community, no matter how nice I am, you know?...If you step into an established group and politely ask "can we borrow 2 hours of your time" -

people are completely open to it. And because they're working with someone they already know, there's already a lot of trust there (B13: 550:558).

In Vancouver, engagement with the community is used as a way to evaluate programs, and care providers in this study have noted that the high level of cultural and linguistic diversity in Vancouver makes it essential to ensure that those voices are heard, given that they are a significant portion of the clientele: "we will ask questions around cultural relevance if we're evaluating your program...and that raises awareness in a huge way...You need to talk to these five language groups, because that's who we're seeing" (B12: 533:547).

Partnering with community organizations also allows the health staff to understand the best ways to try to reach community members for input:

...we have tried, through some more traditional methods, to reach those folks and it's not working. So we have partnered with community associations, with neighbourhood houses, with a variety of different groups, as one strategy to involve those people in the planning and get their input into how services are designed (B12: 175:201).

At the same time it was noted that it is necessary to develop buy in from the health system and care providers in order to ensure that the organization itself is prepared to integrate the feedback from community members: "we do a lot of work to build the readiness for meaningful engagement among the leaders within [the health care system]... it could be anything from telling a group of planners that they need to stop planning while we go and do engagement" (B12: 205:247). It was also necessary to make practitioners aware of the value of this input and its purpose:

People are worried about being told they're doing a bad job when they're already working hard. So we explain that that's not the purpose. We're not

the watchdog [to] wag our fingers and say you're doing this wrong, but to involve the public actively in an on-going way, in health system improvement. So, to overcome some of that resistance in the beginning, we will do...sessions with a staff team and [explain]...this is the purpose of why we do this work with members of the public, and how can we work together (B13: 180:187).

In Montreal, program managers spoke to the value of The Committee in providing advice regarding the services and programs to meet the needs of newly arriving immigrants:

All of their advice is seen through the eyes of the health and social services network and the role that network can play in better meeting the needs of cultural communities. They work with the immigration department, in terms of planning for the arrival of new immigrants, getting together with the regional agencies in order to have staff training around diversity management and all these kinds of things (A9: 12:31).

Community associations also play a key role in providing advice for patient care. For example, a women's association in Montreal had a client who was going through a phase of depression and was very upset. Because she had come to their centre before, the mental health workers wanted them to be in the consultation team to help find some solution for her. The local CLSCs often call upon this association to provide cultural information to the social workers and the nurses working there. In addition, the association does presentations to the health care centres on how to deal with patients from different communities, how to approach them, and how to get information:

Sometimes they call us for not only language but the consultation also. When they are trying to find ways to help this person, they wanted to know the cultural aspects also. So we sometimes are called to give our opinion, point of view, with reference to the culture, why this person is like this, why is she saying things like this? (A3: 363:366).

Health care providers will contact immigrant associations to get their advice on dealing with a particular patient, and community associations will host representatives from

the health care system to discuss matters with their members, such as the services available and how to access them.

8.4.2 Advocacy and Awareness Raising

Developing partnerships between health service organizations and community associations is an important strategy for raising awareness of the issues of diverse communities in the health care setting. Community associations are able to provide a public voice to support those working in the health care system to improve their responsiveness to ethnically diverse communities. At the same time, those working within the health care system are better able to provide advice to community groups on opportunities to effect change in the system, and on strategies for bringing forward their concerns in ways that will gain the attention of decision makers.

People working in the system also noted that there is often a disconnect between the strategies that community groups use to press issues and the way that messages are best received by the health authorities. It was noted by a health care knowledge broker in Vancouver that a key part of their liaison work between the community and the health care system is to work with both sides to develop strategies of effective knowledge translation. Specifically it was emphasized that not only do they work to prepare health care staff to respond to community concerns, they also try to assist community members to focus their concerns in ways that are more likely to promote meaningful engagement rather than confrontation:

I don't always find the immigrant organizations that strategic. Most advocacy organizations kind of take the "you're the big system, we're out here"...Decision makers...don't listen to you when you're pounding the

table. So, I think they have a huge role to play in advocacy and we have a huge role to play in helping them be effective in that (B12: 617:648).

In Montreal, members of The Committee noted that they work to raise awareness of people at senior levels in the system: “Another demand that we formulated is at the level of the decision-makers. Decision-makers include the Ministry and hospital staff, the Vice-Minister and the hierarchy beneath the Minister. We ask that they receive intercultural training” (A4: 471:477). This senior level approach to advocacy was seen as necessary because these people set the agenda and priorities in the health care system. For example, one respondent noted a gap in mental health:

...mental health care of immigrants or refugees is not perceived as really a priority. So we're very worried about that, and what we have been doing is briefing governments, sending them...information about the problem, trying to open doors...lobbying the government so that we can improve the situation (A2: 121:127).

Immigrant associations in Vancouver also noted the importance of framing their concerns in terms that would resonate with the decision-makers:

So, we have to speak the language of risk management. Somebody has an operation, and you take the wrong leg off, because the person didn't understand the informed consent because it wasn't in a language they speak and nobody interpreted it; that's a huge issue for that health authority (B2: 93:96).

Therefore, there is a sense that the moral argument for what is right and just (and in line with legislation) does not resonate with the decision makers in health care.

8.4.3 Community and Health Authority Service Partnerships

Service providers in Vancouver noted that they provide support to community associations through utilizing community based services, or developing project partnerships.

Immigrant associations and program managers in the health authority develop partnerships through providing mutual advice and support for projects and events. The Multicultural Health Fair hosted annually by the Affiliation of Multicultural Societies and Service Agencies (AMSSA) is an example of an ongoing partnership between community associations, service managers and providers in raising awareness about the services that are available to communities. At the health fair, multiple service providers, including health programs and advocacy groups have tables that provide interactive multilingual health related activities and information. In addition, the Vancouver Coastal Health Advisory Committees had representatives at the health fair to provide information on how community members can become engaged in health care planning and evaluation.

It was noted that the role of community associations in providing guidance for immigrant and refugee patients in Vancouver was seen as a welcome help to service providers who have not been trained in cross-cultural care: “because they are so frustrated, so they welcome any help really, because of the work overload, because of their difficulty in communication” (B8: 661:670). The same situation was noted in Montreal, where a community organization worker explained that they were often drawn upon by service providers for advice:

We are working very closely with these government agencies, like CLSCs, hospitals, schools, because [these institutions] have families and children whose parents don't speak the language [using their services]. They need our help [to] understand what is happening, why parents are like this, what is wrong... We are... a liaison between the families and these agencies (A3: 39:44).

In addition, feedback from community members has been an important part of improving the services provided. In Vancouver, it was noted that sometimes the feedback from community can be difficult for the care providers to hear:

For hip fracture, we had feedback from Cantonese and Mandarin speaking patients who were actually quite bitter, and quite angry about the service they received. And it wasn't about being older or having hip fracture, it was about speaking English. And, the staff I think were a little shocked, and a little hurt themselves. Because they want to believe that they are doing the best they can. But it's one of those things where you just don't know what you don't know. So the information from the Cantonese and Mandarin patients was a shock, but after that shock settled in, about three months later...they made changes to their service in order to respond to those needs (B13: 612:626).

There are also examples where the health service organizations have provided community associations with funding in order for them to offer the services in a manner that is more appropriate for the communities being served. In Vancouver it was noted that:

We have a number of examples where we started with consultation or surveying and then eventually where the partnership moved...to have the community running their own program...Instead of having a professionally driven, clinical team, a lot of times through the engagement process the community said "we want peer support...we don't actually need nurses to do it, we need peers from our own community" so the models, in some cases, have radically shifted and...we just fund the new model, to support that community process (B12: 250:262).

In Montreal there are similar examples of community organizations being funded to provide health care services for ethnically diverse communities:

Especially right now the focus...is breast cancer, and the work that they are doing is funded to great degree by Public Health Quebec...So in terms of cancer prevention, diagnostics etc. and sensitizing women of cultural communities, that has been a major concern...So we are trying to give a whole spectrum of training sessions, and that's unusual for [us], but we have become more and more involved with training and such services, over

the years, even though the primary role of [our organization] is not to provide services(A2: 93:107).

Vancouver and Montreal have many immigrant-serving associations offering health promotion and disease prevention services for their members, and many have partnered with the health care system in developing more services. At the same time, such an arrangement can also put additional strain on community associations. In both cities, immigrant associations encounter challenges in securing finances and maintaining sufficient staff. Much time is spent preparing grant applications, and often associations need to compete with each other for limited resources. Adding program delivery to their responsibilities can limit their ability to maintain the advocacy work, which for many of these associations is their primary mandate.

These types of arrangements of moving services under the responsibility of community associations create a contradiction for these organizations. Once again, responsibility for ensuring the appropriateness of overall health services is redirected to creating pockets of culturally appropriate services that are outside of the health care system. Although this may be an easier way for communities to ensure that services are specifically targeted to their needs, the need for adapting the mainstream services gets sidelined. At the same time, organizations are put in a difficult situation, where they are taking on the provision of services that were previously provided by the health care system. While these types of arrangements provide community associations much needed funding to keep their organizations in operation, it limits their ability to take on their advocacy role in overall systemic transformation of health services.

This chapter has demonstrated that engagement between the health care systems and communities in Montreal and Vancouver takes a variety of forms. These forms in turn seem

to influence the types of strategies pursued to improve access. The following chapter brings together a discussion of the interplay of access barriers, strategies for change and the engagement of communities through the development of a model that highlights the need for an integrated analytical approach to understanding immigrants' experiences in the health care system in Canada that examines the interplay of structure and agency.

Historical institutionalists often approach a comparative study looking at why events happen in certain times and places, and not others. Institutional analysis often involves the methodological approaches of comparative politics, as it compares how factors interact differently in divergent institutional structures. Therefore, a comparative analysis of similar change processes in different institutional settings can provide valuable insight into how different contexts can lead to different outcomes of decision-making processes. Examining how the health care system increases responsiveness to ethnically diverse communities in contrasting contexts (of both place and time) can provide insight into the influence of those contexts on the change process.

This brings the analysis back to the conceptual framework introduced in Chapter 2, the relationship between the spheres of influence (SOI - the social, political and economic contexts), and the interaction between patients and care providers and between communities and the health care system in the contested zone of interaction (ZOI) that together shape experiences in the provision of health care for immigrant and ethnically diverse communities in Canada.

Chapter 9: Discussion

The analysis of the data from respondents has shown that the full inclusion of and engagement with immigrants and ethnically diverse communities in public institutions (in this case health care) in Canada is still not being achieved. The policy framework is valuable as a moral and ethical basis for social inclusion of all peoples in Canada regardless of their ethnicity or culture, and thus distinct from the European cases. Despite the legislation at the national and provincial levels and the initiatives within health care organizations, immigrants still face many barriers in accessing the health care system in Canada.

