BLACK HEALTH ALLIANCE

SUBMISSION TO THE

COMMISSION ON THE
FUTURE OF HEALTH CARE IN CANADA

OCTOBER 2002

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TORONTO PUBLIC HEALTH
YOUTH CLINICAL SERVICES INC.
ONTARIO SICKLE CELL ASSOCIATION
WOMEN'S HEALTH IN WOMEN'S HANDS
SOMALI GROUP FOR RATIONAL USE OF DRUGS (SGRUD)
SUBSTANCE ABUSE PROGRAM FOR AFRICAN CANADIAN CHILDREN AND YOUTH (SAPACCY)

THE BHA VISION

All people living in the diverse Black communities of Canada will experience improved ecological, economic, social, physical, emotional and spiritual health and well-being.

OUR VALUES

Canada's health care system is world-renowned and is the envy of many nations. It is one of the main reasons the United Nations consistently rates Canada as one of the best countries in the world to live. The founding principles of the Canada Health Act of 1984; public administration, comprehensiveness, universality, portability, and accessibility in law have provided a solid foundation for the construction of a health care system. The objective of which is "to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial barriers"(Canada Health Act, 1984).

As Canadians, we are proud of our health care system. It is part of our Canadian identity, part of our sovereignty; it is a part of what lies behind the sentiment, "I am Canadian!" Today, as Canadians, we face the unique challenge of reshaping our health care system, improving it, and making it work better for the future. As we start this important work, we must place a few guiding principles at the forefront of our minds:

❑ All citizens must have equitable access to health care and have their health needs met regardless of their economic, racial, cultural, political, geographic, gender or sexual status and age.

❑ The necessary outcome of an effective health care system is the protection, promotion, restoration, enhancement and maintenance of the physical, social and mental well-being of the population in an equitable and financially sound manner.

To enact these principles all levels of government, with respect to their roles in the health care system, must place a high value on the health and well-being of the individual, the family and the community. In so doing, a healthy and strong nation will be created. Let's remember, a nation is only as strong as its people.

The people of Canada have come from every corner of the earth, to live in, work and build this nation. In many ways, Canada is a model country and society. In an equitable and just society,

Canada's diversity is a position of strength. Where inequities exist, Canada's diversity is a mark of shame and at the same time, an opportunity for redemption.

Unfortunately, inequities exist in Canada's health care system.

OUR OBJECTIVES

❑ Mobilize the Black community towards healthier lifestyle choices.

❑ Advocate for research and implementation on health related issues that affect the Black community.

❑ Increase awareness of diseases, illnesses (and conditions leading to their development), in the Black community, among health and social care providers and within health institutions.

❑ Improve the provision of access to healthcare within the Black community.

❑ Create partnerships and strategic alliances with organizations to improve the Black community's access to the determinants of health.

ACTIVITIES

❑ Forming alliances with media, social agencies, and community organizations to facilitate health promotion and awareness.

❑ Conduct and support research initiatives on health related issues that affect the Black community.

❑ Support and initiate outreach progammes that educate the Black community and healthcare providers about diseases and illnesses (and conditions that lead to their development) in the Black community.

❑ To provide advocacy on behalf of the Black community to ensure governments and institutions recognize the impact of the determinants of health including racism.

❑ Collaborate with government and health institutions towards improving the access to health care in the delivery and administration of services.

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BACKGROUND

The Black Health Alliance (BHA) is a network of community organizations working together to improve the health and social well-being of members in the Black community. In this document, the word Black refers to people of African or Caribbean descent who have identified themselves as Black.

Founded in April 2000, the BHA is a volunteer, non-profit, community-based operation. Its leadership consists of executive members from each of the partner organizations: Toronto Public Health, Youth Clinical Services, Ontario Sickle Cell Association, Women's Health in Women's Hands, Somali Group for Rational Use of Drugs, and the Substance Abuse Program for African Canadian Children and Youth and individual community members. Each member has served for many years within the community in different roles; conducting research, planning, organizing, fund-raising, and building programs in the areas of education, culture, and health. The key objective of the BHA is to work with and hold accountable all stakeholders that play a role in shaping the health and well-being of Black people in Canada.

Within the health sciences, it is well known that some diseases impact Blacks at higher rates, and have a more aggressive and debilitating course when compared to Whites. Similarly, there are certain conditions that affect men at higher rates than women and vice versa. Knowing that these differences exist, the only ethical and responsible course of action is to use this vital information to better focus and direct research initiatives, screening, prevention and management programs; thereby, lessening the disproportionate burden of the disease on human beings.

Cancer, diabetes, end-stage renal disease, hypertension, sickle cell anemia, and A.I.D.S. are a few of the major diseases that globally afflict Black people disproportionately. The statistics are frightening. Ignoring the reality perpetuates the crisis. The impact and burden of these major chronic and debilitating diseases on the lives of Black people extends far beyond their individual lives affecting their families, their community and society. Their ability to work, to love, to parent, to contribute, and to live a full life is severely restricted.   Without question, the health status of any community will have a direct impact on the ability of that community to thrive, contribute and develop.

Although the reasons for the racial disparity in health and disease is not entirely clear, it is likely an interaction of genetic factors, environmental influences, socioeconomic status, lifestyle habits,

social pressures including racism, inaccessible health services, and inequitable and discriminatory health service delivery and administration.

As Canadians we place great emphasis on the value of our healthcare system.   It is part of our Canadian identity. Today, we face a unique challenge to this identity: to reshape our health care system, to improve upon it, and to make it equitable for all members of Canadian society. This can only be accomplished if all levels of government place a high value on the health and well-being of **all** individuals in **all** communities.

This report provides valuable recommendations towards the creation of an equitable, accessible, feasible and sustainable, high quality Canadian health care system. The recommendations are based on existing research, clinical and community experience. The changes are necessary and required leading towards the implementation of a more equitable, accessible, feasible, and accountable health care system that all Canadians deserve.

THE FUTURE OF HEALTH CARE IN CANADA

SUMMARY OF RECOMMENDATIONS

DETERMINANTS OF HEALTH

❑   Increase government intervention on the social determinants of health through targeted measures in income, employment, education, and housing.

❑   Canada's health care system must address the determinants of health, including the impact of racism, gender, immigrant/refugee status, violence and abuse, and lack of choice.

❑   All levels of government should fund Canada's health care system. Canada's health care system should not be privatized.

HEALTH RESEARCH AND DATA COLLECTION

❑   All provinces, and territories must put the same priority on routinely collecting and reporting ethno-racial statistics for all disease states and conditions. The information should be collected by race, ethnicity, gender, age cohorts and other vulnerable indicators. The data should also include information on heath care accessibility and the quality of the care provided. This data will lead to the establishment of provincial, territory, and a national database.

❑   Federal and provincial health institutions must create annual health reports based on the information collected in the databases and make them accessible to health and social service organizations.

❑   Health and social service organizations must work in collaboration with researchers and public health officials in developing, implementing and evaluating effective outreach programs using the information derived from the annual health reports.

❑   Disciplinary, ethno-racial research into women's health in order to ensure gender perspectives is incorporated into health policies and programs.

❑   The Canadian Institute for Health Research should be mandated to facilitate research initiatives that examine trends in disease incidence and prevalence in different ethno-racial groups for the purpose of identifying areas of disparity and gaps in service provision.

