EQUIP Health Care
Equipping Health & Social Services for Equity

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A Discussion Tool:

7 Questions to Map Your Landscape for Equity

Audience: health and social service providers and leaders wanting to make health care more "equity-oriented" (in our view, more culturally safe, trauma- and violence-informed and supportive of substance use health).

Purpose: Map your physical, socio-cultural, historical, economic, political and language landscape to know what resources and challenges you might be starting with.

Use: This tool is intended to be used by two or more people as one initial step toward enhancing equity at the organizational level, and can be used as part of the EQUIP Equity Action Kit. Many organizations find it helpful to create working groups that include leaders and those providing direct service in different roles (e.g., nurses, physicians, reception staff, security, custodial staff, etc.). However, since any place is the right place to start, you could also use this tool to get started with one other person to think through the context you work in from an equity perspective. Read and discuss the questions in your equity working group; identify what you know about the inequities experienced by the populations you serve, and what you don't know. For those things you don't know, identify how to fill in the gaps (perhaps each person can tackle one unknown and regroup).

Below we have provided 7 questions to help you map your landscape. To prompt your thinking, we have provided examples from diverse settings that are fictionalized, but represent real circumstances or are composites of real situations. Each example surfaces questions that will be helpful for any setting. These questions are not exhaustive, and you will identify your own!

1 How does your service context (e.g., small rural area, cancer care setting, Emergency Department, hospital, clinic, community social service agency, etc.) create/contribute to and/or mitigate inequities?

Emergency Department Example

Emergency Departments in Canada are intended to treat urgent health issues, such as motor vehicle accidents and other traumatic events, heart attacks, strokes and other life-threatening health crises. However, Emergency Departments are increasingly serving people with chronic illnesses, people facing the health effects of structural inequities such as poverty, and those who, for many reasons, don't have or can't access a primary health care provider such as a family doctor or nurse practitioner. This creates a mismatch between the mandate of Emergency Departments and how Emergency Department health care providers are trained (acute/emergent care), and the actual needs of many people coming to the Emergency Department.

This mismatch often means that staff have to judge whether and how quickly patients should get Emergency Department care, meaning that, especially with the overall crowding we see in Emergency Departments, many are discouraged from care, turned away or made to wait until they leave on their own. People who are better off financially and socially are more likely to have a primary health care provider, and thus less likely to use Emergency Departments for non-urgent conditions; they are also better equipped to navigate health care encounters and less likely to be negatively judged. Further, people less well-off have fewer resources to fend off the impact of negative judgements, stigma and discrimination. Thus, Emergency Departments are typically designed in ways that can deepen inequities unless active steps are taken to promote equity-oriented care.

Ask: How does the mandate and structure of your setting shape inequities?

Primary & Community Care Example

Most primary care in Canada is based on a model of one or a few family physicians, and increasingly, family nurse practitioners, deciding where to set up their business, and which patients to admit into their practice. Given the prevalent fee-for-service funding model in Canada's provinces and territories, there is sometimes an incentive for primary care providers to prioritize rostering patients with less medical and social complexity to reduce financial and time burdens on themselves and their staff. While there are some incentives to have physicians located in rural and remote areas, these are not mandated.

Similarly, while other primary and community care models, including community health centres and nurse practitioner clinics, exist, they are not always available, especially in smaller communities. Thus, many people in Canada, especially those facing barriers to care and those living in rural and remote areas, lack access to primary health care, and/or to the allied health and social services required for effective referrals and 'wrap-around' care.

While walk-in clinics can absorb some of this need, the lack of continuity of care is a problem. Similarly, people using Emergency Departments because they have nowhere else to go can put additional stresses on that system (see Emergency Department example). In general, the way primary care is organized and paid for makes it more difficult for those facing inequities and stigma to access care, and for community-based service providers to provide care in ways that could best support all of their clients.

Ask: How are particular groups systematically advantaged or disadvantaged in accessing care and the quality of care they receive in your setting?

