

Improving access to healthcare: *Learning from Toronto*



**A report by the BME Health Forum
December 2009**

Cover picture: a collage of pictures taken during the visit. Centre picture: a plaque at Parkdale Community Health Centre in Toronto. © BME Health Forum 2009

Acknowledgements

The Black and Minority Ethnic (BME) Health Forum would like to thank Across Boundaries in Toronto for co-ordinating the Forum's visit. In particular, we would like to thank Aseefa Sarang, Across Boundaries' Executive Director, for her support and help prior to and during the visit.

We would also like to thank all the Community Health Centres, community organisations and statutory bodies who participated in this study visit. They are: Access Alliance, Across Boundaries, Community Care Access Centre, Ethiopian Association, Local Health Integration Networks (LHINS), Midaynta Community Services, Ministry of Health and Long Term Care, Parkdale, SAPPACY, St Elizabeth's, TAIBU and Women's Health in Women's Hands.

The Forum would like to thank The Health Foundation for funding and making this visit possible through its Shared Leadership for Change – Improving the Quality of Healthcare for BME Groups Programme.

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Executive Summary

Purpose of the Visit

Members of the BME Health Forum steering group visited Toronto, Canada, to learn about a different system of delivering healthcare to an ethnically diverse population, and to identify examples of good practice that could be applicable in the UK. The trip was funded by the Health Foundation as part of a leadership development programme.

Main Learning Points

Whilst we visited several models of healthcare provision, the model that impressed us the most, and we learned the most from, was the network of Community Health Centres (CHCs). These are voluntary organisations that offer local people a number of services including health services. They are specifically aimed at communities that face barriers in accessing primary care through family physicians. Because they are multi-disciplinary, they support clients not only by providing clinical services but also by dealing with the social, environmental and economic determinants of health. CHCs are community led, accessible (e.g. they use interpreters, offer services to those without documents) and work under explicit anti-oppression policies. Furthermore, the funding agreements for CHCs allow for a considerable degree of flexibility which enables CHCs to respond to the needs of new arrivals very quickly.

The evidence suggests CHCs are cost effective in improving access to healthcare because they reduce hospital admissions, reduce inappropriate referrals and make effective use of non-physician clinicians such as nurses. Furthermore, CHCs show improved outcomes particularly in terms of health promotion and disease management.¹ Consequently the CHC programme is currently undergoing a massive expansion. It is estimated that before the end of 2009 there will be 103 CHCs in the province of Ontario, nearly double the number of CHCs that existed in 2004.

Main Recommendations

Policy and Strategy

In order to reduce health inequalities successfully, policy and strategy need to adopt a community development based approach. This approach should include the following key elements:

- A focus on improving access as an outcome in itself
- A focus on user and community empowerment as outcomes
- A focus on partnership and working across disciplinary and departmental boundaries

¹ Yalnizyan & McDonald, *CHC cost Effectiveness: A Review of the Literature*, Association of Ontario Health Centers 2005, pp. 10-17; 49.

- A recognition of the timescales involved in addressing barriers to effective access to healthcare and other public services and a move away from an emphasis on measurable health outcomes as a short term objective and success indicator

Recommendations for NHS Commissioners

It is recommended that the following actions would support NHS Kensington and Chelsea and NHS Westminster in reducing health inequalities locally:

- Adopting community development objectives as an essential part of their programmes to reduce health inequalities. This might include:
 - Developing a pilot CHC in their areas, based on the principles described in this report.
 - Applying the key principles described above to existing initiatives, particularly in the programme to transform community services and in the local implementation of the polysystem model. Services that would suit well to being offered in a community setting are: therapeutic counselling, routine physical exams including smear tests and mammograms, vaccinations and pre-natal and post-natal care.
 - Incorporating in all commissioning and contract monitoring a recognition of the timescales involved in addressing barriers to effective access to healthcare and other public services, and moving away from a primary emphasis on measurable health outcomes as a short term objective and success indicator. Furthermore objectives relating to improved access and community empowerment should be incorporated as required outcomes.
- Writing tenders in a way that maximises the opportunities for the voluntary sector to bid.
- Building flexibility into funding regimes so that service providers can be more responsive to emerging needs.

Recommendations for Service Providers:

- The CHCs provide learning points for community based service providers. Service providers could become more effective by:
 - Implementing a multidisciplinary approach.
 - Working in partnership with the voluntary and community sector.
 - Adopting explicit anti-oppression policies. Such policies would help healthcare providers to meet their statutory duties to eliminate discrimination and to meet the Care Quality Commission's core standards (C7e, C13a).

Recommendations for the local voluntary & community sector (VCS)

- Create a stronger evidence base through community based research for the effectiveness of the local voluntary sector in addressing health inequality, improving health outcomes and reaching those in the community that the statutory sector finds hard to engage.

- Build capacity and infrastructure so as to be able to tender to deliver mainstream health and social care services, and make sure governance structures are robust.
- Explore possibilities for direct delivery of community-based primary care (e.g. salaried GPs, nurse practitioners, dieticians, counsellors and other health professionals).
- Continue to encourage and facilitate partnership development to create seamless services for patients/clients and reduce unnecessary duplication.
- Make it easier for those outside of the voluntary sector to engage with the sector. For example, provide a single point of contact for health professionals and the public to liaise with and find information about health activities offered by voluntary organisations.

