Report

Health Equity Report

**For the Niagara Ontario Health Team-
Équipe Santé Ontario-Niagara (NOHT-ÉSON)**

TED ROGERS SCHOOL OF MANAGEMENT | DIVERSITY INSTITUTE

ÉQUIPE SANTÉ ONTARIO NIAGARA ONTARIO HEALTH TEAM

Housed within the Ted Rogers School of Management, the Diversity Institute (DI) has over 100 diverse researchers focused on advancing equity, diversity, and inclusion. We work with organizations across sectors to develop customized strategies, programming, and resources to promote new, interdisciplinary knowledge and practice about diversity with respect to gender, race/ethnicity, Indigenous Peoples, abilities, and sexual orientation. Using an ecological model of change, our action-oriented, evidence-based approach drives social innovation across sectors.

DI engages in research and programming with more than 250 partners in for-profit, non-profit, and public-sector organizations to understand the strategic importance of diversity and inclusion within their respective sectors and to develop customized strategies and tools to harness inclusion as a driver for success. DI leads a number of large multi-stakeholder programs for the Future Skills Centre, the Women Entrepreneurship Knowledge Hub, and 50 – 30 Challenge.

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Canadian Mental Health Association – Niagara Branch

Centre de santé communautaire Hamilton Niagara Inc.

Community Addiction Services of Niagara

Community Support Services of Niagara

Consumer/Survivor Initiative of Niagara

Contact Niagara for Children's and Developmental Services

De dwa da dehs nye s

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Fort Erie Meals on Wheels

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Niagara Medical Group Family Health Team

Niagara North Family Health Team

Niagara Region Public Health

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Ontario Health

Pathstone Mental Health

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Contents

Assessment Tool, Resources and Best Practices Guide, and Progress Tracker attached separately.

Executive Summary

In partnership with the Niagara Ontario Health Team-Équipe Santé Niagara-Ontario (NOHT-ÉSON), the Diversity Institute (DI) developed a Health Equity Toolkit ("Toolkit") to support over 45 organizations comprising the NOHT-ÉSON in their health equity journey.

The Toolkit is the cumulative project deliverable, and it consists of four component parts:

Report	Tool	Tracker	Guide
The Health Equity Report (“Report”), inclusive of four Appendices	The Health Equity Assessment Tool (“Tool”)	The Health Equity Assessment: Progress Tracker (“Tracker”)	The Health Equity Assessment: Resources and Best Practices Guide (“Guide”)

The Toolkit is designed to support the NOHT-ÉSON in advancing health equity in Niagara for designated populations, such as Francophones and Indigenous Peoples—as per the Ontario Health Team (OHT) mandate—and other equity-deserving groups. The Toolkit should be used as a roadmap to understand and identify opportunities, priorities, and best practices that may be implemented to achieve organizational-level goals and fulfill OHT-level mandates.

1. Health Equity Report

The Health Equity Report ("Report") is the product of a background scoping review of the Canadian health care industry—with a particular focus on the provincial and regional contexts—as well as consultations with NOHT-ÉSON organizations and their Health Equity Work Group (HEWG).

The Report outlines the project and the formation, structure, and organizational mandate of the NOHT-ÉSON. Key terms, such as equity-deserving groups, Francophones, linguistic minorities, equality, equity, diversity, and inclusion, are defined. The Report also provides a Health Equity Definition specific to the NOHT-ÉSON, developed by DI based on substantive industry resources. The three organizational pillars—the broad areas of assessment that make up the Health Equity Assessment Tool—are discussed. Finally, the Report includes an overview of the Tool: what it is, why it is important, and how it functions.

2. Health Equity Assessment Tool

The Health Equity Assessment Tool ("Tool") was developed by DI in collaboration with the NOHT-ÉSON HEWG in 2022. The Tool is **not** an audit. Rather, it is designed to assess the state of health equity alongside other equity, diversity, and inclusion (EDI) principles and priorities within the NOHT-ÉSON, in order to foster greater organizational diversity and improve equitable and inclusive access to health care for diverse populations in Niagara. The Tool allows organizations to measure and self-monitor their progress toward achieving organizational health equity goals year-over-year. The Tool should be a living document that continuously reflects the current state and progress of organizations. As such, the Tool was designed to capture current trends while allowing organizations to better understand what it means to improve across each of the three organizational pillars.

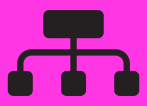
The three pillars are:

1. Leadership and Governance

This pillar addresses the composition and diversity of the Board of Directors/Governing Bodies and Senior Leadership Team.

2. Organizational Values and Culture

This pillar recognizes the importance of an inclusive and diverse work and care environment in the journey toward health equity.



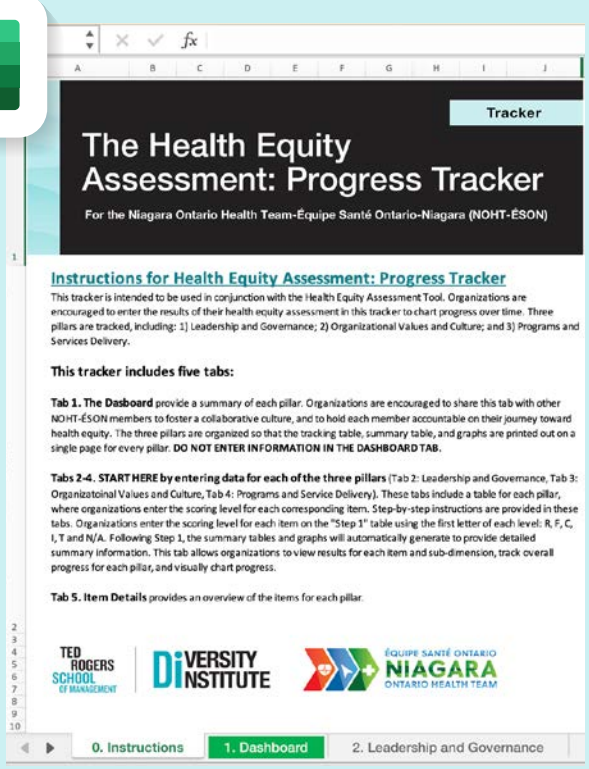
3. Programs and Service Delivery

This pillar challenges organizations to design, develop, and deliver programs and services that meet the needs of diverse populations.

A set of questions was developed for each of the three pillars. Organizations will assess their ranking for each question, based on the following levels: Readiness, Foundation, Champion, Integrated, Transformative, or Not Applicable (N/A). The Tool recognizes that each organization is at a different stage of the journey and seeks to support the growth and development of each NOHT-ÉSON member, as well as the OHT as a whole. Organizations will input results in the Health Equity Assessment: Tracking Template in order to chart their progress in each subsequent year.

3. Health Equity Assessment: Progress Tracker

The Health Equity Assessment: Progress Tracker ("Tracker") accompanies the Tool. The Tracker is a document that allows organizations to input the results of their assessments and track changes year-over-year. The Tracker features a dashboard that reflects the broader results of an organizational assessment based on the Health Equity Tool pillars and sub-dimensions. The Tracker should be used at the end of each year to help summarize the results of the Health Equity Assessment. It can provide organizations a high-level overview of their annual progress and opportunities in each dimension of health equity. The dashboard is intended to be shared within the broader NOHT-ÉSON so that the collective may work together to address dimensions that are particularly challenging across organizations.



The Tracker is a document that allows organizations to input the results of their assessments and track changes year-over-year.

4. Health Equity Assessment: Resources and Best Practices Guide

The Health Equity Assessment: Resources and Best Practices Guide ("Guide") is a collection of recommendations and resources that will help NOHT-ÉSON organizations address health equity gaps that are identified through the Tool. The Guide was developed based on leading best practices from academic, government, and industry sources and also includes resources currently used by individual organizations within the NOHT-ÉSON. The Guide follows the same structure as the Tool and provides itemized resources for each question, sub-dimension, and pillar. Resources may include: policy templates, implementation and evaluation guides, trackers and checklists, up-to-date terminology, and other additional resources and research on the barriers and needs identified for the various populations the NOHT-ÉSON serves.

Project Overview

The Niagara Ontario Health Team-Équipe Santé Ontario-Niagara (NOHT-ÉSON) was established in 2020 to provide a coordinated approach to care and services, with the objective to improve clients' health care experience and outcomes.

The NOHT-ÉSON comprises more than 45 health care, mental health, and social service organizations across Niagara, including primary care, home care, emergency services, public health, social services, mental health and addiction, rehab, and acute care.[1]

One of the NOHT-ÉSON's guiding principles is to improve population health by providing equitable care and access that is inclusive of every community, including Indigenous and Francophone communities, and other **equity-deserving groups** across Niagara.

The NOHT-ÉSON established a collaboration with the Diversity Institute (DI) to facilitate its journey in advancing health equity for the Niagara population and to support its commitment to an equitable and inclusive health care and social service ecosystem. To date, DI has worked with the NOHT-ÉSON to:

+ Define health equity and its associated goals in order to establish a common understanding of this long-term initiative across NOHT-ÉSON members and partners.
+ Develop a tailored Health Equity Assessment Tool ("Tool") to assess the current state of health equity practices within each NOHT-ÉSON organization and track growth internally and over time.
+ Identify resources and partners currently available across Niagara's health care and social services ecosystem through research and stakeholder consultations.
+ Identify best practices and frameworks in equity, diversity, and inclusion across the health care and social services ecosystem and beyond that can be leveraged by NOHT-ÉSON organizations.

The NOHT-ÉSON Health Equity Toolkit ("Toolkit") includes the Health Equity Report ("Report"), the Health Equity Assessment Tool ("Tool"), the Health Equity Assessment: Progress Tracker ("Tracker"), and the Health Equity Assessment: Resources and Best Practices Guide ("Guide"). This Toolkit should be used as a roadmap for this phase of the NOHT-ÉSON's health equity strategy. The four components of the Toolkit should be used together to identify opportunities, priorities, and best practices that can be implemented over time at the organizational level and at the Ontario Health Team (OHT) level. More specifically, in this report, organizations may find: a **project overview**, NOHT-ÉSON **health equity goals and strategic priorities**, the case for health equity and the Niagara region context, as well as a brief **summary of the Health Equity Assessment Tool.**

The **Health Equity Definition, Report, Tool, and Guide** comprise part of a much broader initiative to achieve health equity. The NOHT-ÉSON aims to create a cohesive health care system that serves all residents of Niagara in a way that is inclusive, equitable, safe, and free of barriers to access. Achieving health equity requires a comprehensive strategy to address the social determinants of health, organizational policy and practices, as well as individual attitudes and behaviours. The Report, Tool, and Guide focus on addressing gaps and opportunities at the organizational level, based, at this stage, on internal consultations. Health equity requires ongoing conversation and active collaboration among NOHT-ÉSON organizations across the region, particularly with input from the communities that the NOHT-ÉSON serves. The scope of the current project is to provide a Health Equity Definition and Report and to develop a Health Equity Assessment Tool to support organizations in developing their health equity strategy, supported by a Health Equity Resources and Best Practices Guide that provides examples of best practices (see Table 1).

Table 1. Project Scope, Methodologies, and Expected Outcomes

What	How	Outcomes
Health Equity Definition	• Examination of existing definitions of health equity • Consultation with NOHT-ÉSON partners to identify key focus • Health Equity Working Group meetings	A Health Equity Definition will be developed that is specific to the needs of the NOHT-ÉSON and the communities it serves. The definition is used to guide the work of all NOHT-ÉSON organizations.
Health Equity Assessment Tool ("Tool")	• Survey and consultations with NOHT-ÉSON liaisons • Adapting the well-researched Diversity Assessment Tool to apply it to the unique needs of the health care sector and demographic foci of this project	The Tool will be used to assess the current state of health equity in Niagara's care ecosystem, as well as to benchmark and track progress toward health equity.
Health Equity Report and Health Equity Assessment: Resources and Best Practices Guide ("Guide")	• Collection of leading practices from the health care sector • Consultation with NOHT-ÉSON members and partners in the sector • Research on the needs of and gaps facing equity-deserving and underserved groups in health care in the Niagara context and beyond	The Guide will provide best practices and recommendations to address specific gaps and opportunities identified from the Tool assessment.