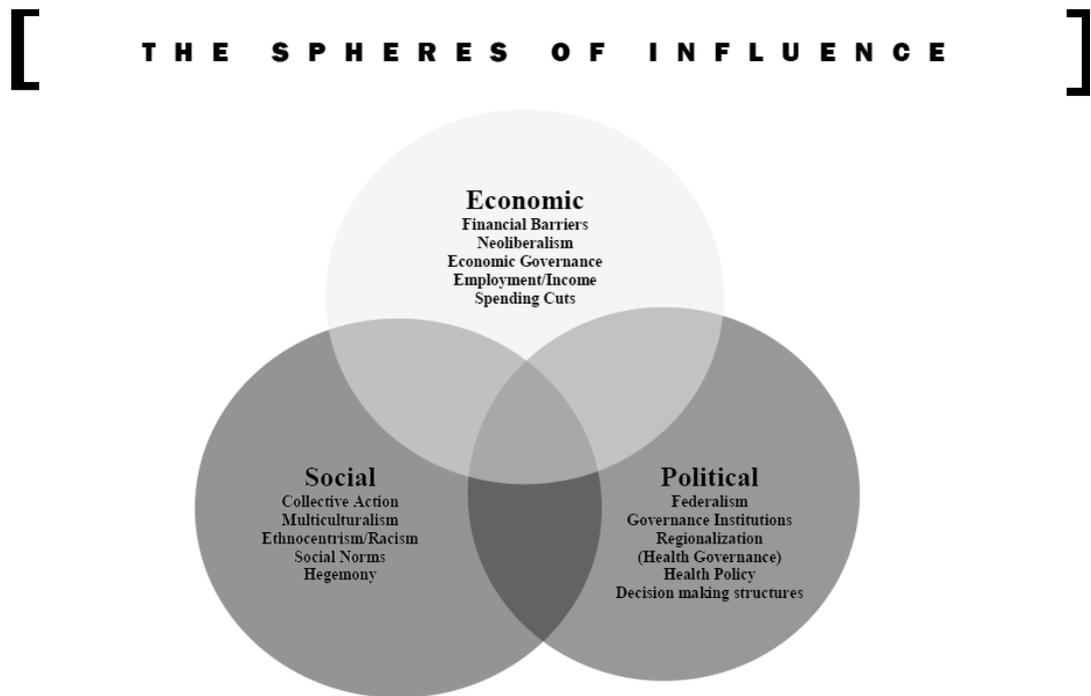
The conceptualization of access barriers discussed in Chapter 2 categorizes the barriers into different types: economic, social and political. Each of these categories have value for conceptualizing the types of barriers; yet the analysis of the empirical data on barriers presented in Chapter 6 demonstrates that barriers are multi-faceted, and do not exist in isolation from each other. The analysis in Chapter 7 shows that addressing only one of the categories of access barriers (i.e. the social barriers) through translation, interpretation and inter-cultural training has been an inadequate approach to significantly changing immigrants' experiences of exclusion in the health care system. I therefore propose below an integrated analytical model that focuses on both the societal and institutional contexts as a way to draw attention to sites and strategies for change. This model builds on the access categories discussed before, by reflecting on the empirical data about access barriers, how these shape interaction, and the role of engagement in developing strategies to address barriers.

9.1 Conceptualizing the Spheres of Influence on Health Services Access

In order to account for the variety of conditions that shape health care access, I have developed a conceptual model that brought together critical and constructivist theoretical paradigms. Critical theoretical perspectives emphasize the importance of examining the broader social, political and economic contexts, which I have labelled the spheres of influence (SOI). Constructivist theory guides the research to examine diverse perspectives and experiences of the interpersonal relationships that take place in socially contested space, or what I call the zone of interaction. Combining these ontologies guide the analysis to examine social concerns (i.e. access to health care) through a combined focus on broader contexts and specific social interactions that together shape experiences in the health care setting.

The resulting model for analysis, the ‘spheres of influence and the zone of interaction’ or SOI/ZOI model, helps organize the epistemological approaches to creating meaning from the empirical data. In developing the model I have incorporated the access concepts discussed in Chapter 2 in the model to incorporate both theoretical paradigms. This model can guide direction for social change (the goal of critical approaches), as well as demonstrate that the actor’s frame of reference within the social, political and economic settings leads to the production of knowledge about the social world that is based on those unique experiences. Figure 9.1 below demonstrates the types of issues within each SOI.

Figure 9.1 The Spheres of Influence



The social sphere embodies the dominant cultural norms of society, including social hierarchies that stem from the relations of patriarchy, colonialism, racism, consumerism, and individualism. At the same time social process within society can change these hierarchies and norms. The political / governance sphere includes policy as well as service design issues, which shapes some of the elements of institutional exclusion. The political sphere examines decision-making in contexts of multi-level governance (as in federal systems), regionalization and the restructuring of the networks of public service institutions. The economic sphere incorporates both the personal economic barriers, as well as the economic contexts of health care institutions, therefore shaping access at both levels. Critical theoretical perspectives have provided guidance on identifying these spheres of influence and the way they shape access, and in this sense can provide direction for the types of changes needed to address these barriers. Constructivist theories direct us to examine the influence of

advocates, such as community associations in the zone of interaction, as they emphasize that engagement can lead to the creation of collective reconstructions that can inform new praxis (Lincoln, Lynham and Guba, 2011: 106). The research presented here demonstrated that the types of changes tend not to address all three spheres.

9.1.1 The Economic SOI

Economic exclusion is operationalized in day to day interactions, reflected in processes of downward mobility that many immigrants experience. The economic sphere includes labour markets, where many immigrants face high unemployment, downward pressure on wages, and discriminatory hiring that does not recognize their credentials or experience. In this dissertation, I present the political economy approach which emphasizes that the broader fiscal and economic policy constraints also should be part of the analysis. The economic context also shapes government spending, and guides the choice of economic policy tools. The success of new initiatives requires resource commitments; therefore resources must be a central concern in assessing the legal commitment to new initiatives. New economic models that enforce efficiency principles on health care service delivery, through the commodification of health services also change institutional norms of health service delivery.

In both Montreal and Vancouver, immigrant associations and health service providers said cuts to health care spending increased access barriers. People noticed a decrease of staff in the system, and less time for staff to spend with patients. The interpretation service in Quebec provided approximately 20,000 translations per year (with the vast majority in Montreal), compared with Vancouver that provided closer to 5000 per year. It was noted by

service providers and immigrant associations that there were recent decreases in funding for immigrant specific services, including language programs and settlement services. In addition, a lot of funding is project based and short-term, creating uncertainty and competition between immigrant serving associations for decreasing dollars. Personal economic factors were also an issue for immigrant access to health care services in both locations. In Montreal, health care providers described that the financial situation of immigrants has worsened over the past decade.

9.1.2 The Social SOI

In both locations it was emphasized that access to services varied across ethnic groups. In Vancouver, people in the health care system noted that larger immigrant communities have better access to services, while in Montreal service providers and immigrant associations felt that immigrants closer to the dominant culture had fewer access barriers. The isolation of immigrant women was highlighted as a concern for women's health and mental wellbeing by immigrant associations in Montreal, and was seen as an access barrier by service providers in Montreal, who noted that immigrant women who are isolated are not learning about the services available to them and have communication barriers when they do access services. Service providers and immigrant associations in Vancouver explicitly stated that existing social networks were essential for facilitating immigrant access, whereas immigrants without these networks had more difficulty in accessing health care. Lack of knowledge of the health care system is an important barrier to access, and respondents noted that this is both patient driven, in that people do not inform themselves of the services they have access to, and system driven, in that inadequate effort is made to reach

diverse communities to make them aware of health services. Immigrant associations in Montreal and health care providers in Vancouver noted that the lack of knowledge of how the health care system works is an access barrier, noting that many immigrants come from countries that do not have a welfare state model health care system, so they are unfamiliar with how the system works.

In Vancouver service providers noted the cultural bias in the system along Western notions of health care, and that different cultural understandings about health care, particularly mental health, between health providers and immigrants made immigrant less interested in accessing the services. Service providers in both locations noted the lack of cross-cultural training amongst staff as an access barrier. In Montreal, service providers and immigrant associations identified racism and ethnocentrism as particular concerns for equality in the health care system.

9.1.3 The Political/Governance SOI

In Montreal, service providers discussed a disjuncture between the professional ethical commitment to provide care and the policies that determine coverage, with specific problems for immigrants or refugees with uncertain status. It was also noted that the institutional norms are not reflective of diversity. There was recognition among service providers and immigrant associations in both locations that there is inadequate planning or commitment to accommodate the growing diversity of populations served by their health care system. In Vancouver, service providers stated that there is insufficient time for intercultural training, and the provision of interpreters is not normalized in the system nor among staff. In contrast, the need for translation is normalized to a greater degree in Montreal because of the

guarantees for French and English speakers although they noted that the design of the interpretation service, which is only open daytime Monday to Friday, is a barrier to access (along with the cost of it, discussed earlier).

Structural issues were identified as a problem by all respondents. Service providers in Vancouver and Montreal thought that the waiting time for health care coverage was a barrier to access. Service providers in Vancouver, despite the existence of the Bridge program, spoke of the confusion about coverage and complicated approval processes for the health insurance plans for new immigrants. In Montreal and Vancouver, immigrant associations also saw the lack of full service coverage for new, irregular or illegal immigrants. Service providers in Vancouver noted that often concerns about deportation preventing service use.

Immigrant associations in Vancouver and Montreal as well as Vancouver service providers stated that the role of family doctors as the gateway into the healthcare system creates a serious bottleneck in the system. Many immigrants (and other Canadians) have difficulties in accessing a family doctor, specifically one that speaks their language. Immigrant associations in Montreal and service providers in Vancouver emphasized that this problem is aggravated by the fact that foreign doctors do not get recognition for their credentials and thus are unable to practice in Canada.

Each of these spheres of influence (SOI) contains complex social processes, and various meanings of the concepts they entail. As we have seen in the data presented here these spheres of influence do not operate in isolation, but are overlapping. The SOI model therefore proposes that instead of having a distinct category of “barriers to equitable access”, the space in the centre of the spheres of influence is the zone of interaction (ZOI), in which experiences take place that are shaped by all three of the SOI.

9.2 The Zone of Interaction

The ZOI is negotiated space, in which there are many actors and a variety of voices can be heard. Increasing pressure from the social sphere of influence has raised awareness of the problems that immigrant patients experience when accessing health services. Community associations have made demands on the system to be more responsive, and numerous initiatives have been put into place within HCOs to address these concerns, although the results presented here demonstrate that there is room for improvement.

The zone of interaction (ZOI) is shaped by the interaction of all three spheres of influence (SOI), and by the complex interaction between people within the health care organization (HCO). The interaction of health care providers and patients is shaped by institutional rules, design, and norms concomitant with the social and economic hierarchies within those. This ZOI is the negotiated space where interaction shapes people's daily experiences — and the creation of “facts on the ground” — in public institutions. The conditions in the SOI can either support or hinder equitable access. Figure 9.2 shows the ZOI embedded in the SOI model.

