

Ethnicity, Income and Access to Health Care in the Atlantic Region: A Synthesis of the Literature

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Executive Summary

The primary goal of this project was to scan the relevant academic and popular literature on the accessibility to health care of different income and/or ethnic groups in the Atlantic region; to present a synthesis of the results of the scan in the form of a document that will highlight the important dimensions of health care accessibility from the point of view of marginalized groups in the region; and to highlight gaps in knowledge that impede the fashioning of well-informed health policies by pointing to the critical areas that warrant ongoing and future investigation.

The literature scan involved a search across several domains – from public and university libraries, community-level institutions, research institutions, and the news media (print as well as visual), to government documents. The search for documents focused on works that provided various perspectives (academic or non-academic) on the relationships between socio-economic status, ethnicity and health care accessibility. The ethnic groups, which were the focus of this study, included Blacks, Aboriginals and Acadians, as well as various immigrant groups whose cultural beliefs and practices differ from those of the dominant culture.

The synthesis contained in this report finds that there is a shortage of research-based literature on the role of ethnicity and low-income status as they relate to health care accessibility in the Atlantic region. As a result, that which exists is thinly spread out. This is in contrast to work being done in other parts of Canada. There is, therefore, a need to make a long-term commitment to such research in the region. On a more specific level, we need more systematic quantitative and qualitative work on the determinants of health care accessibility across the broad spectrum of health care services, and to disentangle more definitively the links between income status, ethnicity, short and long term immigration experiences, and health care usage. As part of this broader research effort, we need documentation on the varying health problems and needs of ethnic minorities, both established and new communities. As noted in the report, the fact that minorities constitute a small proportion of the provincial population is precisely why they can become marginalized, especially those who belong to low-income groups. If health care policy is not informed about these sub-populations, they will continue to be marginalized from mainstream Canadian society.

There is a clear lack of information on the gender aspects of health care accessibility. Much of the existing literature relates only to women. A gender perspective is especially important for understanding the health care access of both groups, and especially ethnic groups whose cultural values differ from those of the dominant cultures.

To build a critical mass of research-based literature on the subject of ethnicity and socio-economic status, as it relates to health care accessibility in the Atlantic provinces, requires a strategic investment in health-related research. There is, otherwise, the danger that Atlantic Canada will continue to lag behind in the creation

of such a body of research. It is also important to note that Atlantic Canada does not benefit from a Metropolis Centre of Excellence on immigration research.

1. Introduction

It is a well-documented fact that the Atlantic provinces are the poorer cousins of other regions of Canada. How that national inequality translates into income and other inequalities in the Atlantic region, and what role other factors such as geographical location (urban/rural) and ethnicity play, are questions that must inform any social policy (national and provincial). Although income clearly plays an important role, the "well-being" of Atlantic Canadians depends upon the opportunities they have to develop "human capabilities", which represent the ability of humans to function in society economically, socially and politically, as noted by Nobel Laureate Amartya Sen (1997). The anchor for human development is health since that determines whether, and to what extent, human beings can function. Thus, good health allows us to enroll in schools, learn skills, look for employment and earn income. It is also the foundation for forming families and raising children. There is also an important inter-generational impact.

How can we ensure that all individuals in a society are able to enjoy good health so that they have a decent standard of living? As first noted by the *Federal, Provincial and Territorial Advisory Committee on Population Health* (1996, p. 4), henceforth FPTACPH, and *Toward a Healthy Future: Second Report on the Health of Canadians* (1999), there are a number of interdependent factors that determine health status such as living and working conditions, the physical environment, biological factors, personal health practices and coping skills, health services, gender, culture, income and social status, social environments, social support networks, education, employment, childhood development; as well as one's immigration and resettlement experience.

The focus of this report is the issue of accessibility to health services. Inequalities in access to health services can be examined in the context of broader inequalities in the socio-economic sphere which might stem from the income status and ethnicity of individuals, their geographical location, as well as age and gender¹. What role do these factors play in determining the availability and affordability of, and accessibility to health care? How do they determine what constraints individuals face, and where? This report synthesizes the existing literature with a view to ascertaining the nature and extent of knowledge on health care accessibility from the perspective of ethnicity and socio-economic status, highlighting the gaps in the knowledge base, and assessing future needs in this regard. This, it is hoped, will provide a first step towards answering the questions raised above so that public

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Of course, income status is likely to be related to ethnic background, as well as to age, gender and geographical location.

policy on health care in Atlantic Canada can be fashioned on the basis of a clearer and deeper understanding of the health constraints and needs of marginalized groups in the region. The report also contributes to our national understanding of the interactions among the determinants of health.

The objectives of the project

The primary goal of this project was to scan the relevant academic and popular literature on the accessibility of health care by low-income and/or ethnic groups in the Atlantic region, and to conduct a preliminary study to:

- *identify patterns relating to health care accessibility and use, according to income class and ethnicity, by rural and urban populations, and the interplay between these, in order to get an integrated picture of the nature of constraints, as well as the settings in which they are encountered;*
- *present a synthesis of the results of the scan in the form of a document that will highlight the important dimensions of health care accessibility from the point of view of marginalized groups in the Atlantic region;*
- *expose gaps in knowledge that impede the fashioning of well-informed health policies by pointing to the critical areas that warrant further investigation.*

The dimensions of accessibility to health care

Health care accessibility is not simply a matter of providing an array of health care products² and services through a collection of facilities, physicians, specialists and other health care professionals, but also of the quality of those health care resources, and of the ability and willingness of various population strata to actually access them, as and when needed. Together, these elements of accessibility are likely to be critical in determining the success with which the health needs of all Canadians are met.

If society is relatively homogeneous, with small differences in income and socio-economic status, there need not be significant departure from equitable health care accessibility. However, in the face of ethnic diversity in the population, and of significant differences in economic and social status, the ability of all groups to access health care becomes an important issue for public policy. Not only does it matter whether overall availability is adequate, but also that the composition of health care products and services – as well as their location – matches the pattern

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The phrase "health care products and services" is meant to capture all aspects of health care provision, including medical products such as over-the-counter as well as prescription medication, and other medical goods needed for treatment.

and location of need. An example of the problem of locational mis-match is best exemplified by the concentration of health care, both in quantitative and qualitative terms, in urban areas of Atlantic Canada.

Ethnicity, as well as the socio-economic status of individuals, can play an important role in their perceptions regarding the availability and usefulness of health care products and services, and also on the degree to which they have knowledge of them or understand them, and/or are able to afford them. Ethnicity could also, via its shaping of cultural values or because of overt or covert discrimination, affect the willingness to access health care products and services. *Toward a Healthy Future: Second Report on the Health of Canadians* notes that although the provision of health services "does not seem to be related to the income of the patient ... there continue to be language and cultural barriers to the provision and/or utilization of services in certain circumstances" (FPTACPH, 1999, p. 145). Where the type of health care products and services available responds to the needs of a diverse population, progress towards health care equity is possible; where this does not happen, marginalization of population sub-groups can occur even when (perhaps especially when) ethnic groups constitute small minorities.

2. *The Nature and Scope of the Study*

The first task of the project involved a scan of the literature on ethnicity, income status and health care accessibility in the Atlantic region, and the organization and documentation of the information thus obtained. The three major elements of the literature scan were:

Information sources:

Public and university libraries, community-level institutions (e.g., Metropolitan Immigrant Settlement Association), research institutions (e.g., Maritime Centre of Excellence for Women's Health in Halifax, NS, and the Muriel McQueen Fergusson Centre for Family Violence Research in Fredericton, NB); media (print as well as visual); government documents.

Information type:

Non-academic and academic written work, both published and unpublished; visual and oral reports; sources of government statistics.

Geographical coverage:

The Atlantic provinces were included with attention to rural/urban location.

Scope of search and review

Time constraints limited the study to a compilation and classification of the relevant literature and information from different parts of Atlantic Canada, and to an identification of broad patterns based on a reading of that material, sufficient to give direction to policy planning and a preliminary knowledge base upon which to build.

The search for documents focused on works that provided various perspectives (academic or non-academic) on the socio-economic status and access to health care of ethnic groups (Blacks, Aborigines, Acadians) as well as various immigrant groups whose cultural beliefs and practices differ from those of the dominant culture. Governmental and non-governmental institutional sources in the four Atlantic provinces were contacted, including the Maritime Centre of Excellence for Women's Health, Advisory Councils on the Status of Women, Population Health Research Unit of Dalhousie University, Centre de Bénévolat de la Péninsule Acadienne Inc., Maritime School of Social Work, University of Prince Edward Island's School of Nursing, Community Health Promotion Network Atlantic, Prince Edward Island Association for Newcomers to Canada, and the Muriel McQueen Fergusson Centre for Family Violence Research in New Brunswick. Also scanned were the web sites of CBC television, newspapers of the region, and other national print media.