Cancer Care Example

Cancer care organizations in Canada typically operate at the provincial level, with mandates to provide specialized oncology care across the cancer continuum, from prevention and screening to end-of-life care. Given the 'specialized' nature of oncology care, most patients will require a referral from a primary health care provider for diagnosis, treatment and management of cancer. Those without a primary health care provider may experience significant challenges accessing care. Oncology care is often compartmentalized by type of cancer (e.g., breast cancer) and/or treatment type (e.g., radiation therapy), and is often described as 'dis-integrated', requiring patients to attend appointments with multiple providers.

This is especially challenging for patients who already experience social disadvantages (e.g., those experiencing poverty and lacking access to a telephone and/or transportation), and often results in tremendous difficulty accessing care, and patients who 'fall through the cracks'. However, integrated models of care are in place in some centers or segments of the cancer care sector, where patients can access multiple providers in the same location at the same time, and care is coordinated around patients' social needs in addition to their physical needs.

Ask: To what extent are the ways care is structured and delivered tailored to the populations served? Is care organized in ways that are more suitable for some groups than others?

2 How does the history of your service context (e.g., hospital, primary/community care clinic, outpost, etc.) create/contribute to and/or mitigate inequities?

Emergency Department Example

In 2022, drones were deployed in Port Alberni around the site of the former Residential School. People living in the community, especially Indigenous people, could not escape the sound of the drones, or their meaning. Imagine the impacts on health and wellbeing. The Emergency Department realized that they had not adequately addressed the impact of the Residential School on the people they served, and began by hosting a series of consultations with local First Nations Elders, Leaders and community members.

In Port Alberni, Indigenous people comprise about 16% of the population. The community was the site of an "Indian Residential School" which has impacted and continues to impact local communities in multiple ways. These impacts both intensified and became more widely understood among non-Indigenous populations after the discovery of about 200 potential burial sites near the former Kamloops Indian Residential School, and the subsequent discovery of 751 unmarked graves at a cemetery near the former Marieval Indian Residential School outside Regina, and continues as other First Nations search for graves.

Indigenous peoples make up about 4% of the total population of Canada, however many Emergency Departments, especially in core urban centres and in the North, see a disproportionate number of Indigenous people (see also above regarding lack of community-based services and primary health care forcing people to use Emergency Departments for non-urgent concerns). Many of these Emergency Departments may also be located near former "Indian Residential Schools" and what were called "Indian Hospitals", and many, especially those founded by religious orders, have direct links to these former sites of trauma and violence for Indigenous peoples. They are also often located on stolen land. It's important to reflect on these kinds of historical factors, as they set the broader context for the care experiences of individuals and groups who seek your care.

Ask: What's the history of social and ethnic groups in your area, and especially, who are the local Indigenous peoples? How have various policies impacted these groups, e.g., what colonial policies have and continue to oppress Indigenous peoples? How do these affect health and wellbeing? Living conditions? Have/can you identify and engage with leaders or members from these groups to develop your own policies to improve safety, belonging and care practices?

Primary & Community Care Example

A primary care clinic in Ontario is located in a community that welcomed thousands of refugees from Syria. However, no additional resources were provided for addressing their pressing health care needs, including the multiple forms of extreme violence and trauma they had experienced. Further, the health care providers were unprepared for the vicarious trauma they began to experience as they witnessed the impacts of what these people from Syria experienced, and the limited support for survival they received in Canada. As the global humanitarian and refugee crises continue to escalate (each year more people are displaced by interrelated wars, economic crises, climate change and environmental disasters than the year before), this will become more common. The clinic started by focusing on reducing and responding to the vicarious trauma staff were experiencing, recognizing that they could not support people coming for care if they themselves were traumatized to the point of "burn out".

Ask: Who are the newcomer populations served? What proportion are refugees? What were the drivers of immigration from the source countries? How have these drivers and immigration processes affected health and wellbeing? Access to social determinants of health? Access to health care? Who among the organizations in your community also serve these populations? Have you talked to them to learn how best you can collectively support newcomers? What is the impact on staff? Does the composition of the staff reflect the composition of the population?