Next Steps

To take the learning from this visit forward, a number of activities have been planned which have either taken place already or will do so in the near future. These include:

- The team will be presenting the findings and recommendations of this visit at policy and decision-making committees and partnership bodies, both locally (in Kensington & Chelsea and Westminster) and nationally (presentations have recently been made at London Strategic Commissioning Conference and The Health Foundation's Shared Leadership for Change – BME event).
- The team is organising visits to UK-based community-led health facilities to identify examples of good practice in the UK. As an example of this, the team will be carrying out a visit to the Bromley by Bow Centre on the 11th December 2009.
- As a result of its participation in the visit, the Kensington & Chelsea Social Council is currently developing a consortium of voluntary and community organisations based on the CHC model, to bid to manage NHS primary care clinics in Kensington & Chelsea.
- The BME Health Forum will be working in partnership with key voluntary and community sector organisations to support them in employing NHS GPs to provide services for people who experience difficulties accessing mainstream GP services.
- The BME Health Forum and all participating organisations will distribute this report to key policy and decision makers locally and nationally.

Introduction

The Black and Minority Ethnic (BME) Health Forum conducted a research project with BME Voluntary and Community Organisations (VCOs) in the boroughs of Kensington & Chelsea and Westminster (KCW) in 2005-2006. The main health priority identified by BME VCOs was access to GPs. Access was considered to be a complex issue encompassing problems with registration, interpreting but also interacting with GPs.²

In a second study by the BME Health Forum in 2007-2008, which interviewed BME residents in KCW, significant levels of dissatisfaction with GP services were found. Dissatisfaction centred mainly around communication issues, involving the language barrier and interpreting services but also problems which superseded these such as not feeling respected and not trusting the doctor.³ Ineffective GP consultations appear to result in a high proportion of repeat visits by BME patients which puts pressure on the NHS without ameliorating the poor health outcomes shown by BME communities.

The BME Health Forum is trying to tackle this problem by working with six local community groups as well as GP surgeries and dental practices to improve access to primary care. In this work, the Forum is aiming to identify examples of best practice which could be mainstreamed across the NHS. In order to achieve this, the Forum decided to research methods of tackling health inequalities in other countries with a similarly diverse population.

The Forum has also been participating in a programme funded by the Health Foundation, a charitable foundation working to improve the quality of healthcare across the UK and beyond. The Shared Leadership for Change – Improving the Quality of Healthcare for BME Groups is a leadership development scheme for teams of healthcare professionals working to improve the quality of healthcare for BME groups. The Forum is one of six teams in the UK who have received an award under this scheme. As part of the award, funds are made available to each team to enable them to participate fully.

The Forum decided to use some of this funding for an international visit to research alternative approaches to tackling health inequalities. After drawing up a comparison of four different cities (Berlin, Paris, Rome and Toronto), Toronto was selected as the destination most likely to be of use to the team. This decision was based on the fact that the Canadian health service appears to be more informed in terms of BME issues than the health services of France, Germany or Italy. The city of Toronto has an estimated 50% BME population which far exceeds the BME populations in Berlin, Paris and Rome. In addition, the Canadian health service shares many similarities with the NHS. The total population in the City of Toronto is 2.7 million.

² BME Health Forum, 'Minding the Gaps, Are BME groups partners or substitutes in health provision?' June 2006, <http://www.westminster-pct.nhs.uk/pdfs/MindingTheGaps.pdf>

³ BME Health Forum, 'Primary Concern, Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster', June 2008, http://www.westminster-pct.nhs.uk/pdfs/bme_Primary_Concern.pdf

The visit to Toronto took place between 27th May –1st June 2009. It was coordinated by a charity called Across Boundaries, a mental health centre for racialized communities (roughly the equivalent of what in Britain we call BME groups).⁴

Purpose of the visit

The purpose of the visit was to learn about a different system of delivering healthcare to a diverse population and identify examples of best practice that could be applicable in the UK.

In particular, areas of interest were:

- National policy and legislation
- Local health structures and governance
- The role of the voluntary and community sector in health delivery and promotion
- Structures for community engagement by health commissioners and providers
- Ways of improving access to primary care for a diverse population and the effect of this on health outcomes

The visit and the main learning points

1. The System

Healthcare in Canada is administered at national, provincial, municipal and local level. The national bodies responsible for health are Health Canada and the Public Health Agency of Canada (PHAC). Both of these agencies are involved with health promotion, disease prevention and carrying out public consultations. The PHAC is also responsible for emergency preparedness and response. Furthermore, PHAC uses grants to fund community, voluntary and not-for-profit organisations to support government policies and priorities, (e.g. the Physical Activity and Healthy Eating Contribution Program).⁵ PHAC currently has 20 Grants and Contributions programmes that fund approximately 1,500 projects across the country and account for almost 40% of PHAC's annual budget.⁶

