LEVEL
YOUTH POLICY PROGRAM

POLICY BRIEF

The Language of Universal Health:

Equitable Accessibility and Quality of Canadian Healthcare for Racialized Immigrant Communities

JULIA CHAI

The LEVEL Youth Policy Program takes place on the traditional and unceded territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) & səl̓ilwətaʔɬ (Tsleil-Waututh) Coast Salish peoples.

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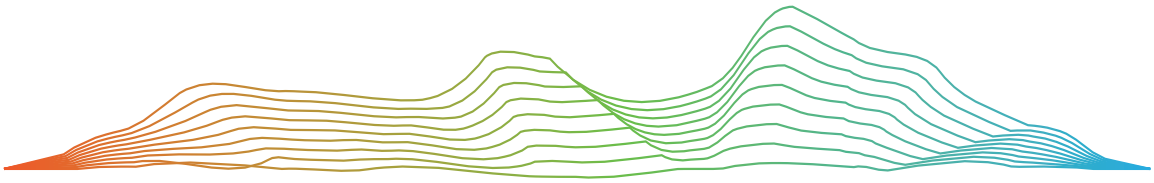
Contents



About the LEVEL Initiative

LEVEL is a youth engagement initiative of Vancouver Foundation that aims to address racial inequity. We do this by investing in the leadership capacity of Indigenous, racialized, immigrant, and refugee youth to create more opportunities throughout the non-profit and charitable sector.

Despite being the fastest-growing youth populations in British Columbia, Indigenous, immigrant, and refugee youth don't have the same opportunities as other young people. Race continues to be a factor that hinders their ability to have a say in decisions that impact their lives.

LEVEL empowers these youth by building their capacity to challenge and change those systems that hinder their ability to build a more just world.

LEVEL consists of three pillars of work to advance racial equity

1. LEVEL Youth Policy Program
2. LEVEL Youth Organizing
3. LEVEL Youth Granting

About the LEVEL Youth Policy Program (LEVEL YPP)

The LEVEL Youth Policy Program (LEVEL YPP) brings together young people between the ages of 19 and 29 from across British Columbia who identify as being Indigenous or racialized immigrants or refugees. Indigenous and racialized Newcomer youth are disproportionately impacted by certain public policies but are rarely included in the development and implementation of public policy process. The LEVEL YPP aims to provide these youth with equitable training and leadership opportunities to better navigate the public policy landscape, and to develop new tools and skills to influence, shape, and advocate for policy changes that are relevant in their own communities. Having young people directly involved in shaping policies that impact their lives is essential to creating systemic, meaningful change. The LEVEL YPP's training is grounded from and within Indigenous peoples' worldviews, which the program acknowledges, could vary from person-to-person or nation-to-nation. Indigenous worldviews place a large emphasis on connections to the land. This perspective views the land as sacred; where everything and everyone is related and connected; where the quality of the relationships formed are key in life; where what matters is the success and well-being of the community, and where there can be many truths as they are based on individual lived experiences.[1] As such, an important premise of this training is to centre and place a particular focus on the fact that the work that has gone into developing this training, as well as the training itself, has taken and will take place on unceded (never given away/stolen) territories of the hən̓q ̓əmin ̓əm̓-speaking Musqueam peoples, of the Halkomelem-speaking Tsleil-Waututh peoples, and of the sníchimspeaking Sḵwx ̱wú7mesh (Squamish) peoples.

1. https://www.ictinc.ca/blog/indigenous-peoples-worldviews-vs-western-worldviews

Biography

Julia Chai

Julia Chai (채주은) is a first-year medical student pursuing her Doctor of Medicine (MD) degree at the University of Calgary, and a Korean-Canadian first-generation immigrant. She also holds a Bachelor of Sciences (BSc) from the University of British Columbia (UBC).

Julia is passionate about addressing race, gender, and socioeconomic inequities in healthcare and disproportionate social determinants of health in under-served populations. With an interest in public health policy, she believes in the power of activism and challenging current institutional systems of thought and function through advocacy, story-telling, innovation, and accountability. Over the past few years, she has researched patient safety and adverse events in multiple-sclerosis treatment and advocated for greater equity, inclusion, and diversity in post-secondary institutional education on multiple boards and representation bodies as a student advocate.

