



Northern Ontario Health Equity Strategy

A plan for achieving health equity
in the North, by the North, for the North

Health Quality
Ontario

Let's make our health system healthier



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Forewords

From Health Quality Ontario's CEO

You can't truly have a quality health care system without having equitable opportunities for health. Equity is one of the six core dimensions of quality care, along with safety, effectiveness, patient-centeredness, efficiency, and timeliness, and it is a dimension to which Health Quality Ontario has paid special attention recently.

Northern Ontario is one region of the province where health equity is often lacking and needs to be addressed with some urgency. *Health in the North: A report on geography and the health of people in Ontario's two northern regions* is a health system performance report we released last year. It documented how the 800,000 people living in Northern Ontario have a life expectancy more than two years lower than the provincial overall and are more likely to die (before age 75) due to suicide, circulatory disease and respiratory disease.

Earlier in my career, I worked in the North as a doctor. I saw first-hand the unique challenges facing those with long distances to travel, poor weather conditions and a shortage of medical resources (including healthcare providers). Those working in our two Northernmost Local Health Integration Networks (LHINs) know these are just some of the reasons those living there do not have the same standard of health and health care seen in other parts of the province. Other inequities associated with the social determinants of health – income, and access to proper housing, clean water and adequate nutrition – also play a big role.

Our quest with others to develop a strategy to address health equity in the North was built on a principle now embedded in the patient advocacy movement – “Nothing about us without us.” Or as Dr. Jennifer Walker, Canada Research Chair in Indigenous Health at Laurentian University, eloquently put it, “Solutions cannot simply be imported from the southern part of the province. The landscape – social and cultural as well as geographic – is totally different.”

Guided by leaders in the North, Health Quality Ontario helped facilitate an in-depth multi-faceted engagement process with hundreds of people living in the North that has led to a northern strategy to address health equity in the North, focusing on those important barriers and opportunities for building health equity.

The Northern Ontario Health Equity Strategy is guided by a vision that all Northerners will have equitable access to social and economic resources, as well as to high-quality health care, regardless of where they live, what they have or who they are.

For too long those living in Northern Ontario have lived and worked on an unbalanced playing field. I am hopeful that this clear vision and goal, and the recommendations outlined as part of this strategy, will provide the impetus to address the challenges facing the North in a manner that will have a significant impact.



Joshua Tepper

President and CEO, Health Quality Ontario

From the Steering Committee Co-chairs

Northern Ontario covers a vast expanse of rugged and breathtaking land – a land so large it covers roughly the same area as all of France. Northern Ontario’s population is diverse and resilient. We live in urban centres, rural villages and remote communities. We are Indigenous and Francophone, long-term settlers and new arrivals. We work in health care and education, resource extraction and retail, and we have deep connections to the land, our communities, and our families. As Northerners, we know we have huge health potential as well as huge health challenges. Compared to the rest of Ontario, the North has higher levels of poverty and poor health, elevated rates of many health-harming behaviours and poorer access to high-quality health care and social services.

Addressing these pressing challenges and leveraging our many strengths requires us to come together. It is only by working together across many different sectors that we will be able to achieve common health goals and ensure everyone has equal opportunities for health. We see great promise in joint leadership bringing perspectives from across the North – East and West, urban, rural and remote – and also across health care, public health, other public sectors and communities. We see this Strategy as a critical step toward achieving joint action on health equity.

We want to thank the many people who took the time to speak with the Northern Ontario Health Equity Strategy team to share their stories and have their voices heard. Hundreds of people from across the North told us of their and their communities’ challenges. They shared their vision for the future and their successes and lessons from the past. The Northern Ontario Health Equity Strategy is inspired by these stories and our future actions must be founded in the wisdom of all of these contributions.

Health equity will be achieved when all Northerners have equal opportunities for health and no one is unfairly disadvantaged. Health equity will also be achieved when health outcomes across the North are leveled up to meet those in the rest of Ontario. Our broad consultations confirmed that we are up to the challenge of improving health equity in the North, by the North, for the North!



Penny Sutcliffe

Medical Officer of Health and Chief
Executive Officer, Sudbury & District
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Co-chair, Northern Ontario Health Equity
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Executive Summary

People living in Northern Ontario experience poorer health and greater health inequities on many indicators compared with the rest of the province. This Strategy and its recommendations come directly from extensive engagement in 2016 and 2017 with those living in the North. It is concerned with the health of those living in Northern Ontario, and is guided by a vision that all Northerners will have equitable opportunities for health, including access to social and economic resources, as well as to high-quality health care, regardless of where they live, what they have or who they are.

The Northern Ontario Health Equity Strategy, developed in the *North, by the North, for the North*, is based on four foundations for action considered most important by stakeholders in the North:

- Addressing the social determinants of health
- Equitable access to high-quality and appropriate health care services
- Indigenous healing, health and well-being
- Evidence availability for equity decision-making

A health equity strategy for those living in Northern Ontario requires that we identify the greatest health disparities and remove barriers for people facing inequities. It also requires that we address opportunities for health in the North as a whole, and identify ways to bring health outcomes across the North up to meet those in the rest of Ontario.

Health Equity is a Shared Responsibility

Our society generally strives toward equity, inclusiveness and creating a sense of belonging, and this is certainly the case in health care. Despite these sentiments, barriers to equity continue to exist and be experienced by Northerners. Throughout extensive engagement, we heard from Northerners that collaborative, intersectoral action is needed to address health inequities in Northern Ontario. The message was clear:

“We are working in silos. To make change we have to get out of those silos. Meaningful change will result from partners working together in a coordinated way across sectors, rather than working in isolation.”

– Northern Health Care Provider

Recommendation: A Northern Network for Health Equity

Although the following Strategy outlines concerns and proposes a variety of solutions, the driving recommendation is to establish a Northern Network for Health Equity (“the Network”) that will support intersectoral action, with a goal to improve health and health equity outcomes for people living in Northern Ontario. The Network itself will neither deliver care nor do the work of any one sector. The Network will focus on health equity broadly, and will bring together network partners and key stakeholders to work on key health priorities which have disproportionate impacts on more vulnerable populations and have been identified by Northerners as priorities for the North, such as mental health and addictions, diabetes prevention and management, and parental and child health.

There is strong evidence in other jurisdictions that this kind of coordinated approach is essential to reducing enduring health and social inequities. Once established, the Network will facilitate intersectoral collaboration that will drive policy and service-delivery change to bridge the inequitable gaps in health outcomes currently experienced in Northern Ontario.

Network Partners and Structure

The Network will be comprised of individuals and organizations from many sectors, including partners from public health, municipalities, Local Health Integration Networks (LHINs), Indigenous organizations and authorities, educational and research institutes, Francophone organizations, provincial and federal ministries, agencies, the business community and community organizations and members. This work is aligned with the LHIN mandate to convene cross-sectoral tables, and supports the current movement towards greater collaboration between public health units and the LHINs.

The Network will be directed by a steering committee that will provide direction and establish priorities for achieving the objectives of this Strategy. The steering committee will be supported by working groups focused on specific issue areas, with representation from the Northeast and the Northwest. The working group members will be individuals with expertise relevant to their group domain, with representation from partnering agencies and sectors, including sectors outside of health. To be effective in driving policy change and developing health equity initiatives, the Network will be resourced with dedicated staff who will provide leadership and coordination to the collaborative efforts of the Steering Committee and its working groups.

Through these collaborations, the combined strength of all partners will have the potential to improve the health of all those residing in Northern Ontario through education, policy

development, and evidence-informed action.

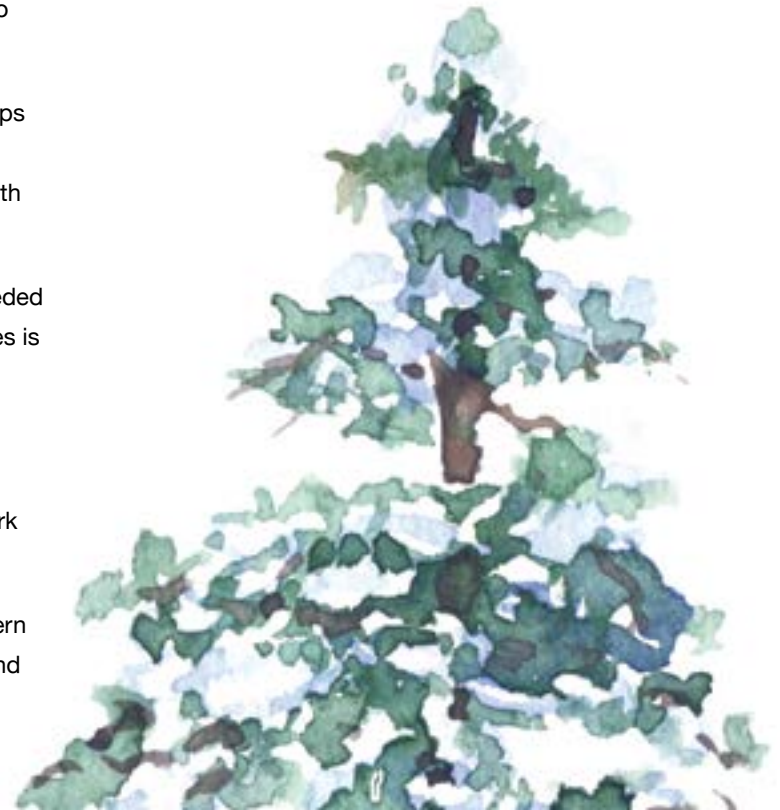
With strong intersectoral enthusiasm and support, the Network will be well-positioned to build on existing work. Because distances in the North are substantial, much of the work of the Network will be done virtually; the Network will not require its own facility but dedicated staff will locate with one of its partnering agencies.

Functions of the Northern Network for Health Equity

- Supporting Northern partners to develop deeper health equity commitments within their own organizational goals
- Engaging stakeholders, partners, government at all levels to collaborate intersectorally and to develop and advance policy solutions to improve health equity
- Collaborating with Northern research groups and agencies to conduct research and surveillance in priority areas to inform health equity action
- Supporting Indigenous researchers as needed to ensure research with Indigenous peoples is Indigenous-led
- Providing guidance, training, technical assistance and leadership to strengthen capacity for intersectoral health equity work in the North
- Facilitating knowledge exchange in Northern Ontario related to evidence, information and best practices

Network Objectives

Preliminary objectives within each foundation for action of the proposed Network were developed through consultation with Northern stakeholders and solidified through an environmental scan. The objectives are far-reaching and ambitious; however, advances in health equity rely on taking bold action and moving forward together for meaningful change. These proposed objectives and options are presented here not as a final mandate, but to reflect the important contributions of participants in the development of this Strategy and to give tangible meaning to the potential for a Northern-led Network. The Network will implement a planning process to further consider these objectives and options for action.