Cancer Care Example

The provincial cancer center in province X serves a diverse population, including a large Indigenous population (First Nations, Inuit and Métis). As a result of historical and ongoing policy decisions (e.g., forced relocation to First Nations reserves; underfunding of health care services in the community), many Indigenous peoples in the province live in remote or isolated areas, and experience significant health and social inequities, creating many challenges to accessing cancer care.

In recognition of these challenges, the provincial cancer center developed a department of Indigenous Cancer Control, new roles for Indigenous nurse navigators to directly support patients, and an Indigenous cancer strategy. More recently, in recognition of the residential school experiences of many Indigenous peoples in the province, and in response to the Truth and Reconciliation Commission's calls to action, all staff at the center are required to participate in cultural safety training, and an advisory group is being established to identify how the organization can create an environment where culturally safe care is prioritized.

Ask: What policies at federal, provincial and local levels shape inequities? How are poverty, geography, racism and other forms of discrimination influencing health risks and access to health care in your setting? What policy windows and opportunities are there? What collaborations are needed?

3 What are the key features (physical, economic, political, socio-cultural) of your service context and how will these features influence your quest for equity?

Emergency Department Example

The Emergency Department in Hospital A has 8 Emergency Department staff serving a population of 30,000 people spread over an enormous area including numerous small remote communities, some of which are only accessible by ice road in winter, or air. It is within a health authority for which most leadership is centered in an urban setting. Further, it is difficult to recruit and retain staff, particularly nurses. The Emergency Department relies extensively on "agency nurses" who work in the community for short periods of time (weeks to months), often only once. The Emergency Department staff are exhausted but rarely able to take time off because they know that doing so increases the burden on their colleagues. However, the hospital has a stable and committed leadership team. They have decided to take a long-term approach, concentrating on a) seeking ways to support training local people as health care providers, and b) identifying what would be required (e.g., employment opportunities for partners) to recruit nurses to the community permanently.

Ask: How is the health and wellbeing of staff in your setting? What factors shape the availability and qualifications of staffing in your setting? How do staffing levels, qualifications and composition shape equity?

Primary & Community Care Example

You work in a small group family medicine practice with three family physicians, a nurse practitioner and two registered nurses, along with two administrative staff. You're located in a part of the city characterized by lower income, lack of recreational services and limited access to consistent public transit, a grocery store, etc. While allied health and community services exist elsewhere in the city, their wait lists are very long, there is often a fee involved, and they're difficult to get to on public transit from your clinic's neighbourhood. Many of your patients need good "wrap-around" care and would greatly benefit from physical or occupational therapy, diabetes care, social work, etc., which would also reduce the burden on your services, and on the local urgent care and Emergency Departments. However, there is no obvious way for you to ensure your patients get linked to the services they most need. So you write what you know are ineffectual referrals that will not be completed.

You can only wait for folks to come back, in even worse shape. This is taking a toll on you and your staff, as well as your patients. As a first step, you convene patient-staff discussions on where the most pressing barriers are, inviting patients to speak first, and honestly, about priorities for improving their experiences in your office, and with other services. You hold several sessions at different times convenient to people, provide bus fare and food, open with a welcome from a local First Nation Elder and have people who can interpret several common languages among your patient roster. You invite leaders and staff from the organizations to which you tend to refer people for additional services, including the mental health and addictions agency, a women's shelter and an alliance of dental care providers that supports low-income patients, among others.

Ask: How do resources available in your community shape health and health care, including access to care? How do the resources available shape your ability to engage the people you serve in designing care? Can you better map and integrate referrals among local providers to support high-needs clients?

Cancer Care Example

The provincial cancer organization in your province has a mandate to provide services across the spectrum of cancer care and control, and serves the entire provincial population. Given its scope, services are designed to meet the needs of the 'majority' population, and not necessarily tailored to meet the needs of specific groups experiencing health and social inequities (e.g., people with mental health challenges, people with substance use health challenges).