Figure 9.2 The Spheres of Influence and the Zone of Interaction

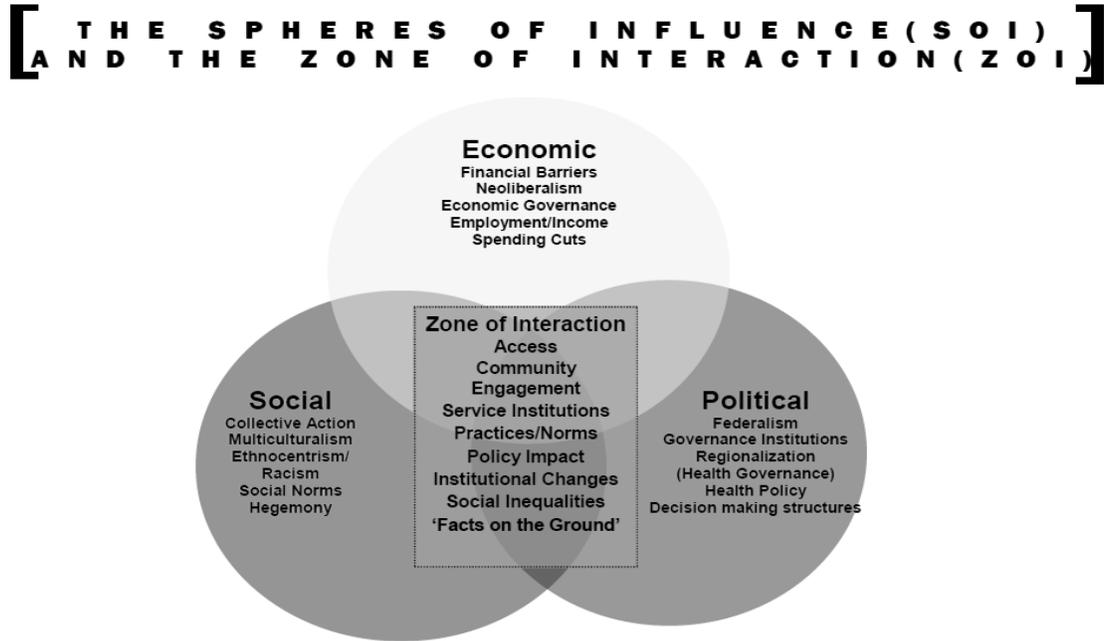


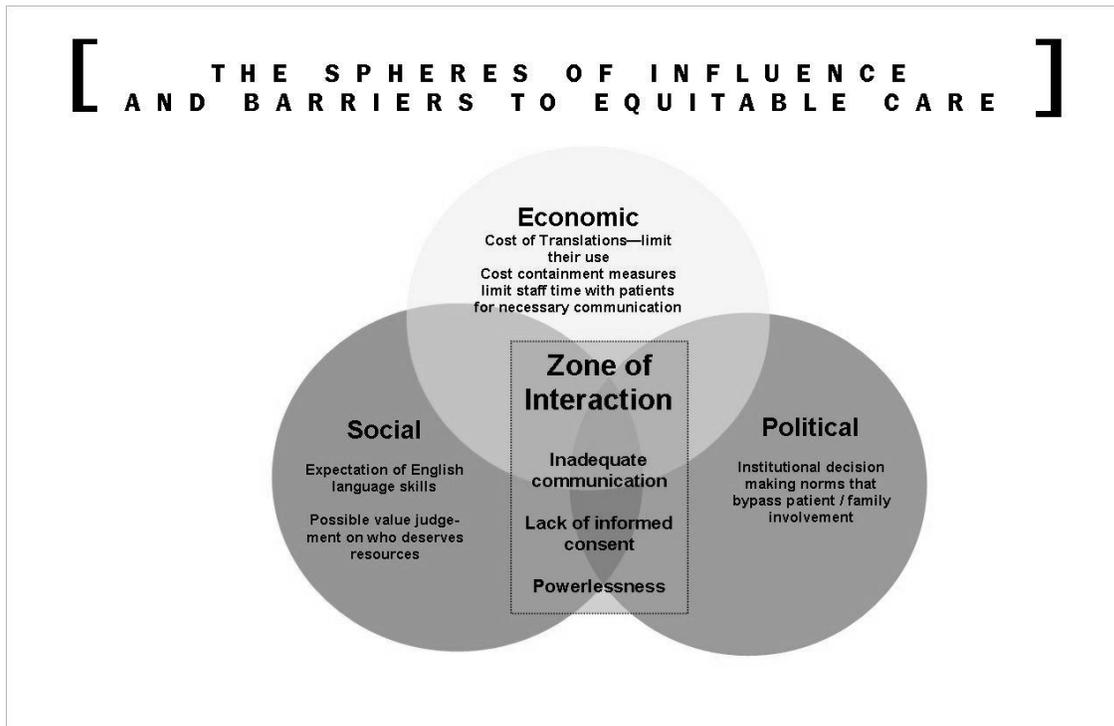
Table 9.1 Experience of Barriers in the Zone of Interaction

IOS	Montreal		Vancouver	
	<i>(white columns are responses from people within the health care system/shaded are from immigrant associations)</i>			
	equal/equitable for immigrants	Access is not equal/equitable for immigrants	Access is not equal/equitable for immigrants	Access is not equal/equitable for immigrants
		Variation across the system	unevenness across locations and service	Variation across the system
	Underutilization - system not user-friendly		Lack of use of preventive care—access through emergency	Unaware of rights to interpreter
	Confidentiality can be compromised Important information can be missed	Confidentiality is compromised because of use of untrained interpreters (staff or family) Risk of improper diagnosis	Interpreters not available across the system and not used Privacy not honoured Inadequate translation services	Confidentiality is compromised because of use of untrained interpreters (staff or family)

Table 9.1 provides the themes emerging from the data on barriers within the zone of interaction. Respondents in general felt that there are many access barriers, and the discussion above lays out some of the many conditions that people feel shape the experiences immigrants have in accessing health care services. Despite the problems identified, respondents also emphasized the significant variation across the regions and services, among service providers, and among ethnic groups. As was noted above, some groups have better access, and some service locations and providers are more responsive to immigrant needs.

Still, service providers in Vancouver and Montreal all expressed that immigrants as a whole under-utilize the health care system. It was noted by all service providers that preventive care is the least accessed, and many immigrants access the system through emergency, when they are seriously ill, or in advanced stages of pregnancy. When accessing the system, service providers and immigrant associations in both locations expressed that there are serious inadequacies in translation / interpretation services. Service providers in Vancouver and Montreal noted that in these circumstances important information can be miscommunicated. Service providers and immigrant associations in Vancouver and Montreal expressed that patient confidentiality is compromised because of the inadequacies of translation services. To provide an example of how this model can help us understand access barriers, the figure below demonstrates how the choice to not use interpretation services may be influenced by a number of factors from the SOI, and shows how these shape the patient's experiences in the ZOI.

Figure 9.3 The Spheres of Influence and Barriers to Equitable Care



In general, immigrant associations, program managers and service providers all identified common access issues and had some concerns with the problem of unequal access. Figure 9.3 presents an example of how this model can be used to help analyze the types of barriers identified by respondents, and how barriers overlap to create context-specific facts on the ground in the ZOI, using the SOI/ZOI model to demonstrate how equity was compromised. This example demonstrates that conditions within each of the SOI have relevance to the experiences patients have in the health care system.

In addition to providing the flexibility to incorporate a variety of issues, the SOI/ZOI model also emphasizes that there are multiple perspectives about the conditions within the ZOI, based on different positions within or perspectives on each of the SOI. Above I presented some of the detailed results for Vancouver and Montreal. Figures 9.4 and 9.5 plot the responses of service providers and community associations in Montreal and Vancouver

regarding the conditions that shape inequitable access to health care for immigrants into the SOI/ZOI model.

Figure 9.4 Vancouver Perspectives on Economic, Social and Political Barriers and the ZOI

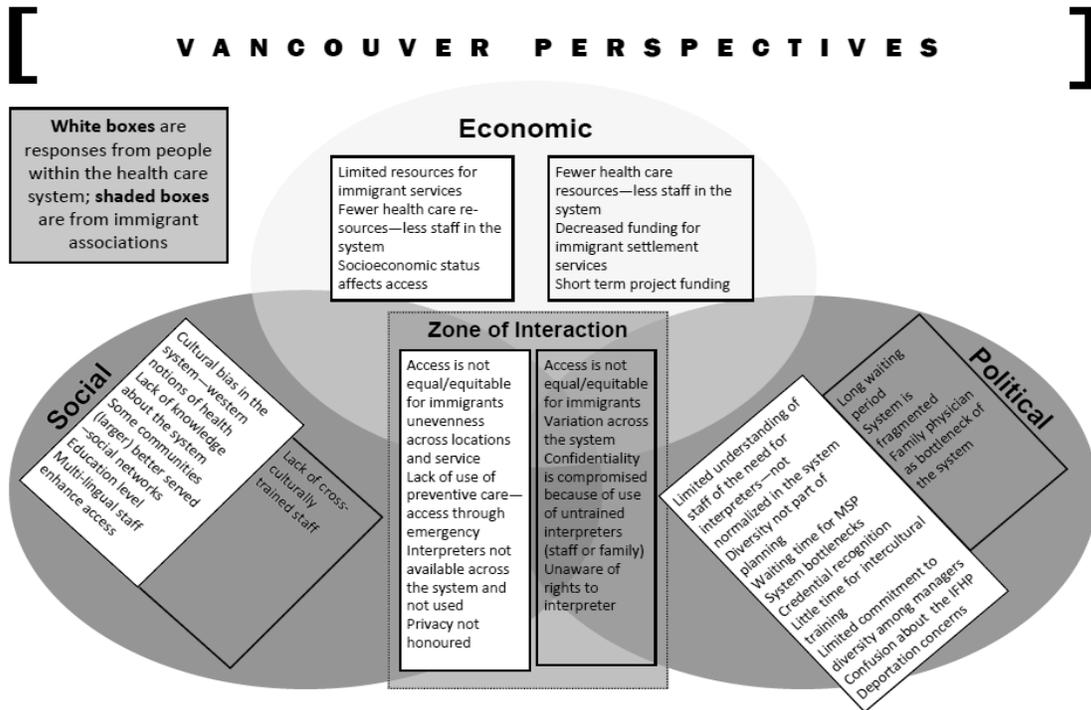
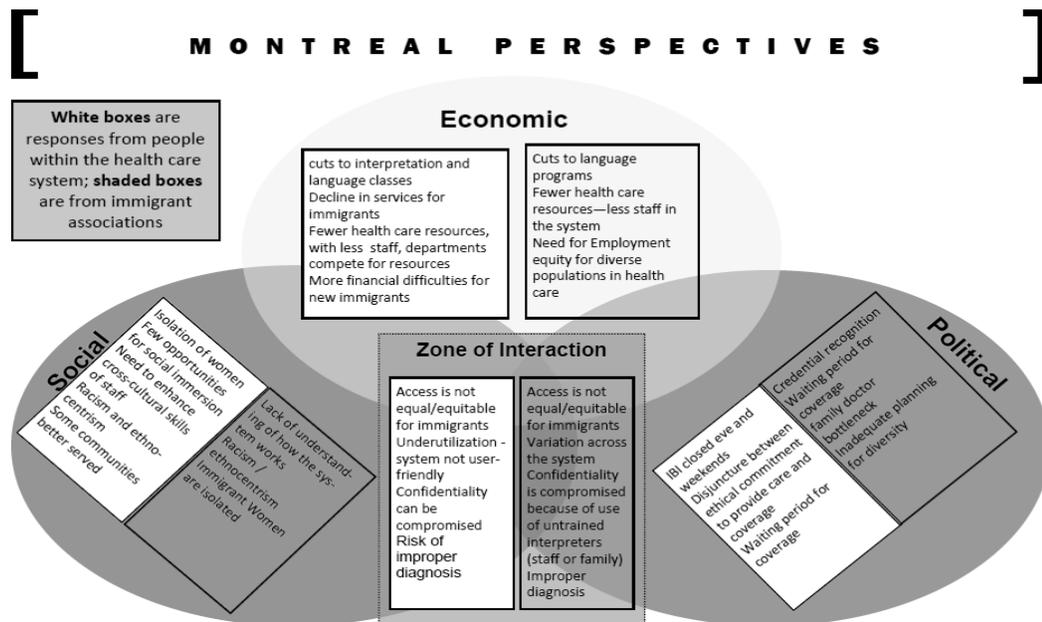


Figure 9.5 Montreal Perspectives on Economic, Social and Political Barriers and the ZOI



The SOI represent structural norms that shape experience in the ZOI. As the figures above demonstrate, these experiences are not the same across locations and respondents. Respondents stated that there are vast differences in access to care, citing issues such as geographic region, specific urban locales, ethnic group, social position, educational background, official language proficiency, legal status, gender, migration history, and the actions of both patients and care providers.

As discussed earlier, although engagement is a common strategy among health care providers to assess community interests, the specific purpose and format of engagement processes follow many forms. The following discusses the processes for community engagement and identifies some of the ways that engagement addresses the access barriers discussed here by providing a voice for ethnically diverse groups working to improve immigrant experiences in the ZOI of health care.

It is important to stress that although the factors within the spheres of influence shape the action taken by people, neither the actions nor outcomes are pre-determined. In addition, “norms and social understandings often have different influences on different agents” (Finnemore and Sikkink, 2001: 397). Different actors in the process will have a different perspective of what the problems are and what needs to be done to respond. As we saw in the data presented earlier in this chapter, there are similarities and differences between and among service providers and immigrant associations in all the locations in this study (see figures 9.4 – 9.5 and data tables 5.2-5.4). Despite a general sense among all respondents that immigrants do not have equal access, there were different suggestions on what the problems were, and therefore on what needed to be done to address those problems.