Foundation 1:

Addressing the Social Determinants of Health

1.1

Improve awareness of the social determinants of health and Indigenous determinants of health in the general public and among health care and social service providers

1.2

Engage partners across sectors to develop poverty reduction strategies

1.3

Work with partners to identify opportunities to improve accessibility to safe, affordable, and culturally appropriate foods across the North

1.4

Work collaboratively across the North to improve access to post-secondary education

1.5

Engage partners across sectors to improve access to safe and affordable housing

1.6

Work with partners to improve access to early childhood education and care

1.7

Work intersectorally to promote social inclusion

Foundation 2:

Equitable Access to High-Quality and Appropriate Health Care Services

2.1

Work with relevant providers to promote timely access to and coordination of health care where people live

2.2

Work across jurisdictions to improve health care provider recruitment and retention rates

2.3

Improve ability of all people, regardless of where they live, to access services

2.4

Improve access to French language health care services

2.5

Improve access to appropriate and inclusive health care services

2.6

Improve access to culturally safe health care services for all Indigenous peoples

Foundation 3:

Indigenous Healing, Health and Well-being

3.1

Work collaboratively across jurisdictions to provide equitable health care services to all Indigenous people

3.2

Move forward the Truth and Reconciliation Commission of Canada's Calls to Action, and support the efforts of Indigenous people in achieving self-determination

3.3

Work with providers and leverage opportunities to facilitate the provision of safe living conditions that allow residents to thrive in all First Nation communities

3.4

Support Indigenous culture as a determinant of Indigenous health

Foundation 4:

Evidence Availability for Equity Decision-making

4.1

Develop a Northern Ontario Data Strategy to streamline collection, analysis, and interpretation of data for equity decision-making

4.2

Support local engagement in research and use of evidence

Looking Forward: Anticipated Impact

Taken together, the actions of a coordinated Network would create opportunities for advancing health equity, with resulting impact in critical areas including mental health and addictions, diabetes prevention and management, and parental and child health. These, and other health issues that are strongly influenced by social and economic conditions, would benefit from an equity-focused intersectoral approach that addresses multiple factors related to health and well-being. The Network's deliverables will include:

In the first two years

- Establish the Network Steering Committee, with geographic and sectoral representation
- Hire core Network staff
- Develop the foundations for collaboration as a basis for action to achieve health equity, such as processes for engagement, inclusion and consultation, development of a Network Charter, and work with Network member organizations on integration of equity priorities into strategic plans
- Undertake process of evidence-informed priority setting, using the potential objectives and actions the Network can take to meet the goal of achieving health equity in the North as a starting point
- Undertake coordinated actions to address determinants of health, building on and strengthening capacity through work already under way within sectors
- Regularly inform government about the priorities of Network partners and the Network work plan



In five years

- Continue to undertake coordinated actions to address determinants of health, building on work already under way within sectors
- The development, measurement and reporting of Northern-relevant equity and health indicators

In ten years

- Improvements in indicators of equity and health among Northern populations
- Progress in equity priority areas identified by Network partners

Next Steps

The formation of the Northern Network for Health Equity is the first step in moving forward the objectives of this strategy. The development of the network would require commitments of stakeholders across Northern Ontario, and staff support to bring Network partners together.

The Strategy is an expression of the ambition, the passion, and the dedication of health and social sectors to work together for a more equitable, healthier Northern Ontario. Through developing this Strategy, we have heard that across the North, and across sectors, there is recognition of a societal obligation to address the pressing inequities facing Northerners. This Strategy is intended to create the foundation to move toward achieving health equity in the North, and will develop capacity to address pressing health equity challenges in the future.

This Network is an ambitious undertaking. It aspires to connect and align diverse leaders and communities from across a large geographical area. If successful, it will achieve the Strategy's vision of equitable opportunities for health for all Northern Ontarians.



Introduction: Health Equity in Northern Ontario

People living in Northern Ontario experience poorer health and greater health inequities compared with the rest of the province. Overall life expectancy is lower in the North¹, and mental health and addictions, diabetes, and parental and child health are of particular concern.² Poor health outcomes in the North are influenced by limitations to social and economic opportunities – income, housing, food security, education, childhood development, social supports, access to services in general, and access to services that are linguistically and culturally appropriate. These health disparities between the North and the rest of the province have prompted the development of this Strategy. This Strategy is concerned with all Northern Ontario populations. Among them, it highlights greater inequities faced by Indigenous populations due to the effects of colonization, historical and current trauma, racism, and the lack of self-determination.

The social and economic opportunities that determine people's health go beyond individual biology and behaviours. They are the living conditions that people are born into and that they grow, live, and work in.³ Although these factors affect everyone, some environments either amplify or diminish health and impact individuals' and communities' opportunities to attain their full health potential. Any differences or variations in health status between groups are known as health inequalities. When health inequalities have the potential to be changed or decreased by changes in policies or social action, they are known as health inequities.⁴ When members of the population experience equal opportunities to reach their full health potential, this is known as health equity.⁵

We are focusing attention on a specific geographic area that is referred to in this Strategy as Northern Ontario. However, we wish to acknowledge the original inhabitants of the treaty areas of Robinson-Huron, Robinson-Superior, Manitoulin Island, Treaty 3, Treaty 5, Treaty 9 and Wikwemikong Unceded Indian Reserve as the traditional owners and custodians of these lands. We honour and respect their ongoing cultural and spiritual connections to this place.

We recognize First Nations, Métis and Inuit as three distinct cultural identity groups, each of which has a unique history, set of traditions and cultural practices, and governance structures. For the purpose of this document the term Indigenous will be used to encompass these populations. However, the term First Nations communities will be used when referring to communities located on reserve.

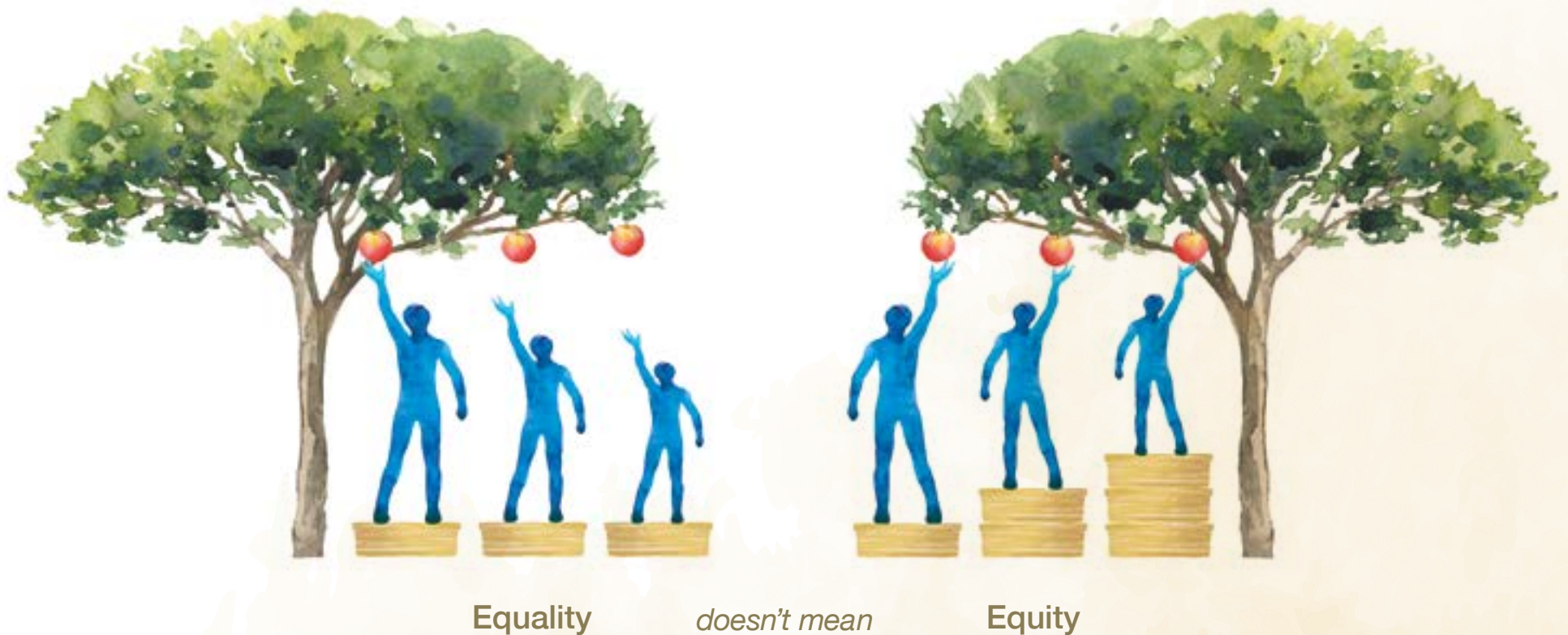
Central to the concept of health equity is the idea of fairness. Whereas *health equality* refers to the division of health-supporting resources into equal parts so that everyone gets the same, *health equity* involves fairness in resource allocation and opportunity so that people have the supports necessary to be healthy (see Figure 1).

Achieving health equity is about creating viable opportunities for the attainment of the “highest level of health for all people.”⁶

A health equity strategy for those living in Northern Ontario requires that we identify the greatest health disparities and tailor our approaches to remove

barriers for people facing inequities. It also requires addressing opportunities for health in the North as a whole, and identifying ways to bring health outcomes across the North up to meet those in the rest of Ontario.

Figure 1: Health equity requires an approach that acknowledges the varying needs of different people and populations⁷



Despite the barriers that Northerners face, the strength of the North and its potential to achieve health equity is clear from actions that have already been taken, programs that have been created, and policies that have improved health equity:

- The Northern Ontario School of Medicine is focused on meeting the needs of Northern, rural, and remote communities through intentional learning opportunities for its students with vulnerable populations, including Indigenous and Francophone communities
- Public health is leading the charge on creating awareness in the general population about the social determinants of health
- Community paramedicine is bringing supportive care to the people that need it the most
- The North West and North East LHINs are moving planning to the sub-region level to help support locally-appropriate approaches to improving health equity for their populations
- Many organizations, both Francophone and Anglophone, are working with the Francophone population to find innovative ways to ensure access to care in French, by use of technology or other solutions when direct patient care in French is unavailable
- Indigenous organizations are advocating for, and providing, care for their population in ways that are more culturally appropriate than ways used in the past
- Research is being conducted in Northern Ontario that focuses on transforming health policy, systems and practice to improve health equity in the North

We are ready to build on the momentum of the great work that is already under way. This strategy leverages the Northern spirit of self-reliance and determination to improve opportunities for health for all with a powerful vision for the future

VISION

All Northerners have equitable opportunities for health, including access to social and economic resources, as well as to high-quality health care services, regardless of where they live, what they have or who they are.

The Northern Ontario Health Equity Strategy builds on what we've heard across the North about what is working, what is not working and what is needed to ensure that *all Northerners have equitable opportunities for health, including access to social and economic resources and high-quality health care services, regardless of where they live, what they have or who they are.*

The content and direction of this Strategy have come from a review of existing documents and extensive multi-sector engagement with individuals, communities, and leaders from across the North, drawing from their experiences living and working in Northern Ontario. Those engaged represent health care, health promotion, education and research institutions, social services (governmental and non-governmental),

enforcement, municipalities, Indigenous communities and organizations, Francophone organizations, LGBTQ² organizations, early childhood development, elder care and many more. A vision, goal, guiding principles, and objectives have been created with significant input from people living in Northern Ontario.