Database scans included: Novanet, Medline, PAIS (Public Affairs Information Service), and Sociofile. The scan also included Statistics Canada National Population Health Surveys, Statistics Canada Health Statistics and CANSIM databases. The search terms were broad and inclusive of the wide range of issues related to health care in the Atlantic region.

Limitations of the study

The time frame of the study was too short to produce optimal results, and consequently constrained the study in a number of ways, of which the two main difficulties were as follows:

- The project initially envisaged meetings with individuals from various non-governmental organizations in the provinces. It was realized that this would not be possible (except locally) within the time frame of the project due to logistical problems. As a result, most of the information was sought through electronic mail, Internet, telephone and fax.
- No critical assessment of the academic literature was done, as this would entail a detailed review of each work and was well beyond the scope of the report. Therefore, the findings are suggestive rather than conclusive, and are meant to be reflective of the types of health-related issues in the area that have been studied or written. This report points to areas for future investigation and research investment.

3. *Income, Ethnicity and Health Care in Atlantic Canada: A Statistical Profile*

To give perspective to the issues that are the focuses of this report, this sub-section presents a brief statistical overview of the Atlantic provinces. Tables 1 and 2 (Appendix A) present some broad comparative statistical indicators of socio-economic status, ethnic make-up and well-being in the Atlantic provinces, as well as Canada as a whole.

Income and educational status

Income per person (GDP per capita) in each province of the Atlantic region is well below that in Canada as a whole, with Nova Scotia showing the highest, and Prince Edward Island and Newfoundland the lowest. The weaker economic status of Atlantic Canada, and that of Newfoundland and Prince Edward Island in particular, is also clear from the pattern of unemployment rates. Median individual income is much lower in Atlantic Canada, and visible minorities across the Atlantic region, except those in Newfoundland, do significantly worse on average than the overall provincial populations. In terms of educational attainment, with the exception of Nova Scotia and to some extent Prince Edward Island, the other Atlantic provinces compare unfavourably with Canada as a whole. As of March 2000, Nova Scotia also has the highest rate of children and single mothers living in poverty.

However, as Ron Colman points out with respect to Prince Edward Island, although the province has weaker economic status, and since this research is focused on relative equality and inequalities, it would be fair to say that Prince Edward Island has the lowest rate of child poverty in the country and one of the lowest rates of low-income altogether. In other words, wages are low in Prince Edward Island but there is a lower rate of poor people and therefore more equity. The wage gap in Prince Edward Island is also the smallest in the country.

Ethnic composition and language

The ethnic make-up shows that Atlantic provinces are well below the national average in terms of both the share of Aboriginals as well as visible minorities in the total population, and immigrants make up a small proportion of this population. In spite of significant shifts towards non-European immigrants in recent years, white immigrants still account for a substantial share of the immigrant population. Relative to other Atlantic provinces, Nova Scotia shows the greatest ethnic diversity; less than 1.5% of the population of Newfoundland is composed of visible minorities. The corresponding numbers are 3.5% for Nova Scotia and 11.2 % for Canada as a whole. Thus, with the possible exception of Nova Scotia, institutional structures and practices in the Atlantic region would most likely reflect the values of the dominant culture. It is precisely in this setting of small minority populations that the potential for marginalization, especially with respect to health care accessibility, becomes especially significant.

Turning to knowledge of the official languages, New Brunswick shows the greatest bilingual ability, but virtually all residents of Atlantic Canada know at least one official language.

Well-being and health

According to the 1995 *Statistics Canada National Population Health Survey*, there are large differences between provinces on health-related issues, but no single province dominates across the entire spectrum of health status indicators. Some of the self-rated indicators of physical and mental health shown in Table 2 (Appendix A) confirm this at least as far as some of the Atlantic provinces and Canada as a whole are concerned. Thus, Atlantic Canadians in Nova Scotia and New Brunswick appear to be more satisfied psychologically and with their jobs than other Canadians, but rate their health status more poorly than their counterparts elsewhere.

Again, as Colman points out, broad generalization on Atlantic Canadians' psychological health and self-rated health status does not actually apply to Newfoundland and Prince Edward Island, both of which register "high" psychological well-being and self-rated health status.

In terms of the more traditional indicators of health, such as life expectancy and infant mortality, provinces have converged, with Atlantic Canada, on balance, ranking somewhat behind the rest of the country. Of course, provincial level statistics mask large differences within provinces, across ethnic groups, and socio-economic classes. Thus, while child poverty rates in Newfoundland are the highest among the provinces, those for low-income single mother families are even higher, and this is true for all provinces (FPTACPH, 1995, p. 60). As of March 2000, Nova Scotia also has the highest rate of children and single mothers living in poverty (see the Maritime Centre of Excellence for Women's Health *Call to Action for Women's Health and Well-Being in Atlantic Canada* released on International Women's Day 2000).

Other data also show that Atlantic Canada spends a greater share of its GDP on health (ranging from almost 14% in Newfoundland to about 13% in the other Atlantic provinces) than central and western Canada; yet, Atlantic Canada's health expenditures per capita are among the lowest in Canada (FPTACPH, 1995, p. 65).

The overall picture, thus, clearly points to the lower relative socio-economic and health status of Atlantic Canadians. In addition, there are significant differences in income across provinces, as also between the incomes of visible minorities and overall provincial populations. These likely play an important role in the inter-provincial and intra-provincial pattern of health status in the Atlantic region.

Synthesis of the literature³

This section brings together the main themes that can be drawn from the literature scan on issues relating to the accessibility to health care by ethnic and low-income Atlantic Canadians.

Nature of the literature

The literature, as it relates to ethnicity and health care accessibility in Atlantic Canada, is limited. That which exists is predominantly about the traditional, geographically concentrated, ethnic groups of the Atlantic region – Aboriginals, Blacks and Acadians. This is especially true of the existing academic literature, although the popular literature as represented by the print and television media is not plentiful either. The newer, visible ethnic immigrant groups are only now beginning to get attention, mainly through the research efforts of individuals and institutions based in Atlantic Canada. That attention also varies across the Atlantic region, reflecting the unequal provincial distribution of these sub-populations.

Health-related issues as they pertain to the economic and social status of individuals, including women and single mothers, and those of rural households, have also been examined in the academic and non-academic literature.

Much of the literature on ethnicity, income and health care accessibility in Atlantic Canada is not of a purely academic nature. A significant amount comes from research organizations such as the MCEWH, and also from government agencies or projects funded by such agencies. Some of these issues have also been covered by the print and broadcast media.

Issues examined

As noted above, the overall volume of literature on ethnicity and income status as it impacts on health care accessibility in the Atlantic region is small. That literature is spread thinly over a range of rather specific issues in the extensive realm of health care issues, and therefore is not amenable to generalization, especially along clear thematic lines necessary for policy formulation. Nevertheless, some categorization of the health care accessibility issues that have attracted the attention of researchers and writers in the academic and non-academic spheres is possible. The main areas of research appear to be as follows:

- Perceptions about well-being, health and health care accessibility among

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In presenting the synthesis, we reference only those articles and reports that are directly related to the themes around which the synthesis is developed. An annotated bibliography for the wider literature that was scanned is presented in Appendix B.

Blacks (mainly in Nova Scotia) and Aboriginal groups (in all Atlantic provinces), and to some extent among ethnic immigrant groups (mainly in Nova Scotia and Prince Edward Island), and the Acadian sub-populations of New Brunswick.

- Related issues of identifying the needs and problems of access of low-income groups (including rural households, disadvantaged ethnic groups and women).
- The relationship between socio-economic status and health care.
- Problems of health care delivery modes as they relate to the needs of an increasingly diverse population.
- Problems of health care access and funding arising from the trend towards greater reliance on community-based health care (i.e., the economic and social burdens of home care, for example in rural communities, and especially for the elderly).
- Description of health-related initiatives targeted towards low-income/ethnic populations.

Patterns of health care utilization in Atlantic Canada

There are no macro level indices or indicators of the patterns of overall use of health care services by different population groups in Canada or the provinces, although it is possible to conceptualize and operationalize indices of this kind. Existing studies of health care utilization use a variety of dis-aggregated measures such as the frequency of physician consultations, length of hospitalizations, etc. This section outlines some of the findings regarding health care utilization with regard to income status, ethnicity and geographical location.