At the provincial level, healthcare in Ontario is administered by the Ministry of Health and Long-Term Care.⁷ As the name suggests, it is responsible not only for healthcare but also for social care. Public Health, however, is administered at municipal level with the city of Toronto belonging to a single

⁴ The term 'racialized' is preferred by Across Boundaries compared to other common Canadian terms to describe the same communities such as 'people of colour' or 'visible minorities'. This term was recommended by the Ontario Human Rights Commission because it 'expresses race as a social construct rather than a description on perceived biological traits'. <http://www.acrossboundaries.ca/index.html>

⁵ <http://www.hc-sc.gc.ca/index-eng.php>; http://www.phac-aspc.gc.ca/pau-uap/fitness/pacp/rfp-2007_e.html

⁶ http://www.phac-aspc.gc.ca/about_apropos/what-eng.php . For a list of funded programmes see <http://www.tbs-sct.gc.ca/rpp/2008-2009/inst/ahs/ahs05-eng.asp>

⁷ <http://www.health.gov.on.ca/en/default.aspx>

municipality. Within Toronto, hospitals, long-term care facilities, community support services, community health centres and mental health agencies are commissioned by new local structures called the Local Health Integration Networks (LHINS).⁸ Within the Greater Toronto area operate five different LHINs. The LHINs were set up across Ontario to introduce increased localisation to service planning and delivery.

Primary care in Canada is delivered on the whole by family physicians (the equivalent of General Practitioners in the UK). Family physicians are directly funded by the Ministry of Health and Long-Term Care. Family doctors are independent providers who are paid according to a set fee per consultation or procedure. They have no legal obligation to provide interpreters for their patients, record ethnic monitoring statistics or collect satisfaction data from patients. They also have no legal obligation to register everyone within their catchment area.⁹

In contrast to family physicians, the LHINs are legally obliged to engage with their communities to find out what local services are required. For example, the Integrated Health Service Plan published in 2006 by the Central LHIN was based on widespread consultation with community groups in a series of public meetings. However, since primary care services are offered through family physicians funded directly by the Ministry there is no connection between issues identified by LHINs and family physician incentivisation. Furthermore, the LHINs usually only fund approved Health Service Providers and therefore would not be able to fund community groups to carry out health and well being activities such as healthy eating workshops etc.¹⁰ (Community organisations do carry out such activities but they are funded by the Ministry of Health and Long Term Care, the national or provincial government or other organisations).

Canada operates a system of universal healthcare free at the point of use. Nevertheless, to receive free healthcare residents need to demonstrate eligibility at the point of use by showing a health card to their health provider. This health card identifies them as being insured under a providential health insurance plan. All Toronto residents are covered by the Ontario Health Insurance Plan (OHIP) even if they are not Canadian citizens, as long as they are permanent residents, refugees or the spouse, same sex partner or dependent child of someone is covered and have been living in Ontario for at least 3 months. Some temporary residents are also covered, as are Canadian born children irrespective of their parents' status as long as they too have been living in Ontario for at least 3 months.¹¹ Non-status or undocumented

⁸Central LHIN health provider list.

http://www.centrollhin.on.ca/uploadedFiles/Home_Page/Connected_with_Care/July2009_CLHIN-HSPsList.pdf

⁹ A web page that provides information to newcomers about how to find a family doctor.
http://www.settlement.org/sys/faqs_detail.asp?faq_id=4000299