She is currently located on the traditional territories of the Blackfoot Confederacy (Siksika, Kainai, Piikani), the Tsuut'ina, the Îyâxe Nakoda Nations, and the Métis Nation (Region 3) of the Treaty 7 region of Southern Alberta. Julia calls both the Musqueam territory in British Columbia (Vancouver, BC) and Treaty 7 region (Calgary, AB) her home.

You can follow her on Twitter: @juliachai_ or on LinkedIn: https://www.linkedin.com/in/julia-chai/

Executive Summary

The experience of racialized patients with low or no English proficiency in the healthcare system is largely different than what most may endure.

Language concordance between the patient and provider ensures effective communication, and communication is a key contributing and differentiating factor toward quality of care and patient safety. Differences in shared language have also indicated lower satisfaction rates for patients, increased risks of safety from miscommunication, increased risk of patient confidentiality and privacy, and increased medication errors among other outcomes. Literature also reveals that the language barrier alone is the most significant barrier to initial health accessibility in Canada.[2]

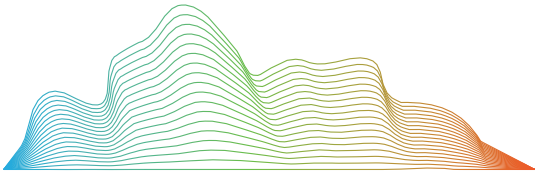
Additionally, the significant insufficiency of available race-based health data and research specific to Canada hinders the capacity to develop effective evidence-informed policies and solutions. It is difficult to generalize research findings to the general population without attention to diversity, and without addressing the impact of systemic and institutional racism on health.

This policy brief will examine and address the effects of language barriers in the quality of care, patient safety, and accessibility of healthcare for racialized foreign-born communities who have undergone the immigration process with Low-English-Language Proficiency (LELP). English and French are the official languages of Canada, and English is primarily spoken in the province of British Columbia. The terms "racialized" and "visible minority/minorities" ("persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour," as defined by the Government of Canada) are used interchangeably in this brief as "visible minority" is an official term defined by the Government of Canada. However, it is noted that the usage of the term "visible minority" potentially belittles the presence and importance of racialized communities despite making up a significant portion of the Canadian population.

Five main barriers faced by racialized LELP immigrant communities in Canada impacting accessibility and quality of healthcare were identified:

1. Lack of race-based data and research in Canada;
2. Effects on quality of care;
3. Diminished patient safety;
4. Cultural linkage to language;
5. Availability of language interpreters.

As a result, four main recommendations were proposed to address both capacities of short-term and long-term effective change on all levels of community, provincial, and federal systemic policy work:



The language barrier alone is the most significant barrier to initial health accessibility in Canada.

2. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-accessibility/language-barriers.html

1. Advocate for collection of race-based, language, and immigrant status data in Canada to better inform policies and solutions for under-served groups;
2. Facilitate creation of standardized visual-aid tools to address the gap in communication between racialized LELP patients and the healthcare system;
3. Promote and enhance cultural competence, safety, and racial-bias training in medical education and current bodies of practicing medicine;
4. Address the lack of diversity in medicine with re-evaluation of medical school admission processes in Canada.

Problem Definition and Background

In Vancouver alone, immigrants make up 40.8% of the population according to 2016 Census data. When expanding to the rest of the province, immigrants compose of 28.3% of the population and visible minority groups compose of 27.3% of the population in British Columbia. This number is and has been steadily rising over time.

Internationally, it is significantly corroborated through health research that racialized communities experience poorer health outcomes compared to non-racialized communities.[3] Correlated social determinants of health related to these poorer health outcomes include racial discrimination and racism, lower socioeconomic statuses, and increased levels of stress, amongst others.

There are five key identified barriers posed to LELP that directly affect accessibility and quality of healthcare: lack of data and research; effects on quality of care; diminished patient safety; cultural linkage to language; and availability of language interpreters.

LACK OF DATA AND RESEARCH

Notably, there is a significant lack of available health data and research on "visible minorities" in Canada, let alone visible-minority immigrants. A scoping review of Khan *et al.*, in 2015 only found five studies that examined nationally representative data to compare health outcomes, conditions, or behaviours in "visible minorities" with White populations in Canada. The study also noted the lack of distinction and recognition of diversity between "visible minorities" and ethnicities within research.

According to 2016 Census data, there exists 7,540,830 foreign-born individuals who came to Canada via the immigration process. Visible-minority individuals make up 22.3% of the Canadian population, and seven in 10 (~70%) of this group are foreign-born through the immigration system. This indicates that roughly 16% of the Canadian population consists of immigrants of "visible minorities."