In addition, the current government's emphasis on cost containment has meant that although the cancer organization continues to push towards offering the latest and most advanced cancer treatments, funding for nursing, allied health and support positions continues to decrease, and positions have been eliminated. Decreased funding has also meant that clinical spaces are at a premium, as funding to expand physical spaces has been cut. As a result, staff have extremely limited time with patients in exam rooms or other private spaces, which has impacted their ability to assess for and address needs related to social determinants of health or psychosocial challenges. The staff have identified that gathering data to demonstrate the long range negative social and economic impacts of the inequitable distribution of resources on both patients and staff is a priority.

Ask: How is the distribution of resources that flow to your setting determined and by whom? How does this distribution of resources deepen or mitigate social, health and healthcare inequities? What data is available and what might be needed to demonstrate how inequities are created and sustained?

4 How does your organization position itself, and how is it seen by the public? How might these perceptions influence equity?

Emergency Department Example

Hospital B positions itself as the largest and busiest Emergency Department, serving the fastest growing and most culturally diverse population in the province. Considerable effort has been expended to serve the high proportions of newcomers to Canada, and to serve a linguistically diverse community. However, racial tensions in the wider community run high, and are felt in the Emergency Department. Among one of the largest racialized communities, the reputation of the Emergency Department is very negative – with stories of patients experiencing racism being featured in local media on a regular basis.

There is a complaints process in place, but few patient complaints of racism are received. The provincial "patient satisfaction" survey shows positive ratings of care for the Emergency Department, but the survey has a very low response rate, is only offered in English, and excludes people who do not have mailing addresses and internet access. One Emergency Department nurse has proposed to implement a task force on antiracism, including prioritizing overhauling the complaints process. The Emergency Department Director is currently taking the proposal to the Hospital Board of Directors.

Ask: What are the key tensions in your workplace? How does racism, poverty stigma, mental health and substance use stigma or other forms of discrimination show up? How are patient experiences of care monitored in your setting and whose perspectives are included? How does the complaints process in your setting work? How effective is it?

Primary & Community Care Example

The new Family Health Team in the north end of City X has been touted as an exemplar for how primary health care should be delivered, with a broad array of professionals, including a social worker and a mental health nurse, employed on salary (rather than fee-for-service) and an emphasis on shared decision-making and patient education using on-site tablets that can tailor content, and a web-based tool that people can access from home. The local media have done several stories about this "patient-centred" and "innovative" model of care. However, the Family Health Team selects and rosters its own clients, and one of the criteria is the ability to use these technical tools in English and have internet access and a device at home. This reinforces the exclusion of groups facing various kinds of stigma and marginalization from accessing team-based primary health care, even though they might most benefit from this approach. Critiques of these "alternative" models of primary health care demonstrate that they often reinforce the needs of physicians and policy decision-makers, not patients, especially those facing barriers to care and good health.

Ask: How do policies within your organization work to mitigate, deepen or obscure inequities?

Cancer Care Example

The provincial cancer center positions itself as delivering the highest quality of cancer care, and staff report treating all patients equitably and with compassion and kindness. Public perception often matches this perception, and patients generally speak very highly of the organization and the care received. However, these perceptions may mask the reality that there is a segment of the population that is not well served by the cancer center, but whose voices and experiences are not often heard or sought. This may obscure the need for actions that purposefully respond to and address inequities.

Ask: How can you widen the diversity of people providing feedback on care? How can you include the perspectives of those least likely to be well served?

5 Who is served and how does that align with the mandate as well as the (self)perception of the organization/unit/setting? Does the reality of those served, and their care experiences, match the rhetoric?

Emergency Department Example

By examining their administrative and patient satisfaction data, Hospital C can demonstrate that it serves over 400,000 people per year, with the majority being of European ancestry and born in Canada. Satisfaction metrics, which are notoriously positively skewed, show that certain groups are very happy with their care, while others less so. Also, people sometimes rate their care highly purely on the basis of not being talked to by Emergency Department staff in dismissive ways – when in the past they were treated rudely or talked down to. Examination of these data against the positioning and perception of Hospital C in its own mandate and mission, and how it talks about itself and is seen (internally and externally), show a significant mis-match.