Overview of the NOHT-ÉSON

Organizational Mandate

Ontario Health Teams (OHTs) have been established so that health care providers —including hospitals, doctors, and caregivers—work in coordination to provide centralized and effective care. The aim of this coordinated approach is to ensure that enhanced integrated care reaches all Ontario residents.[2] Bill 74, The People's Health Care Act, 2019, amends the Ministry of Health and Long-Term Care Act to include the creation of "Indigenous health councils and a French language health services advisory council."[3] With respect to Indigenous health care, beyond the creation of Indigenous health councils, Elders and other community leaders should also be consulted.

Given this priority, when applying to become an OHT, organizations are mandated to successfully partner with Indigenous leaders and French-language entities in the planning and implementation of health care services. In accordance with Bill 74, OHTs must[4]:

+ Eliminate current health disparities experienced by Indigenous Peoples in Ontario.
+ Redesign care that improves and meets the diverse needs of Indigenous communities.
+ Recognize and respect the role of Indigenous Peoples in the planning, design, delivery, and evaluation of services in their communities.
+ Provide culturally safe care for Indigenous Peoples.

Likewise, as per Bill 74, "the public health care system should recognize the diversity within all of Ontario's communities and respect the requirements of the French Language Services Act (FLSA) in the planning, design, delivery, and evaluation of health care services for Ontario's French-speaking communities."[5] For OHTs, this means that they must ensure the accessibility of health care services in French.

While the NOHT-ÉSON is committed to delivering equal services to minority language communities that face language barriers in the health care sector, it specifically aims to remove barriers to care for Francophone communities. In particular, this mandate helps address concerns regarding the quality of care and safety of patients from Francophone communities. For example, managers and health care professionals are encouraged to equip themselves with the necessary skills to navigate linguistic barriers using resources such as eQUITY Link. Specifically, eQUITY Link is a platform that provides evidence-based learning tools to foster understanding of the needs of Francophone and/or Acadian groups in a given area; it also addresses linguistic health and social service and/or community service issues, and offers proven solutions for a range of concerns.[6]

The NOHT-ÉSON is guided by the following principles[7]:

1. Commitment to patients/clients, caregivers, and families and to the Quadruple Aim
2. Authentic partnership and co-design
3. Collaborative culture
4. Population health, equity, and access
5. Coordination and integration
6. Spread and sustainability
7. Innovation and excellence
8. Commitment to quality improvement
9. Creativity/ continuous learning
10. Commitment to a journey
11. Digital transformation

The NOHT-ÉSON is committed to ongoing collaboration and acknowledges the vision and collective benefits of continued partnership in the process of forming the OHT. The full continuum of care is collectively accepted as a journey that is integrated and innovative; improves patient, client, and provider experiences, as well as health outcomes; and ensures value for the broader Niagara community.

Formation and Structure of the NOHT-ÉSON

The NOHT-ÉSON and its various community partners have adopted a "Consensus Decision-Making Framework" to acknowledge diverse perspectives in the decision-making process.

The principles of the framework are:

+ Clarity of process and discipline in speaking and listening.
+ Respect for the unique contributions of all meeting participants, which are carefully considered and used in achieving a resolution.
+ Belief that the best decisions result when the group works co-operatively and not as competing individuals/organizations/sectors.
+ Care to create a co-operative atmosphere in which conflict is expressed, supported, and resolved.

DI learned about the ongoing health equity work that is being undertaken across Niagara through meeting with the Health Equity Working Group (HEWG), reviewing sector reports and resources, and consulting with members of NOHT-ÉSON organizations. The NOHT-ÉSON is committed to eliminating barriers to access for equity-deserving groups in the region. Members understand the importance of the social determinants of health that impact health equity in their decision-making and program implementation processes. In the consultations, members expressed the importance of holistic thinking, both in terms of the healthcare system and in treating the individual. This shift in focus allows organizations to improve non-emergent and non-primary care services for equity-deserving groups.

Organizations highlighted three key areas in the consultation that will strengthen equity, diversity, and inclusion (EDI) and health equity frameworks:

1. Education and training initiatives
2. Strengthening partnerships
3. Building representative organizations

NOHT-ÉSON organizations are participating in education and training initiatives; these reflect both knowledge building and knowledge sharing.[8] The current focus is on learning and training that supports increasing knowledge of Indigenous cultures and traditions, 2SLGBTQ+ issues, Francophone culture, and other issues that affect Francophone communities. Building representative organizations is at the forefront of internal evaluations. Finally, members want to increase knowledge of available services, improve programming to address gaps, and facilitate best practices. Members want to achieve this by strengthening partnerships both internally (within the NOHT-ÉSON) and externally.

Key Terms

Throughout the Health Equity Report ("Report") and the Health Equity Assessment: Resources and Best Practices Guide ("Guide"), we use a number of key terms when referring to the populations of focus for health equity and other important concepts. Meanings and perspectives are ever-changing. The intent of the definitions in the Report and Guide is to frame a shared understanding of terminology based on the current consensus among stakeholders in the EDI space, with priority given to the views and experiences of the subjects of these terms. These definitions should be a starting point to encourage ongoing learning and conversation.

It is also important to note the distinction between diversity, equality, equity, and inclusion. Diversity refers to differences among people with respect to demographic identities or qualities, such as age, class, ethnicity, gender, health, physical and mental ability, race, sexual orientation, religion, physical size, education level, job and function, personality traits, language, and other differences. Equality is equal treatment for everyone, regardless of identity. Equity refers to fair treatment for all by recognizing and remedying historic disadvantages that certain groups have faced. Inclusion is ensuring that people, regardless of their identity or backgrounds, are given opportunities to participate and feel that they belong.

The term **equity-deserving groups** refers to those who experience barriers to equal access, opportunities, and resources due to historic oppression and discrimination, including groups covered under the Employment Equity Act (i.e., women, racialized people ["visible minorities"], people living with disabilities, and Indigenous Peoples) and 2SLGBTQ+ individuals. The term is currently used by a number of public, private, and non-profit organizations and the federal government[9] and is used under the Publicly Available Specification of the 50 – 30 Challenge.[10] It recognizes groups that *deserve* equity and has replaced the commonly used term "equity-seeking," which placed the onus on these groups to "seek" fairness and access[11]—*"if equity is a right, no one should be put into the position of having to ask for it."*[12]

Achieving health equity also requires a focus on other groups that are not covered by legislation. These **underserved groups** experience inequitable health outcomes due to historical and current systems and practices and include (but are not limited to): unhoused individuals; persons living in poverty; the aging population; youth; newcomers, refugees, and temporary foreign workers; and linguistic minorities.

While there are many considerations with respect to the language and culture of Francophone communities in Ontario, the French Language Services Act (FLSA), 1986 specifically addresses service provisions for Francophones in the province. The FLSA legislates the right to receive services in French from government agencies, ministries, and institutions. The law requires that the needs of the Francophone population are taken into account in the development and implementation of programs, policies, and procedures. Furthermore, services received in French must be equivalent to those offered in English, especially in terms of timely access and quality of service. Amendments to the FLSA as part of the Build Ontario Act, 2021 (Bill 43), further legislate improved "access to quality services in French for Ontario's growing Francophone community."[13] These amendments better define the Active Offer of the French language, which means that quality services must be: available at all times, clearly communicated, visible, easily accessible, and equivalent to the quality of services offered in English.[14]

Linguistic minority refers to individuals whose maternal language is neither the majority language nor the official language minority in the province or territory. Ontario is the country's most multicultural province and sees over 50% of newcomer settlement. In terms of health care, lack of language support in accessing services for linguistic minority communities means that patients may not fully participate in their care and may experience negative outcomes due to language barriers.[15] It is important to consider the needs of linguistic minorities in the development and delivery of programs and services as well as to form partnerships to achieve health equity. While other linguistic minorities are not explicitly covered under the FLSA, the mandate and funding priorities for French language integration create many tools and strategies that may also help other language minorities. For context, in Niagara, about 14% of the population have a non-official language as their maternal language, with the top three languages spoken being Italian (18%), German (10%), and Spanish (8%).

Please refer to Appendix A for a complete list of definitions.

The Case for Health Equity

Health Equity Definition Developed for the NOHT-ÉSON

Health equity means that every individual has a fair and just opportunity to reach their best possible physical, mental, social, and spiritual well-being. To achieve health equity, we seek to create equal access to appropriate care and resources and eliminate existing health disparities and systemic barriers stemming from one's gender, race, ethnicity, Indigeneity, sexual orientation, religion, age, language, social class, socioeconomic status, and other social determinants of health.

Health Equity and Why it Matters

We define health equity according to the values and principles of the NOHT-ÉSON, as well as similar organizations. This definition includes what health equity represents, but also establishes *why* this work is important. With a goal of impactful, sustainable change, it is critical that leaders involved in health equity initiatives are fully invested and that the tone is set from the top. Health equity should not be viewed as an undertaking separate from the organization's regular operations, but as work that is necessary for the organization to achieve all of its strategic goals.

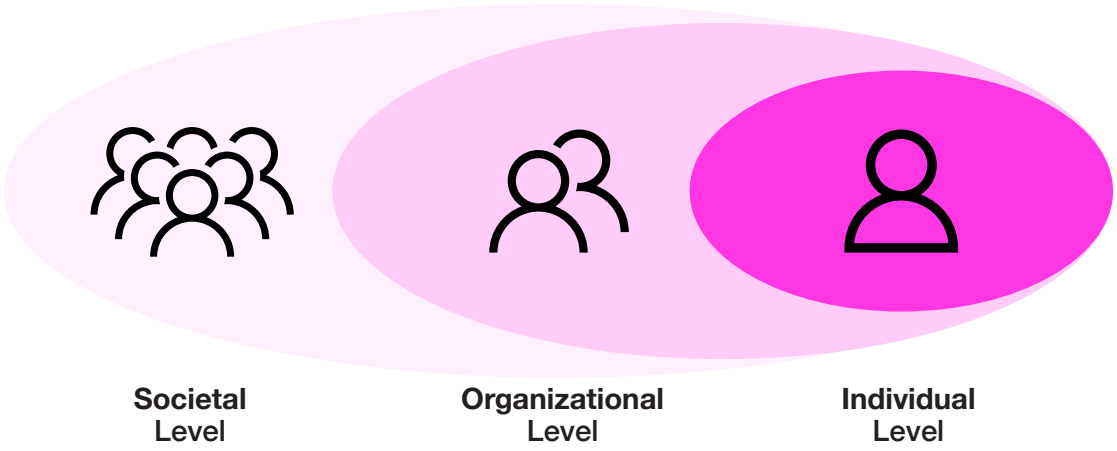
Canada's population is changing. With an aging population and declining birthrate, immigration is the principal source of population growth. Statistics Canada projects that 30% of Canada's total population will be newcomers and nearly 40% of the Canadian population will belong to racialized groups by 2036.[16] Indigenous youth are also the faster growing segment of the Canadian population.[17] Furthermore, 30% of the 2SLGBTQ+ population in Canada comprises youth aged 15 to 24 (compared to 14% of the non-2SLGBTQ+ population); this signals the changing proportion of the 2SLGBTQ+ community in Canada.[18]

Consultations with NOHT-ÉSON member organizations also hint at the changing population in the Niagara region. Care providers from the region have noted an increase of diversity among their patients and clients, such as increasing numbers of racialized, newcomer, 2SLGBTQ+, and Indigenous peoples accessing care. The growing diversity of Canada's population demands a reassessment of existing strategy for achieving health equity, by delivering and removing barriers to access culturally safe and competent care.