This thesis is guided by an understanding that changes within the zone of interaction are made through conscious action/interaction. Individuals’ actions are either facilitated or constrained by a variety of factors, such as those we see in the SOI. Therefore, it is essential to recognize how these structures shape the choices made by people who are working to make improvements in immigrants’ access to health care services. At the same time, it is important to note that the agency of individual actors within these institutions can lead to unique and unforeseen outcomes. People do not simply act as proxy for the institutional structures they represent, neither is their action entirely determined by these institutions. Instead institutions and the people acting within them create the reality of that setting. This approach provides us with the conception of ‘agents as reflexive, knowledgeable and purposeful actors’ (van Apeldoorn, 1999: 20). Individuals play a significant role in adapting healthcare services for ethnically diverse communities, therefore responses are likely to be varied. The conscious action of individuals creates the space of social interaction, which is

shaped by the contexts in which they operate. The actions of people operating within the zone of interaction and informed by an understanding of the spheres of influence can create the driving force behind both changes and the lack of change in the social order. This theoretical stance is supported by institutional ethnography as a method of exploration in which we “understand everyday life to be *constituted by people* whose activities are coordinated in specific ways” (Smith, 2005: 69).

The way that people interact “cannot be understood without reference to the meaning and purposes attached...to their activities” (Guba and Lincoln, 1994: 106). At the same time, the influences that shape people’s practice are not always conscious, but instead can be an unconscious subtext guiding decisions and actions that the actors themselves are either unaware or only dimly aware of. “The strength and continuity of new ideas often depends on the degree to which they become embodied in institutions” (Finnemore and Sikkink, 2001: 407). Institutional norms, such as cultural bias, are often unacknowledged or unrecognized by those from the dominant culture, who then unknowingly perpetuate them in their practice.

The process of changing institutional norms involves the interaction of a variety of social actors (agents), and this interaction can bring about changes to both agents and structures. In this sense, negotiation over the shared space of public institutions such as health care, is the moment of substantive politics. As Checkel notes:

an obvious but too often neglected truism about our social world [is that] the most interesting puzzles lie at the nexus where structure and agency intersect. The real action, theoretically and empirically, is where norms, discourses, language and material capabilities interact with motivation, social learning and preferences (1999: 557-58).

Therefore, “rather than seeing structure and agency then as strictly co-determinate, this approach seeks to analyse the circumstances when structural constraints are overcome

through social and political agency” (Wylie, 2002: 74). When the existing structures are faced with crises, social agents are better able to influence the creation of new social norms than when the structures are stable. Checkel discusses how this process of redefining social norms can occur:

First, individual agency is central: well-placed individuals with entrepreneurial skills can often turn their individual beliefs into broader, shared understandings. Second, such entrepreneurs are especially successful in turning individually held ideas into broader normative beliefs when so-called policy windows are open. This means that the larger group, in which the entrepreneur operates, faces a puzzle/ problem that has no clear answer, or is new and unknown. In this situation, fixed preferences often break down as agents engage in cognitive information searches...Third, processes of social learning and socialization...are crucial for furthering the norm creation process first begun by individual agents exploiting open policy windows. The basic point is that individual agency is insufficient to create durable social norms (Checkel, 1999: 551-52).

When the dominant norms are shown as inadequate, unable to address or even identify the questions posed by the new context, emerging alternatives can offer a new paradigm for action.

In order for institutional change to be effective in meeting the changing needs of the population, it is necessary for agents involved in this process to go through a process of social learning, “whereby actors, through interaction with broader institutional contexts (norms or discursive structures), acquire new interests and preferences...Put differently, agent interests and identities are shaped through interaction” (Checkel, 1999: 548). Yet as the discussion below will explore, engagement is not always a means by which to create new understandings and norms, as existing power dynamics can limit the scope of such processes.

One of the key purposes of this research is to identify, compare and analyse strategies for improving health care access for ethnically diverse populations. One of the key strategies

of health care organizations is the engagement of ethnically diverse communities in health care. This thesis has demonstrated that there are a variety of perspectives on the problems faced, and therefore it seems likely that opinion on what needs to be done to improve immigrant access to health care services will also vary. It was important therefore to explore engagement processes that act as an interface between health policy makers, care providers and ethnic minority communities, in order to understand how these engagement processes are structured, what they aim to accomplish, and how they are perceived by the different actors involved. I will also reflect on how engagement processes are shaped by their structure and the purposes of those involved.

As discussed in Chapter 3, community engagement processes can have a range of aims. They can enhance social inclusion and institutional representativeness through public participation in decision making. As Putnam has argued: “Wise public policy can encourage grassroots organizations, and conversely...social capital of the right sort (‘linking’ social capital) can produce more effective public policies” (Putnam, 2004: 670), thereby emphasizing that the link between social capital within communities and policy/decision makers can support stronger communities and better policy. Community engagement can also be a way for decision-makers to gain legitimacy for difficult decisions. How the structures of engagement shape the way that ethnically diverse communities share their knowledge and perspectives at the health care planning table can influence the inclusiveness of the process. In this sense, the engagement process itself is the negotiated space of the ZOI.

Without a transfer of power to community participants in defining the purpose of their participation in engagement with health service providers, engagement processes could

lead to a simple affirmation of plans already developed behind closed doors. Political science research has noted that:

While most public participation practitioners would confirm that the process of involving the public is not designed to produce right or wrong answers, at some point someone in a position of influence will make a decision about whether or not to incorporate the public's input into the public policy process (Abelson and Gauvin, 2006: 16).

At the same time it is possible for engagement processes to mobilize or activate communities to pressure the traditional power structures to integrate the voice of “the public” into the decisions made. As was discussed in chapter 2, research has emphasized that community engagement can have a variety of permutations and purposes, and not everyone involved in the process have the same conception of its meaning and purpose (Ableson *et al.*, 2002; Callaghan *et al.*, 2006; Church *et al.*, 2002; Kreindler, 2009).

Following these theoretical perspectives on engagement, emphasizing the importance of the spheres of influence that shape the purpose of the process of engagement, I aim to assess whether two different models of participation (institutional forms) changed the type of input and knowledge (content) that was brought by community members to the table. I provide information on community engagement processes, both past and present, derived from public documentation and the interview data on personal experiences in Vancouver and Montreal. I then closely examine two distinct formal processes of engagement: an ongoing selected advisory committee in Quebec, and in Vancouver the approach of broad-based community consultations on program initiatives and evaluations. I also discuss the informal engagement that takes place between communities and health care providers. The discussion presented here examines the types of engagement processes participants are involved in (including these formal as well as informal processes), their perspectives regarding these

processes, and their assessment of the effectiveness of the different engagement strategies. I also draw attention to the kind of changes in the SOI that respondents are advocating in the ZOI.

In order to assess the impact of these engagement mechanisms, this research draws upon a variety of experiences of people, both within and outside of health care, to see how they interpret the role of these processes in providing direction to policy and practice. This will help identify areas where participation has brought forward recommendations for change that improved the ability of the health care system to respond to the needs of culturally diverse communities. The value of this approach is to identify how strategies of engagement and participation take up access barriers and identify the strengths and gaps in the different mechanisms of engagement.

9.2.1 Engagement and Agenda Setting

An important aspect of meeting the needs of immigrants and ethnically diverse communities is the understanding of what those needs are. It is therefore necessary to examine who defines the needs of the society in general and who determines how to provide equal and/or equitable services to those with greater needs. In the process of engagement with the community, who sets the agenda and shapes the discussion? Are the engagement processes effectively integrating the needs identified by community members into the planning of health service delivery?

The results show that these varied formal and informal processes of engagement lead to major differences in the level and scope by which health care services engage the participation of ethnocultural communities in the policy-making process. Moreover the area

of community engagement is one of the key differences between Canada and the European cases. In Canada, there are a number of community associations and networks that: a) put pressure on the health care system to be more responsive to their needs, b) are active participants in ongoing engagement (both formal and informal) with the health care system, and c) work in collaboration with the health care system to provide services.

9.2.1.1 The Advisory Committee Model of Engagement

In the case of Quebec, the main channel of access for formal voice articulation is the Committee established in 2004 to advise the Minister of Health and Social Services on the needs of ethnocultural communities. However, despite its seemingly efficient structure – direct access to the ultimate policy maker in the field of health care – the performance of such strategy for engaging ethnocultural communities display serious shortcomings. For example, it is difficult to determine the impact of such engagement in the actual policy process since the meetings between the Committee and the Minister are fairly infrequent.

The existence of the Committee is seen as a progressive step forward for the representation of interests of the ethnocultural communities. The effectiveness of this agency within the overall structure is difficult to assess, and views differ in terms of its capacity. According to some, it provides an institutional channel for voice articulation at the ministerial level. A program manager noted that the committee has “had an impact in terms of the policy regarding the elderly, the policy regarding mental health for the province; they were the ones that recommended that their committee’s mandate be inscribed in the law, in the Health Act. That was acted upon” (A9: 201:204). Some others think that this Committee exists as a token agency, as their recommendations rarely influence the formal policy of the

government, although often suggestions from the Committee are included in discussion reports. As a participant in the committee noted: “That's how we function, they send us the text and then we go through it...So we look at the ethno-cultural particularities and put them into the project” (A4: 66:67 / 86:86).

Meetings between the Committee and the Minister are infrequent and there is no guarantee of tangible results from their advice. It was also noted that the bureaucracy acts as the intermediary between the Minister and the Committee, filtering their advice:

So far our influence has been very minimal. Because it goes through the bureaucracy, we inform the secretariat and the secretariat will take our recommendations and it goes to the Sous-Ministre. The Sous-Ministre, then, if he decides that it's worth it he will take it all the way up to the minister. But...we don't have the ear of the minister on a regular basis. There's no direct link to the minister. So it filters. In a bureaucracy it filters from what I said over here, by the time it gets to the Minister, it has been watered-down (A2: 652:664).

Some participants in the Committee have noted that there is too much emphasis on a consensual approach or ‘a hesitancy to challenge the powers that be.’ In other words, the Committee is not expected ‘to make noise’. In addition, there is concern that the Committee cannot adequately represent the interests of Quebec's ethnic communities, since the committee is composed of experts and technocrats, albeit from diverse ethnic backgrounds.

However, the Committee has had some tangible influence, in that it has reviewed and re-worked many government plans of action and policies to include references to the needs of diverse communities. The focus of the committee, because of its engagement with the policy makers, tends to be on broader policy issues. Some suggest that it is too early to be able to assess its impact since it is relatively new, and may be too soon to be able to make its mark on the system as a whole, particularly at the service delivery level. In addition, there are

frustrations with the limitation of the scope of their advice, since it was noted its advice is often incorporated into policy documents but not into specific legislation or changes in practice protocols.

9.2.1.2 Topic Specific Engagement Cycles

In the case of Vancouver, the emphasis is more on engagement and knowledge brokerage rather than direct access to the policy-makers in the provincial government. The Community Engagement strategy in Vancouver therefore focuses on engaging large numbers of community members through liaison with existing large networks within ethnocultural communities. In contrast to the emphasis in Quebec on representatives, BC focuses on identifying the needs of the communities with a wider outreach. However the effectiveness of this alternative strategy tends to be limited to areas of service provision, as broader issues that address the overall system priorities and mechanisms that can bring about systematic change tend not to be on the engagement agenda. Bringing the perspective of the community to the planning and evaluation of service delivery relies on the ability of the community liaison personnel to establish trust both with communities and with service providers so that they are open to the input from the engagement process.