Ask: What information can you easily get regarding the experiences of people coming for service?

Primary & Community Care Example

Increasingly, health authorities are setting up clinics to serve "unattached patients" – that is, people who have no stable primary health care provider. Yet, those clinics may not be prepared to address the range of health and social issues that many people have – particularly people who are living on low incomes, in less than adequate housing, people experiencing major mental health issues without adequate supports, people living with multiple chronic health issues, and people who are socially isolated for various reasons.

Think about what would be needed to adequately serve people who are most in need of care. At one clinic, for example, the staff negotiated to have a somewhat reduced patient roster requirement because of the extent of health and social inequities experienced by the local populations served. This is where reviewing locally generated data and making visible the ways in which inequities manifest is particularly useful – to help set reasonable expectations for any given primary and/or community care organization.

Ask: How can your setting be optimally responsive to meet the needs of local communities – given the extent to which health and social inequities impact people coming to your agency?

Cancer Care Example

Provincial cancer organization X has a mandate to provide cancer services across the spectrum of cancer care to all residents of the province, and holds the provision of person-centred and integrated care as core values. Yet people who have experiences of homelessness, substance use, or mental health issues report experiencing stigma, judgment and discrimination, and are not able to access services across the cancer continuum, including screening services, cancer treatment, and end of life care. This contradicts the organization's own mission statement and self-perception as one that provides care to all people diagnosed with cancer.

Although this may be a small portion of the population, there are people who are dying of cancers that are preventable or treatable because they cannot access the care that they need. As a result, the organization is focusing on two such preventable and treatable cancers that are known to be inequitably addressed – lung and cervical cancers – by strategically targeting screening of both. However, this strategy falls short because the communities strategically targeted are also those least likely to access screening services.

Ask: Who is least likely to be well served? What particular health issues within your setting's mandate are least well addressed? How might particular health issues be targeted in ways that reach those least well served?

6 What is your organization's culture with respect to how staff are supported in their work, how patients are treated from the start to the end of their visit(s), and how change can get started and be sustained? Would these cultural factors support equity-oriented care? Why or why not?

Emergency Department Example

Hospital D has started, and stopped numerous quality-improvement efforts in the Emergency Department in the past 10 years. Some of these have been in response to people presenting with mental health crises and more recently in response to the overdose crisis related to the toxic drug supply. However, staff are rarely asked what might work, and rarely see any tangible improvements – they just perceive these change efforts as placing more demands on their time, especially in charting and data collection.

These and other stresses, including fewer full-time positions with benefits like employee assistant programs (EAPs), sick days and vacation, have led to a lot of turnover and burnout. These effects are also seen on patient care, with increasing tensions among staff and between staff and patients. Overall, the approach to change has made things worse for staff and patients, and those who are racialized or face other forms of stigma and discrimination are more likely to report bad experiences and/or leave their employment.

Ask: How does change typically happen in your setting? Who is involved and who is left out? Who is impacted (positively and negatively)?

Primary & Community Care Example

In one medium-sized city that has welcomed several cohorts of newcomers from the Middle East in recent years, including highly traumatized groups from genocidal contexts, the local settlement agency adopted trauma- and violence-informed care (TVIC) as the "door" into equity-oriented care for their entire organization. This included initial and ongoing all-staff training, onboarding of new staff to orient them to TVIC and equity-oriented care, and attention to organizational supports for vicarious trauma and staff wellness.

As staff worked with clients and recognized the high levels of health care needs, and the importance of primary health care as a key link to community integration, they partnered with the local Community Health Centre to start a primary care clinic located at the settlement agency, where newcomers were rostered for two years, then supported to find a permanent primary care home.

Ask: What kinds of knowledge about your community would help show you are taking that knowledge into account in everyday work with people? How could innovative partnerships across health and social services enhance both health and social integration outcomes for people?

Cancer Care Example

Provincial cancer organization Y wants to prioritize delivering culturally safe care, and has mandated a 1-day cultural safety course for all staff. Staff are provided paid time off to attend the training. However, in the day-to-day clinical operations of the organization, the emphasis is on delivering cancer treatment as quickly and efficiently as possible and addressing acute symptoms only. This impacts staff members' ability to develop trusting relationships and/or attend to social needs that must be met in order for patients to be able to get or complete cancer treatment.