Through this engagement process, Northerners identified four foundations for action for a Northern Ontario health equity strategy:

- Addressing the social determinants of health⁹
- Equitable access to high-quality and appropriate health care services
- Indigenous healing, health and well-being
- Evidence availability for equity decision-making

Northerners felt strongly that an intersectoral approach is critical to tackle the complex problems associated with health equity. They shared that the current work under way by a variety of sectors to improve health equity across the North needs to be meaningfully connected. This means aligning work within the health system and with research institutions, education, social services, economic development, municipal affairs, justice, and non-governmental community organizations.



The Strategy's primary recommendation is to establish a Northern Network for Health Equity. The Network will drive action within the four foundations for action previously listed with the goal of improving health equity for those living in Northern Ontario. The Network will focus on health equity broadly, and will begin with three key health priorities that were identified through the engagement process, each of which has disproportionate impacts on more vulnerable populations: mental health and addictions, diabetes prevention and management, and parental and child health.

The following sections provide an overview of how this strategy was developed, the context in Northern Ontario, the health status of people living in Northern Ontario, and challenges that Northerners face when trying to achieve their full health potential.

“Acute care is important but if we don’t deal with the issues that are making people sick, we will never get ahead.”

– Northern Ontario physician





A Health Equity Strategy for Northern Ontario

How This Strategy Was Developed

This Strategy was developed *in the North, by the North, for the North*. It aims to leverage the North's strengths to tackle the challenge of achieving health equity.

In the spring of 2016, Health Quality Ontario developed a Health and Health Care Equity Plan. One of the priorities of this Plan was to work in partnership with those living in the North to develop a Northern Ontario Health Equity Strategy. In October 2016, the Northern Ontario Health Equity Steering Committee was formed. It is comprised of health care, public health, academic and research groups, Francophone organizations, Indigenous organizations, and community leaders and residents from across Northern Ontario.¹⁰ The Steering Committee's task was to direct the development of a strategy that reflects the unique needs and abilities of Northerners and outlines a set of recommended actions necessary to improve overall health and well-being by supporting health equity in Northern Ontario. This Committee provides ongoing direction for the development of the Strategy and was supported by a Northern Ontario Health Equity Strategy team from Health Quality Ontario, in partnership with the Public Health Sudbury & Districts. This work was undertaken with financial support from Ontario's Ministry of Health and Long-

Term Care, demonstrating the Ministry's recognition of the importance of Northern health equity.

In November 2016, a Planning Meeting was held with over 60 people from across Northern Ontario to define the strategy's scope, vision, goal and foundations for action. From January 2017 to November 2017, the Northern Ontario Health Equity Strategy team undertook substantial engagement across Northern Ontario. The engagement process consisted of key stakeholder discussions with individuals representing almost 150 organizations and more than 300 participants, including community members, front-line workers, and decision-makers in rural, remote, urban, Francophone and Indigenous settings. Participant organizations are listed in Appendix A.

In developing the Strategy, the team reviewed existing health equity strategies and programs, research on the health status of people living in Northern Ontario and on health inequities in the North, and other complementary information to support findings from community engagement.

In sum, tremendous commitment and passion from Northerners enabled this work to move efficiently toward a Strategy. For more information about the methodology used to develop this Strategy, please refer to Appendix B.

The Northern Ontario Health Equity Strategy's Guiding Principles:

1. Work collaboratively across sectors to address the fundamental causes of social inequity and ill health
2. Promote inclusion and equity as societal values
3. Support the delivery of programs and services applying principles of health equity
4. Engage, actively involve, and support the North's diverse communities
5. Respect the principles of Indigenous self-determination and the traditions and languages of Indigenous people
6. Respect the French Language Services Act and recognize both official languages
7. Address the North's unique context and challenges by applying the knowledge and skills of northerners to create innovative solutions that are locally responsive
8. Apply principles of evidence-based decision-making

The Northern Context

Northern Ontario encompasses 80% of Ontario's land mass, but it represents only 5.8% of the province's population.¹¹ This creates variation in population density across the North – ranging from high density urban centres to sparsely populated communities accessible only by plane. This variation in population density creates challenges including those related to economic growth and program delivery.¹² As compared with Ontario overall, in Northern Ontario there are

large proportions of Indigenous, Francophone, rural and remote populations. This geographic and population profile presents unique strengths as well as challenges for health, such as access to high-quality health care services, achieving economies of scale for diverse sectors, opportunities for basic determinants of health such as clean water, nutritious foods, adequate and affordable housing, and accessible public transportation.



Figure 2: Northern Ontario¹³

- 80% of Ontario's land mass
- 5.8% of Ontario's population
- 106 First Nations communities



NORTHWEST

3.4% Francophone people
22% Indigenous people

NORTHEAST

23% Francophone people
11% Indigenous people





Why Does Northern Ontario Need a Health Equity Strategy?

Health Outcomes Are Worse in the North

- People in the Northeast and Northwest have life expectancies of 79 and 78.6 years respectively, compared to 81.5 years in Ontario as a whole
- The premature death rates in the Northeast and Northwest are 235 and 258/100,000 people, compared to only 163/100,000 in Ontario as a whole¹⁴
- Only 24% in the Northwest and 28% in the Northeast report being able to see their primary care provider the same or next day when they're sick, compared to 43% in Ontario¹⁵
- 45% of Northern Ontario Francophones feel they are in very good or excellent health, compared to 62% of the province's general Francophone population

Social Outcomes Are Worse in the North

- The unemployment rate in Northern Ontario was 6.5% in September 2017, compared to 5.6% for the province as a whole¹⁶
- Fewer people in Northern Ontario have secondary and postsecondary education than in the province as a whole¹⁷

Overall, this paints a clear picture: Northerners face health inequities relative to the rest of the Ontario population. But beyond this, there are significant inequities within the North itself. Indigenous populations experience some of the worst health outcomes of any population in Canada,¹⁸ and Northern Ontario is no exception. Francophones face challenges accessing healthcare in their own language, which can impede access to quality care and good health. These disparities are socially produced, unfair and unjust.

Specific Health Priorities Emerge for the North

People living in Northern Ontario face many inequities in health, but three health concerns were identified as priorities for the Strategy: mental health and addictions, diabetes, and parental and child health. These priorities will benefit from an intersectoral approach targeting each of the Strategy's four foundations for action: addressing the social determinants of health; improving access to high-quality and appropriate health care services; supporting Indigenous healing, health and well-being; and improving the quality and availability of evidence for equity-based decision-making.

Mental Health and Addictions

People living in Northern Ontario face significant challenges to their mental health. A variety of factors are understood to contribute to this, including economic barriers, geographic isolation, cultural and language barriers for Francophones, and for Indigenous people, intergenerational and current trauma due to discrimination and discriminatory policies.¹⁹

Suicide is the leading cause of death due to injury in Northern Ontario. In the Northwest, the potential years of life lost due to suicide are approximately 300% greater than that of Ontario. In the Northeast, the potential years of life lost due to suicide are 50% greater for men and more than 80% greater for women than in the general Ontario population.²⁰ Suicide rates, especially among youth, are much higher in Indigenous populations. Across Canada, the suicide rate among First Nations youth is five to seven times higher than among youth in the Canadian population as a whole.²¹ There is currently a state of crisis that continues in remote First Nations communities across the North, and communities are experiencing trauma from losing their youth to suicide. In the past 10 years, 42% of suicides among Aboriginal youth in the North have occurred in just seven remote, Northern Ontario Indigenous communities.²² Although these communities are identifying the specific types of supports they require, clearly, it is necessary to address the root causes of suicide on an ongoing basis (including intergenerational trauma due to colonial history, residential schools and land seizures, current discriminatory policies, endemic

poverty, and limited access to mental health counselling and psychiatric services).

Currently, patients who are hospitalized for mental illness or addiction in the North do not receive the support they need after being discharged: In 2014-2015, only 17% of patients in the Northwest and 21% in the Northeast saw a family doctor or psychiatrist within seven days of being discharged, compared to 30% in Ontario as a whole, and 40% in Toronto.²³ For the Francophone population, access to mental health care services is a challenge due to the limited resources available in French. Appropriate language is essential for treatment in mental health and addiction, and because there are limited services available in French, many Francophones are unable to receive the help and treatment they need.

Similarly, misuse of alcohol, opioids, and other substances is a function of a variety of social and economic factors, and disproportionately affects the most disadvantaged members of society. Public health, Local Health Integration Networks (LHINs), and Health Canada can fund preventive and/or treatment services to those living with addiction, but these services do not address the root causes of addictions. Intersectoral approaches to addressing these mental health and addictions challenges include: supporting economic development in disadvantaged communities to improve employment rates and income security; improving educational outcomes in both official languages in all communities; and ensuring individuals and families have stable, safe living environments and housing.

Providers worry that some populations may be falling through the cracks: Community members reported that addiction concerns of patients arriving at the emergency department under the influence of alcohol or drugs often go unreported if addiction is not the presenting complaint. This underreporting minimizes the magnitude of the problem.

Diabetes Prevention and Management

Diabetes is closely linked to income: In Canada, individuals living in lower socioeconomic status neighbourhoods are at a 13% higher risk for diabetes than those in neighbourhoods of higher socioeconomic status.²⁴

The Northeast and Northwest have the highest prevalence of diabetes in Ontario: 12.8% and 12.5% respectively, compared to an average of 10.2% across all of Ontario.²⁵ Diabetes is particularly high among adults living in First Nations communities, with up to 21% reportedly having been diagnosed with diabetes.²⁶

The causes of diabetes and other chronic diseases are often found in social and economic conditions. Although an individual may be genetically susceptible to certain diseases, poverty, combined with the high cost of living in the North, makes it hard for individuals and families to purchase healthy and adequate food, engage in routine physical activity, lead low-stress lives, and participate in other health-promoting behaviours. Remote communities also face a variety of barriers to physical activity. In many remote First Nations communities, unpaved roads, stray dogs, and wildlife impede activities like walking and running on the roads, limiting options for physical activity and increasing the risk of being overweight and developing diabetes.

Diabetes prevention and management at a population level requires coordinated efforts across sectors. Prevention starts with improving living conditions: income, access

to healthy foods, employment opportunities, communities where people can be and stay active. Management requires coordinated efforts across the health system including medical care access, appropriate education and counseling and available home care. For Francophones, the provision of education in French is essential, and translation and interpretation are needed when services are only available in English.

Parental and Child Health

For expectant parents with complex chronic conditions living in low-income neighbourhoods in Ontario, the risk of infant mortality is 25% higher than it is for those in high-income neighbourhoods.²⁷ Further, there are health and health care service challenges for parents, children and youth that are particular to the Northern setting. For example, having a high-risk pregnancy, particularly in remote Northern communities, can lead to challenges like having to relocate to larger centres to give birth, where family and supports are unable to be present. This situation places stress on new parents and families. There are also many communities without birthing services, thereby requiring residents to travel to larger centres to give birth.