❑   Health research must be carried out in an ethical and objective manner. Researchers must be given autonomy and be free of persecution and pressure from funding bodies.

❑   The federal government should encourage the development of a national health information infrastructure in which sharing data on public health, population health and the health care system can be utilized to improve health outcomes.

ACCESSIBILITY

❑ Culturally and linguistically appropriate health information and anti-racist, inclusive health support services must be in place in order to ensure Canadians are able to make informed decisions about their health.

❑ Mandate health professions to increase the representation of Blacks at a level more representative of the demographics in Canada.

❑ Involve marginalized groups in the decision making process at all levels of the healthcare system.

❑ Review the procedure for licensure of foreign trained physicians and specialists with the intent of making it easier for them to gain a Canadian license.

HEALTH PROMOTION AND OUTREACH

❑ Culturally competent outreach programs should be implemented at the regional level to target communities at risk. Community members should play a major role in the development, implementation, and evaluation of the programs.

❑ Develop and fund aggressive health and wellness programs with an aim to modify peoples' behaviour toward adopting healthier lifestyles.

❑ Use legislation, when necessary and where possible, to encourage the adoption of healthy lifestyle practices.

❑ The federal government must show leadership in the development and promotion of Canada's National Vision of Health and Well-Being.

❑ This vision should focus on healthy lifestyles, chronic disease and injury prevention, and Canadians taking ownership and responsibility for their health.

❑ The vision should be a part of a national campaign, which permeates throughout government, business, education and health care creating an attitude of health and well-being in families and communities.

SUSTAINABILITY AND FEASIBILITY

❑ The federal government should guarantee stable long-term funding for the health care system to create security and allow for appropriate budget and program planning.

❑ The federal government must negotiate an exclusion of health services and health insurance from all trade agreements.

PRIMARY HEALTH CARE REFORM

❑ Implementation of regional, multidisciplinary health and wellness networks (HWNs) that encompass all regulated health professions, complementary and alternative medicine, has performance measurement tools in place, and community involvement at the board level.

❑ Regular review and analysis of programs ensuring their effectiveness in reaching and serving the target population.

❑ The funding scheme for HWNs should involve baseline funding and a "health bonus" funding based on improved health outcomes of the population served, therefore providing an incentive for wellness.

❑ The federal government must place strong restrictions on emerging direct-to-consumer drug advertising and internet pharmacies/drugstores. The use of prescription medication must be under the exclusive guidance of a physician or pharmacist.

RATIONALE

The general standard of healthcare is directed toward the achievement of improved health, disease prevention, addressing injury, controlling threats to ones life and influencing social conditions in order to ensure access to healthcare. These goals enable the general community to realize optimal health and quality of life as well as guide healthcare professionals in the provision of health programs and services most appropriate for the clients they serve. The reality of the healthcare environment in which Black communities seek care is one in which a significant portion of the members are faced with barriers hindering their accessibility to health services. Many of these communities' needs do not conform to North American systems of healthcare delivery that are based primarily on a bio-medical, mono-cultural model. Due to this fact, members of Black communities are utilizing healthcare services less and receiving critical diagnosis and treatment significantly later than other populations (Jones, 1997). This is due in large part to the cultural, linguistic, racial, gender and class barriers embedded within this system.

There is growing evidence that the experience of racism is a determinant of health and can have a pervasive and devastating impact on the health and well-being of Black community members (Fernando, 1991). One factor that has been strongly implicated in the exacerbation of this impact is the current inadequacy of healthcare services to provide culturally appropriate, anti-racist inclusive healthcare to all individuals. Inclusive healthcare locates health within the context of socio-economic realities and the analysis of healthcare needs is based on a definition of health that encompasses and incorporates the biological, socio-cultural and psychological, and environmental dimensions of client's lives. Inclusive healthcare recognizes that all of these factors have a direct impact on the state of health and well-being of individuals and further recognizes that gender, religious, cultural and class backgrounds strongly influence how one experiences illness, how and when one is diagnosed and eventually how one is treated by the healthcare system.

The history of Canada has been one based on a continuous process of immigration and incorporation of people who have diverse cultures, languages and values into the Canadian

mosaic. The immigrant population of Canada continues to be a salient feature in the economic, political and cultural evolution of the nation.

Canada's current immigration patterns are changing dramatically. First, the number of immigrants coming to Canada has increased considerably in the last 20 years. Second, the ethnic makeup of immigrants is noticeably changing. Until the late 1960's, the majority of Canada's immigrants arrived from Western European countries and America. By the 1980's, developing countries were the origins of the majority of immigrants. Appendix A outlines the countries of origin of immigrants to Canada. This can be attributed to the political instability of the developing world, the economic stability of Europe and changes made in the 1978 Immigration Act that eliminated selection practices favoring European immigration and discriminated against those from developing countries. Prior to the creation of this act, Canada's official position on immigration was one of explicit discrimination across racial and ethnic lines. Looking at current trends, at least 70 % of immigrants coming to Canada will be from the developing world and the visible minority population will pass 9% (Statistics Canada, 2001).   In larger Canadian cities such as Toronto, 1 in 2 residences are immigrants and 1 in 3 are visible minorities (Statistics Canada, 2001).

With the reality of the changing face of Canada, we can no longer afford to have a healthcare system that excludes valuable members of society from accessing culturally and linguistically adequate programs and services.   In order to ensure the health and well-being of all members of Canadian society, cultural considerations can no longer be an after thought and anti-racist services must be incorporated into all aspects of Canada's healthcare system.

The discussion of racism in healthcare is a discussion of the value that the healthcare system, and ultimately society at large, places on the health of Black communities. For example, it is known that prevalence rates of sickle cell anemia, diabetes and hypertension are high in Black communities but the existence of culturally appropriate and inclusive healthcare services to lessen the burden and address the needs of these communities is lacking (Jones,1997).

Studies in North American and European contexts have found that mainstream agencies have failed to provide accessible and equitable services. Doyle and Visano's (1987) major study of social services in the Toronto area found that institutional discrimination as well as specific discriminatory practices reflected the lack of commitment of mainstream providers to enact the changes that would fulfill the needs of their diverse client bases. White human-service professionals frequently held negative judgments of minority communities which only exacerbated the already systemic alienating factors experienced by these communities such as language barriers, poor access to childcare and transportation (Doyle & Visano, 1987).

Members of the Black community cannot take for granted that medical practitioners will respect their experience, speak their language, understand their culture and that the medical advice they receive will be consistent with both their world view and their material resources. Racial discrimination in the healthcare system at the extreme renders the perspectives and health concerns of the Black community marginal and pathological. The mono-cultural, medical model of healthcare in mainstream Canada renders the perspectives of the dominant culture as normal, neutral and universal. Whether by accident, design, or as a by-product of systemic discrimination, this perspective is problematic for members of the Black community by virtue of their difference from what is presented to be the norm (Razack, 1998).

DETERMINANTS OF HEALTH - THE WHOLE PICTURE

Recently, the World Health Organization identified racism as a major determinant of health (Yach et al. 1998) that further influences the impact of the following determinants on Black people:

❑ education/literacy;

❑ housing/safe shelter;

❑ employment/socio-economic status;

❑ poverty;

❑ healthy environment; and

❑ environmental issues (air quality, water, etc).