In Vancouver community groups noted that they are now starting to see a difference in the health authority with regard to the needs of ethnically diverse communities: “I think they are quite sensitive to it...we have seen in the last 3 or 4 years some momentum” (B2: 464:467). In Vancouver it was noted that although there is a significant role for community participation in planning, the health authority still sets the agenda of what is negotiated: “what are the givens and what are the negotiables in the first place. So we’re not going to say

to people, do you want A, B, C or D, if C and D are not at all considered options from the point of view of the health authority” (B12: 205:247). With this the focus of engagement around very specific program initiatives, so a number of crucial policy issues, such as the recruitment of ethnically diverse staff and recognition of foreign credentials, are issues of concern that are not taken up in these forums of engagement.

Although it was noted that VCH is working to ensure communities voices are heard, the changes remain dependent on the individuals doing that work: “it is dependent on having individuals ...people that get it. And people who are allies and know how to navigate...That’s the challenge of change work, because it’s very dependent on individuals, unfortunately” (B12: 565:575). And in Montreal a similar comment was made by a service provider, “Well it’s just myself, and yeah, I sometimes find it’s a lot for one person to have to speak out. There have to be more voices” (A7: 420:421).

I have compiled some of the results into figures for each Vancouver and Montreal, and a comparative table that collates these results (see Figures 9.6 and 9.7 and Table 9.3). In the discussion below I compare the results from Vancouver and Montreal.

Figure 9.6 Vancouver Perspectives on Engagement

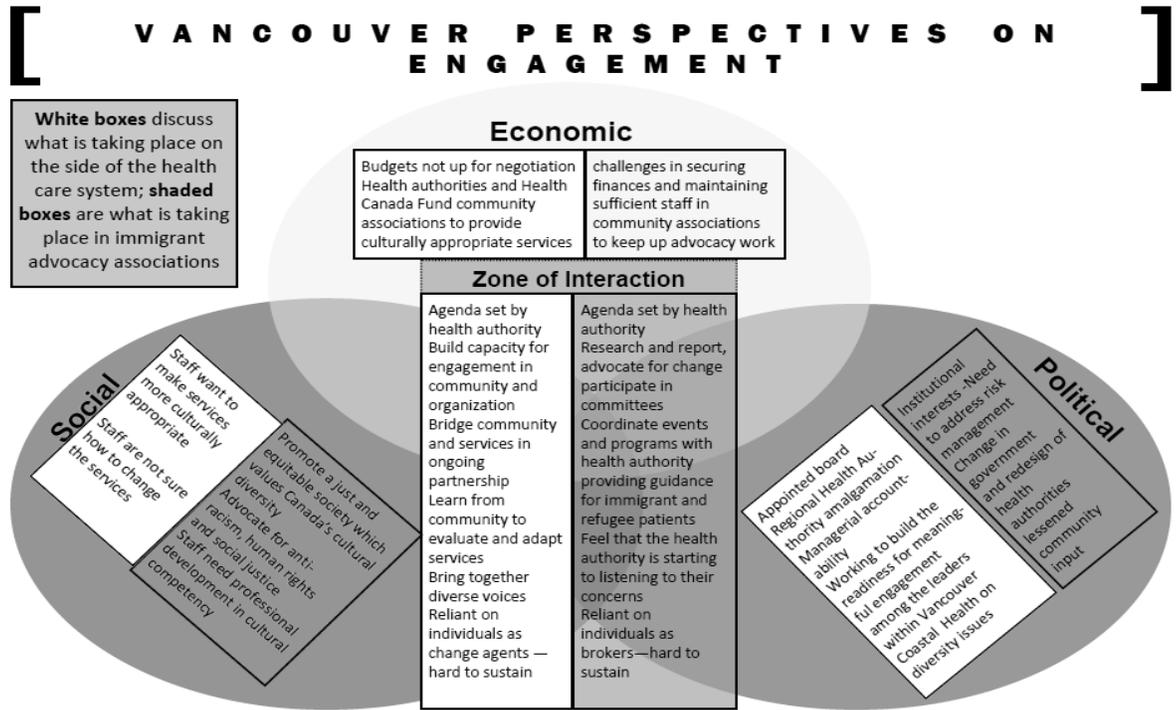


Figure 9.7 Montreal Perspectives on Engagement

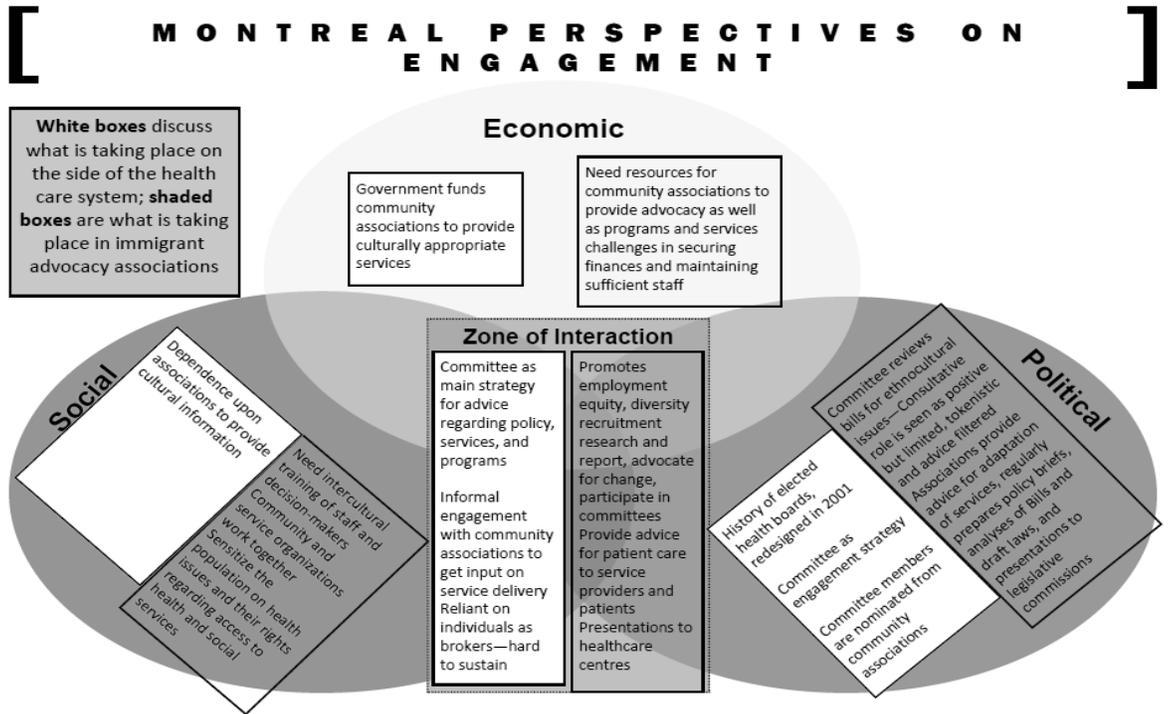


Table 9.2 Engagement Issues

SOI	Montreal		Vancouver	
	<i>(white columns are responses from people within the health care system/shaded are from immigrant associations)</i>			
Economic	Government funds community associations to provide culturally appropriate services	Challenges in securing finances and maintaining sufficient staff Competition over resources	Health authorities and Health Canada Fund community associations to provide culturally appropriate services Budgets not up for negotiation	Challenges in securing finances and maintaining sufficient staff in community associations to keep up advocacy work Competition over resources
Social	Dependence upon associations to provide cultural information	Need intercultural training of staff and decision-makers Community and service organizations work together Sensitize the population on health issues and their rights regarding access to health and social services	Staff want to make services more culturally appropriate Staff are not sure how to change the services	Promote a just and equitable society which values Canada's cultural diversity Advocate for anti-racism, human rights and social justice Staff need professional development in cultural competency
Political	History of elected health boards, redesigned in 2001 Committee as engagement strategy Committee members are nominated from community associations	Committee reviews bills for ethnocultural issues—Consultative role is seen as positive but limited, tokenistic and advice filtered Associations provide advice for adaptation of services, regularly prepares policy briefs, analyses of Bills and draft laws, and presentations to legislative commissions	Appointed board Regional Health Authority amalgamation Managerial accountability Working to build the readiness for meaningful engagement among the leaders within Vancouver Coastal Health on diversity issues	Institutional interests -Need to address risk management Change in government and redesign of health authorities lessened community input

	Montreal		Vancouver	
	<i>(white columns are responses from people within the health care system/shaded are from immigrant associations)</i>			
IOZ	Committee as main strategy for advice regarding policy, services, and programs Informal engagement with community associations to get input on service delivery Reliant on individuals as brokers—hard to sustain	Promotes employment equity, diversity recruitment research and report, advocate for change, participate in committees Provide advice for patient care to service providers and patients Presentations to healthcare centres	Agenda set by health authority Build capacity for engagement in community and organization Bridge community and services in ongoing partnership Learn from community to evaluate and adapt services Bring together diverse voices Reliant on individuals as change agents — hard to sustain	Agenda set by health authority Research and report, advocate for change participate in committees Coordinate events and programs with health authority providing guidance for immigrant and refugee patients Feel that the health authority is starting to listening to their concerns Reliant on individuals as brokers—hard to sustain

Firstly we see that in both locations the health care system provides funding through grants or direct contracts with community associations to provide services for ethnically diverse communities. In Montreal and Vancouver it was noted that there is competition among pro-immigrant associations for funding, and that the funding is short-term and uncertain. Also the funding cuts in health care in general were noted as impacting the engagement agenda, as health care funding cuts were not up for negotiation.

In both locations it was noted that the health care system and service providers within it were heavily dependent on the advice from community associations on how to make services more appropriate for immigrant communities. In Vancouver and Montreal respondents emphasized that this demonstrated a real need for more intercultural training among health professionals. Advocacy work in Vancouver and Montreal emphasized that an

important aspect of the work is ensuring that immigrant patients are aware of their rights in the system. The changing political landscapes were identified as a significant factor in the engagement of immigrant communities in the health care system. In both Vancouver and Montreal it was noted that new governments and policy shifts in 2001 changed the ways that communities were engaged. The restructuring of the health authorities lessened the opportunities for community input into the health care system.

In both cases, participants stated that there are opportunities for engagement, but political changes, funding considerations, and informal networks all play a role in determining the nature of engagement. The official channels for engagement seem to be in flux as health care systems themselves are reorganized or as political sentiment shifts. The data presented here shows that the way the engagement process is structured has an impact on how people are able to exercise their agency in that process. There are limitations to what kind of knowledge is sought by representatives of the health care system from community participants. The limitations on the engagement agenda create narrow parameters for how input is structured and valued, and leave certain decisions to technocratic or bureaucratic judgements, rather than to the shared creation of knowledge.

In order to overcome some of the problems of unresponsive service delivery, informal cooperation between service providers and community groups becomes important in guiding choices on how to improve the responsiveness of the system to ethnically diverse communities in both Vancouver and Montreal. The engagement of communities and different forms of knowledge in the process of designing health care services can lead to important institutional changes. Many intervention studies have shown that socio-culturally targeted programs that use communication appropriate to language skills improve use of services and

prevention screening (Ahmad, Cameron *et al.*, 2005; Ahmad, Shik *et al.*, 2004; Grewal, Bhagat *et al.*, 2008; Hislop, Teh *et al.*, 2004, 2007; Lai, 2004; Loiselle, Semenic *et al.*, 2005; Nimmon, 2007; Reitmanova and Gustafson, 2008; Zanchetta and Poureslami, 2006).

Providing culturally specific programs can be a successful strategy, but at the same time researchers note that providers must not assume all people of one culture want the same care, as many have blended traditional practices with those of their new country (Brathwaite and Williams, 2004; Lu, Sylvestre *et al.*, 2008). In this sense, it is important for institutions to support a reflexive practice, whereby ongoing engagement between communities and service providers can lead to shared understandings on the process of service delivery.