Health equity creates a standard of fairness and leads to more equitable health outcomes for all. It provides a framework that allows health care practitioners and staff to effectively care for patients from increasingly diverse populations. In fact, high ranking hospitals—based on clinical outcomes, patient experience, and staffing factors—are more likely than lower ranking hospitals to prioritize health equity in their strategic planning, to have devoted resources to address issues relating to cultural diversity, and to foster inclusive health care environments.[19]

Organizations with diverse and inclusive workforces are afforded with more cognitive flexibility, as they welcome more diverse input and perspectives, and drive for creative and innovative care solutions.[20] A focus on health equity fosters critical research that can lead to more effective diagnosis and treatment of historically underserved and understudied populations. Moreover, the values of equity, diversity, and inclusion that inform health equity work impact an organization's internal functions, as they are necessary for attracting and retaining strong, diverse talent and can promote a culture of empathy, collaboration, and innovation. When applied practically and consistently within health care organizations, these values avoid legal costs, benefit an organization's reputation, and increase opportunities for key partnerships and funding.

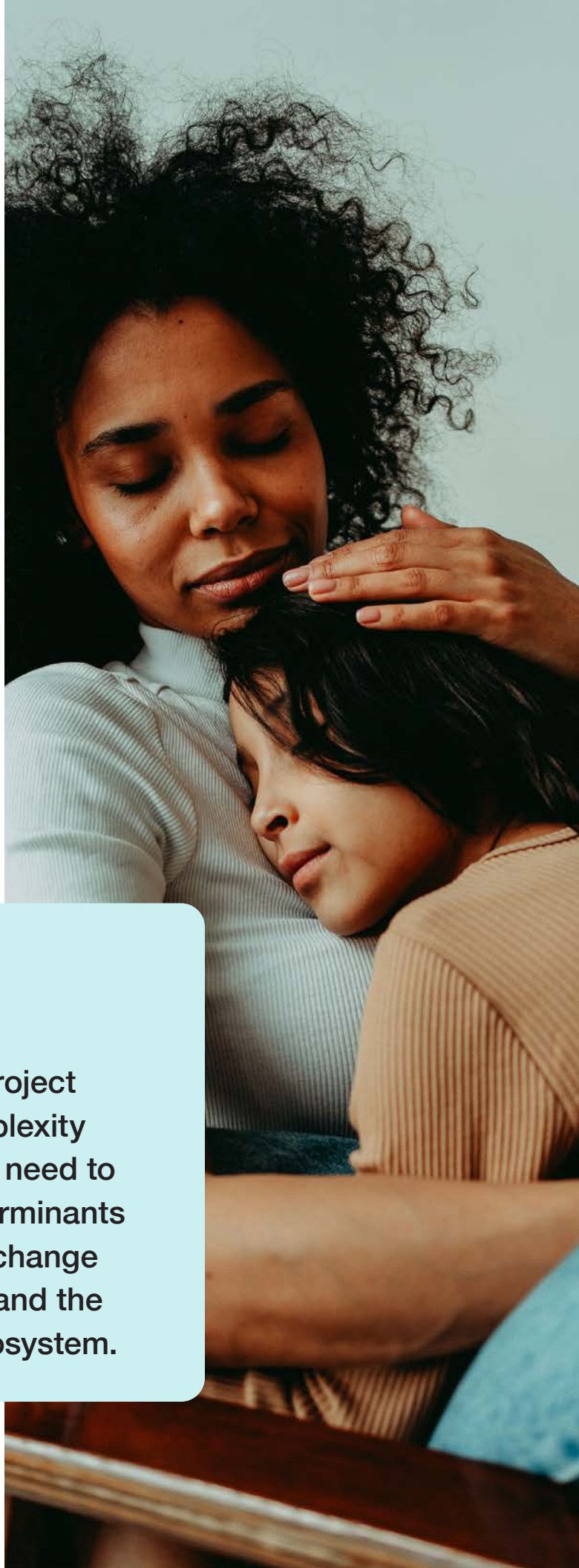
Social Determinants of Health



Social determinants of health are social, economic, and environmental factors that influence how individuals interact with, and thrive in, their communities.[21] They include factors at the individual level (cultural or racial identity, education, beliefs, life experiences), organizational level (policies, hiring practices, organizational culture), and societal level (societal perceptions and bias, media, legislation). Health care practices should account for factors at all three levels that impact how an individual experiences the health care system, as these factors significantly affect individual health outcomes.[22] Addressing social determinants of health is a fundamental part of improving population health and reducing health inequities.[23] The Ontario Ministry of Health and Long-Term Care's Health Equity Guideline recognizes 16 key social determinants of health[24, 25]:

+ Access to health services
+ Culture, race, and ethnicity
+ Disability
+ Early childhood development
+ Education, literacy, and skills
+ Employment, job security, and working conditions
+ Food insecurity
+ Gender identity and expression
+ Housing
+ Income and income distribution
+ Indigenous status
+ Personal health practices and resiliency
+ Physical environments
+ Sexual orientation and attraction
+ Social inclusion/exclusion
+ Social support networks

The growing diversity of the region's population demands a reassessment of the existing strategy for achieving health equity by delivering and removing barriers to culturally safe and competent care. This health equity project recognizes this complexity and acknowledges the need to address the social determinants of health to facilitate change across organizations and the broader healthcare ecosystem. This Toolkit is only the first step toward achieving health equity across Niagara, by supporting NOHT-ÉSON members and stakeholders to identify health equity gaps at the organizational level. This includes organizational processes, policies, and practices that have a direct or indirect impact on the broader ecosystem.



This health equity project recognizes this complexity and acknowledges the need to address the social determinants of health to facilitate change across organizations and the broader healthcare ecosystem.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Demographics and Service Needs in Niagara

Demographic Profile

An understanding of the diverse communities across Niagara is key to building a health system that is rooted in respect and support and that embraces people of all abilities, ages, ethnicities, language backgrounds, gender identities and expressions, races, religions, sexual orientations and expressions, and others.

Francophone*:* As of 2021, the Niagara region's total population was 477,941. This figure represents a 6.7% population increase from 447,888 in the 2016 Census.[26] The Francophone community in Niagara and neighbouring municipalities includes French-speaking newcomers and other diverse ethnic groups. The population of Francophones living in Niagara totals 15,115.[27] The City of Welland (5,355) has the largest Francophone population, followed by St. Catharines (3,575) and Niagara Falls (2,305). The region has a dynamic Francophone community that is reflected in the development of diverse organizations, including community, health, and social care institutions.

Indigenous*:* In Niagara, 2.8% of people identify as having Indigenous roots or heritage, which mirrors the population of Ontario as a whole, where Indigenous communities represent 2.8% (374,395) of the population.[28] Of these groups in Niagara:

+ 1.6% identify as First Nations.
+ 1.0% identify as Metis.
+ 0.1% identify as other Indigenous identities.
+ 0.1% identify as multiple Indigenous identities.

St. Catharines (3,550) has the largest Indigenous population, followed by Niagara Falls (2,240). Port Colborne (920) and Fort Erie (1,395) have the largest population percentage of Indigenous Peoples. Niagara Chapter-Native Women note that 85% of Indigenous individuals now live off-reserve and in different urban and rural settings.[29]

This has led to the formation of response committees, including the memorandum of understanding signed in 2020 by the Ontario Federation of Indigenous Friendship Centres and provincial municipalities in order to "work together to improve the lives of Indigenous people in each municipality."[30]

Looking at other diverse populations in Niagara:

+ 16.6% are newcomers.
+ 8.7% identify as belonging to a racialized community (the most common racialized groups identified are Black, South Asian, Chinese, and Latin American).
+ 14.5% of the Niagara population is considered to be part of a low-income group.[31]
+ Niagara has an aging population; the population aged 65 and over increased 18.2% from 2011 to 2016, compared to 3.8% for all ages.
+ 28.9% identify as having disabilities.

Note that data for the 2SLGBTQ+ population for Niagara is not available. In Canada, there is an estimated total of one million individuals who identify as part of the 2SLGBTQ+ community, which accounts for 4% of the total population.[32]

Priority Populations

One of the core health equity goals for the NOHT-ÉSON is to ensure equitable health outcomes for all by addressing barriers to health care access for groups that face historic and systemic marginalization or exclusion. Equity-deserving populations include women, racialized people, Indigenous Peoples, 2SLBGTQ+ individuals, and persons living with disabilities. In addition, the NOHT-ÉSON has identified a list of other priority groups that are currently underserved in terms of access to health care and social supports, including newcomers and refugees, aging populations, as well as unhoused and low-income individuals. While NOHT-ÉSON member organizations serve a diverse range of clients with varying health care and demographic foci, the Ministry of Health has identified two priority populations as a key focus for all members of Ontario Health Teams (OHTs): Francophones and Indigenous Peoples.

The NOHT-ÉSON partners recognize that equity, diversity, and inclusion (EDI) are important to help support the changing communities in Niagara. The NOHT-ÉSON partners have started their journey toward health equity, with internal and external strategies to strengthen knowledge of the region's diverse communities and their specific needs and of thoughtful and culturally sensitive best practices to support and partner with these distinct groups. Many organizations have engaged in diverse partnerships to support equity-deserving communities. The majority of NOHT-ÉSON partners have also provided extensive education and training opportunities to

expand their understanding of and support for the communities that they serve. Topics include:

+ 2SLGBTQ+ training
+ Ableism
+ Anti-racism, anti-discrimination, and anti-oppression
+ Bystander to allyship
+ Foundational knowledge in equity, diversity, and inclusion
+ Indigenous cultural safety Islamophobia
+ Mental health and well-being
+ Privilege
+ Pronoun workshops
+ Sexism
+ Systemic discrimination and inequality
+ Unconscious bias

The NOHT-ÉSON member consultations revealed a range of internal and external factors that impede equity work in Niagara. Many organizations discussed the complicated geography and demographics of Niagara as necessary to understanding the structural challenges and systemic barriers equity-deserving groups face when attempting to access care. The relatively lower diversity and older population of the region has resulted in slower EDI integration.

That said, all interview participants stressed the necessity of implementing this framework, especially as the region's demographics are rapidly changing.

Niagara encompasses diverse urban and rural settlements; consequently, transportation is one of the most important factors when discussing access to care. Lack of transportation options and insufficient public transit were cited by 35%[33] of organizations as impacting health equity.[34, 35] Other factors noted by organizations include:

+ Limited and unaffordable housing
+ Income disparities
+ Food insecurity
+ Poverty
+ Service provider distribution
+ Limited primary and specialist care providers
+ Limited Indigenous and cultural care providers
+ Unfamiliarity navigating the health care system
+ Stigma
+ Language barriers

While acknowledging the importance of the NOHT-ÉSON mandate to integrate Indigenous and Francophone communities, many members stressed that other equity-deserving and underserved groups must continue to be prioritized. The identified groups are:

+ Racialized persons (Black, Asian, Middle Eastern, and South Asian communities were explicitly mentioned)
+ 2SLGBTQ+ individuals
+ Women
+ Immigrants and newcomers
+ Migrant workers

Organizations interviewed stated that coordination and communication, information sharing, and best practices are required across the NOHT-ÉSON to address inequity. The consensus is that it is easy to identify gaps, particularly with service provision, but much harder to accordingly refer clients given limited knowledge of available services and resources. Improved communication within the NOHT-ÉSON and with external partners would better address gaps, strengthen service provision, and increase access to care. Part of communication across partnerships would include sharing information. Information that interview participants indicated they would like to share and access includes services provided, external resources, intake questionnaires, data collection practices, and self-assessment initiatives. Generally, NOHT-ÉSON members want to understand best practices for EDI implementation and improved health equity outcomes.