Data show that for Indigenous populations, high infant mortality rates compared to the general Canadian population are evidence of health disparities.²⁸ Exposures during pregnancy such as smoking, high levels of stress, and environmental hazards such as poor air quality in substandard housing are more likely to be experienced by

expectant Indigenous mothers than expectant mothers across Canada as a whole.²⁹ Post-neonatal deaths (the deaths of children aged 29 days to one year) are likely to reflect social and environmental factors (e.g., malnutrition, infectious diseases, and unsafe housing conditions). In First Nations populations, infant mortality rates have been found to be almost twice as high (190%) as in non-First Nations populations.³⁰

Prescription opioid use in pregnant women is a concern, with 28.6% of women in a rural clinic in the Northwest found to be using opioids in 2013.³¹ Providing expectant mothers with narcotic weaning and tapering with long-acting morphine precipitated a decrease in the number of babies born with neonatal abstinence syndrome (withdrawal after birth) from 29.5% in 2010 to 18.0% in 2013.³²



“There is little support given to individuals that must relocate for health reasons. There is often an extensive wait for housing in the city where service can be provided and the housing available may not be suitable for families.”

– Northern community service provider

To maintain the good health of infants, children and parents, it's essential that an intersectoral approach be developed to ensure adequate living conditions and health care for expectant parents, and access to public health services and health care for infants and young children.

What we've learned about health equity in the North

Our society generally strives toward equity, inclusiveness and creating a sense of belonging, and this is certainly the case in health care. Despite these sentiments, barriers to equity continue to exist and be experienced by Northerners. Throughout the process of engagement in 2016-2017, individuals from across the North shared their perspectives on barriers to achieving health equity. Additional evidence was collected to bring further depth to these issues. Seven themes emerged from this work:

1. Basic physical needs: inadequate nutrition, housing, and safe drinking water

Participants consistently raised the unaffordability of healthy foods in Northern Ontario as a major concern, especially given the extremely high costs in the far North. For instance, a monthly food basket for a family of four is more than double in Northern First Nations communities such as Attawapiskat than in southern communities like Toronto.³³ In Canada, according to a 2011-2012 survey, 22.3% of off-reserve Indigenous

households were food insecure, with 8.4% being severely food insecure. These rates are three times higher than in non-Indigenous households.³⁴

Many were concerned about insufficient affordable housing, shelters, and supportive housing in Northern communities. In addition, substandard housing issues are highly prevalent in Northern communities.³⁵ The inter-relationship between experiencing homelessness or being under-housed and substance abuse was also raised.

Although by law Ontarians are entitled to expect safe drinking water, there were 37 First Nations communities in Northern Ontario under long-term boil water advisories between 1995 and 2017.³⁶

“It's hard to think about health and well-being without a roof over your head.”

– Community member



2. Safety, security and social inclusion – stigma, colonization, historical and current trauma, racism

Participants identified social exclusion as a pressing issue for several populations, including but not limited to Francophone populations, populations living with low-income, LGBTQ2 populations, racialized populations, newcomers, those living with disabilities, and those who experience poor mental health and addictions. Stigma related to sexual orientation, gender identity and mental health and addictions was cited as a health-related problem in smaller communities, where it's harder to maintain anonymity in health care interactions.

For Indigenous people, stigma and exclusion exist in a context of colonization, historical and current trauma, and systemic racism, and are particular barriers to equity. Indigenous participants shared stories of discrimination in health care settings, in their workplaces, and in their communities. They also shared the impacts that the residential school system had on themselves, their parents and grandparents, and how these experiences continued to affect their mental and physical well-being.

Community members spoke about the importance of social inclusion. One community member told us:

“Over the last several decades, those of us queer people who are older have lived through and survived being declared illegal, mental health diagnoses and the HIV/AIDS crisis. Rejections from family, friends, church groups, and work environments haunt queers daily. Even if direct harassment and rejection isn't occurring, the constant anxiety about its potential is emotionally damaging. Mental health and social acceptance and security are social determinants of health that affect the physical health of LGBTQ populations across the North regardless of age, ethnicity, language or Indigenous status.”

3. Adequate income and sustainable economies

Participants consistently identified poverty as the strongest determinant of poor health, both at an individual and at a community level. Economic insecurity and underemployment were cited as drivers of poverty in Northern communities. Discrimination and stigma due to language, sexual and gender orientation, and race were also cited as drivers of both unemployment and underemployment. Participants noted that increased income supports are needed to afford adequate and healthy food, housing, health-related benefits and other essential determinants of good health. Some participants noted that current initiatives like the provincial basic income pilot and income security reform, if expanded, could have the potential to decrease poverty in the North.

One school teacher noticed that near the end of the month, some students were missing school because their parents didn't have enough money for food and were ashamed to send their children to school without lunches.

4. Indigenous self-determination and jurisdiction

Participants noted that non-Indigenous approaches to health programs and services for Indigenous people are not well-received in Indigenous communities as they often fail to reflect Indigenous values, beliefs and traditions. This failure inhibits the uptake and effectiveness of these programs in dealing with the significant challenges in health and the social determinants of health with which Indigenous people contend.

Participants pointed to a lack of structures to ensure that First Nations communities and Indigenous organizations have autonomy and decision-making power regarding the health and social services they require. It was felt that structural barriers, such as federal/provincial jurisdictional funding arrangements and status legislation, negatively impact health care services and health care systems for Indigenous populations and communities. Health care in

Canada is generally the responsibility of the provinces, but the federal government provides much of the funding for health care programs on First Nation reserves. Health care providers blamed this jurisdictional split for many problems for service delivery in First Nations communities and for organizations providing services for Indigenous people living and/or seeking services off-reserve. Engagement participants felt that there was only limited collaboration and cooperation between the federal and provincial governments and that resources were not being optimized. Health care providers in First Nations communities reported that these multiple sources of funding all required substantial reporting from First Nations communities, taking time and money away from providing direct patient care.

“The stories of the Sixties Scoop and residential schools are our stories and it is our responsibility to address them. We have credible agencies that are able to take control, but we need resources to do this.”

– Indigenous service provider



5. Strong families and healthy child development

Many participants identified that the overwhelming costs of child care can limit parents, predominantly mothers, from maintaining continuity in the workforce while raising their children. Participants also shared that some communities have no formal child care options available. Participants also pointed out that while publicly-funded and community programs are available for some, after school programs are expensive and out of reach for many working parents in their communities.

6. Education and learning opportunities

For many participants, pursuing postsecondary education was reported to be a challenge due to the costs of tuition, the lost wages from not working while in school and, in most cases, relocating. It was reported that programs for skill enhancement for adults in Northern Ontario are difficult to access because of lack of financial support, location, child care needs, or because prerequisite diplomas or courses are not available.

7. Access to health care services

Access to health care services was cited as a major concern for several groups including, but not limited to, Indigenous people, Francophone people, people living in poverty, people identifying as LGBTQ2, people living with disabilities, newcomers and rural and remote residents in general. Overall, these populations face


challenges accessing culturally competent, linguistically competent and/or inclusive care in Northern Ontario, which can result in stress and poorer health outcomes.

Long distance travel is required to access many services, and health and social services are scattered across municipalities. Extreme weather and the risk of animal collisions make travel in the North dangerous for both patients and service providers. For special access communities, such as fly-in communities or those accessible by ice roads, the geographical challenges are even more pronounced. Participants noted that recent withdrawal of financial support for train and bus transportation in the North has resulted in a sparse inter-city transportation system. Limited agency transportation budgets, compounded over many years, have seriously compromised service delivery. Northern Health Travel Grants do not pay for all of the costs of long-distance transportation. As a result, participants reported that individuals living in poverty have difficulty accessing health care services.

Overall, participants from rural and remote communities noted a lack of access to services such as dialysis, rehabilitation services, and addiction services, and reported that many forego treatment due to this lack of access. Lack of pregnancy and birthing services is a gap in rural and remote communities, and particular challenges exist for at-risk pregnancies in remote communities. Participants also reported that seniors' housing, long-term care, assisted living and palliative care beds as well as

rehabilitation beds are insufficient to meet the needs of Northern communities.

Among Indigenous populations, participants noted both a lack of services in Indigenous languages and a lack of services using traditional healing practices. For those facing addictions, Indigenous participants noted a lack of timely, local and culturally appropriate treatment services.



Service providers and community members shared that in terms of health, the right of Francophones to have access to services in French is not respected.

Other marginalized populations such as newcomers, older adults, and LGBTQ2 populations were noted as having specific gaps in care. Many newcomers face challenges finding linguistically competent care and services. LGBTQ2 community members cited challenges transgender patients face finding health care providers who provide adequate care and treatment, and there is a lack of training available for healthcare providers on LGBTQ2-sensitive care.

Participants reported significant gaps in mental health and addiction services. For example: Detox and residential addiction treatment facilities are sparse; there is inadequate access to services focusing on harm reduction for drug and alcohol use in many areas; and there are challenges to accessing emergency psychiatric beds.

In the North broadly, and specifically in more rural and remote areas, recruitment and retention of health care providers is an ongoing challenge. This challenge is greatly accentuated when trying to retain and recruit health care providers with the capacity to offer services in French.

Community members and service providers repeatedly shared concerns about mental health and addictions throughout engagement. Needs include:

- Culturally and linguistically appropriate treatment facilities for Indigenous people living with addictions
- Social assistance programs to support those living with mental health and addictions challenges.



Access to French-language health care services

For Francophone populations, there are difficulties accessing health care services in French in many communities because of limited capacity of services, a lack of agencies with Francophone designation or a lack of will from agencies to provide services in French. In some cases, services may be available but are not actively offered so people are not aware of them. Recently, the Ministry of Health and Long-Term Care of Ontario recognized this situation in its *Patients First* discussion paper: “Franco-Ontarians face

challenges obtaining health care services in French. To meet their needs, and improve their patient experience and health outcomes, we must ensure that the health care system is culturally sensitive and readily accessible in French.”³⁷ Throughout engagement, participants emphasized that patients must feel confident in their ability to communicate their medical concerns to health care providers. In addition, there are concerns regarding the quality of care for Francophones, including having to seek service in English with the concomitant risk of misdiagnosis.



What Can Be Done to Improve Health Equity in Northern Ontario?

Health Equity Is a Shared Responsibility

Throughout engagement, we heard from Northerners that collaborative, intersectoral action is needed to address health inequities in Northern Ontario. The message was clear:

“We are working in silos. To make change we have to get out of those silos. Meaningful change will result from partners working together in a coordinated way across sectors, rather than working in isolation.”

– Northern Health Care Provider

The World Health Organization’s Commission on the Social Determinants of Health recommended that comprehensive intersectoral strategies on improving and “leveling up” the health of individuals, groups, and communities with the greatest needs would have a substantial impact on individual and population health.³⁸ Intersectoral models to address the complex challenges associated with achieving health equity have been undertaken in places such as

England, Australia, and United States, and we can learn from these approaches.³⁹

Key Recommendation: The Northern Network for Health Equity

Many stakeholders are currently working to improve health and health equity in Northern Ontario. It remains an uphill battle; meaningful strides toward health equity require coordinated efforts.