It has been shown that these determinants influence health status through knowledge, time and opportunities to pursue health (McMichael et. al, 2000). Poverty for example has a dramatic influence on health and well-being.

It should also be noted that inclusive healthcare does not restrict our perception to only these mainstream determinants of health. An inclusive model recognizes that racism, gender, abuse, immigrant/refugee status, and lack of choice can directly impact individual health and well-being, as well as impede access to healthcare services. These factors are evident in the disparities that exist in disease prevalence particularly if we consider the intersection of race, class and gender in the discussion. Breast cancer, prostate cancer, diabetes, end-stage renal disease, hypertension, SCA, and HIV/AIDS are a few of the major diseases that are disproportionately prevalent on a global scale among members of Black communities. Although Canadian research is lacking in the areas of ethnic and racial disparity in disease prevalence, most of these conditions are likely caused by the interaction of genetic factors, socioeconomic status, lifestyle habits, and environmental influences that include racism, sexism, oppression, and inappropriate or inaccessible health care systems.

HEALTH RESEARCH AND DATA COLLECTION

In Canada, there is a lack of statistical data on health conditions that affect the Black community disproportionately when compared with Whites. Health data is not routinely collected and disseminated by race or ethnicity. Consequently, few public health initiatives are developed without relevant objective data to justify their existence. Therefore, Black communities in Canada are disadvantaged by not having access to such data. It is imperative that health data collection systems are designed to obtain information on morbidity and mortality rates and key physical and mental health indicators. The information collected should be disseminated by race, ethnicity, gender, age cohorts and other vulnerable social categories. Such data should not be limited to census and vital statistics but should include data on access to and quality of health care (for example, service delivery, diagnosis and treatment, facility availability, provider availability and other related health activities and services). Data incorporating race, disease states, and demographic information will be invaluable to community health groups and public health officials

for planning outreach and public health campaigns. In addition, research initiatives will help identify other areas of disparities such as heart disease or certain types of cancer. This would enable measurement of progress and examination of trends. With the collection of such data, the establishment and implementation of strategies to eliminate disparities based on race, ethnicity, or other social basis of discrimination in relation to access to and quality of health care can be addressed and monitored.

ETHNIC DISPARITIES IN DISEASE AND HEALTH CARE

HIV AND AIDS

According to the Joint United Nations Program on AIDS (UNAIDS) by the year 2000 approximately 36.1 million people were estimated to be living with HIV and 21.8 million people around the world died from complications related to the disease (UNAIDS, 2000). More than two-thirds of all the people living with HIV in the world, 25.3 million men, women and children live in Sub-Saharan Africa (UNAIDS, 2000). By 2002, it was estimated that more than 13 million women will be infected with HIV and 4 million will die from AIDS. Global HIV transmission is currently higher for women than for men.

Until recently, very little was known or documented about HIV/AIDS in relation to African and Caribbean communities in Canada. The Bureau of HIV/AIDS, STD and TB publishes the *HIV and AIDS in Canada: Surveillance Report*. When examining the total number of AIDS cases reported with ethnicity data in Canada since the beginning of the epidemic to December 31, 1998; 86.4% of the reported AIDS cases have been reported among Whites. Persons reported as Black or Aboriginal accounted for 6.8% and 2.5% of AIDS cases, respectively (Health Canada, Aids and Ethnicity in Canada, 1999). Considering that Blacks comprise only 2% of Canada's population, according to the 1996 Census, the data suggests a disproportionately high prevalence of AIDS among Black Canadians (Statistics Canada, Nation Tables, 1996).

In the same Surveillance Report, during the period between 1989-1998, the proportion of reported AIDS cases among Whites decreased significantly yet increased significantly among all other ethnic groups (Black, Aboriginal, Arab/West and South Asian, Asian and Latin American) (Health Canada, Aids and Ethnicity in Canada, 1999). The most dramatic increase occurred among Aboriginals and Blacks. In ten years the proportion of reported AIDS cases among Aboriginals increased from 1.2 % to 10.9%. Among Blacks, it increased from 5.3% to 7.8% (Health Canada, Aids and Ethnicity in Canada, 1999). The suggestion here is that programs in place to control the epidemic of HIV and AIDS was selectively effective.

Anecdotal information from service providers of increasing numbers in their client case loads was not taken seriously until very high rates of maternal-infant transmission were first documented amongst Caribbean and African women (Tharao & Massaquoi, 2000). Reports from Dr. Susan King, Toronto Hospital for Sick Children and the HIV Pediatric Network, revealed that between 1994-96, 70% of maternal-infant transmission of HIV infection had occurred among persons from HIV-endemic regions, mainly Africa and the Caribbean (Remis et al, 1998). In addition to highlighting the issue of maternal transmission, the report also clearly indicated that African and Caribbean populations had become an important component of the Canadian HIV epidemic.   It showed that almost 10% of AIDS cases diagnosed in 1996 were among persons born in Africa and the Caribbean who were residing in Ontario, compared to 3% of AIDS cases diagnosed previously. This was particularly evident among women born in HIV-endemic countries, who represented 32 % of AIDS related deaths in women in 1996 (Remis et al, 1998). According to Remis (1998), this population also had a substantially higher AIDS-associated mortality rate than the Ontario

population as a whole (14.0 compared to 4.2 per 100,000 in 1996. Modeled estimates suggest that approximately 2,346 persons from Africa and the Caribbean were living with HIV in Ontario as of December 1998 constituting about 12% of all HIV infections, a figure surpassed only by men who have sex with men and IV drug users (Remis & Whittingham, 1999). According to Remis and Whittingham (1999) about 30%-40% of these infections occurred after establishment of residence in Canada contrary to the popular belief that the virus is wholly transported during migration (Remis 1999).

The most notable evidence of gender and race disparity in health status is also seen in the growing prevalence of HIV/AIDS among Black women. Although Black women in particular represent a significant part of the HIV epidemic, researchers and policy makers have largely ignored them. The absence of representation by Black communities in the HIV arena in terms of accessing prevention, support, treatment and care initiatives is evident. The staggering numbers of infected Black people are usually represented in epidemiological updates or in reference to prenatal HIV transmission and prevention.

Canadian statistics indicate that the HIV/AIDS epidemic has shifted to include women, girls and children. The proportion of HIV tests among women and young girls below the age of 15 (National Trends of AIDS and HIV in Canada – CCDR Vol.26-23) has increased over the last few years from 18% in 1995 to 24% in 1999. At the national level, more than 1,800 African and Caribbean women are living with HIV in Canada, which represents more than 8% of all HIV infection in women (Remis 2001). Despite such high rates of infection, there are no concerted efforts to mount effective strategies to reduce the spread of HIV/AIDS and its impacts on African and Caribbean women.

There are few, if any HIV/AIDS prevention, support and care programs developed specifically for African and Caribbean women in Canada. Women from these groups are rarely involved in the development, implementation and delivery or in decision making in programs targeted to them. In addition to non-existent or inappropriate programs these women face multiple barriers accessing services resulting in a lack of the most basic HIV/AIDS information. The above statistics indicate an urgent need for further research in this population to contextualize results obtained by statistical modeling and to better understand the psychological, social, cultural and structural determinants of HIV risk.