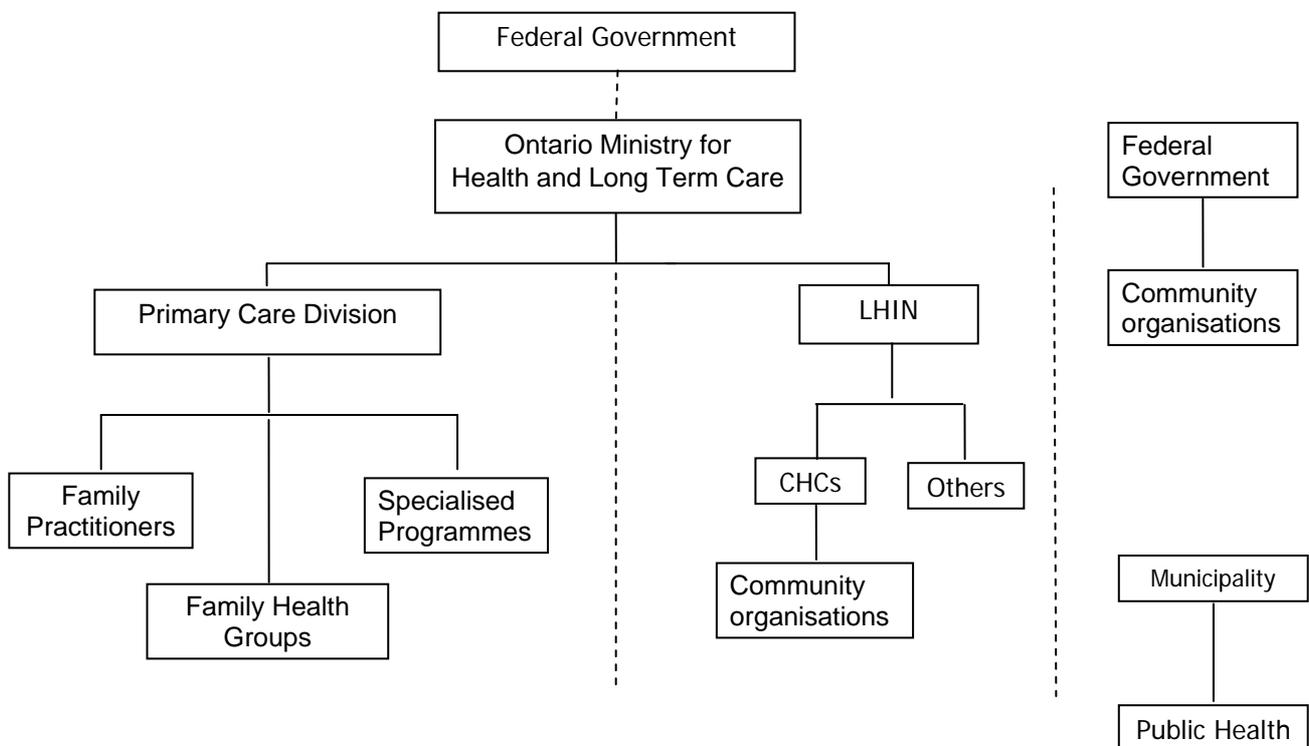
¹⁰ Although the Toronto Central LHIN appears to be funding some community groups.
http://www.torontocentrollhin.on.ca/uploadedFiles/Home_Page/About_Our_LHIN/Organizations%20Funded%202008%2007.pdf

¹¹ <http://www.parl.gc.ca/information/library/PRBpubs/prb0828-e.htm#immigration>
<http://www.health.gov.on.ca/english/public/pub/ohip/eligibility.html>

residents are not covered and neither are Canadian citizens who have been living in Ontario for less than 3 months (for example Canadian citizens who are returning from abroad). In addition, some Canadian citizens who are eligible to free healthcare are unable to receive it by the ordinary route because their health card is lost or expired (new OHIP cards expire after five years).

The presence of a significant population with no health card comprising of not only undocumented migrants but also Canadian citizens has made it necessary for the health authorities to provide channels for free access to healthcare which bypasses family physicians. The most common route for accessing primary care for these groups are the Community Health Centres (CHCs) which are voluntary organisations (and registered charities) funded almost exclusively by the statutory sector and which receive specific, ring fenced funding to service those with no health cards. Once a person has become a CHC client they can be referred for secondary care which will be billed to the CHC. In addition, all the other statutory and voluntary organisations we interviewed (which provide a variety of services including care for mental health issues, drugs and alcohol misuse and nursing and personal care) said that they offer at least some of their services to clients with no health cards.

Health structure in Ontario



Main Learning Points:

- The Ontario health service system offers joined up care in the areas of healthcare and social care. The LHINs and the Ministry of Health and Long-Term Care fund organisations whose primary role is healthcare such as hospitals and family physicians as well as organisations whose roles includes a strong social care element such as care homes and the community care access centres which provide care (nursing and otherwise) in people's homes.
- While healthcare and social care in Ontario seem to be very well joined up, other aspects of the system appear to be fragmented. While the LHINs were created in order to provide the health service with greater local control, their ability to carry this out is limited because important aspects of healthcare such as public health and family physicians are beyond their jurisdiction. Furthermore, because the LHINs fund approved health providers only, and do not provide any funds for community organisations (whose funding for health projects appears to come from the Ministry and from PHAC) they may be perceived to be a step removed from the community.
- The system of healthcards which on the surface would appear to be a system which excludes undocumented migrants from free healthcare provision has by the nature of its own restrictiveness provided the incentive to provide services targeted to those not in possession of a healthcard, including undocumented migrants.

2. The Community Health Centres (Access Alliance, Parkdale, TAIBU, Women's Health in Women's Hands)

Community Health Centres (CHCs) are voluntary organisations that offer clients in their locality a number of services including health services. They are specifically aimed at communities that face barriers in accessing primary care through family physicians. Because they are multi-disciplinary they support clients not only by providing clinical services but also by dealing with the social, environmental and economic determinants of health. They receive their core funds from the LHINs but some also receive grants from other public bodies as well as charitable donations.