Organizational Pillars of Health Equity

To achieve health equity, organizations must identify existing barriers across all functions and processes. The consultation process identified priority areas across organizations that require self-assessment to strengthen EDI practices and improve health equity outcomes. This project focuses on these three organizational pillars, which guide the structure of both the Health Equity Report and Health Equity Assessment Tool as well as the Health Equity Assessment: Resources and Best Practices Guide.

+ 1.0 Leadership and Governance
+ 2.0 Organizational Values and Culture
+ 3.0 Programs and Service Delivery

To achieve health equity, organizations must identify existing barriers across all functions and processes.

1.0 Leadership and Governance

Leadership plays an important role in communicating the importance of health equity and in setting the direction and strategy for the organization to fully foster a diverse, inclusive, and equitable care environment. Diverse leadership is key to creating processes and policies that support the perceptions and experiences of diverse communities in governance, strategy, and organizational decision-making. Leadership diversity can improve health policy and decision-making, and a committed and strategic leadership is key to sustaining an effective health equity strategy that mitigates inequities and barriers, leading to improved patient care and health outcomes.

The Tool can also help organizations assess where they are at in terms of diverse representation and health equity knowledge capacity among leadership. NOHT-ÉSON representatives noted that there were some internal conversations and initiatives within their organizations to diversify boards and other leadership teams, but that there were often challenges with implementation, consistency, and recruitment. The process of changing organizational diversity to reflect the broader demographics of the region requires long-term planning, which the Tool will support by providing a method for benchmarking diversity and measuring progress year-over-year.

Goals:

+ Increase Indigenous and Francophone representation at the Board of Directors and Senior Leadership teams.
+ Work with Indigenous members, partners, and communities in a manner that honours and respects Indigenous voices.
+ Develop partnerships with other NOHT-ÉSON partners to ensure equity is an underlying goal of an integrated, high-performing health system.

2.0 Organizational Values and Culture

Equity, diversity, and inclusion can be embedded in organizational values and culture in health care organizations. According to Ontario Health (OH), "a high-quality health care system, grounded in an organizational culture focused on equity, inclusion, diversity, anti-racism, and Indigenous cultural safety, is fundamental to building and nurturing a healthy workplace within OH and contributing to better outcomes for patients and families within the broader health system."[36]

NOHT-ÉSON members expressed the need to streamline internal policies and processes. This includes human resources policies that would help diversify staff composition by attracting and retaining talent, formalize staff training and development initiatives, and create a process for identifying equity, diversity, and inclusion resources. More broadly, there is a need to strengthen organizational cultures that can better support diverse individuals across the region. Organizations recognized that changing internal culture could help eliminate barriers to access and contribute to a more effective and equitable health care landscape. This section of the Tool aims to provide the means for organizations to build an inclusive and diverse culture and work environment in order to support diverse staff and equip them to best serve their communities.

Goals:

+ Develop internal policies, systems, and processes that promote equity on an ongoing basis.
+ Continuously examine internal biases and actively take a stance against discrimination, racism, and oppression on any grounds within the organization.

3.0 Programs and Service Delivery

There are many considerations across an organization's programs and services that impact diverse clients' experiences and access to care. How programs and services are developed and delivered have a profound impact on access to appropriate care, especially for equity-deserving and underserved groups.

NOHT-ÉSON representatives expressed the need for improved communication and information sharing among member organizations and partners across Niagara. Members were concerned about being able to identify the needs of diverse clients in order to deliver improved and equitable services to underserved communities. They identified limited resources for the specific health care needs of certain populations, including Indigenous Peoples, Francophone communities, newcomers, racialized groups, persons with disabilities or mental health needs, aging populations, those unhoused or living in poverty, and 2SLGBTQ+ communities.

For some health care providers, it is simply an issue of lack of knowledge of how to best support the community; in other cases, there are few specialists or limited financial resources to serve all the needs of patients. Awareness of resource availability and current gaps would allow organizations to more accurately target programming. Other opportunities for service improvement include changes to preventative health programs and primary care initiatives; increasing non-emergent care; establishing more migrant workers', women's health, and mental health programming; and increasing services for youth and children. Organizations expressed that stronger internal and external partnerships and more community consultation would help empower groups. The Tool will support organizations in evaluating their health care service delivery, partnership and engagement, community consultation, and research processes.

Goals:

+ Uphold the policies and systems to establish programs and services that are equitable to stakeholder needs, specifically to the needs of Indigenous and Francophone communities.
+ Identify and revise organizational practices that undermine Indigenous health, and work to increase capacity to serve Indigenous clients.
+ Consistently collect socio-demographic and race-based data to better understand communities.

Data Collection

Related to each of these pillars, NOHT-ÉSON members also noted the need for a **data collection process**, with many organizations stating that they do not have a mechanism for collecting data and others highlighting an industry reluctance to collect data. Data limitations create organizational gaps that prevent improvement of organizational culture and human resources processes, service development, knowledge of equity-deserving communities, and understanding of how these groups want to access care. Organizations are interested in:

+ How to capture data
+ What kind of data to capture
+ Best practices for data collection
+ Integration of empathy and cultural sensitivity in data collection

Organizations noted that limited data and inconsistent demographic information prevent substantive EDI evaluation with respect to both internal processes and service provision. For example, organizations are interested in whether their services reach equity-deserving communities and if these are the best programming options to suit the needs of those groups. Organizations asked whether enhanced language services provided in English and French would meet the needs of all their clients, or if a multilingual focus was needed. Without data on client base, these questions remain unclear. Some respondents also noted that there is a gap in organizational knowledge regarding staff skills and competencies, which may limit service availability. For example, some organizations do not track staff language competencies and may not be able to provide service to certain linguistic communities or may refer those individuals to partner organizations. Better tracking of these skills and competencies can improve service availability and delivery.


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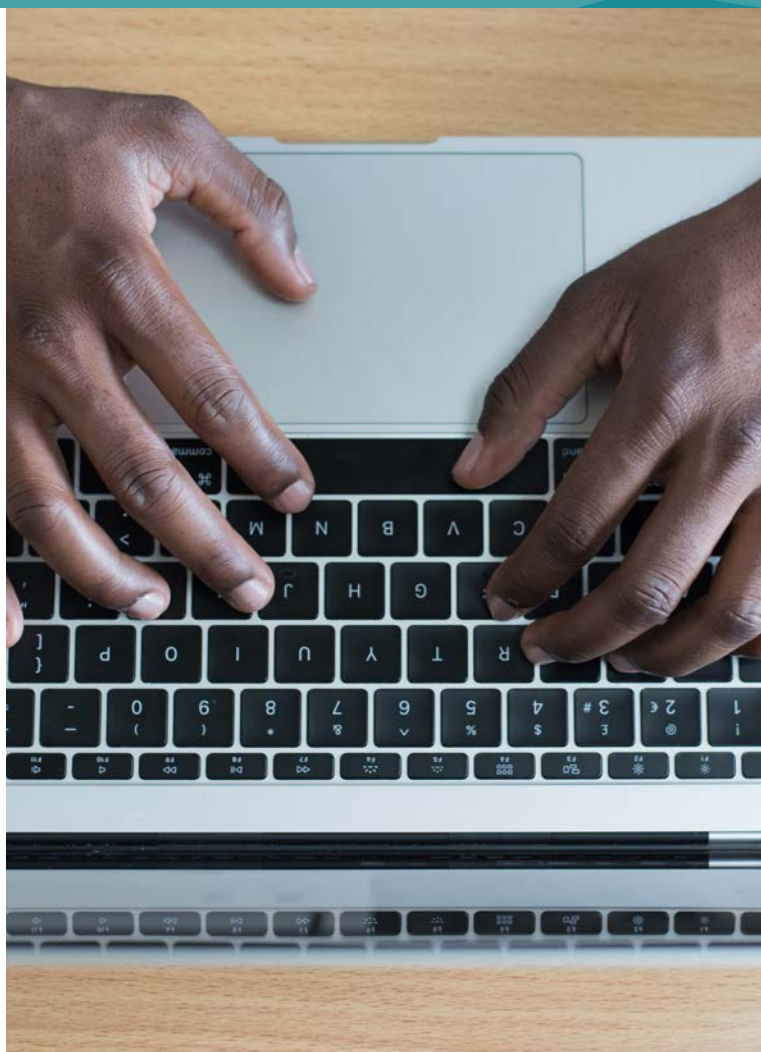
Health Equity Assessment Tool Summary

Development

The Health Equity Assessment Tool (“Tool”) was developed in 2022 by the Diversity Institute in collaboration with the Health Equity Working Group for the NOHT-ÉSON. The Tool is a guide for NOHT-ÉSON organizations to measure and self-monitor their progress toward the health equity goals year-over-year.



The Tool allows organizations to assess and gain a baseline understanding of where they currently stand in terms of their health equity policies and practices. The Health Equity Assessment: Resources and Best Practices Guide ("Guide") section of the Health Equity Toolkit ("Toolkit") is a companion to the Tool and should be valuable for all members, regardless of their various stages of progress and the different journeys members are undertaking. NOHT-ÉSON organizations have conceptualized the Tool in terms of a "living document." As such, the "levels" in the Tool recognize the dynamic nature of this work and that health equity work is ongoing; the Tool supports organizations to make constant and sustainable changes. The Tool should help NOHT-ÉSON members better communicate to avoid duplication of work, share accountability, and share resources. There are three main areas in which organizations expect the Report, Tool, and Guide to provide guidance:

+ Communication and information sharing across partners
+ Accountability and self-awareness
+ Provision of resources

Context

The Health Equity Assessment Tool is not an audit; rather it should be used to assess the current state of health equity practices within an organization and track growth internally. The Tool identifies gaps within an organization and can be used in combination with the Health Equity Report and Guide to address any gaps with curated best practices specific to each question. The Tool should be one part of a broader plan for achieving health equity. The Tool focuses on addressing gaps identified in organizational policies, strategies, and practices. Broader factors at the societal level will also need to be addressed through other mechanisms. Achieving health equity is a complex endeavour that requires ongoing conversation and active collaboration among NOHT-ÉSON organizations and with other organizations in the region.

Every NOTH-ÉSON organization is unique in how health equity is understood and defined and in their varying capacity and resources available to address health equity in the region. The goal of the Tool is to understand an organization's current state and track its journey toward the health equity goals. The Tool will provide organizations and the NOHT-ÉSON with benchmark data, valuable information about current gaps, and focus for next steps. The Tool can provide insight into the areas where organizations have opportunities to take action toward health equity. The results of the Tool can serve as a basis for conversations across member organizations to identify best practices to be leveraged across the network and be a starting point for conversations about next steps and long-term strategies.

Implementation Strategy and Tracking

The implementation of this Tool requires a collaborative effort across multiple teams and individuals within the organization, aligned with the organization's size and scope of services. Organizations should answer each item as honestly and accurately as possible. Implementation Leads should work with key individuals across their organization who can support an accurate assessment of each question. This includes input from staff in human resources, client-facing employees, and diverse staff members.

Implementation Leads may compile evidence from these key individuals where available. This evidence can then be brought forward to a committee (either specific to this purpose or leveraging an existing structure) to provide input on the level the organization is currently at. For example, where a question asks about strategic planning or policies, the Implementation Lead may obtain the most up-to-date documents and review them with their equity, diversity, and inclusion committee or identified implementation partner to determine what level the organization is currently at.