HYPERTENSION

A diagnosis of hypertension or high blood pressure (HBP) is suggestive of an increased workload of the heart. Hypertension is defined as a blood pressure of 140/90 mmHg or higher with or without medical treatment. Anecdotally, HBP is an asymptomatic condition that is often detected on routine medical examinations.

HBP is a major health problem among Black people in North America (Lackland & Keil, 1996). In the United States, for example, the risks of developing HBP are 2 to 3 times greater for Black men and women compared with their White counterparts.

High blood pressure in Blacks has an earlier onset, is more prevalent, and has a higher incidence of complications including kidney disease, and heart disease and stroke (Adrogu9 & Wesson, 1996). It is important to note that Blacks are almost twice as likely to die after a stroke as Whites.

Explanations of contributing factors of a psychosocial, cultural, and socio-economic nature superimposed on a genetic background have been generated to explain these trends. Also proposed to play a significant role in the higher morbidity of high blood pressure in Blacks in the United States are salt sensitivity, environmental stress, varying access to medical health care, racism and poverty (Adroguϑ & Wesson, 1996; Grim & Robinson, 1996).

Estimates of the prevalence of HBP in Canada among Blacks are not available. However, it is difficult to argue that the trends are significantly different. The reduction of HBP is amenable to treatment with education on how to make modifications in lifestyle and medication, as prescribed. Examples of lifestyle changes include reduction of dietary sodium, avoidance of excessive alcohol consumption, weight reduction in obese individuals, smoking cessation, exercise, and stress reduction (Adroguϑ & Wesson, 1996).

DIABETES MELLITUS

Diabetes mellitus (DM) is a chronic, complex condition that "meets the criteria for a public health disorder: a high disease burden, changing burden suggesting preventability, and fear that things are unknown or out of control" (Meltzer, Leiter, Daneman et al., 1998).

The 1998 clinical practice guidelines for the management of diabetes in Canada estimated the diagnosis of DM had been made in approximately 5% of Canadians or 1.5 million Canadians (Meltzer, et al., 1998). In the year 2000, the number of Canadians diagnosed with DM was projected to be 2.2 million and 3 million by the year 2010. The most alarming projection is that for every person diagnosed with diabetes, there may be someone living with DM but has not yet been diagnosed. If this is true as some statistics from the United States predict, the authors of the clinical practice guidelines estimate that approximately 10% of Canadians might have diabetes.

The burden of DM and its associated complications on the lives of those directly affected is devastating. "People with diabetes have poorer health and spend more time managing their health than people without DM" (Meltzer et al., 1998). Complications of DM include blindness, small and large vessel (microangiopathy and macroangiopathy) disease leading to blindness, coronary artery disease, lower limb losses resulting from the development of foot ulcers, and end stage renal disease. Coronary disease is the leading cause of death in Canada. When comparing Black to White populations, racial origin has shown to be a strong contributing factor in the increased risk of coronary heart disease and the progression of diabetic nephropathy (Medline 2001).

The cost to society for DM management is thought to be staggering although its actual cost is unknown. The Canadian Diabetes Association (CDA) estimates that DM accounts for $9 billion in direct and indirect health care spending. A person with DM incurs medical costs 2 to 5 times greater than someone without diabetes (Canadian Diabetes Association, June 2000).

People at high risk of developing DM are those of Aboriginal, African, Hispanic, and Asian descent. In his report, *Diabetes – Strategy for Prevention*, Dr. Colin D' Cunha, The Ontario Chief Medical Officer of Health acknowledged the disproportionate impact of DM on the African-Canadian community. Another important development is the increasing prevalence of Type 2 DM in children particularly among children of high-risk groups (Health Canada, Diabetes and Aboriginal Peoples

1998). The reasons for the existence of these polarized disparities between visible minorities and Caucasians have yet to be clearly delineated in the literature.

One of the most notable disparities in health status is reflected in the prevalence of DM and related complications amongst Black people and Caucasians. For example, the prevalence of DM among Blacks has been estimated to be up to five times higher than White Canadians (Canadian Diabetes Association, 1998). In Canada, Type 2 diabetes currently occurs in 1 to 2% of children of Aboriginal, Hispanic or Black origin and up to 4% of adolescent girls (Meltzer et al., 1998). Given the existence of the aforementioned data, the current recommendations for screening are that people of Aboriginal, Hispanic, Black and Asian decent should be checked more frequently and much earlier than Caucasians (Meltzer et al., 1998).

Socioeconomic status is a factor in the excess prevalence of Type 2 DM among Black women (Journal of Epidemiological Community Health 2000 Nov; 54(11):839-845) and that dietary factors played a significant role in ethnic differences in early risk cardiovascular disease and Type 2 DM when comparing children from Black communities and those from the White population (American Journal of Clinical Nutrition 2000 Mar;71(3):670-671).

Despite this disparity in disease prevalence, there are few DM prevention, support and care programs developed specifically for the diverse cultures within Black communities in Canada. How does this population at high risk gain access to information about diabetes prevention before the onset of the disease? Members of the Black community are rarely involved in the stages of DM program planning, development, implementation and evaluation. In addition to the lack of programs specifically for the Black community, its members face multiple barriers in accessing health care services which further distances them from the most basic DM information and treatment.

It has also been shown that service providers lack an understanding of the social and cultural practices of many ethnic groups with an increased risk and prevalence of DM. The non-pharmacologic treatment of people diagnosed with Type 2 diabetes requires education and lifestyle modifications that include nutritional management, physical activity, stress management, smoking cessation, and education about diabetes self-care as well as blood glucose monitoring (Meltzer et al., 1998). Food and nutrition, being one of the cornerstones of DM management, are intrinsically linked to culture. Consequently, culturally competent diabetes care requires a discussion, within a cultural framework, of how diabetes is perceived by members of the Black community, the role of dietary modifications, and the value placed on taking medications in that culture.

END STAGE RENAL DISEASE

End stage renal disease (ESRD) is the irreversible destruction of the filters (nephrons) within the kidneys. Among their numerous functions, the filters are responsible for the removal of waste products from the body, the regulation of fluids and electrolytes in the body, and for blood pressure regulation. When these functions are lost, ESRD results. Without dialysis or a kidney transplant, death from the accumulation of toxins within the body is certain.

ESRD affects an estimated 0.05% of the Canadian population, yet it costs approximately 1.9% ($1.2 Billion) of the health care budget to provide renal replacement therapies (Jones, 2000). The cost of providing diabetes-related care in Canada has been estimated at $5 to $10 billion annually.

Two leading causes of ESRD in Canada are DM, and high blood pressure. Both DM and high blood pressure are amenable to control or slowed progression toward organ damage such as ESRD and coronary artery disease. Diabetic nephropathy is the leading cause of ESRD in Canada and the western world (Meltzer et al., 1998). The most prominent cause of death among people living with diabetes and end stage renal disease is cardiovascular disease. Efforts for prevention include early screening and detection of microalbumin in the urine.