Although informal collaboration is an important mechanism to bring community perspectives to practice (as well as getting around bureaucratic strategies for maintaining the status quo), the data presented here demonstrates that, with the lack of institutional support, the problems that immigrants face tend to be addressed through piecemeal, localized solutions to broad systemic problems, that are reliant on individuals developing solutions based on their own personal and professional networks. While these ad hoc collaborations help solve real time issues (when a particular patient has a need that either the provider is not sure how to address, or the community association tries to bring to attention of the provider), they do not lead to substantive change to improve practice norms throughout the system.

Pro-immigrant associations are critical actors linking immigrant communities and the health care system. They also perform advocacy work, education about the health care system and raise awareness about the needs of ethnically diverse communities. Despite their critical role in the system, the immigrant associations face at least two challenges in engaging in the policy process in health care. First, they experience major problems due to financing

issues such as the need to apply frequently for grants in order to sustain their activities and staff; this takes time and energy away from their primary role. Second, their involvement in engagement processes is inconsistent, tends to be excluded from institutional, regional or ministerial agenda setting, and is often informal and ad hoc. Thus immigrant associations organized around health care services repeatedly note that there are no established means or procedures by which they could identify their impact on the policy processes.

Although community engagement can be a key strategy for making health services more responsive to the needs of communities, the examples presented here from Vancouver and Montreal demonstrate that engagement with community members needs to become more comprehensive in order to allow for formalized involvement that can address both high level agenda setting and policy, as well as the provision of services in local community contexts. In addition, engagement needs to involve other levels of government in order to address the types of societal factors that can keep people healthy. The strategies introduced for engaging ethnocultural communities in both Vancouver and Montreal do not provide a venue for co-decision making nor joint agenda-setting, although they present promising openings for collaboration between policy-makers and diverse communities around health care issues.

As the figures presented above demonstrate, numerous factors shape engagement. The political climate shapes what issues are up for discussion and who is part of the process. Financial limitations within pro-immigrant associations make it difficult to sustain community advocacy work, and funding cuts in health care in general increase pessimism among community groups about the willingness of the government to commit resources to programs specifically for immigrants. Health service providers are reliant on the expertise of

immigrant associations to help them provide better care for immigrant patients, and this acknowledgement has led to the health authority providing funding to support the community associations to provide services.

Health care organizations are increasingly aware that immigrants and other traditionally excluded groups face barriers in accessing care. The system relies, both formally and informally, on community associations to help them understand these barriers and how to address them. Community associations come to engagement processes with power from the social sphere, in that they have the knowledge that the health care system and service providers want in order to improve services. In this sense, engagement processes are creating more opportunities for bringing community voices from within the social sphere of influence to the zone of interaction. By setting the agenda for engagement, the health care system has opened up the zone of interaction to incorporate an understanding of how to address the barriers from the social realm, while limiting discussion about the barriers created by financial restraints, as this is non-negotiable. Additionally, there is very little opening in the political SOI for incorporating community perspectives into overall decision-making within the health care institutions, and instead a move towards managerial accountability in health care governance.

Although engagement is highlighted by health care organizations as an important strategy for identifying and responding to the needs of ethnically diverse communities, the processes remain lopsided. In reflecting on the engagement literature discussed in Chapter 3, the results presented here demonstrate that the orientation of community participation has little focus on the democratic conception of engagement (with patients having the right to

participate in decision making) to a more consumerist approach of patient satisfaction through developing more culturally appropriate services.

This narrow approach for engagement tends to leave out the discussion of the political and economic spheres of influence as barriers to accessing health care services. As the SOI/ZOI model has demonstrated, all three SOI are interacting within the ZOI, and changes in one area require supports from another. Immigrant associations for example, want health service providers to be more skilled in cross-cultural awareness, but this is not a mandated priority in the governance realm (political SOI), nor adequately funded by providing staff time and resources needed to gain these skills (economic SOI).

As Ramsden has argued, cultural safety approaches emphasize that it is necessary to recognize and challenge power inequities in the health care system. Another important principle of cultural safety is that there needs to be systems in place to allow the “less powerful to genuinely monitor the attitudes and services of the powerful” (Ramsden, 1993: 10) and be free to pass judgement on the problems they identify. When the agenda for the engagement process is already set by decision-makers within the health care system, where it is “so rule-governed, then, by definition, it would be unfree” (Tully, 1999: 164). Engagement processes have fallen short in making fundamental changes in the zone of interaction to fully address the concerns of immigrants in the health care system in Canada, as the engagement processes that have been discussed here do not allow for a full exploration of how to address the barriers from all three of the social, political and economic SOI.

Chapter 10: Conclusion

In exploring immigrant and ethnically diverse communities' health care access barriers, it is clear that although there are good policies and practices committed to by governments and health authorities, there is a disjuncture between what is written and what really takes place. Research carried out in Canada for this project demonstrated a wide range of health care access barriers that immigrants face. Gathering these experiences from multiple standpoints and locations revealed the “embeddedness of social relations in the talk and action of the participants” (Campbell, 2006: 98). Due to this disjuncture between policy (and therefore expectations) and practice, the development of a coherent health care services response to the needs of diverse cultural groups is still seen by many as poorly developed.

Respondents in this study identified a wide range of social, political and economic conditions that restrict access, that as yet are not being addressed. The barriers are significant, and reflect exclusionary norms at both societal and institutional levels. There were clear examples from respondents that racialized populations, not just those with language barriers, and not all of those with language barriers, were experiencing inequalities in the quality of care. Although the policy context of multiculturalism and human rights provides immigrants with rights that promote equity in public institutions, with Quebec making specific reference to the delivery of health and social services, the funding to ensure that there are resources for these programs is, ironically, not part of the legislative context; instead it is left to the institutions to address, where it is economically feasible to do so. Thus, there is a serious disjuncture between the policies developed to facilitate access and the ability of service providers to realize that goal. There are promising practices arising from the

cooperation between civil society groups and health care organizations. These innovative practices, however, are not being supported, nor is there redesign of governance structures for purposes of shared decision making: respondents noted that programs aimed to enhance access for immigrants were inadequately resourced.

In addition, some suggest that there is insufficient knowledge of effective strategies for evidence-informed decision-making on the specific needs of immigrant communities in the health care setting (Bowen, 2006). This dissertation has emphasized that part of the problem is that often the tools to respond to access barriers do not adequately reflect the barriers that emerge from economic, policy or governance issues, instead focusing exclusively on social barriers. As discussed in Chapter 5, understanding the variety of conditions in the three SOI that affect access can help identify gaps in the responses to address barriers.

It is essential to recognize how these SOI shape the choices made within the health care system. Individuals' actions are either facilitated or constrained by a variety of factors, such as those we see in the SOI, yet changes within the zone of interaction are made through conscious action/interaction. People do not simply act as proxy for the institutional structures they represent, neither is their action entirely determined by these institutions. Instead institutions and the people acting within them create the reality of that setting. The empirical results of this study were used to create an analytical model that can integrate the social, political and economic spheres of influence that shape barriers and how they are taken up.

This dissertation also explored community engagement as a process to support the resolution of access barriers. The experiences of interaction vary, and community associations provide advocacy, advice and knowledge brokerage in engagement processes.

This thesis has demonstrated that with a variety of perspectives on the problems faced, opinion on necessary changes to improve immigrant access to health care services will also vary. It was important to explore engagement processes that act as an interface between policy makers, care providers and communities in order to understand how engagement processes are structured, their aims, and how they are perceived. Respondents identified no change in policy as a direct result of the engagement processes in either city. At the same time, there are some promising results to the engagement processes that specifically aim to make changes at a practice level.

Through this research I have found valuable information from care providers and advocacy groups about the social dynamics around access barriers, with the emphasis that much depends on the people advocating for improved access, the people delivering services, and the capacity and ability of the institution to support the necessary changes to practice norms. Examples from Vancouver demonstrated initiative in ensuring that the service providers are also engaged in the process of reorienting services, therefore leading to more effective uptake of new protocols of practice. Montreal has hospitals that stand out as an example of institutional commitment to ensure that the communication needs of immigrant patients are met, through ensuring interpreters are available whenever there is any possibility of miscommunication. The presence of strong community advocates in both cities has also led to formal and informal partnerships between community associations and the health care system that facilitate increased access to services for ethnocultural communities. However, these promising initiatives remain ad-hoc and are unsustainable in the long-run if commitments are not made to adequately integrate and fund them.

10.1 The SOI/ZOI Model in a Research Context

The international research team was guided by an interdisciplinary approach, bringing together political economy and cultural safety in nursing to build upon the health service research approaches to understanding access barriers. The exploration of access barriers and strategies to address them presented here emphasizes the value of examining the broad societal factors that shape access, engagement between the health system and communities, as well as the interaction between patient and service providers in the delivery and use of health care services.

In her PhD thesis, Bowen explicitly noted her desire to facilitate a “discussion of the domains involved in providing equitable and effective care to a diverse society, and encouraging critical analysis of various approaches to providing such care” (Bowen, 2004: 3). As part of the contribution to this discussion, I have sought to build a conceptual model for analyzing the domains that shape access and the provision of care for ethnically diverse communities. The empirical data from this research was examined through the interdisciplinary lenses of political economy and cultural safety, which draw our attention to the important role of social, economic and political conditions (including the structure of health care institutions) in shaping the experiences that take place within the health care system, and the role of people involved in working for change.

This interdisciplinary approach that emerged from critical theoretical paradigms informed by constructivism guides an analysis of the dimensions of access barriers stemming from the broad social contexts that shape institutional norms, and from the interactive process that creates constructed meanings of specific experiences within health care institutions. This approach directed attention to examining how participants’ understandings of immigrant

access to health care services are embedded in social, political and economic contexts and affected by time, place and the agency of patients, community advocates and care providers.

The multiple factors that shape the experiences within a health care organization demonstrate that the “variables being studied may move back and forth in being dependent and independent within the same relationship” (McDaniel *et al.*, 2009: 193). It is true that the SOI variables affect access within an institution, yet at the same time interactions within an organization can overcome these barriers. The interactions within health care organizations show that “[they] have diverse agents that learn including providers, patients, and other stakeholders. Diversity is often a source of creativity and problem-solving ability but can also be a source of communication difficulties” (McDaniel *et al.*, 2009:193). Innovative practices within the health care system to meet the needs of diverse populations can be adapted to improve services for everyone, specifically by drawing our attention to how we can ensure adequate communication and that patients are receiving the right services at the right time, including health services as well as supportive health promoting policies in other areas.

This thesis has developed an interdisciplinary model building upon health services research by embedding it within a political economy analytical framework that draws attention to the three spheres of influence. Social, economic and political contexts are embedded within these spheres and together shape the zone of interaction, the place where institutional practices and immigrants’ experiences come together within the health care system. The results presented in this dissertation demonstrate the variety of conditions that shape the ability of health care organizations to implement policy changes, specifically the promotion of equal access to health services for ethnically diverse communities. The discussion of the barriers in access to care demonstrates that new policy can be supported or

obstructed by factors external to the organization in the spheres of influence. Therefore expanding organizational analysis to include the social, economic and governance contexts in which health care organizations are embedded is valuable in understanding the ability of policy goals to be implemented. Using the analytical lens of the three spheres of influence draws our attention to how social norms, economic constraints and institutional governance simultaneously shape the delivery of health care services and the experiences of ethnic minorities with those services.

There is an increasing recognition of the importance of developing new research perspectives that re-focus attention on socio-economic factors as critical to an explanatory model of immigrant health (Beiser, 2005; Beiser and Stewart, 2005; Newbold and Danforth, 2003). Research carried out by Dunn and Dyck using data from the Canadian Community Health Survey has shown that “socio-economic factors are more important for immigrants than non-immigrants” with regard to health status (2000: 1573).