Ongoing Evaluation

This is not a one-time process. In order to ensure the data gathered from this Tool does not "sit on the shelf" and to move the organization forward, DI recommends coming back to the Tool twice each year, with one comprehensive review per year at the annual strategy review and a mid-year review on areas that are noted to be of most critical importance. This will be detailed during the Implementation Training.

Appendices

Appendix A: Definitions

2SLGBTQ+: An abbreviation for Two-Spirit, lesbian, gay, bisexual, transgender, queer, and other gender or sexually non-binary/diverse individuals.

50-30 Challenge: The 50 – 30 Challenge aims to promote voluntary action toward diversity on boards and/or in senior management. It invites organizations to participate and improve diversity and inclusion on their Boards of Directors and/or Senior Management teams. The 50 – 30 Challenge is motivated by two goals: 1) gender parity (50% women and/or non-binary individuals); and 2) significant representation (30%) of members from equity-deserving groups in Boards of Directors and/or Senior Management teams.

Accommodation: A change in the environment or in the way things are customarily done that enables an individual with a disability to have equal opportunity, access, and participation.

Ally: An individual who supports and advocates for equity-deserving groups from a position of relative privilege or power.

Allyship: An active and consistent process in which a person in a position of privilege and power seeks to act in solidarity with a marginalized group and practices unlearning and re-evaluating oppressive practices and thinking patterns.

Anti-oppressive framework/approach: An anti-oppressive framework is a process that helps organizations and individuals understand the barriers and discrimination faced by certain groups in society. It considers that factors such as colonialism, racism, sexism, homophobia, transphobia, classism, and ableism impact the ways that certain groups experience society. This framework aims to work against discrimination and lessen the impact of persistent inequality.

Bias: Prejudice in favour of or against one thing, person, or group compared with another, usually in an unfair or negative way.

Discrimination: Any form of unequal treatment of equity-deserving groups that results in disadvantage, whether imposing extra burdens or denying services.

Equity-deserving groups: Those that experience barriers to equal access, opportunities, and resources due to historic oppression and discrimination. The term is currently used by a number of public, private, and non-profit organizations and the federal government, and is used under the Publicly Available Specification of the 50 – 30 Challenge. These are groups covered under the Employment Equity Act, as well as 2SLGBTQ+ individuals. Equity-deserving groups include those identifying as:

+ Women
+ Racialized, Black, and/or people of colour ("visible minorities")
+ People with disabilities (including invisible and episodic disabilities)
+ 2SLGBTQ+ and/or gender and sexually diverse individuals
+ "Aboriginal" or Indigenous Peoples

Equity, diversity, and inclusion (EDI):

+ **Equity:** Fair treatment for all while striving to identify and eliminate inequities and barriers.
+ **Diversity:** Having differences among people with respect to their demographic characteristics or qualities, such as age, class, ethnicity, gender, health, physical and mental ability, race, sexual orientation, religion, physical size, education level, job and function, personality traits, language, and other differences.
+ **Inclusion:** Ensuring that people, regardless of their identity or backgrounds, are given opportunities to participate and feel that they belong.

Francophone: People who have a particular knowledge of French as an Official Language and use French at home, including people whose mother tongue may not be French or English.

Indigenous Peoples: The original peoples of North America and their descendants. "Indigenous Peoples" refers to individuals identifying as First Nations Peoples, Métis Nation, or Inuit. These are distinct Peoples with unique histories, languages, cultural practices, and spiritual beliefs.

Linguistic minority: Individuals whose maternal language is neither the majority language nor the official language minority in the province or territory.

Privilege: An unearned, sustained advantage that comes from race, gender, sexuality, ability, socioeconomic status, age, and other differences.

Racialized person: This refers to (but is not limited to) people who identify as Arab, Black, Chinese, Filipino, Japanese, Korean, Latin American, South Asian (e.g., East Indian, Pakistani, Sri Lankan), Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai), and West Asian (e.g., Iranian, Afghan). The term "racialized" is meant to reflect the socially constructed notion of race, while recognizing the systemic oppression and racism experienced by individuals and groups based on skin colour and appearance. The term is inclusive of bi-racial and mixed-race individuals.

Social determinants of health: The social and economic factors that influence an individual's health. These relate to an individual's place in society, such as income, education, or employment. If not considered within the context of a health care system, these factors can result in inequitable outcomes for certain populations.

Systemic discrimination: Organizational policies or structures that result in the unjust treatment of equity-deserving groups and that create or perpetuate disadvantage for these individuals. This can be caused by unintended and often unconscious consequences of a discriminatory system.

Unconscious bias: Unconscious biases are the mental shortcuts that individuals take when processing information. The potential downside is that these shortcuts can lead to prejudice or discrimination against certain groups of people if individuals act on or fail to question negative beliefs about these groups.

Underserved groups: The scope of this project encompasses other groups not covered under legislative definitions of "equity-deserving" or protected groups. These groups also face barriers to accessing health care services and inequitable health outcomes as a result of circumstances beyond their control. These groups include, but are not limited to: unhoused individuals; persons living in poverty; the aging population; youth; newcomers, refugees, and temporary foreign workers; and linguistic minorities.

Appendix B: Methodology

DI used three research methods to create a definition of health equity that is specific to the scope of the NOHT-ÉSON and to develop a Health Equity Assessment Tool ("Tool") for NOHT-ÉSON organizations to benchmark and track their progress in their journey toward a more inclusive health ecosystem within Niagara. The three research methodologies include:

1. **Thematic analysis of health equity definitions** to identify common language and themes observed in other health equity definitions across academic, government, and industry sources. The development of the NOHT-ÉSON's health equity definition was informed by the findings of the thematic analysis.

2. **Analysis of existing health equity tools** to map out the framework and dimensions of other health equity tools, as well as the measurement and key performance indicators that are currently used in the healthcare ecosystem. The NOHT-ÉSON Health Equity Assessment Tool was developed with the results of this analysis in consideration.

3. **Survey and consultation** to gather insights from NOHT-ÉSON liaisons on their population focus; highlight their current progress in the journey toward health equity; identify opportunities to further advance the health equity effort; and set expectations of the Health Equity Assessment Tool from the ground up.

Research and Development of the Health Equity Definition: Thematic Analysis

To develop a definition of health equity for the NOHT-ÉSON, a systematic review was first conducted to curate available definitions across the 47 NOHT-ÉSON partner organizations, as well as in other academic, industry, and government sources. A total of 65 definitions of health equity were collected in this process, including 4 definitions from NOHT-ÉSON member organizations, 11 from academic literature, 21 from government sources, and 29 from other organizations in the healthcare industry. Among the 65 health equity definitions collected, 34 were from Canadian sources, 13 from the United States, 2 from Australia, 3 from global-scale organizations, and 11 from academic sources.

Thematic analysis was then conducted on all the collected health equity definitions to systematically identify, organize, develop, and summarize the themes and patterns that emerged from these definitions. The DI research team followed the thematic analysis process of Braun and Clarke,[37] which included six interconnected phases:

1. **Familiarization with the definitions. The DI research team first read through every collected health equity definition and noted any commonly used languages that emerged during the first read-through process.**
2. **Generating initial codes. After the familiarization phase, the research team then generated a coding key based on common phrases observed during the familiarization phase.**
3. **Searching for and generating themes. The coding key was used to code every definition collected during the review process. The coding key was also organized to generate themes found in each health equity definition.**
4. **Reviewing themes to establish validity and reliability. The coding results for each of the health equity definitions were reviewed carefully to make sure that each coding was done correctly. If there was any disagreement within the research team on the coding for a specific definition, the coding was accordingly replaced by a consolidated code.**
5. **Defining the themes and coding key. The definition of each theme and coding key was developed by the research team.**
6. **Producing interpretation. The last phase of the thematic analysis involved the overall interpretation of findings. The interpretation was then used to inform the development of the health equity definition for the NOHT-ÉSON.**

An NOHT-ÉSON health equity definition was developed based on the four themes and 10 sub-factors identified through thematic analysis. The four themes and 10 sub-factors of health equity definitions are: 1) anti-oppressive framework (including absence of systemic barriers, absence of health disparities, and absence of care disparities); 2) equitable access (including access to care and access to resources); 3) recognition of individual and social factors (including social determinants of health and individualized care practice); and 4) standard of healthy living (including full health potential, fair opportunity to healthy life, and standard high-quality care).

Health equity means that every individual has a fair and just opportunity to reach their best possible physical, mental, social, and spiritual well-being. To achieve health equity, we seek to create equal access to appropriate care and resources and eliminate existing health disparities and systemic barriers stemming from one's gender, race, ethnicity, Indigeneity, sexual orientation, religion, age, language, social class, socioeconomic status, and other social determinants of health.

"... every individual has a fair and just opportunity to reach their best possible…"

+ This statement captures the commonly identified theme on the standard of healthy living, including elements of *full health potential* and *fair opportunity to healthy life.*

"... physical, mental, social, and spiritual well-being."

+ This statement covers the type of care and services provided by NOHT-ÉSON organizations, as well as the focus on spiritual well-being of Indigenous communities.

"To achieve health equity, we seek to create equal access to appropriate care and resources…"

This statement indicates an action-oriented approach to health equity, specifically from the standpoint of creating equitable access.

"... and eliminate existing health disparities and systemic barriers…"

+ This statement provides another action-oriented approach, specifically from an anti-oppressive framework and social justice approach.

"... stemming from one's gender, race, ethnicity, Indigeneity, sexual orientation, religion, age, language, social class, socioeconomic status, and other social determinants of health."

+ This statement captures the *equity* part of the definition, in that the definition acknowledges the differences in health care access and outcomes based on various factors pulled from the social determinants of health.

HEALTH EQUITY THEMES AND FACTORS IN THE 65 DEFINITIONS

Theme	Factors	# of Definitions (out of 65)	%
Anti-oppressive framework	Absence of systemic barriers	33	52%
	Absence of health disparities	23	36%
	Absence of care disparities	5	8%
Equitable access	Access to care	12	19%
	Access to resources	12	19%
Recognition of individual and social factors	Social determinants of health	35	55%
	Individualized care practice	9	14%
Standard of healthy living	Full health potential	32	50%
	Fair opportunity to healthy life	30	47%
	Standard high-quality care	8	13%

Among the 65 definitions, DI identified three health equity definitions that are commonly adopted or cited across government agencies and health care organizations. In Canada, many Canadian government agencies and organizations cite the health equity definition developed by the National Collaborating Centre for Determinants of Health:

> **"Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance... While striving to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among socially and economically disadvantaged populations."**
>
> - **National Collaborating Centre for Determinants of Health**[38]

Many organizations also use the health equity definition developed by Braveman and colleagues, as well as the definition developed by the World Health Organization:

> **"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."**
>
> - **Braveman and colleagues**[39]

> **"Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."**
>
> **- World Health Organization**[40]

In addition to the three definitions above, the NOHT-ÉSON Health Equity definition was also influenced by the definitions put forth by the Niagara Region, Public Health Ontario, and the Alliance for Healthier Communities' Health Equity Charter:

> **"Health equity means that individuals have a fair opportunity to be as healthy as possible and receive high quality care that is appropriate to them and their needs no matter where they live, what they have or who they are."**
>
> **- The Niagara Region**[41]
>
> **"Health equity is created when individuals have the fair opportunity to reach their fullest health potential. Achieving health equity requires reducing unnecessary and avoidable differences that are unfair and unjust. Many causes of health inequities relate to social and environmental factors including: income, social status, race, gender, education and physical environment."**
>
> **- Public Health Ontario**[42]
>
> **"The goal of a health equity approach is to dismantle barriers, eliminate health inequities and improve access to health care, especially for those who have historically faced and continue to face discrimination and disadvantage."**
>
> **- Alliance for Healthier Communities**[43]

Health Equity Assessment Tool Research and Development

To develop a health equity tool, the research team first collected a number of existing health equity tools and key performance indicators that were publicly available in Canada. A total of 10 health equity tools and health equity performance indicators were collected. An in-depth review of each of the health equity tools and performance indicators were conducted to identify the population focus, structures, and organizational dimensions that are relevant in the health care sector.