In 1999, ESRD trends among Blacks, Caucasians and Orientals in Toronto were compared. With respect to incidence, DM was the leading cause of ESRD among the groups and was highest among Blacks (40%), followed by Orientals (32%) and Caucasians (31%) (Jones, 2000). Blacks were more frequently represented in the younger age groups (22 to 44, and 45 to 64) than Caucasians and Orientals. These findings, consistent with reports found elsewhere, should be carefully considered. Any condition that impacts the health of a disproportionate number of people within their most productive working years impacts the economic viability and strength of that community.

A national study examining trends among ethnic groups in Canada was subsequently done by Yeates and colleagues (2001). The results of their descriptive study showed that the incidence rates of ESRD in Canada were lowest among Caucasians (103.3) and highest among Blacks (156.8) and Aboriginals (194.0). The authors concluded that significant racial disparities exist in incidence rates for renal replacement therapies are in Canada.

These statistics point to the need for preventive strategies and initiatives that will heighten awareness and reduce the risk of organ damage associated with HBP and DM within the Black community.

CANCER

One in nine Canadian women are expected to develop breast cancer in their lifetime and one in twenty-five women are expected to die from it (W.E.D.O., 1997). Breast cancer incidence amongst women has increased steadily in the past ten years (from 78.2 to 108.2 per 100,00 women) (W.E.D.O., 1997). Recent mortality data showed that while the incidence is increasing, mortality rates are decreasing. It is not known whether early detection through screening, improved treatment, changes in risk or protective factors or a combination of these factors is responsible for the apparent decline in mortality. Significantly, in 1993, 84% of the women who died of Breast Cancer in Canada were over fifty (Ontario Ministry of Health, 1996).

Anecdotal evidence points to a disproportionate decrease in the survival rate of Black women with breast cancer and certainly, data from the United States where breast cancer is the second leading cause of cancer death for Black women, supports this. African American women with breast cancer are 20% more likely to die from the disease than their White counterparts. "Only 71% of Black women survive for 5 years after having been diagnosed with breast cancer compared to 87% of White women (American Cancer Society "Cancer Facts & Figures for African Americans, 1998-

1999). In addition, although survival rates for White women rose slightly over the past two decades, they declined for Black women.

Whilst it is impossible to extrapolate Canadian breast cancer rates based on United States figures, there are some striking demographic similarities that would lead one to believe that similar figures apply here. Low socioeconomic status is associated with an increased incidence of many common cancers in both the United States and Canada, despite our universal health coverage. The issue of socioeconomic status is particularly relevant, as studies have shown that low-income women are less likely to have mammograms.

Socio-demographic factors that have been associated with ever having had a mammogram include higher levels of income and education, and, having been born or having immigrated to Canada more that ten years ago (Goel, V., Mercer, S., 1997). This is especially significant because it is known that "the only proven strategy to reduce breast cancer deaths is early detection through mammography in women over 50. There is clear evidence that screening mammography can reduce mortality from breast cancer by approximately 30% in women aged 50-69." (Health Canada, Breast Cancer in Canada, April 1999 Cancer Updates.) It is therefore essential that all women be made aware of the considerable benefits of breast cancer screening in reducing mortality.

As in the case with breast cancer in Black women, there is American studies that suggested prostate cancer in Black/African American men occurs at a higher incidence when compared to White men. For the same reasons as mentioned earlier, it is reasonable to assume the same health disparity occurs for Black men in Canada. Race specific research and culturally competent programs are needed to lessen the gap.

SICKLE CELL ANEMIA

Sickle cell anemia (SCA), is a life-threatening, inherited disorder that affects the normal functioning of the red blood cells. Common symptoms include: severe abdominal and bone pain, joint swelling and pain, splenic sequestration, aplastic anemia, vaso-occlusive crisis, organ damage and infection. These individuals may also experience serious respiratory infections. Although sickle cell disease is not curable at the moment, it can be managed by patients, their families and health care professionals with proper education and training.

People whose ancestors were from Africa, India, the Middle East, the Mediterranean (Turkey, Italy, Greece), and Latin America (Cuba, South America, Central America) are more likely to inherit the gene that can cause sickle cell disease (The American Sickle Cell Anemia Association, www.ascaa.org).

Currently, there are no published data on the exact prevalence of sickle cell disease in Canada. In the United States, the disease mainly affects African Americans (1 in 500) and Latin Americans (1 in 1,000 to 1,400) (The American Sickle Cell Anemia Association, www.ascaa.org). Of Black Americans, 1 in 12 carry the sickle cell trait which means that an individual in this group has inherited one defective sickle cell gene from either one of both parents. Extrapolating from US data, it is safe to assume that 1 in 12 African Canadians (who share the same African ethnic origins with their American cousins) also carry the sickle cell trait. Approximately 250,000 to

400,000 residents of the Greater Toronto Area (GTA) including native born Canadians and immigrants from the Caribbean, Africa and the USA trace their ancestry partly or wholly to Africa. Thus, potentially between 20,000 and 32,000 individuals of African ancestry resident in the GTA carry the sickle cell trait.

The potential prevalence of full blown sickle cell disease (i.e. those who have inherited two defective sickle cell genes (one from each parent) amongst African-Canadians in the GTA is estimated to be between 400 and 700 (The Sickle Cell Association of Ontario: www.sicklecellontario.com). These figures do not include the potential prevalence of sickle cell disease amongst GTA residents of Mediterranean, Indian and Middle-eastern origins.

The Sickle Cell Association of Ontario is a strong advocate of newborn screening for SCA, within the Canadian Health System (The Sickle Cell Association of Ontario: www.sicklecellontario.com). Newborn screening is a simple blood test that is collected at birth and used to identify many life-threatening genetic illnesses before any symptoms begin. This test could indicate if a baby has sickle cell trait, sickle cell disease or any of the other abnormal hemoglobins (Xu K, et al., 1999).

If SCA is detected, a baby will need regular doctor appointments and early penicillin treatment. This medication will help prevent life-threatening infections. Children with SCA have increased susceptibility to bacterial infections, cerebrovascualar accidents, and organ failure. Proper treatment, medications and early medical care can reduce serious complications and death (Sickle Cell Information Center: www.scinfo.org). To date, SCA is not included as part of the newborn screening profile; although, other genetic defects such as Pyruvate Kinase Deficiency is included. In most American states, the screening of all babies for SCA is mandatory (Sickle Cell Information Center: www.scinfo.org).

In Canada, a coroner's inquest was called recently into the untimely death of a teenager with SCA. The teenager died after gall bladder surgery at the Hospital for Sick Children in Toronto. On July 19, 2001 a coroner's jury found that the patient's death following gall bladder surgery at the Hospital for Sick Children was accidental and issued a total of 31 recommendations. The report identified the following gaps:

❑ no direct communication among any of the key physicians and surgeons caring for the young patient;

❑ failure of the hospital's hematology and anesthesia departments to properly evaluate the patient before the operation;

❑ lack of understanding among the nurses about SCA and its implications;

❑ inadequate nursing clinical judgment; and

❑ poor communication among nurses (Levy, 2000).

Of the 31 jury recommendations, six focused specifically on the need for improved guidelines, procedures, education and training regarding the treatment of sickle cell patients. Notable among the recommendations is one that the hospital take steps to educate health care workers, patients and family members regarding the management of sickle cell disease.

The fact that this occurred in a major hospital in a city with Canada's largest Black population is a glaring sign of the tragic disparity in health care received by certain ethnic groups. It is not the first time the death of a patient with sickle cell has sparked a coroner's inquest. In 1990, a coroner's jury highlighted the need for staff at another hospital to be educated about sickle cell disease following the death of a patient with the disease.