The primary recommendation of the Strategy is to establish a **Northern Network for Health Equity (the Network)** that would drive intersectoral action to address health inequities in the North. The Network would foster partnership development and facilitate work toward shared goals. The Network itself would neither deliver care nor do the work of any one sector. It would bring together partners and key stakeholders to work on common key priorities identified by Northerners, such as diabetes prevention and management,

mental health and addictions, and parental and child health. Enduring health challenges like these require a coordinated, intersectoral approach to develop long-term solutions.

The Network would be comprised of individuals and organizations from many sectors, including partners from public health, municipalities, LHINs, Indigenous organizations and authorities, community health centres, Aboriginal Health Access Centres, educational and research institutes, Francophone organizations, provincial and federal ministries, municipalities, agencies, and community organizations and members. This work is aligned with the LHIN mandate to convene cross-sectoral tables, and supports the current movement towards greater collaboration between public health units and the LHINs.

The Network would support appropriate partnership development, governance and accountability, coordination, capacity building, and monitoring and evaluation to advance health equity in Northern Ontario.

Network Structure and Partners

The Network would be governed by a steering committee that would provide direction and establish priorities for achieving the objectives of this Strategy. The steering committee would be supported by working groups, with representation from the Northeast and the Northwest. The working group members would be individuals with expertise and responsibilities relevant to their group domain, with representation from partnering agencies and sectors including sectors outside of health. To be effective in driving policy change and developing health equity initiatives, the Network would be resourced with dedicated staff who will provide leadership and coordination to the collaborative efforts of the steering committee and its working groups.

Through these collaborations, the combined strength of all partners will have the potential to improve the health of all those residing in Northern Ontario through education, policy development, and evidence-informed action. With strong intersectoral enthusiasm and support, the Network will be well-positioned to build on existing work. Because distances in the North are substantial, much of the work of the Network will be undertaken virtually; the Network will not require its own facility but dedicated staff will locate with one of its partnering agencies. All partners will sign on to a Network Charter, which will outline Network goals and responsibilities and deliverables of each Network member. Figure 3 conceptualizes this Network.

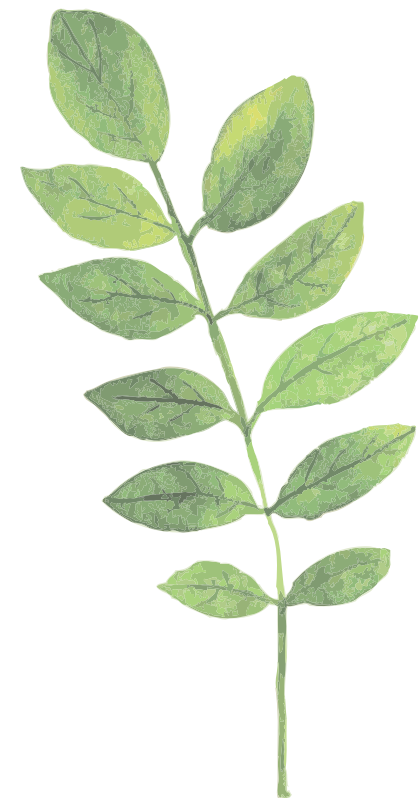
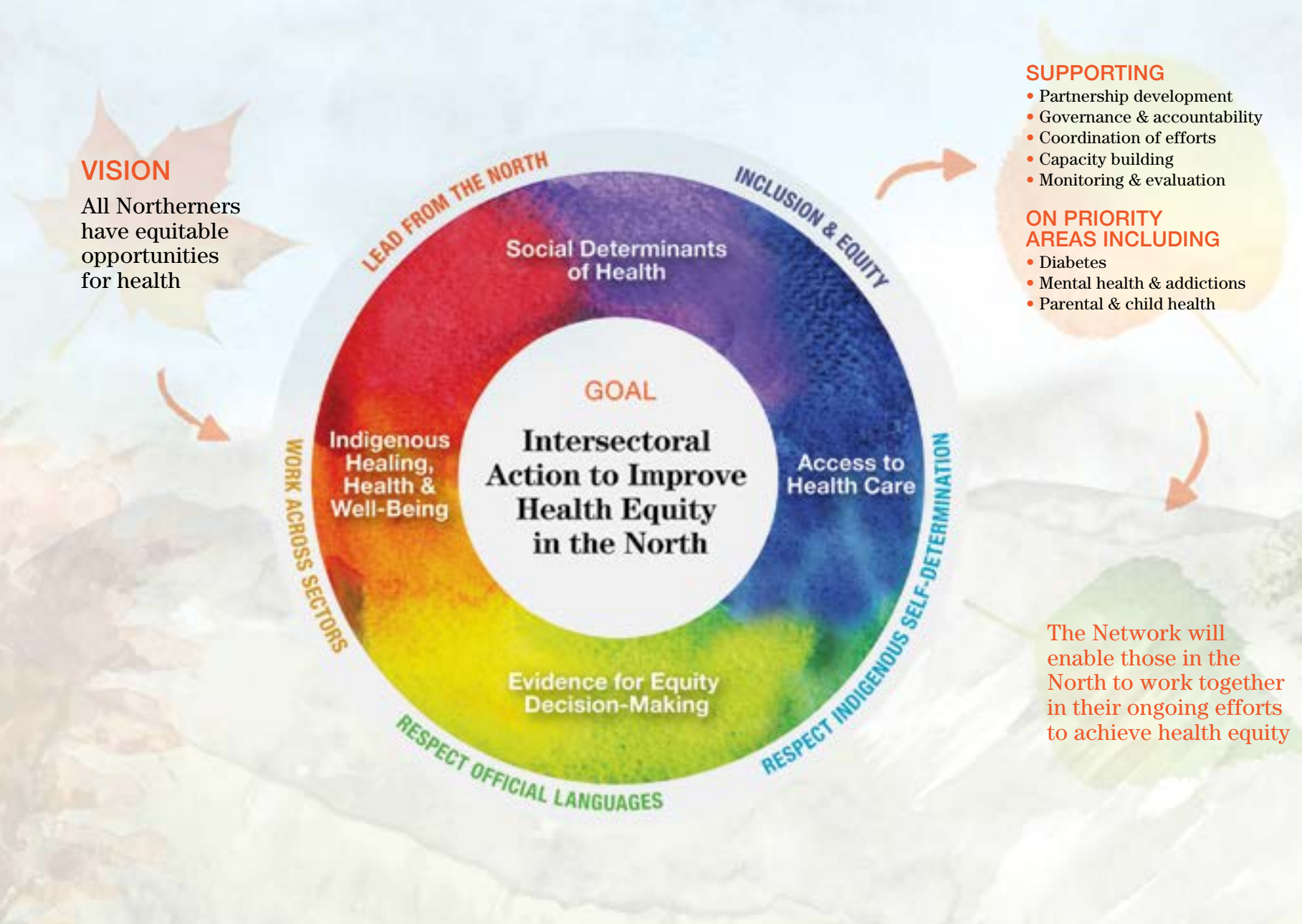


Figure 3: Northern Network for Health Equity



VISION

All Northerners have equitable opportunities for health

SUPPORTING

- Partnership development
- Governance & accountability
- Coordination of efforts
- Capacity building
- Monitoring & evaluation

ON PRIORITY AREAS INCLUDING

- Diabetes
- Mental health & addictions
- Parental & child health

The Network will enable those in the North to work together in their ongoing efforts to achieve health equity

Functions of the Northern Network for Health Equity:

- Supporting Northern partners to develop deeper health equity commitments within their own organizational goals
- Engaging stakeholders, partners, government at all levels to collaborate and to develop and advance policy solutions to improve health equity
- Collaborating with Northern research groups and agencies to conduct research and surveillance in priority areas to inform health equity action
- Supporting Indigenous researchers as needed to ensure research with Indigenous peoples is Indigenous-led
- Providing guidance, training, technical assistance and leadership to strengthen capacity for health equity work in the North
- Facilitating knowledge exchange in Northern Ontario related to evidence, information and best practices

Four Foundations for Action

Stakeholders from across the North identified four foundations for action which must be addressed to achieve health equity in the North. Advances in health equity in the North will rely on progress in each of these areas.

Foundation 1:

Addressing the social determinants of health

Foundation 2:

Equitable access to high-quality and appropriate health care services

Foundation 3:

Indigenous healing, health and well-being

Foundation 4:

Evidence availability for equity decision-making

Network Objectives

Preliminary objectives within each foundation for action of the proposed Network were developed through consultation with Northern stakeholders and solidified through an environmental scan. The objectives are far-reaching and ambitious; however, advances in health equity rely on taking bold action and moving forward for meaningful change. These proposed objectives and options are presented here not as a final mandate, but to reflect the important contributions of participants in the development of this Strategy and to give tangible meaning to the potential for a Northern-led Network. The Network will implement a planning process to further consider these objectives and options for action.

Preliminary objectives within each foundation for action arose from engagement.

Foundation 1: Addressing the Social Determinants of Health

1.1

Improve awareness of the social determinants of health and Indigenous determinants of health in the general public and among health care and social service providers

Awareness of the importance of social determinants of health is a first step in driving policy and program change. This requires working intersectorally to improve awareness about these determinants as well as drivers of health inequity including racism, colonialism, sexism, homophobia, transphobia, ableism and classism.



1.2

Engage partners across sectors to develop poverty reduction strategies

Throughout the engagement process, participants identified poverty as the most important determinant of poor health. Participants emphasized that increased income supports are needed to ensure adequate income to afford food, housing, child care, health-related expenses and other costs of living. Individuals also spoke to initiatives needed to bring communities out of poverty, such as improving housing conditions and supporting educational opportunities for all.

“We need more programs for children and drop-in centres for teens. There are after school programs but they are not affordable for many people. Day care is very expensive. Parents sometimes have to quit their jobs because they can’t afford day care.”

– Parent in a Northern Ontario city

1.3

Work with partners to identify opportunities to improve accessibility to safe, affordable, and culturally appropriate foods across the North

Food security is achieved when people have access to sufficient, safe, nutritious and culturally appropriate food that meets their dietary needs.⁴⁰ Participants noted that food insecurity in Northern Ontario is consistently a problem, both because of poverty and also because of high food prices created by long shipping distances. The loss of traditional food systems has had an additionally devastating impact on food security for Indigenous populations.

1.4

Work collaboratively across the North to improve access to post-secondary education

Access to post-secondary education is an essential driver to ensure income security and long-term health for individuals and their families. More educational opportunities are needed in the North, and solutions are needed to address access issues for those who cannot afford to attend school.

1.5

Engage partners across sectors to improve access to safe and affordable housing

Affordable housing is necessary to prevent people from becoming homeless and to avoid the negative physical and mental health impacts of living in sub-standard housing and/or being precariously housed.