Income status

A cursory review of the literature suggests that lower income individuals tend to have poorer health and are likely to have a greater demand for a variety of health care services. For instance, a survey of scientific evidence by Jin, Chandrakant, Shah & Svoboda (1995) found a strong positive association between economic status (as determined by employment status) and adverse health outcomes. A number of studies show that health care utilization and socio-economic status are inversely related. Colman further suggests that less use of preventive services may eventually lead to higher rates of illness, and therefore higher rates of visits to physicians and particularly hospitalization. He notes that since lower income individuals use preventive services less than those of higher income, this would be consistent with that group depicting higher rates of physician visits and hospitalization (Colman, personal correspondence, April 2000).

The recent report on the health of Canadians points to and finds a greater frequency of physician visits by low-income groups compared to others (FPACPH, 1999, p. 146). In a recent study, Colman quotes studies which report that single mothers are three times as likely to consult a health care practitioner for mental and emotional reasons (see page 22, footnote 65), and that poor women are 62% more likely to be hospitalized than higher income women at ages 15-39, and 92% are more likely to be hospitalized than higher income women at ages 40 - 64 (see source footnote 35). Colman notes that it may be possible for us to infer that as single mothers have particularly high rates of poverty, it follows that they have higher rates of hospitalization and health care usage in general (personal correspondence, April 2000).

Kephart, Thomas and Maclean (1998) analyse survey data from Nova Scotia, and conclude that if one adjusts for age, sex and region of residence, use of treatment services (i.e., physician services) is inversely related to socio-economic status. A lower economic status might also lead to more adverse outcomes in mental health and thus lead to a greater usage of mental health services as noted by Gushe (1994) in connection with the economic decline of the Newfoundland fishery. This body of evidence appears to suggest that Atlantic Canadians at the lower end of the socio-economic ladder, which would include various sub-groups such as Aborigines, Acadians, Blacks, other visible minorities and immigrants, as well as single mothers and older women, would likely depict higher rates of utilization of physician services.

At the same time, patterns of health care utilization of different socio-economic groups can vary across types of health care services, as well as across (and within) provinces. Thus, although poorer people in general seem to utilize physician services more intensively than the rich, the opposite seems to be the case for some types of health care services. Thus, Statistics Canada (1998 Charts 10 and 11) reports that as far as preventive health care (such as mammograms and pap testing) are concerned, the lowest income groups generally use such services more sparingly than those higher up the income ladder. This could reflect a combination of factors such as difficulty of convenient access and/or the lack of information. In addition, utilization of preventive health care services can also vary considerably across provinces. Thus, Prince Edward Island and New Brunswick are well ahead of Newfoundland and Nova Scotia in the area of mammograms (Statistics Canada, 1998, Chart 9). In general, therefore, patterns of health care utilization by different socio-economic groups would likely vary by type of health care service as well as by province and ethnicity.

As noted in *Toward a Healthy Future: Second Report on the Health Canadians* (page 146), lower income Canadians report more frequent visits to a physician, which is consistent with the higher rates of health problems among economically disadvantaged Canadians. In summary, less use of preventive services by low-income Canadians may result in higher rates of physician visits and hospitalization.

Ethnicity

Ethnic background is likely to determine patterns of utilization across health care products and services, given that cultural values influence perceptions about what constitutes good health. Cultural factors have been found to explain low rates of utilization of preventive health care services among various minority groups including Aboriginal women, Asian immigrant women and Black women. An extensive bibliography on this literature is to be found in Women's Health Coalition of Prince Edward Island (1999), henceforth WHC, Health Canada (1999), and Globerman (1998). The WHC study reports the attempt by Well Women's Clinics in Prince Edward Island to get such "hard to reach" women to better utilize available preventive health care services, while a study of 458 Nova Scotian women (which includes both Aboriginal and Black women) found that perceptions of health can differ, with proportionally less ethnic women associating nutrition, mental status and the environment as having a positive impact on health relative to Caucasian women (Barksdale et al., 1999). In the final report (Conrad, 1998) on a conference on women's work and well-being in Atlantic Canada, it is noted that Black women are less likely to utilize breast cancer screening facilities, relying more on community structures to manage health. The Statistics Canada (1998, Chart 9) population health survey overview notes that, with the exception of Prince Edward Island, the provinces of New Brunswick, Nova Scotia and especially Newfoundland lag behind other parts of the country in terms of the percentage of women aged 50 to 69 who have ever had a mammogram screening.

Geographical location

Patterns of health care utilization also depend upon geographical location of low-income and/or minority groups. Specifically, rural communities are known to have lower average incomes and low rates of utilization of a variety of specialist services, including preventive health care. Rural communities are also more intensive users of home care given the urban bias in health care facilities. The use of home care is becoming increasingly important, especially for elderly Atlantic Canadians, as provinces move to shift health care responsibility out of institutional structures. The problems of health care utilization and access in rural communities in general, as well as the problems of home care (provided predominantly by female family members), are discussed in a number of papers – Nova Scotia Department of Health (1997), WCH (1999), Commission on Selected Health Care Programs (1989), Townsend, Anderson and Jenner (1988), Campbell, Bruhm and Lilley (1998), White, Dingle and Pietrusiak (1989), and Martel (1995).

Studies of health care utilization, however, do not tell us unambiguously what the causal factors are, nor what role barriers to health care access play. High rates of utilization by the poor could well reflect their poorer health (FPTACPH, 1999, p. 146). On the other hand, low rates might reflect less need or lack of accessibility. There is likely to be no unique relationship between utilization, accessibility and income status, as well as geographical location, and the interplay between these factors can produce a variety of outcomes, which vary across the spectrum of health

care products and services.

Ethnicity, income and barriers to health care accessibility:

An overview

Our synthesis of the literature from the perspective of ethnicity, income status and the accessibility to health care, is discussed in two parts. The first looks at problems of access that stem from constraints on the supply side (that is, from the point of view of availability), while the second discusses problems of access from the demand side (that is, from the point of view of users of health care).

The supply side: Problems of availability and quality

Although a study by Roos, Bradley, Francoo and Shanahan (1998) found no adverse trends in physician/patient ratios (among the elderly population) in the Atlantic provinces, the aggregate picture masks potentially important inequalities in health care provision. The literature as a whole clearly points to imbalances in the quality and quantity of health care products and services across rural and urban sectors, especially for low-income and/or minority groups. Specific problems identified were:

Shortages

The inadequate supply of doctors, including trained specialists as well as facilities, has received a great deal of attention in the literature, and much of that attention has been focused on rural regions of all provinces (see, for example, McLeod, 1998, 1999; Government of Nova Scotia, 1997, p. 14; Martel, 1995; White et al., 1989). These shortages reduce health care access as well as the quality of that access for low-income and minority rural populations. In some cases, rural doctors are not aware of the types of health care services available, as has been reported by the press to be the case with regard to mental health care in Nova Scotia (MacKinley, 1999, p. 6); in others, the supply of family doctors has been especially inadequate, as has been reported for the Acadian Peninsula (Borsellino, 1998, p. 48). A major implication of the rural imbalance could be a lower incidence of preventive health care utilization by low-income rural groups such as Aboriginals and Blacks (White et al., 1989; Morris et al. 1999, p. 63), and indeed by other low-income, predominantly rural minorities such as the Acadians of northern New Brunswick and Prince County, Prince Edward Island.

Home-care delivery and support

There is greater reliance on home care, especially for the elderly, often by female family members who lack training and skills (Morris et al., 1999). Also noted is the lack of funding for home care, the low wages paid to home care providers and the low quality of care received, as well as the difficulties

of access faced by Aboriginal populations on reserves. Campbell et al. (1998) also found a lack of support for caregivers (which included Blacks, Acadians and Aboriginals) in rural Nova Scotia.