MENTAL HEALTH

According to the most recent Canada census, the influx of new immigrants is the key driving force for population growth in Canada. Citizenship and Immigration Canada (1999) expected 200,000 to 225,000 immigrants and refugees to enter Canada in the year 2000.

The majority of new immigrants to Canada come from Europe, Africa and Asia. A significant number of newcomers to Canada are members of Black communities.   There is a growing body of evidence that many new immigrants from Africa suffer from post-traumatic stress disorder, depression and deteriorating mental health (Boyer, M., Ku, J., & Shakir, U.,1997). Becoming an immigrant is characterized by losses in socio-economic status and social networks. In many cases, new immigrants must cope with pre-arrival traumatic experiences, unemployment, social isolation, racism and discrimination, lack of family support and loss of status (Elmi, 1999). This is compounded by major obstacles in trying to learn, understand, and access the Canadian mental health system. Upon arrival to Canada immigrants have a better health status than the average Canadian (Chen et al., 1996). After 10 years in the country, immigrants are in poorer health and have a higher prevalence of chronic health conditions including mental illness (Dunn & Dyck, 2000).

Immigrants and refugees are particularly at risk for mental illness and other chronic diseases. Barriers in language and understanding of culture between the health care provider and the new immigrant lends itself to reliance on prescribed medications and less use of appropriate counselling. This produces two results. First, these communities are disadvantaged in that they use less mental health services. Second, an increase in the occurrence of suicide and major mental health disorders (Elmi, 1999) in these communities is observed. From a health promotion perspective, mental health promotion is a vital issue for this population (Meadows et al., 2001).

Factors such as dealing with racism, feeling displaced, isolated, responsible for the well-being of others, culture shock, changes in gender roles and in power relations all interfere with the mental health of the individual. Studies have shown that female youth who immigrate to Canada with their families experience adverse stereotypes, low self-esteem, and negative self-perceptions, all of which can impact their health and well-being (Douglas, 1995; Maceda-Villanueva, 1990). This segment of the population is exceptionally vulnerable because of the intersecting prejudices which pervade their existence: being young, female, and a racial minority are all factors that can serve to disempower and thereby lead to feelings of helplessness and low self-efficacy (Henry et al., 1995; Turner, 1995). These negative aspects of one's identity has further been implicated in the development and intensification of serious mental and physical health difficulties (Boyer et al., 1997; Fernando, 1991).

Mental health issues for Black community members in general and Black women in particular also need to be explored in the discussion of inclusive healthcare. Of all demographic variables in

research, gender is the single strongest predicting factor for different types of mental illnesses. Depressive disorders are on average 2 to 3 times more common in females than males. Eating disorders are 8 to 10 times more common in females (The World Health Report, 2000). In general, women are the primary consumers of treatments and services for mental disorders but there is little consideration of clinical findings of gender differences applied to health policy and service delivery systems. (National Institute of Mental Health, 2000). Nor is there a question as to the reasons for overrepresentation of Black women in psychiatric drug treatment and mental health services (Boyer, M., Ku, J., & Shakir, U., 1997)

WHY THE DISPARITY?

The reasons for the ethno-racial disparity in disease are not always clear. In some cases, such as SCA, there may be a genetic predisposition. However in most disease states, researchers believe, it is the interaction between genetic factors, environment, and socioeconomic status that bring about the manifestation of the disease. Indeed, it is a reality that certain cancers and other conditions such as diabetes, hypertension, and cardiovascular disease are more prevalent among Blacks than Whites. However, effective health programs can remedy the situation and decrease mortality and morbidity and reduce health care costs.

A recent study from the Institute of Medicine in the United States is reported as the first comprehensive analysis of racial disparities in health care (Smedley et al., 2002). After reviewing more than 100 studies conducted over the last decade, the report concluded that minorities receive inferior care, even if they had the same insurance as a White (Smedley et al., 2002). These disparities in health care contributed to higher death rates from cancer, heart disease, and HIV infection (Smedley et al., 2002). The report cited that racial bias demonstrated by doctors may have played a significant role in the problem.

Signs of similar disparities in health care are evident here in Canada. These disparities unnecessarily and inhumanely increase the morbidity and mortality of certain diseases within the Black population. At the same time, it significantly adds to health care costs. As a community, we are paying for these unjust disparities in more ways than one!

THE CHALLENGE OF ACCESSIBILITY

A major challenge in population health is the ability or tendency of all Canadians to access the health care system. This has a direct impact on the health and well-being of Canadians. Early detection and appropriate treatment can lessen morbidity and reduce health care costs. Due to racism and other forms of oppression the mainstream medical system fails to address:

❑ Socio-cultural barriers such as cultural health beliefs, values and norms and perceptions of the mainstream health system which create barriers to service for Black communities.

❑ Lack of culturally and linguistically appropriate healthcare information which is available for increased knowledge and education of clients to make informed decision about their health.

❑ Limited support services which are anti-racist and inclusive.

❑ Limited research and medical information available on health issues that impact Black communities.

❑ Imbalanced gender relations which restrict women's decision-making power particularly Black women in the role of client.

All these barriers add to the growing concern of access to appropriate health services for Black communities.

It is important to note that people often feel more comfortable addressing sensitive health matters with someone who is familiar with his or her culture. He or she may also feel that the health professional is more genuinely concerned about them, understands them, and will do more to help them.

In a study conducted by Women's Health in Women's Hands, female youth of color overwhelmingly preferred to receive medical care from a practitioner of similar race and culture to their own (Ali, Massaquoi & Brown, 2001). It was also seen as a key determinant in the seeking of healthcare services for this population. Accessibility can also be improved by implementing culturally competent outreach programs which employ effective social marketing strategies. In essence, health programs should package messages to correspond with the cultural belief systems of the target population. This is most effectively achieved when key members of that community play a major role in the development and delivery of the program from its inception.

As discussed earlier, finding a health care practitioner of similar race and culture can be a significant determinant to accessing health care services. One of the recommendations in the US report on racial disparities in health care was to increase the number of visible minority doctors.

Currently, visible minorities comprise a larger percentage of the student body in Canadian medical schools than in the Canadian population (32.4% versus 20.0%) (Baddour, 2002). However, Black and Aboriginals are severely underrepresented. Blacks and Aboriginals comprise 1.2% and 0.7% respectively of the first year Canadian medical school students yet represent 2.5% and 4.5% of the Canadian population, respectively (Baddour, 2002). In contrast, Chinese and South Asian comprise 20.2% of first year Canadian medical students yet make up only 7.8% of the Canadian population (Baddour, 2002). Of the 2,208 University of Toronto medical school graduates between 1991 and 2001 inclusive, only 24 (1.1%) were Black (Alli, 2002).

Not only does the racial composition of Canadian medical schools differ significantly from the general population, it also differs with respect to socioeconomic status. Canadian medical schools have fewer students from low-income families in general (Baddour, 2002). In Ontario, between 1997 and 2000, the percentage of medical students with a family income of less than $40,000 declined from 22.6% to 15.0% (Baddour, 2002).