1.6

Work with partners to improve access to early childhood education and care

Children’s health is determined by the health of their families; supports for high quality child care is one way to improve families’ health. High-quality child care supports the growth and development of children and gives every child the best possible start in life and reduces stresses on parents. Many communities in Northern Ontario currently lack high-quality or any child care options at all.

1.7

Work intersectorally to promote social inclusion

Inclusion and a sense of belonging are important contributors to good health. Individuals from marginalized groups are particularly vulnerable to social exclusion, and efforts are needed to improve the sense of belonging for these individuals and groups.

“Promoting cultural identity among children and youth and a strong sense of the community’s history and resilience is critically important to overall community wellness.”

– Community members in a remote First Nations community

How Could the Network Address the Social Determinants of Health?

- Build upon and share social marketing strategies and messaging currently underway in the North to educate the population about the determinants of health, like Public Health Sudbury & Districts' "You can create change!" and "Let's Start a Conversation about health...and not Talk about Health Care at All" campaigns.
- Support community and economic development in the North by identifying stakeholders who will create a shared vision, identify data for proposals, support policy development and advocacy work, and engage in a unified way with government at all levels.
- Develop partnerships with Northern businesses and entrepreneurs and explore social entrepreneurship opportunities.
- Work across sectors to explore options to develop adequate income supports for people living in poverty such as basic income guarantee, increases in social assistance rates, and universal pharmacare.
- Build upon work such as Food Secure Canada's 2016 Report, *Paying for Nutrition: A Report on Food*

Costing in the North in order to increase income supports and food subsidies to ensure access to healthy, affordable food for all. Consider options for partnering with agricultural organizations (i.e., Ontario Federation of Agriculture) and academic institutions (University of Guelph) to further research opportunities for rural and remote communities.

- Support the development of supportive housing, residential managed alcohol programs, and transitional housing. This can build upon the North East LHIN's *Innovative Housing with Health supports in Northeastern Ontario Strategic Plan 2016-2019* and the work in progress in the North West LHIN based upon their 2016 forum, "A Healthy Foundation: Bridging the Gap Between Health and Housing".
- Support the creation of new subsidized day care spaces across the north by working with *Ontario's Renewed Early Years and Child Care Policy Framework* (2017).
- Collaborate with school boards to assist in the implementation of Ontario's Education Equity Action Plan, which aims to make the education system fairer and more inclusive for all students by identifying and eliminating systemic barriers.

Foundation 2: Equitable Access to High-Quality and Appropriate Health Care Services

2.1

Work with relevant providers to promote timely access to and coordination of health care where people live

Access to high quality, coordinated health care leads to better patient experiences and improved health outcomes. Timely access to primary health care allows patients to better manage chronic diseases like diabetes and provides opportunities for them to remain up-to-date with preventive care like immunizations and early detection like cancer screenings. It helps to avoid emergency rooms visits for conditions that can be more appropriately treated by a primary care provider and decreases the worry that patients experience when they don't know when or where they will receive care.⁴¹

One physician working in a Northern hospital described why it is currently being used for emergency housing:

“So much affordable housing has been taken away. It’s particularly challenging when it’s cold, when there’s no family to take them in, they have disabilities. There are currently no units, no adequate shelters, and no options. You can’t kick people out of hospital with nowhere to go.”

Timely access, and access as close to home as possible, to services like obstetrical care, rehabilitation services, palliative care, emergency department and inpatient services are also important for the health of both individuals and communities.

“Health care professionals in the North don’t have access to technology or diagnostics that are common elsewhere. This becomes a recruitment issue as professionals are not willing to work without the diagnostics that they are accustomed to. This speaks to the quality of diagnosis available in small communities in the North and to the resulting treatment. Wages are not the only reason for difficulty in recruitment.”

– CEO of small Northern Ontario hospital



2.2

Work across jurisdictions to improve health care provider recruitment and retention rates

Recruiting and retaining health care providers and staff who have experience in and respect for Northern contexts and who are linguistically and culturally competent, ensures continued opportunities to provide high quality care. In small communities in Northern Ontario, recruitment and retention of physicians and other hospital-based health care providers ensures access as close to home as possible to services beyond primary care.

The Chief and Council of a First Nations community shared their overall frustration with the ever-changing range of providers and transient workers arriving to the community.

2.3

Improve ability of all people, regardless of where they live, to access health care services

Improving access means ensuring inclusive, culturally and linguistically appropriate services are available and barrier-free. It also means providing a means of transportation to assist people in accessing services, both within their own communities and in major health hubs.⁴² It is also important that transportation be available for physicians to move patients to more intensive care and back home again⁴³ and for service providers to provide outreach where people live.⁴⁴

2.4

Improve access to French language health care services

Language and culture play an essential role in the provision of safe, high-quality health care services.⁴⁵ French language services must be supported and enhanced so that Francophones can receive care in their own language and provide informed consent for treatments and procedures.

2.5

Improve access to appropriate and inclusive health care services

Across the North, diverse populations — including, but not limited to those recently arrived in Canada, those living with disabilities, those identifying as LGBTQ2S and those living with low-income — face barriers to care due to a shortage of inclusive and appropriate care from health care providers. Health care providers need training and resources to support diverse populations. This

includes inclusivity training, training for health providers to deliver care to transgender and queer patients, and cultural competency training.

2.6

Improve access to culturally safe health care services for all Indigenous peoples

In alignment with the Truth and Reconciliation Commission's (TRC) Calls to Action regarding education and training, the Government of Ontario announced mandatory Indigenous Cultural Sensitivity and anti-racism training for all public service employees. The intent of this training is for organizations to contribute to the development of necessary skills, knowledge, attitudes and values that support the development of meaningful and informed relationships with Indigenous communities.

In a series of focus groups conducted in Northern Ontario, Francophones whose physicians did not speak French in their appointments found that language affected their patient experience. As one participant shared:

“Conversing in English is a challenge. It is more difficult to feel at ease, and it is an obstacle in the communication process.”⁴⁶

How Could the Network Address Equitable Access to High-Quality and Appropriate Health Care Services?

- Support initiatives aimed to recruit and retain health care professionals, particularly in rural and remote communities.
- Work with the LHIN sub-regions to understand local context, and support them in the development and delivery of region-appropriate approaches to improving health equity in the populations they serve.
- Engage with the North East and North West LHINs' clinical leadership to promote and support population health approaches to care with the goal of achieving health equity.
- Support the LHINs with expansion of eConsult to provide primary care providers with better electronic access to specialists for treatment decision support.
- Assess utilization of Ontario Telemedicine Network (OTN) in Indigenous, Francophone, rural and remote communities to work alongside the LHINs to promote and expand the Ontario Telemedicine Network to identify ways to better serve the health care needs of these populations.
- Collaborate with municipalities across Northern Ontario to work with hospitals and the Ministry of Health and Long-Term Care to provide subsidies to transportation providers and to return Ontario Northland to previous levels to increase the number and frequency of trips, especially to major health hubs from outlying areas.

This would build upon the Northwestern Ontario Municipal Association's report, *The future of inter-community bus service in northwestern Ontario*.

- Support the creation and/or expansion of coordinating systems such as Community Health Centres, Aboriginal Health Access Centres, Health Links, rural health hubs, and patient navigator and care coordination programs with partners such as the North East LHIN, North West LHIN, Ontario Hospital Association, and Cancer Care Ontario.
- Support Indigenous Cultural Safety Training and anti-racism training for all health system staff.
- Collaborate with partners like Rainbow Health Ontario to provide LGBTQ2 training for health care providers, and develop a Northern registry of health care providers who are allies and have received this training.
- Collaborate with partners to collect evidence to support policy changes to the Northern Health Travel Grant to meet the needs of people living with low-income who incur costs for both travel and accommodation when receiving care far from home.
- Collaborate with the North East LHIN, North West LHIN and Réseau du mieux-être francophone du Nord de l'Ontario in support of their Joint Action Plan on French Language Services 2016-2019 to improve access and coordination of French language health care services.
- Support the training of all health human resources and providers in the Active Offer of French Language Health Services.

Jordan's Principle

Jordan's Principle is a child-first principle designed to ensure that First Nations children do not experience denials, delays, or disruptions of services ordinarily available to other children due to jurisdictional disputes. Jordan's Principle was named in memory of Jordan River Anderson, an Indigenous child from Norway House Cree Nation, Manitoba, born with a rare neuromuscular disease. Because his medical needs could not be treated on reserve, he was transferred to a hospital in Winnipeg where a team decided Jordan's needs would best be met in specialized foster home closer to his home community. However, federal and provincial governments disagreed regarding financial responsibility for the proposed in-house services, and so Jordan remained in hospital for over two years, though it was medically unnecessary for him to be there. He died in hospital in 2005 at age five, having never spent a day in his family home.

According to Jordan's Principle, when jurisdictional disputes arise between two government parties regarding payment for services for a Status Indian child which are otherwise available to other Canadian children, the government or ministry/department of ***first contact must pay for the services without delay or disruption***. The paying government party can then refer the matter to jurisdictional dispute mechanisms. In this way, the needs of the child get met first while still allowing for the jurisdictional dispute to be resolved.⁴⁷

Jordan's Principle was unanimously adopted by the Canadian House of Commons in 2007. However, in 2017 the Canadian Human Rights Tribunal found the Government of Canada has continued "its pattern of conduct and narrow focus with respect to Jordan's Principle," resulting in unnecessary bureaucratic delays, gaps and denial of essential public services to First Nations Children, and the Tribunal issued its third set of non-compliance orders.

Health Inequities in Northern Indigenous Communities

Colonization and settlement of and around Indigenous communities in Northern Ontario and across Canada have resulted in significant health inequities for Indigenous people.⁴⁸ The 1876 *Indian Act* was enacted to oppress Indigenous people and culture in order to de-populate traditional land and transfer it to settlers and to assimilate Indigenous people into colonial culture and society. It also aimed to undermine treaties and take land.

From the 1880s through to the closure of the last residential school in 1996, children were removed from their families and communities, often separated from their siblings and placed in residential schools where they were victims of widespread abuse. The trauma inflicted on these children continues to impact communities and new generations today. Indigenous communities still experience deep inequities in child welfare and continue to feel the effects of colonial policies designed to suppress culture and cultural practices and erode traditional governments. These colonial policies are built on racist and discriminatory mentalities that are embedded in health and social systems and institutions. Systemic racism and discrimination has resulted in marginalization in all areas of public life including, but not limited to, inadequate access to health care.⁴⁹

Overall, Indigenous people are more likely to experience poverty than non-Indigenous people in Canada.⁵⁰ These high rates of poverty are

directly related to systemic racism which results in unequal distribution of resources, including income, education, employment, housing and health care. In 2011, 29% of Indigenous peoples living off-reserve had less than a high school education, compared to 12% of the non-Indigenous population.⁵¹ Among adults, only 38% of off-reserve Indigenous respondents reported being currently employed, compared to 53% of the general Canadian population.⁵² First Nations people living on reserve are seven times more likely to live in crowded homes, and six times more likely to live in homes in need of major repairs than the non-Indigenous population.