Health care systems and modes of delivery of health care services across the Atlantic provinces are structured along health care perceptions, values and priorities of the dominant cultures, and have yet to respond to the needs of an increasingly diverse population in the face of a newer class of immigrants, as well as to those of existing ethnic groups. The result is unequal access to health care of visible minorities, and also a lower quality of health care experiences. Of the kinds of problems that are seen to emerge from the literature from this perspective, the important ones appear to be as follows:

The lack of effective ethnic representation

Ethnic minorities tend to be poorly represented in the population of health care professionals, on bodies that provide health care or make policy in that regard in Canada in general (Richard and Jagielski, 1999). The same trends are to be found in Atlantic Canada. Skinner (1998, p. i) argues that in Nova Scotia, the "population's ethnic diversity is not a routine consideration in either health research or health policy activities." The study also notes that there is a considerable lack of research-based information to assess the impact of ethnic diversity on health, but that preliminary information appears to indicate "significant and untenable health inequities...along ethnic lines in Nova Scotia." (p. i). The Nova Scotian task force on the access of services by Blacks also points to the lack of Black health care professionals in the health care system (TFBNS, 1996, p. 21-22). The 1999 van Roosmalen and Loppie study suggests that the access to health services of disadvantaged groups such as Acadians, Blacks and Aboriginals is compromised by a number of factors ranging from racial biases and cultural insensitivity, to the anglo-centric orientation of health care systems in the region. A study by Enang (1999) also found that Black women face a number of barriers in accessing health care in Nova Scotia. In a recent paper, Snow (2000, p. 12) notes that in the Acadian Peninsula where a unilingual Francophone could once become a regional director for Community Health and Services, that is no longer possible as a result of the position having become bilingual – a requirement that does not restrict unilingual Anglophones elsewhere.

The information gap

Health care systems in the Atlantic region are not culturally sensitive to, and are generally uninformed about the health care perceptions and needs of a culturally diverse clientele, and also about ethno-cultural diseases and medicines of minorities (see, for example, van Roosmalen et al., 1999; MacKinnon and Lee, 1999; Enang, 1999). For instance, there is little known

about how various diseases affect the health status of Blacks (TFBNS, 1996), and there is little information on the health care problems and needs of visible minorities such as Blacks and Asians (Campbell, 1999, p. 40). However, increasingly across Canada, doctors are trying to incorporate alternative therapies that reflected cultural and religious backgrounds into their treatments (Campbell, 1999, p. 40; Elash, 1997).

Entrenched stereotyping and racism

A number of reports point to the existence of racism within the health care system (see, for example, Enang, 1999; Mabaleka and Thomson, 1999; van Roosmalen and Loppie, 1999), which not only reduces the quality of health care received but also the extent to which visible minorities utilize health care services. Thus, Black women often seem to rely on informal community support for their health care needs (Conrad, 1998), and Aboriginal groups seem to be better served when health care centres are organized within their communities as noted by the Task Force on Aboriginal Issues (Government of New Brunswick website).

The demand side: The ability to access health care

Socio-economic status is an important determinant of the demand for health care. In fact, according to *Toward a Healthy Future: Second Report on the Health of Canadians* (FPTACPH, 1999), low-income status is the most reliable indicator of poor health; that the poorest Canadians are four times more likely than their fellow citizens to have poor health (whatever indicator of health status we look at), and two times more likely to develop long-term activity limitation. Thus, the need for access to health care for low-income groups is critical for their overall well-being. As noted earlier, Colman (2000) recognized that low-income women (especially single women) in the Atlantic provinces tend to show greater rates of hospitalization and health service usage in relation to mental health visits. It may be inferred, although it is not explicit in the Statistics Canada data, that since single mothers have higher poverty rates, they may also have higher overall hospitalization rates. This inference is supported by Kephart et al. (1998) who found that use of physician services is inversely related to socio-economic status, after adjusting for age, sex and region of residence. Of course, actual rates of utilization of health services are themselves not clearly indicative of the ability to access health care, since that usage is sensitive to a myriad of factors including ethnic background, location of services, etc. Nevertheless, it is clear that low-income status restricts the range of choices about the health care products and services that the poor can access given variations in which of these products and services are fully or partially funded and which are not.

For many low-income people, occupational and location constraints make it more difficult to access health care products by increasing the effective cost of accessing them. For instance, a report submitted to the Government of Newfoundland and Labrador by the Social Policy Advisory Committee (1997) noted that the shortage of

health care services (because of budgetary constraints) has led to a growing trend towards private-sector provision of some services which only well-off individuals can afford. The report also notes that access is especially difficult for the rural poor who must travel long distances to access health services. Similar difficulties have been noted for Blacks in Nova Scotia (especially the elderly), who are finding it increasingly difficult to access appropriate health care due to transportation difficulties and the cost of medical services such as Pharmacare (Task Force on Government Services 1996). In general, predominantly rural, especially minority ones, are likely to face the greatest difficulty in accessing appropriate health care due to their low-income status. A study by Beaudin, Boudreau and De Benedetti (1996) notes that the Acadian minority of Prince County in Prince Edward Island is predominantly rural, elderly and poor in relation to other residents of the province. That combination makes it likely that they would not be able to have affordable access to appropriate health care.

Ethnicity plays a role in the ability and willingness of individuals to access various health care services and products. Important ethnic influences are:

Cultural differences in the perceptions of health, and hence need

These differences impact on what health care services will be demanded and accessed. For instance, a study shows that relatively greater proportions of Caucasian women see nutrition, mental status and the environment as important positive elements of health than Blacks or Aboriginals (Barksdale et al., 1999; MacKinnon and Lee, 1999). There is also vast literature on the role of ethnic background and socio-economic background in governing the utilization of preventive health care in other parts of Canada or for Canada as a whole (see, for instance, the report on Canadian research on immigration and health, Health Canada, 1999).

The information gap

Language and communication barriers often mean that ethnic immigrant minorities are not clear about the health care services that are available, or of their benefits, and this impacts adversely on their ability to access them. Several pieces of research point to the lack of information and organizations that could provide vital information to minorities (especially immigrants) who lack language skills, particularly with regard to existing health promotion and prevention programs (MacKinnon and Lee, 1999; Campbell, 1999; Weerasinghe, 1999). As the study by WCH (1999) on Well Women's Clinics noted, ethnic groups are among those most likely to under-utilize preventive health, and information gaps are likely to be an important barrier in this regard.

Conclusion

We conclude this report by highlighting existing gaps in our understanding of the roles that ethnicity and income play in determining the accessibility to health care in the Atlantic provinces, and by suggesting a number of areas where future research would be very useful in enhancing that understanding.

Knowledge gaps

The literature is spread out thinly over a whole range of topics relating to ethnicity and income status as they relate to health care accessibility. This reflects the small overall volume of the literature. As a result, there appears to be a critical gap in research-based knowledge regarding health care accessibility from the point of view of disadvantaged sub-populations in Atlantic Canada. The academic literature on Atlantic Canada is particularly sparse, although there has been fairly extensive work done for other parts of Canada, and indeed in other countries. Many of the research initiatives on issues related to ethnicity and social-economic status in the context of health care have come from regionally-based organizations like the Maritime Centre of Excellence for Women's Health.

- We need more information on the health problems and needs of ethnic minority populations, especially the newer ones. As noted in the report, the fact that new ethnic minorities constitute a small proportion of the provincial population is precisely why they can become marginalized, especially those who belong to low-income groups, if health care policy is not informed about these sub-populations. That older minority groups continue to have difficulties with public health care provision warns against complacency.
- There is a clear lack of information on the gender aspects of health care accessibility. Much of the existing literature relates to only to women. A gender perspective might be especially important for understanding the health care access of both groups, and especially ethnic groups whose cultural values differ from those of the dominant cultures.
- The health care access problems of low-income, rural groups, including ethnic minorities, need more extensive documentation, especially with regard to home care, and the potential for new communications technology such as tele-care that has been used in New Brunswick and Nova Scotia to reach remote communities.
- Although various health policy initiatives aimed at marginalized groups in the Atlantic provinces have been taken, we know little

about how they have been doing, the problems they face and how they have adapted to those problems. Reports of the type put out in the context of the Well Women's Clinics in Prince Edward Island would be especially useful.

Directions for Future Research

Since the purpose of building research-based knowledge is to inform policy, it is imperative that the knowledge base be adequate. In the context of health care accessibility of various ethnic groups and those with low income in Atlantic Canada, we have noted a critical gap in the knowledge base. In order to reduce this gap, the future agenda for research needs to be directed towards the following:

To build a critical mass of research-based literature on the subject of ethnicity, low-income and geographical location as they relate to health care accessibility in the Atlantic provinces. This requires a strategic investment in health-related research. The urgency of this requirement is especially highlighted by the fact that (i) the newer flows of immigrants to the region are not from the traditional sources (Europe and the United States) but from Asia and Africa, with significantly different cultural attitudes and values; and (ii) that there is considerable research on these as well as other minority groups being conducted in other regions of Canada. There is therefore a danger that Atlantic Canada would lag behind without a strong commitment to the creation of research-based health knowledge in the region.