The CHC model is about 20 years old, but the number of CHCs is expanding. It is estimated that before the end of the year there will be 103 CHCs (including satellite CHCs) in Ontario. This is nearly double the number of CHCs that existed in 2004. In the area of the Toronto Central LHIN, CHCs have 75,422 clients, including 9,001 uninsured clients and 3,390 homeless clients while 49.5% of their clients earn less than \$20, 000 per year. Furthermore, many clients have very complex needs –in 2006/2007, 8,000 CHC clients saw more than 4 health professionals in a single visit.¹²

¹² *Ontario's Community Health Centres. Everyone Matters. Who we are and what we do*, March 2008, pp. 12-14. <http://www.aohc.org/aohc/index.aspx?CategoryID=71>

Some key points that were shared by all the community health centres we visited were:

- Working with undocumented migrants
- Having explicit anti-oppression policies
- Conducting research to support their work
- Being community led e.g. users among trustees
- Being multidisciplinary -teams usually include chiropractors, community development workers, dieticians, doctors, health promoters, nurses and social workers
- The health professionals employed are salaried rather than paid by fee for service
- The CHCs' performance management and evaluation framework is grounded in access and wider determinants objectives, not medical interventions

In addition, the community health centre model includes the following values:

- Offering comprehensive, coordinated primary care, encompassing primary care, health promotion and illness prevention
- Being accessible to their communities (for example, offering interpreters)
- Being client and community centred
- Being integrated with other health and social services.
- Dealing with the social determinants of health
- Operating with a community development approach¹³

Many CHCs run projects that are only indirectly related to health. For example, the Regent Park CHC runs a programme targeted at decreasing school drop out rates for academically at risk students and has achieved a 60% decline in dropout rate as well the doubling in the number of young people who attend post secondary institutions.¹⁴

A Community Health Centre in detail - Access Alliance

Access Alliance works with immigrants and refugees from the wider Toronto area and focuses on the newcomers' population.¹⁵ The health services they provide include:

- Preventative health care – screening, teaching and education
- Health education – healthy lifestyle, diabetes management, sexual health care and family planning counselling, well mother and baby, breastfeeding support
- Therapeutic counselling – mental health and family services
- Routine physical exams including annual health checks
- Immunisation for children and adults
- Assessment and treatment of acute episodic illness
- Ongoing management of chronic disease

¹³ Ontario's Community Health Centres. *Everyone Matters. Who we are and what we do*, p. 7.

¹⁴ Ontario's Community Health Centres. *Everyone Matters. Who we are and what we do*, p. 22.

¹⁵ In Canada, the word 'immigrants' rather than 'migrants' is used.

- Pre- and post-natal care and well-baby care
- Triage service for urgent client problems
- Nutrition assessment: diabetes management, cholesterol management, weight management, pre-natal nutrition, child nutrition and food security
- After hours phone consultation

They also take part in a number of activities related to healthcare:

- A project promoting the use of interpreting services in Primary Care
- Community-Based Research on Newcomer Urban Health¹⁶
- Offering fee-for-service health care interpreting in the Greater Toronto Area. This service is an income generator
- Campaigning for improved access to healthcare services

Access Alliance also offer a number of services which are not directly related to healthcare but which contribute to their clients' well being such as:

- Settlement Services including information, orientation, support and advice to newcomers
- Advocacy and Community Action. Access Alliance is a member of a number of networks campaigning for rights for non-status people
- Capacity Building for Immigrant Service Providers, including: what services are available to those without status, training to become an interpreter, capacity building to become more accessible to Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ)¹⁷ refugees and immigrants, increasing newcomer access to food banks and developing culturally appropriate service delivery models

Access Alliance also demonstrated that it was able to respond rapidly where a new need was discovered. When 68 Karen refugees (granted emergency refugee status by the Federal government) arrived in the summer 2006, Access Alliance was able to partner with the immigration services to ensure that the refugees received emergency screening and an X-ray within 24 hours of arriving. In the following 10 days staff from Access Alliance carried out full physical examinations. The refugees were also offered enrolment in skills building programmes.

This intervention demonstrates that CHCs enjoy considerable flexibility by their funders who do not require detailed advance information on how their funds will be spent.

Parkdale

Parkdale is a CHC which operates according to locality rather than target a specific population. Besides health activities, Parkdale run groups that have a social and educational purpose such English conversation club, trips out for

¹⁶

http://www.researchforchange.ca/index.php?option=com_content&task=view&id=35&Itemid=63

¹⁷ These are the terms used by the organisation.

elders, summer camps for kids (in partnership with Scouts), parenting skills courses, professional childcare training for young mums and an ID clinic to support people gain documentation including the OHIP card. They also run regular focus groups and surveys of users which foster a sense of ownership among service users. All programs are community led.

Parkdale also run a Community Crisis Response and Recovery Programme as a result of the murder of a child in the community. The child's guardians, who murdered the child as well as the birth family were Parkdale clients. The murder affected many people in the community and Parkdale developed this programme to respond to the crisis.

TAIBU

TAIBU is a newly established CHC which serves a geographical area in the Malvern neighbourhood of Scarborough, but also has an additional mandate to develop and deliver specialised programs and services to the Black community. The establishment of TAIBU was sponsored by Black Health Alliance, an umbrella organisation comprised of individuals and organisations working in partnership to address the health and wellbeing of the Black community.

The comprehensive primary healthcare services include clinical services provided by physicians, nurse practitioners, a chiropodist, a social worker and a dietician. The emphasis of its service delivery is health promotion and disease prevention and it has a community team comprising of health promoters, community health workers and outreach workers delivering health promotion programmes in the community. The programmes include: chronic disease self management training, programmes on sexual health and mental health & addictions, anti-bullying programmes in schools, Seniors TAI CHI/Yoga, young men's group, early years development programmes, community kitchens, diabetes prevention project and other community development initiatives.