3. http://www.multiculturalmentalhealth.ca/wp-content/uploads/2014/01/

Photo by Ali Yahya on Unsplash

The Census data also reports that 6.8% of immigrants are unable to "conduct a conversation" — a broadly defined concept — in either English or French, and 28.0% of the population only speaks their mother tongue (other than English or French). This indicates a significant portion of the population with existing language barriers in communication. Visible minority and visible-minority immigrant communities make up a significant portion of the Canadian population, yet the data collected and research performed and prioritized to address these health inequities are minimal.

Corroborated by compelling evidence and research, it is known that language barriers have an adverse effect on access to health services — not limited to physician or hospice care, but also health-promotion and prevention programs, and health literacy. Communication is a key contributing and differentiating factor towards quality of care and patient safety.

EFFECTS ON QUALITY OF CARE

Language concordance between the patient and provider ensures effective communication. Quality of care refers to the degree to which health services for populations increase the probability of optimal health outcomes (consistent with current professional and medical knowledge). Based on the literature, differences in language have proven to affect accuracy of patient assessment, appropriate examinations, ancillary testing, diagnosis, prescribed treatment, chronic disease management (*i.e.* asthma, diabetes), palliative care, pain management, reduced access to mental health and counselling-related services, as well as an increased risk of failure to obtain fully informed consent and protection of patient privacy and confidentiality.[3] Language barriers have also proven to contribute to consistent and significant differences in the understanding of conditions and compliance with treatment. The inter-communication process of fully and comprehensively taking the history of the patient (*i.e.* obtaining information from the patient to formulate a diagnosis and prescribe a treatment plan—including symptoms, medication history, social history, and more) is likely significantly affected with the addition of a language barrier. The patient's medical history is often centric to the accuracy of diagnosis.

Communication is a key contributing and differentiating factor towards quality of care and patient safety.

DIMINISHED PATIENT SAFETY

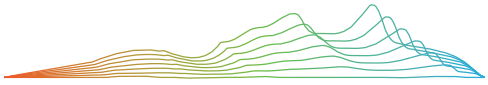
Patient safety refers to the reduction and mitigation of unsafe acts and increased use of best practices leading to optimal health outcomes. Language barriers between the patient and provider have also been shown to lead to increased medication errors, readmissions due to the same health problem, increased risk of intubation for asthmatics, lower rates of optimal pain medication, poorer management of chronic diseases, and prolonged hospital stays in the literature. The United States Joint Commission's Sentinel Event Database also revealed that communication is the root cause of 59% of serious medical adverse events. Patients with LELP are more likely, compared to English-speaking patients, to experience these adverse safety events due to miscommunication.[4]

CULTURAL LINKAGE TO LANGUAGE

Differences in shared language have also indicated lower-satisfaction rates for those patients. Recent research has also indicated that language may be the most significant barrier to initial health accessibility rather than causation from cultural beliefs and practices.[5] However, the inextricable linkage between-language with culture must be recognized as well. The linguistic relativity principle, also known as the Sapir-Whorf hypothesis, refers to the theory that one's perspective, thought, decisions, and cognitive processes are directly influenced or determined by their language. Thus, with the utilization of language interpreters, we must recognize the cultural barriers faced with language translation. Cultural understandings and ideologies cannot be directly translated, a wide diversity of dialects exists in many languages, and non-verbal language varies between cultures and geographical locations. Many terms are not directly translatable between languages, as well — for instance in Korean, "체해, *'che-hae'"* refers to a combination of symptoms of having an upset stomach, and/or a general feeling of bodily unwellness relating to indigestion or the difficulty of digesting, but this is not directly translatable to a single term in English.

AVAILABILITY OF LANGUAGE INTERPRETERS

The realities of the accessibilities and availabilities of language interpreters must be recognized as well. Canada has a constant shortage of interpreters available. The distribution of interpreters across the country is also limited, especially in less-populated urban areas and rural areas. Interpretation programs across Canada vary in size, resources, models of service delivery, and capacity to ensure quality across all systems of health. Many LELP individuals rely on family members, untrained interpreters, or even Google Translate to navigate communication with their provider, posing significant risks as previously outlined.



We must recognize the cultural barriers faced with language translation. Cultural understandings and ideologies cannot be directly translated.

Beyond addressing the presence of language barriers, healthcare serving racialized communities is also tied into the complexities of systemic, institutional, and interpersonal racism and implicit bias within interactions in the healthcare system.