In their review of income and health research in Canada, Raphael et al found that although Canadian research institutions have emphasized the link between income and health, there is:

Little evidence... that addresses the political, economic and social forces that determine how income is distributed across the population. A particularly important area requiring more emphasis is how income and its distribution interact with the presence of social infrastructures, such as public services, to influence health (Raphael *et al.*, 2006: S17).

This gap has led to a “focus on lifestyle and biomedical approaches to understanding and promoting health” (Raphael *et al.*, 2006: S17), which is particularly damaging for research on ethnicity and health, where ethnicity itself is often seen to explain poorer health.

Research in the UK has emphasized that “if socioeconomic position is related to health within groups, it seems probable that inequalities in socioeconomic position might be related to ethnic inequalities in health” (Nazroo, 2003: 278). The lower socioeconomic position that many ethnic minorities experience is linked to broader political and social forces, represented for example by the lack of recognition of their credentials and discriminatory hiring practices. “Skin color reflects the power and social meanings attached to it...Income differences and skin color clearly interact in the social processes of stigmatization, prejudice, and discrimination” (Wilkinson, 2005: 229). Their evidence demonstrates that income is more responsible for health status than ethnicity per se, challenging the notion of the inherent link between ethnicity and health, and the explanation of health problems solely on the basis of cultural or ethnic differences or predispositions.

The economic climate also has a significant impact on the health care system, and on the factors that constitute the social determinants of health, such as housing, employment, social programs, etc. Research on social determinants of health has shown that “inequality is socially divisive” (Wilkinson, 2006: 347) and socio-economic disparities have certainly not gotten any better, indeed they have widened. In this context, ethnic minority communities fare worse:

...the health of most ethnic minorities shows the heavy burden of their social and economic disadvantage. Ethnicity becomes a mark of a collective social status, and its inescapability inevitably increases its health impact. Most of the processes of racism and stigmatization are likely to increase with increasing inequality (Wilkinson, 2005: 216).

The current economic environment in Canada has challenged the fundamental beliefs held by many Canadians around the right to services, such as health care. In this climate of ‘crisis’ in health care, with the high profile concerns around access to acute care, respondents

felt that budgets for interpreter programs were often under threat, as new programs would require resources be shifted from other service areas.

It is important to note that the barriers to care do not only shape the experience of ethnic minority communities. As a study in a Vancouver hospital illustrates, the experience of disenfranchisement in the health care setting is not simply limited to ethnic minority communities (Anderson *et al.*, 2003: 211). Although the experiences of ethnic minorities with health care has the additional element of cultural and linguistic barriers, everyone's experience in health care is shaped by the influence of economic, social and institutional factors, such as their economic standing and the disempowering practices of institutionalized norms within health care that do not give patients a role in defining their care.

10.2 Contribution of the SOI/ZOI Model

The contribution of this research is the development of an integrated model of analysis to examine how these three “spheres of influence” act as a lens through which to provide a more comprehensive understanding of social processes within health care organizations. Each of these spheres of influence encompasses a set of contextual variables that shape social interaction in the health care organization (the zone of interaction). As the situation currently stands, they are part of the contexts shaping the social malaise of Canada. The analysis of the three spheres of influence is an important basis upon which to understand how to overcome the barriers in access to care. As McDaniel et al suggest, “using a greater variety of tools or methods would enable a research design to capture a broader range of system behaviors and be more effective in anticipating change” (2009: 194-95).

This dissertation aimed to examine the barriers that immigrants face in accessing health care services in two Canadian cities. This study makes a unique contribution by addressing two specific gaps in the literature. Firstly, unlike most studies in Canada on cultural competence and responsiveness of health care services, I am not collecting information from patients about their experiences. Rather, this study has focused on those community groups, immigrant advocates and services providers trying to change institutional practices. Secondly, I have identified the significant barriers from the contexts within society, the economy and governance that shape the processes of developing and sustaining innovative health care practices to meet the needs of ethnocultural communities.

Research needs to address the particular context in which innovative practices are developed and delivered, since a model that is successful in one context may not be feasible in another. In order to develop innovative strategies for improving health services for ethnic minorities, it is essential to understand the broad contextual barriers to institutional change. At the same time, there are specific institutional barriers to implementing change, and specific institutional level practices, or even initiatives of individuals working at the front line, that make changes in everyday practice to enhance access and quality of the services provided for ethnically diverse communities. Examples presented here have shown that even in a context of economic pressures, strong commitment to ensuring equity in care can still be a feasible option.

The discussion of the barriers in access to care, as well as some of the barriers to the implementation of initiatives (i.e. the use of interpretation services) demonstrate that policy can be supported or obstructed by factors external to health care organizations, in the spheres of civil society, the economy and governance. Therefore expanding our analysis of barriers to

equality in health services to include the social, economic and governance contexts in which health care organizations are embedded is valuable in understanding the ability to implement policy goals and institutional practices that aim to diminish those barriers. Understanding the broad factors that shape access barriers will allow for a better contextualized understanding of the challenges local level initiatives must address in overcoming those barriers.

Recognition of the impact of broader social contexts on access leads to the recommendation that in order to address access barriers in health care, the responses must include policies that can address the social determinants of health. Therefore developing a comprehensive approach that will improve access to health care services needs to include government departments that are responsible for economic and social policies as well as those that are directly responsible for health care services.

At the same time, the focus on the zone of interaction as the site of change reminds us of the importance of the actions of people. The structural factors that create a number of the problems that immigrants face in the health care system can only be addressed through a long-term coordinated process of developing policies to promote social equity across all aspects of society. Although this is an important long-term goal, research on cultural safety approaches has demonstrated that the conscious action of people working together can break down some significant access barriers. The development of working relationships between community associations and health service providers to resolve some of the specific access barriers, particularly around trust and respect, does make a difference, as was demonstrated in the examples of community and institutional collaboration in service delivery discussed in Chapter 6. The value of interaction between front line service workers, program planners and community organizations show that meaningful change has to involve both the people

delivering the services and those receiving the services, to create an environment of mutual learning that empowers both the patient and the staff.

In this dissertation I have analyzed how social, economic and governance contexts — the spheres of influence—shape the everyday experiences and strategies of individuals working to change the delivery of health care services to ethnocultural communities. Of course it is important to emphasize “that the individual’s experiences are shaped, but not determined, by social structures and that the individual’s relationship to structure is organized by broader social conditions” (Lynam, 2005: 34). This sphere of influence/zone of interaction model makes a contribution in drawing attention to the interacting effects of broad social, political and economic processes in the experiences of social exclusion and inequity, in this case immigrants with the health care system. By conceptualizing access to include these broader contexts, the SOI/ZOI approach draws attention to the multiple sites for interventions to improve health care experiences for ethnically diverse communities. This model therefore suggests that strategies to address immigrants’ access barriers in the health care system should account for the needed changes in the social, economic and political contexts to support institutional level responses to improve access.

10.3 Further Research

This model has potential applicability to other areas of public service (i.e. education) and other communities that experience social exclusion (i.e. Aboriginal peoples). It has drawn our attention of the need to contextualize community engagement processes within these contexts, so that dialogue on changing institutional practices takes up these broader social, political and economic processes that can either obstruct or facilitate meaningful

change to meet societal needs. This dissertation emphasizes that we must acknowledge the importance of the broad SOI factors that shape access and service delivery, and must pursue supports in these spheres if we would like to see a sustainable implementation of practices that can realize the goals of equality and equity enshrined in Canadian, Quebec and BC legislation.

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Appendices

Appendix A : Introductory Letter

I am writing to request your participation in a study entitled “Giving New Subjects a “Voice”: Cultural Diversity in the Health Care System”. First let me tell you a bit about this research project.

This research is being carried out simultaneously in three countries: Germany, Italy and Canada. By comparing patterns of integration of immigrants into the health-care systems this study group investigates the role of participatory practices in multicultural societies. It examines legal and institutional arrangements for an equitable access to health-care services, in decision-making processes in the political system, and in the interpersonal relationships between health-care providers and recipients. At the theoretical level, our claim is that intercultural dialogue is critical for allowing a culturally sensitive integration of immigrants into public life.

Research of this type is important because it seeks to develop a catalogue of innovative approaches for making the policy process and institutional settings of the health-care system more responsive to the needs of immigrants. To this end, we aim to establish a forum of ongoing dialogue and collaboration with policy practitioners, health-care providers and pro-immigrant organisations throughout the entire project, which we hope will continue well beyond the life span of this study group.

The research team in Canada consists of Oliver Schmidtke, Saime Ozcurumez and Lloy Wylie. Oliver Schmidtke is faculty member in the Departments of Political Science and History at the University of Victoria. Saime Ozcurumez is a Post-Doctoral Fellow at the McGill Institute for the Study of Canada. Lloy Wylie is a PhD student in Health Care and Epidemiology at the University of British Columbia. You may contact any of us if you have further questions.

You are being asked to participate in this study because of your position [as a decision-maker in the health system; a representative of an immigrant association; of expertise in this area] If you are interested in participating in this research, your participation will include an interview that would last between 1-1.5 hours, in the location you would prefer.

The potential benefits of your participation in this research is for you to offer your insight into the problems and potential solutions for the development of a health care system that is responsive to the needs of immigrants. Your participation in this research must be completely voluntary, although we will offer you a modest honorarium to compensate you for your time. Your confidentiality and the confidentiality of the data will be protected in a number of ways, which we will explain should you decide to participate.

Given the expertise that you can offer on this matter, we sincerely hope that you are interested in participating in this research project. If you have any questions or require further clarification, please do not hesitate to contact us.

We will be phoning you in the near future to follow up on this invitation. We look forward to speaking to you soon, and hope that you will join us in this important research.

Sincerely,

The Canadian research team,[Contact Info]

Appendix B : Interview Guide

Topics:

- A) Immigrants' health care access (actual status) / Which immigrant organisations play a role?
- B) Successes and failures in immigrants' health care provision
- C) Legal Regulations
- D) Concepts for the accommodation of immigrants' health care needs
- E) Which role do immigrants' health care needs play and how are they articulated?
- F) Relationship with civil society (governmental and non-governmental) in the field of immigrant health care

A) immigrants' health care access (actual status)

- 1 How would (do) you describe the current conditions of immigrants access to health care in Germany (Italy, Canada), in your hospital, in your insurance company?
- 2 Do all immigrant groups have equal access? Which differences in treatment exist between different groups? Why?
- 3 Please describe the health care structures for immigrants in the fields' maternal care and mental health?
Only for representatives of health insurance companies and hospitals
- 4 How many patients/ clients in your hospital/ company out of the total have a immigrant background? Has their number changed during the last years? Are you expecting a future increase or decrease?
- 5 How do you provide for immigrants' specific needs (e.g. religious practices etc.) in your institution (in the health care-system)?
- 6 Do employees with an immigrant background play a role in your company (hospital)? Which role are they playing? Do immigrants participate in the selection of staff?
- 7 Are there specific services offered to immigrants? Which? Do you provide educational materials in different languages? Translation services? Are these services and materials similarly accessible as the standard services/materials?
- 8 Are your employees skilled in intercultural communication? Do you do provide on-the-job training in: a) intercultural communication? B) foreign languages? If yes, how often do you do that per year?

B) Success and failures in immigrants' health care provision

- 9 Have you recently been involved in the improvement of immigrant health care? Which of these improvements turned out positively?
- 10 Which difficulties did you face in this context?
- 11 In which way has the provision of health care for immigrants changed within the last few years?

12 Are there any changes underway that will change how immigrant's health care will be organised in the future? How would you like to see it organised in the future?

13 How suitable are the present health care structures for immigrants?

C) Legal Regulations

14 Which legal bases are in place for facilitating immigrants' inclusion in the health care system?

15 Which legal regulations could improve the inclusion of immigrants in the health care system?

16 Do you see a need for legal regulations for the improved access of immigrants to health-care, such as translation services, affirmative action or the creation of immigrant specific institutions (hospitals, insurance companies).