Women's Health in Women's Hands (WHIWH)

WHIWH is a CHC that provides services to black women and women of colour across the wider Toronto area.¹⁸ It offers extensive primary care services including annual health checks, breast exams, cervical smears, mental health counselling, family planning, abortion and sexuality counselling, and education around diabetes and high blood pressure. It also offers counselling in the clients' language of origin. All services are free with the exception of birth control and orthotics. Between 65% and 70%, of their clients are undocumented migrants. As of June 2009, WHIWH has over 2000 active clients and is currently closed for medical services, as it cannot take any more clients.

The centre also offers yoga, gardening, counselling with referrals to other relevant agencies, exercise, a two-day per week food bank for emergency

¹⁸ The term 'women of colour' is self-defining and includes women from Africa, the Caribbean, Latin America and South Asia. The clients at WHIWH have to be older than 16.

provisions and recipes and information on healthy eating. The centre supports women and children who are victims of domestic violence and runs a community kitchen, which can be used by women learning about nutrition. Clients also have access to a housing worker for one day per week. WHIWH also raise awareness on the issues of food security and its impact on community health.

WHIWH runs focus groups with target communities to help design the services and disseminate educational materials across the various communities. It also uses surveys and post evaluation feedback.

The staff who work in WHIWH are almost exclusively women of colour. The composition of the Board also represents the priority population and includes some former service users.

Main Learning Points

There is evidence that the CHC model works and is cost effective in comparison to Fee For Service primary care providers such as family physicians. In a meta- analysis of available research studies on the cost effectiveness of CHCs, cost effectiveness was shown to be achieved in CHCs by reduced hospital admissions, reduced inappropriate referrals (partly attributed to employing salaried clinicians), and by making effective use of non-physician clinicians such as nurse practitioners.¹⁹ Furthermore, CHCs show improved outcomes particularly in terms of health promotion and disease management.²⁰ Consequently the CHC programme is currently going through a massive expansion.

The success of the CHCs indicates that rather than focusing exclusively on mainstream GP practices as the sole route for access, it may be more cost effective if the NHS were to invest in separate structures which specifically tackle access for vulnerable populations.

Why do CHCs work?

- They offer healthcare to those who cannot access it by other means. They therefore prevent the situation where vulnerable populations are deprived of healthcare thus causing human suffering and increased hospital admissions, and risking public health
- The CHC approach is based on a community development model. This includes operating anti-oppression policies, being governed by boards made up of local people including former clients, providing capacity building for other groups and taking a holistic and multidisciplinary approach as central to their work programme
- Whether locality based (like Parkdale and TAIBU) or population based (like Access Alliance and WHIWH) they tailor their services to suit those in greatest need. This includes using interpreters, offering

¹⁹ Yalnizyan & McDonald, *CHC cost Effectiveness: A Review of the Literature* , Association of Ontario Health Centers, 2005, pp.10-17.

²⁰ Yalnizyan & McDonald, *CHC cost Effectiveness: A Review of the Literature*, Association of Ontario Health Centers 2005, p. 49.

counselling in mother tongue, and offering appropriate clinical and complementary therapies

- They are flexible and able to respond to need as it arises
- Besides primary care services, they also offer services which target the social determinants of health
- They conduct research which means they are able to offer evidence about the kind of services that are required

3. Nursing & Social Care (St Elizabeth's & the Community Care Access Centre)

The LHINs administer the care people receive in their homes through organisations called Community Care Access Centres (CCACs). Staff from the CCACs interview all hospital patients before they are due to be discharged and set up a care package for those in need. Such care includes nursing, personal support, social work, and both short term and long-term services. The CCAC programme has over 500 staff, of whom 400 work in neighbourhoods across the city and 100 are on site in hospitals (around 26 sites). The CCAC also has rehabilitation facilities for which they are responsible and social care and day care programmes for older people.

Care from the CCACs is funded through a co-payment system for those who can afford home care. Basic care is free and extras, like hairdressing or private rooms require payment. Supported housing and retirement living, are also available. Generally, CCACs aim to keep people at home for as long as possible.

St Elizabeth

St. Elizabeth provide care delivered in the home – nursing, social work, bathing, attendant care, health promotion - and they also work in schools. They provide access to home care to all individuals wherever they are, for example, a nurse can accompany a sick child to school and assist the child throughout the school day. Interpreters are used when necessary. Most of the work for St Elizabeth's comes from the CCACs.

St. Elizabeth has had a mental health programme since 1991, the aim of which is to prevent re-admissions and achieve successful discharge through extended support at home. The original envelope of funding for this project was for six weeks of care per patient. This was found to be insufficient, so a secondary support programme has been designed which includes compliance, addressing the side effects of medication, links to social activities and links to long term care management packages.

Main Learning Points

Social Care in Canada seems to be very well integrated with health care.