Although cultural safety is 'prioritized', it is seen primarily as an individual provider responsibility, and not an organizational way of delivering services. This makes shifting to relational approaches to care very difficult. Staff express frustration at wanting to develop trust, ensure continuity of care with patients, and address social needs, but being pushed to see as many patients as possible as quickly as possible. At the same time, the organization's strategic plan includes objectives related to addressing disparities in care, which could be used to drive change.

Ask: What is the relationship between the stated vision, mission and goals of your organization and the reality at the point-of-care? How could commitments at the organizational level be improved to make an explicit commitment to equity? How might such an explicit commitment be leveraged to improve care? What are the mechanisms and channels for such improvements?

7 **How are people talked about in your organization/unit/service setting? How do you think people in the local community perceive or think about your organizations? This can include during formal interactions (provider-patient, provider-provider, provider-supervisor; team case consultations, etc.), informal discussions (hand-offs, coffee-room chat, etc.) and in documentation/charting.**

Emergency Department Example

In an effort to reduce the labels "frequent flyer" and "repeat customer" and associated stigma, Hospital E introduced a program called "Familiar Faces" in which people who frequently use the Emergency Department are identified and their care reviewed with the intention of optimizing their care. Similarly, staff have been asked to be very careful with their language when describing cases (specific or general), avoiding terms like "drug seeker", "junkie/addict" or "difficult". In charting, staff are asked to focus on concrete aspects of the care encounter, using the patient's own words if experiences are described, and excluding their own judgements or labels.

However, over time, the intention of the shift to a "Familiar Faces" program has been eroded; whereas the intention was to develop meaningful care plans for each individual to help ensure their health issues were effectively dealt with both within the Emergency Department and through referral, staff from the program were redeployed to COVID response teams and have not yet been replaced. As a consequence, although the language has changed, "Familiar Faces" no longer has meaningful support for patients, and serves mostly as a label that functions to deem people as "overusing" or inappropriate for the Emergency Department and thus of low priority or not deserving of care.

Ask: Who is constructed as most deserving of care in your setting? Who is identified as a "problem patient"? What language signals those perceived to be most and least deserving? What shifts are needed toward equity? What is required to make these meaningful and sustainable?

Primary & Community Care Example

Although it is not usual practice, several of the primary and community care clinics we have worked with have hosted community lunches at venues such as a Friendship Centre or at a community agency (other than their own) to invite, listen to, and receive feedback from staff who work at other agencies, and from people who use the clinics' services.

These kinds of lunch-time sessions can be hosted by someone from outside your agency – so that people feel free to share their views without fear of reprisal from actual clinic staff. This can be a relatively low cost yet highly productive way to solicit feedback from people who will help you to understand how your agency is perceived, the assumptions circulating in the wider community about your agency, and possibly, the kind of shifts that your agency can make in the spirit of being as responsive to feedback as possible.

Ask: How can you tap into what people in the community really think about your agency, and what relevance does that have in terms of how you might continually improve how you operate, and the care provided?

Cancer Care Example

In the context of cancer treatment, patients are often prescribed chemotherapy or radiation treatment regimens that include treatments that must be given at very specific time points. At cancer clinic X, patients who experience a range of social disadvantages (e.g., homelessness, poverty) sometimes do not have the ability to maintain highly rigid schedules and therefore miss or need to reschedule treatment appointments. Clinic staff discuss these patients amongst themselves, labelling them as “non-compliant” or “no shows”, and document this in chart notes, without asking about or acknowledging the social circumstances that are significantly impacting patients’ attendance.

Ask: How do social circumstances created by social policy (e.g., social assistance rates, lack of affordable housing, lack of affordable child care, minimum wage policies) influence access to the care and services your setting provides? How could policies at the organizational or point of care level mitigate some of these impacts? How might understanding and acknowledging these dynamics improve care?

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