Survey and Consultation with NOHT-ÉSON Liaisons

A short survey was developed and sent to the 47 NOHT-ÉSON organizational representatives to gather insights on the progress of their organizations' health equity journeys, as well as to collect tools and resources that are used by NOHT-ÉSON organizations to advance health equity. In addition to the short survey, the Diversity Institute research team also developed and conducted semi-structured interviews with the NOHT-ÉSON liaisons. In total, DI collected survey data from 18 NOHT-ÉSON partner organizations and conducted 18 deep dive interviews with 17 distinct members. The conversations were guided by five questions:

1. Can you tell me about your role at [organization] and how and why you became involved with the Health Equity work with the Niagara Ontario Health Team?

2. Has equity work been started at your organization? What is the focus? What is the goal of these initiatives, and who in the organization led the push to start them?

3. What tools or resources have been used and would you recommend?

4. Where are there gaps in support for equity-deserving populations in the region? Based on your work with partners or clients, what are the biggest needs for these groups in terms of health and health care access?

5. Who are other important stakeholders in the region, particularly those that have done work connected to the health-related needs of Indigenous Peoples and Francophone people in the community?

The NOHT-ÉSON Health Equity Assessment Tool

Findings from the review of existing health equity tools and the survey and consultation with NOHT-ÉSON liaisons were used to inform the development of the NOHT-ÉSON Tool. The Tool was developed as a diagnostic tool that assesses organizational practices, processes, policies, and programs from a gender equity and diversity perspective, with focus on the inclusion of Indigenous and Francophone communities. The Tool also incorporates key performance indicators, so that organizations are able to generate benchmark data and track progress throughout their journey toward health equity. Three pillars of organizational processes were developed as part of the Tool: 1) Leadership and Governance; 2) Organizational Values and Culture; and 3) Programs and Service Delivery.

Appendix C: Barriers for Equity-Deserving Groups

1.0 Leadership and Governance

Despite the changing population and communities that are being served, there remains a lack of diversity in leadership across sectors in Canada, including health care. While Canadian hospital and health ministries have met gender parity, in that women represent about 50% of executive-level leadership in hospitals and health ministries, racialized communities remain significantly under-represented. In Ontario, there is a representation gap of 20.7% between racialized leaders in the health care sector and the overall racialized population in the province.[44] Across governing bodies, such as the Canadian Medical Association, gender inequity persists, as only 8 of the past 152 presidents have been women. There is also a vast under-representation of women leaders in medical schools, with the first woman becoming a dean only in 1999.[45] That is 170 years after the first medical school was established, and only eight deans have been women since.

The lack of representation stems from inequities due to societal barriers, such as lack of access for certain groups to the education and resources needed to succeed in the labour market, and organizational barriers, such as individual and process biases and lack of equitable recruitment and hiring policies.[46] Other barriers include lack of role models, mentorship opportunities, or career opportunities; discriminatory working environments; and harassment, biases, and stereotypes within health care organizations.[47]

Leadership teams and governing bodies need to first demonstrate buy-in and commitment in order to drive effective change and to strive for health equity. It is important to have diversity at the top to represent the community that is being served.

2.0 Organizational Values and Culture

Organizational values and culture within health care organizations have a significant impact on how patients experience care. Limited research on certain populations can lead to misdiagnosis, inadequate care, and unconscious bias among practitioners.[48] For example, women are under-represented as both researchers and research subjects in clinical research on cardiac health, mental health, access to care, hereditary cancers, addictions and substance abuse, sexual assault, and domestic violence.[49, 50] Women are often overlooked and underserved because health care has not traditionally considered the impact of sex- and gender-related differences.

The limited scope of cultural competency training for health care professionals is also a key concern. When health care professionals do not consider their own biases and limitations while serving patients, they may fail to meet the needs of a diverse population and potentially lead patients from equity-deserving groups to mistrust the health care system, effectively

barring them from accessing appropriate care. Many health care professionals do not receive training on cross-cultural perspectives, and many view diversity training as a quick fix to cross-cultural issues. A broader, intersectional understanding of culture, including the recognition of discrimination, power imbalances, cultural biases, and self-reflection of unconscious biases and prejudices,[51] as well as the importance of the inclusive language used in clinical practice[52] is not yet communicated to the medical community on a systematic level.

For Indigenous populations in particular, there are gaps in organizations' efforts to engage in consultation with Indigenous communities to build relationships of cultural understanding and trust between health care providers and Indigenous peoples. Without this, care providers cannot effectively address the significant health disparities for Indigenous communities and support healing and reconciliation.[53]

These health equity outcomes for patients are tied to internal organizational functions, including equitable hiring policies and organizational norms that impact the employee experience. Unfortunately, gender and racial disparities in the health care industry are still widely apparent. This impacts the industry's reputation and demonstrates ongoing barriers for under-represented populations.[54] Reliance on informal recruiting and hiring processes, such as employee referrals, can also limit diversity in hiring. Yet they remain the primary form of recruitment for Canadian organizations.[55]

Less than half of Canadian hospitals have a documented plan to recruit and retain a workforce that reflects the diversity of their patient population. Only 42% have a program in place to identify diverse employees in the company for promotion. Just 18% have tied performance expectations for hiring managers to diversity goals.[56] A lack of institutional support and recognition, alonside degrading comments from patients and colleagues, can make women and diverse health care workers feel devalued, less competent, and powerless.[57, 58, 59, 60] Many hospitals also demonstrate a lack of effort to tackle the pattern of covert racism encountered by newcomer and foreign nurses and doctors. Incidents of "everyday" discrimination in the workplace add to the sense of divisiveness, which persists through apathy from management and Canadian-born workers. Foreign care workers also rely on employment opportunities to secure residence in Canada, which creates a willingness to avoid conflict and confrontation with employers when facing discrimination, further exacerbating their experiences.[61]

3.0 Programs and Services

There are many considerations across an organization's programs and services that impact diverse clients' experiences and access to care. How programs and services are developed and delivered has a profound impact on access to appropriate care, especially for under-represented groups. This section provides an overview of barriers and specific challenges in health care access at the provincial and federal levels for the Francophone population, Indigenous Peoples, 2SLGBTQ+ groups, racialized people, newcomers and refugees, women, low-income and unhoused individuals, aging populations, and people living with disabilities.

Francophone Groups

Francophone communities situated in predominantly Anglophone regions experience many challenges in accessing timely and quality health care. The Société Santé en français explains that care may be "inaccessible, inequitable, and often non-existent in most provinces and territories of Canada."[62] Language and culture are essential determinants of health for the Francophone population; yet, despite a considerable effort to bridge the language gap, challenges persist.[63]

Specific barriers to accessing health care for the Francophone population include[64, 65]:

+ Lack of French speaking health care professionals
+ Limited French language services, especially specialist programs
+ Accessibility of information and resources
+ Delays in diagnosis and treatment

Indigenous Peoples

Indigenous perspectives on health differ from the Eurocentric model that is currently basis of the care system in Canada. Indigenous groups approach health through a balanced and holistic model that considers connections between spiritual, emotional, mental, and physical dimensions.[66] The forced assimilation of Indigenous Peoples through colonization disrupted important cultural processes including traditional approaches to health care.

The inequities experienced by Indigenous Peoples, including illnesses and other poor health outcomes, are attributed to the lasting effects of colonization. With respect to health care, colonization severed Indigenous Peoples' connection to the land and traditional healing systems, removed access to comprehensive social structures and cultural systems, and displaced traditional foods and foodways.[67] These historic and ongoing injustices continue to represent barriers to care for Indigenous communities.

Specific concerns for Indigenous Peoples accessing health care services are divided into five categories: spiritual, physical, mental health, emotional, and environmental issues.[68] Spiritual concerns speak to the lack of cultural knowledge by health care organizations, loss of culture and disconnect from identity, as well as a general lack of inclusion. Physical issues include limited wellness services, lack of medical centres, and limited sexual health education that also focuses on consent. Mental health issues include systemic and intergenerational trauma, lack of acceptance of culture, and illnesses such as alcoholism, drug addiction, or depression. Emotional issues connect to the feeling of being unsafe and unsupported. Finally, environmental issues encompass the displacement of traditional foodways and access to healthy foods, land, and water.

2SLGBTQ+

In Canada, the 2SLGBTQ+ community has faced many forms of systemic, institutional, legal, and health discrimination and oppression. Although advocacy has contributed to significant systemic and cultural changes, many issues persist and continue to impact access to care for this community.

Risk factors for poor health outcomes in the 2SLGBTQ+ community stem from a lack of support, limited access to health services, and discrimination. Members of the 2SLGBTQ+ community experience higher rates of disability, violence, mental health concerns, and cancer. Within the existing health care system, physicians, nurses, and allied health care professionals are poorly trained and ill-equipped to support the needs of the 2SLGBTQ+ community; this also includes the significant gap in knowledge and understanding of sexual and identity health. As a result, individuals from the 2SLGBTQ+ community continue to face health disparities compared to cisgender and heterosexual individuals due to transphobia, homophobia, and heterosexism.[69] A McMaster University study on the experience of the 2SLGBTQ+ community outlines the following barriers to health equity[70]:

+ Lack of 2SLGBTQ+ specific and competent health services, including sexual health
+ Limited health care professionals who are knowledgeable about 2SLGBTQ+ concerns
+ Discrimination when accessing health care services
+ Discomfort in dealing with individual health care practitioners

Racialized People

Racial equity is the systemic fair treatment of all people, regardless of racial backgrounds, in equitable opportunities and outcomes. In Canada, racial and health equity are intersectional categories of concern for racialized people. Despite a national focus on anti-racism, systemic racism—and particularly systemic anti-Black racism—continues to exist in the health care system.[71, 72]

Since 2005, race and racism have been recognized as social determinants of health. While illness is not inherent to racial differences, it does disproportionately affect racialized people.[73] For example, Black populations rank second, behind Indigenous Peoples, with respect to poor health outcomes in Ontario.[74] Barriers to health care for racialized communities include[75]:

+ Stereotyping and discrimination
+ Lack of trust stemming from historic and generational experience/trauma
+ Lack of representation, especially in leadership positions

+ Limited mental health services that are culturally and linguistically appropriate
+ Limited long-term and home care options that are culturally and linguistically appropriate
+ Limited knowledge of primary care workers on race-specific health issues

Newcomers and Refugees

Canada has one of the largest newcomer populations in the world. Newcomers face similar barriers as racialized communities when attempting to access care. Among these, systemic racism and discrimination are major contributors to poor health outcomes for these groups.

