From Multiculturalism to the Intersections of Diversity:

What can we learn from health care?

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ABSTRACT

Elizabeth Stranger provides a concise review of ten years of health care service policy at the Children's and Women's Health Centre of British Columbia. The C & W's transition from one policy phase to the next, through various definitions of diversity, ends with the recognition of intersections as currently being the most useful approach. These evolving definitions reflect changes in attitude that serve to better meet the needs of Canadians using the health care system.

This article discusses the experiences of Children's and Women's Health Centre of British Columbia (C&W) in developing programs and services to ensure health service equity to the diverse populations it serves throughout BC. We have gone through three phases: a multiculturalism phase, a diversity and equity phase, and presently, an intersection of diversity phase.

C&W is an agency of the Provincial Health Services Authority. It is made up of British Columbia's Children's Hospital, British Columbia's Women's Hospital and Health Centre, and Sunny Hill Health Centre for Children. As a teaching hospital and major provincial resource, C&W has three main roles: patient care, education, and research. C&W's services include:

- caring for B.C.'s most acutely ill or injured children
- providing developmental and rehabilitation services to children throughout B.C.
- offering the full range of health services required by child- bearing women and their babies
- conducting research to advance health and care, supported by the B.C. Research Institute for Children's & Women's Health, which is operated in partnership with the University of British Columbia

Three Dimensions of Health Service Equity

Since 1994, C&W has aimed to achieve three dimensions of health care service equity for the patients and clients we serve.

- **Equity in Access** – that all people the agency is mandated to service have equal opportunity to access available services.
- **Equity in Service Quality** – that services are provided in such a way that all people the agency is mandated to serve receive the same quality of care.
- **Equity in Service Relevancy** – that the services available in a given locale meet the relevant health and health care needs of all people the agency is mandated to serve.

It is much easier, however, to formulate health service goals than it is to achieve them. Of particular interest is the way our original conception of diversity as multiculturalism has shifted over the years to the "intersections of diversity," and how, in so doing, how we have changed our approach.

Multiculturalism

Our original approach was established when we came into existence in 1996. Our first program name was Cross-Cultural Care. The interest in cultural diversity at C&W arose out of two interrelated, and now well-documented facts. First, while immigrants' health status is on average higher than the Canadian born when they arrive in Canada, it declines with length of residence. Secondly, immigrant and ethnocultural minority Canadians have a more restricted access to health service and are likely to receive lower quality health care than their Canadian born counterparts. Moreover, they are less likely to have services available to meet their specific health needs.

Our policy framework in this first phase was 'multiculturalism'. We identified our target groups as immigrants and ethnocultural minority groups. Our model of service delivery was support to individual patients and their families, and we

developed special support services for them. Our products were language and culture-specific volunteer visitors, cultural brokers, the development of cultural profiles, the provision of interpretation services and the translation of health education material into languages such as Chinese, Punjabi, Spanish and Vietnamese. In addition, several ethnospecific services such as the Asian Women's Health Clinic and the Somali Women's Health Project were initiated.

Diversity and Equity

In 1999, we made a formal shift away from multiculturalism to 'diversity and equity'. Our approach was based on the principles that had evolved in Canadian human rights jurisprudence since the coming into effect of the Charter of Rights and Freedoms in 1982. We moved away from developing and delivering special services, and our motto became "integrate diversity into all aspects of the organization." Our target groups became all the protected categories of the BC Human Rights Code (1996).

We developed and passed an organizational diversity policy based on the Four R's of Diversity – to recognize, respect, reflect and respond to diversity at all levels of the organization. We developed and passed a human rights and harassment policy. We developed the only employment equity program in public healthcare in BC, with five, rather than the traditional four, designated groups (adding lesbian/gay/bisexual/transgendered). We participated in the development of a regional planning framework for diversity, and the creation of a health services diversity lens.

Intersections of Diversity

The election of a new provincial government in May of 2001 with a mandate for health care reform led us to operationalize an 'intersections of diversity approach', and this remains the approach we work with to this day. At the heart of the intersections of diversity approach is the recognition that diverse communities share common concerns. It is these concerns that we must address. Here is a brief look at three examples.

Example one: Immigrants who are new learners of English, ASL-speakers, and people with low literacy, or developmental or learning disabilities represent diverse communities in many other respects. They all share a common concern, however, with regards to ensuring they have effective communication with their care providers. In the past, we might have developed special services, programs or training for each group. Today, it is more efficient and effective to create a strategy for effective communication that develops multiple resources within an integrated program: ASL and linguistic interpretation are contacted through one central number, training is provided on working with interpreters, and both linguistic and ASL interpreters are present. Staff receive in-services on 'working with support persons' as part of the health care team, and the support persons can provide a range of possible supports.

Example two: We discovered that very few staff found cultural profiles useful. After some discussion, we learned that staff need information that is more specifically related to their clinical needs. A key issue for many clinicians is assisting patients with food choices. We are developing a workshop on foods for women in the perinatal period, including a question-guide to assist providers to elicit information from patients about the foods they would prefer to eat.

Example three: Admitting information usually asks for the mother's and father's information. Not all families, however, have a mother and a father. In aboriginal families, a tradition of 'adoption' whereby children live with another female relative (aunt, grandmother) is common. In gay and lesbian families, both parents are of the same sex. Changing forms so that they use neutral language such as parent and/or guardian allows for a more inclusive approach to admitting children to the hospital or emergency ward.

These three examples show how useful an intersections approach can be. As we strive to recognize diversity and achieve service equity, we are continually challenged to be creative. It is part of the larger, on-going challenge to ensure that health systems meet people's needs and not the other way around.