4. Mental Health and Drug and Alcohol Misuse Services (Across Boundaries and SAPPACY).

Across Boundaries

Across Boundaries is a mental health centre for people from racialized communities who are experiencing severe mental health problems and /or addiction. Referrals are made either by the clients themselves or by a service provider. Case management is intensive and provides a multiple of functions including assessment, counselling, client advocacy, linking with other services, skills development, health teaching and family support and education. Furthermore the centre offers a variety of other services including alternative healing (traditional Chinese and Indian medicine), art, music and theatre therapies, support groups and skill building groups (for example, ESOL, literacy, computer training, cooking classes). There are also social events and community meetings attended by both staff and clients. The centre also runs outreach programmes for the Afghan, Tamil and Somali communities. Psychiatrists working with the centre conduct educational sessions with both staff and clients. The centre also conducts community based research in partnership with other organisations.

Across Boundaries also offers specialised services for clients involved with the criminal justice system and with youth. The Y-Connect programme for 15-24 yr olds works with an open door policy, recognising that young people in minority communities who have mental health problems are unlikely to seek help from their family doctor. The service focuses on building trust and promoting small steps towards mental well-being. As the service users become better able to acknowledge psychological problems, other services are offered such as psychological counselling and anger management.

The Mental Health and Justice Initiative works with clients currently involved with the criminal justice system and uses an intensive case management approach to work with clients and the full range of services with which they are involved. The case worker often operates as the client's advocate and takes on the role of telling the client's story across these agencies.

SAPPACY (Substance Abuse Prevention Program for Afro-Canadian and Caribbean Youth)

SAPPACY is a service based within the Centre for Addiction and Mental Health (CAMH), Canada's largest mental health and addiction teaching hospital.²¹ SAPPACY work with black youth and their families to provide them with treatment, early intervention and prevention services related to problem substance use. The service works primarily with young people who have substance misuse problems, in addition to those who have both substance misuse and mental health problems. Services are community based and are delivered at a location of the client's choosing. SAPPACY's services are holistic and attend to the broader social determinants of health for Black people.

²¹ http://www.camh.net/About_CAMH/index.html

Main Learning Points:

- Mental Health services in Toronto are well integrated with Substance Misuse services thus providing dual diagnosis clients a service for all their needs.
- Across Boundaries works on the same model as CHCs and is therefore able to offer its clients many of the same benefits –a holistic service which deals with the social determinants of mental health as well as the particular needs associated with mental illness and substance misuse.
- Services directed specifically at BME communities appear to be more effective in providing a service to these communities than mainstream services.

5. Community Settlement Organisations (Midaynta and Ethiopian Association)**Midaynta Community Services**

Midaynta Community Services is a social and settlement services agency. It is open to all communities but it originates from the Somali community. The main services it offers are information and legal advice around immigration issues and obtaining documentation, housing support and employment services. It has also been commissioned by CAMH and COSTI immigration services to carry out research into gambling addiction in the Somali community.²² They also offer a Seniors programme which is funded by United Way, a large charity which funds a network of 200 organisations including Access Alliance and other CHCs.²³

Ethiopian Association in the Greater Toronto Area and Surrounding Regions

This is a large voluntary organisation with an annual turnover of approximately 1.5 million dollars. Its core funds come from Citizenship and Immigration Canada but it also receives funds from other bodies including the Ministry of Health and Long Term Care which funds a social club for seniors and an HIV/AIDS prevention programme. Its services are open to everyone although the majority of their clients are Ethiopian. It provides advice (legal, immigration housing), social activities, health services (Counselling, Drugs and HIV prevention), interpreting and translation services and education services (ESOL classes, employment). There are childminding facilities for those attending classes and programmes. There are also services targeted specifically at women and for young people. Services for undocumented migrants are funded from the providence rather than the federal government.

Main Learning Points:

BME organisations in Toronto appear to be very centralised. There appears to be only one organisation per community for the whole Toronto area - one Somali organisation, one Ethiopian organisation etc. These organisations are

²² Costi is a very large organisation with 14 offices in the Toronto area offering services to newcomers populations. It originates from two Italian organisations which amalgamated in 1980. <http://www.costi.org/whoweare/history.php>

²³ <http://www.unitedwaytoronto.com/whatWeDo/communityFund.php>

well resourced with public funding and offer 'settlement services' which are open to all communities. Some organisations also have a system of associations –e.g. the Greek Community of Toronto works with about 150 local associations in the Toronto area.²⁴

Additional Issues:

- **Explicit Anti-racist Language**
The CHCs and other organisations employ explicit anti-racist language.
- **Annual Health Checks**
All Canadian residents are invited once a year to have a complete health check. The appointment lasts an hour and involves a head to toe examination including a breast exam, cervical smear, urine and blood tests. CHCs provide annual health checks to their clients.
- **211**
In Ontario, the phone number 211 provides information to all community, health, social and other related public services.²⁵
- **BME Staff**
Many organisations employ BME staff in leadership positions. For example, nearly all the staff employed by Women's health in Women's Hands were BME women. They told us that when advertising a position they were able to state that a female candidate from a visible minority would be preferred. Under the Canadian Employment Equity legislation preferential treatment in employment practices for certain designated groups: women, people with disabilities, Aboriginal peoples, and visible minorities is permitted, however this only applies to federal organisations.²⁶ The province of Ontario used to have similar legislation but it was repealed two years after its introduction.
- **Resources**
All organisations in Toronto appear to be very well resourced in terms of space, staff and funding.