Newcomers are generally healthier than their Canadian-born counterparts—known as the "healthy immigrant effect."[76] This is also applicable to refugees, as they have lower mortality rates than Canadian citizens.[77] Despite this, health outcomes for newcomers often decline upon arrival in Canada. Those living in Canada for 10 years or less have fewer chronic illnesses and less chance of disability than those living in Canada longer or Canadian-born citizens.[78] Specific barriers to equitable health outcomes for newcomer populations include[79]:

+ Lack of access to primary care
+ Language barriers
+ Lack of coordination and information
+ Inadequate or lack of culturally-competent services
+ Lack of diversity in leadership

Women

Women's health is a priority in the Canadian care system. However, gender-based disparities in health outcomes continues to persist and impact women's well-being. A report by ECHO Ontario identifies the key priority areas for women's health as mental health and addictions; sexual and reproductive health; chronic disease; and intersecting women's health issues.[80] A national social justice and women's health study found that access to care was impacted by[81]:

+ Defunding and/or underfunding of women's health facilities
+ Unequal access to basic reproductive health services
+ Difficulty in accessing health care services in remote and rural communities
+ Health care costs beyond publicly funded coverage

+ Discrimination and lack of culturally sensitive options for racialized and/or low-income individuals

Low-Income and Unhoused People

Low-income and unhoused people are more likely to experience negative health outcomes. In fact, low-income individuals are less healthy and experience more symptoms of illness than higher income individuals.[82] Those who are unhoused also experience more diseases and have a higher level of mortality than the general population.[83] For these groups, barriers to care include[84]:

+ Limited financial resources
+ Lack of comprehensive health care benefits
+ Lack of affordable transportation
+ Lack of knowledge about available services and resources
+ Discrimination related to socioeconomic status and race
+ Negative prior experiences and distrust of the system
+ Language and cultural barriers

Unhoused individuals experience similar barriers to those in lower income brackets. They also face greater challenges in accessing government-funded programs, particularly as they may not have the required credentials (e.g., identification).[85] The greatest service challenge involves accessing primary and non-urgent care.[86] Other service needs include[87]:

+ Availability of essentials for living (including healthy food to improve nutrition)
+ Access to specialized services (including mental health and addictions counseling)

Aging Population

Generally, aging populations require increased care and service options. Despite the consensus among policymakers and health care practitioners, this group continues to experience barriers with respect to care.

Some of the specific health concerns for aging individuals are[88]:

+ Limited benefits coverage outside of publicly funded care
+ Inadequate long-term care facilities
+ Limited community care options

Other challenges for aging individuals include both mental and physical health services. For example, older individuals have greater difficulty finding primary care physicians and becoming rostered patients.[89] This population also receives inadequate attention with respect to mental health services and social well-being.[90]

People Living with Disabilities

People living with disabilities experience unique health challenges, as there are intersectional factors that impact barriers to health. The Canadian system prioritizes care for this population, but negative health outcomes persist. Those living with disabilities are four times more likely than the general population to experience an inability to access medical care.[91] Some of the dominant barriers to access for people living with disabilities include[92, 93]:

+ Inaccessible environments
+ Lack of transportation options and adaptive technologies
+ Limited insurance coverage outside publicly funded care
+ Limited knowledge of resources and services
+ Lack of specialized care options
+ Insensitivity of health care practitioners
+ Fear and distrust of the system

More broadly, social determinants of health for people living with disabilities in Canada include housing, education, employment, and social well-being.

Appendix D: Benchmarking and Tracking Guide

R **Readiness**	The organization is not yet aware of this item's application toward health equity, but is in a ready state to begin reviewing its importance throughout the organization.
F **Foundation**	The organization is at the starting point of the health equity journey, including fulfilling obligations in accordance with EDI regulations, and makes an effort to understand its role in responding to current issues affecting equity-deserving and underserved groups, as it relates to this item.
C **Champion**	The organization understands the importance and impact of health equity, and individuals have informally taken steps to support equity-deserving and underserved groups within their roles at the organization. These actions and initiatives are not yet formalized into organizational policies and processes.
I **Integrated**	The organization shows an advanced understanding and awareness of healthy equity, applying a health equity lens and taking an active stance in eliminating barriers for equity-deserving and underserved groups. The process is formalized in the form of policy, processes, or strategic planning.
T **Transformative**	The organization has met the requirements for "Integrated," has an added focus on tracking progress, and has an accountability measure in place. The organization ensures that effort toward health equity is sustained in the long term through continuous learning and improvement.
N/A Not Applicable	Acknowledging that the NOHT-ÉSON comprises organizations of different sizes, capacities, and scopes, N/A indicates that the item is not a valid goal for the particular organization. Organizations should include a rationale as to why items are not applicable and regularly reassess these items with changes in capacity and scope.

References

1 Niagara Health. (n.d.). *Niagara Ontario Health Team*. https://www.niagarahealth.on.ca/site/ontario-health-team

2 Ministry of Health. (n.d). *Ontario Health Team*. https://health.gov.on.ca/en/pro/programs/connectedcare/oht/

3 Elliott, C. (2019). *Bill 74, The People's Health Care Act, 2019*. https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-74

4 Elliott, C. (2019). *Bill 74, The People's Health Care Act, 2019.* https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-74

5 Elliott, C. (2019). *Bill 74, The People's Health Care Act, 2019*. https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-74

6 eQUITY Link. (n.d.). *The impact of language barriers on health systems*. https://equity-link.ca/equity-link/

7 Niagara Health. (n.d.). *Guiding principles*. https://www.niagarahealth.on.ca/site/guiding-principles

8 "Knowledge building" refers to training and workshops that organizations partake in, and "knowledge sharing" refers to training and workshops that organizations deliver to partners or external audiences.

9 Government of Canada. (2021). *2021/2022 Deputy Minister commitments on diversity and inclusion.* https://www.canada.ca/en/privy-council/programs/appointments/governor-council-appointments/performance-management/dm-commitments.html

10 DI Consulting. (2021). *50-30 Challenge*. https://diconsulting.ca/

11 University of Calgary. (n.d.). *Office of Equity, Diversity and Inclusion.* https://www.ucalgary.ca/equity-diversity-inclusion/equity-survey-faq

12 Smith, T. (2020). Shifting from equity-seeking to equity-deserving. *Anti-Racism: A cross-institutional initiative at Kwantlen Polytechnic University*. Kwantlen Polytechnic University. https://wordpress.kpu.ca/antiracism/2020/11/20/shifting-from-equity-seeking-to-equity-deserving/

13 Ontario Newsroom. (2021, December 9). *Modernized French Language Services Act receives Royal Assent* [news release]. https://news.ontario.ca/en/release/1001316/modernized-french-language-services-act-receives-royal-assent

14 Le Réseau du Mieux-Être Francophone du Nord de L'Ontario. (2020). *Overview of the training: The active offer of French language health services: why it matters and how to put it into practice*. http://www.entitesante2.ca/fls-cop/wp-content/uploads/2020/07/Active-Offer-of-FLS-HNHB-Community-of-Practice-March-2020-002.pdf

15 Wellesley Institute. (2017, June 21). *The right to language accessibility in Ontario's health care system*. https://www.wellesleyinstitute.com/health/the-right-to-language-accessibility-in-ontarios-health-care-system/

16 Morency, J. D., Malenfant, E., & MacIsaac, S. (2017). *Immigration and diversity: Population projections for Canada and its Regions, 2011 to 2036*. Statistics Canada. https://www150.statcan.gc.ca/n1/pub/91-551-x/91-551-x2017001-eng.htm

17 Statistics Canada. (2018). *First Nations People, Métis and Inuit in Canada: Diverse and growing populations*. https://www150.statcan.gc.ca/n1/pub/89-659-x/89-659-x2018001-eng.htm

18 Statistics Canada. (2021). *A statistical portrait of Canada's diverse LGBTQ2+ communities*. https://www150.statcan.gc.ca/n1/daily-quotidien/210615/dq210615a-eng.htm

19 Futrell, G. D., & Clemons, T. N. (2017). Top ranked hospitals: Does diversity inclusion matter? *International Journal of Pharmaceutical and Healthcare Marketing, 11*(1), 49-59. https://doi.org/10.1108/IJPHM-12-2015-0060

20 Gomez, L E., & Bernet, P. (2019). Diversity improves performance and outcomes. *Journal of the National Medical Association, 111*(4), 383-392. https://doi.org/10.1016/j.jnma.2019.01.006

21 Niagara Region. (n.d.). *Social determinants of health.* https://www.niagararegion.ca/health/equity/social-determinants.aspx

22 World Health Organization. (n.d.). *Social determinants of health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

23 World Health Organization. (n.d.). *Social determinants of health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

24 Niagara Region. (n.d.). *Social determinants of health.* https://www.niagararegion.ca/health/equity/social-determinants.aspx

25 Ministry of Health and Long-Term Care. (2018). *Health equity guideline.* https://health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Health_Equity_Guideline_2018_en.pdf

26 Statistics Canada. (2022). *2021 Census of Population*. https://www12statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page cfm?Lang=E&SearchText=Niagara&DGUIDlist=2021A00033526&GENDERlist=1,2,3&STATISTIClist=1&HEADERlist=0

27 Geographic Distribution. (n.d.). *Francophone population in the Niagara Region*. http://www.bonjourniagara.com/vivre/en/who-we-are/geographic-distribution/

28 Niagara Priority Profiles. (2021). *Indigenous*. Niagara Region. https://www.niagararegion.ca/health/equity/pdf/priority-profile-indigenous.pdf.

29 Niagara Chapter - Native Women Inc. (2021). *Indigenous engagements report off-reserve Niagara Region, Canada 2021.* Niagara Region. https://www.niagararegion.ca/projects/community-safety-well-being/pdf/mno-bmaadziwin.pdf.

30 Niagara Chapter - Native Women Inc. (2021). *Indigenous engagements report off-reserve Niagara Region, Canada 2021.* Niagara Region. https://www.niagararegion.ca/projects/community-safety-well-being/pdf/mno-bmaadziwin.pdf

31 Note: Low-income group is defined by having an after-tax income of less than half of the median after-tax income of all households in Canada.

32 Statistics Canada. (2021). *A statistical portrait of Canada's diverse LGBTQ2+ communities.* https://www150.statcan.gc.ca/n1/daily-quotidien/210615/dq210615a-eng.htm

33 6 out of 17 interview participants.

34 The Niagara Region and several municipalities are developing a transportation plan to address this, but it currently remains an issue.

35 Niagara Region. (2020). *How we go - Transportation master plan.* https://www.niagararegion.ca/2041/transportation-master-plan/default.aspx

36 Ontario Health. (2020). *Building a framework and plan to address equity, inclusion, diversity and anti-racism in Ontario*. https://www.ontariohealth.ca/sites/ontariohealth/files/2021-01/CorpusSanchezInternationalReport.pdf

37 Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

38 National Collaborating Centre for Determinants of Health. (2013). *Let's talk: Health equity.* https://nccdh.ca/images/uploads/Lets_Talk_Health_Equity_English.pdf

39 Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). *What is health equity?* Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

40 World Health Organization. (n.d.). *Social determinants of health: Health equity.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3

41 The Niagara Region. (n.d.). *Understanding health equity.* https://www.niagararegion.ca/health/equity/understanding.aspx

42 Public Health Ontario. (n.d.). *Health equity.* https://www.publichealthontario.ca/en/health-topics/health-equity#:~:text=Health%20equity%20is%20created%20when,that%20are%20unfair%20and%20unjust

43 Alliance for Healthier Communities. (n.d.). *Health equity charter.* https://www.allianceon.org/sites/default/files/documents/Alliance%20Charter%202021-Full-English-Revised.pdf

44 Sergeant, A., Saha, S., Lalwani, A., Sergeant, A., McNair, A., Larrazabal, E., Yang, K, Bogler, O., Dhot, A., Werb, D., Maghsoudi, N., Richardson, L., Hawker, G., Siddiqui, A., Verma, A., & Razak, F. (2022). Diversity among health care leaders in Canada: A cross-sectional study of perceived gender and race. *Canadian Medical Association Journal, 194*(10), E371-E377. https://doi.org/10.1503/cmaj.211340

45 Tricco, A. C., Bourgeault, I., Moore, A., Grunfeld, E., Peer, N., & Straus, S. E. (2021). Advancing gender equity in medicine. *Canadian Medical Association Journal, 193*(7), E244–E250. https://doi.org/10.1503/cmaj.200951