D) Concepts for the accommodation of immigrants' health care needs

17 To what extent is the health care system in Germany (Italy / Canada) and/or your institution accessible for immigrants? Please indicate the accessibility on a scale from 1 to 10, 1 referring to exclusion! What could be done to increase the access for immigrants?

18 Does your institution provide concepts, strategies and quality standards for immigrant access to health care? If yes, which one(s)?

19 What does 'multiculturalism in the health care system' mean for you?

20 How do you view the concept of the 'intercultural opening' of institutions?

21 What do you think about immigrant specific health care services, keyword: Turkish (Vietnamese etc.) hospitals /insurance companies?

22 Are there areas where you find immigrant specific health care useful (meaningful)?

23 What do you think about affirmative action for immigrants as employees in the health-care system?

E) Role and articulation of immigrants health-care needs

24 Which role do immigrants (your immigrant organization) play in the decisions-making process on health care in your hospital (insurance, politics)?

25 Which role does immigrants'/your organizations take (in the decision-making process, e.g. legislation, health insurance company, hospital) to improve immigrants' access to health care? Which role would you like to them to play?

26 Do immigrants participate in decisions over their health care in the areas of maternal and mental health?

27 Are you aware of alternative healing practices immigrants use outside the national health-system? If yes, which kind of practices do they use, why do they use them and where do they get access to them?

F) Relationship with civil society in the field of immigrant health care

28 With which associations (local, regional, international, pro-immigrant or immigrant associations, health insurance companies...) did your institution collaborate mainly in the field of (immigrants) health care?

29 How does your institution engage in decisional processes with immigrant organisations, political associations etc. in the field of (immigrants) health care? Specify the type of contact and the way your institution has engaged in it!

30 To what extent do you (officially and unofficially) cooperate with political decision makers in the area of immigrant health care? To what extent do you find this cooperation useful? What degree of common understanding/conflict do you have with these organisations? In which way do you incorporate those decision-makers into your organisational structure?

31 To what extent are you involved in joint campaigns/initiatives with civil associations at the national/regional/local level? Comment on differences between levels, if any!

32 How representative do you experience civil society associations at the EU or North American/national/regional/local level? Are they valid, representative actors? Do you think there is a difference between the different levels?

Appendix C : Informed Consent Form

You are being invited to participate in a study entitled “Giving New Subjects a “Voice”: Cultural Diversity in the Health Care System” that is being conducted by Oliver Schmidtke, Saime Ozcurumez and Lloy Wylie. Oliver Schmidtke is faculty member in the Departments of Political Science and History at the University of Victoria. Saime Ozcurumez is a Post-Doctoral Fellow at the McGill Institute for the Study of Canada. Lloy Wylie is a PhD student in Health Care and Epidemiology at the University of British Columbia. You may contact them if you have further questions: [CONTACT INFO]. This research is being funded by the Volkswagen-Stiftung project for Study Groups on Migration and Integration.

By comparing patterns of integration of immigrants into the health-care systems of Germany, Italy and Canada, this study group investigates the role of participatory practices in multicultural societies. It examines legal and institutional arrangements for an equitable access to health-care services, in decision-making processes in the political system, and in the interpersonal relationship between health-care providers and recipients. At the theoretical level, our claim is that intercultural dialogue is critical for allowing a culturally sensitive integration of immigrants into public life.

Research of this type is important because it seeks to develop a catalogue of innovative approaches for making the policy process and institutional settings of the health-care system more responsive to the needs of immigrants. To this end, we establish a forum of ongoing dialogue and collaboration with policy practitioners, health-care providers and pro-immigrant organisations throughout the entire project, which we hope will continue well beyond the life span of this study group.

You are being asked to participate in this study because of your position [as a decision-maker in the health system; a representative of an immigrant association; of expertise in this area]. If you agree to voluntarily participate in this research, your participation will include an interview that would last between 1-1.5 hours, in the location you would prefer. The interview is open-ended, but with common questions that are being used in Canada, Germany and Italy. We will make an audio recording of the interview to assure accuracy of our reports. We will also request information about your organization and its position regarding immigrant access to health care.

Participation in this study may cause some inconvenience to you, in particular it may require up to 2 hours of your time. There are no known or anticipated risks to you by participating in this research. The potential benefit of your participation in this research is for you to offer your insight into the problems and potential solutions for the development of a health care system that is responsive to the needs of immigrants.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, you can decide whether or not to allow us to use the data you have provided. If you decide not to allow us to use the data, the data files collected from you will be destroyed.

Given that this research entails personal interviews, your anonymity cannot be protected from the researcher. Your confidentiality and the confidentiality of the data will be protected in a number of ways. You will be asked to select the interview location of your

choice. Interview files will be stored on password protected computers and locked filing cabinets. Analysis of the data will have your organization and personal names removed, along with any other identifying information. If we have received your name from another individual, we will let you know who recommended them to us. We would like to point out that due to these recruiting procedures (recommendations from other people) you will not be entirely anonymous.

Furthermore you will be asked whether, in addition to the interview, you would like to participate in focus groups or not. These focus groups are a form of interactive discussion of issues related to our research. **YOUR ANONYMITY CANNOT BE PROTECTED IF YOU PARTICIPATE IN A FOCUS GROUP OR WORKSHOP**, given the fact that you would meet other project participants.

It is anticipated that the results of this study will be shared with others in the following ways through research reports (that will be provided to you), conference presentations, thesis dissertations, published articles, media releases and on the internet.

Data from this study will be archived for future research purposes, but will be anonymized. Any data that contains information that can identify participants or their organization will be destroyed (electronic data will be erased and paper files shredded, unless you provide consent for the data to be archived).

In addition to being able to contact the researchers at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

<i>Name of Participant</i>	<i>Signature</i>	<i>Date</i>
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A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix D : Themed Poster

Cultural Diversity in Health Systems

Comparative Strategies for the Integration of Diverse Communities

Successes and Enablers

Staff Representation
 .Increase the numbers of staff members from ethnic and cultural communities
 .Development of "Language designated" positions

Networking
 .Need champions within the health care system with high commitment and understanding
 .Initiate info sessions with senior management
 .Collaborate with community partners

Connecting Services
 .Bridging program/services
 .Settlement Health Workers
 .Health and social system referrals
 .Multicultural health fair
 .Population health and social determinants framework provides support and understanding

Cross-Cultural Dialogue and Adaptation
 .Cross-cultural education an important start
 .Intercultural expertise
 .Capacity to adapt clinical approaches (services and programmes)

"Adaptation is a two-way process. We must engage in shifting our mode of thinking and behaviour so that we meet and engage with newcomers on new ground".
 - Marie Serdynska, Montreal Children's Hospital

Mechanisms for Improving Care for Diverse Communities

<p>Interpretation Services</p> <p>Montreal</p> <ul style="list-style-type: none"> Twelve years of centralized interpretation Approximately 60 languages University Training for Health Interpreters Community Interpreters—Available in health and social services Availability of interpreter services in community health centres 20,000 Annual requests in Montreal <p>Vancouver</p> <ul style="list-style-type: none"> Over 300 translated patient education materials Interpreter program services available since 1996 Qualified health care interpreters College training program for health interpreters 5,000 annual requests 	<p>Community Engagement</p> <p>Montreal</p> <p>Provincial Committee on the dispensation of Services to persons from ethnic & cultural communities</p> <p>Undertakes consultations</p> <p>Gives its opinions to the Minister regarding all matters related service planning delivery and evaluation</p> <p>2006 Members: Togo, Haiti, Egypt, Germany, Cuba, El Salvador, Italy, Serbia, Morocco, China, Madagascar</p> <p>Vancouver</p> <p>A two-way interaction process between VCH and its communities</p> <p>Four Community Consultation Committees</p> <p>Community engagement team—ongoing community consultation on program development and evaluation</p>	<p>Intercultural Training</p> <p>Montreal</p> <p>Intercultural training manuals for health care providers</p> <p>Consultation services to health care professionals</p> <p>Cross-cultural workshops</p> <p>Library services</p> <p>Vancouver</p> <p>Cross-cultural health Education and training for staff</p> <p>Program and service development—adaptation of services, program design, and delivery based on community consultation process</p> <p>Works with employees on human rights, discrimination and respect in the workplace in accordance with the BC Human Rights Code</p>
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Cultural Safety

Power and Community Input

Cultural Safety is about recognizing and challenging the inequity of the distribution of power in the health care setting.

We need to rectify this through: "setting up systems which enable the less powerful to genuinely monitor the attitudes and service of the powerful."

Community input has to be integrated in a safe environment where people can express their concerns without the threat of repercussions, in order to ensure an honest exchange that allows critics to discuss broad health determinants, including cultural issues.

Vancouver Coastal Health Community Engagement Framework

Working Together for Change

"Researchers and practitioners... have a social obligation to work with communities and organizations to disseminate knowledge to policy-makers, health authorities, leaders in health-care organizations, and community members – with the aim of shifting social attitudes, correcting past and current injustices, reducing health disparities, and mitigating inequities in access to health and health care" (Browne, Smye and Varcoe 2005: 27-28).

"The frank opinion of people who are culturally different must be included in any assessment of service delivery and cultural risk must be included as a legitimate category for assessment!"
 Ramsden 1993.

Organizational Challenges

Resources and Funding

- Budgetary guidelines limit resources to address impact of diversity
- Overall health system downsizing
- Overworked staff
- Project based funding—lack of sustainability
- Unequal access to interpreters and culturally competent care across regions and service types

Education, and Training

- Lack of ongoing regularized intercultural training and staff time to participate
- Varied levels of material adapted for a multicultural context
- Lack of knowledge and sensitivity to the issues from ethnic and cultural communities
- Lack of knowledge regarding new waves of immigrants
- Limited recognition of the value of culture by service providers
- Lack of appreciation for different cultural values

Political Will

- Limited understanding of cultural/language competence on the impact of care
- Lack of organizational and managerial commitment and awareness
- Competing priorities
- Need a strong dedication and adequate time to build effective partnerships

Structural Barriers

- Prejudicial / discriminatory practices and attitudes
- 90 day waiting period for access to services
- Lack of knowledge regarding resources for referrals
- Need to address power imbalances
- Challenges in "Multiculturalizing" a mainstream program/service

Project Funded by

Poster by Lloy Wylie, PhD student and Dr. Saime Ozcurumez

Contact:
lloy2@shaw.ca

References:

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Appendix E : Coding Schema

Access:

- Access and Quality of Access: Access is not equally available to all people
- Access and Quality of Access: Access is equally available to all people
- Multiculturalism frame: Cultural Diversity in health services as an issue of accommodating diversity
- Universalist Frame: Cultural Diversity in health services as an issue of achieving universal, egalitarian inclusion (same services for all in an assimilationist fashion)

Participation:

- Participation through Claim-making (Actor strategies): by general civil society organizations
- Participation through Claim-making (Actor strategies): by immigrant organizations (with at least 30-50 % immigrants)
- Participation through Claim-making (Actor strategies): by individual efforts (e.g. an individual in a hospital putting pressure to establish migrant-friendly services, multilingual signs etc.)
- Participation through Claim-making (Actor strategies): Through health care sector and state actors (for example the bureau of health accommodating for cultural diversity; community consultation by political authorities etc.)

Strategies:

- Legal regulations do not improve access of immigrants to health-care
- Legal regulations improve access of immigrants to health-care
- Strategies (Action strategies claimed by organisations): developing practice, guidelines, and specific services (i.e. translations services, cultural translators / mediators); raising awareness; constructions of cultural difference
- Strategies (Action strategies claimed by organisations): Drawing attention to issues of risk/liability and patients' rights
- Strategies (Action strategies claimed by organisations): Employing immigrants in health care system: Accepting foreign degrees
- Successes and failures in immigrants' health care provision (best practices and worst examples)