Conclusions and recommendations

There is considerable evidence that barriers to accessing health and other public services have a significant impact on exacerbating health inequalities among excluded and marginalised parts of the population. Consequently, interventions intended to reduce health inequalities need to focus on improving access to health care and other public services.

The CHC model in Canada illustrates that a community development approach can be highly effective in improving access to primary health care and other public services, for marginalised groups in the population. This approach leads to improved health experiences and improved health outcomes for these groups and reduces the burden on secondary care. Furthermore, investing in an accessible system which provides an alternative route to health care from mainstream GP practices may be more effective

²⁴ http://www.ocasi.org/membership/OCASI_Online_Directory.pdf

²⁵ <http://www.211toronto.ca/splash.jsp>

²⁶ http://en.wikipedia.org/wiki/Canadian_Employment_Equity_Act

than concentrating all resources in improving access at GP practices. It is therefore recommended that health policy makers, commissioners and providers of services (including the third sector) consider how this approach can be incorporated into their area of responsibility.

(a) Recommendations for Policy and Strategy

In order to reduce health inequalities successfully, policy and strategy need to adopt a community development based approach. This approach should include the following key elements:

- A focus on improving access as an outcome in itself
- A focus on user and community empowerment as outcomes
- A focus on partnership and working across disciplinary and departmental boundaries
- A recognition of the timescales involved in addressing barriers to effective access to healthcare and other public services and a move away from an emphasis on measurable health outcomes as a short term objective and success indicator

(b) Recommendations for NHS Commissioners

Local PCTs, and specifically NHS Kensington and Chelsea and NHS Westminster could become more effective by:

- Developing a pilot CHC in their areas, based on the principles described above.
- Considering how to apply the key principles described above to existing initiatives and especially the programme to transform community services and in local implementation of the polysystem model.
- Considering whether they can cooperate to offer more specialised services in a community setting. Services that would suit well to being offered at a community setting are: therapeutic counselling, routine physical exams including smear tests and mammograms, vaccinations and pre-natal and post-natal care.
- Adopting community development objectives as an essential part of their programmes to reduce health inequalities and work in partnership with their local authorities to support the capacity of the community sector in their areas.
- Incorporating in all commissioning and contract monitoring, a recognition of the timescales involved in addressing barriers to effective access to healthcare and other public services, and move away from a primary emphasis on measurable health outcomes as a short term objective and success indicator. Furthermore objectives relating to improved access and community empowerment should be incorporated as required outcomes.
- Writing tenders in a way that does not exclude the voluntary sector from bidding.
- Building flexibility into funding regimes so that service providers can be more responsive to emerging needs (as in the example from Access Alliance which was able to respond to the arrival of Karen refugees almost immediately).

c) Recommendations for Service Providers

Elements of the community health centres could be learning points for community based service providers. Service Providers could become more effective by:

- Implementing a multidisciplinary approach. The multi-disciplinary team approach described here is similar to the direction that health providers are expected to be taking as outlined in the Darzi Review and World Class Commissioning.
- Working in partnership with the voluntary and community sector. As commissioners are frequently expecting healthcare providers to engage with their local communities, this model of being community-led could be the basis for providers to truly engage and understand the health needs of their patients and those facing health inequalities. Being community-led in the development of new services by healthcare providers could demonstrate flexibility and innovation within tenders for health services.
- Adopting explicit anti-oppression policies. Such policies would help healthcare providers to meet their statutory duties to eliminate discrimination and to meet the Care Quality Commission's core standards (C7e, C13a).

(d) Recommendations for the local voluntary & community sector (VCS)

- Create a stronger evidence base through community based research for the effectiveness of the VCS in addressing health inequality, improving health outcomes and reaching those in the community that the statutory sector finds hard to engage.
- Build capacity and infrastructure so as to be able to tender for projects such as the management of primary care facilities and mainstream health and social care services; make sure governance structures are robust.
- Provide primary care services by employing salaried GPs, nurse practitioners, dieticians, counsellors and other health professionals.
- Make it easier for those outside of the VCS to engage with the sector. For example, provide a single point of contact for health professionals and the public to liaise with and find information about health activities offered by VCOs (such as the "211" phone number in Toronto).

Visit delegation

Delegate's name	Job Title	Organisation
Amjad Taha	Manager	BME Health Forum
Brian Colman	Head of Equality, Diversity and Human Rights	NHS Westminster
David Truswell	Focused Implementation Site Manager	Central and North West London NHS Foundation Trust
Isis Amlak	Good Practices for Access & Well-being Programme Co-ordinator	BME Health Forum / Migrant & Refugee Communities Forum
Judith Blakeman	Councillor	Royal Borough of Kensington & Chelsea
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Supported by



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