4. https://journals.sagepub.com/doi/

5. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-accessibility/language-barriers.html

Policy Ask: Recommendations

1 Race-Based Health Data.

Canada is much farther behind in the practice of collecting race-based health data and research compared to the efforts of other countries such as the United States and the United Kingdom. Literature focusing on the health of racialized populations in the context of Canada is significantly limited, largely due to the lack of federal policy and infrastructure surrounding the collection of race-based data. Health outcomes of visible minority groups, let alone visible minority immigrant groups, are not well-known, yet racialized individuals make up more than a fifth of the population. In order to effectively propose and inform evidence-based policies and solutions to address the gap of health equities in our under-represented communities, greater research and data must be a forefront priority. It is difficult to generalize research findings to the general population without attention to diversity, and without addressing the impact of systemic and institutional racism on health.

With the COVID-19 outbreak, there has been a greater demand for the necessity of race-based data to assess disproportionate health outcomes of the pandemic for Indigenous, Black, and racialized communities. The Canadian Institute of Health Information (CIHI) has published a discussion document, "Proposed Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada" of recommended pan-Canadian standards for collecting race-based and Indigenous identity data in health systems in July 2020, adapted from the Government of Ontario's Anti-Racism Directorate (ARD) race-data standards. Greater collection of race-based data is essential:

a) **Advocate for the need of race-based and immigrant-based health-data** collection, analysis, and research in Canada:
    i) Separation of ethnicity and race groups is essential with data collection; Ethnicities cannot be clustered or grouped together—this ignores diversity, and further fails to fully address the different needs of each racialized community;
    ii) Include self-reported collection of languages and immigration status.
b) **Work with organizations pushing for same agenda** (*i.e.* CIHI—Canada Institute for Health Information, research groups).
c) **Leverage public knowledge, perception, and importance** by increasing exposure via media and public education (Overton window).

2 Standardized Visual Aids— Inclusion and Equity.

Differences in language and language barriers will continue to persist in the communication aspect of medicine. In order to aid in this limit towards effective communication between the provider and patient, the action of developing standardized visual aids and tools to be used during face-to-face interactions may enhance communication and patient satisfaction for patients with LELP. Thus, a framework may be introduced of standardized creation of visual aids to be available in all areas of regulated BC healthcare such as acute care, rehabilitation services, mental health services, palliative care, and outpatient treatment:

a) **Consult with visible-minority immigrant communities and families** in BC regarding experiences in healthcare in a variety of geographical settings (*i.e.* urban cities, less-populated urban areas, rural areas) to best understand how the language barrier has impacted lack of satisfaction in receiving healthcare and lived experiences:
    i) Ensure a diversity of representation of different racialized groups;
    ii) Host and interview focus groups of varying visible-minority communities in BC;
    iii) Ensure proper compensation of all participants for emotional labour and contributions.
b) **Consult with BC physicians and health providers** of varying specialties and areas of care to understand how to best implement the tools' usage in daily medical practice and encourage regular usage of visual aids when needed;
c) **Hire and work with local, racialized artists** for the creation of the visual tools;
d) **Ensure visual representation** of People of Colour, gender diversity, and disabilities to promote inclusivity and social belonging;
e) **Facilitate creation of visual aids focused on medical and medication treatment protocol** explanations, patient consent and confidentiality, and describing symptoms, as well as history-taking;
f) **Facilitate creation of visual aids for all critical points of contact in navigating the healthcare system** (*i.e.* booking appointments, checking test results, accessing medication, *etc.*) to be widely available online and in healthcare centres;
g) **Hire and work with Interaction Designers (IxD)** to strategize and maximize the accessibility, understanding, and experience of visual aids for patients both in and out of the healthcare setting;
h) **Trial and test efficacy of different models of the aids** in various healthcare settings and online platforms, and in focus groups to inform and enact improvement of the models before widespread and diversified usage;
i) **Work with the BC Ministry of Health and the Provincial Health Services Authority (PHSA)** to strategize and ensure its distribution and availability of the aids to all areas of BC, while catering to the different needs of each community;
j) **Implement feedback mechanisms** (*i.e.* surveys) to gather and assess self-reported patient satisfaction and confidence in racialized immigrant groups and efficacy of visual aids usage to evaluate and measure effectiveness of policy;
k) **Promote collection and analysis of race- and language-based data** to better inform health outcomes.