The specific types and areas of areas of research where gaps are critical:

- We need more systematic quantitative and qualitative work on the determinants of health care accessibility across the broad spectrum of health care products and services, and to disentangle more definitively the links between income status, location and ethnicity, and health care usage.
- As part of this broader research effort, we need information on the varying health problems and needs of ethnic minorities, especially the newer ones, paying attention to the role of gender.
- The special problems of access to health care by low-income populations, especially those with minorities (e.g., Acadians, Blacks and Aboriginals), also need further documentation.
- The emerging problems of home care in general, and how they relate to low-income and/or rural households, with special attention to the gender dimensions would appear to be important items on any research agenda.

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Appendix A

Comparative Statistical Indicators

	Canada	NFLD	PEI	NS	NB
GDP per capita, 1998 (1992 \$)	27712	19775	19752	21019	20945
Population (000) share (%)	28528.1	547155	132855	899970	729625
Aboriginals	2.8	2.6	0.7	1.4	1.4
Visible Minorities	11.2	0.7	1.1	3.5	1.1
Immigrants	17.4	1.6	3.3	4.7	3.3
European	8.2	0.9	1.7	2.5	1.6
United States	0.9	0.3	1	1	1.2
Other	8.2	0.4	0.6	1.2	0.5
Non Immigrants	82.6	98.4	96.7	95.3	96.7
% who can speak official languages					
Only English	67.1	96	88.9	90.4	57.3
Only French	14.3	0	0.1	0.2	10.1
Both	17	3.9	11	9.3	32.5
Neither	1.7	0.1	0	0	0.2
% with education					
Less than 9 years	12.1	17.5	13.3	11.1	16.5
9-12 years	37	37.8	38.7	37.8	38.6
Post secondary (non university)	28	26	25.9	27.7	24.9
Post secondary (university)	23	18.8	22.1	23.4	20
Median income (\$)					
All	18891	13972	15931	16000	15211
Visible minorities	-	15193	12090	12675	12993
Unemployment rate (%) 1999	7.6	16.9	14.4	9.6	10.2

Table 1:

A Statistical Profile of Atlantic Canada

Source: Compiled from statistical tables at www.statcan.ca, and Statistics Canada 1996 Census files. Unless explicitly indicated, all data are for 1995.

% who say they have . . .	Canada	NFLD	PEI	NS	NB
Excellent health	26	23	24	23	21
High psychological satisfaction	9	11	15	10	9
Job satisfaction	50	53	55	54	58

Table 2: The Well-Being of Atlantic Canadians

Source: Federal, Provincial and Territorial Advisory Committee on Population Health, Report on the Health of Canadians, 1996.

Table 1:

Ad Hoc Committee for Persons with Disabilities in Health Care (1995). Piecing Together the Health Reform Quilt Halifax, NS: Dalhousie University, Department of Psychology.

This report is based on the findings of the Ad Hoc Committee for Persons with Disabilities in Health Care, which held Town Hall Meetings across Nova Scotia in order to solicit input for health reform from persons with disabilities. Their recommendations are outlined in the executive summary on pages ii to iv.

Barksdale, C., Willis, S., Davidson, K., van Roosmalen, E., Loppie, C., Kirkland, S., Unruh, A., Stewart, M. and Williams, D. (1999). Women's Definitions and Priorities of Health. Report prepared for the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

This study seeks to learn about women's experiences of health, their perceptions of health and the meaning of health in their everyday lives. It was particularly interesting how definitions and determinants differ between women of different ethnic groups. The study utilizes data collected through telephone interviews of 458 Nova Scotian women (including 81 Aboriginal and 75 Black women). The report's empirical findings on ethnic differences in response to various health-related questions are documented. For instance, it is found that significantly more Caucasian/European women rated nutrition, mental status and environment as having a positive influence on their health.

Beaudin, M., Boudreau, R. and deBenedetti, G. (1996). New Canadian Perspectives: The Socio-economic Vitality of Official Language Communities. Ottawa: Minister of Public Works and Government Services.

This report is a comparative study of the minority Acadian communities of Prince County, Prince Edward Island, and the Anglophone minority of the Gaspé peninsula and the Magdalen Islands. The report discusses in detail the socio-economic characteristics of the two regions, and then reports its findings from surveys conducted in the region to assess how each minority participates in local economic development, and how they contribute to the economic well-being of the local, regional and national economies. The authors note that the largely Acadian Francophones have a much lower socio-economic status than the majority, and that they are much more dependent upon government transfers. The Anglophone minority in the Gaspé is also located in a depressed region by national standards, and on certain socio-economic indicators, they do worse than the Francophone majority.

Borsellino, M. (1998). New Brunswick Losing Its Physicians to Other Provinces: Despite What You Think, We Do Have Vacancies. Medical Post, 34, 48.

This newspaper article reports on the problems of meeting the shortage of doctors in New Brunswick, and the urgent need for funding to recruit and retain the doctors it needs, especially in the areas where shortages are particularly severe (e.g., the Acadian peninsula, Bathurst, Andover and Perth, and Chaleur).

Canadian Council on Multicultural Health (1999). Health and Cultures: It's Time for Action. Newsletter of Canadian Council on Multicultural Health, 14(1).

This newsletter put out by the Canadian Council on Multicultural Health has four short essays, three of which deal with the accessibility to health care by ethnic minorities: the first essay, "Lost and Forgotten: Urban Aboriginal Problems with Disabilities" is based on some national statistics; the second essay, "Affirming Immigrant Women's Health: Building Healthy Public Policy" reports on a qualitative study of immigrant women on Prince Edward Island; and the third essay "Hearing the Voices of the Ethnic Community in Health and Health Care: A Community Perspective" addresses the problem of lack of representation of ethno-cultural communities at the policy-making level of health care in Nova Scotia.

Campbell, J. R. (1999). Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces. Halifax, NS: Health Promotion and Programs Branch, Atlantic Regional Office, Health Canada.

This Health Canada report looks at issues regarding sexual and reproductive health in the Atlantic region. It notes that HIV/AIDS cases for Aboriginal people are difficult to determine because of a lack of identifying ethnic status at health care facilities. It goes on to argue that this is a particular problem for natives residing in urban areas because they are considered “invisible” to health care providers. It also notes the lack of support, information and organizations available to ethnic groups regarding their needs, whilst also noting the work of Aboriginal groups in providing resources to their own people. In addition, the report discusses rural problems and the lack of access to services in the area of sexual and reproductive health.

Campbell, J., Bruhm, G. and Lilley, S. (1998). Caregiver’s Support Needs: Insights From the Experiences of Women Providing Care in Rural Nova Scotia. Report commissioned by the Maritime Centre of Excellence for Women’s Health. Halifax, Nova Scotia.

This qualitative and participatory study of 46 caregivers, which included Blacks, Aboriginals and Acadians, noted the need to value the work of caregivers, to improve their support and service needs, and the problems associated with rural location (e.g. transportation). The bulk of caregiving responsibilities in the family fall to women, who often have to give up jobs to provide care, since they are effectively working all day, seven days a week. Rural caregivers feel that the government needs to direct more resources to community care, as the shift from institutional to community care takes place.

Colman, R.G. (2000). Women’s Health in Atlantic Canada. A Statistical Portrait. Halifax, NS: Maritime Centre of Excellence for Women’s Health.

A statistical review of existing data regarding indicators of women’s health in the Atlantic provinces. Its major findings were that the determinants of health, education, physical fitness, income, etc., are all interrelated. Thus investment in one sector such as increasing income levels or support services for single mothers would bring about a positive change in their health patterns whilst also impacting on health care utilization levels. It also looks at the health impacts of low income. Higher rates of hospitalization and health service usage are noted among low-income groups.

Commission on Selected Health Care Programs (1989). Report of the Commission on Selected Health Care Programs. Fredericton, NB: Government of New Brunswick.

A somewhat detailed but comprehensive report on the health care system in New Brunswick. The report does not specifically address low-income or ethnic consumers, but it does have a section that deals with trends and variations in patterns of use in urban and rural areas.

Community Health Centre Working Group, (1993). Community Health Centre Working Group Report. Submitted to P.E.I. Health Transition Team.

This document summarizes the Prince Edward Island Community Health Centre Working Group recommendations. There is nothing in this report that deals specifically with income or ethnicity.

Conrad, Margaret (1998). Women, Work, and Well-Being in Atlantic Canada. Conference Report, Mount Saint Vincent University, Halifax, Nova Scotia, April-May.

This report stems from a conference and briefly transcribes the main points of the speakers in attendance. Of particular significance is Iona Crawley’s description of a video project that documented the Black experience of violence against women. It goes onto argue that Black women are less likely to go to shelters because of feeling uncomfortable in all-white facilities, and are less likely to be screened for breast cancer. Crawley argues that Black women “in the Atlantic region have relied more on the informal

community structures to manage health, child and elder care and therefore do not benefit from public institutions that are geared to the average women.”