There is rising concern that escalating tuition fees severely compromises accessibility (Sibbald, 1998), particularly to already underrepresented groups. Several American studies have warned that high tuition may restrict access to medical education for those from low-income families, underrepresented minority groups and rural areas (Magnus, 2000; Petersdorf, 1991).

Other American studies emphasize the advantages of a diverse, representative medical student body. In addition to fairness and issues of accessibility, a racially diverse physician population has significant pragmatic considerations. When compared to non-minority medical students, minority students are more likely to treat disadvantaged patients, chronically ill patients and patients with more than one illness (Komaromy, 1996; Moy, 1995; Davidson, 1997). They are also more likely to practice in rural communities, areas of physician shortage and socio-economically depressed

regions (Easterbrook, 1999; Rabinowitz, 2000). Research has also shown that students from underrepresented or economically disadvantaged backgrounds, perform as well in medical school as their more advantaged peers (Fredericks, 1969). The disproportionate under-representation of Blacks exists not only in medical school but across the board in other health professions and Canadian health sciences faculties (Alli, 2002).

There is also a growing population of foreign trained physicians, surgeons, dentists, dietitians and other health professionals who are finding it very difficult and time consuming to gain their Canadian license. The Association of International Physicians & Surgeons of Ontario and the Association Multiethnique des Medecins Diplomes Hors Canada advocate for revisiting and reforming the accreditation and licensure process for health professionals trained outside Canada and for the removal of barriers.

Dr. Adama Youla, president of the latter organization, argues there is institutionalized discrimination toward (foreign trained physicians) on the part of the authorities (ministry of health and college des medecins du Quebec) which fail to recognize their credentials and refuse to grant them permits to practice (Gagnon, 1999). In his report, Dr. Youla also states that foreign trained doctors would fill the voids in care, specialist or generalist, in chronically understaffed outlying regions of the province. If this process was reviewed and streamlined, it would help the human health resources problem and help increase utilization levels within certain communities.

GENDER AND ACCESSIBILITY

Racist and discriminatory practices have limited the basic rights of Black people to employment, housing, education and access to services. Black women face additional barriers based on gender discrimination and sexism. The role of economic status as one of the driving forces of illness is very well understood and documented. People living in poverty are less likely to seek early treatment for illness and consequently have more advanced symptoms when they are presented to healthcare providers (Carrin et. al. 1996). Research has only recently begun to directly address the influence of racism and sexism on the physical and mental health of Black women.   While some of these health issues have been previously explored, there is a critical lack of research directly addressing the interplay between the health needs of Black women and existing gaps in services designed to meet these needs (Javed, 1995; Maceda-Villanueva, 1990).

Health policies and programs should aim to enhance women's physical, mental and social well–being throughout their life span. The cumulative effects of sexism, classism and coupled with racism can have debilitating effects on the quality of life of women in general and Black women in particular. Although women incur many of the same health concerns as their male counterparts, including mental concerns, occupational and environmental health conditions, they experience them differently because of biological and social considerations. The health concerns specific to women often include those related to their reproductive health, and sex specific diseases. Women are disproportionately vulnerable to:

❑   gender-based violence, sexual abuse, rape and incest;

❑   harmful practices such as female genital mutilation; and

❑ inappropriate medical procedures such as unnecessary caesarian sections and over prescribing of drugs particularly those which are psychiatric in nature (Fernando, 1991).

Improving quality of care is critical to improving women's health, to increasing access to and use of health services and to using limited resources effectively. Social and cultural factors often grounded in gender relations are important in determining women's access to services. Black women experience unnecessary morbidity and mortality resulting from disease prevalence such as cancers of the reproductive tract, breast cancer and from sexually transmitted infections, including HIV. For many women, sexual contact is not free from violence, coercion, discrimination and disease (Women's Health, 2000).

In many cases women lack choice around their reproductive lives. Women face unique health risks as a result of gender inequality. The approach to women's health and their access to appropriate good quality healthcare is often severely limited by socio-economic and cultural circumstances and by gender bias in the health care system. Women constitute the majority of healthcare providers in both the formal health sector and in the home often under difficult conditions and underpaid. More interdisciplinary research is needed in women's health so that gender perspectives may be incorporated into health policies and programs. The existing lack of sex-disaggregated data and information hinders the ability of decision makers to develop effective inclusive women's health policies and programs. Adequate institutional mechanism and resources are required for the successful achievement of inclusive women's health policies and programs.

If we are to develop a system of inclusive healthcare we need to base programs and services on the realities of peoples lives. Socio–cultural and economic factors such as poverty, unemployment, sexual abuse, cultural beliefs, values, norms and practices further compounded by racism and other types of discrimination increase the risk of ill health. Programs and policy development must consider these issues.

Healthcare providers must be responsive to individual, social, cultural and medical needs and respect client rights to make informed un-coerced decisions about their own healthcare.

An inclusive healthcare framework must:

❑ Include marginalized groups in decision making at all levels of healthcare;

❑ Ensure that healthcare providers are representative of client populations;

❑ Offer integrated multidisciplinary services where clients can make one visit for more than a single purpose;

❑ Be willing to take healthcare service to the community;

❑ Integrate health services to promote a holistic approach;

❑ Continuously monitor service by the clients to assess quality of care;

❑ Insist on high quality, responsive and respectful provision of healthcare during the client-provider interaction;

❑ Develop services based on client definitions of accessibility, cultural acceptability and availability of services;

❑ Increase multidisciplinary research on the health of people of color and Native communities with special attention to women within these groups. The current lack of sex and race desegregated data hinders the development of health policies and programs;

❑ Review and carefully analyze the potential impact of all their policies and programs on marginalized groups; take steps to prevent any negative consequences; and ensure that policies contribute to the communities health;

❑ Take stronger measures to eliminate discrimination against girls in access to food, education and health services, through social and public education programs, legislation and resource allocation;

❑ Design and implement policies and programs to meet the social, economic and health needs of the growing and changing immigrant population in Canada;

❑ Encourage healthcare and academic institutions to train and equip healthcare workers at all levels to help prevent, identify and treat healthcare needs based on cultural norms. Training should be improved for all healthcare providers including interpersonal and communication skills and counselling, incorporating user and gender perspectives that emphasize sensitive and respectful care as well as technical competence.

PRIMARY HEALTH CARE REFORM

Primary health care is the cornerstone of the health care system. Over the last twenty years the variety of health services and health practitioners has blossomed. Today, Canadians have a great deal of choice when it comes to addressing their health concerns.

The family physician plays a central role as gatekeeper but an increasing number of Canadians are utilizing and benefiting from the services of "non-medical" health practitioners. An April 2000 Ipsos/Reid survey revealed that "half of Canadians have accessed complementary health care services at some point in their lives". We can expect the trend to continue. Estimates of the 1996-1997 period indicated that Canadians spent approximately $3.8 billion (out-of-pocket) on complementary health care (Ramsay, 1998).

Although members of the Black community are very open to "non-medical" or complementary forms of health care, their utilization rate is low compared to White Canadians. This is largely due to financial barriers. The majority of complementary health care services receive limited or no coverage by provincial health insurance plans. Furthermore, many employers with extended health care plans either have no coverage or limited coverage for these same complementary health care services. As a result, despite their clinical competency, and cost-effectiveness, many in the Black community do not truly benefit from their services. Further incorporating the services of dietitians, chiropractors, midwives, and other regulated health professions into primary health care and providing adequate coverage is essential to minimize financial barriers.