46 Fontenot, T. (2012). Leading Ladies: Women in Healthcare Leadership. *Frontiers of Health Services Management, 28*(4), 11–21. https://doi.org/10.1097/01974520-201204000-00003

47 Kalaitzi, S., Czabanowska, K., Fowler-Davis, S., & Brand, H. (2017). Women leadership barriers in healthcare, academia and business. *Equality, Diversity and Inclusion: An International Journal, 36*(5), 457–474. https://doi.org/10.1108/EDI-03-2017-0058

48 FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review.

BMC Medical Ethics, 18(1), 19. https://doi.org/10.1186/s12910-017-0179-8

49 Sebo, P., de Lucia, S., & Vernaz, N. (2021). Gender gap in medical research: A bibliometric study in Swiss university hospitals. *Scientometrics, 126*(1), 741–755. https://doi.org/10.1007/s11192-020-03741-w

50 Stratton, S. (2001). *What is the health gap? The health gap in healthcare research*. https://www.womenscollegehospital.ca/assets/media-kit/Health-Gap-Backgrounder-19Apr2016.pdf

51 Shepherd, S. M., Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y. (2019). The challenge of cultural competence in the workplace: Perspectives of healthcare providers. *BMC Health Services Research, 19*(135). https://doi.org/10.1186/s12913-019-3959-7

52 Raney, J., Pal, R., Lee, T., Saenz, S. R., Bhushan, D., Leahy, P., Johnson, C., Kapphahn, C., Gisondi, M. A., & Hoang, K. (2021). Words matter: An antibias workshop for health care professionals to reduce stigmatizing language. *MedEdPORTAL: The Journal of Teaching and Learning Resources, 17*(11115). https://doi.org/10.15766/mep_2374-8265.11115

53 Guerra, O., & Kurtz, D. (2017). Building collaboration: A scoping review of cultural competency and safety education and training for healthcare students and professionals in Canada. *Teaching and Learning in Medicine, 29*(2), 129–142. https://doi.org/10.1080/10401334.2016.1234960

54 London, J., Peterson, D., Dahms, K., Richards, S., Frankel, B., Ortega, M., Bodgas, M., Reynoso, C., Goodson-Kingo, A., Santos, M., & Barberio, J. (2018). *The state of diversity & inclusion in the healthcare industry.* https://www.diversitybestpractices.com/sites/diversitybestpractices.com/files/attachments/2018/01/healthcare_part_2_workforceworkplace.pdf

55 Garr, S. S., Shellenback, K., & Scales, J. (2014). *Diversity and inclusion in Canada: The current state.* Deloitte. https://www2.deloitte.com/ca/en/pages/human-capital/articles/the-current-state-of-diversity-and-inclusion.html

56 London, J., Peterson, D., Dahms, K., Richards, S., Frankel, B., Ortega, M., Bodgas, M., Reynoso, C., Goodson-Kingo, A., Santos, M., & Barberio, J. (2018). *The state of diversity & inclusion in the healthcare industry.* https://www.diversitybestpractices.com/sites/diversitybestpractices.com/files/attachments/2018/01/healthcare_part_2_workforceworkplace.pdf

57 Nunez-Smith, M., Curry, L. A., Bigby, J., Berg, D., Krumholz, H. M., & Bradley, E. H. (2007). Impact of race on the professional lives of physicians of African descent. *Annals of Internal Medicine*, *146*(1), 45-51. https://doi.org/10.7326/0003-4819-146-1-200701020-0008

58 Moceri, J. T. (2014). Hispanic nurses' experiences of bias in the workplace. *Journal of Transcultural Nursing*, *25*(1), 15-22. https://doi.org/10.1177/1043659613504109

59 Snyder, C. R., & Schwartz, M. R. (2019). Experiences of workplace racial discrimination among people of color in healthcare professions. *Journal of Cultural Diversity*, *26*(3), 96-107.

60 Wheeler, M., de Bourmont, S., Paul-Emile, K., Pfeffinger, A., McMullen, A., Critchfield, J. M., & Fernandez, A. (2019). Physician and trainee experiences with patient bias. *JAMA Internal Medicine*, *179*(12), 1678. https://doi.org/10.1001/jamainternmed.2019.4122

61 Nourpanah, S. (2019). "Maybe we shouldn't laugh so loud": The hostility and welcome experienced by foreign nurses on temporary work permits in Nova Scotia, Canada. *Labour: Journal of Canadian Labour Studies/Le Travail : Revue d'Études Ouvrières Canadiennes, 83*, 105–120. https://doi.org/10.1353/llt.2019.0004

62 Société Santé en Français. (2021). *Opinion letter: Francophone and Acadian communities demand better access to health care in French.* https://www.santefrancais.ca/en/2021/09/15/opinion-letter-francophone-and-acadian-communities-demand-better-access-to-health-care-in-french/

63 Immigration, Refugees and Citizenship Canada. (2019, March 18). *Meeting our objectives: Francophone Immigration Strategy 2018-2023*. Government of Canada. https://www.canada.ca/content/dam/ircc/documents/pdf/english/corporate/publications-manuals/francophone-immigration-strategy/franco-immigr-strateg-eng.pdf

64 Société Santé en Français. (2021). *Opinion letter: Francophone and Acadian communities demand better access to health care in French.* https://www.santefrancais.ca/en/2021/09/15/opinion-letter-francophone-and-acadian-communities-demand-better-access-to-health-care-in-french/

65 Research in Focus on Research. (n.d.). *Barriers and strategies to offering health services to French-speaking patients: Perspectives from family physicians in Northeastern Ontario.* http://documents.cranhr.ca/pdf/focus/FOCUS15-A1e.pdf

66 Public Health Agency of Canada. (2018). *Key health inequities in Canada: A national portrait-executive summary.* https://www.canada.ca/en/public-health/services/publications/science-research-data/key-health-inequalities-canada-national-portrait-executive-summary.html.

67 Niagara Region Public Health. (2021). *Niagara priority profiles.* https://www.niagararegion.ca/health/equity/pdf/niagara-priority-profiles.pdf

68 Niagara Region Public Health. (2021). *Niagara priority profiles.* https://www.niagararegion.ca/health/equity/pdf/niagara-priority-profiles.pdf

69 McMaster University. (2019). *Mapping the void.* https://labourstudies.mcmaster.ca/documents/mappingthevoid.pdf

70 McMaster University. (2019). *Mapping the void.* https://labourstudies.mcmaster.ca/documents/mappingthevoid.pdf

71 Dryden, O., & Nnorom, O. (2021). Time to dismantle systemic anti-Black racism in medicine in Canada. *Canadian Medical Association Journal, 193*(2), E55-E57. https://doi.org/10.1503/cmaj.201579

72 Dryden, O., & Nnorom, O. (2021). Time to dismantle systemic anti-Black racism in medicine in Canada. *Canadian Medical Association Journal, 193*(2), E55-E57. https://doi.org/10.1503/cmaj.201579

73 Greater Hamilton Health Network. (2021). *Greater Hamilton Health Network's health equity framework: An anti-oppression, anti-racism, sex/gender based, intersectional approach.* https://ihpme.utoronto.ca/wp-content/uploads/2021/12/GHHN-Health-Equity-Framework.pdf

74 Greater Hamilton Health Network. (2021). *Greater Hamilton Health Network's health equity framework: An anti-oppression, anti-racism, sex/gender based, intersectional approach.* https://ihpme.utoronto.ca/wp-content/uploads/2021/12/GHHN-Health-Equity-Framework.pdf

75 Greater Hamilton Health Network. (2021). *Greater Hamilton Health Network's health equity framework: An anti-oppression, anti-racism, sex/gender based, intersectional approach.* https://ihpme.utoronto.ca/wp-content/uploads/2021/12/GHHN-Health-Equity-Framework.pdf

76 Greater Hamilton Health Network. (2021). *Greater Hamilton Health Network's health equity framework: An anti-oppression, anti-racism, sex/gender based, intersectional approach.* https://ihpme.utoronto.ca/wp-content/uploads/2021/12/GHHN-Health-Equity-Framework.pdf

77 Beiser, M. (2005). The health of immigrants and refugees in Canada. *Canadian Journal of Public Health, 96*(2), S30-S44. https://doi.org/10.1007/BF03403701

78 Newbold, K. B., & Danforth, J. (2003). Health status and Canada's immigrant populations. *Social Science & Medicine, 57*(10), 1981-1995. https://doi.org/10.1016/s0277-9536(03)00064-9

79 Greater Hamilton Health Network. (2021). *Greater Hamilton Health Network's health equity framework: An anti-oppression, anti-racism, sex/gender based, intersectional approach.* https://ihpme.utoronto.ca/wp-content/uploads/2021/12/GHHN-Health-Equity-Framework.pdf

80 Echo-Ontario. (2012). *Echo: Improving women's health in Ontario: Sharing the legacy–Supporting future action.* Women's College Hospital. https://www.womenscollegehospital.ca/assets/pdf/echo_improving_womens_health_in_ontario.pdf

81 Maritime Center of Excellence for Women's Health. (1999). *Social justice and women's health: A Canadian perspective.* https://cdn.dal.ca/content/dam/dalhousie/pdf/diff/ace-women-health/ACEWH_social_justice_womens_health_canada.pdf

82 Williamson, D. L., Stewart, M. J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I., & Wilson, D. (2006). Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy 76*(1), 106-121. https://doi.org/10.1016/j.healthpool.2005.05.005

83 Hwang, S. W. (2001). Homelessness and health. Canadian *Medical Association Journal, 164*(2), 229-233. https://www.cmaj.ca/content/164/2/229

84 Williamson, D. L., Stewart, M. J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I., & Wilson, D. (2006). Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy 76*(1), 106-121. https://doi.org/10.1016/j.healthpool.2005.05.005

85 Homeless Hub. (2014). *How can we improve healthcare access for the homeless?* https://www.homelesshub.ca/resource/how-can-we-improve-healthcare-access-homeless

86 Homeless Hub. (2014). *How can we improve healthcare access for the homeless?* https://www.homelesshub.ca/resource/how-can-we-improve-healthcare-access-homeless

87 Homeless Hub. (n.d.). *Public health care & service delivery.* https://www.homelesshub.ca/about-homelessness/service-provision/public-health-care-service-delivery

88 Ontario Human Rights Commission. (n.d.). *Specific issues facing older persons.* https://www.ohrc.on.ca/en/discussion-paper-discrimination-and-age-human-rights-issues-facing-older-persons-ontario/specific-issues-facing-older-persons

89 Angus Reid Institute. (2019). *Access to health care a significant problem for one-in-five Canadians 55 and older.* https://angusreid.org/senior-health-access/#:~:text=The%20study%20finds%20more%20than,diagnostic%20tests%2C%20or%20specialist%20visits.

90 Ontario Human Rights Commission. (n.d.). *Specific issues facing older persons*. https://www.ohrc.on.ca/en/discussion-paper-discrimination-and-age-human-rights-issues-facing-older-persons-ontario/specific-issues-facing-older-persons

91 Marks, M. B., & Teasell, R. (2006). More than ramps: accessible health care for people with disabilities. *Canadian Medical Association Journal, 175*(4), 329. https://doi.org/10.1503/cmaj.060763

92 Marks, M. B., & Teasell, R. (2006). More than ramps: accessible health care for people with disabilities. *Canadian Medical Association Journal, 175*(4), 329. https://doi.org/10.1503/cmaj.060763

93 The Saint John Human Development Council. (2021). *Serious problems experienced by people with disabilities living in Atlantic Canada.* https://www.justice.gc.ca/eng/rp-pr/jr/pwdac-phca/docs/RSD_RR2021_Persons_with_Disabilities_Atlantic_Canada_EN.pdf

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