Dale, Linda (1988). Women’s Health Education Project: An Evaluation. Report for the Atlantic Office of the Health Promotion Directorate, Health and Welfare Canada.

This dated report covers 57 communities in Newfoundland and Labrador and evaluates a participatory health education project that looked at women’s perceptions of health care. It is a fairly dated and broad study that is really focused on the style of the project (i.e., how well did it work), although it gives a reasonably detailed contextual overview. It documents (with some charts) women’s responses to questions regarding what they see as health problems in their communities.

Department of Health and Social Services (1990). The Aging Impact Study. Report of the Ad-Hoc Committee, Charlottetown, Prince Edward Island.

This report studies the impact of an aging population on government manors, hospital services, private nursing homes, community care facilities, home care, and support programs on Prince Edward Island. The report includes a number of recommendations vis-à-vis both the formal and informal health care system.

Department of Health and Social Services (1999). Prince Edward Island Highlights: Second Report on the Health of Canadians. Charlottetown, PE: Document Publishing Centre.

This report provides an overview of the health of the population on Prince Edward Island. The report identifies some areas of concern: Prince Edward Island has high rates for asthma and other respiratory diseases; women have the lowest rate of pap smear screening in Canada, and a correspondingly higher rate of cervical cancer; life expectancy is the lowest in Canada, as are the rates of physical activity and blood pressure testing. Page 17 of the report provides a good summary.

Doucet, C. (1997). Grant Given to Help Women’s Health Group. The Chronicle Herald, Feb. 27, p. A11.

Newspaper article reporting on a grant given to help the Black Women’s Health Program in Halifax to increase knowledge about health.

Enang, J.E. (1999). The Childbirth Experiences of African Nova Scotian Women. Master’s of Nursing dissertation, Dalhousie University, Halifax, Nova Scotia.

This dissertation explores the childbirth experiences of African Nova Scotian women within the Nova Scotian health care system, with a view to document the effects of racism on those experiences so that health care providers and policy makers can provide health care more efficiently to Canadians of all races. Based on the participatory action research methodology used, the author concludes that, amongst other things, Black women lack access to health care services, that there is a lack of information on Black health issues and of culturally sensitive care at both the individual and institutional level, and that racism exists within the health care system in Nova Scotia.

Federal, Provincial and Territorial Advisory Committee on Population Health (1996). Report on the Health of Canadians. Ottawa: Health Canada.

This first of two reports was prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health. According to Health Canada, “This report provides an opportunity to communicate with the public about the current health status of Canadians and the factors that influence their health. It is also intended to serve as a tool to help policy makers, health workers, and the public measure Canada’s progress in achieving better overall population health and to identify actions that can be taken to make continued improvements.” The report contains a section called: “Are the factors that influence health

shared equally by all Canadians?” which disaggregates the findings on a provincial level, and briefly discusses low-income and Aboriginal Canadians.

Federal, Provincial and Territorial Advisory Committee on Population Health (1999). Towards a Healthy Future: Second Report on the Health of Canadians. Ottawa: Health Canada.

This second report is structured in much the same way as the first. More up-to-date statistical information is provided, and provincial level statistics are provided in Appendix B.

Fraser, R. (1998). The Black Women’s Health Project. Phase V, Report submitted to the Maritime Centre of Excellence for Women’s Health, Halifax Nova Scotia.

This report provides an overview of the Black Women’s Health Program (BWHP) which began in May 1996 as an initiative of the North End Community Health Centre. The mandate of the BWHP is: “To promote holistic health in Black communities of the Halifax Regional Municipality, specifically as it relates to the Black women, with an emphasis on all the determinants of health...” The program has had five phases, which are summarized in the report.

Globerman, S. (1998). Immigration and Health Care Utilization Patterns in Canada, Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis, Working Paper # 98-08.

A report on the usage rate for health care services amongst different ethnic groups in Canada as a whole. It provides a statistical profile of health care utilization by immigrant groups. It concludes that there are no significant differences in the utilization of health care services between immigrant and native-born Canadians, and thus the utilization rates for immigrants cost no more than for the native born.

Government of New Brunswick. Issues and Recommendations: First Nation Services, <http://inter.gov.nb.ca/hcs-ssc/english/publications/hsrc/5/firsnati.htm>.

Report of the Health Services Review Committee about problems regarding the health programs and services directed towards First Nations people. Includes recommendations.

Grypma, S. (1993). Culture Shock. The Canadian, September, 33-36.

The article points to the need for those in the nursing profession in Canada to understand cultural differences that now exist in Canadian society, as increasingly new Canadians come from non-European backgrounds. The article provides many examples of how the values and behaviours of peoples from the many cultures that are now part of the Canadian mosaic differ.

Gushue, J. (1994). Hard, Hard Times Again: MDs Search to Find a Way Out of Newfoundland’s Unimaginable Crisis. Canadian Medical Association Journal, 151(3), 341-344.

General article that considers the impact of the close of the Newfoundland fishery on the local community and how that will impact on doctors and the kinds of problems that will have to be faced. The main focus of the article is on the impact on doctors of increasing levels of community mental health problems.

Health Transition Team Prince Edward Island (1993). Partnerships for Better Health, Charlottetown, Prince Edward Island.

This document summarizes the recommendations of the Health Transition Team Prince Edward Island on how to implement the Health Task Force Report (1992) recommendations. There is nothing in this report that deals specifically with income or ethnicity.

Health Canada (1999). Canadian Research on Immigration and Health. Ottawa: Health Canada.

This document summarizes research on immigration and health in Canada. The research identified a

number of main themes and remaining gaps in immigration health research, including: “a predominance of material on health determinants... yet there are significant gaps in knowledge; evidence for considering the immigration experience itself as a health determinant; a need for more gender analysis in immigration health research; a wide scope for additional research related to health system support and renewal; a need for an immigration perspective on management of risks to health; little focus on the strengths of immigrants or their positive effect on the health care system; a need for a focus on immigrant sub-populations.”

Jones, J. (1996). We Can't Afford to Undermine Health of Canadian Black Women. The Chronicle Herald, May 16, p. C2.

Newspaper article outlining African-Canadian health care needs in the context of cuts to health care in Nova Scotia. It points to the feeling among Blacks that their illnesses do not get the same priority as sickness in the majority community, and notes the lack of documentation on the diseases and conditions that affect African Canadians. It notes the positive aspects of the Black Women's Health Project in this situation.

Kephart, G., Thomas, V.S., and Maclean, D.R. (1998). Socio-economic Differences in the Use of Physician Services in Nova Scotia. American Journal of Public Health, 88(5), 800-803.

This article summarizes the results of research that examined the socio-economic differences in the use of physician services in Nova Scotia. The socio-economic differences were estimated and adjusted for age, sex and region of residence. The article concluded that the “use of physician services is inversely associated with socio-economic status.”

LeBlanc, S. (1996). Curing Mi'Kmaq Health Ills: National Survey First Step. The Chronicle Herald, October 1, p. A2.

A newspaper article reporting on a health survey (which is part of a national Aboriginal health study) that will be carried out in Nova Scotia's Mi'Kmaq reserves.

LeBlanc, J.C. (1996). Women's and Children's Health in Nova Scotia. Report of the Population and Health Research Unit, Dalhousie University, prepared for the Partnership Development Program of the IWK Grace Health Centre, Halifax, Nova Scotia.

This report contains a general overview of the state of women's, children's and families' levels of health. Charts and graphs are used to highlight various aspects of health status, such as infant mortality, breast cancer rates, types of illness by county, hospitalization by county, etc. The report does not contain information on ethnic or low-income groups.

Lomas, J. et al. (1997). Devolving Authority for Health Care in Canada's Provinces, Canadian Medical Association Journal, 156(4), 513-520.

This study is based on the findings of a mail survey designed to obtain information on the socio-demographic background, training, experience and activities of the members of boards of devolved health care authorities. The study concluded that the “board members are most likely to meet the expectations of provincial governments. Fewer appear well equipped to accommodate the views of their providers and even fewer to incorporate the perspectives of their community”.

Mabaleka, W. and Thomason, M. (1999). Report on Service Delivery for African Immigrants. Sponsored by the African Canadian Services Division of the Department of Education and Culture, Government of Nova Scotia, Halifax, Nova Scotia.

This study explores a wide range of issues impacting on the delivery of social services by African immigrants. A section on accessibility to health care notes problems of access, including racism.

MacKinlay, S. (1999). Mental Health, More Access: Services Consolidated in Central Region. The Daily News, February 16, Halifax, Nova Scotia. p. 6.