There is progress being made to reduce these inequities. Across Ontario, Indigenous leadership is driving change and improving the health and well-being of Indigenous people, through creating opportunities for community ownership and self-determination with respect to the underlying determinants of health, such as education, economic development and health. Additionally, the growing understanding among the general public about the importance of reconciliation is a promising step toward eliminating the health inequities faced by Indigenous people in Northern Ontario.

Foundation 3: Indigenous Healing, Health and Well-being

3.1

Work collaboratively across jurisdictions to provide equitable health care services to all Indigenous people

Providing equitable opportunities for physical and mental health for Indigenous populations may mean that services are provided in different locations, in different ways, and that are community-determined, trauma-informed and culturally safe. Old system patterns can not be changed unless underlying assumptions, policies, and services, together with attitudes and behaviours, are challenged. New delivery systems must be developed with an Indigenous worldview and within the control of an Indigenous framework. For equity to be achieved, Jordan's Principle (see page 42) must be upheld for children and expanded to all First Nations people. Urban Indigenous people require culturally-specific health care services for improved health service access and equity and overall improved health outcomes.⁵³

Indigenous healing and wellness must be guided by Indigenous beliefs, values, customs, languages and traditions that complement those of the current and future health systems. The health system in large part operates from a curative perspective while Indigenous culture-based approaches, which are holistic in nature, emphasize health promotion and prevention as an ongoing component of health. Indigenous communities recognize healers, medicine people, Elders, midwives, community health workers, and community support systems, along with providers represented in the *Ontario's Regulated Health Professions Act*, as health care providers.

“How many organizations do HR right? How many have looked at the tool they use in hiring to make sure it is appropriate for Indigenous culture and hiring? There needs to be personal accountability in leadership to ensure that Indigenous people are not excluded within the hiring process. This DSSAB is revisiting how we recruit new hires. If we have to repost three times, we are doing something wrong.”

– CEO of a Northern Ontario DSSAB (District Social Services Administration Board)

3.2

Move forward the Truth and Reconciliation Commission of Canada's Calls to Action,⁵⁴ and support the efforts of Indigenous people in achieving self-determination

The Truth and Reconciliation Commission (TRC) of Canada's Calls to Action call upon all levels of government to acknowledge that the current state of Indigenous health in Canada is a direct result of discriminatory policies and practices. To move forward, it is necessary to resolve jurisdictional disputes, develop indicators to close health gaps, provide sustainable funding for Indigenous healing centres and to support the use of Indigenous healers alongside the Canadian health care system. In addition, the TRC calls upon the health system to increase the number of Indigenous health care providers, ensure their retention in Indigenous communities, and to ensure Indigenous cultural safety training for all health care providers. Beyond health, the 94 Calls to Action seek to address child welfare, education, language and culture, justice, and outline steps toward reconciliation.

Non-Indigenous approaches to health programs and services for Indigenous people are not well-received in Indigenous communities as they often fail to reflect Indigenous values, beliefs and traditions. This failure inhibits their uptake and effectiveness in dealing with the significant challenges in health and the social determinants of health with which Indigenous people contend. Ongoing prescriptive solutions by government on Indigenous health issues have entrenched fear and mistrust in the intent and form of health care

services, institutions and systems. A change in approach to Indigenous health issues, supporting Indigenous self-determination, is essential to achieve health equity for Indigenous populations.

3.3

Work with providers and leverage opportunities to facilitate the provision of safe living conditions that allow residents to thrive in all First Nation communities

Assistance is required to ensure safe living conditions, such as in the provision of appropriate, mould-free housing, clean water and sanitation infrastructure. Other infrastructure investments, including paved roads and keeping stray dog populations under control, will also improve living conditions.



“We know that we will have less visits to the emergency department for asthma treatment if people are not living in substandard housing. There are also less visits to the emergency department when people can afford to buy the medications that they have been prescribed. Acute care is important but if we don’t deal with the issues that are making people sick, we will never get ahead.”

– Health care provider in remote First Nations communities

3.4

Support Indigenous culture as a determinant of Indigenous health

Over centuries, Indigenous people have been subject to a cultural genocide through colonial and Canadian laws and policies (both past and current) to eliminate or negate their cultural identity, which has had devastating impacts on their health and well-being. When Indigenous culture is able to flourish in the lives of Indigenous people, it can positively transform all aspects of life, including health. Various components of culture, including spirituality, sport, food, craft, and connection to the land are all integral to Indigenous identities. Understanding and supporting of culture as a key driver of creating healthy, self-sufficient and vibrant individuals and communities is essential to ensuring Indigenous healing, health and well-being.

Foundation 4: Evidence Availability for Equity Decision-Making

4.1

Develop a Northern Ontario Data Strategy to streamline collection, analysis, and interpretation of data for equity decision-making.

Practice, program and service decisions to improve health equity must be based on the best available evidence. A data strategy would provide a systematic approach to guide, support and synchronize the work of multiple organizations that are collecting population-based data. The development and refinement of indicators

and metrics from a Northern perspective would bring increased relevance and value to Northern health and health equity work.

4.2

Support local engagement in research and use of evidence

Community direction and involvement in data collection, evidence use and research contributes to increased relevance of the processes, and better, more grounded decisions.

“Accurate statistics are required to provide a complete picture of the population we serve so that we can better serve these populations and advocate for them.”

– Public Health leader in Northern Ontario

How Could the Network Address Indigenous Healing, Health and Well-Being?

- Develop accountability structures to ensure implementation of the *Truth and Reconciliation Commission Calls to Action* (2015) among all Network partners.
- Work toward the availability of Indigenous language translation services in hospitals. For example, the Meno Ya Win Health Centre in Sioux Lookout has devised a translation guide; similar guides can be developed for other communities.
- Secure funding for Indigenous organizations to develop programs to support Indigenous cultural practice, including hunting, fishing and harvesting traditional foods, learning history, language, craft, and sports.
- Coordinate provincial, federal and First Nations governing bodies on funding for infrastructure projects such as roads, hospitals, schools, and housing in First Nations communities to ensure safe and healthy living conditions.
- Create an opportunity for Indigenous communities and the health and public health sectors to collaborate with post-secondary research and educational institutions to promote the Truth and Reconciliation Calls to Action by building on the *Northern Ontario School of Medicine's Response to the Truth and Reconciliation Commission's Calls to Action* (2017).
- Encourage all health and social service providers to take Indigenous cultural competency training that is delivered by Indigenous organizations, such as Ontario's Indigenous Cultural Safety Training Program.
- Support public health programs within Indigenous communities and learn from existing models. Weeneebayko Area Health Authority and Sioux Lookout First Nation Health Authority, for example, have undergone extensive community engagement to move forward expanded public health service in the communities they serve.

How Could the Network Address Evidence Availability for Equity Decision-Making?

- Support the development of service agreements that encourage data sharing among organizations to facilitate program planning.
- Ensure the application of OCAP® (Ownership, Control, Access and Possession)⁵⁵ or similar data governance principles for those collecting data from First Nations, Inuit and Métis communities.
- Support the application of principles for ethical, culturally appropriate and community-led research in Indigenous communities, which can be informed by the USAI (Utility, Self-Voicing, Access, Inter-Relationality) Research Framework as developed by the Ontario Federation of Indigenous Friendship Centres.
- Systematically collect data related to the Francophone population through the Linguistic Variable in health records and share this information with system planners in order to plan for French language services.
- Provide a forum for collaboration for partners such as the Institute for Clinical Evaluative Sciences North (ICES North), the Centre for Rural and Northern Health Research (CRaNHR), Canadian Institute for Health Information (CIHI), and the Northern Policy Institute (NPI) to identify Northern Ontario health equity indicators that could be used to measure progress in achieving health equity.
- Support collaboration with key institutions and agencies working in and supporting the North, such as ICES North, CRaNHR, Our Health Counts Ontario, and the NPI to support local research, evaluation, and analysis that is suitable for the unique northern context, geography, and populations.
- Assist health and social service agencies with the adoption of the Health Equity Impact Assessment and other tools to be used for program planning and decision making.
- Partner with communities to develop local research capacity including support for research design, data collection, analysis and data sharing to improve local programming and health equity across the North.



Moving Forward: Impacts

Taken together, the actions of a coordinated Network will create opportunities for advancing health equity, with resulting impact in critical areas including mental health and addictions, diabetes prevention and management, and parental and child health. These, and other health issues that are strongly influenced by social and economic conditions, will benefit from an equity-focused intersectoral approach that addresses multiple factors related to health and well-being.

Specific goals of the strategy will be determined by the Network Steering Committee and working group members. The roadmap below outlines the Network's short- and long-term deliverables:

In the first two years

- Establish the Network Steering Committee, with geographic and sectoral representation
- Hire core Network staff
- Develop the foundations for collaboration as a basis for action to achieve health equity, such as processes for engagement, inclusion and consultation, development of a Network Charter, and work with Network member organizations on integration of equity priorities into strategic plans
- Undertake process of evidence-informed priority setting, using the potential objectives and actions the Network can take to meet the goal of achieving health equity in the North as a starting point
- Undertake coordinated actions to address determinants of health, building on and strengthening capacity through work already underway within sectors
- Regularly inform government about the priorities of Network partners and the Network work plan.

In five years

- Continue to undertake coordinated actions to address determinants of health, building on work already underway within sectors
- The development, measurement and reporting of Northern-relevant equity and health indicators

In ten years

- Improvements in indicators of equity and health among Northern populations
- Progress in equity priority areas identified by Network partners

Next Steps

The formation of the Northern Network for Health Equity is the first step in moving forward the objectives of this strategy. The development of the Network would require commitments of stakeholders across Northern Ontario, and staff support to bring Network partners together.

The Strategy is an expression of the ambition, the passion, and the dedication of health and social sectors to work together for a more equitable, healthier Northern Ontario. Through developing this Strategy, we have heard that across the North, and across sectors, there is recognition of a societal obligation to address the pressing inequities facing Northerners. This Strategy is intended to create the foundation to move toward achieving health equity in the North, and will develop capacity to address pressing health equity challenges in the future.

This Network is an ambitious undertaking. It aspires to connect and align diverse leaders and communities from across a large geographical area. If successful, it will achieve the Strategy's vision of equitable opportunities for health for all Northern Ontarians.



Appendix A: Methodological Approach

Described below is the process used for the creation of the Northern Ontario Health Equity Strategy. Direction for the strategy and this report was provided by Health Quality Ontario in conjunction with the Northern Ontario Health Equity Strategy Steering Committee. Engagement was conducted by the team from the Public Health Sudbury & Districts with support from Health Quality Ontario and environmental scans were conducted by both the Health Quality Ontario and Public Health Sudbury & Districts teams.