Canadian citizens are lighting the path for government. Primary health care reform calls for greater utilization of non-medical, regulated health professions, which have demonstrated clinical competency, cost-effectiveness, and patient satisfaction. The 'new model' of primary health care is a regional, multidisciplinary, network of health professionals and facilities, providing high quality, accessible, accountable and cost-effective health care.

The goal of each "Health and Wellness Network" (HWN) is to optimize the health outcomes of the citizens it serves. The selected health outcomes must be based on a comprehensive needs assessment conducted in the community. Therefore, it is the community that determines what its needs are and if they are being met. In addition, members of the community are involved in the management of their HWN at the board level.

A HWN would be operating effectively if it shows a steady rate of improvement with respect to specific, targeted, health outcomes. For example, consider a HWN that serves a community of 350,000 individuals. In year one 2% require kidney dialysis, 9% chemotherapy for lung cancer, 8% low birth weight babies, etc. In year two these percentages decrease to 1.5%, 7.6% and 6.9% respectively. Each year a HWN shows an improvement in health outcomes, it receives a "health bonus", in addition to baseline funding. The "health bonus" can then be spent on new diagnostic equipment, research projects, outreach programs, and a financial bonus to the health practitioners within the HWN. At all times the focus must remain on health and wellness. This will help make wellness profitable.

Since the mandate of each regional HWN is to improve the health outcomes of the people it serves, it necessitates using culturally and linguistically appropriate health promotion, education and intervention programs. Each HWN competes against itself. Those that serve poor areas would receive additional funding for health education and outreach programs to increase utilization rates.

THE FEASIBILITY AND SUSTAINABILITY OF CANADA'S HEALTH CARE SYSTEM

Studies have shown that the single most effective way to reduce health care costs is through effective health promotion and prevention programs. Priorities must include understanding the causes of illnesses by examining research and data. This will determine the source of costs and aid in the development and implementation of preventive strategies. We know that the solution to our health care system is not simply to spend more on health care. If that were the case, the United States, which spends the most money on health care (13% of GDP) would have the best population health outcomes. The key is where the money is spent and the effectiveness of health care programs.

There has been minimal activity in the integration of health promotion and disease prevention strategies in the health care system as a whole. There is a definite lack of health promotion and disease prevention programs targeted for the Black community. A national effort is required to initiate effective programs in order to raise awareness of the importance of wellness and health promotion among all Canadians.

Despite the fact that many industries survive on a steady flow of sick and dependent people, we must develop the will to make wellness profitable. When health care is commodified, as it often is when healthcare is privatized, the priority is on making money by managing disease and creating long-term drug dependence, instead of creating conditions for good health and promoting healthy lifestyles. This is one reason privatization of health care is not the answer.

As we shape the future of health care in Canada, the new and improved system must include race and culture specific initiatives. Certain aspects of these initiatives may not seem financially profitable – at least not in the short-term. For example, developing and testing health education tools, conducting needs assessments, and "grass roots" community level interaction have a high demand on both human and financial resources. As such, private, "for profit" institutions will not "buy-in" or commit to the development, implementation, follow-up and evaluation of such programs.

Canada's health care system must be funded by all levels of government. Carefully selected partnerships can and should be made with health and social agencies provided the principles and values of Canada's health care system is neither ignored nor jeopardized.

Directing Canadians to lead healthier lives is the answer to the financial sustainability of the Canadian health care system. If government has the will, aggressive public education in partnership with legislation, can change attitudes and behaviour. The use of seat belts and smoking cessation are two examples.

Funding health care can be likened to retirement saving. Invest a little now to reap great rewards in the future. Year after year, as a greater percentage of Canadians, of all ages and backgrounds, adopt healthier lifestyles - there will be a marked decline in the percentage of Canadians requiring kidney dialysis, cancer treatment, undergoing bypass surgery, treatment for HIV and AIDS, delivering low birth weight babies and so on. This will yield millions of dollars saved and a better quality of life for Canadians. This will be a definite win - win situation.

ROLE OF THE FEDERAL GOVERNMENT

There are numerous models of health care worldwide. We can learn from their success and failures. At all times, Canadians have the right to self-determination as a sovereign nation. Canadians value the right to dictate what is best for Canadians. The federal government must play a strong leadership role as defender and promoter of Canada and Canadians. The federal government must build unity and cooperation among the provinces and territories, as we share a common vision for Canada.

The federal government is best equipped to set guidelines, and health care policies to ensure accountability and adherence to the objectives and goals. Canadians do not want to see 'finger pointing' between the federal and provincial government surrounding the health care system. It is time for cooperation and time to make firm, long-term commitments that will instill confidence and security in health administrators, health practitioners and Canadians. It is time to take the necessary steps to ensure an equitable, inclusive, high quality, and accessible health care system is in place to guarantee the health of the nation for today and tomorrow.

The federal government can protect our cherished programs from international agreements which may cripple our ability to ensure Canadians receive high quality health care. In essence, the health of Canadians and our health care system must be a sacred trust, a covenant that will not be broken. Canadians will hold the federal government accountable for any transgressions.

A NATIONAL VISION OF HEALTH AND WELL-BEING

Today, most Canadians can remember the 'Participation' campaign which encouraged Canadians to be physically active and eat a balanced diet. Today, if you watch one hour of prime time television you are likely to see half a dozen commercials focusing on pain and symptom relief but none on healthy living. Where is our focus? What is our vision of health for Canadians? The federal government must use all resources at its disposal to disseminate and communicate the vision of health and well-being to Canadians.

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<u>**APPENDIX A**</u>

Immigrant Population by Place of Birth and Period of Immigration

Immigrant Population by Place of Birth and Period of Immigration, 1996 Census Canada.

Place of Birth	Current Total Population	Before 1961	1961-1970	1971-1980	1981-1990	1991-1996
United States	244,695	4.3%	6.4%	7.4%	4.2%	2.8%
Central and South America	273,820	0.6	2.2	6.8	9.7	7.3
Caribbean and Bermuda	279,405	0.8	5.7	9.6	6.6	5.5
United Kingdom	655,540	25.2	21.3	13.3	5.8	2.4
Other northern and Western Europe	514,310	26.9	11.5	6.0	4.4	3.1
Eastern Europe	447,830	16.6	5.2	3.2	10.2	8.5
Southern Europe	714,380	21.6	31.0	13.2	5.3	5.0
Africa	229,300	0.5	3.3	5.8	5.9	7.3
West-central Asia and the Middle East	210,850	0.5	1.9	3.1	7.1	7.9
Eastern Asia	589,420	1.9	4.9	10.5	15.8	24.3
South – east Asia	408,985	0.2	1.8	11.2	14.9	11.4
Southern Asia	353,515	0.4	3.7	8.1	9.1	13.5
Oceania and other	49,025	0.4	1.2	1.5	0.9	1.0
Total	**4,971,070**	**100%**	**100%**	**100%**	**100%**	**100%**
Source:	*Statistics Canada, 1996 Census <u>Nation</u> tables*					

BLACK HEALTH ALLIANCE

Inquires or responses to the Black Health Alliance
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