This article reports on the setting up of a restructured mental health administration in the central health region of Nova Scotia; briefly highlights the problems that currently exist; and doctors being unaware of what mental health services are available in their area. It also notes the lack of government resources as still being a major factor in the provision (or lack thereof) of services.

MacKinnon, M. and Howard, L.L. (1999). Affirming Immigrant Women's Health: Building Healthy Public Policy, Final Report to the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

This qualitative study, based on a study group of immigrant women from Prince Edward Island, used an exploratory descriptive design to uncover immigrant women's perceptions of health, their experience with health, and the significance of gender and the health care provider. They find that language and the ability to communicate were significant problems, that immigrant women indicated a need for professional interpreters trained in health terminology, and showed a preference for female doctors. They also felt that support systems, socio-economic factors and personal health practices were also relevant factors in maintaining good health.

Martel, R. (1995). Rural Medicine Needs Help. Canadian Family Physician, 41, 974-976.

Looks at the impact on rural physicians of dwindling population base and fewer resources being directed at rural communities. It argues that changes need to be made that will allow for the retention of existing doctors and efforts redoubled to attract new ones.

Mcleod, C. (1998). NB Physicians Call for Government to Address Shortages in Rural Services. Medical Post, 34, p. 50.

This newspaper article reports on the call by two prominent physicians in New Brunswick for major changes in the health care system to address the long waiting lists for access to many services. Among other things, the physicians suggest that government should address issues of physician resource planning, access to care and the strengthening of rural medicine. The need to fund more positions in medical schools is also indicated.

Mcleod, C. (1999). Wholesale Changes Urged for NB Health. Medical Post, 35, 1 & 56.

This newspaper article reports on the long-awaited Health Services Review Committee Report on health care in New Brunswick. The report calls for sweeping changes to almost every aspect of health delivery, contained in 122 recommendations to deal with chronic physician shortages, to develop alternate payments schemes, and to stay out of micro-management of health care. The report notes that Dalhousie University in Halifax is not providing medical education that meets the needs of rural practice in the province.

Miedema, B. (1999). Barriers and Strategies: How to Improve Services for Abused Immigrant Women in New Brunswick. Research paper for the Muriel McQueen Fergusson Centre for Family Violence Research, University of New Brunswick.

This paper "attempts to document some service needs and explores ways to improve services to abused immigrant women in New Brunswick", a province with few immigrants. The interplay of cultural norms and structural oppression is a profound barrier to services for abused immigrant women. It notes that the most important change needed is that abused immigrant women are assured that they would be treated with respect and understanding, regardless of country of origin, religious or cultural background.

Morris, M., Robinson, J., Simpson, J., Galey, S., Kirby, S., Martin, L. and Muzychka, M. (1999). The Changing Nature of Home Care and Its Impact on Women's Vulnerability to Poverty. Ottawa: Status of Women Canada.

This extensive study, drawing upon three case studies in Winnipeg, Ottawa and St. John's looks at the role of women as home care providers and how the current policy of home care in Canada impacts on women. Among other things, they find that women provide the bulk of home care (without compensation); that wages are low, leading to low standards of care, problems of access to home care for ethnic groups such as Aboriginals on reserves, especially those with HIV/AIDS; and the lack of culturally sensitive services.

Nova Scotia Council on Multicultural Health. (1996) Multicultural Health Policy: An Exploration and Analysis in Nova Scotia. A report submitted to Canadian Heritage. Halifax: Nova Scotia Council on Multicultural Health.

The purpose of this project was to explore at the policy level how hospitals and health care agencies are addressing the health needs of clients from culturally diverse groups. The report contains recommendations to the Nova Scotia government and health care agencies to initiate systematic changes in the health care system to provide accessible, equitable and responsive health care to members of culturally diverse groups. The report also situates the Nova Scotia context within a review of multicultural health care practices and policies across Canada (3 provinces had multicultural health care policies, and 4 provinces have put mechanisms in place to respond to health needs of culturally diverse communities). The project collected data from health services staff and managers about their collection of culturally relevant data. Cultural ethnic origin was reported to be collected in 27% of the cases, and socioeconomic status data was collected 30% of the time (N=100 staff and managers in Nova Scotia). This data was collected to demonstrate the need for a multicultural health policy in Nova Scotia.

Pereira, J. (1999). Access to the Environment: Exploring Links between the Perception of Access to Ethnomedicine and the Well Being of the Mikmaq Community of Indian Brook, Shubenacadie. Project funded by the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

This project proposes to answer the question: What is the perception of accessibility to the environment and ethno medicines among indigenous people living on the Indian Brook Reserve in Shubenacadie and in Nova Scotia? What are the implications of their perceptions for this sense of well-being?

Reamy, J. (1995). Health Service Regionalization in New Brunswick, Canada: A Bold Move. International Journal of Health Services, 25(2), 271-282.

This paper covers the New Brunswick experience with reorganizing its health care delivery in terms of amalgamating the previous health boards into new regionalized centres. The central theme in this is to ensure regional goals are met. The paper's focus centres on the government's response and the creation of a new health board structure. No specific mention is made to income, ethnicity or access.

Richard, J. and Jagielski, M. (1999). Hearing the Voices of the Ethnic Community in Health and Health Care: A Community Perspective. Health and Cultures, 14(1).

This article discusses the lack of ethnic representation on community and regional health boards, and then reports on a project that sought to train representatives from the ethnic community in health-related matters so that they could then go and share that knowledge with members from their own community. It finds that the main barrier to meeting the health care needs of ethnic communities is a lack of knowledge about how the health care system actually operates, of ethno-cultural representation on the respective health boards, and the inadequacy of the training given to health care professionals regarding the health concerns of ethnic and culturally diverse communities.

Roos, N.P., Bradley, J.E., Fransoo, R. and Shanhan, M. (1998). How Many Physicians Does Canada Need to Care for Our Aging population? Canadian Medical Association Journal, 158(10), 1275-1284.

This article examines changes in the physician supply between 1986 and 1994 and assesses the availability of physicians in 1994 relative to population growth and aging, and relative to supply levels in the benchmark province (Alberta). This is examined at the provincial and national level. It finds that there is no serious threat of shortages of physicians in general, nor to most specialized groups.

Robb, N. (1995). Physicians Remain Sceptical as Metamorphosis of Health Care Continues in PEI. Canadian Medical Association Journal, 153 (8), 1155-1159.

This article discusses how Prince Edward Island has restructured its health care system by dismantling former decision-making bodies and establishing provincial and regional health boards and a policy council. The article does not contain anything specific about low-income or ethnic consumers.

Skinner, E. (1998). Meeting the Health Needs of a Culturally Diverse Nova Scotian Population. Written in conjunction with the Nova Scotia Department of Health and the School of Health Services Administration, Dalhousie University, Halifax, Nova Scotia.

This paper considers the extent to which race and ethnicity are currently addressed in health research and policy in Nova Scotia. Overall, while it recognizes the absence of a strong body of research and literature on the topic, it does provide a contextual synopsis of health, culture, and social factors to provide an excellent overview for some of the main issues of race and access to health care. It also provides a snapshot of the current health status of Nova Scotia Blacks, Aborigines, and immigrants, and discusses barriers to and utilization of health services and programs. It mentions some of the positive initiatives that have been undertaken to address these problems.

Snow, C. (2000). Reflections on Social Investment in the Acadian Peninsula Region. In, NB Reference Group Social Investment: Appendices, A Working Document, Prepared for the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

This paper discusses the crisis in the Acadian peninsula, resulting from repeated budgetary cuts, which are being accompanied by other socio-economic problems such as illiteracy, unemployment and the exodus of youth. Cuts to unemployment insurance have brought much hardship, and the economic disparity between the region and other parts of the province have become striking. Social values have been eroded, and the State has left the private sector and the community to provide security for its citizens. The paper talks about various initiatives that have been successful since they have been adapted to needs and attitudes of the people of the region, and points to directions social policy needs to take to revive the region.

Social Policy Advisory Committee (1997). Volume II: Investing in People and Communities: A Framework for Social Development. Department of Social Services, Government of Newfoundland and Labrador.

This report deals with a wide range of social issues in Newfoundland and Labrador. A one page section deals specifically with health care, outlining the problems of the health care system, noting specifically the problems of access for low-income persons, especially those located in rural areas.

Statistics Canada (1996). Health Reports, 7(4).

This document is a compilation of, *inter alia*, four research articles based on Statistics Canada's National Population Health Survey. Of these four articles, the most germane is one titled "The Health of Canada's Immigrants in 1994-95". This article shows that "recent immigrants, particularly those from non-European countries, tend to have fewer chronic conditions and disabilities than the Canadian-born population. However, among those in Canada for a decade or more, this 'healthy immigrant effect' is less

pronounced.