3 Cultural Competence Training and Racialized Equity Education.

Our current healthcare system is one that is rooted in colonialism and institutional racism. Health is intrinsically intersectional, and culture and social well-being are embedded in one's health and health outcomes, especially for racialized communities. Although social accountability is becoming increasingly emphasized in medical education and training of physicians, there is a significant gap in equity, diversity, and inclusion awareness and cultural competence training.

The direct and potentially harmful impact of implicit racial bias (attitudes or stereotypes that unconsciously affect our understandings, actions, and decisions) from physicians and the healthcare community on the health outcomes of certain populations is rarely discussed. Multiple studies have shown that physicians manifest these biases to a similar degree as the general public. Implicit bias and interpersonal racism of physicians play a key role in the accessibility and quality of healthcare that patients receive, and significantly shape patient-provider interactions, treatment decisions and adherence, and health outcomes. A systematic review by Hall *et al.* found that most healthcare providers had implicit biases of positive attitudes towards White populations and negative attitudes towards People of Colour. Hoffman *et al.* examined the relationship of racial bias with false understandings of biological differences between Black and White populations and found that trainees and physicians often assigned lower ratings of pain to Black patients, which resulted in less-accurate treatment recommendations. Perpetuated false beliefs about biological differences are and have been misused to inform medical judgments, which contribute to racial disparities in pain assessment and treatment.

Thus, embedding and promotion of increased and intersectional cultural competence and sensitivity in medical education is crucial to ensuring that medicine is increasingly equitable, and the accessibility and quality of healthcare is consistent across all under-represented and racialized groups. There needs to be greater training and awareness for future and current physicians in understanding and navigating culturally-sensitive care, while also dismantling implicit bias and social constructs:

a) **Examine and re-evaluate current curriculum** specific to cultural competence and safety, and building understanding towards racism, ethics, and equity, diversity, inclusion in medicine — work with associated Canadian medical education organizations and accreditation bodies (*i.e.* Association of Faculties of Medicine of Canada and Committee on Accreditation of Canadian Medical Schools);
b) **Consult with and centre the voices of racialized medical students, faculty, and physicians** to develop an understanding of racism of medicine and medical education;
c) **Form a working group of racialized medical students, faculty, and physicians to review current accredited medical education and policies**, and develop a list of recommendations to address systemic racism in medicine and promote greater attention to intersectionality and integration of cultural competence in medicine;
d) **Ensure proper compensation of all consulted bodies** for emotional labour and contributions;

e) **Review the Provincial Health Services Authority's Standards of Conduct policy and Canadian Medical Association Code of Ethics and Professionalism** to include clauses of commitment and responsibility towards anti-racism and increased cultural competence of physicians.

4 Diversity in Medicine.

The healthcare and medical system of Canada should be representative of our communities and populations served. Beyond addressing practices within medicine, broadening representation and the diversity of health professionals should be a forefront priority. In the US, while racialized groups compose 26% of the total population, only 6% of practicing physicians are of Black, Latino, or Indigenous ethnicities.[6] In Canada, due to the absence of collection of race-based data, there is not enough data to comprehensively assess current racial diversity within medicine. Based on very limited data, only 2.9% of all medical students reported identifying as African or Caribbean compared to being represented in 4.2% of the population nationally in 2012 in Canada.[7] Beyond race, there also continues to be a significant gap in representation of women in medicine. Intersecting gender and racial inequity are further reflected in the significant lack of representation of Women of Colour in medicine.

6. https://www.hopkinsmedicine.org/news/articles/diversity-in-medicine-has-measurable-benefits

7. https://www.cmaj.ca/content/cmaj/187/1/11.full.pdf

Many medical-school admission systems across Canada currently lack comprehensive infrastructure that examines the effect of privilege and racism on admission success. This is also partially due to the lack of collection of race-based data in admission processes. Greater review and evaluation of admissions processes must be prioritized:

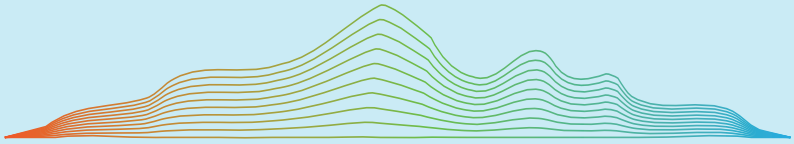
a) **Form a working group of racialized medical students, faculty, and physicians to review current accredited policies on medical-school admissions**, and develop a list of recommendations to address systemic racism in the admission process and the qualities and characteristics sought by schools. The effects of privilege, wealth, racism, socioeconomic factors, and gender, amongst other factors must be examined with admission rates;
b) **Promote the collection of race-based data in admissions processes** to examine trends of successful and unsuccessful admission, and evaluate the representation of future physicians compared to the racial diversity of the communities being served;
c) **Work with associated Canadian medical education organizations and accreditation bodies *(i.e.* Association of Faculties of Medicine of Canada and Committee on Accreditation of Canadian Medical Schools) to externally review admission processes** of medical schools and advocate for individual medical school systems to evaluate their admission procedures.

Challenges & Opportunities

With the proposed policy recommendations, a few considerations of potential limitations and opportunities arise (but are not limited to):

1. Usage of visual aids may not be inclusive for all. For persons who are visually impaired, they cannot rely on using visual aids to aid in the communication barrier. This may especially impact individuals who are intersectionally affected (*e.g.* visually impaired, LELP, racialized). Visual aids are a short-term solution to address the communication barrier for a limited group within the community;
2. Relying on visual aids alone will not solve the language barrier that exists in our systems of healthcare. Not only must the usage of visual aids must be paired with greater accessibility of language interpreters, there needs to be a greater cultural shift in medicine and healthcare to address systemic health inequity and institutional racism that exists. Greater cultural integration beyond clinical care in medicine is essential to its comprehensiveness.

Conclusion



The communication gap in health that comes with the difference of languages spoken between the patient and the healthcare system is not limited to a matter of dialogue. Language barriers in healthcare for racialized communities pose a health inequity. This is a systemic issue that disproportionately affects and disadvantages a significant subset of the Canadian population, complicated by the additional barriers, challenges and social isolation that exist with being racialized in a colonialized system. Canadians may all have access to healthcare with a system based on universal healthcare, but the accessibility and quality of healthcare available are inequitably shifted and distributed between certain communities.

Health is intersectional, and the concept of health and well-being varies by culture and social values. This policy brief outlines both short-term and long-term recommendations towards bridging the health inequities that exist for racialized immigrant LELP communities, primarily stemming from language barriers in communication. The current structure of medicine and healthcare still lacks comprehensive measures to fully serve our racialized and Indigenous communities. Greater physician and healthcare training and system reform is necessary to comprehensively address the systemic inequities that are embedded within medicine. Representation of the health professional community must greater reflect the populations we are serving, and should be a forefront priority of our medical schools. Continuing to limit the diversity and inclusion of our healthcare systems will only further hinder the capacity of medicine to serve its populations and patients.

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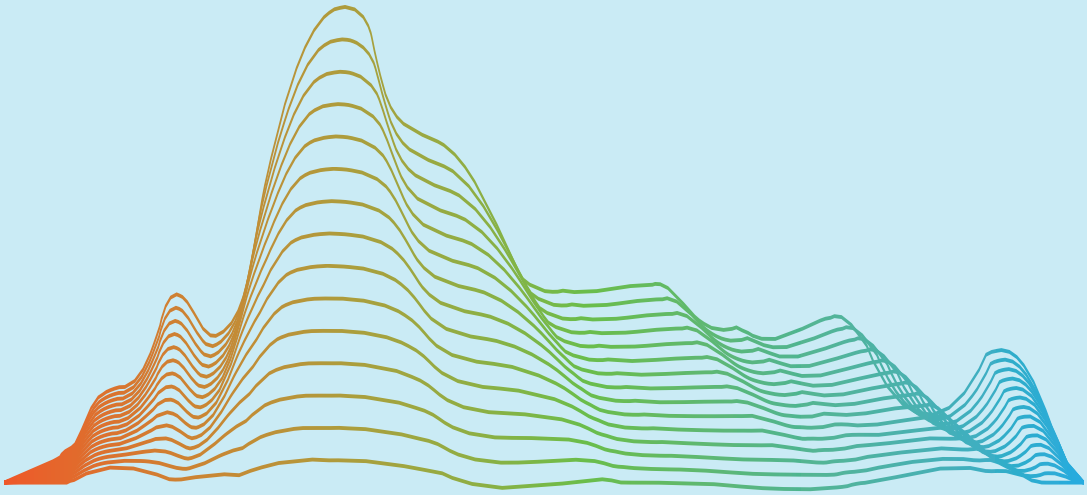

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