Formative Phase

Health Quality Ontario developed a Health and Health Care Equity plan for the organization. One of its priorities of this plan is to work in partnership to develop a Northern Ontario Health Equity Strategy. To keep this strategy *in the North, by the North, for the North*, a partnership was forged between Health Quality Ontario and the Public Health Sudbury & Districts which provided a Northern Ontario team. To oversee the Northern Ontario Health Equity Strategy and champion the strategy's recommendations, a steering committee was struck which included

individuals with experience of health inequities in the North which represented the following areas: Indigenous, Francophone, public health, health care, mental health, research, and education. Groups participating in the steering committee included Health Quality Ontario, Public Health Sudbury & Districts, Northwestern Health Unit, North West Local Health Integration Network, North East Local Health Integration Network, Canadian Mental Health Association, Centre for Rural and Northern Health Research, Ministry of Health and Long Term Care, Northern Ontario School of Medicine, Sioux Lookout First Nation Health Authority, Réseau du mieux-être francophone du Nord de l'Ontario, as well as community representation.

Planning Meeting Preparation

Names of those interested in health equity work were gathered by Health Quality Ontario and others who had been involved in initial discussions with Health Quality Ontario and Public Health Sudbury & Districts about the creation of a Northern Ontario Health Equity Strategy. Invitations to the planning meeting were sent to people on this list. Anyone that

approached the planning committee with interest in attending was also included in the meeting.

In preparation for the meeting, an environmental scan was conducted to find existing health equity strategies (mainly from Ontario but a few were included from Canada and beyond). Selected strategies were used to help define a potential scope for the Northern Ontario strategy.

Planning Meeting

Sixty Northern Ontario leaders, academics, health and social service providers, policy makers, funders and individuals with lived experience gathered for a one day meeting at the Northern Ontario School of Medicine simultaneously in Sudbury and Thunder Bay, the traditional territories of the Atikameksheng Anishnawbek and Fort William First Nations, while others participated remotely.

The purpose of the planning meeting was to identify health equity initiatives, scope for future health equity work, and a process for developing a Northern Ontario health equity strategy.

An exercise was completed by participants to help define the scope of the strategy. Twenty-six statements were presented to the groups, as collated from the environmental scan, and participants ranked their top ten choices and added some of their own. These were discussed in small groups and the top five picks of the groups were collated to inform the scope. Five areas of focus rose to the top: addressing the determinants of health, equitable access to health care services, Indigenous health, data availability for decision making, and partnership and collaboration. It was decided that the first four would become areas of focus with awareness that partnership and collaboration would be foundational for all areas of focus.

Participants were asked about who should be engaged and how they should be engaged. There was a very clear indication that discussions needed to occur at the community level, in English and French, with individuals, caregivers, service providers, and municipal and Indigenous leadership. It was also thought that discussion should include provincial and federal government representatives to further understand jurisdictional and ministerial barriers. It was thought best to consult with communities on how best to reach participants. It was considered important for consultations with decision makers, front line workers and those with lived experience be face-to-face where possible. These needed to be coordinated to fairly represent the Northwest and Northeast, rural, urban and remote settings, and Indigenous and non-Indigenous communities.

Engagement Process

The engagement process was twofold:

Engagement discussions through the Steering Committee members' existing committees:

Steering Committee members identified appropriate meetings to discuss the Northern Ontario Health Equity Strategy and solicit feedback from meeting participants; and

Key stakeholder discussions with individuals and groups:

The steering committee and planning meeting participants identified additional key stakeholders that must be engaged to assist in providing a complete picture of the health equity landscape in Northern Ontario and recommended future actions. Invitees included people from urban, rural, remote, and First Nation communities. Front-line providers, decision makers and people facing inequities were invited to participate.

Engagement Questions

How do we create awareness of and act upon the social determinants of health?

What needs to be done to improve access to high quality health care that is timely, available, and appropriate?

What needs to be done to improve Indigenous healing, health and well-being?

What is the best approach to collecting and accessing data for health equity planning and service delivery?

Engagement sessions

In order to answer the above questions 32 group discussions were held (with more than 300 participants in total, representing 125 agencies) and five key informants throughout the Northeast and Northwest were engaged. These participants represent community members, front line workers, and decision makers and individuals living in rural, urban and Indigenous settings. A list of agencies represented during engagement sessions can be found in Appendix B. Groups were engaged through focus groups.

The engagement sessions and key stakeholders interviews were conducted by the Northern Ontario Health Equity Strategy Project Officer and the Project Lead in both French and English.

Analysis

Information from the engagement sessions and interviews were analyzed using themes generated from the engagement questions. Statements were broken down into health inequities and proposed solutions for achieving health equity. Subthemes were identified for most areas of focus. From here, overarching principles, objectives, actions, and a single recommendation for the strategy were created.

Validation

The results of the engagement sessions were validated by the Steering Committee and at the Northern Ontario Health Equity Strategy Summit on May 25, 2017. The purpose of the Summit was to clarify and validate the findings and proposed solutions and to work through ideas for implementing the proposed solutions. Further validation of principles and objectives and a single recommendation which were derived from engagement and summit occurred through an online French and English survey sent to all steering committee, planning meeting, engagement, and summit participants. Principles and objectives were modified as per survey responses.

build upon. Given that the recommendation of the strategy was to create a Northern Network for Health Equity in Northern Ontario, a search was conducted to find potential models for a collaborative network and for existing collaborative networks upon which a Network could be based.

Additional and Ongoing Engagement

Additional engagement was conducted post summit based on identified gaps as well as to engage groups that were unavailable during the initial phase of engagement. These engagement sessions used more targeted questioning to fill in identified gaps.

Secondary literature searches

A secondary literature search was completed to fact check the information collected during engagement. A provincial scan was conducted to locate existing government programs that the Northern Ontario Health Equity Strategy could

Appendix B: List of Engagement Participants and Partners

Members of the following organizations contributed to the development of this document.
We are grateful for their wisdom and interest in the advancement of health for those living in Northern Ontario.

L'Accueil Francophone, Thunder Bay

AEFO, Thunder Bay

Algoma Family Services

Algoma Public Health

Alzheimer's Society, Manitoulin

AIDS Committee of North Bay and Area

Anishnawbe Mushkiki, Thunder Bay

Assignack Family Health Team

Assisted Living, Manitoulin

Atikameksheng Anishnawbek

Atikokan General Hospital

Attawapiskat First Nation

Brain Injury Service of Ontario

CMHA, Cochrane/Temiskaming

CMHA, Fort Frances

CMHA, Kenora

CMHA, Sault Ste. Marie

CMHA, Sudbury/Manitoulin

Canadian Red Cross, Timmins

Cancer Care Ontario

Carrefour Santé de Kapuskasing

Carrefour Santé de Kirkland Lake

Carrefour Santé de Timmins

Centre de santé communautaire
du Grand Sudbury

Centre de santé communautaire du Temiskaming

Centre for Rural and Northern Health Research

Centr'Elles, Thunder Bay

City of Greater Sudbury

City of Kenora

City of Sault Ste. Marie

Cochrane District EMS

Cochrane District Social Planning Council

Cochrane DSSAB

Cochrane Temiskaming Resource Centre

Community Care Access Centre, Little Current

Community Care Access Centre, Kirkland Lake

Community Living, Fort Frances & District

Community Living Manitoulin

Conseil scolaire catholique de district des Grandes-Rivières	Health Sciences North	Monarch Recovery Services
Conseil scolaire de district catholique des Aurores boréales, Thunder Bay	Health Sciences North, Mental Health and Addiction, Manitoulin	Neighbourhood Resource Centre, Sault Ste. Marie
Conseil scolaire de district du Nord-Est de l'Ontario, Timmins	Huron School Board	Nipissing University
Consortium National de Formation en Santé, Université Laurentienne, Sudbury	Institute of Clinical Evaluative Sciences (ICES) North	Nokiiwin Tribal Council
Constance Lake First Nation	Independent First Nations Alliance, Sioux Lookout	Noojmowin Teg Health Centre
Crane Institute for Sustainability, Sault Ste. Marie	Jubilee Centre, Timmins	North Bay and District Multicultural Centre
Dilico Anishinabek Family Care, Fort William First Nation	Kapuskasung community members	North Bay Parry Sound District Health Unit
Elder Abuse Ontario	Kenora Association for Community Living	North Eastern Ontario Family and Children's Services, Timmins
Elevate NWO	Kenora Chiefs	North East Local Health Integration Network
Elliot Lake Family Health Team	Lakehead University	Northeastern Manitoulin Family Health Team
Elliot Lake Pride	Laurentian University	Northern Ontario School of Medicine
Emo & Area Assisted Living	M'Chigeeng Health Centre	Northern Ontario Service Deliverers Association
Englehart & District Hospital	Maamwesying North Shore Community Health, Cutler	Northwestern Health Unit
Espanola Rural Health Hub	Maison McCulloch Hospice, Sudbury	North Shore Health Centre
Firefly Best Start Hub, Kenora	La Maison Verte, Hearst	North West Local Health Integration Network
Fort Frances Tribal Health Services	Manitoulin Central Family Health Team	NorthWest LHIN Regional Palliative Care Program
Fort William First Nation	Manitoulin Health Centre	NorWest Community Health Centres
Foyer des Pionniers, Hearst	Manitoulin Sudbury DSB Paramedic Services, Little Current	Notre-Dame Hospital, Hearst
Gizhewaadiziwin Health Access Centre, Fort Frances	Marathon Family Health Team	Ontario Hospital Association
Group Health Centre, Sault Ste. Marie	Ministry of Health and Long-Term Care	Ontario Native Women's Association
	Misiway Milopemahtesewin Community Health Centre, Timmins	Ontario Federation of Indigenous Friendship Centres
		Ontario Provincial Police, Fort Frances

Ornge	Sioux Lookout Meno Ya Win Health Centre
Porcupine Health Unit, Timmins	Smooth Rock Falls Health Centre
Pratique de Sage-femme de Hearst	South Cochrane Addiction Service
Pride Manitoulin	Sudbury Action Centre for Youth
Project Love, Timmins	Public Health Sudbury & Districts
Rainbow Health Ontario	Superior Family Health Team
Rainy River District School Board	Temiskaming Health Unit
Rainy River DSSAB	Temiskaming Hospital
Regional Rehabilitative Care Programs	TG InnerSelves
Réseau du mieux-être francophone du Nord de l'Ontario Sudbury	Thunder Bay District Health Unit
Réseau du mieux-être francophone du Nord de l'Ontario, Timmins	Thunder Bay Pride
Réseau du mieux-être francophone du Nord de l'Ontario, Thunder Bay	Thunder Bay Regional Health Sciences Centre
Riverside Health Care, Fort Frances	Thunder Bay Regional Palliative Care Program
Sagamok Anishnawbek First Nation	Timmins Family Health Team
St. Joseph's Care Group	Grand Council Treaty #3
St. Joseph's General Hospital, Elliot Lake	United Native Friendship Centre, Fort Frances
Sault Area Hospital	Victoria Order of Nurses, Little Current
Sault College	Weeneebayko Area Health Authority
Sensenbrenner Hospital, Kapuskasing	West Nipissing General Hospital
Serpent River First Nation	Wiwemikong Health Centre
Shelter House, Thunder Bay	West Parry Sound Health Centre
Sioux Lookout First Nation Health Authority	

Appendix C: Northern Ontario Health Equity Steering Committee

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