Statistics Canada (1991). Language, Tradition, Health, Lifestyle and Social Issues, 1991 Aboriginal Peoples Survey. Ottawa: Statistics Canada.

This is a statistical document that contains tables on a number of key health-related indicators for Aboriginal peoples in the Atlantic provinces.

Task Force on Government Services to the Nova Scotian Black Community (1996). Task Force on Government Services to the Nova Scotian Black Community. Halifax, Nova Scotia.

This document summarizes the findings of the Task Force on Government Services to the Nova Scotian Black Community. Included in the report is a section on health which discusses, *inter alia*, AIDS/HIV, seniors and persons with disabilities. It notes that the cost of medical services such as Pharmacare is difficult for many low-income Blacks to bear. It also notes the problems of seniors, especially in rural areas, where access to home care is limited.

Task Force on Aboriginal Issues (1999). Report of the Task Force on Aboriginal Issues, http://www.gov.nb.ca/OP_CPM/task/task.htm.

This report summarizes the findings of the New Brunswick Task Force on Aboriginal Issues. It covers a broad range of issues, however only one paragraph is devoted to health. "Many First Nations have developed health centres in their communities...have made great strides in addressing health concerns such as diabetes, proper nutrition etc., there remains a great need in many communities to find solutions to substance."

Thomas, C.G. (1996). AUBANS Women's Institute: Family Violence Workshop Action Plan. Report by CGRT's Consulting, Nova Scotia.

Report from the African United Baptist Association of Nova Scotia "Violence Against Women" Workshop (96) Committee. Among other things, the report identifies the need for 'safe houses' in urban centres in Nova Scotia for Black women who are victims of family violence, for education programs to reduce such violence, and for government to support on-going efforts to eliminate violence.

Thomas Bernard Consulting (1999). Including Black Women in Health and Social Policy Development. Project funded by the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

A contract to conduct participatory action research aimed at "understanding the barriers that Black mothers with addictions face when their addiction interferes with their ability to effectively parent their children, and a child welfare agency becomes involved."

Thompson, K. (1993). Self-Governed Health. The Canadian Nurse, September, p. 29-32.

This article covers the issue of health care delivery for native peoples. It takes a broad approach arguing that Band-controlled health care can potentially offer better service and use of resources. However, it also mentions some of the pitfalls in adopting a system that is still structured in a non-native approach such as misappropriation of funds, and conflicts with differing styles of governance. It ends with some recommendations for addressing these concerns such as more native nurses and listening to the needs of the native community.

Townsend, E.A., Anderson, S.C. and Jenner, S. (1988). Developing Rural Health Services: An Occupational Therapy Case Study. Canadian Journal of Public Health, 79, 92-96.

This article looks at the provision and delivery of community occupational therapy health services in rural Nova Scotia from the perspective of what would be the most effective strategies for the development of

this rural community health service.

Travers, K. (1995). Using Qualitative Research to Understand the Socio-cultural Origins of Diabetes among Cape Breton Mi'Kmaq. Chronic Diseases in Canada. Health Canada, 140-143.

This article describes the design, data collection approaches, and the preliminary findings of a qualitative research project aimed at developing an understanding of the socio-cultural factors underlying the high incidence of diabetes among the Mi'kmaq of Cape Breton, Nova Scotia. The study indicates that many participants in the study expressed concern over their ability to buy nutritious foods given their low-income status, and noted that some participants found the diabetes education offered in hospital-based clinics to be culturally irrelevant

Travers, K. (1994). The Social Organization of Inequities in Health: Cape Breton Micmac Communities and Diabetes Canadians. Research project undertaken by the Department of Human Ecology, Mount Saint Vincent University, Halifax, Nova Scotia.

A one-page description of a study to be carried out by the Department of Human Ecology at Mount Saint Vincent University. The study aims to clarify “the socio-cultural aspects of Aboriginal lifestyle which increase the risk of developing diabetes and affect treatment choices; and the social organization of health inequities evident in Micmac populations in Cape Breton, NS.”

Union of Nova Scotia Indians (1997). The Health of the Nova Scotia Mi'Kmaq Population. Report of a Health Survey, UNSI, Sydney, Nova Scotia.

This document highlights the results of a 1997 health survey on the general health of the on-reserve Mi'Kmaq population in Nova Scotia. Recommendations are included.

van Roosmalen, E. and Loppie, C. (1999). Women's Voices: Women's Perceptions of the Determinants of Health and Well-Being. Report prepared for the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

A participatory-based quantitative study that involved 50 women from across Atlantic Canada and included Aboriginal, Black, Acadian, Francophone, rural and low-income women. The study focused on learning about women's experiences, their perceptions and meanings of health. It argues that there exists a general lack of awareness regarding the social and cultural factors that influence health to ethnic or marginalized groups. It notes that a perception exists among the Black community of racial and social bias within the health care system. It argues that there is a general lack of awareness and sensitivity among health care professionals regarding Blacks, as well as Acadians and Aboriginals.

Verma B.S. and Verma, U. (1999). Ethnic Seniors in the Next Millennium and Their Concerns. Paper submitted for presentation at the Fourth Global Conference on Ageing, International Federation on Ageing, Montreal, Quebec.

This paper deals with the needs and concerns of aging Canadians who “inherently belong to religions and cultures greatly different from the dominant religion and culture”. The paper focuses on Canadians of East Indian origin in Nova Scotia, noting that seniors have problems of accessing the health care system because of language barriers, indifference, and religious and cultural insensitivity of service providers.

Weerasinghe, S. (1999). Equitable Access to Health Care, Promotion and Prevention by Immigrant Women in Nova Scotia, Canada. Project funded by the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

The objective of this project is to “increase awareness among immigrant women on already existing health promotion and prevention programs and also to increase the knowledge of health care providers and policy makers regarding ethno-culturally related diseases, health related quality of life, cultural and

religious beliefs”.

Wien, F., McIntyre, L. and Rudderham, S. (1999). An Exploration of the Stress Experiences of Mi'kmaq Female Youth in Nova Scotia. Project funded by the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

This research proposal by the Mi'Kmaq Health Research Group seeks to “to deepen our understanding of what lies behind the stress experience of Mi'Kmaq female youth with an eye to policy and program intervention.”

White, F., Dingle, J. and Pietrusiak, M.A. (1989). Socio-Demographic Study of Areas Served and Not Served by the New Brunswick Extra-Mural Hospital. Canadian Journal of Public Health, 80(6), 459-460.

This article discusses the question of accessibility to the services of the New Brunswick Extra-Mural Hospital, noting that unserved health care areas are more likely to be rural and be associated with higher levels of unemployment and lower levels of income. It also reports on other findings that suggest that Francophone health status and access to services may be worse than for the Anglophone population, particularly in northern and rural parts of the province. It also notes that Mic Mac communities have less access to the New Brunswick Extra-Mural Hospital and suggests that in part this is due to the historical reliance by this ethnic group on Federal government health services.

Wuest, J. (1992). Joining Together: Students and Faculty Learn About Transcultural Nursing. Journal of Nursing Education, 31(2) 90-92.

The article discusses a University of New Brunswick (Fredericton) initiative that involves incorporating transcultural nursing into a third year nursing course to emphasize the importance of understanding the role of culture in health and health practices, as North American society become increasingly multicultural. It discusses how the learning is useful when theory (classroom work) is combined with experience (field work).

Women's Health Coalition of P.E.I. (1999). P.E.I. Well Women's Clinics: A Case Study of Gender Specific Clinics to Increasing Screening Rates. Report prepared for the Maritime Centre of Excellence for Women's Health, Halifax, Nova Scotia.

The report states that “Increasing cervical cancer screening, other health promotion screening practices, and offering health promotion education plays a significant role in improving women's health.” Well Women's Clinics have been successful in increasing screening rates of ‘hard-to-reach women’. It contains an extensive bibliography relating to ethnicity and health issues in general.

Young, D.E. and Smith, L.L. (1992). The Involvement of Canadian Native Communities in their Health Care Programs: A Review of the Literature since the 1970's. Canadian Circumpolar Institute, University of Alberta, Edmonton, Alberta.

This report reviews the literature around Native people's experience with gaining health care services in Canada since the 1970's. In particular, it deals with such issues as the political and logistical aspects of getting drug rehabilitation programs for those in the James Bay area. It also argues that First Nation peoples are moving away from institutionalized health delivery to one that is either of their own making or one that they are involved with.